TUFTS Health Plan

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August 17, 2015

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

Dear Deputy Commissioner Whitney:

On behalf of Tufts Associated Health Maintenance Organization, Inc. and its affiliates (collectively, "Tufts Health Plan"), we appreciate the Division of Insurance ("Division") undertaking a review of all existing regulations to determine whether there is a clearly identified need for continuing to retain the particular regulation. We support this important effort to streamline administrative processes and reduce the burden of unnecessary cost and complexity on Massachusetts businesses.

Tufts Health Plan is committed to and has undertaken a variety of efforts to control both medical expenses and administrative costs. However, health plans are heavily regulated and the cost of complying with government requirements adds to the cost of coverage. Accordingly, we have compiled the following list of regulatory areas where we would request 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:

No New Sub-Regulatory Guidance
Often, rather than issuing regulations, an agency will issue sub-regulatory guidance which corrects or clarifies 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 and when they are online, are generally not organized by subject matter or in a format where they are easy to locate when seeking guidance on a particular topic.

We strongly encourage the Division to post any and all sub-regulatory guidance and bulletins, such that they will be permanently available on the agency's website in a well-organized format. We also request that notice be given to all interested parties to ensure continuous access.

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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 and regulated entities to understand the processes used in the same way across agencies.

We recommend the Division require consistent use of terms across state regulations and align those terms with federal regulations.

Cross References to 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. Cross-referencing federal requirements, rather than restating them within state regulations with slightly different wording, will prevent duplication as well as remove the significant burden of having the same requirement written by the state in a slightly different way that creates additional complexities for the health plans. It would also prevent issues that arise when federal regulations are updated but the corresponding state regulations are not updated at the same time.

We therefore recommend that, where applicable, any federal requirements be cross-referenced within the body of the state regulation.

Repeal Obsolete Regulations
There are a variety of regulations that are no longer applicable, as they are in reference to a one-time event, have sunset, or have since lapsed. This includes, but is not limited to:

- 211 CMR 151 – Certified Group Purchasing Cooperatives
- As we are a merged market, there is no need for 211 CMR 41 (Non-group Health Insurance Rate and Policy For Filings, Review and Hearing Procedures) and 211 CMR 42 (Form and Contents of Individual Accident and Sickness Insurance)
- References to pre-existing conditions, such as those at 211 CMR 40.07(3), 211 CMR 66.07, 211 CMR 41.04.

We recommend that the Division conduct a thorough review of existing regulations and remove any provisions that have sunset or are no longer applicable.

Notification Requirements
Plans are currently required to issue documentation to providers, including 60 day notice of modifications that have a substantial impact on the rights and responsibilities of providers. In addition to the administrative burden of sending paper copies of the notices, this restricts the ability of plans to make changes as quickly as is desirable, as changes must

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be timed in order to be included in the next provider notice, which sometimes results in a four plus month delay between an internal plan decision and effective date.

Regulations should allow for these processes to be handled electronically, unless paper is requested. It is costly and administratively burdensome to issue all materials by paper, and a majority of people now prefer to access materials electronically. For the minority of members who wish to continue receiving information and materials in paper form, an opt-in is practicable.

Modernize Coordination of Benefits regulations (211 CMR 38)
The Commonwealth's Coordination of Benefits (COB) regulations were written at a time when the nuclear family was the societal norm. However, family structures are much more diverse today and the COB regulations should be revised to account for the various types of families. Specifically, we recommend that the word "separated" be replaced by "living apart" throughout 211 CMR 38.05 to account for couples that were never married. Additionally, we suggest the Division clarify, where custody of a child is considered, that the regulation is referring to "physical" custody.

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 health maintenance organization (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.

To streamline this process, we recommend the Division eliminate the requirement for submission of duplicative information already on file. 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.

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. This process is duplicative.

We recommend that the Division require carriers to file with the NAIC and allow the Division of Insurance to pull the report from the NAIC, thus eliminating the need to file the same information with multiple entities. Further, the Division should obtain membership data from the APCD.

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Re-accreditation (211 CMR 52.00)
The accreditation filing required by 211 CMR 52.00 allows carriers to obtain deemed status if they are National Committee for Quality Assurance (NCQA) or URAC accredited. Additionally, under federal regulation, Qualified Health Plan (QHP) issuers are obligated to be accredited by a national accreditation organization. We respectfully request the Division eliminate the accreditation process under 211 CMR 52.00 and allow health plans to submit their NCQA or URAC certification instead.

Enrollment/Disenrollment Information in the Explanation of Coverage (211 CMR 52.15)
Plans are currently required to include the voluntary and involuntary disenrollment rates 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. We recommend the Division either eliminate the requirement altogether or allow plans to post the metric on their website rather than requiring it be mailed to members annually.

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. Annual Medicare Supplement rates are also filed through the SERFF system and can be easily checked for historical reference if necessary. We respectfully request the Division eliminate the reporting requirement at 211 CMR 71.12(9) to streamline the process.

Reporting of Multiple Medicare Supplement Insurance Policies (211 CMR 71.19)
Plans are required, annually on or before March 1st, to report information for individuals for which the plan has more than one Medicare Supplement Insurance Policy in effect. However, eligibility requirements for individual Medicare Supplement Insurance Policies do not allow members to have more than one policy in force. We therefore recommend the Division eliminate this reporting requirement.

Training Brokers on Limited and Tiered Networks (211 CMR 152.00)
211 CMR 152.00 places an undue burden on carriers selling or soliciting Limited and Tiered Network plans by requiring carriers to provide appropriate training to any employee or insurance producer selling, soliciting, or negotiating its insurance products about the carrier's health benefit plans that use Limited Provider Networks, Regional Provider Networks or Tiered Provider Networks. Carriers are further required to maintain records of those employees and insurance producers who have satisfactorily completed such training and make such information available to the Commissioner upon request.

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While tracking employee training is reasonable, brokers are not direct employees, making it burdensome to track them down. We strongly urge the Division to eliminate these requirements.

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 primary care physician (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.

Plans are required to include this information in the Provider Directories, which are available electronically. We therefore recommend the Division eliminate this separate notification requirement.

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.

As all of the information required by 211 CMR 152.09 may be obtained from the All Payer Claims Database (APCD), we recommend elimination of this reporting requirement.

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 has interpreted this to mean the actual dollar amount of the premium, information which is more readily available from employers.

We suggest the Division replace the 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.

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Annual Certification Process – Mental Health Parity and Addiction Equity Act Requirements (DOI Bulletin 2013-06)

Bulletin 2013-06 requires 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 as part of the managed care accreditation filings under 211 CMR 52.06.

We urge the Division to adopt a similar process to the managed care accreditation application whereby plans submit information in the form of a checklist that indicates whether there are any changes and provide substantive information only if a material change has been made regarding the information sought.

Again, we thank you for your consideration and look forward to continuing to work with the Division on this matter. Should you have any questions or if we can provide further information, please do not hesitate to contact me at (857) 998-9915 or via email at Nicole_Waickman@tufts-health.com.

Sincerely,

Nicole Waickman
Manager, Regulatory Affairs and Public Policy
Tufts Health Plan