Health Benefit Exchange Authority Standing Advisory Board Meeting

DRAFT MINUTES

Date:	**Thursday, June 30, 2016**
Time:	**3:00 PM**
Location:	**By Conference Call Only**
Call- in Number:	**1-877-668-4493; access code 731 411 863**

Members Present: Chile Ahaghotu (via telephone), Dave Chandrasekaran, Kevin Dougherty (via telephone), Chris Gardiner, Laurie Kuiper (via telephone), Billy MacCartee (via telephone), Claire McAndrew, Dania Palanker, Jill Thorpe (via telephone)
Absent: none

I. **Welcome, Opening Remarks and Roll Call,** Chris Gardiner, Chair

Chris Gardiner called the meeting to order at 2:03 pm. A roll call of members present confirmed that there was a quorum with seven members present (Mr. Dougherty, Mr. Gardiner, Ms. Kuiper, Mr. MacCartee, Ms. McAndrew, Ms. Palanker, Ms. Thorpe).

II. **Approval of Draft Agenda**, Chris Gardiner, Chair

It was moved and seconded to approve the draft agenda, with Mr. Dougherty, Mr. Gardiner, Ms. Kuiper, Mr. MacCartee, Ms. McAndrew, Ms. Palanker and Ms. Thorpe voting yes.

III. **Approval of Minutes**, Chris Gardiner, Chair

It was moved and seconded to accept the minutes from the February 18, 2016 meeting, with Mr. Dougherty, Mr. Gardiner, Ms. Kuiper, Mr. MacCartee, Ms. McAndrew, Ms. Palanker and Ms. Thorpe voting yes.

IV. **Discussion Item**, Chris Gardiner, Chair

Mr. Gardiner stated that today's meeting is pursuant to a request by the Executive Board Insurance Market Committee for the Standing Advisory Board (SAB) to provide recommendations on further steps that should be taken in the District of Columbia to ensure network adequacy. Specifically, the Board has asked SAB to review a model law passed by the National Association of Insurance Commissioners (NAIC) on network adequacy, consider laws passed by other states, and provide recommendations to HBX.

The NAIC is composed of insurance commissioners in every jurisdiction. The NAIC model law was approved by that body by a consensus vote of all its members. It is a compromise package that took significant time to develop and the group considered input from all stakeholders.

Importantly, this model law is written to apply across the entire health insurance marketplace in each state. That means it is one set of rules for the individual, small group and large group insurance markets. The action we are considering today is a recommendation to the Executive Board Insurance Market Committee about steps the District should take to enhance network adequacy requirements across the health insurance markets in DC. As such, it is beyond the scope of HBX and that is why it must take the form of a recommendation.

HBX staff will also present information from state laws that have gone further than the NAIC model act in some particular components of network adequacy.

At present, the District has no standards with regard to network adequacy that apply across all markets. As we will hear from HBX staff in our upcoming discussion, through HBX certification standards, HBX has put in place protections for the individual and small group markets. However, the need for network adequacy standards that apply across the District is critical.

The Board needs to consider carefully whether we can reach a consensus recommendation urging the District to take further action to enact network adequacy standards. And by consensus, we mean unanimous agreement.

This topic is an important one. I am hopeful we will have strong participation from the public as well. People are here in person and on the telephone. As a reminder for those on the telephone, the materials for this meeting are posted online at hbx.dc.gov and can be found at the bottom right of the front page under "calendar of events" where the Standing Advisory Board Meeting is posted.

Ms. McAndrew, vice-chair of the Board, stated that this issue is being scrutinized across the country, and many states have taken action to enact the NAIC model and review the issue in general. In the recent final Benefit and Payment Parameters rule, the Center for Medicare & Medicaid Services (CMS) deferred to the states on network adequacy and did not impose a federal standard. CMS expects the states to adopt the NAIC model.

a. **Background on Network Adequacy standards and law** -- Purvee Kempf, General Counsel and Chief Policy Advisor

Ms. Kempf said that network adequacy, generally, is a concept that encompasses several things: the sufficiency of the network; that is, that the network has sufficient numbers and types of providers, including essential community providers, so that services may be obtained without unreasonable delay; and accurate provider directories. The discussion will also encompass surprise bills, where a person who receives services at an in-network facility receives a bill from an out-of-network provider. The most common example is an out-of-network anesthesiologist or radiologist who performs services while the patient is having surgery at an in-network hospital.

As a reminder, HBX has been active in network adequacy since its inception. In 2013, baseline standards were developed and required of carriers for HBX certification. In 2014 another review of the standards occurred and they were updated, resulting in the Board approving a resolution in 2015.

The network adequacy standards began with the requirement that carriers file templates created by the federal government to review networks for adequacy. The standards include the requirement to have a provider directory, and the requirement for approval from an accrediting body. Plans are also required to post an email address or telephone number where directory inaccuracies can be reported, and the plans are required to review those reports and make corrections if the report is correct. Carriers are required to take certain steps to review the accuracy of their directories, such as regular auditing of the directory, or validating provider participation in the network when no claims have been filed by the provider in a certain timeframe. Last, the carriers must submit the provider directory to HBX electronically; HBX took the step of creating a unified doctor directory in both the individual and SHOP markets. This unified directory allows the consumer to search for a particular doctor and find out in what plan(s) the doctor participates, without having to search each carrier separately on the carriers' websites. This tool is powered by CONSUMERS' CHECKBOOK, which takes some additional steps to attempt to validate doctor participation in the networks and notify the carrier of any inaccuracies it discovers. Finally, HBX asked the Department of Insurance, Securities and Banking (DISB) to track complaints relating to network adequacy.

Earlier this year, the federal government issued updated network adequacy standards by regulation. Some specific provisions added are the requirement for a dedicated link for consumer reporting of inaccuracies; the requirement to publish certain information, such as if the provider is accepting new patients; protocols for continuity of care when a provider is leaving the network; and a provision on surprise billing. On this issue, effective for plan year 2018, if a covered person receives a surprise bill, the payment by the covered person may be counted against the maximum out-of-pocket limits of the policy; or, the covered person receives advance notice of the possibility of receiving a bill from an out-of-network provider.

Ms. McAndrew asked for clarification of whether the entire surprise bill or just the cost-sharing dictated by the plan's provisions (i.e. the out-of-network deductible versus the in-network deductible) related to that bill that can be counted toward out-of-pocket maximum. Ms. Kempf replied it was the latter.

Presently, the District does not have any statutory provisions regarding network adequacy.

Mr. Gardiner welcomed the HBX Executive Director, Mila Kofman, to the meeting. Ms. Kofman thanked the members of the Board on behalf of the Executive Board and its Insurance Market Committee for taking on this important task.

Mr. Gardiner also welcomed the newest Board member, Dave Chandrasekaran, to the meeting and to the Board. Mr. Chandrasekaran said he was excited to participate in the activities of the Board, and noted that he was a customer of DC Health Link.

b. **Review of NAIC Model Law on Network Adequacy –** Mary Beth Senkewicz, Associate General Counsel and Policy Advisor

Ms. Senkewicz recounted her experience with the original NAIC model when it was developed in the mid-1990s when she was Senior Counsel for Health Policy at the NAIC. She stated she had listened in to many of the NAIC calls as the amendments were developed. The full name of the amended model is *Health Benefit Plan Network Access and Adequacy Model Act* (NAIC model or model).

The model amendments were developed to provide the states with maximum flexibility and not a one-size-fits-all approach. Ms. Senkewicz focused on areas of the model amendments that received a lot of attention and discussion:

- Tiered networks
- Provider directory
- Consumer information and transparency
- Surprise bills

Section 5 is the first major section of the model. The general standard is that the carrier shall "maintain a network that is sufficient in numbers and appropriate types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay." NAIC Model §5.A.(1). The insurance commissioner is responsible for determining the sufficiency of the network, and the model lays out criteria the commissioner may use to make the determination, such as provider-covered person ratios, geographic accessibility and wait times for an appointment. NAIC Model §5.B.The original model was murky as to who was responsible for that determination.

The NAIC drafting group made a conscious decision to use general standards instead of quantitative standards. States can add quantitative standards if they think they are appropriate for their markets by either amending the model or placing those standards in a regulation developed pursuant to the law. This position is reflective of the state flexibility the model maintains.

Section 5.E provides that the carrier has to file an access plan with the commissioner, either for review or approval, as the state determines. In Maryland, which passed a version of the model recently, the access plan is filed for review. A filing for review means that the carrier can use the plan after filing it and the Commissioner

does not need to approve the plan formally. The Commissioner can always go back, if circumstances warrant, and review the access plan and ask for changes.

Ms. Kempf stated that HBX certification process required an access plan, but did not move forward and develop criteria for such a plan. Now that we have the NAIC model, HBX can provide a basis for criteria for an access plan. Ms. Senkewicz noted that subsection F provides the requirements for the access plan. According to Jolie Matthews, NAIC staff for the group that developed the model amendments, lots of discussion and negotiation took place with respect to this subsection.

Section 6 sets forth requirements for carriers and participating providers. Not many changes were made to this section. One discussion revolved around continuity of care, which can occur when a provider leaves the network voluntarily or is removed. Pursuant to subsection L, in that situation there must be 60 days' notice to each other. The section also lays out what happens when an insured is in an active course of treatment. The maximum amount of time an insured may continue to be treated by the affected provider is 90 days, unless the carrier's medical director finds that a longer period of time is warranted. "Active course of treatment" is defined as ongoing treatment for a life-threatening condition, a serious acute condition, or a condition for which a treating provider attests that discontinuing care by the provider would worsen the condition or interfere with anticipated outcomes, or the second or third trimester of a pregnancy.

The amendment discussion also included tiering of providers. Pursuant to subsection T.2, the provider must be notified of any change in participation status. The discussion reflected the fact that tiering occurs with providers, and just not with prescription drugs. How providers may be tiered, and the standards for doing so, appears in subsection F.

Section 7 covers requirements for participating facilities with non-participating facility-based providers. This section received numerous comments and was the subject of significant discussion during the model amendment process. The section addresses one narrow aspect of surprise bills: you are in an in-network facility and unbeknownst to you, you receive services form a non-network provider during the surgery.

The section requires that the carrier establish a mediation process to occur between the carrier and the provider. The goal is to keep the consumer out of the middle of the dispute between the carrier and the provider.

When the non-participating facility-based provider sends a bill directly to the covered person, the bill must include a "Payment Responsibility Notice," which outlines the covered person's options: pay the bill; submit to the carrier for mediation (if the bill is more than $500' difference between the billed charge and the plan's allowed amount); or avail yourself of any rights and remedied provided by law. Model Section 7.D.2. Ms. McAndrew noted that many states have not set a threshold for protection ($500) as the model does.

The model provides notice to the consumer in several instances. In addition to the above, when the consumer checks into the network facility for services, the consumer receives notice that the consumer may be treated by a non-participating provider. This notice is acknowledged by the consumer. The model also provides that when the non-participating provider submits to the carrier for approval for the service, the carrier must notify the

covered person that there may be non-participating providers at the facility. Additionally, the carrier must assist the covered person in finding a participating provider, if available.

Ms. McAndrew noted that the “assistance” the carrier is required to provide may be only that the carrier gives the covered person a list of in-network providers. Ms. Palanker said that it seemed that if the consumer requests that the facility have one of the providers on the list provide services, the facility has no obligation to honor that request.

The state sets a benchmark on any particular service of the higher of the carrier’s contracted rate or XX% of the Medicare payment rate for the same or similar services in the same geographic area. Any bills within the benchmark are presumed to be reasonable.

Ms. Kempf added that under the model, consumers have no obligation to pay any surprise bill when services are performed in an emergency room setting.

Section 9 is about provider directories. This section also received numerous comments and was the subject of significant discussion during the model amendment process. Most of the standards refer to electronic directories as print directories generally are obsolete upon printing.

The directories must be made available to all, not just enrollees or prospective enrollees. The directories must be in a searchable format. They must be updated at least monthly. They must provide certain basic information, such as name, telephone number, etc., including languages spoken, and for health care professionals, whether they are accepting new patients. They must provide an electronic link, or email address and telephone number, for people to report inaccuracies. Reported inaccuracies must be investigated and corrective action taken if the report is correct. The directories must accommodate the communication needs of people with disabilities and must contain information about assistance for persons with limited English proficiency. Last, the carriers need to audit, periodically, a reasonable sample size of its directories.

According to a drafting note, if a consumer relies on a material misrepresentation in the directory that the provider is in network, the consumer should be treated as having received services from a participating provider.

The scope of the model is major medical plans. Limited scope products, such as dental and vision, are not within the scope of the model. A drafting note states, however, that states can establish network adequacy standards for dental plans if they so desire.

Ms. Kempf noted that the original proposed federal regulation had numerous standards for network adequacy that were not adopted in the final regulation. CMS, in the final regulation, encouraged states to adopt the NAIC model.

c. **Review of several state laws that have gone further on particular provisions than the NAIC Model Law –** Mary Beth Senkewicz, Associate General Counsel and Policy Advisor

Ms. Senkewicz reported that Maryland had updated its network adequacy standards based on the NAIC model. One significant departure from the NAIC model is that under the law, the Insurance Commissioner must adopt quantitative network adequacy standards, and, if appropriate, non-quantitative standards, in consultation with interested stakeholders. The Commissioner may take into consideration things such as geographic accessibility, wait times, etc. The law has a similar provision for dental plan standards. Apparently the process of developing the standards has just begun.

Ms. Kempf thanked Ms. McAndrew, who had presented on a variety of state laws to the Insurance Market Committee. The laws Ms. Senkewicz is presenting on today were chosen based on the discussion of the Insurance Market Committee, which has expressed an interest in states that had done things beyond the model. Ms. Kempf noted that all were available on the HBX website.

Georgia passed a bill on provider directories that is very similar to the NAIC model. One difference is that the Georgia law requires a carrier to perform a "sweep" of the entire provider directory by January 1, 2017. Another provision in the law, that was in a drafting note in the model, gives the Commissioner discretion to require a carrier to treat out-of-network services as in-network if the consumer reasonably relied on a material misstatement in the provider directory.

Another thing Ms. Senkewicz saw in the Georgia law had to do with providers who have not submitted a claim within a certain period of time. She noted that while not common, there are circumstances where providers do not provide much direct care, such as researchers. Those providers may want to remain in the network even though they do not file a claim for a long period of time. The Georgia law requires the carrier to investigate and reach out to the provider, but if the provider does not respond, the provider shall be removed from the directory. It is the only state that she knows of which requires the carrier to remove the provider.

Florida passed surprise bill legislation in the 2016 session that ended recently. In a non-emergency situation, the law provides protection for the consumer receiving non-network services in a network facility if the consumer does not have "the ability and the opportunity" to choose a participating provider. The bill also provides for multiple notices – the hospital must post, on its websites, the networks in which it participates, and the names of participating professionals, and the carrier must have language in the policy, starting January 1, 2017, warning the consumer that lesser benefits are paid for services from non-participating providers.

The bill also protects the consumer by setting a reimbursement standard for out-of-network providers. Reimbursement shall be the lesser of the provider's charge, usual and customary charges for similar services in the community where the services are provided, or charges mutually agreed upon by the carrier and the provider.

Ms. McAndrew noted that in Maryland, network adequacy standards already existed and the law was updated after amendment of the model. In the District, there is nothing on the books in this regard. Maryland already had

continuity of care provisions, up to 90 days, in place. Maryland also allows for assignment of benefits; a consumer who gets a surprise bill can assign it to the carrier to work out with the provider.

With regard to quantitative standards, Ms. McAndrew clarified that the NAIC model says the Commissioner shall determine if a network is sufficient and can consider a number of quantitative standards such as provider-covered person ratios by primary care and specialty providers, geographic accessibility of providers, geographic variation and population dispersion, waiting times for an appointment, hours of operation, etc. Quantitative standards are not foreign to the NAIC model; the model just does not set quantitative standards for the states as the federal regulation did not set standards for states.

Ms. McAndrew clarified that the Georgia law also has transparency standards with respect to provider tiering so that consumers know which tier a particular provider occupies.

Ms. McAndrew noted that the Florida law was based on a New York law that has been in effect longer and might shed light on how the Florida law might play out.

V. **Public Comment**

David Kennedy (America's Health Insurance Plans – AHIP) wanted to let the Board know about a pilot program AHIP has launched dealing with provider directories. AHIP is working with two vendors in three states (CA, FL, IN) that will verify provider information. The pilot creates one point of contact for providers to update required information for directories. The information will be shared with the carriers for updating their directories. Ultimately there will be an evaluation of feedback provided by stakeholders that may result in a best practices product. The written information on the pilot was shared with HBX and is posted on the HBX website.

Ms. Kofman wanted more information about the pilot and whether there was a "single source" that could be accessed by both providers and carriers for updated information. Mr. Kennedy said he would get back to HBX with more information.

Ms. McAndrew asked about issues she had seen in researching directories and the vendors who provide those services to carriers. She said that even when alleged erroneous information is verified as erroneous, carriers have said that they cannot correct the information due to contract issues or other barriers. She wanted to know if the AHIP pilot would correct that problem and allow carriers to correct their directories. Mr. Kennedy said he would check out that issue.

Rob Metz (CareFirst) said CareFirst would support network adequacy legislation that mirrored the Maryland legislation. He said that the legislative process in Maryland included the input of many stakeholders, resulting in some modifications to the NAIC model. He said CareFirst would support legislation based on the Maryland law as a "holistic" piece of legislation, but would have concerns about adding different pieces to any bill.

Ms. McAndrew asked if Mr. Metz could elucidate about which certain pieces of the Maryland legislation CareFirst thought important to stay in place. Mr. Metz responded that the removal of providers from directories due to not having filed claims in the last six or 12 months was of particular concern to subcategories of

providers such as researchers or specialty providers. Ms. McAndrew said the Maryland law provided that carriers had to perform periodic audits of a reasonable sample or review claims history to determine providers who had not filed claims in the last six months and see if they wanted to remain in the network. Mr. Metz said CareFirst supported that approach. In fact, CareFirst does do a "claims sweep" every quarter, looking back at the last 12 months, to identify providers who have not filed claims. Mr. Chandrasekaran asked if those providers were then contacted; Mr. Metz replied yes.

Mr. Gardiner said that because Ms. McAndrew had lots of experience with provider directories, he asked her to draft a consensus recommendation for the Board to consider. Then the Board will have another meeting to consider the recommendation. Ms. McAndrew invited assistance with the assignment.

Ms. Palanker said she supported the District adopting network adequacy standards that reflect the District's specific needs.

A Board member on the telephone asked if the goal was to address the three elements of network adequacy, directory accuracy and surprise bills. Ms. Senkewicz replied that all three were elements of network adequacy and were addressed in some fashion in the NAIC model.

Ms. Kuiper (Kaiser Permanente) said the NAIC model does not recommend specific network adequacy standards. She asked if Ms. McAndrew intended to recommend specific metrics. Ms. McAndrew said she thought recommending specific quantitative standards was beyond the scope the Board. Ms. Kuiper agreed, saying other states conducted considerable research and outreach to a variety of stakeholders, and took a lot of time, when developing specific metrics.

Mr. Chandrasekaran noted that there are a lot of elements on the table. He wondered if it might be prudent to develop a menu of possible options as an approach. Dr. Ahaghotu agreed with Mr. Chandrasekaran, and also thought it would be useful to come up with certain guiding principles about how we would like a network adequacy bill to look, without getting into technical detail. Ms. Kuiper said this Board would not be developing legislation as any recommendation would be forwarded to the Commissioner, who intends to implement vis regulation. Dr. Ahaghotu said guiding principles could be used to form the basis of implementation. Ms. McAndrew said she thought there might be a middle ground between quantitative standards and guiding principles; she thought the Commissioner probably already had principles in mind and she wanted the Board to add value to the equation. She would draft something and Board members could respond to the written draft.

Ms. Palanker said she would assist Ms. McAndrew with drafting.

VI. **Closing Remarks and Adjourn**

Mr. Gardiner said he hoped the Board could come to a consensus recommendation by the end of July.

The meeting was adjourned at 3:30 p.m.