FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

January 20, 2015

DC Health Benefit Exchange Executive Board Insurance Market Committee

Re: Draft Plan Certification Requirement Recommendations for 2016

Families USA is a non-profit, nonpartisan organization dedicated to the achievement of high-quality, affordable health coverage and care for all. We are located in the District of Columbia and we appreciate the opportunity to provide comments on the DC Health Benefit Exchange Draft Plan Certification Requirement Recommendations for 2016. We commend the Exchange for thoughtfully revisiting and addressing these important issues that deeply effect how consumers fare when they select and enroll in a health plan through DC Health Link. We hope that dialogue on these and other related issues will continue for years to come as the Exchange learns more about what consumers need from DC Health Link in order to be able to afford their health plans and covered health care services and to receive medically necessary care of the highest quality. If you have any questions about our comments, please contact Claire McAndrew, Private Insurance Program Director, at cmcandrew@familiesusa.org or 202-628-3030.

Network Adequacy

Network Adequacy Template

Families USA supports that carriers in the District must submit the CCIIO Network Adequacy Template to DISB. We recommend that the Exchange and DISB provide greater clarification on how the template will be reviewed for medical and dental QHPs in the District. At a minimum, we recommend that DISB review the templates for reasonable access in accordance with the reviews that CCIIO conducts for the federally facilitated exchange (FFE), as outlined in its Draft 2016 Letter to Issuers.[1]

The CCIIO review assesses reasonable access generally, and also with a more specific focus on providers that historically have presented network adequacy concerns for consumers (namely primary care providers, mental health providers, oncologists, hospitals, and dental providers, when applicable). We urge DISB and the Exchange to seek technical assistance from CCIIO in implementing this review process so that District consumers know that the plans in the District's exchange are at least as closely scrutinized for network adequacy as are those in federal exchanges.

In addition, we urge the Exchange and DISB to clarify that issuers in the District must also submit the federal Essential Community Provider template that is also described in the aforementioned Letter to Issuers. We urge the District to use an ECP inclusion standard and review process that is at least as robust as that applied by CCIIO for federal exchange plans for 2016. However, we note that many states including Connecticut, Montana, and Washington have found these federal standards to be quite weak and have implemented much stronger standards that could serve as a better standard of review for the District in later years.[2]

---

[1] http://www.cms.gov/CCIIO/Resources/Regulations-and Guidance/Downloads/2016DraftLettertoIssuers12-19-2014.pdf

[2] *Standards for Health Insurance Provider Networks: Examples from the States*, available at: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf; http://csi.mt.gov/news/bulletins/57FormsFilingMemorandum.pdf

FamiliesUSA.org
1201 New York Avenue, NW, Suite 1100
Washington, DC 20005
main 202-628-3030 / fax 202-347-2417

Network Adequacy Standards

Going forward, we believe it is critical that all District of Columbia insurance enrollees have certain basic guarantees of access to in-network care. We therefore recommend that, in accordance with the Executive Board resolution passed in March 2013 that indicated that the Exchange would implement DC-specific standards for network adequacy,[3] the District outline a plan for how it will strengthen network adequacy protections so that consumers have actionable rights if they cannot access in-network providers when they are in a marketplace plan. Specifically, we recommend that the District explore implementing at a minimum the following three protections:

1. **Appointment wait-time standards,** such as those that have been implemented in California and Washington state that, for example, require insurers to demonstrate that enrollees can get primary care appointments (for non-preventive services) within 10-days of request and specialty visits when referred within 15 days for non-urgent care.
2. **Travel time and distance standards,** such as those implemented in New Jersey that require people to have access to care within a reasonable travel time by public transit in geographic areas where 20 percent or more or the population relies on public transit.
3. **Rights to go out of network for care at in-network costs,** such as those implemented in New York and Delaware, which require plans to authorize consumers to see out-of-network providers at no extra cost if the plan does not have a geographically accessible provider with the right expertise who can see enrollees in a timely manner for medically necessary care.[4]

The District is in a rather unique position of having no network adequacy standards in place to protect insurance consumers, even in tightly managed HMO plans. We therefore believe the above protections should be implemented to provide tangible rights to accessible, timely care for health plan enrollees in DC.

Network Adequacy Complaint Tracking

Families USA strongly supports DISB and the Exchange's efforts to track complaints related to network adequacy. Complaint tracking should serve as a monitoring mechanism to understand whether plan networks are providing appropriate, geographically (and public transit-) accessible care in a timely manner for all covered services as medically necessary. However, we are concerned that consumers may not be aware of DISB's availability to provide assistance with health plan issues, and therefore that the complaints received paint a very limited picture of access problems that consumers encounter.

Complaint Tracking Recommendations: We urge DISB and the Exchange to notify consumers of where within DISB to make network adequacy complaints, such as by requiring issuers to list on their provider directories DISB's complaint line information with a disclaimer indicating that if consumers have difficulties accessing providers they should first contact their plan but can also contact DISB if they have a complaint or would like to speak to a regulator. In addition, we urge the District to streamline network adequacy complaint data from multiple sources and track them to the extent possible such that complaints received by DISB, the Health Benefit Exchange directly, the Health Link Call Center, the Ombudsman, and even the plans themselves could be examined collectively to get a better sense of what consumers are experiencing regarding challenges accessing providers. An annual public report on such complaints would be beneficial to understand what

[3] http://hbx.dc.gov/publication/resolution-network-adequacy-standards

[4] All of the state example standards referenced here can be found with complete state statutory and regulatory citations in Families USA, *Standards for Health Insurance Provider Networks: Examples from the States*, available at: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf

problems consumers are facing, how DISB, the Exchange, and issuers are addressing them, and what more stakeholders could do together to improve access to providers for DC health insurance consumers.

Carrier Provider Directories

Families USA supports the development of a **searchable, integrated provider directory** for DC Health Link. We believe this tool will make it easier for consumers to identify which providers are in which networks than relying on separate provider directories for each plan. We also hope that having an integrated directory will help avoid some of the technical issues that occurred with individual issuers' directories during the first year of enrollment when individual directories were inaccessible for portions of the year. We hope that an integrated directory will eventually bring improvements in the accuracy of provider directories in the District as well, for example, by allowing updates to occur in an integrated fashion such that if a provider retires or passes away he or she can be removed from all issuers' directories simultaneously instead of each plan having to individually remove the provider. In addition, we hope that the District will consider using the contractors producing the directory or others to conduct formal assessments of the accuracy of the content in the integrated directory, such as by conducting a full-scale secret shopper study of the directory to assess whether the providers listed have accurate contact information, whether they are really in the plans' networks, and whether they are seeing new patients. Such a study can also be used to assess network adequacy overall because its findings can be used to assess geographic accessibility of providers to enrollees, and by assessing when appointments are available through the study, the District could get a sense of whether access is timely for consumers.

Families USA also strongly supports a requirement that carriers prominently post information on how **consumers can report inaccurate provider directory information** on online and print provider directories. We recommend that this requirement be altered to indicate that the phone number or email used must be used *solely* for this purpose to better assure that problems will be tracked and addressed promptly. We also recommend that the exchange define the requirement that carriers take "timely action" on such reports by clarifying that they must investigate the reports and modify the directory information if necessary within 14 days. Finally, we support the requirement that carriers keep a log of these provider directory complaints and that these logs will be accessible to DISB and the Exchange. We urge the Exchange to also require that each carrier create a report of aggregated complaint data and a narrative summary of complaints received that is publicly available at the end of each year so that the public, our legislators, and stakeholders can understand if directory accuracy problems are improving or can help to improve them if more work is necessary.

In addition, we also support requirements for carriers to take **program integrity steps** to improve their provider directory accuracy. However, we believe the requirements outlined need to be more prescriptive and comprehensive to ensure they are sufficient to increase provider directory accuracy. We recommend that carriers be required to both:

1. **Perform an annual audit** in which they call at least 30 percent of providers in each specialty in their directory (or for specialties in which 30 or fewer providers or facilities are listed, to call all providers and facilities in the specialty) to assess: 1) whether their contact information is correct, 2) whether they are really in the plan's network, and 3) whether they are taking new patients. If any of the information listed in the directory is found to be inaccurate based on the findings of the audit, carriers should be required to update the information in the public directories within one month of the date in which the specific inaccuracy is discovered.
2. **Contact providers listed as in network who have not submitted claims** within the past year to determine whether the provider still intends to be in network. Based on the provider's response, the plan must update the directory accordingly within one month of receiving the specific response. If the

provider does not respond within 30 days, the plan must attempt contact again, and if the provider does not respond within another 30 days, the plan must remove the provider's information from the directory. (This recommendation is based on NJ regulation N.J.A.C. 11:24bC–4.6.)

The currently proposed certification standards would allow carriers to propose their own actions for approval by DISB that could count towards meeting program integrity requirements for directory accuracy, such as "validating provider information based on provider demographic factors such as an age where retirement is likely." While we believe carriers should be encouraged to take this step, it alone would not provide a comprehensive review of provider directory accuracy (since it would only assess one factor that could lead to inaccuracies) and we therefore urge the Exchange to require carriers to implement the more comprehensive program integrity steps outlined above and not deem any steps as fully compliant with program integrity requirements unless they would result in a comprehensive review of provider directory accuracy.

Review of Rates

Families USA supports the DC Exchange 2016 plan year process for rate review, with a few clarifications:

1) Please clarify that the consulting actuary's role is to provide an opinion on whether the proposed rate is justified, and would be in the interest of qualified individuals and qualified employers.

We see this as consistent with the federal statute: The Exchange's role in certifying a plan is to determine that "making available such a plan is in the interests of qualified individuals and qualified employers." Exchanges are to consider premium increases and their justifications in making that determination.

2) Allow consumers and their representatives to suggest questions for the actuary to examine.

In Vermont, Vermont Legal Services poses questions that are addressed by an actuary, and this has been a useful partnership. Consumer organizations often know of a public concern with a proposed rate, but need the expertise of an actuary to examine the issue of concern.

3) To the extent possible, please make the consulting actuary's report public before final rates are approved.

If consumers or consumer advocates wish to comment to DISB on a proposed rate, they may find it helpful to review an actuary's opinion. Local organizations rarely have the resources to hire their own actuary. If the Exchange has hired an actuary, the public may better be able to prepare informed comments on a proposed rate if they are able to review that actuary's report. We recognize, however, that the timeframes may not always lend themselves to advance review, particularly if the insurer is adjusting a filing in response to concerns raised by an actuary and DISB.

In states such as Oregon, Connecticut, and Vermont, consumer advocates have had a strong role in the rate review process and their comments have helped to lower unjustified premium increases. In Connecticut, the State Health Advocate and the Attorney General have utilized the Exchange's Actuary; in Oregon, OSPIRG is funded through the state's rate review grant to represent the public interest and can hire its own actuary.

Overall, we see this as a good proposal. Since federal grants for rate review are coming to a close, resources that the DC Health Benefit Exchange is able to devote to the rate review process will help to ensure that premium increases are justified.

Quality of Health Plans

Families USA supports the Exchange relying initially on the required federal standards and approach to make quality data available to consumers. Federal agencies have put extensive research and testing into their quality reporting system and consumer experience survey design, and the District alone would not have the resources to design such advanced tools. It therefore makes sense to fully invest in implementing these systems and making information from them about Health Link plans fully available to consumers. In the future, once all of the systems mentioned in the draft certification standards are implemented and the information from them available to District insurance consumers, the Exchange should evaluate whether, in addition to the NCQA public report cards for health plans mentioned in the draft standards, the District should supplement the federal systems with additional quality improvements or quality reporting to meet the unique needs of the District.

For the qualified health plan consumer experience survey, it is critical that complete results for all survey questions be available on the DC Health Link website for each available plan at the most granular level of data possible (i.e., at the plan level so that shoppers can see the results for the exact combination of benefits and cost-sharing that they would consider purchasing).

In addition, the federal government also designed a survey of marketplace consumer experience that must be used in each individual marketplace to assess how consumers fare regarding enrollment processes, applying for tax credits, selecting plans, interacting with assisters, and undergoing other key components of the enrollment process, which is more rigorous and comprehensive than any survey that the District would likely have the resources to produce and implement on its own. We believe it is critical that all marketplaces make the results of this survey public on their websites each year. The results of such a rigorous publicly funded survey should be transparent, as they could greatly help many entities including navigators and assisters, our legislators and agencies, advocates, researchers, and others engage in work to help improve the enrollment and plan selection process in the marketplace.

Non-discrimination Provisions

Families USA supports DISB issuing further guidance regarding discriminatory benefit design. We urge DISB to issue this guidance with a public comment period to allow stakeholders to provide recommendations on discriminatory practices to include in the final guidance.

In DISB's review of form filings, we recommend that it review all of the following plan design elements for discriminatory design: covered benefits and drug formularies; medical necessity definitions; benefit exclusions; provider networks; waiting periods; rating; visit limits; and utilization management. We recommend that DISB review individual plans' benefits in addition to conducting outlier reviews. Outlier reviews alone can overlook discriminatory plan elements that are commonly used by issuers.

We support the DC Health Benefit Exchange making all qualified health plans' insurance contracts publicly available on its website. This level of information is important for consumers as they consider health plan options and promotes transparent monitoring of QHP compliance with nondiscrimination requirements of the Affordable Care Act. We also strongly recommend that the DC Health Benefit Exchange's website clearly provide contact information for reporting complaints of discriminatory benefit design to DISB and provide an easy to use online reporting tool for consumers to submit complaints. This will help ensure that consumers can easily submit problems to DISB that could help identify trends in discriminatory plan practices.