health law advocates
Lawyers Fighting for Health Care Justice

HEALTH CARE FOR ALL

October 6, 2015

Robert A. Whitney
Deputy Commissioner and General Counsel
Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston, Massachusetts 02118

Dear Deputy Commissioner and General Counsel Whitney:

Health Law Advocates (HLA) and Health Care For All (HCFA) respectfully submit these comments to the Division of Insurance (DOI) regarding the regulatory review process pursuant to Executive Order 562. HCFA seeks to create a patient-centered health care system that provides comprehensive, affordable, accessible, culturally competent, high quality care and consumer education for all Massachusetts residents, especially the most vulnerable among us. HLA is a non-profit public interest law firm that serves some of the Commonwealth's most vulnerable populations. HLA provides pro bono legal representation to low-income Massachusetts residents who have been unjustly denied health care access and to those who are burdened with unaffordable medical debt.

We appreciate the opportunity to respond to comments submitted by carriers and others following the listening session held on August 7, 2015.

A. HCFA and HLA adamantly oppose any change to weaken DOI enforcement of mental health and substance abuse parity laws.

At a time when our entire Nation is moving in the direction of improving access to mental health and substance abuse services, in part by making insurance coverage more equitable, Massachusetts should not distinguish itself by rolling back reasonable measures designed to protect vulnerable patients. DOI regulations at 211 CMR 154.00 and DOI Bulletin 2013-06 were issued pursuant to authority conferred by the Affordable Care Act and M.G.L. c. 26, §8K.[1] One commenter proposes that the DOI amend 211 CMR 154.00. Two commenters recommend that the DOI alter reporting requirements set forth in Bulletin 2013-06. Massachusetts' parity enforcement structure is the result of a thoughtful and thorough process and protects consumers against discriminatory health plan practices that have long harmed consumers in the absence of active government intervention. We vigorously oppose the changes as unwarranted and harmful to the vulnerable consumers the regulatory scheme should protect.

[1] Public Law 110-343, section 511 (codified at M.G.L. c. 26, §8K).

1. The DOI should not amend its parity compliance regulation.

Minuteman Health proposes that the DOI "clarify" regulations concerning enforcement of Mental Health Parity Laws at 211 CMR 154.00 by:

- Deleting language requiring carriers to comply with "any interim or final regulations, guidelines, sub-regulatory guidances, or related instructions that have been issued or promulgated by the Federal Mental Health Parity Law Agencies in their exercise of appropriate authority over Federal Mental Health Parity Law" (211 CMR 154.02 (2)(a));
- Deleting the requirement that certification of a carrier's review of its compliance with Parity Laws be signed by the carrier's chief executive officer in addition to its chief medical officer (211 CMR 154.03(2)(b)); and
- Amending 211 CMR 154.05 to permit the Commissioner, after a hearing pursuant to M.G.L. c. 30A, to suspend or revoke a carrier's accreditation, license or certificate of authority for parity violations only if the carrier acted with intent or willful disregard.

We strongly oppose these proposed changes. First, regulations and guidance are a lawful and necessary means by which Federal Mental Health Parity Law Agencies protect consumers. While it is beyond dispute that carriers must abide by these Agencies' rules and guidance, it is important to explicitly articulate that duty.

Second, we oppose removing the requirement that a carrier CEO sign the certification of parity compliance. The CEO has ultimate responsibility for ensuring that the carrier complies with the Parity Laws. While the chief medical officer has clinical expertise, the CEO is responsible for legal compliance in every aspect of the carrier's business. Requiring the CEO's signature on the certification of parity compliance is therefore appropriate and necessary.

Finally, requiring willful disregard or intent for imposition of certain penalties would excuse carriers that are negligent, even grossly negligent, in making administrative practices consistent with the Parity Laws. We anticipate that the Commissioner will exercise restraint in imposing the strongest sanctions, doing so only where there is substantial evidence of serious malfeasance by a carrier. However, it is important that the Commissioner have the authority, after due process is provided, to hold noncompliant carriers accountable for all violations of the Parity Laws.

2. The DOI should not weaken carriers' reporting duties.

DOI Bulletin 2013-06 requires carriers to submit information to DOI to demonstrate compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). MAHP and Tufts Health Plan recommend that the DOI eliminate certain of these reporting requirements on the grounds that they duplicate the accreditation requirements at 211 CMR 52.06. Specifically, MAHP and Tufts recommend that, for MHPAEA compliance, the DOI require only a "checklist" that indicates any changes made by the carrier and require a substantive filing only where there has been a material change.

The DOI should maintain current data reporting requirements for MPHAEA compliance. Executive Order No. 562 seeks to improve efficiency within government, not to weaken lawful and necessary regulatory actions. DOI Bulletin 2013-06 is an integral tool for enforcing the parity laws and was fully vetted at the time of issuance. DOI regulations and guidance for parity compliance reporting do not duplicate other DOI provisions, as the information and analysis required to determine parity compliance are unique. We therefore oppose any change in the frequency of data reporting, or in the substance and scope of data required of carriers for parity compliance. The proponents of this change have failed to demonstrate that the change will not harm consumers. Any reporting burden on carriers is outweighed by the benefits of increased transparency, more useful information, and thorough compliance review.

B. HCFA and HLA oppose certain proposed changes to tiered network regulations.

We oppose the recommendation that plans no longer provide a letter to subscribers regarding tier reclassification under specified circumstances 30 days prior to the reclassification date. *See* 211 CMR 152.04(5). Tiered networks can be opaque and confusing for patients, making it difficult to make informed choices about where to seek care based on cost and quality data. When carriers move providers from a lower-cost tier to a higher-cost tier, patients may face disruption in care if they cannot afford the additional expense of seeing their usual providers.

Reducing disclosures regarding provider reclassification will lead to further confusion and could have a particularly detrimental impact on patients who are in their third trimester of pregnancy, who are terminally ill, or who rely on their primary care provider for ongoing care and to coordinate services. While reclassification information may eventually be available in the provider directory, patients are entitled to direct, timely notice of this critical information. Requiring patients undergoing a continuing course of treatment to constantly seek out tier classification information is not realistic or fair. We therefore oppose rolling back transparency protections for individuals enrolled in tiered network plans.

We also oppose the recommendation to eliminate the requirement that plans train and track brokers in limited and tiered network plans. *See* 211 CMR 152. Tiered network plans are complicated. Carriers do not use uniform or standardized cost or quality criteria to classify providers, resulting in inconsistent determinations of tier level from one health plan to another. For example, while Tufts Health Plan tiers affiliated doctors and hospitals together, Harvard Pilgrim Health Care tiers doctors based on their group, and Blue Cross Blue Shield of MA only tiers PCPs and hospitals but not specialists. Within these provider categories, cost and quality metrics differ and are weighted inconsistently across plans. Therefore, it is particularly important for insurance brokers to be appropriately trained on the complexities of tiered network products and their impact on purchasers and members. Similarly, brokers should fully understand the structures and limits of limited or regional network plans, as these plans significantly impact how consumers access care.

C. HCFA and HLA oppose reduction in the information required to be provided in plan Evidences of Coverage.

We oppose the recommendation to eliminate the requirement that Evidence of Coverage (EOC) documents contain the plan's voluntary and involuntary disenrollment rates. This information can be a useful indicator of member satisfaction and nothing prohibits carriers from providing additional information regarding the reasons for disenrollment. If the information is not provided in the EOC, at a minimum the EOC should direct the consumer to find the information on the carrier's website.

D. HCFA and HLA oppose limitations on consumer access to paper copies of important plan documents, such as their Evidence of Coverage, or Provider Directories.

We are concerned with comments that propose the use of *only* electronic notification for important documents that describe member rights and obligations under a health plan, such as the Evidence of Coverage and Provider Directories. Not every consumer has the resources or capability to access electronic documents. However, in the interest of sustainable business practices, we would support efforts to promote the use of electronic access, especially for lengthy documents such as provider directories, so long as consumers actively and affirmatively agree to electronic access. For instance, carriers could place an "opt-in" option for electronic access, or for future electronic communications, on their website consumer portals. Then the carrier could invite the member to the portal, where the member could opt-in to electronic access if desired. Implementing such a process would allow carriers to print and mail fewer paper documents, while providing some assurance that members that opt-in are fully able to access electronic documents.

However, even if a consumer has previously opted-in, unforeseen circumstances may prevent the individual's continued access to an online interface. Therefore, carriers should continue to be required to inform plan members that print documents are available, free of charge upon request, and to comply promptly with any such request.

E. HCFA and HLA oppose the elimination of the Notice of Benefit requirements.

Some comments suggested eliminating the Notice of Benefits requirement for approvals of admissions or other requested services under M.G.L. c. 176O, § 12(c). Consumers rely upon notices of approval from their health plans, especially if they are waiting for a treatment or service that requires prior authorization. We have also seen instances where a health plan's approval of requested services is in fact only a *partial* approval of the requested services, and thus operates as an adverse benefit determination even though not labeled as such. Such a partial denial can be grounds for an appeal, so requiring carriers to provide a clear and concise description of the approved services in writing protects member rights and fully informs members about the nature of the care they can expect to receive.

F. HCFA and HLA oppose reduction in data submission requirements.

A number of carriers proposed amending certain regulations to reduce data filings with the DOI on the grounds that the information can be obtained from other sources. The data mentioned includes information on tiered and limited network plans, financial reports and membership data. While we understand the health plans' desire to avoid duplicative data filing, we urge the DOI to carefully review these requests to ensure that the substance and frequency of data reported to the DOI remains unchanged. (See Section B2 above for our comments on proposed reductions in reporting requirements for parity compliance.)

G. The DOI should continue to issue sub-regulatory guidance

We support the suggestion that the DOI better organize and make available all sub-regulatory guidance. The DOI should continue to issue bulletins and other sub-regulatory guidance as a means to clarify how current laws and regulations apply to emerging situations in health care access, coverage and delivery of care. Bulletins in particular can be a valuable and effective means to communicate information that describes or clarifies how state laws impact consumer rights in health care.

H. HCFA and HLA oppose the elimination of DOI regulations, especially where state and federal statutes offer different protections.

Some commenters suggested that the DOI work to adopt regulations that make uniform and consistent the requirements created under federal law and those created under state law. For example, an "appeal" under federal law is called a "grievance" under state law. Similarly, another recommendation proposed that state regulations be eliminated in many places, and replaced by a cross-reference to a corresponding federal regulation. There may be instances where the use of uniform or consistent language is consistent with the law and promotes clarity. However, we urge the DOI to consider carefully the important differences between federal and state laws that the DOI enforces through regulation. The Affordable Care Act created vital protections for consumers, but in many areas, Massachusetts laws provide comparable or even stronger protections. The ACA permits states to implement such consistent and stronger requirements, as long as minimum federal standards are met. The success of health reform in Massachusetts depends upon improving health care quality, while reducing the ever-present rise in costs. Massachusetts' leadership in these areas will continue to create differences between federal and state law, and state rules must reflect those differences.

In addition, federal rules could change quickly if national political tides change. Therefore, defining state regulatory requirements only by cross-reference to federal rules could increase ambiguity and confusion for consumers. By contrast, using state regulations to clearly define the consumer rights that have an independent basis in state law assures Massachusetts consumers that their state law rights will not be abridged by future federal changes.

I. The DOI should reopen the public comment period on the network adequacy regulation.

Given the number of comments related to the network adequacy regulation, the pending finalization of the NAIC network adequacy model act, and the two years passed since the public comment period on the network adequacy regulation, we recommend that the DOI hold a new public comment period on the network adequacy regulation, 211 CMR 52.13.

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Thank you for the opportunity to submit additional testimony regarding the DOI's regulatory review process. If you have any questions or need additional information, please contact Alyssa Vangeli at avangeli@hcfama.org or Clare McGorrian at cmcgorrian@hla-inc.org or 617-275-2983.

Sincerely,

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