Minutes
Executive Board Insurance Market Working Committee
Friday, January 9, 2015, 9am

Date:	**Friday, January 9, 2015**
Time:	**9:00 AM**
BY PHONE ONLY:	Call- in Number: 1-877-668-4493, Access Code: 737 360 674

I. Welcome, Opening Remarks, Kevin Lucia, Chair

Kevin Lucia called the meeting to order at 10:05 AM. A Roll call was taken of those who chose to introduce themselves online. In addition to the three Committee Members (Kevin Lucia, Kate Sullivan Hare and Henry Aaron), these people identified themselves: Dana Bebe, Joe Winn and; Beth Ziegler with Aetna; Suzanne Dowell, Colleen Cohan, John Fleig and Bill Talamantes with UnitedHealthcare; Geralyn Trujillo with AHIP; Anne Doyle with CareFirst; Patricia Quinn with DCPCA; and Claire McAndrew with Families USA and a Standing Advisory Board Member for HBX. From HBX staff, Purvee Kempf, Debbie Curtis, Brendan Rose, and Rob Shriver were in attendance as well.

Kevin provided opening remarks welcoming the Exchange board members Henry Aaron and Kate Sullivan Hare and those joining from the public:

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.

This meeting is taking place by telephone only. There is an agenda and draft staff recommendations that are available on the HBX website. They are available at www.hbx.dc.gov

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 have had three 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 (DISB) and we appreciate all their prior and continued efforts on this.

At our second meeting DISB and HBX staff reviewed how each of these certification requirements has been implemented.

At our third meeting, we heard from numerous experts from the field to 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.

At that meeting, we asked HBX staff to work develop recommendations taking into consideration staffing, capacity and feasibility. Over the past month, HBX staff have talked to each health carrier participating in our exchange marketplace numerous times to understand their operations and ability to implement different ideas that were presented by experts in the field. They have talked to staff at DISB and other pertinent stakeholders.

At today's meeting, Purvee Kempf, HBX General Counsel and Chief Policy Advisor, will present these staff recommendations. We will discuss them and ensure there is a full understanding of the proposed recommendations.

Toward the end of the meeting we will discuss next steps and seek public comment.

Howard Liebers with DISB is also on the phone and is available to answer questions. Howard, thank you for joining.

II. Presentation of Recommendations by Purvee Kempf, HBX General Counsel and Senior Policy Advisor

Thank you for joining us by phone today for this meeting to discuss these staff level recommendations on plan certification standards in the four key areas of network adequacy, rate review, quality, and non-discrimination.

In the context of this discussion, it is important to note that on November 26, 2014 the Federal Government issued proposed regulations *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016* that impact plan certification nationwide. These rules are not yet final, but, for example, in the provider directory arena, the proposed rule will require plans to post up-to-date provider directories and note whether providers are accepting new patients, address of the provider, contact information, whether the provider is part of a larger medical group, and medical institutions with which the provider is affiliated. The directory must be able to be viewed by a link or tab by anyone who is interested – it cannot require an account or policy number in order to access. Going even further, the proposed regulation asks for comment on whether the file format should be required to be in a "machine readable file format" or if a specific file format should be designated by the Federal government so that this data can be easily translated into additional formats for Exchanges and health insurance carriers and others to replicate it and use it in other formats.

All this provider directory information is being highlighted to make clear that the Federal government is active in this arena as well and as we move forward, we need to make sure none of our work is contradictory to what the Centers for Medicare & Medicaid (CMS) is pursuing.

In developing these staff recommendations, I also want to be clear that staff have spoken with all the health plans individually, met with other stakeholders, and have worked closely with DISB staff to really understand the capacity and feasibility of each proposed recommendation and other suggestions that have been made throughout this process. As these public meetings have been held, presenters came forth with numerous ideas which included changes in law, regulations, guidelines, and practices.

Now, we will go through each topic area and discuss the staff recommended policies under each one.

I. NETWORK ADEQUACY

1. Under the Affordable Care Act, carriers are required to have a sufficient number and type of providers to ensure that all services are accessible without unreasonable delay in each of their health plans; that the plan networks have mental health and substance abuse service providers; and the networks include a sufficient number of essential community providers.

Currently, carriers attest to meeting network adequacy requirements and submit the Center for Consumer Information and Insurance Oversight (CCIIO) Federal Network Template to the DISB for review.

Carrier:

- For plan year 2016, in addition to submitting the CCIIO Federal Network Template, carriers must also submit the CCIIO Network Adequacy Template to DISB.

DISB

- DISB will track complaints related to network adequacy and will update their tracking mechanism as necessary

Kate: I just want to clarify on the mental health network requirement, does the law specify the range of mental health providers or not?

Purvee: These are federal law, I don't know the answer to that off the top of my head and will need to research and get back to you.

2. Under the Affordable Care Act, carriers are required to make available health plan provider directories online and in print if requested, including information relating to providers not taking new patients.

Currently, DISB reviews the carriers' website links.

Carriers: provider directory
For plan year 2016, in addition to the current requirements:

- Carriers must submit provider data at intervals and in formats as determined by HBX for use to populate DC Health Link's provider directory search tool. Carriers participating in the individual market have already begun providing provider information to populate a DC Health Link individual market provider directory search tool

scheduled to “go live” in Spring 2015. Timing of developing and implementing a DC Health Link provider directory for the small group marketplace will be determined after experience and consumer use of individual marketplace provider directory tool.

- In time for the 2016 plan year open enrollment (beginning October 1, 2015), carriers will be required to prominently post a telephone number or email address on their online and print provider directories for consumers to report inaccurate provider directory information. Carriers will be required to take timely action to validate reports and, when appropriate, correct the provider information. The carrier will be required to maintain a log of consumer-reported provider directory complaints that would be accessible to DISB or HBX upon request.

- Carriers will be required to take program integrity steps to maintain a high level of accuracy in their provider directories. Beginning in calendar year 2015 and annually, a carrier is required to take at least one of the following steps and report such steps to DISB:

    1. Perform regular audits reviewing provider directory information.
    2. Validate provider information where a provider has not filed a claim with a carrier in two years (or a shorter period of time).
    3. Take other innovative and effective actions approved by DISB to maintain accurate provider directories. An example of an innovative and effective action could be validating provider information based on provider demographic factors such as an age where retirement is likely.

Bill Talamantes, UnitedHealthcare: How much lead time will we be provided to produce this data?

Purvee: On the small group side, which is where United participates in the Marketplace in the District of Columbia, we don’t have a set timeframe yet. We will be sure that you have appropriate lead time to do this. We have been in meetings with each of the carriers already as we developed these recommendations and you will be provided the necessary time.

Purvee: To further discuss these recommendations, we heard the concerns raised by carriers about being too prescriptive on these requirements. That’s why we broadened them so that we are not requiring just a dedicated email for consumers to note problems with the provider directory. We are allowing the carriers to choose how to best make this input easily available to enrollees and our goal is just to ensure that these steps are taken.

With regard to the third item, there seems to be wholesale interest, including carriers, to increase the accuracy and integrity of provider directories. In our conversations with carriers, it is clear that great work is going on in these arenas with our plans. Again, that is why we have recommended a broader path that achieves our goal of better accuracy of provider directories, but provides flexibility to the carriers on how best to achieve that.

Kevin: Why is it a two year period for a carrier to validate a provider who has not submitted claims, rather than a one year period?

Purvee: Some carriers are doing this now and a one year time period may be too short. This recommendation is kept broad to ensure feasibility. It does not mean a carrier has to wait for two years; it can set tighter limitations.

Henry Aaron: How important is this provision at all given that most people are looking for provider directories to see if providers are taking new patients and none of this seems to address that need?

Purvee: Patients also go on provider directories to see if their provider is with a different plan. Even if their provider is not accepting new patients, if people are interested in switching plans, they need to know what other plans their providers participate in. There are many reasons people access provider directories. This provision does not address the issue of whether the provider is accepting new patients though. That is correct.

Kevin: We will take comments over the next two weeks and hope stakeholders provide feedback on this point that has been raised by Henry.

Henry: Perfect Kevin, please proceed.

Kate: I am most interested, selfishly, in having this searchable provider directory accelerated into the SHOP marketplace as well.

Purvee: There is one remaining item in the Network Adequacy category and that the Access Plan. As previously approved by the Executive Board, HBX will implement the requirement that carriers submit an Access Plan by working through the Plan Management Advisory Committee.

Rob Shriver, HBX Staff: To respond to Kate's concern, adding the searchable provider directory to SHOP is a priority and we are moving that process forward. United is the one plan not in the loop on this front as they are only in our SHOP Marketplace. We will reach out to them to make sure they understand our plans.

Debbie Curtis, HBX Staff: Another reminder is that Washington Checkbook, which is the vender preparing the provider directory work for HBX, has a large footprint in the District marketplace with many employers and others using its information. It is highly possible that the carriers have worked with Washington Checkbook before. And, another reminder is that the proposed Federal regulations in this arena are quite strict so much of this work may be required at the federal level as well.

Tricia, DCPCA: Do we have a benchmark on how the provider directories now rank so that we can measure improvements?

Purvee: Our Standing Advisory Board appointed a committee to investigate our individual market plan provider directories for several key categories of providers. We are hopeful they will publish a report in the near future. It will not be a statistically valid study, but it will provide some measure. DISB also does have complaint data. Finally, as part of its contract, Washington Checkbook will do some minimal verification of providers. If that minimal check brings up significant inconsistencies, that will give us some sense of the quality of the existing provider directories as well. All of these things will help.

Rob Shriver: We have also asked the carriers for metrics they can provide.

Tricia, DCPCA: This is all helpful, I agree a full-blown audit is not needed.

Claire McAndrew, Families USA: I know that CCIIO collects the templates in order to do research on them. Will we do the same?

Rob Shriver: Our first step is to get the templates. At this point we are developing the review.

Howard Liebers, DISB: We did not collect this template in the past because it is a new one put forth by CCIIO late last year after our process was complete. We are now talking to CCIIO about how it uses the data. This template provides detailed information which does all for research. We may be able to add additional standards in the future; this year we will start with review, check for adequacy, etc.

Claire McAndrew: Is the only difference between how the Individual and SHOP marketplaces are being treated differently with regard to the searchable provider database? In other words, all these other provisions apply in both marketplaces, right?

Purvee: Yes, that is accurate.

Purvee: There is one final discussion point in this arena. Staff also investigated the ability for us to map where providers are in the DC Metro area. We cannot get a cost estimate that includes links to public transit travel times and locations because that would require significant more work for the vender to determine as the software is not readily available. Thus, it is likely much more expensive as well. We were able to find that a simple mapping of providers with mileage information from your location would cost somewhere under $100,000. Is this something the Committee members are interested in us pursuing and should it be added to the recommendations? On the positive side, you would see a map of where all providers are located and that may help you select providers. On the negative side, most people do not drive to their appointments so the mileage component is not hugely helpful within the District; it would not also indicate whether providers are taking new patients; and it is a point in time estimate that is subject to becoming outdated.

Kate: I use these services through my insurer. Is this duplicative to what they are already doing?

Purvee: That is a good point.

II. REVIEW OF RATES

Purvee presented the recommendation as follows:

Under the Affordable Care Act, HBX is required to collect, review and consider information on premiums and increases in determining certification for a qualified health plan.

For plan year 2016:

- Similar to reviews that occurred in 2013 and 2014, HBX is clarifying that for 2015 (plan year 2016 rates): 1) HBX will have a carrier's rate and form filings as filed with DISB;, 2) Carriers are required to respond to requests for additional information from consulting actuaries for HBX; and 3) Consulting actuarial review of the assumptions in carrier rate filings and the actuarial reports will be published on HBX webpage and submitted to DISB for consideration. Published reports will not contain confidential information provided by carriers.
- In this work, HBX will coordinate with DISB to minimize duplication of effort and maintain confidentiality of submissions consistent with current practice.
- In addition to these steps, HBX will develop an enhanced process under its legal authority. HBX will coordinate with DISB and will work with carriers, consumers, and other stakeholders to develop an enhanced process.

Purvee: I know the last bullet brings up a lot of questions. It has not been fully flushed out yet. We are still working with carriers, other stakeholders, and DISB on this enhanced process. It will be developed in a public format as we have moved forward all policies through HBX.

Laurie Kuiper, Kaiser Permanente: So, 2015 will be similar to 2014's process?

Purvee: Yes, at least the same as that. Again, the final bullet highlights that we may enhance that process in 2015 for the 2016 plan year, but those decisions are not final yet.

Laurie: When your actuary reviewed rates in 2014 did they only review already approved rates from DISB?

Purvee: No; our actuaries had access all the way through the process with DISB and, in fact, their final reports were completed before DISB finalized the rates so that their comments could be taken into consideration.

Kevin Wrege: What is the timeline for the enhanced process?

Purvee: As always, we will maintain close communication with the carriers on these potential enhancements, but I cannot provide a timeline at this moment. We know that any work in this arena does need to be done in a timely manner as plans will be filing rates at specified times.

III. QUALITY OF HELATH PLANS

Purvee presented the staff recommendations as follows:

Under the Affordable Care Act, the exchange is required to consider quality of health plans in certifying plans for the exchange, including considering quality improvement strategies, data from consumer surveys, and work with patient safety organizations.

Currently, HHS is working on measuring quality of qualified health plans by: 1) Developing and testing a quality reporting system; 2) Developing a quality improvement strategy; 3) Implementing a consumer experience survey; and 4) and Requiring carriers to work with patient safety organizations.

HBX

For plan year 2016:

- HBX will use federal standards and approach to make data on plan quality available to consumers.
- HBX will establish a web link to the 2015 NCQA public report cards for health plans.

Purvee: this is another place where I need to mention the November 26 proposed federal regulations which go into more specificity with regard to steps the federal government is taking on quality including increased financial incentives to carriers to progress in this arena. There are many specific federal standards in this area and we know that carriers are working to meet those requirements. We do not want to interfere with that work. We also know that all of our carriers in DC Health Link have achieved NCQA accreditation. NCQA does annual report cards, not at the plan level, but at the carrier level. As we work toward the federal standards, this is interim information that is helpful to consumers.

It was opened for discussion and there was none requested.

IV. NON-DISCRIMINATION PROVISIONS

Purvee presented this recommendation as follows:

Under the Affordable Care Act, carriers are prohibited from having a benefit design that has the effect of discouraging the enrollment of individuals with significant health needs or discriminating on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation. In addition, carriers are required to make available to a consumer the individual coverage policy or group certificate of coverage. Currently, DISB conducts a review of form filings and other plan documents using CCIIO tools through the plan year.

Carriers:
- For plan year 2016, carriers must submit to HBX a copy of the insurance contract also known as a certificate of coverage/evidence of coverage for each certified qualified health plan. Submission to HBX shall be at the health plan level and shall be made at the same time federal law requires disclosure to consumers.

HBX:
- HBX will make the insurance contract (certificate of coverage/evidence of coverage) publicly available on DCHealthLink.com.

DISB:
- DISB will review the need for promulgating guidance with examples of discriminatory benefit design.

It was opened for discussion and none was requested.

III. Request for Final Comments by Kevin

Now that we've heard the presentation from staff and had discussion on each of these categories by Committee members and the public, let me open the floor to comments on the entire package. Are there any general comments from participants on the call today?

Hearing none, let me move to next steps.

IV. Next Steps

Kevin: We need to act quickly if we want to get any of these recommendations in place for the certification process this current year (for plan year 2016).

COMMENT PERIOD: Staff have provided draft recommendations today. Our committee is seeking written comments from everyone on the draft recommendations discussed today by **noon on Tuesday, January 20, 2015** (that is the Tuesday after the Martin Luther King holiday).

(NOTE: If any changes need to be to the draft based on today's discussion, staff will make those and repost today)

NEXT MEETING: Our next Insurance Market Committee meeting will be an in person meeting at **1pm on Wednesday, January 21, 2015**. At that meeting we will deliberate to consider the comments, take further public comment, amend the recommendations as appropriate, and vote on a set of recommendations.

EXECUTIVE BOARD: A board meeting will be scheduled for Friday, January 30, 2013 (exact time is still to be determined). At this meeting, our Insurance Market Committee recommendations will be presented to the full board. The board may discuss and take public comment.

EXECUTIVE BOARD: There is a regularly scheduled February board meeting on Monday, February 9, 2015 at 5:30pm. At this meeting, the Executive Board will discuss, take public comment, and is expected to vote on a final resolution.

To review the highlights:

1. Comments due on today's recommendations by noon on Tuesday, January 20, 2015.
2. Next Meeting of the Insurance Committee on Wednesday, January 21, 2015 at 1pm.
3. Presentation to the full Executive Board, Friday, January 30, 2015 (time to be determined).
4. Final vote on a resolution by the full board on Monday, February 9, 2015.

We will also post this information on the HBX website.

V. Public Comment

I am going to open the floor one more time for public comment today – even though we have had significant public participation throughout the meeting. Please be sure to make your comments heard during this process. Stakeholder input is critical.

Please identify yourself and the organization you are representing if applicable.

Geralyn Trujillo, AHIP: Where exactly should we send comments?

Purvee: Good point, we need to identify a mailbox to receive comments. We will do that ASAP and will email that information to participants and post it on our website. Thank you for raising this as it was an oversight on our part.

VI. Closing Remarks and Adjourn

Kevin: 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.

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

And, there will be a report of this Committee process so that will be available before the Executive Board votes on these recommendations. The Meeting adjourned at 11:12 am.