Health Benefit Exchange Authority

Executive Board Insurance Market Working Committee

Final Minutes

November 4, 2014

Welcome, Opening Remarks

Kevin Lucia, Chair: Good morning to the Exchange board members Henry Aaron and Kate Sullivan Hare and those who are joining from the public both in person and on the 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.

This Committee met on October 16th to begin the process of reviewing the qualified health plan certification requirements.

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.

At the last meeting, Purvee Kempf, staff at HBX, reviewed each certification requirement and the legal authority for each requirement at the federal and district level. There are many certification requirements and we will not be able to take a deep dive on all these requirements. We sought public comment on your priorities for a deeper dive.

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

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

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 this meeting, DISB and HBX staff will review how each of these certification requirements has been implemented.

At the end of this meeting we will discuss next steps and meetings.

Today's public meeting of the Insurance Market Committee of the Executive Board is taking place at HBX's office: 1225 I Street, NE, 4th floor. I appreciate those that are in attendance and on the phone. I want to remind everyone that there will be an opportunity for public comment and input after the presentation and I ask that everyone from the public hold all comments until then allowing for a smooth conversation among committee members.

Approval of Agenda and Minutes

Today's agenda was approved and minutes were approved from the October 16th, 2014 meeting.

Presentation of the Implementation of Health Plan Certification Requirements

Kevin Lucia: We will begin our work today with an introduction from Purvee Kempf, General Counsel and Chief Policy Advisory for the HBX. Purvee will briefly review the four certification requirements as mentioned earlier for a deeper dive. Afterwards we will hear from Howard Liebers, Health Care Policy Analyst with DISB on how DISB is implementing each of the four certification requirements. Finally, we will hear from Brendan Rose, Plan Management & Enrollment Program Manager with HBX on any additional steps HBX is taking on those four certification requirements.

Henry and Kate, if you have any additional question on certification requirements not among the four determined for a deeper dive, feel free to ask those questions as well.

Purvee Kempf: Good morning, at our last meeting I reviewed the plan certification requirements as they exist. On the website are background materials – in particular a checklist of all qualified health plan certification requirements. This outlines the requirements, the source of the law, and the DISB and HBX role in each of these requirements. We'll review the four priority areas, but please review the full document and your comments are welcome on any and all of it.

The deep dive will begin with network adequacy. I'll review the policy, Howard Liebers will review the DISB role and Brendan Rose will review the HBX role. Then we'll turn to review of rates, then discrimination, and the final area being quality of health plans.

Network Adequacy: This requirement is statutory in the ACA. Requirements include ensuring a sufficient number and types of providers available without unreasonable delay, appropriate geographic distribution of providers, and the inclusion of essential community providers. In addition, the provider directory must be online and available in hard copy upon request and it must note when providers are not accepting new patients. There are two specific District

requirements: That the exchange will collect of data on network adequacy and for plans, they must submit "access plans."

Howard Liebers, DISB: The HBX carrier manual highlights all of the self-attestations required.

DISB has access to review tools provided by CCIIO and those tools allow for the review of some specific elements including essential community providers and service areas. We don't have any standard for the District of Columbia that is unique for DISB to investigate. So for DISB, we receive the attestation and run the CCIIO tools to see if anything jumps out at us.

Note, at times I will defer to Lekiewa Rasberry of DISB. She ran all of the tools so she can share more detail about what is in each tool.

Henry Aaron: I am very curious about how that works. Beyond the statement of the insurer is it possible to do a stress test as to whether these things work in practice?

Howard Liebers: We have a consumer services division that investigates anything that comes through as a complaint and we work with the Ombudsman office on that as well. That serves as a stress test/audit in that respect.

On network adequacy, I haven't heard any trend or spike on complaints regarding access to providers. We would investigate.

Essential Community Provider (ECP) Template: This is a form that HHS prepopulates that with information about 340 B eligible entities. In the District we have some ECP providers who have not attained this status (FQHC) and we can add providers to the list. NAIC is currently reviewing the Network Adequacy model act. Current act is from 1996 so that is an ongoing opportunity for states to provide input and share information and update this standard.

Kevin Lucia: Today we should focus on what we are doing and turn to what else is happening outside at another meeting. I think that's more productive.

Purvee Kempf: I handed out the attestation sheet that carriers submit. It is appendix C of the carrier manual for HBX. You can get it online as well. It shows you clearly what they are attesting to. That is the federal template that we use. In addition, I want to reiterate other templates that exist: the essential community provider template lists, by provider, addresses, zip codes, whether they are on the federal ECP list and they list the network IDs so you can identify which ECP goes with each network.

Kevin Lucia: The template process is a new federal process for the carriers to populate information into federally created templates. There is an ECP one and there is a pharmacy one

and then the electronic tools were created to monitor. DC chose to defer to the federal tools. So, what other tools are there?

Purvee Kempf: DISB will discuss that. I also wanted you to know there is a network template that lists all of the networks a carrier has.

Brendan Rose: The federal templates are a companion to the traditional rate and form filings at DISB. Pragmatic use of these templates is that they convert to XML and then we can load and verify this information in DC Health Link so that you can shop effectively. Though, we tend to link to URLS for the carriers in order to link in a more consumer friendly way to review. But, in the future, our goal will be to use the template to pull this info directly onto DC Health Link and provide even better shopping. We wanted to minimize duplication of efforts by the carriers so it made sense to use the federal templates.

Kevin Lucia: It sounds like on network adequacy, you see every ECP, but on providers, you don't see every provider, you just see the name of the network being used.

Howard Liebers: That is correct. Though, there is a URL so you can link to the full network. But all are not live yet as we're pending 2015.

Kevin Lucia: What are the tools being discussed by DISB?

Lekiewa Rasberry: Network adequacy, there is no real tool. It is more review of the templates. However, we can look at the essential community providers and note the percentage.

Howard Liebers: The percentage of ECP is the percentage of ECP providers they are contracting with in the geographic area per HHS.

Kevin Lucia: We don't have a percentage that we require of ECP providers, right?

Howard Liebers: That is right. We record the information so we have it. If HBX changes the policy, we will have the information.

Mila Kofman: So what are you reviewing when you pull the percentage?

Lekiewa Rasberry: We look at the number of ECPs they are contracted with. That's the only review we are doing.

Kevin Lucia: As HBX didn't put in a percentage, there is no standard, correct? Again, all we are collecting is ECP data – we don't collect types of doctors, other providers. That other info isn't being collected in any way. You can't analyze the network – we did that by design and that is on us.

Mila Kofman: Before we opened for business, in states where there were no specific standards on network adequacy, many states used NCQA or URAC standards which call on health plans to have internal controls and show that they are meeting their standards. We are continuing that approach. If the health plan has the URAC or NCQA accreditation, they must attest they are meeting their own standards.

Howard Liebers: Yes, but that is different from our review. NCQA does include network adequacy, etc. and so we do a double check on that as well.

Mila Kofman: When we get to options, we could ask DISB to dive deeper into how well the health plans are complying with their own standards and make that part of their review.

Kevin Lucia: Making the provider directory available is a requirement. Do we check to see if the links work?

Howard Liebers: Yes, we check.

Brendan Rose: Yes, we do it as well and there have been times we have found dead links and pushed hard to make them fix it, but that is on the carrier.

Howard Liebers: Time and Distance is one item. We perform the check that plans have included this in standards, but we don't have policy to enforce. Types of providers – we've been building lists of provider types and this includes mental health and substance abuse. It is among the first attestations. There are no additional standards, such as for geographic distribution.

Henry Aaron: If there is a particular service available in Friendship Heights it counts for being available in Anacostia?

Howard Liebers: Attestation states they have adequate capacity to service the entire service area. They could decide that is one group in Friendship Heights. But, DISB isn't looking behind that.

Kate Sullivan Hare: Do they have to be in the District? Does that qualify?

Howard Liebers: We don't look at that currently.

Lekiewa Rasberry: We do look at the ECPs and look if they are in MD and VA as well.

Howard Liebers: There are alternative standards for staff model plans. This would apply to Kaiser-type model and we'd need to apply different ECP standards as they are a closed network.

Kate Sullivan Hare: Medstar and Hopkins are hiring more physicians now, will that play a part?

Howard Liebers: The District doesn't have a standard on that now. I defer to Brendan Rose and the Consumer Checkbook work.

On the DC requirement to review collected data, DISB doesn't have a specific role. Access plans – carriers must submit, but to date there has been no request for an access plan and I don't believe any plans have submitted them.

Mary Beth Senkewicz, HBX Staff: We thought it only had to be submitted when they weren't accredited. Though, maybe there is conflicting policy on this.

Kevin Lucia: I remember the same thing, access plans were only an issue for plans not accredited.

Purvee Kempf: The network adequacy group did require that plans submit the access plan. So that happened later and overruled the previous action in plan certification. However, Howard is specifying that neither HBX nor DISB had templates for this and no one submitted.

Howard Liebers: If we are moving to required accreditation, you should look at which levels of accreditation you want to require.

Purvee Kempf: Right now, all of our carriers are NCQA accredited. All of the NCQA detail is something the District would need to pay for to get access to. We know they have or have not been accredited, but we know nothing else.

Howard Lieers: NCQA has a public portal with basic info and then we could pay more for various levels of access to information.

Brendan Rose: We work closely with DISB on these issues and meet regularly throughout the year. On the provider directory, currently, we utilize the URLs from the carriers. Once those are submitted, the exchange reviews them. First step is to ask for clarification on the URLs and the products they go with. We need to be sure they are properly matched. We worked over the last year on improvements to the provider directories and drug formulary access. We have seen improvements on access to provider directories for DC residents. So, the URLs will go right to the local plan network – not having to filter all the way through a website to get there. On the exchange side, we are working with Consumer Checkbook to develop a comprehensive provider directory. We are collecting data from carriers to populate on the website all of this carrier information on the DC Health Link website. We are working through the steps of data collection and what it means for us to house and provide this information. We have to be sure that if we own this provider directory model that it is properly maintained. We are currently

looking at quarterly updates, but we want to up that frequency. We are trying to do this in the most pain free way to the carriers.

Kevin Lucia: So you will require the carriers to give you this info?

Brendan Rose: Yes, they are updating their own directories regularly anyway.

Kevin Lucia: What is status of the build?

Brendan Rose: We have sign off from the three carriers to provide the data and now we need to build the portal and establish the standards for use. Our goal is to have it up by February 15th. We are holding it until post open enrollment because we couldn't have it ready by November 15th. Next step will be to move to the SHOP directory and move that online as well.

Purvee Kempf: The next topic is review of rates. First is the more general part with making sure plans are submitting rates for the full year or quarterly for SHOP, that DC age rating curve is used, there is no tobacco variation, and only family variation as outlined in statute. Rates must be filed for DISB review and submitted to Exchange for justifications for rate increases. The carriers must prominently post rate justifications on their websites.

Howard Liebers: This applies to rate and form review. The majority of information submitted is available to the public and you can go to website serff.disb.gov and can access any of that information – though it is massive amounts of information. Forms are there as well. There are also consumer groups that do additional checks – for example HIV community has reached out to review this information.

DISB has its own authority under District law to approve rates and we are approved by CCIIO as having an effective rate review program. We also received rate review grant funds to help in this effort. We have staff actuaries who review and we receive initial rate submissions, review them, and go back and forth with the carrier over several months. DISB's two fold mission is to make sure rates are sufficient and not inadequate with respect to solvency and that they are not unfairly discriminatory for consumer access. That is a balance.

This information is shared with the exchange.

One item that DISB has not followed through on, nor has the exchange, is requiring carriers to prominently post rate increase justifications on their own carrier websites.

Kate Sullivan Hare: Why haven't we required carriers to follow the federal law?

Mary Beth Senkewicz, HBX Staff: It is really an issue for the 2015 shopping experience as these are the first renewals of new products.

Kate Sullivan Hare: Will they be doing so in for 2015?

Brendan Rose: We have not discussed this in the Plan Management Advisory Committee. We need to discuss this week.

Kate Sullivan Hare: It is not adequate to not do this.

Mila Kofman: Brendan, can you confirm that plans will post their rate justifications?

Howard Liebers: If you are talking about justifications for each plan rate increase, it might not be useful for consumers.

Brendan Rose: This can be facilitated and should be, but we need the Board to define what a consumer friendly justification would be.

Kate Sullivan Hare: We can tell you what consumers tell us. We are getting hammered by people we know. People want to know what the hell is going on with 35% premium increases.

Mila Kofman: There is a federal law requirement so in plan management can you confirm with carriers that they are prominently posted on their websites and they are complying with that requirement? Separately and apart from that, is a question about what we need to do to be most helpful for consumers.

Kate Sullivan Hare: They had to justify their rates to DISB, use that.

Kevin Lucia: We should look at what other states are doing. I thought there was a template of sorts that dictated the information needed on them.

Mila Kofman: We'll look at the federal standard for non-effective rate review states, we'll look at Oregon, Arkansas, and we'll have options for you at the next meeting. At the very least, Brendan will follow up that the carriers are posting something.

Melanie Williamson, HBX Staff: There is also a requirement that the Exchange provide access to rate justifications as well. Right now, we link to DISB.

DISCRIMINATION

Purvee Kempf: This is the certification requirement that carriers don't discriminate on basis of health status and that benefit design and marketing do not have the effect of discouraging enrollment of people with significant health needs. The one other provision I want to highlight is Sec. 1557 of ACA which is a general nondiscrimination provision that applies to contracts of coverage by insurers. That one is enforced by Office of Civil Rights and the Department of Justice has coordinating responsibility. Section 1331(c), a nondiscrimination provision in plan

structure or marketing is a certification standard that the Exchange enforces, it is an exchange specific standard.

Section 2706 is a market reform applicable to plans in and out of the exchange enforceable first by the state. If state tells CMS it does not have the legislation to enforce the law or is not otherwise enforcing, then CMS enforces. Or CMS can enforce if it determines that the state is not substantially enforcing the requirements.

So, there are multiple methods of enforcement in this arena.

Kevin Lucia: Feds have given very little guidance on this. This is very challenging.

Purvee Kempf: Feds have talked about their FFM actions – they do outlier reviews of plans to see if any are out of the norm and will require resubmission of plan designs. They also review the exclusions sections of plans to see if anything looks discriminatory.

Henry Aaron: have there been complaints?

Howard Liebers: DISB received zero complaints for 2014. When we do QHP certification for the next year, plans must attest that they don't discriminate, and then there are review tools from CCIIO. There are three nondiscrimination tools. The main one looks at all the plans and reviews benefits to see if any particular plan has significantly higher cost sharing; it flags specific outliers with an unusually large number of drugs subject to prior authorization or step therapy in several key areas; and a tool that looks at availability of drugs in four key areas.

Kate Sullivan Hare: Who created these tests?

Kevin: This is an ACA requirement.

Howard Liebers: There are no DC specific rules on discrimination. We are using the federal standard. Again, we haven't heard complaints in 2014.

Mila Kofman: Can you run reports on the data elements you collect for the consumer services section so you can see if there are areas where special checks should be made? If we're looking for information on consumer complaints because a Hepatitis C drug isn't in a formulary appropriately, could you run an inquiry to search on the complaint database?

Howard Liebers: We will check that. We also work closely with Ombudsman on this.

Kevin Lucia: Issuers also have access to these tools and they can run them and make sure the data is accurate. Did you find anything in forms that may be a discriminatory in nature?

Marybeth Senkewicz, HBX Staff: Forms check all mandated benefits in DC. I can attest to that. In terms of discrimination, this is very subjective. We can be pioneers in this area. It is very subjective. We can take deeper dive on this.

Rob Shriver, HBX Staff: Just because these tools are available to plans does not mean that they are using them or adjusting their filings based on this. It is still important to run this test.

QUALITY OF HEALTH PLANS

Purvee Kempf: Quality Improvement Plans were to be submitted in 2014 and report off the shelf quality measures. In 2015, standardized quality improvement plan as determined by HBX, post on HBX website, quality improvement strategies are to be pursued.

Howard Liebers: Quality Improvement Plans have been submitted to DISB, but there is not a specific standard about what DC requires on this front. We've met with NCQA. Feds are coming forth with regulations and quality ratings will then go on the HBX website. As part of our internal reporting, we collect some data on where a plan may have been noncompliant on some star ratings for Medicare Advantage plans.

Brendan Rose: Quality Improvement Plans, it is a matter of design on where to put that and what level of detail to provide. That's where we are now: how to make it accessible and meaningful. My suggestion would be we think about specific guidelines to frame what we want to share with consumers. Maybe that is a next step to take a deeper dive.

Kate Sullivan Hare: I chaired the working group and we did it for 2014 as there were no standards from HHS; make this available now as an interim step. Then, we learned that they couldn't access that information. The intent is to ensure that when HHS standards are out, that the plans begin to do this in a standardized understandable way. And, should be part of the forms review for 2016 as part of that process to ensure they have it. And, eventually, it is the intent to put in specific quality measures for priorities for DC – maternal health, HIV, smoking cessation and diabetes. Develop that after the federal standard.

Kevin Lucia: When does HHS standard kick in?

Purvee Kempf: HHS is developing a quality rating system. All plans have to participate in the beta test in 2015 and then public reporting should be provided in 2016 for 2017 coverage year. At the Standing Advisory Board, there was a review of policy priorities for 2014. At that time, it was agreed that quality resolutions should wait for HHS to provide additional information and build off that and that it would become more of a priority for 2016 plan year. HEDIS and CAPS data is collected as part of NCQA for accreditation.

Public Comment

Claire McAndrew, Families USA, Vice Chair of SAB: Thank you for all this information, really exciting to be talking about these issues and it is where the rubber hits the road with consumers being able to access benefits.

Complaint data from DISB and Ombudsman is great, but do people really know to complain to those entities? If you can't find a provider, do you know where to complain? How many complaints come in generally to DISB? Keep in mind, people do not feel empowered when they are accessing health care. Few citizens know what DISB is. How do Ombudsman and DISB really connect on these complaints? Mental health cases are a real difficulty for Ombudsman.

With the provider directories, it really concerns me that we aren't worried the links are not active right now. The directories are for year round use. I've checked year round and they are often not working. And, one carrier in particular has been the worst. There are limits on some of the provider directories that don't allow appropriate searching. Moving forward on the directories, the concern is the frequency of updates on directories, but we've seen many providers stay in directories after they've died or quit practicing. You can't rely on the provider to update their own info if they are dead. We need internal auditing by the plans to update the directory. If there is an active provider list for DC, we need to run that against these directories. There also needs to be somewhere for consumers to complain about inaccuracies on the networks. Carriers do not provide this. Because we have no laws on network adequacy in DC, we have no benchmarks.

I served on the Network Adequacy Working Group and am very disturbed that access plans are not being collected. That was a compromise position to get the data needed to make policy for the future. We need that information collected.

Rate justifications must be posted ahead of time; they are not any use if posted after the fact. Look to other states for simplified postings.

On quality, I am concerned that we understand what the quality rating system and HHS survey are. They have gone through extensive field testing, being developed with prominent researchers, and I see a lot of value in that. It will be a robust system. Maybe we can have someone present to us on what it is? I hope it is fully embraced on our website.

Are we participating in the beta test on this survey? We should be taking advantage of that.

Lekiewa Rasberry: When we review forms, plans have to meet the DC Benchmark formulary plan. I just wanted to clarify that that is a DC-specific requirement.

Next Steps and Closing Remarks

This was the second of our meetings. Next time, we will hear from what's happening in other states and maybe some experts on this topic. Does anyone have questions about areas outside of these four key areas?

Mila: It is really important that this committee hear from consumers and plans if any of these four areas to understand if any of these are show stopper areas for plans or not enough for consumers. Now is the time to raise these issues. If there is a show stopper for health plans, we need to know that now so it is part of the discussion.

Hank: I am concerned from standpoint of insurers with regard to reliability and validity of our quality standards. There has been a lot of criticism of provider quality ratings. The relationship of network adequacy and quality is difficult. Narrow networks can hold down costs, but still be a good network. And, an open network could still be poor quality. So, we all need to be nervous about validity of quality measures.

Kevin Lucia: We have set aside time for 3 more meetings. The next meetings are:

Tuesday, 11am – November 18th
Tuesday, 11am – December 9th
Tuesday, 11am – December 16th

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

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.

Mila is right, 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.

So please continue to join us in this process. Minutes and audio are posted for each meeting if you missed it.

The meeting adjourned 12:57 pm.