Health Benefit Exchange Authority

Executive Board Insurance Market Working Committee Meeting

Minutes

Date:	**Thursday, November 20, 2014**
Time:	**10:00 AM to 2:00 PM**
Location:	**1225 Eye Street, NW, 4th Floor, Board Conference Room**
Call- in Number:	1-877-668-4493, Access Code: 737 360 674

Welcome, Opening Remarks, Kevin Lucia, Chair

Kevin: Good morning to the Exchange board members Henry Aaron and Kate Sullivan Hare who are joining by telephone, and those joining from the public both in person and by phone. My name is Kevin Lucia and I am the chair of the Executive Board Insurance Market Working Committee, a committee of the HBX Executive Board.

In early spring of 2013 the Executive Board established a stakeholder working group to advise the Board on the initial certification process. The Board adopted the consensus recommendations, which HBX has been using to date.

Now with two years of experience, the Insurance Committee is reviewing the process in preparing for plan year 2016.

We've had two meetings already. At the first, we reviewed each certification requirement and the legal authority for each requirement at the federal and district level.

Based on your input and on the review provided we decided to take a deeper dive of the following areas:

1. Network Adequacy
2. Review of Rates
3. Quality of Health Plans
4. Discrimination

The implementation of these requirements is a joint effort with the District's Department of Insurance Securities and Banking and we appreciate all their prior and continued efforts on this. At our last meeting DISB and HBX staff reviewed how each of these certification requirements has been implemented.

Today, we will learn what other states and the Federal Marketplace have done in each of these areas where standards or processes are broader than the District's. Once again, Purvee Kempf, HBX General Counsel and Chief Policy Advisor, will lead us through this discussion. Howard Liebers, Health Care Policy Analyst with DISB will also participate. And, we'll hear from outside experts in each of these categories as you can see on your agenda.

We have a lot to cover today. You'll note that there are time frames for each subject area and I will be working to see that we stick to the allotted time per topic.

Knowing that many participants may not be able to stay for the full four hours and have specific interests in particular subjects -- we've provided for public comment at the end of each topic. We will also have a general public comment period at the end.

I also want to provide a schedule update as we've changed what we'd previously announced. The Board members are asking HBX staff to develop recommendations for updated plan certification requirements, after today's meeting. We need to provide some time for that work to happen. So, we'll cancel our previously announced December 9th meeting. Our next meeting of this Committee will be Wednesday, December 17th from 10:00 am – 12:00 pm. (Note: this is a change from the previously-announced date of December 16th).

Today's public meeting of the Insurance Market Committee of the Executive Board is taking place at HBX's office: 1225 I Street, NW, 4th floor. Thank you in advance to all participants on the phone and in person and in particular I want to thank our guests who have agreed to come and share their expertise in these important subject areas with us.

Approval of Minutes, Kevin Lucia, Chair
Let me start with some housekeeping, you have all received a copy of the draft minutes from the last meeting of the committee. Are there any changes?
It was moved and seconded to adopt the minutes. The motion passed.

Network Adequacy Presentations and Discussion (10:10am to 11:30am)
Purvee Kempf, HBX General Counsel and Chief Policy Advisor: We are focused on the certification requirements for network adequacy for QHPs in the exchange. One, there must be a sufficient number and type of providers for services to be accessible without unreasonable delay, including specialized providers such as mental health and substance abuse providers. There must also be geographic sufficiency. Two, the network must contain a sufficient number of essential

community providers. Three, a provider directory must be available online and in hard copy upon request.

1. Robert Ellis, Consumer's Checkbook

Robert: I am the Vice-President of Operations and Online Resources at the nonprofit Center for the Study of Services, better known as Consumer's Checkbook (CC). We are working on an all-plan provider directory for DC Health Link. The objective is to create a good consumer experience, a one stop shop where consumers can enter their doctors' names and see all the networks the doctor is in at the plan name level. CC controls the hardware and the software so it can ensure that any level of need can be satisfied quickly, unlike some carrier sites that are slow and can crash. CC gets data feeds from the carriers, and runs some validations to help ensure accuracy. CC hopes to improve the user experience and decrease consumer frustration. Searches can be run in a number of ways, such as name or specialty, or even if the doctor is accepting new patients. Research shows that whether a certain doctor is in a plan is second most important to the consumer, after price. CC is building an all-plan provider directory that is tailored to the DC area and weights in the factors that CC's forty years of experience has shown it to be important to consumers, and gives them a quality, low stress experience that will give them all the information they need to choose a plan based on doctor participation.

Kevin: so the carrier sends the data to you and you upload it into your system?

Robert: The data feeds go from the carriers to a data aggregator partner. CC applies merge methodology to bring the doctors and the carrier networks together. CC then takes the merged lists and compares them against other doctor information sources to see if there are any conflicts in the data before the data is published to the website.

The Consumer's Checkbook presentation can be found here.

Purvee: the next two presenters are from accreditor organizations. As part of the certification requirements, the plans are required to be accredited. NCQA and URAC do much of the accrediting, and as part of that process, they hit on a number of issues in which we are interested.

2. Frank Micciche, National Committee for Quality Assurance

- Good morning. I'm Frank Micciche, the Vice President of Public Policy and Communications at the National Committee on Quality Assurance.
- Among other things, we accredit health plans serving more than 170 million Americans – and about 85 percent of the plans offered in public health insurance marketplaces. I appreciate the chance to speak with you today about NCQA's Health Plan Accreditation standards as they relate to network adequacy and Marketplace plans.
- We have been tracking this issue actively, as part of the continuous review of our accreditation standards and, specifically, in regards to the National Association of Insurance Commissioners' work to update its Model Act. As an organization that reviews health plans

across the country, we are big fans of any attempt to reach consensus among state regulators on an issue as important as this. As such, we believe the updated Model Act will be important for laying the groundwork for how network adequacy will be overseen moving forward. We have provided our letter to the NAIC to you for your reference.

- This is obviously a very timely discussion and one we are happy to be a part of. Because we have only 5 minutes, I'm going to jump directly to the issues the Marketplace staff asked us to address: essential community providers (ECPs) and provider directories.
- NCQA accreditation does not currently look at whether Marketplace plans include ECPs in their networks. We debated doing this but because of the variation in how some states are defining ECPs we decided against it. We'd also like to observe the implementation of the Affordable Care Act's requirement that Marketplace plans include sufficient ECPs before imposing a new standard. But we remain open to discussing how best to address the inclusion of ECPs.
- On the latter point, we do have Health Plan Accreditation standards on provider and hospital directories. As part of their accreditation, plans are scored on the requirement that they maintain online and searchable provider and hospital directories that display key information, such as name and specialty for providers and name and location for hospitals. We expect health plans to update both directories within 30 days of receiving new information from either party.
- At the same time, we expect the plan to highlight, for each piece of information, where it came from, the frequency it is validated and its limitations if there are any. We also require plans to test the usability of their online directories every three years. We are actively exploring additional ways to promote more accurate provider directories.
- We are, for example, considering requiring periodic (perhaps annual) assessment of the accuracy of the directory. Plans would have the flexibility to perform validation and outreach activities in ways that work best for them. One way would be for plans to run claims data and conduct outreach to those providers that have not submitted a claim over a certain period of time. Ultimately the intent would be to set a performance threshold for accuracy which would determine credit earned toward Accreditation.
- Health Plan Accreditation also includes standards on network adequacy. We have requirements on the availability of practitioners and accessibility of services: health plans need to set standards for the number and geographic distribution of primary care, high-volume behavioral health and high-volume specialty practitioners. They must also evaluate themselves against those standards annually, using a valid methodology (which we check).
- Similarly, plans must set standards for enrollee ability to access routine care, urgent care and after hours care and evaluate themselves against those standards at least annually. Our reviewers have indicated that the vast majority of standards that plans set are in a very reasonable range. States often prescribe these standards in insurance statute or regulation.
- We also have standards on the continuity of care. Plans must allow vulnerable members to continue to access discontinued providers if they are under an active course of treatment. These patients may continue to see that provider for 90 days or until 1the period of active treatment is over, whichever is less. This allows the member to continue to see the provider

with which they have a relationship until they are able to work with the plan to identify a new provider.

- I will close by saying there are other important standards in our program that relate to how narrow networks are designed and how members experience is monitored. We have shared the summary of these requirements with the Marketplace staff.
- I would be happy to discuss these issues with you in the Q&A. Thank you again for the opportunity to speak.
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Kevin: you said you look at the provider directory every three years?

Will Robinson, NCQA staff: Every three years for usability testing. They need to market test the directory for font size, the website for flow, to make sure people are not dropping off in the key parts of the website. There are several factors in the standard that comprises the usability testing.

Kevin: does that include testing to see if the network is adequate? You do not set a standard, correct? The carrier sets the standard?

Will: yes. The number and geographic distribution of providers is set by the carrier.

3. Kylanne Green, URAC

Kylanne: I am Kylanne Green, the President and CEO of URAC. I think you will see some similarities as well as contrasts between URAC's and NCQA's approach to network adequacy. We are a smaller accreditor. We have plans in 28 of the exchange areas so we are specifically the accreditor of the regional plans in the exchanges, with member levels of about 300,000 enrollees.

Our standards focus on the consumer. You will see through the principles that underlie the standards the consumer focus. We require written policies and procedures that are specific as to how providers are recruited and credentialed, and how the network is managed specific to those providers. A number of our plans are in professional shortage areas, so we do not require x number of these or those providers. Like NCQA, it is the plans, considering the needs of the consumers in the regions they serve, that develop adequacy standards. URAC does engage in a determination that in every day practice, the plan is cognizant of the standards it has developed and lives up to those standards.

URAC also requires a robust appeals process for consumers. We focus on two-way communication between the consumer and the plan. URAC is also studying the issue of health literacy, which tends to be lower in rural and underserved regions. There is a standard for routine review of the information and interaction with the consumer on an annual basis.

Kevin: what type of appeal processes do you have?

Kylanne: Several. There is an appeal process for the consumer that believes s/he requires care from an out-of-network (OON) provider; up front, there is an understanding of the benefit for OON care, and that the consumer will be placed in hardship if it is not provided. In addition, the standard requires that the plan use the appeals mechanism and its documentation to report through its quality mechanism.
The scope of services standard is aimed at both the physical and behavioral health side. URAC looks for a plan that addresses both. Again, no numbers are set in stone. The health plans must meet the underlying principles in its own plan.
URAC's review also focuses on OON and emergency services, and how that is communicated to the consumer. Does the consumer know where to go in a crisis situation? URAC believes those two areas are important to health plan literacy.

Kate: It's been coming up a lot lately that insureds show up at an in-network emergency room and discover that the doctors are not in-network. Is that something you are looking at standard-wise?

Kylanne: It is an issue that we have heard about. There is not a specific standard that requires a health plan or carrier to contract with the staff providing the service at the facility.

Henry: Is it possible to have a standard with the facility that is in network regarding what contractual procedures they must have with groups that are OON to avoid the sometimes outrageous prices that have been levied?

Kylanne: It is an issue, but the standards are with respect to carriers, not the facility.

Kevin: You are not setting the standards, just ensuring that the carriers live up to the standards they set, correct? You are not putting new standards on top of the carrier's standards.

Kylanne: Yes, what they hold themselves out to be, they are, in a communication that is easily understood across the membership, that is updated periodically to reflect any changes, and that is delivered in a manner and in a language that consistent with the consumer. Also, we expect that pans will monitor requests for OON services and if they have a large number of them, they address it. There is a quality process that addresses it. It is a continuous feedback loop.
Another significant review for us is that the plan has a process and a plan and can document the fact that it is in compliance with state law.

Kevin: In addition to state law, are you tracking certification requirements?

Kylanne: Yes. It is part of the review process.

Again, we focus on the consumer, the fact that access is defined by the consumer, that they have recourse, that they have two-way communication, that they have choice among plans, and that there are alternatives where choices are narrowed.

The URAC presentation can be found here.

4. Claire McAndrew, Families USA and Standing Advisory Board member

Purvee: Next is Claire McAndrew of Families USA, and a member of the Standing Advisory Board SAB). She will be presenting in both capacities.

Claire: I chair the SAB's subcommittee on network adequacy. The scope of the work is large – we were charged to collect data to support the resolution passed by the Executive Board on network adequacy. The resolution refers to network adequacy and provider directory requirements of the ACA. The subcommittee is in the process of producing a report on the accuracy of provider directories and the availability of appointments within certain medical fields to residents of the District in the individual market.

The subcommittee accessed the provider directories as any consumer would, through DC Health Link and the links provide therein. It focused on primary care providers, ob-gyns, mental and behavioral health providers, oncologists and neurologists. Thirty providers were called, or in the case where a specialty did not have 30 providers, all of them. A complete report is anticipated by the end of the year, but I will make some general comments. A caveat: this was a very small sample.

On PCPs, the biggest concern with respect to inaccuracy was contact numbers – levels of 40%-50%, meaning that the provider was deceased, the person who answered the telephone had no idea what the plans was, or the provider used to be at the location. For those whose contact information was correct, almost 100% were in the network. On new patients, less than half were taking new patients. For those that were taking new patients, most could get an appointment in five weeks or less. The range was next day to five weeks.

Ms. McAndrew recommended that carriers be required to have a dedicated email address or telephone line for consumers to report inaccurate directory information, and that carriers be required to correct the information within a set period of time, e.g. 10 business days; that carriers be required to internally audit their directories on an annual basis; that carriers be required to contact providers that have not filed a claim in one year to determine if they still are part of the network; and that if a consumer relies on erroneous information in a directory and receives care from a provider who turns out to be OON, the consumer not be charged OON charges.

Ms. McAndrew reported that on a positive note, the links to provider directories are all working at this time, which was not always the case as they tried to do their research.

Families USA just released a report on other state activity:

Timely access standards: CA – primary care appointment within 10 day of requests; specialist care within 15 days. WA is similar.

Time and Distance: modified in NJ for public transit.

NJ, NH – required specialties and subspecialties.

When access is not available, the insured should have the right to go OON for IN prices. NY just passed a law or regulation on this giving the consumer the right to an external appeal.

DE, CT have passed QHP certification standards.

The first thing we need to do is get accurate provider directories so we can begin to figure out what types of standards should be applied to them.

The Families USA Report can be found here.

5. Tammy Tomczyk, Oliver Wyman Consulting Actuaries

Tammy: I am Tammy Tomczyk, a principal and consulting actuary with Oliver Wyman. Most of our work for state and federal regulators is on rate development and rate review, so network adequacy is not our area of expertise. However, we do have a tool we were asked to talk about.

One of our regulatory clients was concerned about network adequacy and wanted to test the carriers' networks. On slide 3 you see one of the areas that the tool can test. It can look at urban versus rural areas, specialties, and miles to providers. On slide 4, you can see the tool uses 5 digit zip code areas and GPS coordinates to flag areas that might be investigated further. The tool is testing, for example, whether there is a primary care provider (PCP) within X miles. We are able to get mapping capability using Census Bureau data. Slide 5 shows a schematic of the data and the rules the tool will test. Slide 6 shows two graphs: the left side is PCPs, and the right side is cardiovascular providers. The yellow dots are the providers. Green means it passes the test. The pink ones are failing. Sometimes there are false positives because of oddly-shaped zip code areas. They can test the ratio of providers to enrollees and to general populations. The tool does not know whether the provider is taking new patients. On slide 7, challenges are listed, such as false positives. Drive time is harder to test than distance. She was unable to contact a colleague to determine whether the tool could factor in mass transit.

The Oliver Wyman presentation can be found here.

6. Howard Liebers, DC Department of Insurance Securities and Banking

I had previously reported that the NAIC is updating its model act on Network Adequacy. One of the requirements that will be in the model will be submission of access plans to Departments of

Insurance. We previously discussed information available through SERFF filings and various templates. A new template is the 2015 Network Adequacy template, which was finalized after the DC recertification process had begun. This template will allow the carriers to list specific provider information, such as identification number, specialty, address, and network identification. The FFMs used this template this year. We could require it in 2016.

Ms. Kempf noted that another report had been posted on our website that had been developed by consumer representatives to the NAIC. They had developed a survey that was sent to state insurance departments. She noted a response rate of 30 jurisdictions out of 52 requests. She highlighted questions regarding the type and timing of network adequacy reviews. Eighty-five percent of HMO reviews were done at the time of licensing while 36% were done on the PPO side. With respect to HMOs, in 50% of cases the entire filing was reviewed while in PPO cases it was 36%.

California and New York are actively looking at the issue of being in a network hospital and being served by non-network providers.

7. Public Comment on Network Adequacy

Kevin Wrege, representing AHIP and Aetna, urged caution on the issue. One regulator is better than two; he strongly recommends that DISB and HBX reach consensus on the issue. The carriers are concerned that they not be required to abide by two sets of standards. His second observation was that health plans traditionally had three ways to address affordability for consumers: underwriting, benefit design and provider networks. Cost management was managed by use of those three tools. A national trend now is the carriers are using tailored but high quality networks to manage underlying costs while controlling quality. He cautioned to allow carriers the flexibility to continue using the last tool they have at their disposal to manage costs.

Review of Rates Presentations and Discussion (11:30am to 12:15pm)

1. Tammy Tomczyk, Oliver Wyman Consulting Actuaries

Slide 9: Presently Oliver Wyman works for several states, either directly, or for CCIIO in states that do not have effective rate review programs. OW works in states with SBMs and FFMs. OW typically does not work for the exchange; DC is an exception. In most states they are working for the regulator department of insurance. OW's involvement varies from being the primary reviewer, generally in states that do not have in-house actuaries, to being a secondary reviewer assisting primary reviewers with developing tools for effective rate review or actually reviewing the filings.

Slide 10: Primary review work – OW has a detailed checklist and rate review process based on the federal regulation outlining requirements for an effective rate review program. OW reviews key assumptions such as trend and actuarial pricing values. Sometimes they are reviewing for reasonableness and reviewing the actuarial analysis of the carrier. In other cases they get data

from the DOI and analyze the data itself. In addition to key assumptions OW is reviewing the methodology for ACA compliance in the individual and small group markets. OW prepares questions and communicates directly with the carrier or through the DOI and SERFF. The final work product varies by state as well. In some states it is a brief opinion letter summarizing their review; in other states it is a full-fledged report and testify at rate hearings.

Slide 11: Rate review in states where they are not the primary reviewer – OW has developed standard actuarial memorandum requirements, designed to ensure the requirements for an effective rate review program are met. In some states OW has developed rate review training manuals that include all the components of an effective rate review. They are guidelines and benchmarks that highlight potential areas of further questioning. The training manuals also assist the state in consistency of reviews. OW has developed checklists, templates and analytical tools. Some tools can be used to compare data from year to year.

Slide 12: Reviews that impact rates – In some states OW reviews metal actuarial value and look at unique plan designs. Most of the reviews conducted on this slide are reviewed prior to filing of rates. Benefits come in first because if they change it will impact rates. The carriers are requires d to use the federal actuarial vale (A/V) calculator to determine the metal level, but it does not accommodate all cost-sharing options. In such a case, the actuary may make an adjustment and attest to it. OW reviews the screen shots of the A/V calculator, the attestation, the description of the methodology used to make the adjustments and the magnitude of the adjustments themselves to determine if they are appropriate and meet requirements.

Kevin: Is that normally done by the actuarial reviewer at the DOI?

Tammy: Most of the time the people doing the benefit review can do it, but they are not actuaries, so many times they ask us to do it.

Henry: Do you take into account the influence of cost-sharing of a specific service on the utilization of those services that will be provided?

Tammy: The carrier actuary should be doing it, yes.

We also perform cost-sharing reduction plan reviews, meaningful difference reviews and discriminatory benefit testing based on state guidelines, and EHB substitution in states where it is allowed.

Slide 13: This slide contains a list of other reviews and assistance we provide, such as development of standard benefit package plan designs, and microsimulation modeling.

Kevin: Is the nondiscrimination tool a federal tool?

Tammy: No, it is not a tool. A state had broad guidelines and we helped the state look at the benefits in light of the guidelines.

2. Purvee Kempf, DC Health Benefit Exchange Authority

Purvee reviewed the requirements briefly, detailed in the first meeting minutes of October 16, 2014.

Information on California: California has adopted an active purchaser model. The carriers submit to Covered CA; Covered CA selects a number of carriers and negotiates with the carriers they allow into the exchange. Covered CA hires an independent actuary to review rates. Timeline: applications released in March; applications due in June; apps are evaluated in June; negotiations occur in July; by end of July public release of carriers in the exchange. Afterwards is the rate filing process to the DOI; certification is contingent upon completion of that process. Applications and negotiations are confidential. It is a robust bidding and negotiation process on price, networks and quality. Final certification is September 30.

Information on Connecticut: Access Health CT had a process specific to the exchange on rates. AHCT, concurrent with the DOI rate review and approval, reviewed the rate filing. Actuarial Reviewer hired by AHCT was able to communicate directly with carriers on the rates. Sometimes the responses were robust, others not. The final report was submitted to the DOI formally as a public comment. CT has a formal comment and public hearing process for rates.

Public posting of justification – the federal government had posted the 10% or greater rate requests, but that site was taken down and is in the process of being revived. In the meantime, the federal government has a lot of information in a public use file on each of the filings available.

Vermont has a requirement of a plain language posting of rate increase justifications.

Posting on carrier websites has not been successful in most states, but they are available on DOI websites.

Kevin: the I-Rate system has a way of creating a very easy public access file to see justifications. DISB is using the I-Rate system.

3. Public Comment on Review of Rates

Cheryl Parchum: In DC I understand there was an independent review of rates that was not part of the public comment process. Can you explain why?

Kevin: Yes, HBX hired an independent actuary that worked collaboratively with DISB. The firm had access to confidential information. Ultimately the report was made public.

Cheryl Parchum: The public advocate in CT was very active useful in influencing rates there.

Kevin: Yes, she is on the Board and the Exchange gave her money for the rate review process. Also there was a hearing and the report was useful.

Kevin Wrege, representing AHIP and Aetna: He did not address the legal authority issue at the moment. His clients have concerns about whether this is good policy. What happened at the Executive Board meeting awhile back was a disagreement between two agencies about the HBX appropriate role in the rate review process.

The issue is two different regulators looking at rate review, a sensitive process. DISB is the appropriate voice and primary regulator of rates. We realize there will be an exchange of information between the agencies, but the primary regulator of rates.

Speaking personally, he said he knows that the Executive Director is looking to grow the size of the carrier base in the District. He thinks having two regulatory bodies adds significant burdens to the carriers, resulting in carriers having to reach the lower number. That number may not be the right number for a carrier to meet its costs.

Finally, he suggested, a differentiating factor in the District is the combined, single market.

BREAK (12:15pm to 12:30pm)

Quality of Qualified Health Plans Presentations and Discussion (12:30 to 1:15pm)

1. Representative from Centers for Medicare and Medicaid Services

Mary Beth Kaiser and Tanya Alterrez from Booz Allen Hamilton presented on behalf of CMS . Marketplace Quality initiatives and provisions that are intended to inform QHP certification; assist consumers in plan choice; and ultimately help CMS monitor plan quality.

Patient safety – beginning 1/1/15, a QHP must comply with patient safety standards: contract with providers that (1) have a defined patient safety evaluation system in place, (2) meets specified quality improvement criteria including counseling. QHPs attest and maintain documentation.

Enrollee satisfaction survey – CMS has developed a Marketplace Survey and an Enrollee Satisfaction Survey. Marketplace Survey intended to evaluate consumers' experience with the marketplace and marketplace services – website, open enrollment experience, contact center, in person support. Using CAPS framework to help improve marketplace performance. Results not intended to be publicly reported – will be shared with marketplaces. QHP Enrollee Survey intended to evaluate enrollee experience with his/her QHP. Largely based on CAPS Health Plan

5.0 survey. High level questions about plan experience, not individual providers. Will be publicly reported in 2016.

Timing – detailed in presentation slide 7. Slide indicates testing using FFM and SPM. Mila: those use federal IT platform. Is CMS going to survey re: SBMs without pre-testing of state IT platforms? It is voluntary for SBMs to participate in the testing.

Quality Rating System – based on quality and cost. Required as part of certification process. Applies to family and adult coverage IVL and SHOP. Technical guidance link in slide deck.

Issuers required to collect, validate and submit data as specified. Clinical measures and survey measures included. Total 43 measures in set, but not all reportable in 2015 due to multiple year lookback. Public display in 2016 for 2017 plan year on SBM and healthcare.gov. One to five star rating .

Hank: What can consumers take away from a star rating that is inherently understandable. Blending of host of different measures of quality.

BAH: CMS in process of consumer testing now, over the next year and beyond.

Quality Improvement Strategy – certification requires a QIS. Intended implementation in 2016 for PY 2017. Attestation to QIS. Under design so timing fluid.

2. Will Robinson, National Committee for Quality Assurance

- Thank you for the opportunity to discuss how NCQA promotes quality through our health plan accreditation program. I wanted to make sure everyone knew that NCQA was a sub-contractor to Booz Allen Hamilton on the Quality Rating System contract. Please direct any additional questions about the QRS to them.
- I'm going to focus my comments today on our clinical quality (HEDIS) and patient experience (CAHPS) reporting requirements that are included in Health Plan Accreditation. The Health Care Effectiveness Data and Information Set, or HEDIS, is the most widely used set of quality measures in the country. HEDIS measures look at whether health plan members receive evidence-based preventive care, achieve positive outcomes when battling chronic disease, or are subject to failures of care management and care coordination, such as hospital readmissions. The Consumer Assessment of Health Plan Providers and Systems or CAHPS is a member experience survey that asks patients about their experience accessing and receiving care. Both HEDIS and CAHPS are widely used to gauge the quality of care and patient experience by state Medicaid programs, state Departments of Insurance and federal agencies such as CMS and the Office of Personnel Management.
- All NCQA accredited health plans are required to report a core set of HEDIS measures. Results from those measures are included in accreditation scoring and used annually to update health plans accreditation status. We vary the plans status based on performance:

statuses in include Excellent, Commendable and Accredited. Plans accredited for their Marketplace line of business will report measure results for the Marketplace population.

- Similarly, NCQA accredited health plans report CAHPS survey results annually. The survey is conducted via mail – using a certified vendor to ensure apples-to-apples comparisons – and it asks patients a range of questions about their care experience: How often was it easy to get the care, tests or treatment you needed? How often did your personal doctor listen carefully to you? There is an adult version of the survey as well as a version for children and the survey is designed and maintained by the Agency for Healthcare Research and Quality, or AHRQ. Like HEDIS results, CAHPS results are included in accreditation scoring and used to update health plan's overall accreditation status (accredited, commendable, excellent etc.) annually.
- Currently, NCQA does not require Marketplace plans to report HEDIS and CAHPS for accreditation. Because enrollment began in January and continued through March, they have not had the requisite coverage time needed for accurate and valid measurement. Most measures require at least a year; some require two. In addition, we are waiting for CMS to determine the requirements for plan quality rating and quality improvement systems. We plan to evaluate those requirements once they are made public, although we are likely to align our accreditation requirements for Marketplace plans with both. All but one of the measures that CMS has announced that comprise the Quality Rating System are HEDIS measures. So, we expect that there will be significant alignment between CMS requirements and NCQA Accreditation requirements.
- Finally, Marketplace staff asked us to address what information we make available to the public. Our website includes a health plan report card that identifies all NCQA accredited plans and their performance in the 5 keys areas of accreditation (access and service, qualified providers, staying healthy, getting better, and living with illness). Access to this is free of charge. We also annually publish health plan rankings under a joint project with Consumer Reports. This information is available both through the Consumer Reports magazine (paid) and our website (free). There is information on DC-specific products available.

Kevin: wants to make clear that it is not plan level. It is product level. It will not help the consumer trying to choose between two policies under the same umbrella.

- We also make detailed, measure-level data available through Quality Compass, our web-based analytic tool that includes regional and national benchmarks for Commercial, Medicare and Medicaid plans. It also includes many years of trended data (Medicare, Medicaid and commercial) and is available for a fee.

3. Marybeth Farquhar, URAC

Ms. Farquhar is the Vice-President for Research and Measurement. URAC uses measures that are in the public domain but refines the measures specifications. URAC is looking at the population health level and cross-cutting measures. URAC is patient-centric and uses patient surveys to help provide URAC information.

URAC is partnering with a data company called Inovalon to collect the URAC measures. URAC is using the QRF measures, plus eight URAC at the population level: two on network adequacy, two in asthma, one on heart failure, one on diabetes, one on medications for the elderly, and one on drug interactions. URAC is developing outcomes measures rather than relying solely on process measures.

More recently, the National Pharmaceutical Council and Discern issued a whitepaper on measures in accountable care. It is a very good report.

Inovalon is collecting the data: member demographic information; member enrollment coverage information; provider demographic information; lab results; prescription drugs; claims data; and EHR information. URAC has access to the data. It can be customized – for example, Arkansas has a high blood pressure problem, and URAC can run any measure for Arkansas down to the element.

Mila: we are regional – can that be segregated? URAC said yes. Inovalon collects zip code information. Arkansas will be purchasing a certain service. But at the request of regulators, URAC will provide information such as access maps at no charge after notice to the client within three days. The information at this point would be a giant pdf.

4. Purvee Kempf, HBX

Highlights other state information: Covered CA has its own QRS rating system. It is using enrollee survey data from the full CA marketplace for the Star Rating System. Covered CA requires submission of ten CAHPS measures, a single summary score for each plan compared to the regional benchmark, and the star rating system.

Colorado also implemented its own QRS rating system. It provides significant additional data such as complaint information, and ratings on different types of questions. But it is not at the plan level.

Kevin: This confuses me because it does not give consumers all the information they need. Plan level information is harder. It is a difficult issue. If my mother is trying to choose between Plan A and B from carrier X, all she gets is the star rating for carrier X.

5. Public Comment Quality of Qualified Health Plans

Claire McAndrew, Families USA and SAB: On the consumer experience survey (CES) that reflects how people feel about their health plan, the survey is at the plan level, although not at the metal level. It will be one of the components that form the star rating. Originally CMS said it would not be published, but now it is up to the SBM as to whether to make the full CES publicly available for each plan. She would advocate for public information.

For both surveys, the surveys were drafted by qualified individuals with a lot of testing. She believes that they are really well done, and no SBM would have the resources to develop the surveys so rigorously. She hopes CMS will make them both publicly available.

Purvee: We will get more clarity around the various terms and what they mean (health plan level, product level etc.).

Anti-Discrimination Certification Requirement Presentation and Discussion

Purvee: Clarified that we are not talking about the sec. 1657 provision enforced by the Office of Civil Rights. We are talking about the health plan certification anti-discrimination provision that the health carrier does not discriminate on the basis of race, color, national origin, disability, age, sex, gender, national origin, identity or sexual orientation and the health plan does not have a benefit design that have the effect of discouraging enrollment of individuals with significant health needs. Specifically we will focus on what a state can do with this certification requirement and what may be happening beyond the District.

1. Katie Keith, Trimpa Group, LLC

Health Plan certification requirements – these are significant new protections. These requirements are new to world of health plans.

Her group wanted to get a baseline for 2014, somewhat of a daunting task. They interviewed regulators in 10 states, advocacy groups, and carriers to see what people are thinking about non-discrimination. There is no ideal standard. What they heard was it is a lot of business as usual and regulators and carriers are not doing anything new specifically. They did poll people about potential concerns and got the following: narrow networks, formularies, exclusions and more. She encouraged the District has the opportunity to take a more proactive approach to the issue.

Form filing is an issue. Matrix filings make it difficult for the regulator to spot potentially discriminatory provisions. The Committee discussed the difficulties of form filing and finding information at length.

Ms. Keith said the District has done many things well – banning substitutions in EHB, defining habilitative services, and the gender dysphoria bulletin. Potential things to do include issuing guidance with examples of discriminatory provisions. Ohio has some information on its website.

Diane: what about case law? We have been dealing with discrimination for a long time.

Katie: this is the first time we are dealing with the content of the benefit rather than the entry into having benefits. There is no disparate impact analysis. It is a paradigm shift. Discrimination was legal before. Benchmark plans were created when carriers were allowed to discriminate.

HBX could require carriers to post their actual evidence or certificate of coverage, or full plan documents. Advocates can then review the documents and point out discriminatory language. And it takes time for forms to catch up to the law. For example, smoking cessation provisions took a while to come up to speed.

DISB Complaint Process Presentation and Discussion (1:30pm to 1:45pm)

Howard Liebers, Health Care Policy Analyst, DC Department of Insurance Securities and Banking

Monitoring complaints is an overarching way to lend back-end support to the attestation process. DISB has a complaints division that receives complaints against all insurers, not just health carriers. The National Association of Insurance Commissioners (NAIC) provides a system for tracking complaints, the State-Based System, or SBS. DISB is able to track complaints that are specific to the exchange. It has added a tab, "Health Exchange," to track exchange complaints. Mr. Liebers ran a report including the primary reason and investigator comments for 63 complaints in the system. Those reasons include complaint handing, policyholder service, delays or no response from carrier, premium billing, and issues with application. Mr. Liebers said that DISB has the ability to capture complaint information robustly.

The DISB complaint division is in regular contact with the call center and the Ombudsman's office and they work hand-in-hand together to ensure that District residents obtain the services to which they are entitled under the insurance contract. DISB follows up with the carriers on complaints, and DISB has the authority to take action against a carrier if there is an egregious situation.

Debbie: can a complaint about a company and the provider not being in the network be captured?

Howard: the contact person who receives the call will elicit as much information as possible and instructs the caller to file a formal complaint in the system with that information.

Mila: can a search for small group and/or individual complaints be run?

Howard: I am not sure. We will need to investigate what key words are in the system that are searchable. He stated he would work with HBX to figure out the best options.

Ms. Curtis stated that the Ombudsman deals with the cases where people have problems accessing health care. The majority of the Ombudsman's work is on Medicare and Medicaid, not commercial health insurance. In 2013, 23% of the Ombudsman's work was on people with commercial health insurance. The Ombudsman takes the cases on medical necessity, which would not be forwarded to DISB. Sixty-three percent of the 2013 commercial cases involved medical necessity. Another 13% involved access and coverage issues. The total count was 274 cases. The Ombudsman always tries to work with the carrier to resolve the issue, as opposed jumping straight to external review.

Next Steps, Kevin Lucia, Chair

As I stated at the beginning, we've adjusted the formerly announced schedule. Over the next several weeks, we are asking HBX staff to develop recommendations for our review on updated plan certification processes in these areas. This should include a review of staffing, capacity and feasibility. It will take some time to develop those. So, we are cancelling the previously announced December 9th meeting. We will next convene this committee on Wednesday, December 17th at 10 am to 12:00 pm, in this same location. Prior to that meeting, by December 10th or so we will post DRAFT recommendations from the staff for new plan certification policies. We want public comments in writing on those draft recommendations, or in person at our December 17th meeting. After considering public input, discussing and reviewing the recommendations, making any needed updates to the recommendations, we will reconvene this Committee in early January to vote on the recommendations and be prepared to take them to the Executive Board for its consideration at the regularly-scheduled January 14, 2015 Executive Board Meeting.

Public Comment

There was no further public comment.

Closing Remarks and Adjourn, Kevin Lucia, Chair

Thanks to everyone who participated today and in our previous meetings. It is important that the District's exchange is taking the time now to reevaluate the certification processes and we thank you for providing input into that process in time to effect certifications for Plan Year 2016.

As always, the meetings and meeting materials will be posted on the HBX website, www.hbx.dc.gov.

It is very important for us to have input from the insurance companies who do business through us. It is also critical for us to have input from our customers and consumer and patient advocates. Please continue to join us in this process.

Minutes and audio are posted for each meeting if you missed it.