

Plan Certification Subgroup

Meeting Summary

July 10, 2012

I. Welcome and Preview of the Agenda

Ms. Katie Burns welcomed members back to the plan certification subgroup and provided an overview of the agenda. Ms. Burns noted a few outstanding items from the previous meeting and suggested that those be addressed before proceeding with the agenda.

II. Outstanding Topics from the June 27 Meeting: Provider directories, notice of terminations of providers from networks, and essential community providers.

Ms. Burns noted a few outstanding topics from the June 27 meeting including provider directories, provider terminations as they relate to network adequacy, and requirements related to essential community providers.

Notice of Terminations of Providers From Networks to Regulators and Enrollees:

Ms. Burns introduced Ms. Lisa Taft from the Managed Care Systems Section at the Minnesota Department of Health (MDH) to discuss the current HMO notification requirements related to provider contract terminations pursuant to Minnesota Statutes 62Q. 56. Ms. Taft explained that HMOs are currently required to notify MDH 120 days in advance of a clinic level provider termination when the termination is “not for cause”, but that in practice the actual termination rarely occurs. The HMO must also notify all affected enrollees within 30 days of a provider contract termination. Ms. Taft clarified that there is no notification requirement when providers are added to an HMO network.

Ms. Taft stated that provider terminations resulting in network adequacy problems are very uncommon. She further noted that HMOs are required to notify enrollees 30 days prior to clinic level provider terminations, and in some circumstances patients who are in currently undergoing treatment have continuity of care rights (Minnesota Statutes 62Q.56, Subd. 1a) and may remain with a provider until the treatment episode is complete.

- One member asked about the medical conditions triggering the continuity of care requirements. Ms. Taft referenced the requirements and provided examples of a few conditions included in the current standard including pregnancy beyond the first trimester and end of life care.
- Overall, workgroup members supported maintaining the 30 day and 120 day notification requirements related to HMO not for cause provider terminations.

Updating of Provider Directories:

Workgroup members made note of the following issues:

- Should we think differently about updating information for different purposes?
 - Updates for network adequacy

- Network information for consumer information during open enrollment
- Network information for consumer choice at time of care (noted that carriers are best point of contact for this information)
- Members were concerned about maintaining accurate and up to date provider directory information for consumers selecting health plans. While members noted the importance of updated provider directories through the calendar year, members generally agreed that up-to-date directories were particularly important during open enrollment periods. Members noted the importance of the Exchange being clear about the date at which provider network information was most recently updated.
 - A few members discussed potential intervals of provider network updates to the Exchange (real time, monthly, quarterly, etc.). Carriers explained the challenges associated with real-time network updates, which includes communication from providers to carriers as well as information technology challenges. There was generally consensus around the suggestion that carriers file networks for certification, provide updates shortly before open enrollment, and at some regular interval throughout a coverage year, potentially on a monthly or quarterly basis.

Essential Community Providers

- With respect to essential community providers (ECPs), workgroup members voiced support for current state requirements. The state requirement to offer contracts to ECPs is more expansive than the QHP certification requirements to ensure networks include a sufficient number of ECPs. Ms. Burns noted the group's support for the current state standard and that this support would be reflected in its draft recommendations.

III. Discussion of Service Area Standards

Ms. Burns reviewed a background paper prepared by Exchange staff related to service area requirements. This document can be found on the Exchange web site at <http://mn.gov/commerce/insurance/images/ExchPlanBkgrndPaper7-10-12.pdf>. This background paper has two purposes:

- 1) to describe federal Exchange requirements related to service areas and compare those requirements to existing related state laws and rules. As previously noted in work group discussions, these existing standards will serve as the basis for addressing federal certification requirements for the first year of Exchange certification and operation;
- 2) to outline potential service area standards that may be considered for implementation starting in 2015. Adoption of new standards would require modification of existing statutes and/or rules. Insurers would subsequently need adequate lead time to develop and seek certification for new products meeting different standards.

As noted in the background paper, service areas are geographic areas within which issuers market and sell health plans. As defined in the federal rules for Exchanges, individuals must reside or be employed within the QHP's service area in order to enroll. Service areas are distinct from rating areas which provide geographic boundaries established or approved by state regulators by which issuers may adjust premiums. Minnesota's regulatory requirements for health maintenance organizations link service areas to network adequacy standards, ensuring that covered services are accessible to enrollees.

Workgroup members made note of the following issues:

- One member asked about whether the exchange would require at least two plans in each service area to ensure enrollee choice. Ms. Burns clarified the Exchange cannot assure such availability as it is not acting as a purchaser and suggested that the multi state plans may help ensure consumer choice in the event certain geographic areas are served by only a few carriers.
- Workgroup members agreed the carriers should establish their own service areas, provided those service areas met some minimum criteria (rather than the Exchange establish a standardized set of service areas). Having the Exchange define service areas would significantly depart from current state standards, pose challenges for existing carriers, and create barriers for new entrants into the marketplace.
- With some exceptions, members agreed that service areas for QHPs should be no smaller than a county.
 - Members supported the guidance from the Medicare Advantage “county integrity rule” that establishes criteria for regulators evaluating service areas smaller than a single county. To obtain an exception from the county minimum, a Medicare Advantage organization must demonstrate that the sub-county area is necessary, non-discriminatory, and in the best interest of beneficiaries.
 - Workgroup members also observed the potential to carve out healthier segments of risk within a county.
 - Workgroup members may want to revisit their recommendations related to service areas depending on how the MN Department of Commerce establishes rating areas (see next topic). Depending on the timing of when Commerce sets rating areas and how those areas are set, members may wish to reconsider whether they want to recommend tying service areas to rating areas as part of 2014 or 2015/future year QHP certification criteria.

IV. Request for Information Related to Geographic Rating Areas

Ms. Burns introduced Ms. Julia Phillips, State Health Actuary from the Minnesota Department of Commerce, to discuss the recently released request for information for establishing geographic rating areas. The Minnesota Departments of Commerce and Health are currently soliciting comments related to the establishment of market wide geographic rating areas under the Patient Protection and Affordable Care Act (Affordable Care Act). Under current state law, carriers propose their own rating areas that must meet certain

statutory criteria (such as being at least seven contiguous counties) and seek approval for these carrier-specific rating areas from the Minnesota Departments of Commerce and Health. The Affordable Care Act requires each state to establish specific rating areas to be used by all carriers operating in that state beginning in 2014.

- One member voiced support for coordinating service areas with rating areas. Separate rating areas and service areas may introduce more variation in premium amounts and hinder competition.
- It was also noted that it would be helpful to know how Commerce will set rating areas before the workgroup considers tying service areas to rating areas.
- Ms. Phillips suggested that coordinating service areas and rating areas create difficulties for some carriers serving smaller markets. Should the state establish a large rating area, carriers who didn't want to serve the entire rating area may need an exception under the service area criteria for QHPs. This would likely create an administratively burdensome process for both regulators and carriers when a smaller service area requirement may be a more reasonable standard for the marketplace rather than something that is only available through an exception process.
 - It might be desirable to revise the current seven county minimum rating area requirement, particularly if service areas are tied to rating areas.
- The Minnesota Department of Commerce hopes to have initial recommendations for rating areas sometime in the fall.

V. Network Adequacy and Service Areas

Exchange staff produced a one page summary of network adequacy standards for HMOs in Minnesota for reference during this discussion. Ms. Burns asked for comments on whether any components of the network adequacy requirements appeared unnecessary beyond the HMOs to which they apply as the workgroup endorses the concept of extending these requirements to all QHPs.

- One member observed that the referral requirements that are part of the HMO network adequacy standards are not consistent with the market outside HMOs. Irene Goldman with the Managed Care Division in the Minnesota Department of Health suggested that the requirement that issuers coordinate referrals was only appropriate for closed network plans where referrals were needed.
- Members brought up the following issues for group consideration for 2015 and beyond QHP certification criteria:
 - Establishing wait time standards and a requirement to pay out of network if an issuer is unable to comply
 - Network adequacy requirements for subspecialists (pediatric oncologists, etc.)
- In considering criteria for 2015 and beyond, the group could also consider current enrollee assessments of provider availability in HMO products to evaluate current network adequacy standards.

- Members are invited to submit additional comments or suggestions about detailed aspects of current network adequacy requirements that may not be relevant outside of HMOs.
- Ms. Burns asked whether or not the group felt comfortable with network adequacy requirements linked to the QHP service area. Currently, the Minnesota Department of Health approves HMO service areas after determining the organization has sufficient providers in the area to meet network adequacy standards. There was general support for this concept.
- Another workgroup member expressed concern that state QHP certification standards will be more stringent than the federal standards for multi state plans operating in the state. The Office of Personnel Management, a federal entity that oversees administration of the Federal Employee Health Benefit Plan among other responsibilities, will set the standards for multi-state plans. A multi state plan may lack the kind of robust provider network needed to meet standards for other plans sold through the exchange.

VI. Wrap Up and Next Steps

Ms. Burns announced that Exchange staff will issue a call for comments on our plan certification crosswalk document circulated during the June 19th meeting. Interested parties can look for an announcement this week through our email listserv. The exchange also published a request for proposal for a contractor to develop a health plan quality rating methodology. Prior to our next meeting on August 2, Exchange staff will distribute materials on enrollment and termination criteria for QHPs and on standardization of plan and benefit information by metal level.

Next Meeting: August 2, 2012 from 9:30 AM to 12:30 PM
Sibley/Summit Rooms, Golden Rule Building

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