January 28, 2015

District of Columbia Health Benefit Exchange Authority
Executive Board Insurance Market Working Committee
Update to 2016 Plan year QHP Certification Requirements

INTRODUCTION

This report is submitted by the Executive Board Insurance Market Working Committee, chaired by Kevin Lucia with members Henry Aaron and Kate Sullivan Hare. The Committee's charge was to (1) review the initial certification process adopted and used in 2013 and 2014 for qualified health plans in 2014 and 2015 by the Health Benefit Exchange Authority (HBX) and implemented by HBX and the Department of Insurance, Securities and Banking (DISB); (2) review federal and District law with regard to marketplace responsibilities for certification of qualified health plans to be made available through DC Health Link; and (3) recommend updates for specified certification requirements for 2015 applicable for the 2016 qualified health plans.

BACKGROUND

In 2013, HBX established the Qualified Health Plan (QHP) Issuer Certification Working Group, an advisory group to HBX to develop and recommend on an initial certification process for qualified health plans. The consensus recommendations of the working group were adopted by the HBX Executive Board on March 13, 2013. The recommendations included a recommendation "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."

With two years of experience, the Executive Board Insurance Market Working Committee reviewed the process in preparing for plan year 2016. The Committee held five (5) public meetings, on October 16, November 14, and November 20 of 2014 and January 9 and January 21 of 2015. The Committee determined, with input from DC Health Link carriers, consumer advocates, and other interested parties, to focus its review on the following areas for the 2016 certification process: (1) network adequacy; (2) review of health plan rates; (3) non-discrimination requirements for health plans; and (4) quality of health plans. The Committee members voted on final recommendations in these four certification areas on January 21, 2015.

PROCESS

At the first meeting, Mr. Lucia, chair, asked Purvee Kempf, General Counsel and Chief Policy Advisor at HBX, to perform a general walk-through of all the certification requirements and standards for qualified health plans (QHPs) derived from both federal and District law, including any resolutions passed by the HBX Executive Board.

In overview, each exchange marketplace is required to make available only qualified health plans. There are numerous explicit requirements for certification as a QHP in the Patient Protection and Affordable Care Act (ACA), mostly in Sections 1311 and 1302, in HBX's enabling legislation, and in HBX-passed resolutions. These include the broad requirement that marketplaces make QHPs available only if it determines the plan is in the "best interest" of the individuals and employers in the state where the marketplace operates. In addition, the federal law specifies that QHPs must abide by any additional restrictions provided by the marketplace. Federal law also requires that each exchange marketplace develop a procedure for certification, decertification, and recertification of QHPs.

A detailed chart, available here, lays out the legal requirements for certification, then describes the existing implementation process. All requirements were discussed during committee meetings and the list below provides an overview of these requirements.

- Licensed Carrier
  In the ACA and DC Statute, each issuer must be licensed and in good standing.

- Plan Offerings and Benefit Structure
  In general, each plan must offer the essential health benefits (EHBs). The HBX working group process, executed through resolutions adopted by 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 must contain two drugs at each level; a prohibition on benefit substitution; additional benefits may be offered above the EHB; and the defined habilitative services. These were all developed through working groups, adopted by the Executive Board and added to District statute.

  All plans must meet the annual out-of-pocket limitations and cost-sharing structures as specified by the ACA and reiterated in DC Code.

  Each plan must offer one bronze, silver and gold level plan through the Exchange. District law goes beyond federal law as the federal law only requires silver and gold. Plans are subject to the meaningful difference standard to vary plans.

  Federal law requires child-only plans as well.

  Plans must submit a description of covered benefits and cost-sharing to the Exchange at least annually.

- Network Adequacy
  The ACA requires a provider network for each plan that has a sufficient number and types of providers, such as mental health and substance abuse providers, to ensure that all services are accessible with unreasonable delay. It also requires the inclusion of essential community providers (ECPs), and contains an alternate standard for HMOs. In addition, the ACA requires a provider directory that is published online and available in hard copy upon request. The directory should identify providers that are not accepting new patients.

  There are two specific District requirements passed by Executive Board resolution. HBX requires the collection of data to assess procedures and processes to learn the scope of gaps in network adequacy. HBX required carriers to submit "access plans" that include information on sufficiency of providers, access to ECPs, and provider directory accuracy.

- Review of Rates
  Federal law requires that health plans set rates for the entire plan year. In the HBX SHOP, the annual submission includes quarterly updates. Rates must be the same inside and outside the exchange marketplace, and they must specify the allowable rate variation (geographic area, age, tobacco, family structure). The District has determined that there is no geographic variation in DC, the age band is set in DC law at 3-1, similar to the federal age band, but not identical, and there is no tobacco rating in the District per HBX resolution and determination by the DISB.

  The federal and District law specify that exchange marketplaces shall require plans seeking certification to submit a justification for any premium increase, post it on their website, and the exchange marketplace shall take this information into consideration when deciding whether to certify such a plan for the exchange marketplace. This is an exchange-specific requirement and is separate from states having effective rate review as outlined elsewhere in the ACA.

- Applications and Notices
  Federal law requires that applications and notices be in plain language and accessible to all. The language access act in the District also requires oral and written translations.

- Transparency
  The ACA contains explicit provisions on transparency in sec. 1311, including that carriers must make cost sharing information available and use plain language.

- Enrollment
  There are many details regarding enrollment that the Qualified Health Plan (QHP) Issuer Certification Working Group detailed here. They are explicit in federal law, and HBX has adopted clear policies regarding enrollment. For example, the Executive Board has enacted three separate resolutions specifying "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 advanced premium tax credit

contribution and has enacted transition of care standards for enrollees in the midst of care.

- Accreditation Standards
  Federal law and regulations are explicit on requirements for accreditation. Executive Board resolutions require accreditation through NCQA or URAC.

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

- Non-Discrimination
  The health plan certification non-discrimination provision requires that the health carrier does not discriminate on the basis of race, color, national origin, disability, age, sex, gender, national origin, identity or sexual orientation and the health plan does not have a benefit design or marketing that has the effect of discouraging enrollment of individuals with significant health needs.

- Segregation of Funds
  Federal law requires that the exchange does not use federal funds for abortion.

- Internal Claims and Appeals and External Review Processes
  The District requires plans to follow the federal law and its specific requirements.

- Limitations on HBX 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 District Code also has a restriction that prohibits the Exchange from limiting certification based on the number of health plans being offered.

FOCUS ON FOUR CERTIFICATION REQUIREMENTS

After the presentation of all the health plan certification requirements, Committee members discussed the resources required to review every health plan certification requirement and decided to narrow their focus and staff work. Based on public input, stakeholder interest, and the discussion at public meetings, Committee members decided to focus on four certification requirements for potential updates for QHP plan certification in 2016: (1) network adequacy; (2) review of health plan rates; (3) non-discrimination requirements for health plans; and (4) quality of health plans.

Mr. Lucia, chair, asked Ms. Kempf to summarize how HBX and DISB are implementing all QHP certification requirements. A detailed chart is available here specifying the implementation of each requirement and the specifics steps taken by DISB and HBX respectively. In addition, he asked Ms. Kempf and Howard Liebers, Health Care Policy Analyst with DISB, to discuss with Committee members and present at the public meeting the implementation of the four certification requirements selected for a deep review.

In addition, Committee members requested information from 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.

Public Discussion on these Four Certification Requirements

For the four areas selected for deeper consideration, this report includes comments received in the earlier meetings, presentations by various stakeholders, and public comment received after the presentations.

Network Adequacy

Requirements: The network adequacy requirements are discussed above.

Implementation: Plans are required to submit the following Centers for Consumer Information and Insurance Oversight (CCIIO) templates related to network adequacy: 1) ECP template, a form that HHS prepopulates that with information about 340 B eligible entities. It lists, by provider, addresses, zip codes, whether they are on the federal ECP list and the network IDs so one can identify which ECP goes with each network; and 2) the network template which includes a list of the networks available for each health plan and provides a link to the carrier's website with information on the networks.

The federal templates are a companion to the traditional rate and form filings at DISB. The pragmatic use of these templates is that they convert to XML. The data can then be loaded and verified, making shopping on DC Health Link more effective. HBX links to URLS for the carriers provider networks.

In addition, plans attest that they have adequate networks and meet the requirements under law. 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. The tools include the following:

- Non-discrimination Tool (outlier analysis for QHP discriminatory benefit design)
- Non-discrimination Formulary Outlier Tool (PA / step therapy drugs for insulins, anti-diabetic agents, immunomodulators, immune suppressants, and anti-HIV agents)
- Non-discrimination Clinical Appropriateness Tool (covered drugs associated with diabetes, rheumatoid arthritis, bipolar disorder, and schizophrenia)

The District does not have any standards that are unique for DISB to implement. DISB receives the attestation and runs the CCIIO tools to detect outliers or problems. DISB collects complaints on network adequacy, but does not track complaints specifically by this topic. DISB has indicated that it has not had any significant trend of complaints regarding access to providers, and it works closely with the Ombudsman's office on complaints.

Committee members discussed that NCQA or URAC standards call on health plans to have internal controls and show that they are meeting their standards. If the health plan has URAC or NCQA accreditation, it must attest it is meeting its own standards.

It is possible that the Executive Board could ask DISB to dive deeper into how well the health plans are complying with their own standards and make that part of its review.

With respect to provider directories, making them available is a certification requirement. DISB checks to see if the links work, as does HBX. Where dead links are found, HBX or DISB pushes the carrier to fix the problems on the carrier's website.

HBX utilizes the URLs from the carriers. Once those are submitted, HBX reviews them. HBX requires clarification on the URLs and the products they go with. HBX needs to be sure they are properly matched. HBX worked over the last year on improvements to the provider directories and drug formulary access, and has seen improvements on access to provider directories for DC residents. Some URLs will go right to the local plan network and not have to filter all the way through a website to get there.

On the exchange marketplace side, HBX is working with Consumer's CHECKBOOK to develop a comprehensive provider directory for the individual market. HBX is collecting data from carriers to populate a centralized provider directory on the DC Health Link website, and is working through the steps of data collection and what it means for us to house and provide this information. HBX's plans to have this new functionality up after February for the individual market. The next step will be to establish a small business market provider directory.

DISB has been building lists of provider types, including mental health and substance abuse providers. There are no additional standards, such as for geographic distribution. Carriers attest that they have adequate capacity to service the entire service area and make determinationss as to whether a specific number or type of providers is sufficient for the District. DISB does not

evaluate whether it is in fact adequate for every health plan submission but follows up on specific complaints.

DISB noted that there are alternative standards for staff model plans, which would apply to the Kaiser-type model. However, the District has not adopted any network adequacy standards for these plans.

The Executive Board adopted a requirement that carriers submit access plans. However, neither HBX nor DISB has developed a template for access plans and therefore, no carrier submitted one.

Commenters:
Cheryl Parchum, Families USA suggested coordinating with the Healthcare Ombudsman's office that is charged with collecting grievance and complaint data on health plans, including Medicaid managed care plans.

Claire McAndrew, Families USA, and vice chair of Standing Advisory Board, suggested that relying on complaints is limiting because people may not know where to complain or who the Healthcare Ombudsman or DISB are. She also reported that the HBX Standing Advisory Board (SAB) looking into network adequacy as an essential priority and will be issuing a report on the issue. She is concerned that provider directory links are not always working and about the frequency of updates on directories, particularly when a provider passes away. She suggested carriers audit their plans internally to update the directory. If there is an active provider list for DC, that should be run that against the directories. She also recommended a dedicated email address or telephone number for consumers to report inaccuracies on the directories. Finally, she served on the Network Adequacy Working Group and is 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. That information needs to be collected.

Kevin Dougherty, National Multiple Sclerosis Society: Network adequacy is a major theme for his organization, especially for those with significant health needs.

Wes Rivers, DC Fiscal Policy Institute echoed Ms. McAndrew's comments on network adequacy and said that based on reaching out to other consumer advocates this was a key issue given the history in DC on this issue.

Mr. Lucia indicated that he did not think the Committee would re-evaluate the network adequacy standards or develop a new set of standards; that is something better suited to a working group. Rather, he thought the Committee would look at whether HBX needs more information from plans to ensure the standards are being met. He would like to address process changes that might be needed to ensure that carriers are meeting the standards. Dr. Aaron agreed.

Presentations:
1. Robert Ellis, Consumer's CHECKBOOK

Mr. Ellis is the Vice-President of Operations and Online Resources at the nonprofit Center for the Study of Services, better known as Consumer's Checkbook (CC). CC is working on an all-plan provider directory for DC Health Link's individual market. The objective is to create a stable active website where consumers can search for providers across health plans and carriers. CC gets data feeds from the carriers, and runs some additional validations to improve accuracy.

The Consumer's CHECKBOOK presentation can be found here.

2. Frank Micciche, National Committee for Quality Assurance

Mr. Micciche is the Vice President of Public Policy and Communications at the National Committee on Quality Assurance (NCQA). NCQA accredits all health plans offered through DC Health Link.

For purposes of accreditation, health plans set network adequacy standards and the health plans must also evaluate themselves against those standards annually, using a valid methodology (which NCQA checks). NCQA reviewers have indicated that the vast majority of standards that plans set are in a very reasonable range. States often prescribe these standards in insurance statute or regulation.

Health plans are scored on the requirement that they maintain online and searchable provider directories as well. NCQA expects health plans to update both directories within 30 days of receiving new information from either party. NCQA is actively exploring additional ways to promote more accurate provider directories such as reviewing claims data and conducting outreach to those providers that have not submitted a claim over a certain period of time. NCQA is also considering requiring periodic assessment of the accuracy of the directory.

NCQA accreditation does not currently look at whether Marketplace plans include ECPs in their networks, but does have standards on continuity of care. Plans must allow vulnerable members to continue to access discontinued providers if they are under an active course of treatment.

NCQA stated there are other important standards in its program that relate to how narrow networks are designed and how members experience is monitored.

3. Kylanne Green, URAC

Ms. Green is the President and CEO of URAC. She stated there are some similarities as well as contrasts between URAC's and NCQA's approach to network adequacy. URAC accredits plans with smaller memberships in numerous exchange marketplaces.

URAC standards focus on the consumer. URAC requires written policies and procedures that are specific as to how providers are recruited and credentialed, and how the network is managed specific to those providers. Like NCQA, health plans develop the network adequacy standards, considering the needs of the consumers in the regions they serve. URAC does engage in a determination that in everyday practice, the plan is cognizant of the standards it has developed and lives up to those standards.

URAC also requires a robust appeals process for consumers who are having access issues.

URAC is also studying the issue of health literacy, which tends to be lower in rural and underserved regions. There is a standard for routine review of the information and interaction with the consumer on an annual basis.

Committee members questioned Ms. Green about insureds who show up at an in-network emergency room and discover that the doctors are not in-network. Ms. Green stated that it is an issue, but there is not a specific standard that requires a health plan or carrier to contract with the staff providing the service at the facility.

A Committee member wondered whether it was possible to have a standard with the facility that is in network regarding what contractual procedures it must have with groups that are out-of-network (OON) to avoid the sometimes outrageous charges? Ms. Green stated that the standards are with respect to carriers, not the facility.

The URAC presentation can be found here.

4. Claire McAndrew, Vice-Chair, Standing Advisory Board and Families USA

Ms. McAndrew chairs the SAB's subcommittee on network adequacy. She, Kevin Dougherty, and Dania Palanker and have partnered with the DC Behavioral Health Association to research the accuracy of provider directories for health plans available through DC Health Link. The subcommittee is in the process of producing a report based on a secret shopper sampling on the accuracy of provider directories and the availability of appointments within certain medical fields to residents of the District in the individual market.

The sampling focused on primary care providers, ob-gyns, mental and behavioral health providers, oncologists and neurologists. This was a very small, not statistically significant sample. A complete report is anticipated, but not ready.

All the links to provider directories were working. On primary care porviders, the biggest concern with respect to inaccuracy was contact numbers – levels of 40%-50%, meaning that the provider was deceased, the person who answered the telephone had no idea what the plans was, or the provider used to be at the location. For those whose contact information was correct, almost 100% were in the network. Another finding was that a number of providers were listed as primary care when they are specialists.

Ms. Sullivan Hare asked if the research was going beyond the number of providers in an area to include issues such as how long it takes to get an appointment. Ms. McAndrew said yes. On new patients, less than half were taking new patients. For those that were taking new patients, most could get an appointment in five weeks or less. The range was next day to five weeks.

Ms. McAndrew recommended that carriers be required to have a dedicated email address or telephone line for consumers to report inaccurate directory information, and that carriers be required to correct the information within a set period of time, e.g. 10 business days; that carriers

be required to audit their directories internally on an annual basis; that carriers be required to contact providers that have not filed a claim in one year to determine if they still are part of the network; and that if a consumer relies on erroneous information in a directory and receives care from a provider who turns out to be OON, the consumer not be charged OON prices.

In addition, Families USA just released a report that reviewed state activities with respect to network adequacy requirements, such as timely access standards, geographic access, time and distance requirements (and public transit considerations in metropolitan areas), and QHP-specific standards. The report can be accessed here.

Review of Rates

Requirements: The review of rates requirement is discussed above.

Implementation: HBX contracted with consulting actuary at Oliver Wyman to review rates submitted by health plans for HBX certification, develop reports, and share this information publically. Oliver Wyman actuaries worked closely with DISB actuaries on questions and responses. The full process was presented by Tammy Tomczyk.

Separately, DISB has its own authority under District law to approve rates. DISB is approved by CCIIO as having an effective rate review program. DISB also received rate review grant funds to help in this effort. DISB has staff actuaries who receive the 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.

One item that DISB has not followed through on, nor has HBX, is requiring carriers to prominently post rate increase justifications on their own carrier websites. It is an issue for the 2015 shopping experience as these are the first renewals of new products. HBX staff is following up with the carriers to ensure this requirement is met.

Commenters: Cheryl Parchum, Families USA, stated that rates have been of concern. She suggested that DISB pay a consumer group to represent consumers in rate filings. It has not been done in DC, but she thought it could be of help to consumers.

Claire McAndrew, Families USA, stated that rate justifications must be posted ahead of time; they are not any use if posted after the fact. She suggested HBX look to other states for simplified postings.

Presentations:

1. Tammy Tomczyk, Oliver Wyman Consulting Actuaries

Ms. Tomczyk is a principal and consulting actuary at Oliver Wyman (OW). Presently OW works for several states, either directly for a Department of Insurance, an exchange marketplace, or for CCIIO in states that do not have effective rate review programs. OW's involvement varies from being the primary reviewer, generally in states that do not have in-house actuaries, to being a

secondary reviewer assisting primary reviewers with developing tools for effective rate review, reviewing the filings, or helping on the marketplace certifications.

For states where it is acting as a primary reviewer, OW has a detailed checklist and rate review process based on the federal regulation outlining requirements for an effective rate review program. OW reviews key assumptions such as trend and actuarial pricing values. In addition to key assumptions OW is reviewing the methodology for ACA compliance in the individual and small group markets. OW prepares questions and communicates directly with the carrier or through the state's department of insurance. The final work product varies by state and may be a brief opinion letter summarizing its review or a full-fledged report and testimony at rate hearings.

For states where it is not the primary reviewer, OW has developed standard actuarial memorandum requirements, designed to ensure the requirements for an effective rate review program are met. In some states OW has developed rate review training manuals that include all the components of an effective rate review. OW has developed checklists, templates and analytical tools. Some tools can be used to compare data from year to year.

OW may review metal actuarial value and look at unique plan designs where the federal actuarial value (A/V) calculator does not accommodate all cost-sharing options. In response to a Committee question, OW stated that the carrier actuary should be taking into account the influence of cost-sharing of a specific service on the utilization of those services that will be provided.

OW also performs cost-sharing reduction plan reviews, meaningful difference reviews and discriminatory benefit testing based on state guidelines, and EHB substitution in states where it is allowed. On the discriminatory testing review, a state had broad guidelines and OW helped the state look at the benefits in light of the guidelines.

The OW presentation can be viewed here.

2. Purvee Kempf, DC Health Benefit Exchange Authority

Ms. Kempf reviewed the certification requirements briefly, detailed in the first meeting minutes of October 16, 2014. In addition, Ms. Kempf provided information on some other state based marketplaces and on posting of rate justifications.

Information on California: California has adopted an active purchaser model. The carriers submit to Covered CA; Covered CA selects a number of carriers and negotiates with the carriers certified for the exchange. Covered CA hires an independent actuary to review rates. Afterwards is the rate filing process through the department of insurance. Certification is contingent upon completion of that process. Applications and negotiations are confidential. It is a robust bidding and negotiation process on price, networks and quality. Final certification is September 30.

Information on Connecticut: Access Health CT had a process specific to the exchange marketplace on rates. AHCT reviewed the rate filings, concurrent with the department of insurance's rate review and approval process. Actuarial reviewers hired by the exchange

marketplace communicated directly with carriers on the rates. Sometimes the responses were robust, other times not. The final report was submitted to the DOI formally as a public comment. CT has a formal comment and public hearing process as a part of its rate review process.

Public posting of the justification: the federal government had posted the 10% or greater rate requests, but that site was taken down and is in the process of being revived. In the meantime, the federal government has a lot of information in a public use file on each of the filings available. Vermont has a requirement of a plain language posting of rate increase justifications. Posting on carrier websites has not been successful in most states, but they are available on DOI websites.

Mr. Lucia, Chair, reported that the I-Rate system has a way of creating a very easy public access file to see justifications. DISB is using the I-Rate system.

Public Comments after Presentations:
Cheryl Parchum, Families USA, understood that HBX contracted for an independent review of rates that was not part of the public comment process. She asked why. Committee members explained that HBX hired an independent actuary that worked collaboratively with DISB. The firm had access to confidential information. Ultimately the report was made public with all confidential information being taken out.

Ms. Parchum stated that the public advocate in CT was very active and useful in influencing rates there. Mr. Lucia stated that the public advocate is on the Board and the Exchange gave her money for the rate review process. Also there was a hearing and the report was useful.

Kevin Wrege, representing AHIP and Aetna: Mr. Wrege stated that his clients have concerns about whether this is good policy and HBX's role in reviewing rates. He stated that DISB is the appropriate voice and primary regulator of rates. Mr. Wrege's clients realize there will be an exchange of information between the agencies, but the primary regulator of rates is appropriately DISB.

Speaking personally, Mr. Wrege said he knows that HBX is looking to grow the size of the carrier base in the District. Mr. Wrege thinks having two regulatory bodies adds significant burdens and costs to the carriers. Finally, Mr. Wrege stated that a differentiating factor in the District is the combined, single market.

Quality Assurance

Requirements: The quality assurance requirement is discussed above.

Implementation: Quality Improvement Plans (QIPs) have been submitted to DISB, and HBX staff is determining the appropriate place to post them.

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 the 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 HHS guidance and that it would become more of a priority for the 2016 plan year. HEDIS and CAHPS data is collected as part of NCQA for accreditation. Information on ratings can be made available on the DC Health Link website.

Ms. Sullivan Hare noted that she chaired the quality working group and the intent was to ensure that when HHS standards are out, that the plans begin to comply in a standardized understandable way. She stated it should be an aspect of the forms review process for 2016 to ensure the plans comply.

Dr. Aaron was concerned from the standpoint of insurers with regard to reliability and validity of 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.

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

Wes Rivers, DC Fiscal Policy Institute, said that quality improvement reporting is also key for his organization.

Claire McAndrew, Families USA, was concerned whether HBX fully understands what the quality rating system and HHS survey are. They have gone through extensive field testing, they were developed with prominent researchers, and she sees a lot of value for the District consumer.

Presentations:

1. Representative from Centers for Medicare & Medicaid Services

Booz Allen Hamilton presented on behalf of CMS.

The Marketplace Quality initiatives and provisions are intended to inform QHP certification; assist consumers in plan choice; and ultimately help CMS monitor plan quality.

Beginning 2015, a QHP must comply with patient safety standards: they must contract with providers that (1) have a defined patient safety evaluation system in place, and (2) meets specified quality improvement criteria including counseling. QHPs attest to compliance and maintain documentation.

On the Enrollee satisfaction survey, CMS has developed a Marketplace Survey and an Enrollee Satisfaction Survey. The Marketplace Survey is intended to evaluate consumers' experience with the marketplace. The survey is using the CAHPS framework to help improve marketplace performance. The results are not intended to be publicly reported, but will be shared with marketplaces. The QHP Enrollee Satisfaction Survey is intended to evaluate enrollee experience

with his/her QHP. The survey contains high level questions about plan experience, not individual providers. It will be publicly reported in 2016.

The Quality Rating System is based on quality and cost. It will be required as part of the certification process. It applies to family and adult coverage in both individual and SHOP markets.

Carriers will be required to collect, validate and submit data clinical and survey measures. Public display of the data is intended in 2016 for plan year 2017.

The Quality Improvement Strategy certification requires a Quality Improvement Strategy. The intended implementation is in 2016 for plan year 2017.

The details of the presentation are available here.

2. Will Robinson, National Committee for Quality Assurance

Mr. Robinson focused his comments on NCQA's clinical quality (HEDIS) and patient experience (CAHPS) reporting requirements that are included in Health Plan Accreditation. The Health Care Effectiveness Data and Information Set, or HEDIS, is the most widely used set of quality measures in the country. HEDIS measures look at whether health plan members receive evidence-based preventive care, achieve positive outcomes when battling chronic disease, or are subject to failures of care management and care coordination, such as hospital readmissions. The Consumer Assessment of Health Plan Providers and Systems or CAHPS is a member experience survey that asks patients about their experience accessing and receiving care. Both HEDIS and CAHPS are widely used to gauge the quality of care and patient experience by state Medicaid programs, state Departments of Insurance and federal agencies such as CMS and the Office of Personnel Management.

All NCQA accredited health plans are required to report a core set of HEDIS measures and report CAHPS survey results annually. Results are included in accreditation scoring and used annually to update health plans accreditation status. NCQA does not require Marketplace plans to report HEDIS and CAHPS for accreditation because plans have not had the requisite coverage time needed for accurate and valid measurement.

With respect to information NCQA makes available to the public, the website includes a health plan report card that identifies all NCQA accredited plans and their performance in the five key areas of accreditation. Access to this information is free of charge. NCQA also annually publishes health plan rankings under a joint project with Consumer Reports. This information is available both through the Consumer Reports magazine (paid) and NCQA website (free). NCQA also makes detailed, measure-level data available through Quality Compass, its web-based analytic tool that includes regional and national benchmarks for Commercial, Medicare and Medicaid plans. It also includes many years of trended data and is available for a fee.

3. Marybeth Farquhar, URAC

Ms. Farquhar is the Vice-President for Research and Measurement. URAC uses measures that are in the public domain but refines the measures specifications. URAC is looking at the

population health level and cross-cutting measures. URAC is patient-centric and uses patient surveys to help provide URAC information.

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

Inovalon is collecting the data: member demographic information; member enrollment coverage information; provider demographic information; lab results; prescription drugs; claims data; and EHR information. URAC has access to the data and can share some of it at no cost whereas other data can be purchased.

4. Public Comment Quality of Qualified Health Plans

Claire McAndrew, Families USA and SAB: She advocated for making the consumer experience survey publically available. She says both surveys were drafted by qualified individuals with a lot of testing. She believes that they are really well done, and no state based marketplace would have the resources to develop the surveys so rigorously.

Non-Discrimination

Requirements: The non-discrimination requirement is discussed above.

Implementation: Health plans attest that they do not discriminate unlawfully. DISB received zero discrimination complaints for 2014. CCIIO provides three nondiscrimination review tools. The main one looks at all the plans and reviews benefits to see if any particular plan has significantly higher cost sharing; a second that flags specific outliers with an unusually large number of drugs subject to prior authorization or step therapy in several key areas; and a third that looks at availability of drugs in four key areas.

Commenters: Kevin Dougherty, National Multiple Sclerosis Society, stated that compliance with nondiscrimination standards is a major theme for his organization, especially for those with significant health needs.

Presentation:

1. Katie Keith, Trimpa Group, LLC

Non-discrimination requirements are new to health plans, and there is no ideal standard. Based on a survey of 10 states, generally no new steps were taken. Participants in the survey were most concerned about narrow networks, formularies, and exclusions.

She suggests some proactive steps starting with making the actual evidence or certificate of coverage, or full plan documents easy to access. Advocates can then review the documents and point out discriminatory language. And it takes time for forms to catch up to the law. For example, smoking cessation provisions took some time to be enacted into plans. Matrix filings make it difficult for the regulator to spot potentially discriminatory provisions. The Committee discussed the difficulties of form filing and finding information at length.

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

STAFF RECOMMENDATIONS - UPDATING QHP CERTIFICATION REQUIREMENTS

Committee members asked staff to develop recommendations for updating the qualified health plan certification requirements for plan year 2016 in the four areas of 1) network adequacy; (2) review of health plan rates; (3) non-discrimination requirements for health plans; and (4) quality of health plans. Committee members asked staff to take into consideration staffing, capacity, and feasibility. Over the next month, staff worked closely with DISB and exchange marketplace carriers, meeting with each numerous times to understand their operations and ability implement different ideas that were presented by experts in the field and through public input.

Staff presented draft recommendations on January 9, 2015 to the Committee members and the public, taking questions from all.

Ms. Kempf began by reviewing regulations proposed by the Department of Health and Human Services that would impact qualified health plans certification requirements related to network adequacy, provider directories, quality of health plans, and non-discrimination. 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 direct link or tab. The proposed rule requests comments on requiring the directory to be in a "machine readable file format". In addition, the proposed regulations reiterate that health plans are required to post and make available the evidence of coverage for all qualified health plans during open enrollment and throughout the year. The regulations discuss making prescription drug formulary information accessible and discuss the development of a quality improvement strategy by a health plan.

The Draft recommendations are as follows by topic:

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 Department of Insurance Securities and Banking (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

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 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 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 2 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.

   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.

Questions:
Bill Talamantes with UnitedHealthcare asked about timing of implementing a DC Health Link universal small business marketplace provider directory. HBX will be sure to work with UnitedHealthcare to ensure appropriate lead time. In addition, Consumer's CHECKBOOK, which is the vendor preparing the provider directory work for HBX, has a large footprint in the District marketplace with many employers and others using its information.
Mr. Lucia, chair, asked 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? Some carriers are doing this now and a one year time period may be too short. This recommendation was kept broad to ensure feasibility. However, a health plan can set tighter limitations.

Mr. Aaron asked how important this provision is 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? Patients also go on provider directories to see different health plans accepted by their existing provider if they are considering switching plans.

Ms. Patricia Quinn with DC Primary Care Association (DCPCA) asked about whether there is a benchmark on how the provider directories now rank so that improvements can be measured? The Standing Advisory Board appointed a committee to investigate the individual market plan provider directories for several key categories of providers. The SAB is expected to publish a report in the near future. It will not be a statistically significant study, however, it will provide some measure. DISB has complaint data. Health plans are being asked about what metrics they can provide. Finally, as part of its contract, Consumer's CHECKBOOK will do some minimal verification of providers. If that minimal check demonstrates significant inconsistencies, that will give us some sense of the quality of the existing provider directories as well.

Ms. McAndrew with Families USA asked about whether HBX is doing research on the CCIIO templates collected. The first step is to get the templates and then develop the steps taken with that information. Mr. Liebers with DISB said that DISB is talking to CCIIO about how it uses the data.

Also in response to a question by Ms. McAndrews, staff clarified that all the certification requirements apply equally to the individual and SHOP marketplace except the DC Health Link universal provider directory.

Ms. Kempf discussed one final recommendation, the ability for HBX to map where providers are in the DC Metro area. A simple mapping of providers with mileage information from your location would cost somewhere under $100,000. Adding information on transit time to a provider by metro may be possible as well. 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 particularly helpful within the District; it would also not indicate whether providers are taking new patients; and it is a point in time estimate that is subject to becoming outdated.

Ms. Sullivan Hare said she uses these services through her insurer and therefore this feature may be duplicative to what some carriers are already offering.

REVIEW OF RATES

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.

Questions:

Laurie Kuiper with Kaiser Permanente asked whether 2015 will be similar to 2014's process. Staff confirmed that the recommendations are consistent with the process over the last two years, aside from adding an enhanced process, but those decisions are not final yet. Ms. Kuiper also asked about when Oliver Wyman actuaries reviewed rates in 2014. Did they only review already approved rates from DISB? Oliver Wyman actuaries had access all the way through the process with DISB and their final reports were completed before DISB finalized the rates so that their comments could be taken into consideration.

Kevin Wrege, representing AHIP and Aetna, asked about the timeline for the enhanced process. Staff confirmed that HBX would maintain close communication with the carriers on any potential enhancements, but there was no timeline at this moment.

QUALITY OF HEALTH PLANS

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.

NON-DISCRIMINATION PROVISIONS

Under the Affordable Care, 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.

Comments and Final Recommendations

On January 21, 2015, Committee members reviewed the written comments received and took additional verbal comments as well. Written Comments were received from America's Health Insurance Plans, the District of Columbia Association of Health Plans, the District of Columbia Primary Care Association, and Families USA. All comments are available here.

Committee members discussed the comments after Ms. Kempf reviewed them. Some stakeholders provided additional clarification on the comments.

Network Adequacy

Overall, Families USA requested the establishment of network adequacy standards in the District, dedicated telephone number or email be on the provider directories to report inaccuracies and such inaccuracies be rectified within 14 days, and a requirement that plan both audit their directories and validate providers that have not billed the carrier in one year. DCPCA discussed the importance of an accurate provider directory and a healthcare needs assessment for behavioral health providers. AHIP and DCAHP suggested that the a dedicated phone number or

email would be an administrative burden without a corresponding benefit for consumers, that validating providers if they do not bill carriers in the past two years be eliminated, and that information in an access plan be protected under the DC open records laws

Committee members discussed the vagueness of requiring "timely action" on validating and updating a provider directory when there is a report of inaccuracies. Families USA suggested a 14 day timeframe. AHIP comments included a statement regarding updating provider directories within 30 days. Committee members agreed to change "timely action" to "within 30 days" and will seek any additional comment AHIP may have at the full board meeting.

Committee members agreed to clarify that the recommendations are not requiring a dedicated email or telephone number for reporting provider directory problems. A general telephone number or email can be used if the information is being validated and corrected as appropriate.

Committee members asked about AHIP's suggestion to strike the words "program integrity". AHIP representatives at the meeting were unsure of the reason, but Committee members agreed that it would not change the thrust of the recommendation and agreed to strike that term.

Committee members agreed to have the Plan Management Advisory Committee take into consideration the DC open records laws when determining what information is reported in the plan.

Committee members discussed keeping the remaining network adequacy recommendations as drafted – including not adding additional standards, not eliminating any of the steps towards accuracy in the directory.

Committee members unanimously voted to pass this recommendation with the changes specified.

Review of Rates

Overall Families USA supported the recommendations and added that consumers and their representatives be allowed to suggest questions to the actuaries to submit to carriers, make the consulting actuary's report public before the final DISB approval of rates, and asking the actuaries to provide an opinion on whether the proposed rate is justified.
Overall AHIP and DCAHP stated that HBX should not have a separate rate review process from DISB, that dueling regulatory bodies would create a burden on carriers and confuse the public, and that HBX does not have all the information necessary to make determinations about final rates.

Committee members reiterated that the process as currently drafted is akin to the process that occurred over the last two years and that if an enhanced process is developed it would be shared for public comment. Mr. Wrege suggested that the current HBX recommendations duplicate DISB's role and put the agencies at odds. Mr. Aaron and Mr. Liebers from DISB specifically responded that DISB is supportive of the recommendation and in agreement with HBX's role as drafted. Further, Mr. Aaron stated that any enhanced process would be developed jointly with DISB.

Committee members did not make any changes based on the comments and unanimously approved the recommendations.

Quality of Health Plans

DCPCA discussed the importance of having health plan quality information available for consumers. AHIP, DCAHP, and Families USA were supportive of the recommendations. AHIP suggested that quality improvement strategies include the use of positive and negative incentives. However, no one from AHIP was able to specify what negative incentives included. Families USA supports posting of survey data from the HHS surveys.

Committee members agreed to include some technical edits, but unanimously approved the recommendations.

Non-Discrimination

AHIP and Families USA suggested that HBX and DISB clarify the CCIIO tools used for review of plans. AHIP and DCAHP stated that guidance from DISB on discriminatory benefit design examples was not necessary.

FINAL RECOMMENDATIONS

Final recommendations are available below and can be found online at this link:

Qualified Health Plan Certification Requirement Recommendations (1/21/2015)

The following standards would apply to qualified health plans for 2016 unless otherwise noted.

NETWORK ADEQUACY

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.

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marketplace will be determined based on experience and consumer use of individual marketplace provider directory tool.

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<u>HBX: access plan</u>

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DISB:

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

Committee Members and Commenters

The Insurance Market Working Committee is comprised of Board members Kevin Lucia, Chair; Henry Aaron; and Kate Sullivan Hare. Diane Lewis, Chair of the HBX Executive Board also attended some meetings. Five public meetings were held, on October 16, November 14 and 20 of 2014, and January 9 and 21 of 2015, all meetings, except January 9th, were held in-person with telephone participation permitted. The January 9, 2015 meeting was by phone only. Votes on recommendations were taken at the fifth meeting. Written minutes and recordings of each session can be found on the HBX website here. The following persons contributed to the comments submitted and discussions held by the Committee:

Stakeholders that Commented or Contributed During Meetings	
Colleen Cohan	UnitedHealthcare
Kevin Dougherty	National Multiple Sclerosis Society
Robert Ellis	Consumer's CHECKBOOK
Marybeth Farquhar	URAC
Kylanne Green	URAC
Katie Keith	Trimpa Group, LLC
David Kennedy	America's Health Insurance Plans
Laurie Kuiper	Kaiser Permanente
Claire McAndrew	Standing Advisory Board Vice-Chair and Families USA
Frank Micciche	National Committee for Quality Assurance
Cheryl Parchum	Families USA
Patricia Quinn	DC Primary Care Association
Wes Rivers	DC Fiscal Policy Institute
Will Robinson	National Committee for Quality Assurance
Bill Talamantes	UnitedHealthcare
Tammy Tomczyk	Oliver Wyman Consulting Actuaries
Geralyn Trujillo	America's Health Insurance Plans
Eric Vicks	DC Primary Care Association
David Wilmot	DC Association of Health Plans
Kevin Wrege and David Kennedy	America's Health Insurance Plans and Aetna
Staff Advisors & Support DC Health Benefit Exchange Authority	
Mila Kofman	Executive Director
Purvee Kempf	General Counsel and Chief Policy Advisor
Debra Curtis	Senior Deputy Director for Policy &

	Programs, HBX
Mary Beth Senkewicz	Associate General Counsel and Policy Advisor
Rob Shriver	Director for Business, Policy, and Marketplace Operations
Brendan Rose	Plan Management Program Manager
Shayla Hamlin	Executive Assistance, HBX
Support from the Department of Insurance Securities and Banking	
Philip Barlow	Associate Commissioner for Insurance
Howard Liebers	Health Care Policy Analyst
Lekiewa Rasberry	Health Insurance Analyst