Executive Board Insurance Market Working Committee Minutes

Tuesday, March 19, 2013, 10am

Members Present:

Kevin Lucia (Chair), Dr. Henry Aaron, Kate Sullivan Hare, Commissioner William P. White

Members Absent:

Director Wayne Turnage

Staff Present:

Mila Kofman, Executive Director

Jeff Gabardi, General Counsel

Debra Curtis, Senior Deputy Director for Policy & Exchange Programs

Purvee Kempf, Deputy General Counsel

Brendan Rose, Plan Management Program Manager

Opening and General Updates:

The meeting was called to order by Committee Chair Kevin Lucia who explained that this committee is meeting today to take up items where consensus was not reached in the Essential Health Benefit Working Group and the Plan Offering and Qualified Health Plan Benefit Standardization Working Group.

The non-consensus items being considered by the Committee were the topic of extensive public input through the relevant working group. The working groups, which are deliberately composed of multiple stakeholder representatives from the DC community, have provided detailed input and written reports summarizing consensus and non-consensus items and will serve as the primary record. The public and various stakeholder organizations were provided numerous opportunities for public comment over the weeks and months the workings groups met and numerous organizations and individuals participated.

Overview and Status of Consensus work by the two working groups:

Essential Health Benefit Working Group:

The Essential Health Benefit Working Group met over a number of meetings and through their discussions they reached consensus on the following important items:

Consensus Item 1: Behavioral health inpatient and outpatient services be covered without day or visit limitations to the benefit.
Consensus Item 2: That there be no age restriction on eligibility for habilitative services and the National Association of Insurance Commissioners (NAIC) definition of "habilitation" be applied for habilitative services. This definition is "[H]ealth care services that help a person keep, learn or improve skills and functioning for daily living."

Plan Offering and Qualified Health Plan Benefit Standardization:

The **Plan Offering and Qualified Health Plan Benefit Standardization** Working Group met over a number of meetings and through their discussions they reached consensus on the following items:

Consensus Item 1: The Exchange should allow Issuers to offer additional benefits to QHPs beyond EHB ("additional benefits" defined as services eligible for claims submission and reimbursement).
Consensus Item 2: Issuers participating in the Exchange should be required to offer at least one plan at the Bronze level.

NON CONSENSUS ITEMS DISCUSSION AND RECOMMENDATIONS:

Non-Consensus items from the Working Group on Essential Health Benefits:

Item #1 - The Essential Health Benefits Working Group reached consensus for using the National Association of Insurance Commissioners (NAIC) definition of "habilitation" for habilitative services with one outstanding issue: Should the D.C. Exchange modify the NAIC definition substituting in "maintain" for "keep"? The NAIC definition for habilitation is: "[H]ealth care services that help a person **keep**, learn or improve skills and functioning for daily living."

Item #2: Should the definition of habilitative services specifically reference applied behavior analysis as a modality of treatment for autism?

Discussion:

With regard to item #1, Board Members asked Exchange staff for clarification of the decision-making at the NAIC for the development of the definition and were informed that it was carefully thought through word by word, including with a medical linguist expert.

Committee members noted that they were hard pressed to find a serious distinction between keep and maintain.

With regard to item #2, all the Committee Members were moved by the testimonials of people who have benefited from this treatment and were influenced by the fact that more than 30 states have moved forward to act in this arena. It was recognized that many states have dollar limitations on the benefit, but that such limitations will not be allowed under the Affordable Care Act any longer. Committee members reviewed materials submitted as testimony and also spent time specifically discussing the definition used by Michigan on applied behavioral analysis as that definition was accepted by the federal government as not creating a new state mandate, but simply as defining habilitative services. There was also significant discussion about the fact that medical management tools and medical necessity requirements will still apply to applied behavioral analysis just like they do every other benefit and service. In the end, the Michigan definition was found to be the best solution.

Recommendation #1 - DC's essential health benefit habilitative services category shall be defined as: health care services that help a person keep, learn or improve skills and functioning for daily living, including, but not limited to, applied behavioral analysis (ABA) for the treatment of autism spectrum disorder.

Vote: unanimously in favor

Non-consensus items from the Working Group on Plan Offering and Qualified Health Plan Benefit Standardization:

Item #1 - Should there be a maximum number of Qualified Health Plans an issuer can offer per metal tier (bronze, silver, gold and platinum)? If so what should that maximum be?

Discussion: It was noted that there was no consensus on this issue in the working group and that some felt very strongly for limitations and others were adamantly opposed. There was discussion about how there is little evidence from plans in the DC market arena plan to flood the market with new, complicated insurance choices and so any limitation might be an attempt to address a problem that won't exist. And, there was strong preference that plans be encouraged to be creative and innovative so that consumers obtain the plan designs that best suit them. There was also recognition that a greater number of choices are vital for the small business community and that factor needs to be taken into account. Executive Director Kofman, upon request by the Board, provided her perspective that limiting choices of plans in one big marketplace is difficult public policy to justify and

highlighted that it is the goal of the Exchange to have an IT filtering capability that will allow consumers to voluntarily limit (or expand) the choices they see based on their top priorities.

Recommendation #2 : Do not limit the number of Qualified Health Plans offered in the Exchange.

Vote: unanimously in favor

Item #2 - Should health insurance issuers be required to demonstrate a "meaningful difference" among plans they propose to offer?

Discussion: Board members felt there was a strong overlap between this issue and the previous recommendation with regard to limiting plan choices. If plan choices were limited, demonstrating meaningful differences would be a lower priority. Upon request, Exchange staff explained the new rules for the Federal Facilitated Exchange states that will be managed by the Centers for Medicare and Medicaid Services (CMS) at the federal level. All Committee Members agreed that this notion of a meaningful difference is important. With input from the Department of Insurance, Securities and Banking (DISB) Commissioner William White, who is on the Committee, and input from Exchange Executive Director, it was determined that DISB could adopt a key role in oversight and enforcement of meaningful differences. With that, the Committee came to the following recommendation:

Recommendation #3: The intent of the Exchange Board is to offer meaningful choices for consumers. The Board asks the Department of Insurance, Securities, and Banking (DISB) to apply the Federally Facilitated Exchange's "meaningful difference" standard, the elements of which are outlined in a letter from the Centers for Consumer Information and Insurance Oversight (CCIIO) and the Centers for Medicare and Medicaid Services (CMS) to issuers dated March 1, 2013 (available at http://cciio.cms.gov/resources/files/issuer-letter-3-1-2013.pdf, see page 16), as a part of their certification of qualified health plans for the 2014 plan year. The Board asks that the marketplace offerings continue to be monitored and the "meaningful difference" standard updated as needed to provide for meaningful consumer choices.

VOTE: unanimously in favor.

Item #3: Should the D.C. Health Benefit Exchange Authority require health insurance issuers to offer at least one health plan with a standardized cost sharing structure at each metal tier in which they are participating with appropriate consideration to consumer preferences and carrier feasibility? If the answer to 2 is yes, would this be plan offerings for open enrollment in 2014 or no later than 2015?

Discussion: It was noted that there was strong, though not complete, support for standardization in the working group as an important consumer protection so that purchasers can compare plans most effectively across companies. There was also agreement that standardization shouldn't be done for its own sake, it needs to be done in a manner that results in standard products that consumers want to buy. Thus, there was a substantive rationale for holding off on standardization until 2015 so the Exchange can benefit from market experience in 2014. Regardless of their desire to have standardization now, it was recognized that implementing standardization in 2014 is simply impossible given how late we are in the year. There was strong desire from Committee Members to have it implemented in 2015 at the latest. It was also noted that there may need to be more than one standardized plan per tier to account for differences in plan design that are possible. The discussion then turned to whether DISB could take on this priority for in early 2014 and lead this work for DC. Consensus was that that would work. Because the federal law requires the issuance of silver and gold plans, there was a firm commitment that standardization could be achieved for those tiers by 2015, however, because of resource concerns, there was flexibility provided for the bronze and platinum tiers with the possibility that they could wait until 2016. The goal is to achieve standardization for all in 2015.

Recommendation #4 : The Board asks the Department of Insurance, Securities, and Banking (DISB) to develop one or more standardized benefit plans (benefits and cost sharing) at the silver and gold metal level for the 2015 plan year and at the bronze and platinum metal level not later than the 2016 plan year based on input from consumers, employers, carriers, and based on early purchaser preferences. Carriers will be required to offer one or more standardized plans at each metal level in which the carrier is participating for plan years where there is a standardized plan in addition to other plans the carrier may offer.

Vote: unanimously in favor

Item #4 - Should insurance issuers be required to offer at least one plan at the Platinum level?

Discussion: It was explained the working group was split on this issue because of the recognition that carriers are already offering these plans so there was uncertainty that there was any need to require them to be offered. Consumer groups uniformly preferred to require the offering. Carriers, employers, benefit consultants and brokers were divided. Health providers abstained.

Recommendation #5 – Do not require carriers to offer a platinum qualified health plan.

Vote: 2 yeah, 1 Nay

Adjournment:

The meeting adjourned at 1 pm.