DC Health Benefit Exchange Authority Executive Board Meeting Minutes

Wednesday, February 12, 2014

1100 15th street NW, 8th Floor

Members Present: Dr. Henry Aaron, Dr. Mohammad Ahkter, Dr. Leighton Ku, Diane Lewis (Chair), Kevin Lucia, Chester McPherson, Khalid Pitts, Kate Sullivan Hare, Wayne Turnage (via telephone),

Members Absent: David Berns**,** Joxel Garcia

I. Welcome, Opening Remarks and Roll Call, *Diane Lewis, Chair*

There was a roll call of members present to confirm that there was a quorum. A quorum was met with seven voting members present listed above.

II. Approval of Minutes, *Diane Lewis, Chair*

The minutes from the January 15th meeting were unanimously approved.

III. Executive Director Report, *Mila Kofman, Executive Director*

- There was a hearing on permanent policy legislation on January 29th before the Health Committee in which Ms. Kofman and Ms. Lewis testified. The next Oversight hearing will be February 26th and the Budget Hearing is tentatively scheduled for May 9th. The Exchange was asked to submit answers to written questions for the hearing; once they are drafted they will be presented to the Board for feedback.
- Currently working with DISB on timeline for submission rates and forms for 2015. As soon as there are dates and timelines the Exchange will seek feedback from health plans to ensure that the timelines are reasonable.
- DC Health Link Outreach events January 15th :

- Participating at numerous tax centers in the city to enroll consumers at those locations,
- Congresswoman Norton’s tax day
- Union Market outreach and enrollment
- “Skating on Thin Ice” geared toward Young Invincibles

Board member Chester McPherson joined the meeting.

IV. Executive Board Finance Committee, *Dr. Henry Aaron, Chair*

A process was established for approving change orders for the IT contract between DHS and Infosys. The Exchange pays either the cost allocated amount for service or the full amount. Change orders that cost $100,000 or more must go through the finance committee before going to the Board. The committee also reviewed the FY 2013 and 2014 spending for the Exchange based on information from the Exchange, DHCF and DHS. There was a focus on spending paid for by Federal level 1 and 2 grants. In addition, the committee reviewed the financial sustainability issue and approved the financial sustainability report to present to the Mayor and Council that the Board later approved.

V. Enrollment Update, *Mila Kofman, Executive Director*

Enrollment data was released February 10th:

- 5,090 people enrolled in private health plans through the DC Health Link individual and family marketplace;
- 8,451 people gained Medicaid coverage through DC Health Link; and
- 12,639 people enrolled through the DC Health Link small business marketplace.

In addition, enrollment data by metal levels (bronze, silver, gold, and platinum) demonstrates an even distribution which is different compared to other jurisdictions. DC has a young risk pool; 60% of uninsured are under age 40. The largest enrollment age category is 26-34 year olds at 37%.

Ms. Kofman expressed her continued concern about the population that is eligible for Advance Premium Tax Credits (APTC) and has not yet selected a health plan. About 90% of those enrolled in a health plan are full pay. Ms. Kofman thanked Dr. Ku and his colleagues at George Washington University for providing the uninsured and demographic data. The data shows that about 8,800 people in DC qualify for APTC. The Exchange team is shifting gears to target this population to get them enrolled. The team is following up with calls and emails to put these consumers in direct contact with DC Health Link trained experts.

Mr. Christian Berrera, a representative of the Deputy Mayor, inquired if there was a goal for the amount of people to enroll per month.

Ms. Kofman responded that the long-term goal is to reach universal coverage in three years. The Exchange staff goal for open enrollment in the first three months was to enroll 5,000 people and expectations were exceeded. Ms. Kofman added that success will not be achieved until every person in the District has health insurance coverage.

VI. 2014 Policy Priority Recommendations, *Chris Gardiner, Standing Advisory Board (SAB), Chair*

The Standing Advisory Board had been asked to review 2014 policy priorities and make recommendations to the Board. (Appendix A)

Network Adequacy – Mr. Gardiner stated that the 2013 resolution calls for a hybrid approach, whereby insurers attested for the 2014 year to network adequacy. During 2014, Health Benefit Exchange (HBX) staff is to work with the Department of Insurance, Securities and Banking (DISB) to monitor network adequacy and carriers are to submit access plans by July 2014 that report how they have met network adequacy requirements and their plans to correct any deficiencies. In 2015, based on data presented to HBX through the aforementioned reporting, HBX is to issue a request for additional data on District-specific metrics with the goal of having District-specific standards for 2016. Mr. Gardiner reported that SAB considered network adequacy a top priority.

Standardized Benefits – The resolution approved in 2013 called for DISB to develop standardized plan models for gold and silver plans in 2015 and bronze and platinum plans in 2016. Mr. Gardiner noted that SAB recommends that this project be delayed until 2015.

Quality – The resolution approved in 2013 lays out a variety of requirements on quality for the future. For 2014, it requires that QHPs start submitting a Quality Improvement Plan annually and make them available on the Exchange website for the public. It also requires that the Exchange work with QHP issuers to upload off-the-shelf quality information to DC Health Link. Mr. Gardiner noted that quality standards are still being developed by the U.S. Department of Health and Human Services (HHS), so this project should wait until 2015.

Composite rating – The Board previously approved a composite rating system for SHOP premiums, but the system's technology has been unable to support it. Mr. Gardiner noted that SAB thought it was an important issue and should be addressed as soon as possible.

Preventive Benefits Outreach/Education – The approved resolution aspired to ensure that the website provides information about preventive benefits, and that carriers communicate with enrollees and providers about these important benefits. As part of the training for DC Health Link Assisters, they are provided descriptive materials on tobacco cessation treatment and other

preventive benefits. The resolution also envisioned that HBX utilize alternative vehicles for communication, such as providing educational materials to small business owners and benefit administrators, and that HBX maintain ongoing discussions with key stakeholders to identify additional opportunities. Mr. Gardiner stated that SAB wanted to take a longer look at this issue and will have recommendations at a later date.

De-certification processes – Mr. Gardiner noted that these processes need to be developed for health and dental carriers, brokers, certified application counselors and navigators. He stated that development of decertification processes should be a priority for 2014.

Market Study on Employee Choice – The approved resolution calls for a market study to collect valid data that includes: a survey of employers and employees regarding their experience with employee choice; actuarial analysis of premiums; examination of options to expand employee choice; and an evaluation of the experience in administering employee choice. Mr. Gardiner stated that a market study is important to conduct, but it is premature at this time. The SAB recommendation is to conduct the study later in 2014 when the HBX has sufficient information to move forward.

Survey on new coverage – Mr. Gardiner noted that the system does not capture whether someone was previously uninsured prior to enrolling for coverage through DC Health Link. The SAB recommendation is to conduct a survey after open enrollment to determine prior insurance status (uninsured; insured but a preexisting condition not covered; insured but affordability issues for OOP and premiums; whether tax penalty lead the person to buy insurance, etc.)

Shifting from enrollment focus post March to a focus on ensuring people are able to use their insurance effectively – Mr. Gardiner stated the SAB will discuss this issue and provide recommendations to the Board.

Dental Plans – Mr. Gardiner noted the ongoing concern from dental insurers is that qualified health plans should be required to offer policies through DC Health Link that do not include pediatric dental benefits. SAB recommends that the Dental Plans Advisory Working Group be re-established to consider this item as soon as possible.

Broker Steering/CAC Steering/IPA Steering – Mr. Gardiner noted that any potential problem would be monitored through the complaint process.

Federal Grace Period for premium payments by APTC enrollees –Mr. Gardiner noted the disconnect between the 90-day grace period for enrollees and the 30-day claims payment requirement. Providers (mainly doctors and hospitals) could be on the hook for care provided to APTC enrollees who have failed to pay premiums after 30 days. He stated that a working group of SAB would be formed to provide recommendations to the Board. Standing Advisory Board Member, and physician, Barry Lewis, agreed to vice chair this Advisory Working Group.

DISB Enforcement of the ABT services as part of the habilitative benefit – Mr. Gardiner noted that this issue had been raised. The SAB recommendation is to have the Plan Management Advisory Committee review this issue as part of their overall review of consumer information.

Consumer Information: The SAB discussed whether better access to plan design information and drug formulary information could be made available on DCHealthLink.com rather than requiring consumers to consult the summary of benefits and coverage. Mr. Gardiner explained that the Plan Management Advisory Committee has already begun meeting to provide recommendations for additional information that can be put onto DCHealthLink.com to improve customer shopping.

*Discussion:*Dr. Akhter statedthat the Board should look carefully at how to collect information on these priorities. He stated it must be done in an analytical and thoughtful way in order to be credible.
Dr. Aaron stated that the priorities touch on a wide range of topics, such as allocation of resources, how to measure consumer satisfaction, and determining methods of presenting information to consumers on plan selection. Dr. Aaron agreed with Dr. Akhter on approaching this systematically.

Mr. Lucia inquired about additional data needed for standard benefits. Ms. Kofman responded that to make informed decisions about standardizing not only benefits but cost sharing, we need to know what plans consumers are enrolled in. She noted that proponents of this issue have data from other states. At present, we do not know much, and without information, any analysis would be performed in a vacuum. She believes that data will inform the discussion.

Mr. Lucia inquired if the priority list was a unanimous vote from the SAB. Mr. Gardiner confirmed that it was. Mr. Lucia added that the quality policy issue should not wait until 2015. Ms. Sullivan commented that it would be better to wait until HHS provides guidelines to address this priority in 2015. Ms. Kofman responded that federal government plans to issue very prescriptive guidance on quality.

Mr. Pitts inquired if the Exchange staff or SAB will decide on the metrics for standardized benefits. Ms. Kofman stated that after open enrollment is over March 31st and all consumers have paid their premium the team can analyze more accurate data to see, for example, what the popular plans are, HMO vs. PPO, and metal levels.

Mr. Lucia inquired about network adequacy as a top priority. Mr. Gardiner responded that after Ms. Kofman presented these priorities to SAB members it was viewed as important to consumers. Ms. Lewis added that consumer advocates were very vocal on this issue and were pleased that it is a priority issue.

Dr. Aaron noted that network adequacy is a tricky area. He noted that carriers can use networks to redline and carve out undesirable risks. While that result is not good public policy, narrower networks can reduce costs, and carriers should not be inhibited. Ms. Kofman noted that the Board already approved the policy decisions to tackle the issue, but we needed to find out what was happening on the ground.

Ms. Kofman stated that two surveys would be conducted for 2014 going into 2015: the consumer survey to determine newly insured numbers would be sooner; and the market survey, later.

She thought a Board committee should be established to address data issues. Ms. Lewis agreed and said she would appoint members to a new Executive Working Committee on Data Collection & Analysis Mr. Lucia stated that the committee should determine all the data that needs to be collected, and not just for the two surveys.

Dr. Akhter moved, and Mr. Khalid seconded, to approve the 2014 Policy Priority Issues recommendations from the Standing Advisory Board. A roll call vote of the Board members present was unanimous in favor of approving the resolution. Those voting in favor were: Dr. Aaron, Dr. Akhter, Dr. Ku, Ms. Lewis, Mr. Lucia, Mr. Pitts, and Ms. Sullivan Hare.

VII. Proposed Assessment Rule for Financial Sustainability, *Dr. Henry Aaron, Finance Committee Chair*

Dr. Aaron stated that the draft for the assessment rule was posted on the Exchange website for informal public comment. Based on the comments received one modification was being recommended to the Board, to change the 10 payment period to 30 days.

Ms. MaryBeth Senkewicz, DC HBX staffer, briefly reviewed the efforts of the Financial Sustainability working group that was chaired by Dr. Ku with assistance from Wakely Consulting with actuarial projections and other issues. Wakely modeled three options for financial sustainability of the Exchange: 1) assessment on Exchange enrollment only; 2) assessment on total non-group and small group market; and 3) assessment on the entire health insurance market.

On June 6th there was a unanimous vote by the Board for the recommendations from the working group. On December 13th the Board approved financial sustainability draft report which states "the Authority intends to adopt a rule that provides for the imposition and collection of a licensing fee by assessing all health insurance carriers in the District."

Informal public comments included:

- Dislike for open-ended assessment. Ms. Senkewicz disagreed that it was open-ended as it is tied to the Exchange budget.

- HIPAA excepted benefits should not be included in funding the exchange. Ms. Senkewicz noted that the modeling showed that a market wide assessment results in the lowest premium percentage assessments across the most carriers.
- Medicaid MCOs not being included, citing federal law issues. This issue has been discussed at length with Director of DCHF Wayne Turnage and he agrees with Medicaid MCOs participating in the assessment.
- Legal basis of the assessment (user fee, licensing fee versus other assessments). This issue was specifically addressed in Financial Sustainability Report to the Mayor and the Council.
- Reevaluate the position in two years or try to go even broader than just assessing the carriers. The working group thought the general fund issue was not feasible.
- Timing issue- when will the carrier know what and when the assessment will be. Ms. Senkewicz stated it does not need to be in the rule. HBX intends to issue the assessment by the end of the second quarter in 2014.
- Clarify that premiums attributable to employees FEHP should not be included in the assessment. Ms. Senkewicz stressed that FEHBP premiums are not included pursuant to federal law. However, premium attributable to congressional employees enrolling through the DC SHOP Exchange are included. Those premiums should be reported on the NAIC blank as small group premium.

Discussion:

Ms. Sullivan Hare inquired about second option from the Wakely consulting group for financial sustainability. Ms. Senkewicz responded that the second option, non group and small group markets, included all health insurance, not just major medical coverage.

VIII. Public Comment

Ms. Geralyn Trujillo of America's Health Insurance Plans (AHIP) stated that AHIP wants to work with HBX and ensure that the exchange is strong financially. She commented that carriers are concerned about an open-ended assessment and a clearly defined budget. AHIP members are worried about unilateral change. AHIP believes consumers and members could potentially be put in jeopardy. In terms of legal authority, Ms. Trujillo urged HBX to make sure that point is evaluated. Under federally-facilitated marketplaces, HIPAA excepted benefits are excluded from the funding base. Ms. Trujillo stated support for exchange funding that is as broad as possible. Supplemental benefit carriers are very concerned for themselves financially and for consumers. She questioned whether a cap could be placed on the percentage of premium assessed.

Mr. Pitts inquired about a mechanism for those to express their recommendations for the assessment. Ms. Senkewicz stated if the Board gives an affirmative vote for the assessment the rule will be submitted to the DC Register for formal public comment. Once it is published that will start the 30 day comment period.

Mr. Lucia inquired about HIPAA excepted benefits products. Ms. Trujillo stated that those include long-term care, disability income, and Medicare supplement insurance. Ms. Cindy Goff of AHIP stated that many of these products are indemnity-based, but there are products like Medicare supplement which are expense-based but pay the portion that Medicare does not cover. These products do not cover major medical expenses. The majority of indemnity products are sold as supplemental products.

Dr. Aaron disagreed that a cap could be placed on the percentage of premium assessed. He noted that the exchange budget will vary from year to year. In 2016, the small employer definition will increase to 100 employees. The Authority could decide to increase participation to include large employers. It is impractical to impose a cap. Furthermore, the exchange budget is vetted through the District budgeting process and is subject to Congressional oversight. He thought it was inaccurate to say the assessment is open-ended.

David Wilmont of DC Association of Health Plans applauded the broad based approach, but stated that it could be broader and the general fund should be included. He noted that his members were not unaccustomed to assessments. He did think a ceiling should be placed for the assessment rate in order for costs to remain reasonable. He stated it was preferable to be classified as a tax because it can be excluded from the health plan benefits administrative costs for the purpose of the medical loss ratio.

Ms. Laurie Kuiper of Kaiser Permanente applauded the very thorough, thoughtful, deliberative and transparent process employed by HBX and the working group. She stated that the financing mechanism should be revisited in the future for the opportunity to make it broader. She supported the rule as drafted.

Ms. Joann Waiters of American Council of Life Insurers (ACLI) stated concern about long term care and disability income products sold by some ACLI members. ACLI's concerns include that the proposal is not legally sufficient, is inequitable and of questionable constitutionality because the carriers get no direct benefit from the assessment, that the impact of the assessment will result in premium increases, and that the assessment is open-ended and the rate is not specified.

Mr. McPherson inquired about indirect benefits and wanted the industry to address indirect benefits. Ms. Goff responded the Exchange was created to ensure that people had major medical coverage and the insurance products being discussed cannot be sold on the Exchange. She stated she could get more detail on indirect benefits. Dr. Ku added that a consumer may choose to have a supplemental plan depending on the cost sharing among the different metal levels.

Marty McGuinness of UNUM stated that it is not fair to be assessed for products that cannot be offered on the exchange. He noted that many more carriers would have liked to attend the meeting, but he admitted they became aware of the issue late in the process. He stated that the cost to UMUM will be about $400,000. He asked the Board to consider excluding excepted benefits or delay the adoption of the rule.

Dr. Aaron moved, and Mr. Lucia seconded, to approve the rule with the 30 day amendment. A roll call vote of the Board members present was unanimous in favor of approving the rule. Those voting in favor were: Dr. Aaron, Dr. Akhter, Dr. Ku, Ms. Lewis, Mr. Lucia, Mr. Pitts, and Ms. Sullivan Hare.

VI. **Closing Remarks and Adjourn to Executive Session**

A motion was made to move into closed executive session pursuant to DC Code Sections 2-575(b)(2) and 31-3171.11 to discuss contracting matters. Upon a unanimous roll call vote of the members present, the meeting went into closed executive session. Voting in favor were Dr. Aaron, Dr. Akhter, Dr. Ku, Ms. Lewis, Mr. Lucia, and Ms. Sullivan Hare, Mr. Pitts. The meeting moved to closed session at 7:34 PM.

Appendix A

2014 POLICY PRIORITIES January 31, 2014

POLICY ISSUE	2014	2015	Working Group or Advisory Committee 2014	Standing Advisory Board 2014
NETWORK ADEQUACY	Top Priority			
STANDARDIZED BENEFITS		Will have more data and experience to inform development of standardized plans		
QUALITY		HHS regulations will inform this (prescriptive)		
COMPOSITE RATING	Important priority to move forward Issue: IT timing			
OUTREACH ON PREVENTIVE BENEFITS				✓
De-Certification Processes	✓			
Market Study on Employee Choice	Important, but per the resolution, need to wait to do until we have more experience			
Survey on New Coverage	Top Priority After open enrollment in 2014			
Shifting focus from enrollment to ensuring				✓

people are able to use their insurance				
Stand Alone Pediatric Dental Plans			Re-establish last year's working group which didn't get to this issue so that they can consider it.	
Broker, CAC, IPA Steering	Will monitor through a complaint driven process			
Federal Grace Period for premium payments by APTC enrollees			Establish a working group in May – after we have some experience in the new marketplace. Dr. Barry Lewis of the SAB has volunteered to Vice Chair.	
Applied Behavioral Analysis Benefit			Plan Management Advisory Committee – asked to review this issue as part of their broader look at consumer information.	
Consumer Information on health plans			Plan Management Advisory Committee – meetings start Feb 5, 2014 to look at how we can improve the website to	

			provide better consumer information on plans. Will also look at better ways to link through to plan information.	