December 15, 2022

Kevin Beagan, Deputy Commissioner
Rebecca Butler, Counsel to the Commissioner
Massachusetts Division of Insurance
1000 Washington Street #810
Boston, MA 02118

By email to kevin.beagan@mass.gov and rebecca.butler@mass.gov

Re: Comments Regarding Chapter 177 of the Acts of 2022 - Parity Enforcement Issues

Dear Deputy Commissioner Beagan and General Counsel Butler:

On behalf of the Children's Mental Health Campaign (CMHC), thank you for holding listening sessions and written comment opportunities on various provisions of Chapter 177 of the Acts of 2022, *An Act addressing barriers to care for mental health.*

Please find below comments regarding parity enforcement provisions in Chapter 177 and related issues, including the ongoing implementation of Behavioral Health for Children and Adolescents and provider directory regulations.

Please do not hesitate to contact us with any questions or to discuss our comments further.

Sincerely,

Mary McGeown
Executive Director, MSPCC
On behalf of the Children's Mental Health Campaign

THE CHILDREN'S MENTAL HEALTH CAMPAIGN is a large statewide network that advocates for policy, systems, and practice solutions and shared responsibility among government and institutions to ensure that all children in Massachusetts have access to resources to prevent, diagnose, and treat mental health issues in a timely, effective, and compassionate way.

The CMHC Executive Committee consists of six highly reputable partner organizations: The Massachusetts Society for the Prevention of Cruelty to Children, Boston Children's Hospital, the Parent/Professional Advocacy League, Health Care for All, Health Law Advocates, and the Massachusetts Association for Mental Health. The CMHC network includes more than 200 organizations across Massachusetts.

<u>Parity Enforcement Provisions in Chapter 177</u>

1. **<u>Re: parity complaint investigation under Section 22 of Ch. 177</u>: Create a unique and separate process to receive consumer parity complaints, including a) new customized web pages educating consumers about parity rights and about the parity complaint process; b) a new consumer parity complaint form customized to the statutorily defined information to be considered in evaluating such complaints; c) guidance or regulations describing the timeline and consumer and carrier obligations during the parity complaint process; and d) guidance clarifying whether and how behavioral health providers can file parity complaints or raise parity issues with the Division of Insurance**.

We appreciate the work of the Division of Insurance ("DOI" or "the Division") in the last year to significantly improve the online consumer complaint form. However, based on the many specific requirements under the newly enacted Section 22 of Chapter 177, we request that the Division create a distinct and customized process to accept, investigate and issue written decisions on mental health parity complaints. Most if not all of the requirements under Section 22 currently apply only to the Division's duties and obligations to investigate parity complaints. These include the Division's new express duties:

- To conduct and conclude the investigation of the complaint within 90 days.
- To request medical records and medical opinions from the complainant's treating provider if the carrier fails to do so.
- To exercise enforcement authority, including reprocessing of claims, notification of consumers likely to have been affected, as well as fines, policy changes, staff training and ongoing monitoring of a carrier by the Division.
- To receive complaints referred by the Massachusetts Office of Patient Protection.
- To create a process for a consumer to request the appointment of an authorized representative to act on the consumer's behalf.

See M.G.L. c. 26, §§ 8K(b) - (f).

In addition, the design and use of a dedicated parity complaint form would assist the Division's efforts to accomplish a prompt investigation of a parity complaint within the 90-day statutory timeline. The Division should create a parity complaint form that can:

- Ask the consumer to describe their dispute with their health plan/carrier concern behavioral health benefits;
- Allow the consumer to authorize the release of their relevant medical records by both their health plan and their relevant medical providers;
- Allow the consumer to identify and authorize the release of any other "additional information from the involved parties or outside sources" that the consumer wishes to include. See M.G.L. c. 26, § 8K(f);
- Allow the consumer to describe or identify "any related right to a treatment or service under any related state or federal law or regulation" that is related to their dispute and parity complaint. <u>Id</u>.

Finally, any effective process for consumers to file mental health parity complaints also requires some webpages dedicated to informing consumers, their providers and advocates, about both their mental health parity rights and about the Division's process for filing parity complaints. The Children's Mental Health Campaign would be glad to work with the Division, including its privacy officer, to develop these

materials to ensure that they are both understandable, and to ensure that the appropriate safeguards for the privacy of consumer health information shared with the Division in the context of a parity complaint are clearly and accurately described, in order to prevent any potential chilling effect upon consumers.

2. **Issue guidance and/or a webpage that publicly invites and instructs behavioral health providers to participate in helping the DIvision identify possible violations of state and federal parity laws**

Many carrier practices that could constitute a potentially illegal non-quantitative treatment limitation under federal law would be practices that directly affect behavioral health providers, and not consumers. For instance, a requirement to join a provider network, reimbursement rates, and medical necessity standards are just a few of the types of non-quantitative treatment limits (NQTLs) that the U.S. Department of Labor has identified as "red flag" issues that could indicate a violation of federal parity law. Yet, in most instances, all of these practices by carriers would be directly seen and most clearly understood by providers, and not necessarily consumers. This illustrates why behavioral health providers are essential to the process of identifying parity violations. Toward the goal of helping such behavioral health providers participate fully in the process to help end illegal carrier practices that violate federal or state parity laws, we recommend that the Division create a webpage containing specific information for behavioral health providers who may be interested in assisting in this effort. Such a web page should include specific instructions about how behavioral health providers can either file formal complaints with the DIvision, and/or instruct them about any less formal process they can use to effectively communicate with the Division about their parity concerns. Finally, if there was a requirement that a provider must identify a discrete consumer who is treated by the provider, affected by the practice, and covered under a fully-insured health plan in order to file either a formal parity complaint or another less formal process, it would be helpful if guidance or a provider-focused webpage could describe that process and any related requirements.

3. **Corrections to the Division's current health insurance complaint process**

The current DOI website, complaint process, and forms are a generally-applicable set of resources for all insurance complaints. (See https://www.mass.gov/file-an-insurance-complaint). Unfortunately this generic, one-size-fits-all attempt to describe the complaint process includes several instructions to the public and requirements for consumers to participate in DOI's complaint process that we feel are neither appropriate nor lawful with respect to parity complaints or any other health insurance complaint.

We recommend that these instructions and restrictions be removed. However, if these restrictions or requirements are necessary for the Division's handling of other types of insurance complaints (such as home, auto, or life insurance), then we recommend that the Division create a separate process, as described in sections 1 and 2 of this letter, to accept both parity and other health insurance complaints.

Exclusions of complaints by consumers who are represented by counsel or involved in litigation should be eliminated for both parity complaints and other health insurance complaints

The current DOI web page concerning insurance complaints at https://www.mass.gov/how-to/filing-an-insurance-complaint states: "If your complaint involves ongoing litigation or if you have an attorney representing you, do not complete this form." This statement implies that the Division will not accept complaints from any consumer who has either hired an attorney or who has become involved in litigation related to the dispute.

We cannot find any basis under Massachusetts health insurance laws to deny consumers access to the Division's authority to investigate a consumer's health insurance complaint on the basis either that the consumer has engaged the representation of an attorney, or that the consumer's dispute has proceeded to the point of litigation.[1] Nothing in Section 22 or any other provision of Chapter 177 or any other state health insurance law that we are aware of grants the Division the discretion to refrain from investigating a complaint because the consumer has obtained the assistance and representation of an attorney, or because the consumer may have initiated litigation.

Unusually burdensome requirements to appoint an advocate to act on a consumer's behalf in the Division's complaint process should be eliminated or narrowly tailored to appropriate circumstances

The Division's "insurance complaint" webpage currently requires a consumer to execute a notarized Power of Attorney document in order to appoint a family member or advocate to file a complaint or represent the consumer in the complaint process. The website states "In order to process your complaint, we also need the following information from you: … A signed and notarized Power of Attorney (POA) if you are filing on behalf of a family member." (https://www.mass.gov/how-to/filing-an-insurance-complaint). We are not aware of any requirement under the health insurance laws that would make this administrative barrier applicable to health insurance complaints. Certainly, no parent of a minor child should need to obtain such documentation. Regardless of the age of the consumer, it is extremely onerous for patients and their families, while struggling to access needed services and disputing coverage with their health insurance carrier, to have to retain an attorney to draft a Power of Attorney (POA) and then visit a notary public to execute that POA.

With respect to consumer's mental health parity complaints, such an administrative burden would likely create an insurmountable barrier for some if not most individuals with behavioral health conditions who are not receiving adequate treatment. In our experience, such individuals rely heavily upon their family members or other advocates to help them navigate the administrative processes imposed by health insurance carriers, and navigating the Division's complaint process would be no different.

In place of the current requirement of a notarized POA, we recommend that the Division adopt an approach similar to that of the Massachusetts Office of Patient Protection, MassHealth, comparable state regulators in California, or that of insurance carrier Blue Cross Blue Shield of Massachusetts. These entities require only a signed authorized representative form. Examples of such forms are attached and are also available at: https://www.mass.gov/request-an-external-review-of-a-health-insurance-decision (Massachusetts Office of Patient Protection); https://www.mass.gov/doc/authorized-representative-designation-form-english-0/download (MassHealth); https://www.bluecrossma.org/sites/g/files/csphws1866/files/acquiadam-assets/Member's%20Designation%20of%20an%20Authorized%20Representative.pdf (Blue Cross Blue Shield of Massachusetts), and https://www.dmhc.ca.gov/FileaComplaint.aspx (California Department of Managed Health Care). The latter form used by California regulators allows that any patient who is able to complete and sign the

[1] See M.G.L. c. 26 generally, including sections 3A, 6, 7, 7A, 8, 8E, 8K, 8M. We do not have a position on whether the Division has the discretion to receive or investigate a consumer complaint related to life, home or auto insurance.

form may do so in order to appoint a family member or friend to act an authorized representative on their behalf. Only in the narrow circumstance where a patient is not actually able to sign the authorization form does California require the patient's authorized representative to furnish a duly executed POA document. While in this situation we agree that requiring a POA document is appropriate, we would also recommend that the DIvision should accept a holder of duly executed Health Care Proxy document or POA document as a person authorized to act as person's authorized representative to file a complaint with the Division. In any event, we remain opposed to any requirement by the Division that any such health Care Proxy document or a POA document must be 'notarized.' Massachusetts law allows both Health Care Proxy and POA documents to be executed without notarization. A health care proxy document must be witnessed by two adults. See M.G.L. c. 201D, § 2. A POA document does not need to be notarized. See M.G.L. c. 190B Article V, Part 5.

Review and revise the Division web pages to remove any potentially misleading instructions that are not applicable to consumer parity or consumer health insurance complaints

More generally, the Division should review the current consumer complaint webpages for consistency with the new requirements under Section 22 of Chapter 177. For instance, the webpage at https://www.mass.gov/how-to/filing-an-insurance-complaint states: "If your complaint concerns a medical necessity denial, you should file a complaint with the Office of Patient Protection." It also states: "Please do not send us any medical records." Both of these instructions would be inappropriate for both parity and health insurance complaints, and the instructions would create confusion for consumers if their inapplicability to parity and health insurance complaints is not somehow addressed.

Remove outdated consumer complaint forms from the website

The DOI website still offers consumers a downloadable version of a consumer complaint form at https://www.mass.gov/how-to/filing-an-insurance-complaint and https://www.mass.gov/doc/doi-insurance-complaint-form/download. This downloadable complaint form is from 2020 or earlier, and it includes the misleading statement: "complaints and inquiries filed with the Division of Insurance are public record and may be available for review upon request." This statement fails to acknowledge state laws protections and the DOI practices to redact personally identifying information in consumer complaints, as required under M.G.L. c. 4, § 7(26)(c).[2]

This appears to be an oversight, because this older complaint form is not consistent with the Division's more recently updated online-fillable complaint form located at https://sbs.naic.org/solar-web/pages/public/onlineComplaintForm/onlineComplaintForm.jsf?state=MA&dswid=-401. Health Law Advocates and the Mental Health Coalition have raised these issues with the Division previously. We appreciate that the Division has removed these misleading statements from their updated online-fillable complaint form. We request that the older, downloadable consumer complaint form be deleted and replaced with a downloadable version of the Division's updated complaint form available at https://sbs.naic.org/solar-web/pages/public/onlineComplaintForm/onlineComplaint

Form.jsf?state=MA&dswid=3066.

[2] M.G.L. c. 4, § 7(26)(c) excludes from the public records law information that is "received by any [] agency [such as] personnel and medical files or information; also, any other materials or data relating to a specifically named individual, the disclosure of which may constitute an unwarranted invasion of personal privacy."

4. ***Immediately start the process of conducting parity market conduct exams of carrier practices related to mental health parity and provider reimbursement rates.***

The growing behavioral health crisis has been exacerbated by COVID-19, and, therefore, access to behavioral health providers is more crucial than ever. To protect consumers, DOI must pay attention to critical issues that impact consumer's ability to access care, including adequacy of behavioral health networks and equitable reimbursement rates for behavioral health providers, both of which are specifically spelled out as critical areas of concern for market conduct exams within Chapter 177. The market conduct exam process can be lengthy, as demonstrated by the DOI market conduct examination of carriers' provider networks several years ago. Starting parity exams as soon as possible will help to efficiently uncover and ameliorate any illegal barriers to behavioral health care. Moreover, to the extent that the Division can examine and publicize any one potentially illegal practice by a carrier, doing so promptly will provide earlier notice to the remaining carriers (for example, alerting carriers to problemsome practices, such as unreasonably low reimbursement rates or overly restrictive medical necessity guidelines). Such early notice would allow other carriers to address such issues independently, apart from their participation in their own market conduct exams.

5. ***Improve carrier communication, information and consumer access to intermediate behavioral health services for children and adolescents (BHCA).***

The CMHC appreciates the Division's stakeholder engagement process to implement new coverage requirements and consumer protections enacted through Chapter 177. We ask DOI also to give attention to two key issues related to mental health parity and behavioral health access requirements, which can be instructive in rolling out Chapter 177.

Four years after the release of the Division's bulletin instructing carriers on their obligation under state mental health parity laws to cover intermediate and wraparound services for children and adolescents (see https://www.mass.gov/doc/bulletin-2018-07-access-to-services-to-treat-child-adolescent-mental-health-disorders-issued/download), families continue to face barriers accessing these services. The CMHC is grateful for the thoughtful approach that DOI, the Department of Mental Health, and other state agencies took in engaging the CMHC and our partners in the implementation of this policy, and we recognize that this is a major policy advancement for children's mental health. However, confusion exists among families and providers about how the BHCA services align or are similar to those provided through the Children's Behavioral Health Initiative (CBHI). Much of the carrier information about these benefits is dense and hard to understand. The CMHC would be interested in working with DOI and other relevant state agencies and stakeholders to develop a crosswalk of CBHI and BHCA services, and refreshing existing information about BHCA benefits and how to access them that could be cross-posted on a variety of websites and made widely available for use by insurance carriers, providers, families, state agencies, and advocates. Many issues also stem from confusion about what type of plan a family has -- whether it is fully-insured (and required to cover intermediate and wraparound services for youth) or self-insured (and not required to cover such services, and leaving the family the option to obtain MassHealth as a secondary payer to access needed services). There have also been some reports of misinformation about covered benefits by health plans, including plans that refuse to confirm whether these BHCA services are covered or not. Evaluating the implementation of BHCA, and the associated communications with and materials provided to families, would not only improve access for these

specific benefits, but also be instructive for all involved stakeholders as we work collectively to implement new coverage and parity provisions enacted through Chapter 177.

Notably, the lack of ready and reliable information consumers have about what type of plan they have, and the benefits covered by those plans also speaks to the importance of requiring health plan member id cards to include a statement about whether the specific plan is subject to state law coverage requirements. We feel that the Division has the authority to require such a simple disclosure that "this health plan is regulated by the Massachusetts Division of Insurance" on plan id cards under the agency's broad statutory authority to ensure the "administration of the division's statutory and regulatory authority for oversight of the small group and individual health insurance market, oversight of affordable health plans, including coverage for young adults, as well as **the dissemination of appropriate information to consumers about health insurance coverage** and access to affordable products." G.L. c. 26, § 7A (emphasis added).

Consumer Appeal Rights Provisions in Chapter 177

6. ***Issue interim guidance and future final guidance and regulations on the clear requirements under Chapter 177 that carriers accept consumer appeals and consumer-authorized representative forms electronically***.

Currently, it is our understanding that Blue Cross Blue Shield of Massachusetts (BCBSMA) is the only carrier that accepts consumer appeals electronically, and that no carrier currently accepts authorized representative forms electronically. Because electronic communications between carriers and plan members in all individual and group health plans are regulated by federal regulations issued under ERISA and the ACA, we recommend that the Division issue guidance noting that carriers should create systems to accept appeals and authorized representative documents electronically that are in accord with those requirements. (See 29 C.F.R. § 2560.503–1(g)(1)[re employer group plans]; and 45 C.F.R. § 147.136(b)(3) [re individual plans], incorporating the requirements under 29 CFR 2520.104b–1(c)(1)(i), (iii), and (iv); 29 C.F.R. § 2590.715–2719(b)(2)(ii)(E) [re incorporating electronic notice requirements under 29 C.F.R. § 2560.503–1(g) to appeal decisions by employer and individual plans].)

With respect to accepting electronic appeals, the systems for use by consumers to submit these documents electronically should be consumer-friendly and should not require extensive log-in or other authentication steps that could be a barrier to consumer use. For example, BCBSMA allows their members to simply send appeals to an established email address. If carriers have questions about the authenticity of appeal requests that are received, BCBSMA may be able to offer some guidance to the Division regarding how the carriers can investigate such situations.

DOI guidance should clarify that authorized representative forms could be submitted electronically via email or fully electronically online through a website or portal. We recommend that DOI guidance instruct carriers to deem a plan member's ability to log-in to the consumer portal to be adequate to authenticate the person's identity, and thus allow members to provide an electronic signature on the form, avoiding the onerous process of printing and scanning documents only to obtain a written signature.

<u>Other Consumer Rights to Improve Access to Behavioral Health Services</u>

7. ***Promptly issue the final provider directory and network adequacy regulations.***

The CMHC takes this opportunity to reiterate our December 5, 2022 email request for information about the status of the proposed provider directory regulatory changes under 211 CMR 52.15. These regulations are important to create more transparency for consumers about behavioral health providers available in their health insurance networks, including whether they are available to accept new patients and other key information, as well as to inform network adequacy oversight. This issue is of great importance to the CMHC, and we are grateful that we have been able to engage in mange opportunities to help shape policy around provider directories, specifically with an eye towards improving access for children and families in the Commonwealth. We look forward to receiving the requested information and continuing to work with you upon final promulgation of the regulations to monitor compliance and continue to improve access to in-network behavioral health providers.

List of Attachments:

1. Massachusetts Office of Patient Protection External Review Form, excerpt re: authorized representative designation form, 4 pages
2. MassHealth member Authorized Representative Designation form, 4 pages
3. Blue Cross Blue Shield of Massachusetts Members Designation of an Authorized Representative form, 2 pages
4. California Dept. of Managed Health Care Authorized Assistant form, 1 page

The Commonwealth of Massachusetts
Health Policy Commission
Office of Patient Protection
50 Milk Street, 8th Floor
Boston, MA 02109
(800)436-7757 (phone)
(617)624-5046 (fax)

REQUEST FOR INDEPENDENT EXTERNAL REVIEW OF A HEALTH INSURANCE GRIEVANCE THROUGH THE OFFICE OF PATIENT PROTECTION

If your health insurance company will not pay for treatment that you believe you need, you may be able to ask the Office of Patient Protection (OPP) to have an outside medical expert to review your insurance company's decision. This process is called an external review. If a patient's medical condition is urgent, you can request an expedited (fast) external review.

- **Standard External Review** - For a regular external review, you must first file a grievance with your insurance company, asking for an internal review of the decision. If after the internal review the answer is still no, you can request an external review within four months of receiving a "final adverse determination" letter from your insurance company. A final adverse determination is the letter from your health insurer telling you that your claim is being denied based on medical necessity, appropriateness of health care setting and level of care, or effectiveness of treatment, and that you have exhausted the insurer's internal appeals process.
  Next Steps : Complete pages 2-8 of this form
  Attach final adverse determination letter and other documentation
  Send form and documents to OPP (see checklist on page 2)

- **Expedited External Review** – If your health care professional certifies that a delay in treatment would pose a serious and immediate threat to your health, you may request an expedited external review. You can request an expedited external review within four months of receiving an adverse determination or final adverse determination letter from your insurance company. You may choose to file a request for an expedited external review at the same time that you request an expedited internal review from your insurance company. If you file the request for an expedited internal review and expedited external review at the same time, you do not need a final adverse determination letter, but include the first denial letter or adverse determination from your insurance company.
  Next Steps : Complete pages 2-8 of this form
  Ask your health care provider to complete pages 9-11 of this form
  Attach adverse determination or final adverse determination and other documents
  Send form and documents to OPP (see checklist on page 2)

- **Continuation of Coverage** – If you want your health insurance company to pay for your treatment while your case is being reviewed, you and your health care professional may request continuation of coverage within two business days after the day you receive the adverse determination.
  Next Steps : Complete expedited external review request as described above
  Complete the continuation of coverage request on page 9

EXTERNAL REVIEW CHECKLIST – WHAT TO SEND AND WHERE TO SEND IT

Please be sure to complete all applicable sections of the form, and include **all** of the following. Incomplete external review requests cannot be processed. Please include:

- ☐ This completed application form (pages 2-8 for standard external review).
- ☐ If you are requesting an **expedited external review with or without continuation of coverage**, the completed forms at pages 9-11 where applicable.
- ☐ A copy of the final adverse determination or denial letter from your health insurer (or the first adverse determination letter if you are filing a request for expedited external review at the same time that you are filing a request for expedited internal review with the insurer).
- ☐ A copy of your insurance card and/or your insurance company and insurance ID number
- ☐ Any medical records, statements from your treating health care providers, or other information that you would like the independent review agency to consider in reviewing your case (the independent review agency will request records of the treatment that is the subject of the adverse determination).
- ☐ A check or money order for $25 made out to the Commonwealth of Massachusetts (unless you ask OPP to waive the fee on page 8). If you fax your external review request, you may mail the check or money order to OPP separately.
- ☐ Send the completed application form and other documents to OPP by fax or mail. If you are requesting an **expedited external review**, fax your application to OPP, then call 800-436-7757 to advise OPP that you faxed the request.

Fax: 617-624-5046

Mail: Office of Patient Protection
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Questions? Call OPP at 800-436-7757

PATIENT INFORMATION

1. Patient's Name:	
2. Mailing Address:	
3. Phone and Email:	
4. Patient's Date of Birth:	

INFORMATION ABOUT THE PATIENT'S HEALTH INSURANCE COVERAGE

5. Policyholder's Name:	
6. Patient's Insurance ID Number:	
7. Name of Health Insurance Company:	
8. How did the patient get this insurance? Check all that apply.	☐ Employer ☐ Health Connector ☐ Insurance company ☐ Parent ☐ Spouse or former spouse ☐ Other: ______________________
9. Person at insurance company involved with your appeal (if known):	

10. Describe the disagreement with your health plan. • If possible, indicate the services for which coverage was denied • Attach additional pages if needed • Attach the adverse determination letter (the denial letter from the insurance company) • Attach any other information from your health plan or health care provider that you want the external reviewer to consider

INFORMATION ABOUT YOUR TREATING HEALTH CARE PROVIDER

Name of health care provider who ordered the service which was not covered:

____

Type of Provider: ☐ Physician ☐ Other (please specify): ______________________

Provider Mailing Address:

____

____

Provider Phone Number: _________________________________

INFORMATION ABOUT YOUR HEALTH HISTORY

If you want the external review agency to consider records of your previous treatment, please list the provider(s) and dates here. Attach additional sheets if needed.

Provider Name: ____

Provider Mailing Address:

____

____

Provider Phone Number: ______________________________________

Dates of treatment: ____

AUTHORIZED REPRESENTATIVE FORM

Fill out this section only if someone else will represent you in this review. You can represent yourself, or may ask another person, including your health care provider, to act as your personal representative. You may revoke this authorization in writing at any time.

I hereby authorize __________________________ to pursue my external review on my behalf.

____ ________________

Signature of Patient or Legal Guardian* Date

* Specify if signed by parent, guardian, conservator or other: __________________________

Please note: If the patient is 18 or older, he or she is usually a legal adult and must sign. Parents or other family members cannot authorize the release of another adult's records

Address of Authorized Representative:

____

____

____

Phone number: _________________ Fax number: _____________________

Questions? Call 800-436-7757 or visit www.mass.gov/hpc/opp

HPC-OPP External Review Form, Rev. 5/2019

Authorized Representative Designation Form

You can submit this form if you would like to designate an authorized representative to act on your behalf. If an authorized representative signed your application for you, or if you are an authorized representative applying on behalf of someone else, you **MUST** submit this form for the application to be processed.

You do not need to fill out this form if you live in an institution and want copies of eligibility notices sent to you and to your spouse who still lives at home. We will do that automatically.

Note: An authorized representative has the authority to act on an applicant's or member's behalf in all matters with MassHealth and the Health Connector, and will receive personal information about the applicant or member until we receive a cancellation notice terminating their authority, or upon the death of the applicant or member. Their authority will not automatically terminate once we process your application.

You can choose someone to help you.

You may choose an authorized representative to help you get health care coverage through programs offered by MassHealth and the Health Connector. You can do this by filling out this form (the Authorized Representative Designation Form). You or a representative can sign for yourself and for any of your dependent children under the age of 18 for whom you are the custodial parent. **You are not required to have a representative in order to apply for or receive benefits.**

Who can help me?

1. An authorized representative can be a friend, family member, relative, or other person or organization of your choosing who agrees to help you. It is up to you to choose an authorized representative if you want one. Neither MassHealth nor the Health Connector will choose an authorized representative for you. You must designate in writing (fill out Section I, Part A) the person or organization who you want to be your authorized representative. Your authorized representative must also fill out Section I, Part B. We sometimes refer to this person or organization as a "Section I authorized representative."
2. If you cannot designate an authorized representative in writing and you do not have an existing authorized representative or other person who is authorized by law to act on your behalf, a person (not an organization) who certifies that they will act responsibly on your behalf can be your authorized representative if that person fills out Section II of this form. We sometimes refer to this person as a "Section II authorized representative."
3. An authorized representative can also be someone who has been appointed by law to act on your behalf, or on behalf of the estate of an applicant or member who has died. This person must fill out Section III and either you or this person must submit to us, together with this form, a copy of the applicable legal document stating that this person has authority to represent you, or the estate of a deceased applicant or member. We sometimes refer to this person as a "Section III authorized representative."
4. A **Section III** authorized representative may be a legal guardian, conservator, holder of power of attorney, or health care proxy, or, if the applicant or member has died, the personal representative of the estate.

What can an authorized representative do?

A **Section I** or **II** authorized representative may

- fill out your application or renewal forms;
- fill out other MassHealth or Health Connector eligibility or enrollment forms;
- give proof of information reported on these forms;
- report changes in income, address, or other circumstances;
- get copies of all of your MassHealth and Health Connector eligibility and enrollment notices; and
- act on your behalf in all other matters with MassHealth and the Health Connector.

What a **Section III** authorized representative is authorized to do for you (or for the estate of a deceased applicant or member) will depend on the wording of the legal appointment.

Please note: Eligibility notices may include information about other members of an applicant's or member's household. If there are multiple people in your household we may not be able to send copies of some of your notices to your authorized representative unless each household member has also designated the same authorized representative by completing a separate Authorized Representative Designation Form.

SECTION 1 Authorized Representative Designation (if applicant or member is able to sign)

Part A—to be filled out by applicant or member. Please print, except for signature.

Applicant's/Member's Name	Applicant's/Member's date of birth (mm/dd/yyyy)

MassHealth ID number __ __ __ __ __ __ __ __ __ __ __ __ **OR** last four digits of the Applicant's/Member's SSN __ __ __ __

Applicant's/Member's email address

I certify that I have chosen the following person or organization to be the authorized representative for myself and any dependent children under the age of 18 for whom I am the custodial parent and that I understand the duties and responsibilities this person or organization will have (as explained earlier in this form).

Applicant's/Member's signature	Date (mm/dd/yyyy)
Authorized representative's name	**Authorized representative's phone number**

Authorized representative's address (mailing address, city, state, zip)

Part B—to be filled out by authorized representative. Please print, except for signature.

B1. COMPLETE IF AUTHORIZED REPRESENTATIVE IS A PERSON.

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to me by MassHealth or the Health Connector.

If I am also a provider, staff member, or volunteer affiliated with an organization, and am acting in my capacity as a provider, staff member, or volunteer in connection with my designation as an authorized representative, I certify that I will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information and conflicts of interest including those set forth at 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10, and 45 C.F.R. § 155.260(f).

Authorized representative's signature	Date (mm/dd/yyyy)
Authorized representative's printed name	**Authorized representative's email address**

B2. COMPLETE IF AUTHORIZED REPRESENTATIVE IS AN ORGANIZATION.

I certify, on behalf of the organization set forth below, that such organization will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to the organization by MassHealth or the Health Connector.

I, the provider, staff member, or volunteer of the organization set forth below, completing this form, certify on behalf of myself and on behalf of the organization I represent, that any providers, staff members, or volunteers acting on behalf of the organization in connection with this authorized representative designation will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information, and conflicts of interest, including those set forth at 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10, and 45 C.F.R. § 155.260(f).

Signature of provider, staff member, or volunteer completing form	Date (mm/dd/yyyy)

Printed name of provider, staff member, or volunteer completing form

Email of provider, staff member, or volunteer completing form	Authorized representative organization name

SECTION 2 Authorized Representative Designation
(if applicant or member cannot provide written designation)

To be filled out by authorized representative. Please print, except for signature. Please provide a separate form for each applicant or member.

AN ORGANIZATION IS NOT ELIGIBLE TO BE AN AUTHORIZED REPRESENTATIVE UNDER THIS SECTION.

I certify that the applicant or member set forth below cannot provide written designation and to the best of my knowledge does not otherwise have an individual who can act on his or her behalf such as an existing authorized representative, guardian, conservator, personal representative of the estate, holder of power of attorney, or an invoked health-care proxy. In addition, I certify that I am sufficiently aware of this applicant's or member's circumstances to assume responsibility for the accuracy of the statements made on his or her behalf during the eligibility process and in other communications with MassHealth or the Health Connector, that I understand my rights and responsibilities as this person's authorized representative (as explained earlier in this form). If this person can understand, I have told the person that MassHealth and the Health Connector will send me a copy of all MassHealth and Health Connector eligibility and enrollment notices and this person agrees to this, and I have told this person that they may remove or replace me as their authorized representative at any time by the methods described earlier in this form.

I further certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth below that is provided to me by MassHealth or the Health Connector.

If I am also a provider, staff member, or volunteer affiliated with an organization, and I am acting in my capacity as a provider, staff member, or volunteer in connection with my designation as an authorized representative, I further certify that I will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information and conflicts of interest including those set forth at 42 CFR part 431 subpart F., 42 CFR §477.10, and 45 CFR §155.260(f).

Applicant's/Member's Name	Applicant's/Member's date of birth (mm/dd/yyyy)

MassHealth ID number __ __ __ __ __ __ __ __ __ __ __ __ **OR** last four digits of the Applicant's/Member's SSN __ __ __ __

Authorized representative's signature	Date (mm/dd/yyyy)
Authorized representative's name (first, middle, last)	Authorized representative's phone number
Authorized representative's address (mailing address, city, state, zip)	Authorized representative's email address

If the Section II authorized representative is affiliated with an organization, and is acting in such capacity, an individual authorized to act on behalf of the organization, such as an officer, must sign below to indicate the organization's acknowledgment of and agreement with the representations and warranties made above.

Officer's Name	Officer's Title
Officer's Signature	Date (mm/dd/yyyy)

SECTION 3 Authorized Representative Designation (if appointed by law)

To be filled out by an authorized representative appointed by law (with authority to act on behalf of the applicant or member in making decisions related to health care including, but not limited to, a guardian, conservator, personal representative of the estate of an applicant or member, holder of power of attorney, or an invoked health care proxy.) Please print, except for signature. **Please submit a copy of the applicable legal document with this form.**

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member as set forth below, that is provided to me by MassHealth or the Health Connector.

Applicant's/Member's Name	Applicant's/Member's date of birth (mm/dd/yyyy)
MassHealth ID number __ __ __ __ __ __ __ __ __ __ __ __ **OR** last four digits of the Applicant's/Member's SSN __ __ __ __	
Authorized representative's signature	Date (mm/dd/yyyy)
Authorized representative's name (first, middle, last)	Authorized representative's phone number
Authorized representative's address (mailing address, city, state, zip)	Authorized representative's email address

How does an authorized representative designation end?

If you decide that you no longer want a **Section I** or **Section II** authorized representative, you must notify us at the time you want the designation to end by mail, fax, or phone. See our contact information below. If you mail or fax this notice to us, the notice must include your name, address, and date of birth, the name of your authorized representative, a statement that the designation has ended and your signature or, if you cannot provide written notice, the signature of someone acting on your behalf (in the case of a **Section II** authorized representative only).

In addition, if your authorized representative notifies us that such person or organization is no longer acting on your behalf, we will no longer recognize the person or organization as your authorized representative.

The authority of a **Section I** or **Section II** authorized representative will end upon the death of the applicant or member.

A **Section III** authorized representative's designation ends when his or her legal appointment ends. The authorized representative must notify us as instructed above.

In addition, an authorized representative's designation for a minor child ends on the child's 18th birthday.

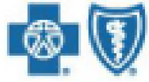
How do I submit this form?

If you are applying for health benefits, send your filled-out Authorized Representative Designation Form to us with your application.

If you are already getting benefits, you must submit the form to us at the time you want to designate an authorized representative, or you want the declared designation to end, by

- Mailing your form to

  Health Insurance Processing Center
  PO Box 4405
  Taunton, MA 02780;
- Faxing your form to **(857) 323-8300**; or
- Calling us at **(800) 841-2900**, TDD/TTY: **711**.



MASSACHUSETTS

Member's Designation of an Authorized Representative

An *authorized representative* is someone chosen by a member to assist the member with health care issues, and to whom Blue Cross Blue Shield of Massachusetts (Blue Cross) is allowed to disclose and discuss the member's protected health information. An authorized representative is not, however, a person who has legal authority to act on behalf of a member. Use this form to designate an authorized representative to speak to Blue Cross on your behalf and to provide access to your information as shown below. The member should be the person signing this authorization and designating the release of information.

- If the member is a minor, a parent or legal guardian must sign.
- If this form is completed by a legal representative (example: a person who has legal authority to act on the member's behalf), they must complete and submit the Blue Cross Documentation of Legal Representative Status Form prior to submitting this form to Blue Cross.

A. MEMBER INFORMATION
Member's Name:
Member's ID#:
Date of birth:
Address:
Phone number:

B. AUTHORIZED REPRESENTATIVE INFORMATION
Name of person:
Address:
Date of birth:
Phone number:

C. INFORMATION THAT BLUE CROSS MAY DISCLOSE

I grant Blue Cross permission to discuss with or disclose to my authorized representative on my behalf:

☐ **All my information.** This may include a diagnosis (name of illness or condition), procedure (type of treatment), claims, doctors and other health care providers, and financial information (like billing and banking). **This does not include sensitive information (see below), unless explicitly approved below.**

✛ If "all my information" is not checked above, I authorize Blue Cross to disclose **only the following specific information, excluding sensitive information (unless approved below)**. (check all boxes that apply).

☐ Appeals	☐ Benefits and coverage	☐ Billing
☐ Claims and payment	☐ Dental	☐ Diagnosis and procedure
☐ Eligibility and enrollment	☐ Financial	☐ Medical records
☐ Pharmacy	☐ Other:	

✛**Sensitive information**. I approve the disclosure of the following types of sensitive information by Blue Cross (check all boxes that apply):

☐ HIV or AIDS	☐ Mental or behavioral health	☐ Alcohol and substance abuse ***(*Member must designate specific reason for disclosure of this sensitive information.)***

***If alcohol and substance abuse list reason for disclosure:**

☐ to assist with claim(s) payment (including FSA, HRA, HSA, and Coordination of Benefits)	☐ coordination of care	☐ assist with treatment	☐ Other (specify):____________

D. DATE YOUR DESIGNATON EXPIRES
This authorization expires (*check one*):
☐ One-year from the date of signature; or
☐ _______________ (date to be completed by member/legal rep.; not to exceed 1 year from date of signature)

E. MEMBER (OR LEGAL REPRESENTATIVE) SIGNATURE AND DATE

I have read the contents of this form. I understand, agree, and allow Blue Cross to discuss and/or disclose my information as I have stated above. I understand that Blue Cross does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or eligibility benefits. I understand I am entitled to a copy of this form and agree that a photocopy is as valid as the original.

I understand this designation is valid until I revoke it or it expires as described in Part D above. I may revoke this designation at any time by notifying Blue Cross in writing at the address provided below. I understand that a revocation will not apply to information that was already disclosed. I understand that once information has been disclosed according to these instructions, the Health Insurance Portability and Accountability Act (HIPAA) and other privacy laws may no longer protect the information.

Print name: ____

Signature: ____

Date: ____

If not the member, please state your relationship to the member (for example, “parent”) here: __________________________

Blue Cross may request information, now or in the future, as it deems necessary to confirm authorized representative status.

Questions about this form should be directed to the Member Service department at the phone number listed on the front of your member ID card.

Mail or fax this completed form to:

- Blue Cross Blue Shield of Massachusetts, Member Service Correspondence, P.O. Box 9134, N. Quincy, MA 02171-9134
- Fax: 1-617-246-3674

Please keep a copy of this form for your records.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

ATTENTION: If you don’t speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).

AUTHORIZED ASSISTANT FORM

- If you want to give another person permission to assist you with your Independent Medical Review (IMR) or complaint, complete Parts A and B below.
- If you are a parent or legal guardian filing this IMR or complaint for a child under the age of 18, you do not need to complete this form.
- If you are filing this IMR or complaint for a patient who cannot complete this form because the patient is either incompetent or incapacitated, and you have legal authority to act for this patient, please complete Part B only. Also attach a copy of the power of attorney for health care decisions or other documents that say you can make decisions for the patient.

PART A: COMPLETED BY PATIENT

I allow the person named below in Part B to assist me in my IMR or complaint filed with the Department of Managed Health Care (Department). I allow the Department and IMR staff to share information about my medical condition(s) and care with the person named below. This information may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information.

I understand that only information related to my IMR or complaint will be shared.

My approval of this assistance is voluntary and I have the right to end it. If I want to end it, I must do so in writing.

Patient Name (Print)____________________________________

Patient Signature____________________________ Date____________

PART B: COMPLETED BY PERSON ASSISTING PATIENT

Name of Person Assisting (Print)______________________________

Address____

City____________________________ State_____ Zip____________

Relationship to Patient____________________________________

Primary Phone #____________________Secondary Phone #________________

Email Address____

☐ My power of attorney for health care decisions or other legal document is attached.