June 15, 2015

Brian McKeon, Project Coordinator
Executive Office of Administration and Finance
Massachusetts State House, Room 373
Boston, MA 02133

re: Executive Order 562 – To Reduce Unnecessary Regulatory Burden

Dear Mr. McKeon:

I write on behalf of the Massachusetts Association of Health Plans, which represents 17 health plans that provide coverage to 2.6 million Massachusetts residents, to commend Governor Baker on Executive Order 562 initiating regulatory reform review. We support this important effort to reduce the burden of unnecessary cost and complexity on Massachusetts businesses and foster competition, business growth, and job creation for our local economy.

MAHP member plans are committed to and have undertaken a variety of efforts to control both medical expenses and their administrative costs. According to the Center for Health Information and Analysis' 2014 *Annual Report on the Performance of the Massachusetts Health Care System,* total spending in the commercial insurance market grew by 2.2%, with MAHP member plans well below the state's 3.6% cost growth benchmark. However, health plans are heavily regulated and the cost of complying with government requirements adds to the cost of coverage. Accordingly, with input from our member plans, we have compiled the following list of regulatory areas requiring changes or modifications in order to streamline administrative processes and reduce unnecessary costs within the health care system.

The proposed changes below will help improve the efficiency of the healthcare system through simplification of administrative requirements:

Consistency in Guidance and Aligning with Federal Law

1. ***Sub-regulatory Guidance***
   Often, rather than issuing regulations, an agency will issue sub-regulatory guidance which correct or clarify regulatory requirements. This type of guidance can be difficult to track and to ensure compliance with for a number of reasons. Sub-regulatory guidance is often issued piecemeal, so plans must be aware of all sub-regulatory guidance to get the full scope of the requirement. Also, unlike regulations, historical administrative bulletins and other such guidance are not readily accessible online.

Recommendation: The Administration should require sub-regulatory guidance and bulletins be permanently posted on the agency's website, with notice given to all interested parties to ensure continuous access.

2. ***Consistency of Terms Across Regulations***
   Currently, terminology is not used consistently across various state and federal regulations. For example, the Office of Patient Protection uses the term "grievance" where CMS uses the term "appeal." This makes it difficult for consumers to understand the processes used in the same way across agencies.

   Recommendation:
   We recommend the Administration require agencies use terms consistently across state regulations and align those terms with federal regulations.

3. ***Cross-Referencing Parallel Federal Requirements***
   In many instances, the state has adopted ACA and other federal requirements. For example, the Office of Patient Protection regulations are largely in other guidance, including the Affordable Care Act, as are the state mental health parity requirements.

   Recommendation: Where applicable, we recommend the federal requirement be cross-referenced, which will prevent duplication and remove the significant burden of having the same requirement written by the state in a slightly different way.

4. ***Elimination of Provisions that have Sunset or are No Longer Applicable***
   There are a variety of regulations that are no longer applicable, as they are in reference to a one-time event or have since lapsed.

   Recommendation: We recommend that each agency conduct a thorough review of existing regulations and remove any provisions that have sunset or are no longer applicable. Similarly, we recommend that all agencies conduct a thorough review of regulations to ensure references to agency names are correct.

5. ***1099HC – MA Reporting***
   The Massachusetts individual mandate requires residents enroll in health insurance coverage meeting minimum standards or pay a fine if affordable coverage is available to them and they do not enroll. Employers are to provide their employees residing in Massachusetts with proof of creditable coverage via the 1099HC form, and a separate report verifying the statement to the Department of Revenue. An individual mandate is also a component of the ACA. Form 1095-B is used to report certain information to the IRS and to taxpayers about individuals who are covered by minimum essential coverage and therefore are not liable for the individual shared responsibility payment.

   Recommendation: Remove the 1099HC reporting and notice requirements. The form and reporting processes are inconsistent, confusing, and unduly burdensome for individuals, carriers, and employers. Now that plans must comply with the federal 1095-

B reporting requirement, it is costly to produce and mail the state forms when the same form could be used for and satisfy both mandates.

6. *Re-accreditation – 211 CMR 52.00*
The accreditation filing required by 211 CMR 52.00 allows carriers to obtain deemed status if they are NCQA or URAC accredited. Under federal regulation, QHP issuers are obligated to be accredited by a national accreditation organization.

Recommendation: Eliminate the accreditation process under 211 CMR 52.00 and allow health plans to submit their NCQA or URAC certification instead.

Division of Insurance Reporting and Licensure Requirements

1. *Quarterly Report, Financial and Membership – 211 CMR 43.05*
Currently HMOs are required to file three copies of a quarterly financial report with the Commissioner within 45 days of the close of its quarter in the format specified by the NAIC or otherwise as specified by the consumer.

Recommendation: Require carriers to file with the NAIC and allow the Division of Insurance to pull the report from the NAIC, thus eliminating the need for carriers to file the same information with multiple entities. The Division of Insurance should obtain membership data from the APCD.

2. *Limited, Regional, and Tiered Provider Network Enrollment Information – 211 CMR 152.09*
Plans are required to submit information identifying the prior year's utilization trends of employers and individuals enrolled in the Carrier's Limited Provider Network plans and Tiered Provider Network plans, including the number of insureds enrolled by plan type, aggregate demographic and geographic information on all insureds, direct premium claims incurred in limited and tiered network plans as compared to direct premium claims incurred for the carrier's non-tiered and non-limited plans, utilization by tier during the plan year, and requests by insureds enrolled in limited provider network plans for out-of-network coverage within the plan year.

Recommendation: Eliminate this reporting requirement as all information may be obtained from the All Payer Claims Database (APCD).

3. *Evidence of Coverage Reporting of Employer Premiums*
Plans are required under M.G.L. c. 176O §6(a)(2) to include a "clear, concise, and complete statement of: … (2) the prepaid fee which must be paid by or on behalf of the insured" in the EOC. The Division of Insurance has interpreted this to mean the actual dollar amount of the premium, information which is more readily available from employers.

Recommendation: Replace this requirement that health plans include the prepaid fee on behalf of the insured in the EOC with a statement that the insured should seek

information from their employer pertaining to the pre-paid fee. Since this data is more readily available from employers, it would encourage employees to be more engaged with how their care is paid for.

4. ***Health Plan Licensure – 211 CMR 43.00***
   Plans are required to submit licensure information annually to the Division of Insurance. M.G.L. c. 176G §14 requires HMO licenses to be renewed on an annual basis, but does not dictate the contents of the licensure renewal, other than the requirement that an HMO shall notify the Commissioner of a material change to the information submitted in the original license application in a form and at a time approved by the Commissioner.

   Recommendation: Eliminate the requirement for submission of duplicative information already on file with the Division of Insurance. Information required for renewal should be limited to the minimum necessary, particularly in light of the regulatory requirement that an HMO submit any material change to its licensure filing 30 days prior to the effective date of the change.

5. ***Annual Certification Process – Mental Health Parity and Addiction Equity Act Requirements – DOI Bulletin 2013-06***
   The bulletin required carriers to provide substantial information regarding the medical necessity criteria, authorization processes, and business practices for mental health and substance use disorder treatment versus medical/surgical treatment by October 1, 2013 and thereafter on or before July 1 of any subsequent calendar year. This information is already submitted to the Division of Insurance as part of the managed care accreditation filings under 211 CMR 52.06.

   Recommendation: The Division of Insurance should adopt a similar process to the managed care accreditation application whereby plans submit information in the form of a checklist that indicates whether they've made any changes and provide substantive information only if a material change has been made regarding the information sought.

6. ***Enrollment/Disenrollment Information in EOCs – 211 CMR 52.15***
   Plans are currently required to include the voluntary and involuntary disenrollment rate among their insureds in their evidences of coverage. This information is not a useful tool for members, and provides metrics unrelated to quality of care and member satisfaction.

   Recommendation: Either eliminate the requirement altogether or allow plans to post the metric on their website rather than requiring it be mailed to members annually.

7. ***Annual Medicare Supplement Insurance Policy Rate Manual Filings – 211 CMR 71.12(9)***
   Plans are required to file an up-to-date rate manual for all Medicare Supplement Insurance Policies, riders, and endorsements currently available for sale in Massachusetts no later than 45 days after approval of new rates or policy forms.

Recommendation: Eliminate this requirement. Annual Medicare Supplement rates are filed through the SERFF system and can be easily checked for historical reference if necessary.

8. *Reporting of Multiple Medicare Supplement Insurance Policies – 211 CMR 71.19*
   Plans are required, on or before March 1st annually, to report information for individuals for which the plan has more than one Medicare Supplement Insurance Policy in effect.

   Recommendation: Eliminate this requirement. Eligibility requirements for individual Medicare Supplement Insurance Policies do not allow members to have more than one policy in force.

9. *Tiered Network Letter – 211 CMR 152.04(5)*
   Thirty days prior to the reclassification date for tiered network products, plans are required to provide a letter detailing information on reclassification in several different instances, including if the plan allows or requires designation of a PCP and the PCP has been reclassified to a higher cost-sharing tier, if the member is in her second or third trimester of pregnancy and a provider in connection with her pregnancy is reclassified to a higher cost-sharing tier, and if a member is terminally ill and their treating provider is reclassified to a higher cost-sharing tier.

   Recommendation: Eliminate this requirement. Plans are required to include this information in the Provider Directories, which are provided to members upon enrollment and annually thereafter, and available electronically as well.

10. *Notification Requirements – 211 CMR 52*
    Plans are currently required to issue documentation to members in commercial and Medicaid products, including provider 60 day notice, provider directories, printed handbooks for MassHealth and OneCare, printed list of covered drugs for OneCare, notice of privacy practices and mental health parity compliance for MassHealth and OneCare.

    Recommendation: These processes should be handled electronically, unless paper is requested. It is costly and administratively burdensome to issue all materials by paper, and a majority of members access their materials electronically. For the minority of members who wish to continue receiving information and materials in paper form, an opt-in is practicable. Further, the need to include a separate printed notice of privacy practices and a separate mental health parity sheet as components of the Welcome kit should be eliminated, since both pieces are part of the member handbook already.

11. *Training Brokers on Limited and Tiered Networks – 211 CMR 152*
    Plans are required to provide appropriate training to any employee or insurance producer selling, soliciting, or negotiating its insurance products about the Carriers Health benefit Plans that use limited provider networks, regional provider networks, or tiered provider networks. Plans are also required to maintain records of those employees and insurance

producers who have satisfactorily completed the training and make that information available to the Commissioner upon request.

Recommendation: Eliminate the requirement that plans provide training and track training for insurance brokers. While employee training and tracking of employee training is reasonable, plans have less control over brokers as they are not direct employees and it is burdensome to track their training.

MassHealth Reporting Requirements

1. ***Medicaid MCO Reporting Requirements***
   MassHealth requires a significant level of reporting by Medicaid Managed Care Organizations (MCOs) throughout the year. The combined programmatic, behavioral health, and financial provisions included in the MCO contracts results in more than 200 individual reports, certifications, or attestations sent to MassHealth over a 12-month period. Depending on the subject and type of report, MCOs may be required to submit the information annually, semi-annually or quarterly.

   Recommendation: MassHealth should continue its efforts in evaluating the necessity of the reports it requires, including eliminating, consolidating, or reducing the required number of submissions per year.

2. ***Federally Required Disclosure Form – MassHealth Contractual Requirement***
   MassHealth requires each health plan to collect a Federally Required Disclosure Form which they themselves also get. This process is redundant and burdensome; there is also resistance on the part of the providers to completing the form for health plans because the form requests owner and key employee social security numbers

   Recommendation: Eliminate the requirement for health plans to collect the form. MassHealth should continue to collect the forms on behalf of the plans, which should be sufficient to meet the requirement.

3. ***MassHealth Physician Eligibility Requirements***
   MassHealth requires that physicians be either board-certified or board-eligible in order to participate. This is unlike commercial plans in that it excludes excellent physicians from the state products and creates extra work for Medicaid plans. About 10% of licensed physicians in Massachusetts are not board-certified or board-eligible. As a matter of routine, plans verify board certification for all physicians. Then, for the state, in order to determine if those physicians who are not certified are eligible, plans must take extra steps by reviewing non-board-certified physicians to see if they remain board eligible. Since every medical board has different requirements about who can remain in a board-eligible status, health plans must review all non-certified physicians against their board to see if they remain eligible. If the physician is not board-certified or board-eligible and the plan wants to include the physician in their network, the plan may complete a waiver form to request an exception.

Recommendation: Eliminate the requirement that physicians be either board-certified or board-eligible in order to participate in the Medicaid product. The extra process for Medicaid plans provides no additional value and keeps physicians out of networks.

Center for Health Information Analysis (CHIA) Reporting Requirements

While the All Payer Claims database shows great promise, the suggestions below recognize the current limitations of the data submitted to the APCD. As the Division and CHIA continue working towards increased utilization of the ACPD, the following suggestions represent potential uses of the APCD in the future.

1. *Total Medical Expense Reporting – 957 CMR 2.04*
   Plans are required to report TME by physician group and physician local practice group for Massachusetts members required to select a primary care physician, for practices with at least 36,000 member months for the calendar year, pursuant to certain guidelines.

   Recommendation: As the data in the APCD becomes more robust, information should be obtained from the APCD to the extent feasible and reporting requirements that would require reporting of redundant information should be eliminated.

2. *Relative Price Reporting – 957 CMR 2.05*
   Plans are required to report Relative Price data separately by Medicare, Medicaid, Commonwealth Care, and commercial (fully-insured and self-insured) for inpatient and outpatient hospitals, separated by hospital category, and for behavioral health only for acute hospitals with psychiatric or substance abuse units with the psychiatric hospital file.

   Recommendation: As the data in the APCD becomes more robust, information should be obtained from the APCD to the extent feasible and reporting requirements that would require reporting of redundant information should be eliminated.

3. *Alternate Payment Methodologies Reporting – 957 CMR 2.06*
   Plans are required to report APM data separately by Medicare, Medicaid, Commonwealth Care, and commercial (fully-insured and self-insured) for inpatient and outpatient hospitals, separated by hospital category, and for behavioral health only for acute hospitals with psychiatric or substance abuse units with the psychiatric hospital file.

   Recommendation: As the data in the APCD becomes more robust, information should be obtained from the APCD to the extent feasible and reporting requirements that would require reporting of redundant information should be eliminated.

Statutory Requirements

1. *Notice of Benefits – Approvals*
   Health plans are required by M.G.L. c. 176O §12(c) to provide the insured and the provider with written notices of benefit approvals. Currently, health plans are required to notify providers by telephone within 24 hours after they have approved an admission,

procedure or service. The health plan must then provide written or electronic notice to both the provider and the member within two working days.

Recommendation: Remove this requirement. While the notice requirement in the case of a denial is an important consumer protection, there is no corresponding benefit to members or physicians in sending approval notices. Generally, the physician has already received notice by telephone of the approval and members are receiving subsequent notice of approval after the admission, procedure, or service has already occurred.

Thank you again for the opportunity to comment on this initiative. We believe that the proposed changes could substantially reduce administrative costs with negligible impact on patients, providers, and employers. We look forward to continuing to work with you on these efforts and would be happy to talk with you or members of your staff in greater detail about the items outlined in the letter.

Sincerely,

Eric Linzer
Senior Vice President of Public Affairs and Operations