MASSACHUSETTS

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December 20, 2013

David Seltz, Executive Director
Health Policy Commission
Two Boylston Street, 5th floor
Boston, MA 02116

Marylou Sudders, Chair
Quality Improvement and Patient Protection Committee
Health Policy Commission
Two Boylston Street, 5th floor
Boston, MA 02116

Jenifer Bosco, Director
Office of Patient Protection
Health Policy Commission
Two Boylston Street, 5th floor
Boston, MA 02116

Re: **958 CMR 3.000 – Health Insurance Consumer Protection**

Dear Executive Director Seltz, Chairwoman Sudders, and Director Bosco:

Blue Cross Blue Shield of Massachusetts (BCBSMA) provides the following comments as the Health Policy Commission (HPC) and Office of Patient Protection (OPP) promulgate amendments to 958 CMR 3.000 implementing consumer protection provisions within Chapter 35 of Acts of 2013 (Chapter 35) and the federal Affordable Care Act (ACA).

BCBSMA works to ensure that our nearly three million members have access to the high-quality, affordable health care they expect and deserve. For more than 75 years, our company has worked with the community in a spirit of shared responsibility to make quality health care affordable. Consistent with our corporate promise to always put our members first, we are rated among the nation's best health plans for member satisfaction and quality. The National Committee for Quality Excellence (NCQA), a national organization that evaluates the quality of health plans, consistently rates us as "Excellent." Recently, NCQA named us a *Top Performer in*

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Quality for providing superior care to patients with heart conditions. NCQA's Health Insurance Plan Rankings 2013-2014 found that we are America's #3-ranked private health plan.

BCBSMA supports the effort to amend 958 CMR 3.000 concerning reforms to state's internal and external review requirements with an emphasis on increased transparency as well as consumer ease. We are very familiar with the consumer protection requirements within the grievance process as they have been in place since the passage of Chapter 141 of the Acts of 2000. We have found them both reasonable and helpful for our members. We would also note that the current grievance process has been a successful effort with only a small number of cases overturned on appeal by independent third party external review agencies.

While we support the majority of the proposed changes to 958 CMR 3.000 since they work to improve our member's experience, we have concerns relative to certain proposed changes that go beyond the ACA and Chapter 35 and may have unintended consequences that add to the overall cost of health care. We respectfully submit for your consideration additional revisions or explanations as outlined below.

Section 3.101: Carrier's Medical Necessity Guidelines

As we continue our efforts with regard to the implementation of Chapter 224 of the Acts of 2012 (Chapter 224), we recognize that Chapter 224 contains related provisions which require carriers to undertake specified transparency (carrier website) activity with regard to a carrier's medical necessity criteria. Chapter 224 was planned, drafted and publicly debated for over a year. Since that time, the Division of Insurance has been very engaged on the topic of transparency having recently issued Bulletin 2013-10 concerning transparency requirements for cost-sharing obligations.

Proposed section 3.101(3) requires carriers to provide "utilization review criteria and medical necessity criteria and protocols" to the OPP and members of the general public upon request, and at no charge. The addition of section 3.101(3) is not specifically addressed in either the ACA or Chapter 35 and unlike provisions within Chapter 224, does not contain reasonable provisions relative to licensed, proprietary criteria purchased by a carrier or utilization review organization. We rely on rigorously developed criterion as a critical tool in the effort to provide access to better patient outcomes through integrated, evidence-based clinical decision support criteria. While we support the overarching goal of transparency, we are concerned that the currently drafted regulation may increase consumer confusion due to the complexity of the criteria as well as the expected chilling effect that this new requirement will have on the marketplace.

Chapter 224 explicitly recognized the need to address the propriety nature of private medical necessity criteria through its specific exclusion language in section 199. The same limited exclusion should apply within these regulations. Accordingly, we would request that section 3.101 (3) be deleted and fees be permitted to reflect the cost of fulfillment consistent with Chapter 224. Again, BCBSMA understands the importance of increased transparency of medical care related to medical necessity determinations through required utilization review activity. We currently make our criteria available to participating providers and members. We also include relevant portions of our medical necessity criteria with adverse determination notice issued to

members. To achieve an approach that both meets the new requirements and recognizes issues around its propriety nature and is consistent with the Chapter 224 provisions on point, we urge additional guidance related to this licensed, third party criteria.

As such, we would request that the final regulations delete section 3.101(3) in its entirety or revise section 3.101(3) to include provisions, similar to those found within Chapter 224, which allow for increased transparency while recognizing the proprietary nature of the underlying licensed criteria as follows:

(3) Utilization review criteria and medical necessity criteria and protocols shall be made available by carriers to the Office of Patient Protection **in a format determined to be acceptable to the Office of Patient Protection** upon request, and at no charge **. However, a carrier shall not be required to disclose licensed, proprietary criteria purchased by a carrier or utilization review organization to the general public.**

Section 3.305: Time Limits for Resolution of Non-Expedited Internal Grievances

Former section 3.305(3) was deleted from the regulations. Previously, section 3.305(3) was included to serve a very valuable purpose. This provision allowed time limits to be waived or extended by mutual written agreement of the insured, or the insured's authorized representative, and the carrier. Mutually-agreed upon extensions within the grievance process have proven to be immensely helpful in allowing the needed time to obtain additional relevant information which is in the member's best interest. Without the ability to pursue an extension when necessary, carriers would likely need to render a decision without the needed supporting documentation, leading to an unnecessary increase in denials. Unfortunately, this new scenario will also increase the administrative burden associated with managing this type of case as many will need to be reopened once the additional information becomes available.

Based on our review, we did not find any prohibitions on this issue within the ACA or Chapter 35. Accordingly, we would suggest that section 3.305 (3) be re-inserted into the regulations to allow mutually-agreed upon extensions to continue enabling needed time to access addition information necessary to render an appropriate review and provide access to care in the member's best interest.

Section 3.307: Form of Written Resolution of the Internal Grievance

Section 3.307(2)(f) adds a carrier requirement that the written adverse determination notice specify covered alternative treatment options and identify providers who are qualified, accessible and available. This new requirement creates significant resource and timing problems and contravenes the critical principle that any recommendation of treatment should squarely reside between a member and their provider. Accordingly, we would suggest that this new requirement be stricken or, in the alternative, the requirement be satisfied through carrier communication to the member (e.g., the member "may want to discuss any possible alternative treatment options with your attending, prescribing or primary care physicians."). BCBSMA has long regarded

decisions regarding treatment options following an adverse determination to be member-centric. As noted above, for a carrier to issue an adverse determination and then be required to find providers who are qualified, accessible and available would necessitate significant staffing resources to fulfill this highly manual process while adding to the cost of care. For these reasons, we would request that proposed section 3.307(2)(f) be deleted.

Section 3.312: Coverage or Treatment Pending Resolution of Internal Grievance

Section 3.312(1) has required a carrier to provide coverage for ongoing treatment through completion of the internal grievance process regardless of the final internal grievance decision and at the carrier's expense, if a grievance is filed concerning the termination of ongoing coverage or treatment provided that the grievance is filed on a timely basis. We appreciate the need for this requirement. Section 3.312(1) has included pertinent language that the ongoing coverage or treatment include only that medical care that, at the time it was initiated, was authorized by the carrier or utilization review organization (unless it concerns an expedited review) and does not include medical care that was terminated pursuant to a specific time frame or episode related exclusion from the insured's contract for benefits [emphasis added]. We disagree with this approach as it does not recognize longstanding health insurance contract terms and practice. We would request additional clarification for the proposed change given the serious implications relative to covered services and the underlying benefit agreement. As an example, skilled nursing care coverage is widely limited to a number of days (e.g., 100 days). Today, a grievance would be ineligible for review once the patient has reached the limit. Without this prior clause included, denied services due to day, dollar or visit limits within a member's subscriber agreement are no longer excluded from a consumer's ability to access the external review process.

Thank you for your consideration of our comments in regard to 958 CMR 3.000. BCBSMA supports the effort to implement reforms to the state's internal and external review requirements. We continue to support these important consumer protections with the reasonable amendments noted above. We look forward to continuing this important policy dialogue in support of the effective implementation of these consumer protection regulations.

Please contact me if you have any questions.

Sincerely,

Michael T. Caljouw

Cc: Lois Johnson, Health Policy Commission
Kevin Beagan, Division of Insurance