America's Health Insurance Plans

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January 20, 2015

Kevin Lucia, Chair
Insurance Market Working Committee
DC Health Benefits Exchange
1225 Eye Street, NW, Suite 400
Washington, DC 20005

Re: Proposed Recommendations for Plan Year 2016 Qualified Health Plan Certification

Dear Mr. Lucia,

On behalf of America's Health Insurance Plans (AHIP), I am writing to comment on the proposed recommendations that were drafted by the District of Columbia's Health Benefits Exchange (HBX) staff for the Insurance Market Working Committee (Committee) regarding Plan Year 2016 Qualified Health Plan (QHP) Certification. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual and small group insurance markets, and public programs such as Medicare and Medicaid. Our members offer a broad range of health insurance products in the commercial marketplace and have also demonstrated a strong commitment to participation in public programs. AHIP has been working, at both the federal and state levels, to promote an affordable and stable insurance marketplace, with a wide array of plan choices for consumers and families.

Across the country, health plans are delivering high-quality, affordable insurance options to consumers in the new marketplaces. Health plans are driving affordability by: implementing innovative benefit designs that provide incentives for patients to use lower-cost, high quality treatments and providers; partnering with providers to implement innovative care delivery and payment models; and utilizing proven care management tools that promote efficiency and quality in care, such as better continuity and coordination of care for patients with chronic conditions. By keeping the focus on affordability and improving the consumer experience, we can help build on the early success and continue to make progress in making high-quality health insurance affordable and accessible to millions of Americans.

The Committee's proposed recommendations focus on four key issues surrounding the QHP certification process: network adequacy, review of rates, quality, and non-discrimination provisions. In reviewing the proposed recommendations, we are pleased to see several recommendations that we would fully support and encourage the Committee, and the HBX to implement. However, we are gravely concerned about the potential for a dual regulatory environment in the review of rates. AHIP does not support nor recommend that any agency, other than the existing regulatory authority for insurance, the Department of Insurance,

Securities, and Banking (DISB), serve to review and qualify rates for the District's insurance market. DISB reviews rates to assure they are not discriminatory, excessive, or inadequate. DISB is responsible for reviewing carriers' solvency, and rates are a component of that determination The HBX's authority under the ACA is limited to a determination of whether carrier's rates are "in the best interests of consumers," and not to whether those rates are adequate.

Network Adequacy

As we offered to our federal regulators, in our public comments regarding the proposed Notice of Benefit and Payment Parameters for 2016, AHIP supports requirements for QHP issuers to provide updated information to provider directories; in fact, we believe that directories should be updated within 30 days of notification of a change by a network provider. Health plans consistently make an effort to ensure provider directories are as up-to-date as possible and health plans currently meet standards provided under various health plan accreditation programs, such as providing the frequency of validation or last validation date for physicians listed in their online directories.

We support the requirement to make the provider directory available but need timely and accurate information to be submitted by providers, including information on the acceptance of new patients or changes in network status. Health plan efforts to ensure that provider directories are up-to-date and accurate can be challenging because providers often do not notify the issuer of changes in their provider status as a participating provider or changes regarding their acceptance of new members. Providers change practices, or move, and fail to notify the plan in a timely manner. As a result, it is a challenge for issuers to maintain the absolute accuracy of providers' status in directories. Nonetheless, health plans make great efforts to assure the accuracy of their directories and keep them up-to-date. We encourage policies that embrace a shared responsibility between health plans and providers, which enlist the assistance of providers to maintain up-to-date health plan physician directories. We would support HBX outreach to the provider community in DC reminding them of the importance of providing updates of any changes to health carriers to assure directory information is accurate and up-to-date.

Regarding the first bullet under "Carriers: provider directory" in the proposed recommendations, we request that the HBX continue to work with Exchange carriers to develop a provider data format, for both the individual and small group markets, that balances the HBX's need for data to populate the provider directory search tool with appropriate timeliness and acknowledgment of the need to limit the administrative burden on the carriers. Particularly in terms of provider data for the small group market, this may require significant work on the part of the carriers to produce the data in a way that meets the HBX's requirements. While the majority of the format has been established for the individual market at this time, the small group is not as established and will require some additional effort by the affected carriers.

We oppose some of the recommendations made in the second and third bullets in the provider directory section. While the intention is to increase accuracy, the fact is such actions, if

mandated, will only impose additional administrative requirements on carriers to perform actions that would not have the intended effect. For example, companies that have provided a call-in number just for provider inaccuracies have found that consumers used the number for general customer service inquiries the vast majority of the time. Companies must already track complaints, and follow-up on complaints about provider information, providers' office hours, access or even discrimination. To address these points, we've made recommended changes to the proposed language in the attachment to this letter.

We also recommend that language regarding "HBX: access plan" include reference to the need to provide the protection of confidential, proprietary or trade secret information that may be included in initial network access plans, or in updates at later dates. To address this we also provide recommended changes to the language in the aforementioned attachment.

Review of Rates

The National Association of Insurance Commissioners has recognized that state regulators performing rate reviews need to continue to familiarize themselves with various new elements that issuers have to consider, and have an understanding of the significant number of unknowns that issuers must estimate, as well as the interplay of new elements. Those elements include:

- Actuarial Value Determinations;
- Potential/Projected Exchange Market Enrollment for QHPs (individual and small group, and the project types of risk represented);
- New Taxes, Fees, and User Fees under ACA and Exchanges; and
- The Sequence and Interplay of the 3Rs, the three risk mitigation programs which, per the final rule, are designed:
    - To protect insurers "against adverse selection" (risk adjustment),
    - To address inaccurate rate-setting" (risk corridors), and,
    - To "offset high cost outliers" (reinsurance).

Health actuaries need to include the impact of these three programs, as well as all of the other changes mentioned for pricing for 2016 and beyond.

AHIP firmly espouses the view that premium rate review should be tied to actuarial soundness, not politics. Therefore, we are concerned that the recommendations that the Committee is making in regards to the review of rates makes no reference to the key goals of appropriate rate review: ensuring that rates are 1) not inadequate, excessive or discriminatory, 2) reasonable with respect to the benefits offered, and 3) adequate to cover expected expenses and losses. Without consideration of the last factor, health insurers risk becoming financially impaired, or even insolvent. While the HBX is clearly within its authority to consider the rates of plans when evaluating them for QHP certification, the act of approving rates should and must remain solely within the purview of DISB. DISB alone has the regulatory authority, as well as the experience and expertise, to balance the key goals of appropriate rate review. Furthermore, DISB has met

the requirements of the ACA and federal review as having an effective rate review program in both the individual and small group markets.[1]

Rate review is not a cost containment strategy, and arbitrarily capping premiums without focusing on the increasing costs of medical services will jeopardize solvency and undermine the coverage that consumers count on today. Sound rate review should be based on actuarial standards and principles. Given the federal approval of DISB's rate review program, there is no justifiable need to require an enhanced process of rate review within the HBX. Additionally, it serves as an unnecessary and administratively confusing dual regulatory environment that will impact consumers and carriers alike. Further, by publicly posting non-DISB actuarial reports, which do not take into consideration the full breadth of information that DISB's review does, the HBX introduces further confusion and unnecessary politicking in what should be a focused and balanced review.

AHIP also has concerns that, given the single market in the District for the individual and small group, the process of hiring actuarial analysts is an unnecessary and costly expense for the HBX. We are also concerned that this attempts to effectively supersede the Commissioner's authority to determine rates and evaluate solvency. Per Section 14(a) of DC statute that establishes the HBX: "Nothing in this act, and no action taken by the Authority pursuant to this act, shall be construed to preempt or supersede the authority of the Commissioner to regulate the business of insurance within the District." Further, Section 10(b)(2) of the DC statute provides that the Authority shall not withhold certification from a health benefit plan, "[t]hrough the imposition of premium price controls by the Authority." Per Section 10(a)(2) of that same statute, it clearly states that plans must "obtain prior approval of premium rates and contract language from the Commissioner" in order to be certified as a QHP.

We acknowledge the HBX's responsibility to evaluate rates as part of its authority, as described by the ACA and DC statute, to certify plans, evaluate premium justifications, and determine whether making plans available through the exchanges is in the interest of qualified individuals and qualified employers. We support the HBX's efforts to understand and apply the approved rates as part of the equation that is used to determination certification as a QHP. However, we do not support the interjection of the HBX in attempting to usurp DISB's established and approved regulatory authority as the rate authority in the District.

AHIP also notes that CMS defers to effective rate review programs, when they review plans for QHP certification in the federally-facilitated marketplaces. Further, they consider more than just rate increases and rely on the state regulator to provide the necessary context and rationale when considering QHP certification.

> *For the 2015 benefit year, CMS will consider issuers' data and actuarial justifications provided in the Unified Rate Review Template (URRT), other information submitted as part of a filing under an Effective Rate Review program and any recommendations provided to CMS by the applicable state regulator*

[1] http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html

> *about patterns or practices of excessive or unjustified rate increases and whether or not particular issuers should be excluded from participation in the Marketplace. In future years, CMS will also take into account other factors such as rate growth inside and outside the Marketplace as required by the Affordable Care Act.*
>
> *CMS does not plan to duplicate reviews that a state is already conducting to enforce state law...CMS anticipates integrating state and other CMS rate reviews into its QHP certification processes, provided that states provide information to CMS consistent with federal standards and agreed-upon timelines.*[2]

Quality of Health Plans

AHIP supports the recommendations of the Committee in terms of the quality of health plans. We have strongly advocated in support of state flexibility when it comes to quality reporting and we have proposed strengthening the language to support a harmonized reporting strategy for quality improvement strategies (QIS) that is consistent across both federal and state based exchanges, in order to avoid the use of disparate requirements and allow QHP issuers to implement consistent and measurable programs.

There are a variety of tested and to-be tested provider and member facing incentives to encourage quality improvement. The focus of improvement strategies should be driven by the needs of the QHP members, which could include areas such as reducing readmissions or improving wellness and health promotion. QHP issuers should be encouraged to leverage known tactics as well as test new approaches to generate a QIS.

We recommend that plans have the flexibility to use both positive and negative incentives as part of their QIS. This is consistent with current practices in the private sector and would align QHP issuers with HHS programs which also use disincentives and shared-risk, resulting in a consistent signal to providers.

Non-Discrimination Provisions

AHIP supports review of QHPs' benefit designs for any non-discrimination. We request that the HBX publish the CCIIO tools they are using as their procedure for such review, so that carriers understand and utilize those same tools' standards as they review their own QHP filings. We do not believe that DISB, nor the HBX, need to promulgate guidance with examples of discriminatory benefit design. We are concerned that could be a form of informal rulemaking, without the benefit of the regulatory process of openness and opportunity for comment that carriers and other stakeholders would expect.

[2] http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf

As indicated, AHIP supports the recommendations surrounding quality and non-discrimination provisions for QHP certification. We encourage the HBX to consider the time and administrative burdens that will come with establishing an online provider directory for the small group market. However, we have serious and significant concerns as regards the review of rates and the related recommendations made by HBX staff. Given the other responsibilities and priorities of the HBX, we would strongly urge you to eliminate any attempt to serve as a dual regulator within the District, as relates to rate review. It is our belief that the expertise and time of the HBX is better served elsewhere.

We share the Authority's goal for a successful, sustainable health insurance market and stand ready to work with you as the HBX marketplace continues to evolve. We appreciate your time and consideration of our comments and recommendations and look forward to additional deliberations on this important issue. If you have any questions or would like additional clarification of these comments, please feel free to contact me directly. I can be reached by telephone (202-778-1149) or by email (gtrujillo@ahip.org).

Sincerely,

Geralyn Trujillo, MPP
Regional Director

cc: Kevin Wrege

Attachment

ATTACHMENT

AHIP 's Recommended Revisions to the Staff Proposed Language:

Network Adequacy:

Carriers: provider directory

second bullet:

- ~~In time for the 2016 plan year open enrollment (beginning October 1, 2015), Carriers will be required to prominently post a phone number or email address on their on-line 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~~ update provider network directories information. ~~The~~

- Carriers 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 2 years (or a shorter period of time).~~

  ~~3~~2. 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.~~

HBX: access plan

- As previously approved by the Executive Board, HBX will implement the requirement to submit an Access Plan by working through the Plan Management Advisory Committee. Initial Network Access Plans and subsequent update shall be afforded the protections of the DC open records law in determining whether a particular provision, if any, in the access plan is [proprietary, competitive or trade secret] information that should not be made public, based on information received from the carriers supporting the request that such information not be made public.