Insurance Market Committee Meeting on Health Plan Certifications

Thursday, October 16, 2014

1225 Eye Street, NW, Suite 400, Board Conference Room (with call in line)

Committee Members Present: Kevin Lucia, Chair; Henry Aaron, Kate Sullivan Hare

HBX Staff in Attendance: Mila Kofman, Purvee Kempf, Debbie Curtis, Marybeth Senkewicz, Shayla Hamlin (ANYONE ELSE)

I. Welcoming Remarks – 10:08 am

Kevin Lucia welcomed attendees and explained that he is 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 will review the process in preparing for plan year 2016. 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.

The Insurance Committee will have a series of meetings. This is the first meeting and will include a detailed walk-through Federal and District law and HBX's responsibilities as a state-based marketplace.

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

Today's public executive board meeting is taking place at HBX's new office. 1225 I Street, NW, 4th floor. There will be an opportunity for public comment and input after the presentation and the public was asked to hold all comments until then to allow for a smooth conversation among board members.

II. Presentation by HBX Staff

Mr. Lucia turned the meeting over to Purvee Kempf, General Counsel and Chief Policy Advisor of the DC Health Benefit Exchange Authority. She was asked to review the federal and District law with regard to DC Health Benefit Exchange Authority responsibilities for certification of

health plans to be made available through DC Health Link. She also reviewed the initial certification process adopted in 2013 by the DC Health Benefit Exchange Authority.

Purvee Kempf: Good morning, I am going to do a general walk through all the certification standards for the health plans. We owe a lot to the 2013 working group on health plan certifications. For background materials, we have the work group report, our current HBX carrier manual, the Health Plan Certification Resolution. For those on phone all info is on the website at www.hbx.dc.gov

In overview, each exchange is required to make available only qualified health plans and there are numerous explicit requirements in ACA – mostly in Sections 1311 and 1302. Exchanges can make these QHPs available only if the Exchange determines the plan is in the "best interest" of the individuals and employers in the state where the Exchange operates. In addition, the law specifies that QHPs must abide by any additional restrictions provided by the exchange. Each exchange shall also develop a procedure for certification, decertification and recertification of QHPs. That is in the law, and our carrier manual indicates that the Plan Management Committee will develop those processes.

In the ACA and DC Statute, each issuer must be licensed and in good standing. That is a minimum requirement.

BENEFIT STANDARDS: In general, each plan must offer the EHB and our working group process executed through resolutions through the executive board also has a number of additional standards: behavioral health without day and visit limitations, mental health parity, a requirement that drug formularies have to have 2 drugs at each level, a prohibition on benefit substitution, additional benefits may be offered above the EHB, and there is a definition of habilitative services. These were all developed through working groups and then added to statute in DC.

COST SHARING: All plans must meet the annual limitations and cost sharing structure as dictated by ACA and reiterated in DC Code.

OFFERING REQUIREMENTS: Each plan must offer one bronze, silver and gold level plans through the Exchange. District goes beyond federal law as feds only require silver and gold.

MEANINGFUL DIFFERENCE: Plans are subject to the meaningful difference standard to vary plans. DISB enforces the definition used by the Federal Government in the Federal Marketplace. That is the 2013 definition used by them. Specifically the DC Code states that the policy enforced is the meaningful difference standard in Federal guidance in 2013 or as otherwise adopted by the Executive Board. So we have the flexibility to update that standard, but it doesn't evolve on its own as federal government perfects theirs for the FFE.

Kevin Lucia: The Federal Marketplace rules don't come to states unless feds put out new regulatory guidance that applies it to all states. Is that correct?

Purvee Kempf: Correct, guidance for FFE has no bearing on what we do. We look to ACA statute, regulations, federal guidance, DC Code and resolutions passed in the Executive Board.

Purvee Kempf: Let me clarify that for this presentation, we are just looking at the law. As next step, after we do more research, we can answer specific questions. We need to work with DISB and research all of this and will provide that information at the next meeting.

STANDARD PLANS: Resolution enacted by the Executive Board calls for a standard. There are still discussions for standardized benefit packages. At this time, this requirement isn't in place.

Federal law requires child only plans as well.

There are federal and District requirement that plans not discriminate.

Benefit designs cannot have the effect of discouraging enrollment of those with disabilities – explicit in ACA.

It is required that plans submit a description of covered benefits and cost sharing to the Exchange at least annually.

That's the synopsis of the plan offering, benefit structure requirements by Federal Government and District Code. All the resolutions are on our website at www.hbx.dc.gov and can be found under the Executive Board button.

Kevin Lucia: On non-discriminatory benefit design, that is a federal requirement, right? But, the federal government hasn't filled in what that means and so we can fill that in if we choose right?

Purvee Kempf: Yes. And the PHSA is the place where these provisions are placed. By the nature of that, states can always go further than the Federal minimum standard.

Mila Kofman. To clarify, the Federal Government hasn't issued any regulations or bulletins around benefit design?

Purvee Kempf: There are regulations, but they basically mimic the federal statutory language rather than adding more meat to the bones.

Mila Kofman: This issue has been in the news in Florida with regard to drug package designs where patients are alleging that all drugs are in a specialty tier which they believe is discriminatory.

Kate Sullivan Hare: How are these rules enforced?

Kevin Lucia: That depends on the question. EHB are dependent on the state, civil rights get a broader federal hook.

Mila Kofman: We need to work through this and ensure that in the way our process works we are protecting consumers -- as just going to court isn't a meaningful protection to most people.

Kevin Lucia: Under Civil Rights division at HHS and they are reviewing the Florida case… This is something we need to understand. It speaks to why we need to ensure the benefit designs are non-discriminatory.

Purvee Kempf: We will get this information before our next meeting.

GENERAL RATING STANDARDS

Federal law says that plans set rates for the entire plan year, rates must be the same inside and outside the exchange, and that they specify the allowable rate variation (geographic area, age, tobacco, family structure). The District has determined that there is no geographic variation in DC, there is age band but it is set in DC law, is 3-1, but not identical to the federal rating limitations, and there is no tobacco rating in DC per executive board action.

RATES AND JUSTIFICATIONS

ACA specifies that exchanges shall require plans seeking certification to submit a justification for any premium increase, post it on their website, and exchange shall take this info into consideration when deciding whether to accept such a plan in the exchange. This is in ACA language, mimicked in the CFR and in DC Statute as well.

This part is separate from states having effective rate review as outlined in ACA elsewhere. This is an exchange specific provision and is in the exchange requirements of the ACA. It specifically states the exchange "shall".

Henry Aaron: Could a state legislature instruct an exchange to take a decision by the Insurance Commissioner as fulfilling this responsibility?

Purvee Kempf: That would have to be determined by the preemption statute. I think it would run afoul.

Purvee Kempf: DC Code mirrors this language, it is in the health plan certification language.

DC also says the plan must promptly notify people of increases. It also requires that HBX shall take the justification into consideration when determining if the exchange shall make the plan available for sale on the exchange and must take into consideration any information from DISB on a pattern or practice of unjustified premium increases.

In addition, the District added specific language that to be certified as a QHP a plan shall at a **minimum** "obtain prior approval for premium rates and contract language from the Commissioner" (DC CODE Sec. 31-3171.09). Clearly, we cannot circumvent DISB review.

Two additional things to note:

Federal Register: Commenters requested that exchange abilities to investigate rates be limited. HHS expressly rejected that in the preamble of that rule:

> We encourage the Exchange to leverage existing State rate review processes to the extent appropriate. As we highlighted in the preamble to the proposed rule, such coordination could include posting or adopting the same format used for rate justifications submitted to the state. However, we note that in some cases an Exchange may engage in *more in-depth consideration of QHP issuers' justifications when determining whether to make a QHP available on the Exchange.* ***As a result, we do not limit the ability of Exchanges to conduct additional reviews of rate justifications[.]*** 77 FR 18310-01 at *18407 (emphasis added).

When the HBX enabling legislation was moving through DC Council, the history indicates that key stakeholders specifically requested the District to impose statutory restrictions on the Exchange rate review at the time the Exchange enabling legislation was being considered by the Council of the District of Columbia—and none were codified.

MARKETING

Specific certification requirement in ACA and Federal regulations. DC Code adopted and mimics that language – shall not discourage enrollment of those with significant health needs. That applies in benefit design and marketing.

NETWORK ADEQUACY

Standards are in the Federal law and we focused attention on it with a stakeholder working group on this topic alone in 2013. In March 2013, the Executive Board adopted a resolution that enacted the recommendations of the working group.

ACA requires inclusion of essential community providers, an alternate standard for those in HMOS, a network for each plan with enough providers, including those who treat mental health, without unreasonable delays, a provider directory made available for publication online and for potential enrollees that identifies providers that don't accept new patients.

The Year One Executive Board Resolution requires attestation by health plans that they meet these standards. It then calls for HBX to work in year two year 2 with DISB to collect data and assess the current information on network adequacy. Metrics for primary care, specialty, mental health, and distance to travel to the doctor, wait times, access to essential community providers,

and accurateness of the provider directories, and more. In 2015, HBX will issue requests for additional data from carriers to have District specific standards in place for the 2016 plan year.

Diane Lewis: I chaired that Committee and we were told by carriers that they provided that information to DISB and our thinking was we wanted to see that information and then make more DC centric metrics going forward so we could look at the information they provide.

Henry Aaron: To whom did they make that information available?

Diane Lewis: DISB. When we talk to DISB we should get access to that information and make our own determinations to determine if it is appropriate.

Mila Kofman: Just to clarify, DISB collects and reviews this info on our behalf. DISB provides us with operational help and they have been doing those reviews. We can ask them for what the have and one of the options would be, if we change the standards, to have DISB continue to collect and enforce this.

Purvee Kempf: We have the carrier reference manual here for review with the detail of the network adequacy and other requirements that DISB does for us.

Mila Kofman: Because we adopted self-attestation by health plans, some information is required to provide to DISB by the health plans and others is just self-attestation. We may need to ask the plans for that additional information if we want to go further.

Kevin Lucia: Remember, we were just trying to turn the lights on at that point. It was all we could do at that moment. The idea then was to get started and we might need to fine tune.

Marybeth Senkewicz: DISB has hired an additional person on the certification front and I think more review of the materials is happening now. I will check on that and follow up with more information.

APPLICATIONS AND NOTICES

Federally required that they be plain language, accessible to all, and language access act in DC also requires oral and written translations. This is happening in different ways.

TRANSPARENCY

1311 explicit provisions, reiterated in the CFR, exchange is making available information on the plans; enrollee rights; etc. Issuers must make cost sharing info available and use plain language

ENROLLMENT

Less detail here as there are many rules in the exchange on this already. These standards are explicit in federal law and Board has gone further to state clear policy on this front. For example, the Board has enacted three separate resolutions specifying special "qualifying life

events" which grant someone the opportunity for a special enrollment period outside of open enrollment. In addition, the Board has set a default percentage for the APTC contribution; enacted transition of care standards for enrollees in midst of care, and so on.

There are a host of these rules and we won't go into greater detail here unless you desire. All of this is in the back of our certification report as well and you can review there.

ACCREDITITION STANDARDS

Federal law and regulations are explicit on requirements for accreditation. Board resolutions talk about accreditation through NCQA or URAC in addition plans are required to submit info consistent with HEDIS and CAPS data.

QUALITY ASSURANCE

There are federal requirements around quality improvement strategies, quality reporting, case management, chronic disease management, readmission prevention, wellness and health promotion activities, and activities to reduce health care disparities. In addition, HBX had a quality working group that made recommendations that were adopted by the Board in the summer of 2013. It recommended that: in 2014, health plans submit their quality improvement plans that will be made available on the exchange website; 2015 will use off the shelf quality measures and ensure accreditation; 2016 – update information based on federal regulations and local District priorities.

Kate Sullivan Hare: These were strong intentions and then we were told the exchange can't do x and y and much of this will not happen, nothing was updated for the upcoming year; this remains a priority for everybody. As soon as staff and IT resources can be dedicated to this, it is a board priority.

SEGREGATION OF FUNDS – Laid out in federal law that the exchange does not use federal funds for abortion.

COMPLIES WITH INTERNAL CLAIMS AND APPEALS AND EXTERNAL REVIEW PROCESSES. We follow federal law.

OTHER POINTS IN WRAPPING UP:

Federal law does limit Exchange Authority: The Exchange cannot withhold certification because a plan is a fee-for-service plan nor based on imposition of a premium price controls.

The DC Code also has a restriction that prohibits the Exchange from limiting certification based on the number of health plans being offered.

Also in District statute is a requirement that health plan issuers provide accurate attestations as required through the certification process. That provides ability to enforce on that rule.

III. Next Steps

Before moving to public comment, Kevin Lucia explained next steps by reiterating that this was the first of what will be a series of meetings. He stated that we still need to learn more about implementation of these rules. Much has been done by attestation, but there are documents to review and understand. It is a joint effort with DISB and we appreciate all of their efforts on this. We also want to hear how other states have implemented these standards and hear from experts in the field who are involved in these reviews. That is critical before we develop our standards. We have a lot we can learn from other states.

For more meetings have been prescheduled. All may not be needed, but they are scheduled now and will be posted on the HBX website. They will be:

Tuesday, 11am – November 4th
Tuesday, 11am – November 18th
Tuesday, 11am – December 9th
Tuesday, 11am – December 16th

The Committee will decide which areas we do a deeper dive into so we need to hear the public's priorities. As we move to public comment, we really want to know what certifications you think are most important. We can't hit all of them now. We need to figure out the 3-4 to take a deep dive into this next year. It will be an evolving process.

Thank you Purvee for digging into all of this. Now, let's open to public comment and input. Please make sure your comments heard and identify yourself.

IV. Public Comment

In Person Attendees:

Cheryl Parchum, Families USA. Process question. I also sit with the Ombudsman Advisory Committee in DC. They are charged with collecting grievance and complaint data on health plans. Reports that come in are in a format that isn't useful. Advisory committee has tried to delve into the high rate of mental health denials. Effort there to revise the grievance reporting tool and might be useful to coordinate with them on that. Also raised issues of consumer concerns for special needs children and what happens when they transition to adulthood. They would have anecdotal information about real life problems that would be of use to you. So, interviewing that staff might be very helpful.

Kevin Lucia: I don't have a clear sense of where complaint data is coming in in DC. As I understand, it comes into DISB.

Cheryl Parchum: It goes to Ombudsman and to DISB. Ombudsman does medical necessity component.

Kevin Lucia: What if we get complaints at HBX?

Debra Curtis, HBX Staff: We work with DISB – they need to file the form with DISB so it can be researched.

Cheryl Parchum: Rates have been of concern to the exchange and as a member of the public, I know that DISB was interested in reaching out to pay a consumer group to represent consumers in rate filing. We haven't done that in DC, but I think it could be of help to consumers…

Kevin Dougherty, NMS Society: Network adequacy is a major theme for us as well as compliance with non-discrimination standards, especially for those with significant health needs. Those are my concerns.

Henry Aaron: Are there recent problems in DC that spur these concerns?

Kevin Dougherty: No, not at this time, though there certainly have been in the past.

Claire McAndrew, Families USA, and vice chair of Standing Advisory Board: The Standing Advisory Board is looking into three key items for the Health Benefit Exchange Authority – one of which is network adequacy as an essential priority. This has been a longtime issue in DC prior to the exchange. The work of the committee has been intensive so the report isn't done yet. Myself, Kevin Dougherty, and Dania Palanker and have partnered with DC Behavorial Health Association to research accuracy of provider directories for health plans on DC Health Link. We are finding serious concerns with dead phone numbers and providers who are not longer taking that insurance or are actually deceased, providers as primary care when they are specialists; we don't think these are only directory issues, we think it is a network adequacy issue.

Kate Sullivan Hare: Is it enough to say how many doctors are in an area or is it something that has to include how long it takes to get an appointment?

Claire McAndrew: The wait times are important and that is a proxy for adequacy. Time and distance may not be key here given our size, but then again, we are a segregated community that raises these issues within our boundaries.

Henry Aaron: Are there some jurisdictions that have done better, like Maryland?

Claire McAndrew: Not Maryland. CA and WA are doing a lot of this front. Families USA will put out a new paper soon on this. Maryland has done good work on continuity of care.

Wes Rivers, DCFPI: I want to echo Claire on network adequacy. I reached out to other consumer advocates in advance of this meeting and got a lot a lot of feedback from other advocates that this was a key issue given the history in DC on this. Quality improvement reporting is also key for us.

Public Comments via Phone:

Laurie Kuiper, Kaiser Permanente: Quality metrics – Kaiser is really supportive of posting prominently on the exchange website and we'd like to see if DC might be able to do that in the 2015 calendar year. HHS will require in 2016, but other states have posted that info currently. In addition to using networks and price in their choices for coverage, consumers should use quality measures as well.

Kevin Wrege, AHIP and AETNA: Will there be a separate opportunity to discuss the policy questions of DISBs role vs HBX role, existing rules on MLRs, solvency, etc. And, when can we weigh in on that publicly?

Kevin Lucia: At this point, we are focused on plan certification and HBX legal requirements, next will be to look at how we're implementing this both at HBX and DISB. From there, we'll look at what we may want to revisit with regard to certification, and at that point there will be a robust discussion on the policy front.

During the first working group process in 2013 we looked at all of these areas and for the most part accepted attestation. In many of these areas I expect that will continue to be appropriate, but there may be areas where we want to collect specific data to review if the federal and DC standards are being met.

We really aren't going to revisit all of this. For example, we probably aren't going to re-evaluate the network adequacy standards, we are looking at whether we need more info from plans to ensure the standards are being met.

Purvee Kempf: You have both options. It may be process changes. In some areas you may want to change the policies to strengthen them, etc. Those are your choices.

Kevin Lucia: If we're going to reconsider network adequacy standards, I think we can't hammer that out in a few hours, nor do I think it would be appropriate. I think we can look at whether we're doing enough to enforce the standards that exist? Is self-attestation enough? Should we do more to make sure the standards are being met?

The Committee should discuss this. In DC we've started from the bottom with stakeholder agreement on policy, then the Executive Board adopts consensus policies. I don't want to run around that process. I think we're the only state doing this at that level and with such deference to the community. I would like to address process changes that might be needed to insurer that issuers are meeting our standards.

Henry Aaron: Agreed, we aren't going to be revising standards, we will focus on process.

Mila Kofman: Once you get briefing on state efforts, then you may learn there is something you want to adopt. You could adopt changes in this process like that. You don't want to close off the opportunity to adopt specific things here if it warranted.

Kevin Lucia: Looking at other states and data they use, if they have a better process, we want to adopt, but I don't think we have the time to change standards. I don't think this is the format to do this.

Mila Kofman: One issue shared with me via a Councilmember is one that deals with transparency. She had an issue figuring out her co-insurance liability for a specific procedure. Her health plan denied her that information when she inquired. She is very upset about this and believes it violates the law. That's something to look at as well.

Kevin – If no further comments, we'll move to closing remarks.

Gerilyn Trujillo, AHIP: I heard questions on risk adjustment and reinsurance and want to say that we are happy to share information with the committee on that topic if it is useful.

V. Closing Remarks

Kevin Lucia: The recommendations of the Qualified Health Plan Certification Process Working Group, adopted by the full Executive Board, specifically said "*The working group recommends that the HBX Board revisit these standards prior to QHP recertification in the second plan year, since the HBX will have additional data and experience to evaluate whether regulator verifications based on prospective evidence or means of accreditation other than issuer certifications should be required for certain standards."*

It is important that the District's exchange marketplace 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.

Meeting adjourned at 11:55 am.