**DC Health Benefit Exchange Authority**
**Executive Board Meeting Minutes**
**Thursday, April 18, 2013**
**11:00 am – 1:00 pm**
**441 North Capitol Street, NW, Suite 820N**
**Washington, DC 20001**

**Members Present:**
Dr. Mohammad Akhter (Chair), Dr. Henry Aaron, Kevin Lucia, Kate Sullivan Hare, Dr. Saul Levin, Khalid Pitts, Dr. Leighton Ku

**Members Absent:**
Diane Lewis, Wayne Turnage, Bill White, David Berns

## I. Opening Comments

The meeting was called to order by Dr. Akhter. He welcomed the members and public and reviewed the agenda.

## II. Approval of Minutes

The minutes of the April 8, 2013 were approved unanimously by voice vote as circulated.

## III. Report from the Executive Director

Executive Director, Mila Kofman, provided the Board with a brief update report covering the following:

- LETTERS OF INTENT FROM INSURERS: On April 15th, we received three (3) carrier letters of intent indicating that they plan to offer qualified health plans on the Exchange. One carrier raised several questions and could not commit. We will wait for an update from them.

- CARRIER MANUAL MEETING: We walked through the draft carrier manual with the carriers, however several questions were raised:
  - What if a parent insurance company has an HMO and the HMO is only in one market?
  - What happens if an insurance company is in one particular market and not in both?

  We will update the Carrier Manual on both of these points.

  At that meeting, DISB made clear to carriers that rate filings will be confidential until all are submitted by the May 15th deadline. This is to encourage earlier submission by carriers.

  We also discussed whether plans intend to offer platinum plans in the individual market. Between that discussion and preliminary information from the letters of intent, it appears clear that there will be ample platinum offerings in the small group and individual arenas. Therefore,

we aren't going to suggest an action item for the Board on this front at that time. If it turns out as the filing process continues that our information changes, we will come back to you.

Discussion: Several board members discussed the platinum issue to make clear that its everyone's understanding that options will be available to people and that the Board will revisit if that turns out to be wrong.

- IT UPDATE: We've submitted numerous artifacts to CCIIO and second wave testing has started.

  Discussion: Kevin Lucia asked about Maryland delaying their SHOP enrollment to January 1, 2014 and Executive Director Kofman assured him that we should not run into the same problems they have because we are refraining from customizations to the IT system that would require such a delay.

- TOBACCO CESSATION PROMOTION: In follow up to our last Board meeting on April 8th, the Plan Management Advisory Committee met on this issue and expects to have recommendations next week. They agree that it is vitally important to promote all the new preventive and wellness benefits that will now be offered in the individual and small group marketplace – including tobacco cessation.

**IV. Consideration of Resolutions**

DENTAL RESOLUTIONS: Dr. Akhter asked Chairman Leighton Ku of the Dental Working Group to explain the consensus items and then asked Chairman Kevin Lucia of the Insurance Market Working Committee to explain the non-consensus dental item so both could be considered together by the Board.

Leighton Ku presentation: Consensus was reached on many items, but not all.

Certification process: The group quickly determined that the certification process should mimic that of the Qualified Health Plans, but be modified as needed to fit their unique plans. The working group report lays out in detail those modifications.
Adult dental: The group quickly agreed that adult dental packages could be offered on top of the required pediatric dental essential health benefits and made clear that the rules surrounding adult dental will differ from those for the pediatric dental essential health benefits.
Labeling of QHPS: There are a variety of ways that the pediatric dental benefit can be offered. It may be embedded in the overall Qualified Health Plan, it could be offered in conjunction with a QHP, or it could be offered as a stand-alone benefit. There will be confusion for consumers among those options. The group achieved consensus around requiring that QHPs clearly label whether their plan does or does not provide the pediatric dental essential health benefit so that people understand what they are purchasing.

Out of Pocket Maximum Limits: The group was unable to reach consensus on the maximum out of pocket limit for stand-alone dental plans offering the pediatric dental essential health benefit and so that issue was bumped to the Insurance Market Working Committee and Kevin Lucia will present on it shortly

DISCUSSION: There was a discussion among board members about a letter received from dental insurers after the conclusion of the working group and some confusion about what that group was asking for. Board members made clear that while there was a desire from the stand-alone dental plans to require various ways to redefine the choices between an embedded product and a stand-alone product for the pediatric dental essential health benefit, that the Board Members understood from Exchange staff that it will not be technologically possible – due to IT limitations – to separately price the pediatric dental essential health benefit within embedded plans. Nor, is it feasible to require QHPs to market two versions of each plan (one with pediatric dental EHB and one without) since filing has already started for the plans this year. Board Members emphasized that decisions made for this year are not final decisions for the future and as we learn from our experience in the marketplace, that this could certainly be an issue to revisit in the future.

Kevin Lucia Presentation on the Out of Pocket Maximum Spending Limit:

The Insurance Market Working Committee utilized the report presented by the Working Group, was briefed by Chairman Leighton Ku and had the services of the professional facilitator MaryBeth Senkewicz when looking into this issue. The Committee also was able to benefit from a decision by the federal government, which was released after the conclusion of the Dental Working Group, that defined safe harbors for out-of-pocket maximum limits in the Federally-facilitated exchanges for stand-alone dental plans at $700 for one child, increasing to $1400 for two or more children.

The Committee reached a unanimous decision to recommend a $1000 out of pocket maximum for one child and $2000 for two or more children. They based this decision on two key factors. Those are the levels chosen by Maryland which is our closest neighbor operating a state-based exchange and a state in which many of the same plans do business. Second, the Committee felt that DC is a fully urban community which means that expenses are higher here than in most states.

RECOMMENDATIONS FROM THE PRODUCERS & CONSUMER ASSISTANCE AND OUTREACH ADVISORY COMMITTEES REGARDING THE ROLES AND TRAINING FOR ASSISTERS AND PRODUCERS IN THE EXCHANGE:

Kate Sullivan Hare, Chair of the Insurance Market Working Committee led this presentation. She walked through the detailed document walking through the decisions made by these advisory committees which are made up of people in the community representing a broad spectrum of interests. She emphasized that these decisions were all reached by consensus.

The full document is embedded here which walks through the policy (italicized):

*IPA Program Goals*

*The District's IPA program will aim to:*
*1) Reduce the number of uninsured individuals in the District through a) raising awareness of coverage options; 2) facilitating enrollment in qualified health plans (QHP) and insurance affordability programs; and c) promoting the retention of coverage.*

*2) Develop a highly knowledgeable IPA workforce who can educate consumers on their full range of health coverage and access options and teach consumers how to understand and use health coverage.*

*3) Coordinate with related programs and entities, serving as a one-stop shop with the ability to provide warm hand-offs to other health and social services.*

*4) Take an evidence-based approach with clear measures of success.*

*IPA Target Population*
*The IPA program should be focused on uninsured and hard-to-reach populations. Outreach efforts should be focused on both individuals and small groups who would be eligible to use the DC Health Benefit Exchange, though IPAs will serve all those interested in enrolling in QHPs and insurance affordability programs.*

*The uninsured have been described in a report by the Urban Institute titled, "Uninsurance in the District of Columbia: A Profile of the Uninsured, 2009," by Barbara A. Ormond, Ashley Palmer, and Lokendra Phadera. In addition to the groups outlined in the Urban Institute profile, the committee believes the IPA program should emphasize outreach to the LGBT community and those who would have difficulty filling out the online application, such as those with limited literacy or limited English proficiency and those who do not have easy or regular access to a computer or the Internet. The committee notes that the prevalence of uninsured individuals varies by region, and seeks innovative strategies for reaching the target populations where they live and work. IPAs' target populations should include reaching out to and educating uninsured and "hard-to-reach" employer groups (that have similar characteristics to target group individuals) about their (and their employees') options and obligations under the ACA, the importance of health care coverage, and how to secure more information and help with group or individual coverage.*

*Grant-Making Approach*
*The Committee recommends that the DC Health Benefit Exchange issue an open call for proposals that allows applicants to submit proposals based on the populations they currently serve and their existing areas of expertise. While the call for proposals will not include a specific requirement that organizations jointly apply, it should encourage cooperation and sharing of best practices. The grantees should meet regularly and take a coordinated approach to meeting the goals of the program.*
*Duties*
*Federal guidance outlines the following duties for Navigators and IPAs:*

- *Conduct public education to raise awareness about the availability of qualified health plans (QHPs);*
- *Distribute fair and impartial information;*
- *Facilitate enrollment into QHPs;*
- *Provide referrals to the appropriate entity or agency for consumers with a grievance, question or complaint; and*
- *Provide information that is culturally and linguistically appropriate to meet the needs of the population being served by the Exchange.*

*Although an IPA shall be required to provide the full spectrum of assistance from outreach to eligibility, enrollment and follow-up, some IPAs may focus more on outreach and education where they have existing networks that allow them to communicate with "hard-to-reach" small groups. Such IPAs would be required to build relationships with producers that will facilitate a smooth cooperative working relationship or hand-off to producers for assisting such groups to enroll in employer-sponsored insurance. Producers should leverage the knowledge and expertise of IPAs where it may be helpful to provide the best service to a client, such as in overcoming language barriers.*
*IPAs should make a strong commitment of resources and time to finding the uninsured of low- to moderate-income, educating them about the value of healthcare coverage, helping them to get a determination of their eligibility for various subsidized coverage programs, and to access the DC Exchange for selecting commercial insurance. Producers should be trained to perform these same functions, but will not be conducting the same level of outreach and education to reach uninsured individuals as IPAs. IPAs could build relationships with producers for plan selection and follow-up where it would be helpful to an individual.*

*Conflict of Interest*

*The Committee notes strong federal requirements related to conflict of interest for Navigators and recommends that IPAs be held to that standard.*

*The Committee does not propose to add further conflict of interest requirements beyond the federal standards. The Committee believes that the DC Health Benefit Exchange should provide clear legal guidance to potential grantees about how to comply with the rules. Grantees should sign an affidavit stating that they have no known conflict of interest, including a financial or non-financial interest (past, present, or anticipated) that could prevent them from providing impartial information to consumers. The DC Exchange should monitor IPAs by tracking enrollment patterns and conducting consumer satisfaction surveys that include questions related to the quality and impartiality of the advice they receive from their IPA.*

*Language and Cultural Competency*

*It is a high priority of the committee to have IPAs with strong language and cultural competency skills. Potential grantees should be asked to specify how they will provide culturally and linguistically competent services. Successful grantees should be able to show previous experience and existing relationships with targeted groups.*

*Training*

*Adequate training will be critical for the success of the IPA program. The committee recommends that training include information on the following:*

- *Affordable Care Act;*
- *Eligibility and enrollment rules and procedures, including information related to premium tax credits, tax implications of enrollment decisions, and changes in income and eligibility that could take place during the year;*
- *How to use the online enrollment portal and how to complete paper coverage applications;*
- *How to help consumers weigh the range of QHP options including the quality, cost and overall value of available QHPs (including qualified dental plans);*
- *Basic information on how insurance works and various terms consumers will need to understand;*
- *Essential Health Benefits;*

*• Provider networks;*

*• Understanding notices sent by the DC Health Benefit Exchange and health plans;*

*• Coverage renewal;*

*• Managing coverage transitions and special enrollment periods;*
*• Medicaid/Alliance;*

*• Needs of underserved and vulnerable populations, including*
*- immigrants;*

*- those with limited proficiency in English;*

*- those with disabilities; and,*

*- those with particular health conditions, such as HIV/AIDS or MS, who may be looking for unique features in a health insurance plan;*
*• Culturally and linguistically appropriate approaches, services and materials;*

*• Ensuring physical and other accessibility and usability for people with a full range of disabilities;*

*• How to comply with requirements that information be offered in "plain language," including how to present oral and written information in a clear and understandable way;*

*• Outreach and marketing approach and protocols;*

*• Means of appeal and dispute resolution;*

*• Conflict of interest;*

*• Privacy and security;*

*• Protocols for hand-offs with other relevant groups including: Medicaid/Alliance, DC Ombudsman, DISB, call center, producers, and other IPAs; and*

*• SHOP-specific training.*

*The committee recommends that individual IPAs be required to pass a practical, skills-oriented competency exam in order to be certified as an IPA. IPAs should receive continuing education and be re-certified annually. Training modules (including continuing educations) should reflect information collected through the performance metrics, lessons learned and shared challenges among IPA grantees. The core training curriculum should be offered at regular intervals so new employees can be trained in a*

*timely way. During the application process, potential grantees should provide information to verify that they have qualified staff who are capable of completing the training and passing a competency exam. The Committee notes that IPAs that will focus on providing outreach to small groups may need additional specialized training related to the unique needs of those buying in the small group market.*
*Performance Metrics*
*The committee recommends the following performance metrics:*

- *Number of applicants enrolled;*
- *The rate of completed enrollments relative to applicants assisted;*
- *Time taken to complete various types of applications;*
- *Outreach activities and follow-up completed;*
- *Number of referrals (or enrollments) made to Medicaid;*
- *Number of referrals to social services programs such as the Supplemental Nutrition Assistance Program (SNAP) or the Women, Infants and Children (WIC) program;*
- *Number of referrals to producers;*
- *Number of applicants in various target populations assisted and enrolled;*
- *Outreach method: how consumers were contacted;*
- *Site of service;*
- *High scores on customer satisfaction surveys;*
- *High use of the web portal;*
- *Rates of continuous coverage;*
- *Enrollment patterns (to ensure consumers are not being steered to one plan or another); and*
- *Accuracy of the applications submitted.*

DISCUSSION: Executive Director Kofman explained that we've submitted a grant proposal to the federal government for approximately $10 million in assister grants. We're expecting to hear back soon. Our approach will be to use a vender/venders to do the training and monitoring and oversight. We'll move forward with this as soon as we have CCIIO approval for the funding.

Executive Director Kofman also highlighted that CCIIO regulations limit what types of organizations in the community can qualify as assisters. These rules will prohibit the Chamber of Commerce and other business groups from qualifying as In Person Assisters; however, the DC Exchange is committed to

working out other ways that we can work together with organizations in the business community as these partnerships will be key.

Dr. Aaron raised particular concerns about evaluation of the assisters and Executive Kofman made clear that evaluation will be built into the contracts for any venders we use to run this program.

It was also clarified that the recent announcement of newly available funding for navigators from the Federal Government is not something we are missing out on. Those funds are only for Federally-facilitated and partnership exchanges. There are still no other federal funds available to state-based exchanges like DC to set up a navigator program. That's why we are focusing on the In Person Assister program this year. We'll transition to navigators next year.

**V. PUBLIC COMMENTS**

Kevin Wrege, on behalf of Delta Dental: testified to the continued concern of Delta Dental as to the inability of consumers to fairly measure the differences between an embedded pediatric dental essential health benefit and stand-alone products. They want to ensure an apples-to-apples comparison and don't believe that will be possible the way the system is currently designed. Recognizing the limitations placed on us due to IT barriers and the fact that plans have already starting filing their plans for 2014, he encouraged the Board to consider these thoughts as the process moves forward. He also described different models being considered in other states – emphasizing that some are prohibiting embedded dental benefits.

Peter Rosenstein, on behalf of the American Association of Orthotics and Prosthetics: Raised concerns about the way the decision to prohibit tobacco rating was rolled out in the media recently and concerns about IT limitations.

**VI. Voting Items**

- **Resolution to establish certification requirements for Qualified Dental Plans.** Presented by Dr. Ku.

  The resolution was adopted unanimously.

- **Resolution to establish an In-Person Assistor (IPA) program, including goals, target populations, grant making structure, duties, conflict of interest rules, language and cultural competency requirements, training requirements, performance metrics, and an evaluation component.** Presented by Kate Sullivan-Hare
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  The resolution was adopted unanimously.

- **To establish a reasonable out-of-pocket maximum for Qualified Dental Plans.** Presented by Kevin Lucia.

The resolution was adopted unanimously.

## VII. Closing Remarks and Adjournment

There are procurement and personnel issues before the Board. The Board moved to a closed session to discuss those issues.

The meeting adjourned at 12:43 pm.