MHA MASSACHUSETTS HOSPITAL ASSOCIATION

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The Massachusetts Hospital Association (MHA), on behalf of our member hospitals and health systems, appreciates the opportunity to participate in the **Division of Insurance's (Division's) regulatory review public comment session on health insurance regulations**. Per the executive order, only those regulations which are mandated by law or essential to the health, safety, environment, or welfare of the Commonwealth's residents shall be retained or modified. The Division is already aware of concerns raised by MHA regarding the risk certificate and waiver processes pursuant to 211 CMR 155.00, as these have been detailed in previous communications. The intent of this regulation is to protect consumers from potential insolvency by providers who have taken on more risk than they can support. However the Division has created a regulation that surpasses the intent of the law and places undue and unnecessary burdens on providers. Our specific concerns are specified below:

211 CMR 155.00: RISK-BEARING PROVIDER ORGANIZATIONS

155.05 – Risk Certificate Waivers

The statute requires that a risk bearing provider organization (RBPO) may be deemed to be in compliance with the division's standards if the division determines that the provider organization's alternative payment contracts do not contain significant downside risk. However, the regulation states that it shall be within the discretion of the commissioner to issue or renew a risk certificate waiver. This has led the Division to deny waivers to organizations that had as little as ½ of 1% downside risk, subjecting them to the full risk certificate process. This is an expensive, time consuming and completely unnecessary process for these organizations as under those circumstances there is virtually no risk of insolvency. Each of the organizations that applied and were denied a waiver in 2014 received the same form letter, stating that the Division has carefully reviewed the materials and has determined that the organization has not met the burden of demonstrating that the downside risk contained in any alternative payment contract does not contain significant downside risk. The letters provided no detail as to why or how the Division came to this conclusion, what methodology the Division used to calculate significant downside risk or what the Division actually considered as significant downside risk.

According to Filing Guidance Notice 2015C, when an RBPO can demonstrate that it has only a small proportion of it's revenue from alternative payment contracts with downside risk and the RBPO has the net worth sufficient to fund any losses, the Commissioner is likely to issue a waiver . There are other important factors that should be included in the Commissioner's decision, such as

- the percentage of a provider organization's members who are in "at risk" contracts,
- the actual amount of risk,
- the size of the provider organization and the years of experience in managing risk,
- the protections that the provider organization has in place to guard against financial insolvency, such as withholds, stop loss and reinsurance.

The regulation should be modified to require that the Division indicate the specific criteria it is using and that any denial letters must contain a complete explanation of what criteria were not met. A regulation that leaves the decision "to the discretion of the commissioner" with no further explanation or rationale and no appeal right is anti business, anti consumer, and completely lacking in transparency.

Proprietary concerns

MHA continues to be concerned that all of the materials submitted to the Division as part of the application process are subject to public disclosure. Much of the information is proprietary and not all of it is required by the statute. **We recommend that the Division collect the minimum amount of information required by statute to protect providers from unfair competition and potential unintended consequences.**

Section 155.06(2)(b), requiring that a provider organization provide the names of health care payers and employers with which it is seeking to enter into an arrangement will give competitors as well as health plans an unfair advantage. It does not provide the Division with any meaningful information and should be removed from the regulation. Likewise, Section 155.06(2)(i) requires a description of the level and nature of risk assumed across all of the provider organization's contracts including details about aggregate number of members covered under alternative payment contracts. Neither of these sections are required by the statute and both contain potentially anti-competitive information that could be damaging to the provider organization and to the healthcare system in general if subject to public disclosure. They are not necessary for the Division to be able to issue a risk certificate as this information will be part of the actuarial certification. In addition, much of this information is available through the HPC's provider registration process.

Examination

According to the proposed regulation, the examination of the RBPO shall be conducted in accordance with the procedures set forth in M.G.L. c. 175 section 4 and M.G.L c. 176 T section 4. Chapter 175 governs insurance companies and many of the provisions in section 4 are not applicable to provider organizations, such as requiring that the examiner observe guidelines and procedures set forth in the examiners' handbook adopted by the National Association of Insurance Commissioners. We also have concerns about the cost of the examination given that section 4 allows the commissioner to retain attorneys, appraisers independent actuaries, independent certified public accountants and other professionals and specialists as examiners, the proper cost of which shall be borne by the company which is the subject of the examination. The statute only references subsection (6) of section 4 of chapter 175 in relation to conducting and charging for the examination, not the entire section as is referenced in the proposed regulation. MHA requests that the Division clarify its intention. It is critical to keep in mind that the organizations being examined are not insurance companies and that this requirement poses an unnecessary burden on providers.

Duplication, Consistency of terminology

It would be very helpful if the Division would align its requirements with those used by the HPC for the registered provider organization process. For example, allow the information to be submitted at the health system level, as is done for the HPC, versus the contracting affiliate level. This would significantly reduce the burden and would align with the information submitted to the HPC without compromising the statutory requirements.

In addition, any information that has already been provided to the HPC should not be duplicated by the Division. For example, the Division should obtain the most recent materials submitted to the HPC pursuant to MGL c. 6D section 12 directly from the HPC if they are not already on file with the Division. There is also duplication with the HPC requirements for contracting entities. State agencies should share information, not require providers to duplicate what has already been submitted or is available from a different state agency.

Thank you for the opportunity to provide comments on 211 CMR 155.00. MHA looks forward to continuing to work with the Division on reducing the regulatory burden for our members. If you have any questions, please contact Karen Granoff, Sr. Director Managed Care at KGranoff@mhalink.org.