MAHP
MASSACHUSETTS ASSOCIATION of HEALTH PLANS

August 17, 2015

Kevin Patrick Beagan, Deputy Commissioner
Division of Insurance
1000 Washington Street, Suite 810
Boston, MA 02118-6200

Dear Deputy Commissioner Beagan:

On behalf of the Massachusetts Association of Health Plans, which represents 17 health plans that provide coverage to 2.6 million Massachusetts residents, we 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 to foster competition, business growth, and job creation for our local economy.

MAHP member plans have undertaken a variety of efforts to control both medical and administrative expenses. 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.

We appreciate the ongoing work that the Division has undertaken to work collaboratively with the Center for Health Information and Analysis to obtain access to comprehensive data available through the All Payer Claims Database in an effort to improve efficiencies. We also encourage the Division to engage its sister agencies, particularly the Executive Office of Health and Human Services and the Health Connector, in a joint review of their regulations for the purpose of achieving closer alignment in terminology and processes.

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

Division of Insurance Reporting and Licensure Requirements

1. ***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: Amend the accreditation process under 211 CMR 52.00 and allow health plans to submit their NCQA or URAC certification to satisfy those requirements that can be

addressed through submission of a NCQA/URAC certification. Eliminate accreditation requirements that are available through other sources.

2. ***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 National Association of Insurance Commissioners (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 All Payer Claims Database (APCD).

3. ***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 members enrolled by plan type, aggregate demographic and geographic information on all members, 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 members 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 APCD.

4. ***Evidence of Coverage Reporting of Employer Premiums– 211 CMR 52.00***
   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 Evidence of Coverage. 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 with a statement that the insured should seek information from their employer pertaining to the prepaid 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.

5. ***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.

6. ***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.

7. ***Enrollment/Disenrollment Information in EOCs – 211 CMR 52.15***
   Plans are currently required to include the voluntary and involuntary disenrollment rate among their members 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.

8. ***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.

9. ***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.

10. ***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 are available electronically as well.

11. ***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 lists of covered drugs for OneCare, and 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.

12. ***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 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 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.

<u>Statutory Requirements</u>

1. ***Notice of Benefits – Approvals***

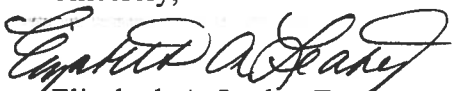
Health plans are required by M.G.L. c. 176O §12(c) to provide the insured and the provider with written notices of benefit approvals. Currently, health plans are required to notify providers by telephone within 24 hours after they have approved an admission, procedure or

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,



Elizabeth A. Leahy, Esq.
Research Analyst