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August 17, 2015

Daniel Judson, Commissioner
Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston, Massachusetts

RE: Division Of Insurance Regulatory Review: Health Insurance, 211 CMR 52.00

Dear Commissioner Judson:

On behalf of the Massachusetts Society of Optometrists ("MSO"), which represents over 700 primary eye care doctors throughout the Commonwealth, I am writing first to thank the Division of Insurance ("Division") for its efforts in engaging stakeholders as part of its regulatory review pursuant to Executive Order 562. The MSO welcomes this opportunity to work with the Division and provide feedback relative to each regulation's impact and necessity, as suggested would be helpful to and considered by the Division at the August 7, 2015 Health Insurance Regulation Listening Session. Over the years and many iterations of recent health care reform laws' enactment, many aspects of the regulations pertaining to health insurance have warranted thoughtful reconsideration. The MSO has consistently advocated for various changes to certain regulations to improve access, quality of care delivered, and to also contain costs for Massachusetts residents and businesses. Certain health insurance regulations at 211 CMR 52.00 are ripe for review as these regulations have not implemented certain important changes required by various health care reform laws and as a result, adversely affect Massachusetts patients, providers and the competitive environment in the Commonwealth.

In particular, the MSO recommends changes to the health insurance regulations that would improve clarity and promote consistency in the regulatory structure. Our membership struggles with the inconsistency of the various regulations as they apply to different providers based on credentialing, reimbursement and oversight. In light of these observations, the MSO respectfully submits the following comments to the Division relative to certain outstanding areas that are ripe for implementation in the Division's health insurance regulations pursuant to various state and federal laws: Uniform Credentialing, Network Adequacy, Vision Care Services, Provider Rights and Nondiscrimination (Section 2706 of the Affordable Care Act). To that end, please consider the following:

1. **Uniform Credentialing (New Language and Amendments to 211 CMR 52.10).** Uniform credentialing, which provides for consistent credentialing processes for all health care professionals, has been a requirement since the passage of Chapter 288 in 2010, yet the regulations to implement those changes have yet to be promulgated. As you know, the Division prepared draft regulatory changes to this end and released them on September 10, 2013, which the MSO fully supported at that time. In fact, the MSO submitted detailed comments in support of the proposed language as well as additional language that would strengthen some of the provisions, as contemplated by Chapter 288. The MSO would like to take this opportunity to resubmit these specific for the Division's consideration. (See, Appendix A).

2. **Network Adequacy (New Language and Amendments to 211 CMR 52.00).** In order to gain a clear picture of the distribution of healthcare services and points of access, regulations pertaining to network adequacy ought to be added to the regulations. Again, network adequacy requirements were established in the passage of Chapter 288 in 2010, but have yet to be implemented through regulations. The Division drafted proposed language that was released for public comment in September 2013. At that time, the MSO weighed in to support those changes and suggested additional clarifying language in an effort to strengthen the provisions. The MSO would like to take this opportunity to resubmit these specific for the Division's consideration. (See, Appendix B).

3. **Standards for Provider Contracts (New Language and Amendments to 211 CMR 52.03 and 211 CMR 52.12).** Currently, the health insurance regulations do not extend sufficient protections, remedies or pathways to transparency in health insurance contracts. Providers are required to rely on growing provider networks that can utilize negotiation leverage to protect their rights, which leads to an increasing drive towards health care consolidation. While this may be suitable for providers who consolidate, the independent and smaller health care providers, with little to no bargaining power, are left without the ability to negotiate. The vast majority (84%)[1] of optometrists own their own practices and have no negotiation leverage whatsoever. As a single entity, there exists little recourse to defend against unfair business practices employed by some insurers and sub-contractors, such as unilateral changes to the provider agreements without notice. Again, language regarding standards for provider contracts was required in the passage of Chapter 288 in 2010. The Division drafted proposed regulatory changes to this end, released them for public comment on September 10, 2013, yet these changes were not implemented. The MSO fully supports the implementation of the changes proposed by the Division of Insurance to regulations regarding Standards for Provider Contracts along with additional clarifying language for certain definitions. The MSO would like to take this opportunity to resubmit these specific for the Division's consideration. (See, Appendix C).

4. **Definition of Vision Services (Amendments to 211 CMR 52.03).** Vision care services, in practice, relate narrowly to vision. "Vision Care Services", as currently defined in 211 CMR 52.03, however, include a variety of medical eye care services, including, but not limited to the diagnosis, prevention and treatment of illness, injury or disease. While ophthalmologists and optometrists perform these health care services for patients on a daily basis, they do <u>not</u> fall within the narrower category of "vision care services". Accordingly, ophthalmologists and optometrists are not limited to treating only "vision care services" as defined in practice, and as the current definitions of "Vision Care Provider" and "Vision Care Professional" in 211 CMR 52.03 indicate. As such, the MSO recommends that the definition of "Vision Care Services" be amended to reflect health care practice as follows:

> "Vision Care Services or Vision Services", services to measure, and when appropriate issue prescriptive correction for standard astigmatism, myopia, hyperopia refractive errors and presbyopia and to assess the binocular status and health of the ocular system."

5. **Nondiscrimination in Health Care (Amendments to 211 CMR 52.14, et. seq.).** Section 2706(a) of the federal Affordable Care Act ("ACA"), Public Law 111-148, contains strong language that prohibits insurers from discriminating against providers acting within their scope of practice with respect to coverage or participation in a plan. The nondiscrimination provisions of the ACA are critical to meaningful health care reform that achieves both greater patient access and cost savings. Section 2706(a) addresses issues that have grown over the years as the health care market has evolved in a manner that allows for widespread anti-competitive behavior to dictate health insurance coverage norms that reinforce systemic high costs. In particular, some health plans have begun to categorically

[1] American Optometric Associations 2010 Census of Optometric Practice.

exclude certain providers (based on type of provider) from participation in certain networks. These practices stifle opportunities for cost savings and close off patient access to value-based providers[2]. In Massachusetts, the Division of Insurance was charged with state implementation of this section, however neither regulations nor guidance has been issued by the Division to date. The Massachusetts health care market would greatly benefit from such guidance coming from the Division as part of this process. As such, the MSO would like to take this opportunity to suggest recommendations for the Division's consideration in connection with its interpretation and implementation of Section 2706(a) in the Commonwealth; please see Appendix D.

In addition to the above, the MSO encloses several additional recommended changes to the Division's regulations in Appendix E.

Understanding that the Commonwealth's regulations for health insurance are more than a mechanism for the Massachusetts Division of Insurance to make sure that a carrier is financially sound and consumer friendly, the MSO respectfully urges the Division to consider these proposed amendments. The Division's regulations are a mechanism to ensure that health care reform efforts are implemented effectively and efficiently and also provide a pathway to support transparency in health insurance carrier contracts facing both the consumer and provider sides.

Thank you for your thoughtful consideration of these important matters. The MSO looks forward to continuing to work with the Division throughout this process. If you have any questions or concerns, please do not hesitate to let us know.

Sincerely,

Richard Lawless,
Executive Director, Massachusetts Society of Optometrists

Cc: Mr. Robert Whitney, Deputy Commissioner and General Counsel, Massachusetts Division of Insurance

Mr. Christopher Joyce, Deputy General Counsel, Massachusetts Division of Insurance

Mr. Kevin Beagan, Deputy Commissioner, Health Care Access Bureau, Massachusetts Division of Insurance

[2] Section 2706(a) of the Patient Protection and Affordable Care Act (Public Law 111-148, 124 Stat. L. 119) ("ACA").

APPENDIX A - UNIFORM CREDENTIALING (211 CMR 52.10):

In connection with the Division's implementation of uniform credentialing requirements pursuant to Chapter 288 of the Acts of 2010, please consider the following:

(1) 211 CMR 52.10. Carrier Accreditation Contingent Upon Utilization of Uniform Credentialing Standards. While Section 37 of Chapter 288 of the Acts of 2010 is clear that a carrier's accreditation is conditioned upon that carrier's utilization of uniform standards and methodologies, the proposed amendments to 211 CMR 52.00 lack such a provision. This important statutory provision, which in essence indicates that carriers cannot apply different credentialing standards to different providers providing identical health care services, is a critical component of the law and, subsequently, to these proposed regulatory changes. To that end, the ramifications of a carrier failing to use uniform credentialing methodologies are not clearly stated. Adding such a statement will not only help to ensure that carriers are put on notice, but will serve to clarify the scope and application of this statutory provision.

Accordingly, please insert an additional subsection to 211 CMR 52.10 as follows:

(10) "A Carrier's accreditation is dependent upon the Carrier's utilization of uniform standards and methodologies in its current credentialing and recredentialing processes for all providers, including any health care providers licensed under chapter 112 that provide identical services."

(2) 211 CMR 52.10(1). Applicability of NCQA Standards for Credentialing. Many health care providers have frequently been advised by carriers that they do not credential certain types of licensed health care professionals. In doing so, the carriers have referred to the National Committee for Quality Assurance (NCQA) standards for credentialing to support this decision. NCQA requires credentialing of all physicians, but leaves discretion to the carrier as to whether to credential certain other providers. The statutory language adopted in 2010 was intended to prevent the anticompetitive behavior when coverage for services is provided by carriers and the provision of those services is within the lawful scope of practice of other health care professionals within the marketplace. As written, the proposed regulations may be interpreted as not requiring uniformity[3].

Therefore, we strongly urge the Division to adopt the following changes to 211 CMR 52.10(1), highlighted below in bold:

52.10(1): **Standards for** Credentialing (1) A Carrier's **uniform** credentialing and recredentialing processes **for Providers of identical services** set forth in the Carrier's application for Accreditation will be reviewed for compliance with the applicable NCQA Standards for

[3] It should be noted that striking the word "Standards" from the section heading and referencing only NCQA in this section potentially denotes that NCQA policy is the standard for the Commonwealth. Despite listing additional national accreditation organizations in 211 CMR 52.03, the regulations, as drafted, may inadvertently undercut the legislature's directive that "the bureau shall establish by regulation as a condition of accreditation that carriers use uniform standards and methodologies for credentialing of providers, including any health care provider type licensed under chapter 112 that provide identical services". (Section 37 of Chapter 188 of the Acts 2010). (For instance, NCQA standards give Carriers' discretion as to whether or not they choose to credential certain provider types (i.e. nurse practitioners, physician assistants, etc.). Such a standard is in direct opposition to the uniform credentialing requirements in Massachusetts, which require that Carriers credential all provider types.).

credentialing and recredentialing; **provided further, that there is a credentialing and recredentialing process for all licensed provider types.**

(3) 211 CMR 52.10(3). Applicable Policy for Additional Credentialing Information. The legislature has consistently sought to avoid discrimination by carriers against health care professionals based upon the providers' type of licensure.[4] Instead, the legislature has sought to improve access to a wide variety of trained health care professionals. For example, Massachusetts law mandated coverage long ago for services rendered by advanced practice registered nurses, such as nurse practitioners (NPs), when a policy or contract provides benefits to subscribers and members for identical services rendered by a provider of health care licensed by the commonwealth. (*See* Section 4T of chapter 176B, Section 47Q of chapter 175, Section 8S of chapter 176A and Section 4 of chapter 176G of the Mass. Gen. Laws.). Pursuant to chapter 176R of the General Laws, this same protection is afforded to nurse practitioner in the proposed regulations at 211 CMR 52.12(16) regarding "Provider Contracts". Finally, section 37 of Chapter 288 of the Acts of 2010 specifically mandated *uniform standards and methodologies for credentialing of providers, including any health care provider type licensed under chapter 112 that provide identical services.* (emphasis added).

Accordingly, we respectfully request that the proposed language of 211 CMR 52.10(3) be amended follows:

"211 CMR 52.10(3). Nothing in this section shall be construed to prevent a Carrier from utilizing additional credentialing information in selecting the Providers with which it contracts **so long as the carrier does not require additional credentialing information for a Provider of identical services solely based upon the Provider's type of licensure**." (amendment in bold).

(4) 211 CMR 52.10(4). Information for Providers that Meet Carrier Credentialing Criteria. Historically, providers have not been privy to carriers' credentialing processes and selection criteria. Frequently, health care professionals receive letters from carriers that their credentialing application has been rejected. For many providers, the process can be ambiguous and inconsistent. As a result, a provider who is not selected to be a "participating provider" has very limited information as to the reason for non-selection – even if the provider met the carrier's credentialing criteria. Geographic area is one particular area of concern. For instance, a provider's request to the carrier for information about the denial is frequently answered with a simple statement indicating that the provider was not needed in the carrier's geographic area. Further requests for information about the carrier's service area offer no explanation or rationale for such determination. Under this scenario, a provider has no ability to improve his or her likelihood of acceptance as a participating provider within the carrier's service area.

In order to extend fair opportunities for providers to participate in carrier plans, providers should have access to more information about the carrier's determination with respect to his or her particular application. Not only will a provider gain meaningful information as to how a carrier's credentialing criteria may have applied to them, but it will give the provider insight as to how he

[4] To wit, legislation to streamline credentialing solely for physicians has been consistently rejected by the legislature over the past seven years. *See also* Section 3 of Chapter 176D, added by Chapter 288 of the Acts of 2010 (e.g. unfair or deceptive acts include a "refusal by a nonprofit hospital service corporation, medical service corporation, insurance or health maintenance organization to negotiate, contract or affiliate with a health care facility or provider because of such facility's or provider's contracts, type of provider licensure…".)

or she can make his or her application more competitive. By sharing this information, carriers will help stimulate a more competitive pool of applicants in the future, which will undoubtedly provide for greater coverage and care for the insureds.

To support the exchange of meaningful information as it relates to a particular provider's credentialing application, we recommend that 211 CMR 52.10(4) be amended to include the following language after the first sentence:-

"Upon a Provider's written request, Carriers shall provide a written response detailing the reasons Carrier did not select the Provider that otherwise met the Carrier's credentialing criteria."

(5) 211 CMR 52.10(6). Uniform Time Frame for Credentialing. To facilitate the implementation of uniform credentialing standards and methodologies for providers, the new regulations in 211 CMR 52.00 should clarify that carriers must complete credentialing of health care providers, regardless of provider type, within the same, uniform time frame. This will ensure that the time periods within which carriers must complete credentialing will be uniform and reasonable for all providers, regardless of provider type.

To that end, we recommend that 211 CMR 52.10(6) be amended by inserting, after the words "complete credentialing", the words "**of all Health Care Providers**".

"(6) All Carriers shall complete credentialing **of all Health Care Providers** within a reasonable time frame, and shall inform the Provider within 60 days of receipt of a Clean and Complete Credentialing Application of the status of the application, including the reason for delay, if any, and a timeline of the expected resolution of the application."

Pursuant to Chapter 288 of the Acts of 2010, the Division diligently proposed new regulations to effectuate credentialing uniform in 2013. The MSO supports the Division's thoughtful amendments and appreciates the Division's consideration of the aforementioned recommendations that could strengthen regulations on uniform credentialing.

APPENDIX B - NETWORK ADEQUACY (211 CMR 52.00)

In connection with the Division's implementation of network adequacy requirements pursuant to Chapter 288 of the Acts of 2010, please consider the following:

(1) 211 CMR 52.12. Consistent Reference to Select Network Plans. With regard to the proposed amendments to 211 CMR 52.12 Provider Contracts, we are unaware of any rationale to substitute the word "select" for the word "limited" before the phrase "network plan" in this section. In addition, the reference to "tiered network plan" is also missing. In doing so, the proposed regulations appear inconsistent with the statutory text adopted in Section 9A(a) and (b) of section 39 of Chapter 288 of the Acts of 2010. Further, regulatory use of the word "limits" in the same sentence using the phrase "limited network plan" appears confusing. To avoid unnecessary confusion or potential for litigation, we respectfully ask the Division to review this section in detail to ensure clarity and common understanding of the types of carrier products available to consumers.

(2) 211 CMR 52.13(1). Maintenance of Network Adequacy. As far as the patient is concerned, a network is adequate to the extent that the patient has both the freedom to choose a provider and the access needed to efficiently obtain health care services. To best serve patient needs, the regulations should encourage carriers to organize networks that are not only sufficient in the number of providers, but also in the type of provider. By doing so, the Division will afford insureds the opportunity to choose among service providers. Specifically, we recommend that the Division adopt the following changes to 211 CMR 52.13(1), highlighted in bold below:

"(1) A Carrier offering a plan(s) that includes a Network(s) shall maintain such Network(s) such that **Insureds shall be able to access health care services from a range of providers, including identical services offered by any health care provider type licensed under Mass. Gen. Laws chapter 112** to assure that all services will be accessible to insureds without unreasonable delay."

(3) 211 CMR 52.13(2). Carriers' Access Analysis of High Quality, Lower Cost Providers. As you know, the proposed amendments 211 CMR 52.13 would require carriers to file an access analysis plan with the Commissioner. We strongly support these new requirements, as the components of the access analysis plan will help carriers to systematically evaluate the sufficiency of their current networks. One component of this plan that has yet to be addressed, however, includes the carrier's efforts to encourage the use of lower cost, high quality providers. Carriers that promote the use of lower cost providers undoubtedly help to control costs to the overall health care system, while at the same time fostering efficient patient access to needed health care services.

To that end, we recommend that the Division include under its minimum requirements for the access plan described 211 CMR 52.13(2), "**the carriers' efforts to encourage the inclusion and use of high value Providers in its Network**;"

(4) 211 CMR 52.13. Network Adequacy. The MSO fully supports the additional provisions concerning Network Adequacy that the DOI is contemplating in its proposed amendments to 211 CMR 52.13. Information, such as the geographic access tables, will certainly serve to help Carriers, the DOI and patients gain a clear picture of the distribution of health care services and points of access. To further strengthen these provisions, the MSO recommends that the DOI require Carriers to indicate the total numbers by provider type wherever possible. Further, while 211 CMR 52.13(3) requires Carriers to make their selection criteria available to the Commissioner upon request; it would be extremely beneficial to afford all health care providers

the opportunity to understand a Carriers' selection standards. Not only will this help providers to become more competitive applicants, but it will result in a better healthcare marketplace for patients. (Note: With little to no cost, this could simply be met by posting the standards on a carrier's website.) Accordingly, the MSO recommends that 211 CMR 52.13(3) be amended by inserting the following amendment (in bold):

"A Carrier shall make its selection standards for Participating Providers available for review by the Commissioner **and available to Providers upon request. A Carrier shall apply its selection standards uniformly to all Providers of identical services. Carriers shall provide an appeals process to Providers who were not selected, but have otherwise met the Carrier's credentialing criteria.**"

While eye care and vision health comprise a smaller percentage of all health care expenses than other specialties, it represents a health care service which almost everyone utilizes. Through their perspective as primary care eye doctors, optometrists have been able to witness the changing landscape for health care first hand. As a result, it has become increasingly clear that all health care providers must be treated the same when providing identical services. Whether through uniform credentialing standards or tools necessary to determine network adequacy, all health care providers should be treated equally by insurance companies. It is no longer a matter of fairness; it is a matter of delivering high quality health care services at reduced cost.

APPENDIX C – STANDARDS FOR PROVIDER CONTRACTS (211 CMR 52.03 and 211 CMR 52.12)

To effectively deliver covered care, health care providers and health insurers must work hand in hand in accordance with the terms of not only the insurance policy, but also in accordance with the provider agreement. Over time, and due at least in part to the inherent imbalance in bargaining power between individual providers and the insurers they contract with, provider agreements have in practice failed in terms of extending protections and providing recourse for providers. The Division can play an important role here through a few relatively minor changes to strengthen the regulations governing standards for provider contracts. In fact, the Division began to proceed with some important proposed changes as part of its draft amendments to 211 CMR 52.00 pursuant to Chapter 288 of the Acts of 2010, which were released for public comment in September 2013. The MSO supported those proposed changes and offers the following additional comments for the Division's consideration:

(1) 211 CMR 52.12. Standards for Provider Contracts. In addition to supporting the draft language (proposed section 211 CMR 52.12(5)) as proposed by the Division in 2013 which specified the types of provider agreements that are not permissible, the MSO recommends that the Division add the following language:

   a. To proposed section 211 CMR 52.12(7) / current section 211 CMR 52.12(6), add the highlighted language in bold, "Contracts between carriers and health care providers shall state that a carrier shall provide a written statement to a provider of the reason or reasons for such provider's involuntary disenrollment. **A formal appeal process before an independent party shall by established by carriers exercising involuntary disenrollment procedures."**

   b. At the end of 211 CMR 52.12, add, **"Provider contracts shall state that the Provider has the right to opt out of any product or plan 60 days before the effective date of such modification or renewal of plan or individual product."** This language provides for consistency with the "opt out" language in 211 CMR 152.05(3) that is currently applicable to "Limited and Regional Provider Network Plans". The "opt-out" language in 211 CMR 152.05(3) is clear and gives providers a reasonable time to digest and react to plan and contractual changes and revisions.

(2) 211 CMR 52.12(11). The language of this section, "Nothing in 211 CMR 52.12 shall be construed to preclude a carrier from requiring a health care provider to hold confidential specific compensation terms[.]" is now in conflict with the new transparency and price disclosure requirements of Mass. General Laws Chapter 111, Sec 228, as amended by Chapter 224 of the Acts of 2012. The MSO respectfully suggests that the Division remove this subsection to provide for consistency with existing statute.

(3) 211 CMR 52.03. The current definition of "Complaint" in 211 CMR 52.03 provides, "any inquiry made by or on behalf of an insured to a carrier or utilization review organization that is not explained or resolved to the insured's satisfaction within three business days of the inquiry", which affords complaints to be made on behalf of an insured, but does not afford this recourse for providers. Providers may face issues with their provider agreements in the same way insured's may have issues with their policies. As such, the MSO suggests that the Division consider broadening the scope of complaint by adding the highlighted language (in bold) to the definition as follows, "Complaint, (a) any inquiry made by or on behalf of an insured **or provider** to a carrier or utilization review organization that is not explained or resolved to the insured's **or provider's** satisfaction within three business days of the inquiry; or […]"

The Commonwealth's regulations for health insurance are more than a mechanism for the Massachusetts Division of Insurance to make sure that a carrier is financially sound and consumer friendly. These regulations are a mechanism to ensure that consumers and providers are treated in a non-discriminatory manner – one that does not adversely affect their ability to receive treatment or provide treatment, respectively.

APPENDIX D - NONDISCRIMINATION (Implementation of Section 2706 (a) of the ACA)

In connection with the Division's implementation of section 2706(a) of the Affordable Care Act, Public Law 111-148, which is intended to drive value to the health care system by eliminating discrimination based on provider license-type from health insurance plans in today's marketplace, please consider the following:

I. Health plans violate section 2706(a) where the plan excludes a whole class of providers based on licensure-type.

Health insurance plans serving the Massachusetts market have developed access standards that effectively discriminate against providers based on their licensure. As you know, section 2706(a) states that "a group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State Law." While this clause does not require insurers to contract with "any willing provider", a reasonable, conservative interpretation of this provision suggests that plans should build networks based on access to covered services, not simply access to only one type of provider who is able to provide the covered service.

To this end, optometrists are the most accessible primary eye care providers with close to a thousand licensees practicing in both urban and rural settings across the state. Insurance plans continue to assert they have developed "adequate" networks, despite excluding optometrists from provider panels altogether (Note: optometrists are often the only eye care providers in certain communities). As this type of discriminatory practice creates barriers to patient access, stifles competition in the marketplace and contributes to the high cost of healthcare; we respectfully request the Division to recognize this as a violation of section 2706(a) and issue guidance to that effect.

II. Health plans violate section 2706(a) where the plan employs a different coverage policy based on provider license-type.

Many health insurance plans in the Commonwealth treat optometrists differently from other providers who render eye care services. This perpetuates discriminatory practices with respect to coverage. Section 2706(a) prohibits discrimination "with respect to participation under the plan or coverage". Optometrists have long worked under a complex system of contractual arrangements under which the individual provider has essentially no bargaining power. This system has evolved to the point that health insurance plans now "carve out" the coverage and claims administration for eye care services to third party administrators. Unlike other eye care providers, optometrists have no ability to elect to remain part of the primary health insurance plan. Instead, the insurer transfers eye care benefits and the handling of eye care claims to a third party administrator, but only when those services are rendered by an optometrist. The inherent discrimination lies in the fact that ophthalmologists and other medical doctors, remain under the primary insurance plan, even when providing the exact same eye care services as an optometrist.

These actions significantly impact optometrists. For optometrists, there are many disadvantages in being "carved out" to a third party administrator, ranging from grossly inadequate reimbursement schedules (substantially lower than even the differentials between optometrists and ophthalmologists under the primary insurance plan), overly burdensome claims submission requirements, and contractual limitations on supply vendors. These same restrictions do not

apply to ophthalmologists and other providers providing the same scope of eye care services under the primary insurance plan.

This discriminatory "carve out" practice further distinguishes a class of practitioners solely based on provider license-type. The nondiscrimination provisions of section 2706(a) empower the Division to take a closer look at these practices and consider the discriminatory byproduct or impact of these carve outs. For eye care services, this may require all eye care services to be handled by third parties, regardless of whether an ophthalmologist or an optometrist renders the care. Or perhaps this requires parity with respect to the terms of coverage (i.e., parity in reimbursement schedules, covered benefits, and products and supplies such that third party coverage and provider agreements mirror the coverage and provider agreements offered by the primary insurer). At the very least, the MSO respectfully requests the Division ensure that insurers are not using policies and contracts with third party administrators as a loophole through which they can escape accountability for meeting state and federal requirements and standards such as section 2706(a).

III. Health plans violate section 2706(a) when reimbursement rates vary based on provider license-type alone.

Reimbursement rates vary widely in today's health care marketplace, often established based on license-type, with no identified difference in quality or performance of service. Section 2706(a) states that "[n]othing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures." The MSO fully supports reimbursement rates that vary based on quality and performance. To date, however, quality and performance have not been quantified and reimbursement rate variations based on license-type alone have become the convenient norm. Any successful effort to control costs requires that policymakers and providers have honest conversations about what health care services cost and whether quality and performance measures are truly the basis for the rate differentials that exist today.

Despite significant overlap in their scope of services – requiring the same legal standard of care – an optometrist receives a fraction of the reimbursement due to an ophthalmologist for providing the same exact services. There is no recognizable difference in quality nor is the standard of care different based on the license-type of the individual who provides the care. Currently, an ophthalmologist does not necessarily receive a higher reimbursement rate because he or she gives a better quality examination, or has completed more examinations, or has more training in such examinations. The ophthalmologist has more training in surgery and other modalities that fall outside of an optometrist's scope of practice, none of which are at issue here. Where services fall within a given health care provider's license, he or she is considered to be thoroughly and sufficiently trained (and licensed by the state) to provide those services. Policies with reimbursement rates that are capped or established with different rate schedules due to license-type alone are discriminatory and violate section 2706(a). The Division should issue guidance to ensure that insurance plans base rate differentials on proven quality and performance standards.

In sum, diversity and competition in the marketplace is critical to controlling costs and meaningful reform. Health care providers who are systematically not selected to participate in insurance plans will be carved out of the health care system and their livelihood threatened. To address this, providers need the Division to issue guidance on this matter before insurers commit to models that discriminate against certain types of providers. At a minimum, providers need a mechanism for ensuring the Division, as the oversight agency for insurers in the Commonwealth, holds insurers accountable for potentially discriminatory actions.

APPENDIX E – MISCELLANEOUS, Proposed Amendments to 211 CMR 52.14, 211 CMR 148.02, 211 CMR 51.00, 211 CMR 148.00, 211 CMR 152.00

Finally, the MSO submits the following proposed changes for the Division's consideration as part of its effort to strengthen and clarify provisions of existing regulations under the purview of the Division:

(1) 211 CMR 52.14(7). Required Disclosures for Carriers and Behavioral Health Managers. This subsection (7) provides that, "A carrier, including a dental or vision carrier, shall provide to a health, dental or vision care provider, a written reason or reasons for denying the application of any health, dental, or vision care provider who has applied to be a participating provider." In practice, however, MSO members have seen carriers apply these stated reasons for denial in a manner that treats providers of identical services differently, based on license type or practice setting. In order to ensure that businesses and individual practitioners are being treated equally, such disclosures should be evidence of the manner in which the carrier would treat all providers of identical services within a given geographical region for a specified period of time. This enhances transparency and gives providers a realistic sense of when it may be able to reapply to become a participating provider in a carrier's network. As such, the MSO recommends that the following highlighted language (in bold) be added to 211 CMR 52.14(7), at the end thereof, "**Reason of denial of application or participation shall be applied to all providers of the same services in a particular geographic region.**"

(2) 211 CMR 148.02. Definitions. In today's health insurance market, third party administrators are being more frequently employed by carriers to administer and apply entirely different policies, coverage terms and provider agreements to providers of identical services, based on provider license type alone. This practice is contrary to health care reform efforts, specifically ACA Section 2706(a). As such, the MSO recommends clarifying in the Division's definition of "Third-party Administrator" as follows (proposed amendment in bold), "Third-party Administrator: A person domiciled inside or outside of the Commonwealth who, on behalf of a Health Insurer or purchaser of health benefits, receives or collects charges, contributions or premiums for, or adjusts or settles claims on or for residents of the Commonwealth. Unless noted otherwise, a purchaser of health benefits shall not include an entity to the extent it offers a policy, certificate or contract that does not qualify as creditable coverage as defined in M.G.L. c. 111M, § 1; provided, however, that a purchaser of health benefits shall include an entity that offers a policy, certificate or contract that provides coverage solely for dental care services or vision care services **and said policy, certificate or contract will apply to all providers of the same services.** Third-party Administrator shall also include pharmacy benefit managers and any other entity with claims data, eligibility data, provider files and other information relating to health care provided to residents of the Commonwealth and health care provided by health care providers in the Commonwealth, except that Third-party Administrator shall not include an entity that administers only claims data, eligibility data, provider files and other information for its own employees and dependents. Third-party Administrator further shall not include "intermediary", as defined in M.G.L. c. 176J, § 1 and 211 CMR 66.04: Definitions."

(3) 211 CMR 43.08. Premium Rates. In the Division's regulations governing HMO's, there are established requirements that the HMO issue specific descriptions detailing the bases for paying similarly situated providers different rates. Theses bases which are enumerated in the regulations include: quality of care delivered, mix of patients, geographic location at which care is provided and intensity of services provided. This language is consistent with ACA Section 2706(a) and would help to support the health care reforms recently passed in state legislation. As such, the

MSO recommends that the Division duplicate this language in the following additional sections of regulations:

a. 211 CMR 51.00 Preferred Provider and Workers' Compensation (i.e., in 211 CMR 51.05 (c) add paragraph 3);

b. 211 CMR 148.00 Third Party Administrators;

c. 211 CMR 152.00 Health Benefit Plans using Limited, Regional or Tiered Provider Networks (i.e., in 211 CMR 152.05(4) add (e) "If the Carrier intend to pay… [Insert 211CMR 43.08 (5) (j) language.]).

In sum, regulations to uphold nondiscrimination language and improve uniform credentialing will lead to improved access, inefficiency and value for the residents of the commonwealth. The fact of the matter is, with tremendous upheaval in the healthcare market and health insurance realm, it behooves the commonwealth to make specific regulations to uphold transparency and fairness amid all this change.