DC Health Benefit Exchange Authority
Executive Board Meeting Minutes
Thursday, May 9th, 2013
5:30 pm- 7:30 pm
441 North Capitol Street, NW, Suite 820N
Washington, DC 20001

Members Present:
Dr. Mohammad Akhter (Chair), David Berns, Kevin Lucia, Kate Sullivan Hare, Dr. Saul Levin, Dr. Leighton Ku, Wayne Turnage, Diane Lewis

Members Absent:
Dr. Henry Aaron, Khalid Pitts, William White

I. Opening Comments

The meeting was called to order at 5:37 pm by Dr. Akhter. He welcomed the members and public and reviewed the agenda.

II. Approval of Minutes

The minutes of the April 25, 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:

1. NEW STAFF: We've doubled in size. Introductions of new staff members were made: Kelvin Robinson, Katrina Reynolds, Hannah Turner, Mallory Isaacs, Paula Isaacs Walker, Paulette Saunders, Nicole Matthews, Cherie Smith, and Keith Fletcher

2. WAVE II TESTING UPDATE: We were the first of the state-based exchanges to pass WAVE II testing which is a significant milestone for our IT development.

3. PENDING CMS GRANT: We've requested an additional $18 million ($10 million of that request for the IPA program) and we've been told it will be another couple weeks before we hear back from CMS.

4. MARKET RESEARCH UPDATE: We're in the midst of pursuing our market research so that we understand the information needs of consumers. Focus groups are occurring this week. This will help us gauge interest in using the Exchange, understanding barriers to interest in joining the Exchange, learning how consumers view good customer service, and enabling us to complete branding of our name, logo, etc. Kate Sullivan Hare's Working Committee on Marketing and Consumer Outreach is

involved and will review the recommendations before it comes before the full Board, most likely at our next meeting.

5. DC COUNCIL LEGISLATIVE DIRECTOR'S MEETING & MAYOR'S COUNCIL BREAKFAST: Both of these events occurred since our last Board meeting. Both meetings went well, were well attended, and enabled us to continue our education efforts on the Exchange.

6. REMINDER OF UPCOMING ROUNDTABLE: Health Committee Chairwoman Yvette Alexander will hold a Roundtable on our pending legislation on Monday, May 13th at 11 am. Board Chair Akhter and Executive Director Kofman will testify. Scheduling of the vote on the legislation is still uncertain, but it could occur on an emergency basis as soon as May 22, 2013.

7. NEXT BOARD MEETING: We need to do it earlier than the second week in June and would like to do on Thursday, June 6th with an earlier start time of 4 or 4:30 to avoid parking problems in our garage. Staff will follow up on that.

DISCUSSION: Board Members welcomed new staff and Directors Berns and Turnage thanked their staffs for all of their work to help us get through the CMS WAVE II testing. Director Kofman noted that our next phase of IT testing is likely to begin the third week of May and that we've again asked CMS to go at the head of the line.

IV. Issues for Consideration

Eligibility, and Churn Committee Working Group – Wayne Turnage, Chair
Discuss consensus items from eligibility, enrollment and churn working group

Director Turnage, Chairman of the Eligibility, Enrollment & Churn Working Group went through the 8 consensus items (summary of the 8 items is copied below):

CONSENSUS ELIGIBILITY, ENROLLMENT & CHURN RECOMMENDATIONS

1. Income Change Non-Report Threshold

The District of Columbia Health Benefit Exchange will not require enrollees to report a change in income that is below a monthly average of $150 or $1,800 annually. All notice language sent to enrollees regarding the duty to report shall include the following language: "All changes in income will affect the amount of premium tax credit you are eligible for, and could impact your federal taxes, but you are not required to report a change in income below $150/month ($1,800 annually)."

2. Periodic Electronic Notices to Report

The District of Columbia Health Benefit Exchange will send electronic notifications regarding the duty to report changes relevant to enrollment in the Individual Marketplace or for tax credits to individuals who have consented to electronic notifications, on March 31 and June 30 of each calendar year. These reminders are in

addition to the language included in eligibility determination and redetermination notices of the individual's duty to report.

3. Effective Date for Changes During Benefit Year

For those individuals enrolled in a QHP who experience a change in eligibility during a benefit year, but who do not lose their eligibility for enrollment in a QHP, the District of Columbia Health Benefit Exchange will implement eligibility changes determined on or before the 15th day of the month to be effective the first day of the following month. For those eligibility changes made on the 16th day or thereafter, the effective date of the change will be the first day of the second month following the date of the redetermination notice.

4. Default Online APTC Setting

The portion of the online system used by individuals to compare and select plans shall display a default APTC of eighty-five percent (85%) of the maximum APTC the individual is determined eligible for. The online system shall indicate that the amount can be changed to a higher amount, up to the maximum APTC for which the individual is eligible, or a lower amount.

5. Churn Mitigation

Establishment of Care Transition Plans by QHP Issuers:

QHPs in the District of Columbia Health Benefit Exchange shall implement policies that address transition care for enrollees in the midst of active treatment. Such policies must require that QHPs, upon request by the enrollee, allow non-participating providers to continue to provide health care services for the lesser of the remaining course of treatment or 90 days (except that such time limit is not applicable to maternity care). The transition policy shall be similar to that which was adopted by the Maryland Health Progress Act of 2013, as appropriate.

Counseling by In-Person Assisters and Brokers:

In-Person Assisters under contract with the District of Columbia Health Benefit Exchange shall counsel individuals about transition risk upon changes in program eligibility. The training available to In-Person Assisters and Brokers shall include information on risks associated with transitioning from one form of coverage to another during a course of active treatment.

6. Extension of Inconsistency Period for Good Faith effort:

Individuals who make a good faith effort shall be provided an additional 30 days, beyond the 90 mandated in 45 C.F.R. §155.315(f)(2)(ii), to resolve any inconsistencies with Exchange eligibility verification data sources. Good faith effort shall be defined as an individual requesting the additional 30 days from the Exchange either online, through the call center, in-person at a service center, or by mail.

7. Default Termination of QHP Coverage Based on Medicaid Eligibility

The District of Columbia Health Benefit Exchange will terminate an enrollee's QHP enrollment upon notification of Medicaid eligibility with the effective date dependent on the date of the Medicaid eligibility determination. Determinations made on or before the 15th of the month would have a default termination effective the first day of the next month, determinations made after the 15th would have a default effective date of the first day of the second month following the determination. An individual can request to continue enrollment in their

QHP, without any subsidies, before the scheduled default QHP termination date. Individuals will be advised of their default termination date in the redetermination notice sent following the Medicaid eligibility determination. Default terminations do not alter an individual's right to terminate under 45 C.F.R. §155.430.

8. Special Enrollment Periods for "Exceptional Circumstances"

The District of Columbia Health Benefit Exchange will consider it an exceptional circumstance, permitting a new special enrollment period, when an applicant or enrollee does not select a plan during Initial Enrollment, Open Enrollment, or an SEP granted on other grounds, due to one of the following circumstances if the individual does not otherwise qualify for an SEP under the categories in 45 C.F.R. §155.420(d)(1) – (8):

1) *Based on the individual's self-attestation, he/she is eligible for Medicaid but the eligibility determination is pending paper verification of an eligibility factor and the individual is ultimately determined ineligible for Medicaid after the enrollment period has expired. The first day of the SEP shall be the date of the notice of Medicaid ineligibility. This SEP would exclude Medicaid applicants who were denied due to their failure to timely provide the requested documentation.*

2) *An individual misses the Individual Exchange enrollment period while waiting for their employer to be approved for the SHOP. Under this scenario, an individual's employer applies to participate through SHOP during the individual open enrollment period and is ultimately denied due to not meeting minimum participation requirements. By the time the employee is notified that he/she cannot enroll through the SHOP, the individual's enrollment period has passed.*

3) *The individual's enrollment or non-enrollment in a QHP was unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of a QHP issuer, or its instrumentalities as evaluated and determined by the D.C. Department of Insurance, Securities and Banking. In such cases, the Exchange may trigger the SEP and take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.*

DISCUSSION: It was asked how the issues were developed and Executive Director Kofman reminded the Board that many came from the staff and others were discovered during the working group process. A Board Member highlighted that this level of decision-making via a public process is uncommon and demonstrates why the DC Health Exchange is such a strong example of community involvement and how this stakeholder process is so useful and important.

Dr. Akhter emphasized that all of these decisions are consumer friendly and consumer protective.

The IT and Eligibility Working Committee - Leighton Ku, Chair

There were three items on which the Eligibility, Enrollment and Churn Working Group did not reach consensus. Per our process, these three items were referred to the Executive Board's IT and Eligibility Working Committee. The Committee benefited from the participation of Wayne Turnage, Chair of the Eligibility, Enrollment and Churn Working Group as well as the help of HBX staff Alex Alonso who had helped staff the working group.

Dr. Ku described the three issues and discussion happened after each topic.

Pregnancy Special Enrollment Period (SEP): This issue was brought to the Working Group by advocates for women's health. The group was divided with none of the carriers wanting to extend such a special enrollment period, and consumers having mixed opinions on it.

The Working Committee recognized the importance of prenatal and maternity care, but simultaneously the concerns that such a special enrollment period would bring inherent adverse selection. Such a SEP could have the effect of having women wait to obtain coverage before they need it which is one of the overall goals of the Affordable Care Act. Additionally, it was difficult to distinguish an SEP for pregnancy from other compelling situations. Examples include someone who is uninsured and discovers they have cancer or have an accident. Even though all these instances call out for health insurance, based on this discussion, the Working Group decided that no SEP was warranted for this case.

Requiring Qualified Health Plans to Make a Good Faith Effort to Contract with Federally-Qualified Health Centers (FQHCs): The Working Group did not reach consensus on this issue because the carriers uniformly opposed being told with whom they had to contract and there was mixed opinion among the health centers about whether to support his notion. Working Committee Members recognized that it would discourage churn, but felt it would be hard to determine what constituted good faith efforts to include FQHCs in the network. Working Group members were sympathetic to the issue, but determined that they should remain consistent with the work of the network adequacy working group from earlier in the process which decided against adding requirements in this arena, choosing instead to monitor the issue. Board Members believe that there are many incentives and reasons for the plans to contract with the FQHC's already.

Auto-Enrollment in a Similar Plan, and a new Special Enrollment Period: Federal law requires automatic enrollment of individuals who continue into a new plan year with their same plan if that plan continues to exist. However, in some instances, that plan may no longer exist. The Working Group was tasked with determining if there should be an automatic enrollment process into a similar plan in that instance. A similar plan would be defined as the same carrier, the same metal tier, and the same provider network. The working group considered several options in this instance, but did not reach consensus.

The Working Committee chose to combine two of the approaches considered by the Working Group as this combined approach was most protective of the enrollee. If there is a similar plan, the Exchange will automatically enroll the individual if they haven't made another selection. However, that individual will then have a new special enrollment period of 60 days to select a different plan if this one didn't meet their needs. The Working Committee also clarified that if there is not a similar plan, there will be no auto-enrollment. However, there would be a new SEP to allow that individual one more chance to select a plan in the new year.

Plan Management Committee - Dania Palanker, Chair

Recommendations to encourage tobacco cessation and other preventive benefits: She reminded the Board that this issue had been sent to the Plan Management Committee at their request and that it had led to a

robust discussion of the need to do outreach and education surrounding the new no-cost preventive benefits. She also made clear that their Committee did not want to add costs to the plans and recognized that plans already communicate with their enrollees and providers and that it would be better to add to those notices than to create additional ones.

They reached consensus on the following six recommendations:

1) As part of the general information on the DC HBX website, HBX should provide descriptive information on the ACA covered preventive services including tobacco cessation and when feasible, link to carrier websites which describe the availability of their tobacco cessation/preventive benefits.

2) Recognizing that carriers now communicate with new enrollees, ensure that carriers include information about tobacco cessation and other preventive services in their new member communication. Note: this recommendation is not intended to duplicate existing communication or add to costs.

3) Recognizing that carriers now communicate with providers, ensure that carrier communications to their providers include up to date information on the preventive benefits and tobacco cessation programs to be provided with no cost sharing. Note: this recommendation is not intended to duplicate existing communication or add to costs.

4) As part of training for navigators, in-person assistors (IPAs), and certified application counselors (CACs), the DC HBX should require descriptive materials on the availability of no cost preventive services including tobacco cessation for use in enrollment counseling sessions. These counselors should stress the importance of enrollees speaking directly with their carrier to obtain more information on these benefits.

5) Utilize alternative vehicles for communication, other than carriers, including providing educational materials to small business owners and benefit administrators on the availability of preventive services including tobacco cessation.

6) Maintain ongoing discussions with key stakeholder groups to identify additional opportunities to increase the use of preventive services including tobacco cessation. Stakeholder groups should include at least carriers, providers, and community organizations.

DISCUSSION: Board Member Leighton Ku, who originally raised this issue at an earlier board meeting complimented the work of the Plan Management Committee and emphasized that they had done a terrific job in grappling with these issues. There was also a discussion about the concerns of sometimes having no cost sharing preventive services convert to diagnostic services with patients then having a cost sharing requirement. This is a problem in Medicare with colonoscopies, but it was supposedly fixed for the ACA. We need to remain on the lookout for those issues so we don't replicate that problem. A preventive service should stay that and should be provided at no cost. Executive Director Kofman said we would add that to our list of issues to stay on top of.

V. Public Comment

Request was made for public comment for those in attendance and those on the phone. No comments were provided.

VI. Votes

1) There are 8 consensus items from Eligibility, Enrollment and Churn committee with resolution for each. Chairman Ku proposed to vote on them en bloc unless reservations by any board member.

   All agreed.

   Motion made and seconded to approve all 8 consensus items en bloc.

   Unanimously approved.

2) Automatic Enrollment in Similar Plan with a new SEP, the full resolution was read by Leighton Ku, Chair of the Eligibility and IT Working Committee.

   Motion made and seconded to approve the resolution

   Unanimously approved.

3) Recommendations to encourage tobacco cessation and other preventive benefits , the full resolution read by Leighton Ku

   Motion made and seconded to approve the resolution

   Unanimously approved.

VII. **Contracting Update** - by Executive Director Mila Kofman. The Board received copies of the three items for voting today and reviewed prior to the meeting.

1. Outside legal counsel – received 4 proposals, will conclude and ask for Board approval next week or following week.

2. 3 IT Procurements – emergency procurements were needed for three critical IT staffing contracts to help complete the IT build on time. It was clarified that there will be cost allocation of monies with regard to Medicaid and that DHS has worked that out at the staff level.

   Networking for the Future $811,800
   New Light Technologies $488,000
   Enlightened $561,600

   These are all do not exceed amounts and if approved will be effective April 30 (retroactive).

   Board unanimously approved these three contracts.

Mercer Actuary contract – This is a proposed sole source contract for actuarial services to have HBX review the rate filing that will be filed with DISB by the end of May. The Exchange is not supplanting the work of DISB, but providing them feedback on the rates. This is on a fast track because the current deadline for rate filings is May 15th although the Exchange will likely extend that deadline to the end of May. There was discussion of when rates will be made public and Director Kofman said that it's her understanding that no filings will be made public until all the plans have filed. This led to a discussion of the Maryland rate filings and whether we expect similar filings here. Director Kofman noted that the DC risk pool is very different from that of Maryland. The District has the second lowest uninsured rate in the nation, and that the 42,000 uninsured individuals are younger and healthier. Additionally, the District doesn't have a pre-existing condition pool whose members will join the Exchange unlike Maryland.
Mercer contract is estimated to cost approximately $150,000. However, we do not know the number of plans that will enter the marketplace. Therefore this contract should have flexibility built in and will not exceed $500,000.

The Board unanimously approved this contract.

3. Grant Administration and Oversight of IPA Program - Institute of Public Health Innovation
Dr. Levin disclosed that he sits on the Board of the Institute of Public Health Innovation and will not take part in the discussion of this proposed agreement.

Director Kofman proposed a sole source agreement with the Institute for Public Health Innovation (IPHi) to provide grant administration and oversight of the grants for the in-person assister program. She described the program and noted that the Board had just voted to establish an in-person assister program on April 19, and time was of the essence. In the next two weeks the Exchange needs to contract with a grants administrator to help finalize and issue the RFP for the assister grants. This timeline will help ensure a good response from potential assister entities and allow sufficient time to select recipients and train them. Section 2E of our contracting rules allows us to use sole source procurement when only a single entity can provide a service. Director Kofman indicated we reached out to a number of potential vendors locally, but all lack either the experience or the ability or the capacity to administer the program on our tight timeline. The vendors who did have the necessary experience could not offer a competitive price.

Director Kofman indicated the Institute for Public Health Innovation is a DC based not for profit that is able to provide support to us to manage the overall grant making process. IPHi can provide program administration, monitor grantees and support them and help with the reporting. This entity has experience managing a broad range of government grants at both the state and federal level and is one of the leading experts in the District in the design and implementation of navigator type programs.

This entity's scope of work for the first year would not exceed $335,526.00 and we have the option to extend that through December 2014. If we chose to execute the option, it will not exceed an additional $203,349.00.

The Board unanimously approved the contract.

VIII. Adjournment

The meeting adjourned at 7:13 pm.