Consumer Information Guide

Health Insurance and Managed Care Plans in Massachusetts

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

GREGORY BIALECKI
SECRETARY OF HOUSING AND ECONOMIC DEVELOPMENT

BARBARA ANTHONY
UNDERSECRETARY OF CONSUMER AFFAIRS AND BUSINESS REGULATION

JOSEPH G. MURPHY
COMMISSIONER OF INSURANCE

ver. 10032012

TABLE OF CONTENTS

INTRODUCTION

We all know that good health is important. We also know that seeing a doctor even for routine preventive care can be costly. Medical care for a major illness or injury can cost more than most of us can afford on our own. Fortunately, you can get health care coverage to help manage these costs. In fact, Massachusetts law now says that if you live in Massachusetts and you are age 18 or over you must have a health plan.

You now have access to many types of health plans and many ways to buy a health plan. You also have certain protections and rights from the state and the federal government when you buy and use your health plan. This guide will tell you about the plans that you can get, the ways you can get them and your rights under the law.

This guide will tell you about health plans that cover hospital and medical expenses. These health plans do not pay for the cost of long-term care that is meant to help you to live independently. If you would like information about long-term care plans, please see the "Long-Term Care Guide" at http://www.mass.gov/ocabr/consumer/insurance/health-insurance/consumer-guides/long-term-care-guide/ or call 1-617-521-7794 to get a copy.

Many of the requirements discussed in this guide do not apply if your employer "self-funds" its health benefits plan. "Self-fund" means that the employer pays your health claims from its own funds and does not pay premiums to an insurance company. The employer decides the plan coverage, including employee eligibility, covered benefits and exclusions, employee cost-sharing and policy limits. Federal law exempts these self-funded plans from state insurance laws, so these plans do not need to include state mandated benefits. You can ask your employer if your health plan is self-funded.

There are many special terms that are unique to health care and health insurance. You will find a glossary at the end of this guide that explains many of the terms that are used.

SECTION I: HEALTH CARE SERVICES

1 - What Are Health Care Services?

Health care can mean any service, supply, equipment or prescription that you get to help you stay healthy. It includes preventive care (like your yearly check-up), care for an illness or injury, a hospital stay, surgery, visits to a doctor's office, lab tests and X-rays, and even prescription drugs.

You may make use of some other types of services to help take care of your health, like buying over-the-counter medicine or keeping track of your own blood pressure. In this guide, though, "health care" means only those treatments that you get from a trained and licensed health care provider, like your doctor or nurse practitioner.

2 - Who Provides Health Care Services?

Health care services include many services provided by different kinds of trained and licensed providers. These services can be in places like a hospital, a doctor's office or a health clinic. Under Massachusetts law, all hospitals must be licensed by the state. Other health care providers must be licensed by the state Board of Registration in Medicine or a related board. Your health plan may cover many of these providers, but remember that, depending on your plan, you may pay the costs if the provider is not in your health plan's network.

Appendix I, "Finding Health Care Providers," tells you about types of health care providers and the agency that you may contact to learn more about a provider.

3 - How Much Does Health Care Cost?

Depending on the health care you need and the treatment you have, your costs could be high. In general, the more services you get, and the more intensive the treatment, the more it will cost.

Massachusetts does not set the prices for health care services. Different providers may charge different amounts for a similar service. Many insurance companies negotiate the rates they pay to providers. If you are insured, you get the benefit of those negotiated rates. If you don't have insurance, you may have to pay a higher rate.

Inpatient care is the most expensive kind of care. Inpatient care is when you are admitted to a hospital. In 2004, the average cost of a hospital stay for a Medicare patient in Massachusetts was $4,474 per day.[1] Although most stays are short and some stays cost much less than the average, many can last a long time and cost more than this average.

1 Source: Massachusetts Division of Health Care Finance and Policy derived from 1998 Urban Institute report

Besides an inpatient stay, the average cost for some other types of care were:

- Urgent-care facilities - $225 per visit average;
- Emergency rooms - $800-$1000 per visit average; and
- Primary care doctor office visit - $80 - $100 per visit average. [2]

These are average costs and depend on the level of care you get, the number of times you get care and the type of doctor or provider you see. These costs also reflect the rates that the insurance company might pay. If you don't have a health plan, the cost of the services might be even higher than these averages.

"Long Term Care for the Elderly: Profiles of Thirteen States" based upon 1994 data "Long Term Care for the Elderly: Profiles of Thirteen States" based upon 1994 data.

2 Source: www.teladoc.com.

SECTION II: HEALTH PLANS

1 - Do I Need to Have Health Insurance?

Yes. Massachusetts has something called an "individual mandate." Under this law, if you live in Massachusetts and are age 18 or older you must have health insurance, and your health insurance must have certain basic benefits, called "minimum creditable coverage." [3]

To fulfill the individual mandate your plan needs to meet at least these "minimum creditable coverage" standards:

1. Covers prescription drugs (may have deductible of up to $250 per individual/$500 per family
2. Covers regular doctor visits and check-ups before any deductible
3. Caps any annual deductible at $2,000 for an individual or $4,000 for a family
4. If you have a deductible or co-insurance on core services, caps out-of-pocket spending for health services at $5,000 for an individual or $10,000 for a family each year
5. Has no cap on total benefits for a sickness or for each year; and,
6. Has no cap on spending for a stay in the hospital.

Also, any of the plans listed below will meet the minimum coverage standards:

1. A Young Adult Health Plan offered through the Health Connector
2. A High Deductible Health Plan that meets federal requirements for a Health Savings Account
3. A Commonwealth Care Plan
4. A Student Health Insurance Plan
5. A Medicare plan
6. A Medicaid plan
7. A Tricare plan
8. A medical care program of the Indian Health Service or of a tribal organization;
9. A state health benefits risk pool
10. A health plan offered under 5 U.S.C. 89
11. A public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701(c)(I)(I), as amended by Public Law 104-191
12. A health benefit plan under the Peace Corps Act
13. Any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996, as it is amended.

You may claim a Religious Exemption by contacting the Health Connector or as part of your Massachusetts income tax return.

3 Minimum Creditable Coverage standards are established by the Commonwealth Health Insurance Connector Authority ("Health Connector").

If you cannot afford health insurance that meets the standards, you can contact the Health Connector for a waiver. You can go to the Health Connector website at www.mahealthconnector.org for information and look at the Affordability Tool to help you decide if you might be able to get a waiver. If you get a waiver, you will not pay a penalty for being uninsured.

If you do not have a health plan that is minimum creditable coverage, you face monthly penalties. The penalties add up for each month without health coverage, and must be paid at tax filing time. Short gaps in coverage (up to three months) are allowed without a tax penalty. Penalties are based on ½ the cost of the lowest-priced Commonwealth Choice plan available. The penalties vary by age and income, based on percentages of the Federal Poverty Guidelines (FPG). People with incomes at or below 150% of the FPG do not have to pay a penalty if uninsured.

If you are not able to afford health insurance according to these standards, you will not be penalized. You also have the opportunity to file an appeal with the Health Connector asserting that hardship prevented you from purchasing a health plan.

2 - How Do I Get Coverage in a Health Plan?

To meet the individual mandate and protect yourself from high health care costs, you may want to join a health plan. If you work, your employer or union may offer a choice of one or more health plans as an employee benefit. If your employer does not help you pay for a health plan, you may be able to buy one through the Health Connector, a state agency that makes health plans available to individuals and small groups. You can also go directly to one of the companies that sell health plans to individuals in Massachusetts. You might also be able to get a lower cost health plan through the state if you meet income and other eligibility rules.

Employment-Based Coverage

If your employer or union offers a health plan, you will probably want to join that plan. Many employers pay part of the premium and may offer more choices than you could get on your own. If you do get your plan through your employer or union, they will choose the plans that they offer to you and they will buy the plan from the insurance company or managed care organization. You can then choose the health plan that is best for you from the choices offered by your employer or union.

Employers that buy health insurance must allow every eligible full-time employee to join any health plan that the employer offers. If the employer pays for a part of the premium, the insurance company must make sure that the employer does not pay more of the premium for higher paid employees than it does for other employees.

Large Employer Groups

Many employers (those with over 50 eligible employees) do not buy insured health plans from insurance companies. Instead they pay for health services from their own self-funded accounts. Although these employers may use insurance companies to process claims and handle other administrative tasks, the insurance companies are only Third Party Administrators. These plans

are called "self-funded" plans. They are not considered to be insured plans and federal law exempts them from state insurance laws. To find out if the state laws apply to your plan, you should ask your employer if your plan is self-funded.

Other large employers buy insured health plans from insurance companies. These plans must follow state insurance laws. This includes mandated benefits, eligibility rules and continuation of coverage protections. If the large group buys the health insurance in Massachusetts, the plan must follow Massachusetts insurance laws. However, a large group may buy the health plan in another state as part of their national plan and the group would then follow the laws of the state in which that plan was purchased.

Small Employer Groups

Many employers with between 1 and 50 eligible employees[4] include a health plan as part of the employee benefits package. In Massachusetts, sole proprietors are considered to be small employers and can buy the same small group health plans available to other small employers.

All small group plans in Massachusetts are "guaranteed issue" and "guaranteed renewable." This means that a company cannot turn down your application or refuse to renew your plan based on the amount or cost of services that you have used or may use. The company can only refuse to offer or renew a plan for certain reasons such as fraud or non-payment of premiums or may elect to nonrenew all of its health benefit plans delivered or issued for delivery to eligible small businesses in Massachusetts.

Individual Coverage

Directly from Carrier or Intermediary

If you do not have access to employment-based coverage that is "minimum creditable coverage," you may buy a health plan directly from an insurance company. Some companies require you to go through an intermediary. An intermediary is an entity that handles the enrollment and premium collection for the company. Insurance companies must offer the same health plans to individuals that they offer to small groups. If you are eligible for Medicare, you may buy a Medicare Supplement plan or Medicare Advantage plan directly from a company that offers that type of plan.

Through the Health Connector

If you do not work for an employer that pays at least 33% of your health plan premium, you can buy coverage from the Health Connector. These special plans are called "Commonwealth Choice."

If your family income is less than 300% of the federal poverty level, you may be able to buy a "Commonwealth Care" plan from the Health Connector. Massachusetts helps pay for the

4 A small group in Massachusetts must have at least 50% of the employees living in Massachusetts to be considered eligible to purchase a small group health plan.

Commonwealth Care premiums. This means that you pay a smaller premium or none at all, depending on your income.

If you are between the ages of 19 and 26, and are not eligible for subsidized coverage from your job, the Health Connector offers a Young Adult Benefit Plan for Massachusetts residents.

Go to www.mahealthconnector.org or call **1-877-623-6765** to learn more about all of these Health Connector plans.

Student Health Insurance Programs (SHIP)

If you are enrolled as a student in a Massachusetts college or university, you can buy a special health plan directly from your school. This Student Health Insurance Plan (SHIP) is designed for students and is only available while you are an enrolled student. Keep in mind that you must have insurance if you are enrolled at least ¾ of the time in a Massachusetts college or university. This is true whether or not you consider yourself a Massachusetts resident. You are not eligible for Commonwealth Care if you are required to purchase a SHIP or have coverage as a student.

Government Health Benefit Plans

MassHealth

MassHealth is a Medicaid program paid for by state and federal taxes for eligible persons. Please go to **www.state.ma.us/dma** or call **1-800-841-2900** to learn more about MassHealth.

Medicare

If you are over 65, or if you have a certain type of disability, you may be eligible for Medicare. To learn more about Medicare eligibility and benefits, call the Social Security Administration at **1-800-772-1213** or visit your local Social Security Office. TTY users may call **1-800-325-0778.**

Other Government Health Plans

The state and federal government provide lower cost health coverage for certain people through public health programs. This includes the Indian Health Services, Peace Corps, CommonHealth, HealthyStart and other programs. Please call **1-800-841-2900** to learn more about these programs.

3 - What Are the Types of Health Plans?

Many different types of health plans are sold in Massachusetts. This guide only tells you about health plans that offer comprehensive hospital and medical care coverage. The sections below will explain how these plans work.

Medical/Indemnity Plans (Open Choice or Open Network Plans)

These plans usually cover hospital and medical expenses for an accident or illness. These plans may only cover a fixed percentage of any covered cost. For example, the policy may say that the plan pays 80% of the usual and customary charge ("U/C") of a service and you must pay the other 20% plus the difference between what the provider charge and the U/C, if any. With these plans, you are covered for any licensed health providers.

Health Maintenance Organizations (Closed Network Plans)

These plans cover hospital, medical and preventive care. You are only covered if you get your care through a network of providers, except in the case of an emergency. With most HMO plans you pay a flat dollar copayment for covered services. However, some HMO plans also have deductibles, coinsurance and benefit limits.

Preferred Provider Plans (Different Levels of Benefits from Preferred Providers)

These plans usually cover hospital, medical and preventive care. Preferred provider plans have a network of preferred providers, but they also cover services for out-of-network providers. The benefits covered for preferred providers are usually greater than the benefits for out-of-network providers.

4 - What Is Covered in a Health Plan?

Your insurance company or your employer will give you an "evidence of coverage" certificate that tells you about your benefits. You may receive this certificate directly from the insurer, through your job, or through the internet. Not all health plans are the same, so you should read your certificate carefully. In order to get all of the coverage available to you, you should know your benefits and the procedures you must follow.

Benefits

It is important that you read your policy carefully so that you know the benefits and services that are covered under your plan. You should also know the benefits and services that are excluded from coverage. Massachusetts law requires that certain benefits be covered by all plans. However, apart from these required benefits, other services are only covered if they are specifically listed as a benefit in your plan certificate.

Health plans may have limits that apply when you first join the plan. Some plans have a pre-existing condition limit or a waiting period for enrollees over the age of 19 during which the enrollee is only covered for emergency treatment. According to Massachusetts law, insured plans may not have a pre-existing condition limitation of more than six-months. They may not have a waiting period of more than four-months. Also, if you were covered by another health plan before you joined and you did not have more than 63 days between plans, the time that you were in the other plan may reduce or eliminate the pre-existing condition limit or waiting period.

Keep in mind that even when your plan covers a service, you must still pay any cost-sharing. This means that you must pay for any deductibles, coinsurance or copayments that are part of your health benefit plan.

Dependents

If you have a health plan that covers dependents, you may keep your dependents on the plan until the dependent's 26th birthday. [5]

Newborn infants are covered on a family plan from the moment of birth. You must be sure to follow your insurance company's rules to add the newborn infant to the plan within 30 days of birth.

Continuation of Coverage

You may have the right to continue your group health plan when you no longer qualify for coverage through your employer. Some of the ways you can do this are:

COBRA

> You may choose to continue your group health plan under federal COBRA or state continuation of coverage laws. Depending on the reason that you no longer qualify for your former employer's health plan, you can keep that health plan temporarily after the date your coverage ends. However, you will probably need to pay as much as 102% or more of the premium. This includes any portion of the premium formerly paid by your employer.

Plant Closing

> If you do not choose COBRA, or if your COBRA coverage ends, you have a state-mandated 90-day eligibility period for continued coverage in the event of a plant closing or partial plant closing, as determined by the Commissioner of the Department of Labor and Workforce Development. This provision does not apply to HMO plans.

Involuntary Layoff or Death

> If you do not choose COBRA, you have a state-mandated 39-week eligibility period for continued coverage if you become ineligible for continued participation in a group plan because of involuntary layoff or death of the subscriber. Coverage is for up to thirty-nine weeks from the date of the ineligibility or until the subscriber, spouse and dependents become eligible for benefits under another group health plan, whichever comes first. However, you will probably need to pay the premium that the employer pays to the insurance company. This provision does not apply to HMO plans.

---

5 There is one exception, according to the federal Affordable Care Act, until 2014, grandfathered group plans do not have to offer dependent coverage up to age 26 if a young adult is eligible for group coverage outside their parent's plan. You can ask your company if your plan is a grandfathered plan. If so, according to state law you can extend the coverage to two years after the last year in which you (or your ex-spouse) claimed the dependent on your federal income tax return.

Divorced Spouses

If the subscriber does not choose COBRA, a divorced spouse must be allowed to stay on the ex-spouse's group health plan without additional premium, unless the divorce judgment has other terms. The divorced spouse can stay on the ex-spouse's group health plan until the remarriage of either the subscriber or the spouse, or until a time provided by the divorce judgment. If the subscriber remarries, the former spouse has the right to stay on the ex-spouse's group health plan on a rider to the family plan or through an individual plan. Either of these options may require additional premium rates.

Other Ways to Obtain Coverage

Although you may be able to continue your group coverage in one of the ways shown above, in Massachusetts, you can also join a plan from one of the companies offering individual plans or through the Health Connector.

5 - How Do I Use a Health Plan?

Massachusetts has certain protections for you if you have a managed care plan. Your health plan is a managed care plan if it has a network of providers or if it uses any "utilization review."

HMOs (Health Maintenance Organizations), PPOs (Preferred Provider Plans) and POSs (Point-of-Service Plans) are all managed care plans that use a network of providers. In an HMO plan, non-emergency care is covered only when it is provided or arranged by a network provider. In a PPO or POS plan, the plan covers medically necessary care from any health care provider, but usually pays more for services provided within the network.

Health plans use "utilization review" to decide if a service is necessary according to their medical standards. If they decide that a service is not medically necessary or appropriate to treat your condition, the plan may deny or reduce payments. For many health plans, this medical necessity decision is made before treatment. For other health plans, the decision is made when the company gets a bill from the provider.

If your insurance company decides that a service is not medically necessary, the insurance company must explain in writing the reasons for the decision. The company must also tell you that you have the right to file a grievance with them. If you file a grievance and they continue to deny coverage, you may appeal the decision to the Commonwealth of Massachusetts Office of Patient Protection.

Internal Grievance Protections

A managed care plan must allow you to file a grievance whenever they determine that a service is not medically necessary. You may file the grievance by calling, writing or faxing the grievance to the company. The company must send you a notice within fifteen days acknowledging receipt of the grievance. They must resolve the grievance within 30 business days - unless you agree to an extension. They must send you a written resolution of the grievance within 30 business days.

External Review Protections

If you get a denial of your internal grievance, you have the right to file for an external review with the Office of Patient Protection (OPP), as long as you file within four months of receipt of the notice of the denial. When the insurance company sends you the denial letter, they should also send forms that you can submit to the OPP. The OPP will arrange for an independent external review. You may also get these forms by calling the OPP. To learn more, call **1-800-436-7757** or go to the OPP website at **http://www.mass.gov/dph/opp.**

6 - What Are the Costs of Health Plans?

When you choose a health plan, you need to understand the entire cost of your coverage. You will probably need to pay all or part of the premium. You may also have "cost-sharing". Cost-sharing means that you pay for part of the cost of a service covered by your health plan. You need to understand both the cost of the premium and the amount of any cost-sharing you may expect over the next year.

Premiums

The insurance company that offers your health plan sets the premiums that you must pay for the plan. You might not pay the full premium yourself - many employers pay at least some of the premium for their employees. The insurance company sets the premiums according to different rules depending on whether the health plan is offered to a large group, a small group or an individual. Insurance companies in Massachusetts may not set premiums based on the number or cost of any services that you personally have used in the past or are expected to use in the future. However, the number and cost of services that your group or a class of groups has used may be used as a factor in setting premiums.

Cost Sharing

Most health plans in Massachusetts only cover some of the cost of care and include "cost-sharing" features. Cost-sharing means that the insurance company pays for part of the cost of a health service and you pay the rest. Some of the cost-sharing features you may have in your health benefit plan include:

Deductible

A deductible is a dollar amount that you must pay before the health plan starts to pay for a covered service. Some health plans may have a separate prescription drug deductible. The deductible amount does not include the premiums that you pay. For example, you may pay a $1,000 deductible toward your health care services each year before the plan pays any benefits. A health plan may have a deductible for a calendar year (from January 1 to December 31) or for a plan year (from the policy effective date to one year later). If your plan has a deductible, be sure to know the time period.

Copayment

A copayment is a fixed dollar amount paid by you directly to a doctor, hospital, pharmacy or other health care provider at the time that you get a service. For example, you may pay $20 toward a covered office visit and the plan pays the rest. A plan may have different copayments for different types of services. For example, the copayment for a primary care visit may be $20 and the copayment for an emergency room visit may be $100.

Coinsurance

Coinsurance is a percentage of the allowed charge that you will pay for a covered service after any copayments. For example, you may pay 20% of the cost of a covered office visit and the plan pays the rest.

Benefit Limit

Some plans have a limit on the number of visits or dollars allowed for specified covered service. For example, the plan may allow only $350 for a scalp hair prosthesis (wig) and you will pay for any cost beyond the $350 limit.

Exclusion

Exclusions are listed services for which there is no benefit. For example, the company may exclude (not pay for) cosmetic surgery and you will pay for the entire cost of the service.

Out-of-Pocket Maximum

An out-of-pocket maximum is a cap on your cost sharing for a year. Once your cost share amounts have equaled the out-of-pocket maximum, the health plan will pay 100% of the covered services for the rest of that year.

Usual and Customary Charge ("U/C") /Usual, Customary and Reasonable ("UCR")

The amount that a carrier determines to be the usual fee charged by similar health care providers in the same geographic area. Some health plans may limit coverage of certain providers to the usual and customary amount.

APPENDIX I: FINDING HEALTH CARE PROVIDERS

Health maintenance organizations and preferred provider plans usually have a network of providers from which you pick your primary care provider and any other providers you need. You should make sure that your provider is in your health plan's network. Below are some of the types of providers that you may need at different times. Also shown are government licensing agencies that can tell you more about the provider.

INPATIENT SERVICES

Hospital - A facility that provides medical treatment on an inpatient basis for acute conditions resulting from illness or injury. Contact the Massachusetts Department of Public Health at (617) 624-6000 or www.mass.gov/dph.

Nursing Home - A facility that provides nursing care and related services on an inpatient basis for short and long-term care stays at skilled, intermediate or custodial levels of care. Contact the Department of Public Health at (617) 624-6000 or www.mass.gov/dph.

Outpatient Services, Health Clinics, Urgent Care Centers, Ambulatory Surgery Centers

Acupuncturist - Contact Board of Registration in Medicine at (617)654-9800 or www.massmedboard.org.

Allied Mental Health Professionals: Psychologists, Licensed Social Workers, Mental Health Counselor – A provider who applies principles, methods and theories of counseling and psychotherapeutic techniques to define goals and develop a treatment plan of action aimed towards the prevention, treatment and resolution of mental and emotional dysfunction and intra or interpersonal disorders. Contact the Board of Registration in Allied Mental Health Professionals at (617)727-3080 or www.mass.gov/dpl/boards.htm.

Audiologist – A providers who identifies, assesses and interprets, diagnoses, rehabilitates and works to prevent communication disorders. Contact the Board of Registration in Speech-Language Pathology and Audiology at (617)727-3071 or www.mass.gov/dpl/boards.htm.

Doctor of Chiropractic (D.C.) - A provider who treats musculoskeletal and neuromuscular conditions and is concerned with improving and maintaining the integrity of the biomechanical systems of the body. Contact Board of Registration in Chiropractors at (617)727-3093 or www.mass.gov/dpl/boards.htm.

Doctor of Dental Surgery (D.D.S.) and Doctor of Dental Medicine (D.M.D.) - Contact Board of Registration in Medicine at 1-800-414-0168 or www.mass.gov/dpl.boards.htm.

Doctor of Optometry (D.O.) - A primary health care provider who examines, diagnoses, treats and manages diseases and disorders of the visual system, the eye and associated structures. Contact Board of Registration in Optometry at www.mass.gov/dpl/boards.htm or (617)727-3093.

Doctor of Podiatric Medicine (D.P.M.) - A provider who deals with medical and surgical treatment of foot disorders. Contact Board of Registration in Podiatry (617)727-3093 or www.mass.gov/dpl/boards.htm.

Home Health Care - Skilled medical and other services, including nursing, occupational therapy, physical therapy, speech therapy and home health aide services, are supplied by certified home health agencies and other professionals to help individuals remain at home. Contact the Home Care Alliance of Massachusetts at (617)482-8830 or www.hhcam.org.

Hospice Care - Medical services with an emphasis on providing comfort and pain relief for those who are terminally ill. Contact Medicare at 1-800-MEDICARE or www.medicare.gov or the Hospice Federation of Massachusetts at (800)962-2973 or www.hospicefed.org.

Medical Doctor (M.D.) and Osteopathic Doctor (O.D.) - Contact Board of Registration in Medicine at (617)654-9800 or www.massmedboard.org.

Nurse, including: Registered Nurse (R.N.); Nurse Practitioner (N.P.); Licensed Vocational Nurse (L.V.N.); Certified Nurse Midwife (C.N.M.); Certified Registered Nurse Anesthetist (C.R.N.A); and, Nurse Specialist in Psychiatric Care - Contact Board of Registration in Nursing at 1-800-414-0168 or www.mass.gov/reg/boards/rn/default.htm.

Physical Therapist (PT), Occupational Therapists (OT), Respiratory Therapists (RT) - Occupational therapists use occupational activities to help people prevent, lessen or overcome physical, psychological or developmental disabilities. Physical therapists provide rehabilitative care for patients with physical disabilities or dysfunctions. Contact Board of Registration in Allied Health Professionals at (617)727-3071 or www.mass.gov/dpl/boards.htm.

Physician Assistant (P.A.) – Contact the Board of Registration in Physicians Assistants at 1-800-414-0168 or www.mass.gov/reg/boards/ap/default.htm.

Speech-Language Pathologist – A provider who screens, identifies, assesses and interprets, diagnoses, rehabilitates and works to prevent disorders of communication. These disorders can include articulation, fluency, voice and language. Contact the Board of Registration in Speech-Language Pathology and Audiology at (617)727-3071 or www.mass.gov/dpl/boards.htm.

APPENDIX II: GLOSSARY OF HEALTH CARE TERMS

Adverse determination - A determination, based upon a review of information provided, by a carrier or its designated utilization review organization, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.

Benefit limit - A specified limit on the visits or dollars allowed for a specific covered service.

Carrier - An insurer licensed or otherwise authorized to transact accident and health insurance under M.G.L. chapter 175; a nonprofit hospital service corporation organized under M.G.L. chapter 176A; a non-profit medical service corporation organized under M.G.L. chapter 176B; or a health maintenance organization organized under M.G.L. chapter 176G.

Coinsurance - A percentage of the allowed charge, after a copayment, if any, that an insured will pay for covered services under a health benefit plan.

Commonwealth Care – Publicly subsidized health plans that are offered through the Health Connector and that are available to a qualified, uninsured Massachusetts resident who is 19 years old, makes under 300% of the federal poverty level, and is a U.S. citizens or legal permanent resident.

Commonwealth Choice - Commercial health plan for uninsured individuals and small groups not eligible for Commonwealth Care. Offered as of July 1, 2007 through the Health Connector with the Connector Seal of Approval that certifies the plans as products of good value to consumers.

Commonwealth Health Insurance Connector Authority (Health Connector) - A state agency that assists Massachusetts residents with the purchase of health insurance.

Copayment - A fixed dollar amount paid by an insured to a physician, hospital, pharmacy or other health care provider at the time the insured receives covered services.

Core Services [6] - Physician services, inpatient acute care services, day surgery, and diagnostic procedures and tests.

Creditable coverage - Coverage of an individual under any of the following health plans with no lapse of coverage of more than 63 days:

(a) Group health plan

[6] As defined in the Commonwealth Health Insurance Connector Authority regulation 956 CMR 5.00 "Minimum Creditable Coverage."

(b) Health plan, including, but not limited to, a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under section 18 of M.G.L. chapter 15A or a qualifying student health program of another state
(c) Part A or Part B of Title XVIII of the Social Security Act
(d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928
(e) 10 U.S.C. 55
(f) Medical care program of the Indian Health Service or of a tribal organization
(g) State health benefits risk pool
(h) Health plan offered under 5 U.S.C. 89
(i) Public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701(c)(I)(I), as amended by Public Law 104-191
(j) Health benefit plan under the Peace Corps Act, 22 U.S.C. 2504(e)
(k) Coverage for young adults as offered under section 10 of chapter 176J; or,
(l) Any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996, as it is amended, or by regulations promulgated under that act. This definition applies to creditable coverage for portability in relation to any pre-existing condition provision or waiting period. It is not intended to define creditable coverage as it is defined by the Health Connector Board for purposes of determining individual responsibility for maintaining health coverage.

Deductible - An annual dollar amount that must be paid by an insured for specified health care services that the insured uses before the health plan becomes obligated to pay for covered services. Some health plans may include separate prescription drug deductibles. The deductible amount does not include the premiums that the insured pays.

Eligible dependent - The spouse or child of an eligible person, individual or eligible employee, subject to the applicable terms of the health plan covering such individual or employee.

Eligible employee (in an eligible small business or group) - An employee who:

(a) Works on a full-time basis with a normal work week of 30 or more hours, and includes an owner, a sole proprietor or a partner of a partnership; provided however, that such owner, sole proprietor or partner is included as an employee under a health care plan of an eligible small business; and provided, however, that "eligible employee" does not include an employee who works on a temporary or substitute basis; and,
(b) Is hired to work for a period of not less than five months, provided, however, that a carrier cannot require that a person must have worked for an unreasonable length of time in order to qualify as an "eligible employee." For the purposes of 211 CMR 66.00, five months shall be deemed to be an unreasonable length of time when determining "eligible employee."

Eligible individual - An individual who is a resident of the Commonwealth of Massachusetts and who is not seeking individual coverage to replace an employer-sponsored health plan for which the individual is eligible and which provides coverage that is at least actuarially equivalent to minimum creditable coverage as defined by the Connector.

Eligible small business or group - Any sole proprietorship, firm, corporation, partnership or association actively engaged in business who, on at least 50% of its working days during the preceding year, employed from among one to not more than 50 eligible employees, the majority of whom worked in Massachusetts; provided, however, that the sole proprietorship, firm, corporation, partnership or association need not have been in existence during the preceding year in order to qualify as an "eligible small business or group." In determining the number of eligible employees, companies that are affiliated companies or are eligible to file a combined tax return for purposes of state taxation are considered to be one business. A business shall be considered to be one eligible small business or group if: (1) it is eligible to file a combined tax return for purpose of state taxation, or (2) its companies are affiliated companies through the same corporate parent.

Federal poverty level (FPL) - Income guidelines set by the federal government annually. These levels are used to determine financial eligibility for many programs, including Commonwealth Care. Go to www.mass.gov/connector for information on the current federal poverty levels.

Late enrollee - An eligible employee or dependent who requests enrollment in an eligible small business' health insurance plan or insurance arrangement after the group's initial enrollment period, his or her initial eligibility date provided under the terms of the plan or arrangement, or the group's annual open enrollment period.

Mandated benefit - A health service or category of health service provider that a carrier is required by its licensing or other statute to include in its health plan.

Medical necessity or medically necessary - Health care services that are consistent with generally accepted principles of professional medical practice as determined by whether (a) the service is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual; (b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or (c) for services and interventions not in widespread use, is based on scientific evidence.

Minimum creditable coverage - The lowest threshold health plan that satisfies the legal requirement for a Massachusetts resident, over age 18, to have health coverage. See page 6 of this guide for a description of the current minimum creditable coverage standards.

Pre-existing condition - A condition that was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before the date. Genetic information is not treated as a condition in the absence of a diagnosis of the condition related to that information. Pregnancy is not a pre-existing condition. Trade Act/HCTC-eligible persons are not subject to any pre-existing conditions provision. Health carriers that impose a pre-existing condition limitation must waive or reduce the period if an insured had prior creditable coverage up to 63 days before completing the application.

Preventive health services - Any periodic, routine, screening or other services designed for the prevention and early detection of illness that a carrier is required to provide pursuant to Massachusetts or federal law.

Rating period - The period for which premium rates established by a carrier are in effect, as determined by the carrier.

Resident - A natural person living in the commonwealth, but the confinement of a person in a nursing home, hospital or other institution shall not by itself be sufficient to qualify a person as a resident. A carrier may ask for reasonable evidence of residency.

Trade Act/HCTC-Eligible person: or TA/HCTC-eligible person - Any eligible trade adjustment assistance recipient or any eligible alternative trade adjustment assistance recipient as defined in section 35(c)(2) of section 201 of Title II of Public Law 107-210, or an eligible Pension Benefit Guarantee Corporation pension recipient who is at least 55 years old and who has qualified health coverage, does not have other specified coverage, and is not imprisoned, under Public Law 107-210.

Usual and Customary Charge ("U/C") /Usual, Customary and Reasonable ("UCR") - The amount that a carrier determines to be the usual fee charged by similar health care providers in the same geographic area. Some health plans may limit coverage of certain providers to the usual and customary amount.

Waiting period - The time immediately after the effective date of an insured's coverage under a health plan during which time the plan does not pay for some or all hospital or medical expenses, but in all cases pays for emergency services. Trade Act/HCTC-eligible persons are not subject to any waiting period.

Young Adult Health Benefit Plan - A health plan offered to Massachusetts young adults between the nineteenth (19^{th}) birthday up until the day before the twenty-seventh (27^{th}) birthday who do not otherwise have access to a health benefits plan subsidized by the young adult's employer.