Health Benefit Exchange Authority Executive Board Meeting

FINAL MINUTES

Date:	**Monday, January 12, 2015**
Time:	**5:30 PM**
Location:	**1225 Eye Street, NW, 4th Floor, Board Conference Room**
Call- in Number 1:	1-877-668-4493; access code: 730 225 966
Call –in Number 2:	After Executive Session, the Executive Board will reconvene for additional Executive Board Business, the call in line will be: 1-877-668-4493; access code 736 271 343

Members Present: Henry Aaron, Deborah Carroll, Kate Sullivan Hare, Nancy Hicks, Leighton Ku, Kevin Lucia, Diane Lewis, Khalid Pitts
Members Absent: Chester McPherson, Wayne Turnage

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

Chair Diane Lewis called the meeting to order at 5:45 pm. A roll call of members present confirmed that there was a quorum with seven voting members present (Dr. Aaron, Ms. Sullivan Hare, Ms. Hicks, Dr. Ku, Ms. Lewis, Mr. Lucia, Mr. Pitts). Ms. Lewis welcomed new Board member Nancy Hicks to the group.

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

It was moved and seconded to add an item, "Update from Standard Plans Working Group," to the agenda. The motion passed unanimously with all voting members voting yes. It was moved and seconded to add an item, Oracle software license contract, to the agenda. The motion passed unanimously with all voting members voting yes.

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

The minutes from the December 10, 2014 meeting was unanimously approved by voice vote with all voting members voting yes.

IV. Executive Board Business, Discussion and Vote on 2015 Executive Board Committee Assignments – *Diane Lewis, Chair*

It was moved and seconded to adopt the Committees and assignments as reflected in the "Executive Board Working Committee Membership 2015." Ms. Sullivan Hare requested that SHOP issues be given a high priority. Ms. Kofman stated that a working group needed to be appointed with a Board member as chair and perhaps a Standing Advisory Board member as vice-chair to address a variety of small group issues still being researched by staff. The Committees and assignments were unanimously approved by voice vote with all voting members voting yes.

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

Ms. Kofman reported that in December, HBX staff commented on two proposed rules from the federal government. The first was on the multistate plans (MSP) proposed regulation directed to OPM, strongly opposing any assessment with respect to those plans that would be passed on to state-based marketplaces, carriers or consumers. She reported that staff time is devoted to the MSPs since they are slightly different than the other QHPs, so that in fact it costs HBX to administer the MSPs. The second set of comments were to CMS, focusing on some proposed technical definition changes that would require IT changes and therefore would cost HBX unbudgeted dollars to implement, and commenting on the proposed open enrollment dates. Ms. Kofman stated the comment letters would be posted on the website.

Dr. Ku asked if the federal government or HBX approved MSPs. Ms. Kofman responded that OPM works very well with both HBX and the Department of Insurance, Securities and Banking (DISB). DISB ensures that local requirements and OPM ensures that the federal requirements are met. Once OPM certifies an MSP and the underlying rates and forms have been approved by DISB, the plan can be sold through DC Health Link.

Ms. Kofman next addressed 1095As, a form that a state-based marketplace (SBM) is required to send to policyholders, which documents the coverage the person had for individual responsibility purposes. It will also indicate the APTC of the covered person. They must be sent by the end of January 2015. HBX will send them in phases and all will be sent by the federal deadline. HBX staff has been working with its carrier partners to ensure as much accuracy as possible. Customers will have an opportunity to correct the 1095A if they can demonstrate it is not accurate. The Call Center staff is being educated on the issue so staff can answer any questions that might come in. The IRS has issued guidance. Ms. Kofman's biggest concern is that the IRS does not have sufficient resources to handle inquiries about this new requirement. HBX is not a tax expert, but will help a consumer as much as possible. In addition to mailing the paper form, HBX staff is working to make them available to be downloaded electronically.

Ms. Kofman explained that HBX sends significant data reports to IRS annually and monthly. The annual report has fields that include the 1095A information plus other information. The reports are required to be in a specific format.

Mr. Lucia asked if HBX had discretion to send a cover letter with the 1095A. He was aware that the Robert Wood Johnson Foundation was helping states to determine the right information to go into the cover letter. Also, a colleague at work was working with state Departments of Insurance (DOI) with standard information since the DOIs are expecting calls as well. Ms. Kofman thanked him for that intelligence, and noted that staff has draft copies of letters from other SBMs and would develop an appropriate cover letter, including

instructions on how to make corrections. Dr. Ku suggested contacting TurboTax and H&R Block. Ms. Kofman stated that HBX is in conversations with Intuit to see if the goal of the tax software being able to pull the relevant data and prepopulating tax return forms.

Mr. Lucia asked if HBX had received any requests for exemptions regarding the tax penalty. Ms. Kofman said HBX relies on CMS, so she would check with staff to see if any come through HBX and she would get back to the Board.

Ms. Sullivan Hare asked about the concern that carrier records be accurate. Ms. Kofman said that HBX had been working with the three carriers since the summer on reconciliation of data. She recognized, however, that no system is 100% accurate and HBX works with customers to ensure accuracy.

Ms. Sullivan Hare asked how employees in SHOP received their data. Rob Shriver, Director, Marketplace Innovation, Policy and Operations, HBX, said employees receive the information through their employer. Discussions are occurring as to what the marketplace responsibilities might be in the future, but for now it is from the employer.

Ms. Kofman reported on enrollment:

October 1, 2013 – January 11, 2015 cumulative history:

970,159	Total website visits	
74,180	Total number of people who came through DC Health Link	
39,137	Medicaid eligible	
19,473	Individuals who selected a plan. Includes:	
	15,729	2014
	3,744	2015
	13,242 passive renewals in 2015	
	2,558 new customers	
15,570	Total covered lives SHOP. Includes:	
	13,711	Congressional
	1,726	non-Congressional

Existing 2014 individual market customers:

1,186	Total made changes
651	Changed plan
451	Changed metal level
118	Changed carrier

Ms. Kofman said the numbers correlate to what happens with large employers and open enrollment – the vast majority of employees do not make changes to their health plan. HBX messaging was, if you are happy with your plan, do nothing. If you are unhappy or want to shop around and maybe find a better deal, go into the system and make changes.

Mr. Lucia noted that other SBMs may have acted differently the HBX. For example, people in the Rhode Island exchange had to proactively go into the system to renew or change. He wondered what level of change took place there; whether active renewal resulted in more customers making changes. He thought the process we used this year was fine, but he is interested in research on the issue. Dr. Aaron agreed. For example, in 401ks active opt-in or out makes a huge difference. He believed HBX should research what happened in other states. Mr. Lucia thought we should look at it over the next two-three years. Ms. Kofman thought that for the next open enrollment, HBX should target those in the second-lowest silver plan. That plan changed from 2014 to 2015. She agreed that HBX could learn a lot from what happened in other states.

Dr. Ku wondered of those who changed metal level, did they go up or down? Ms. Kofman said she would get back to the Board with that information.

Ms. Kofman stated the numbers would be posted to the website.

Ms. Hicks thought the numbers were quite good. She asked if HBX had a target number for the open enrollment occurring presently.

Ms. Kofman replied that last year, no target number had been set. The ultimate goal is near-universal coverage in three to five years. She noted that staff had learned lessons from last year's open enrollment that are being used for this year.

VI. **Finance Committee Report,** *Henry Aaron, Chair*

Dr. Aaron reported that the Finance Committee met earlier in the day.

CURRENT MONTHLY SPENDING: The Committee reviewed monthly expenditures by HBX. Nothing was out of the ordinary.

CONTRACT APPROVALS: The Committee approved five contracts that will be discussed later this evening during our executive session and then voted on by the full Board when we return to public session tonight.

CITYWIDE AUDIT: The Committee was updated by HBX Staff regarding the ongoing City-Wide Audit which HBX is subject to. KPMG auditors are currently completing their field work and testing. Once completed, HBX management will be notified of any findings and or recommendations and be given an opportunity to respond…all is on course for a February 1st submission to Congress.

VII. **Insurance Committee Report,** *Kevin Lucia, Chair*

Mr. Lucia reported that in early spring of 2013 the Executive Board established a stakeholder working group to advise the Board on the initial certification process. The Board adopted the consensus recommendations, which HBX has been using to date.

Now with two years of experience, the Insurance Committee is reviewing the process in preparing for plan year 2016.

The Committee has met four times. At the first, the Committee reviewed each certification requirement and the legal authority for each requirement at the federal and district level.

Based on public input and our review, we decided to take a deeper dive into the following certification requirements:

1. Network Adequacy
2. Review of Rates
3. Quality of Health Plans
4. Discrimination

The implementation of these requirements is a joint effort with the District's Department of Insurance Securities and Banking and we appreciate all their prior and continued efforts on this.

At the Committee's second meeting DISB and HBX staff reviewed how each of these certification requirements has been implemented.

At the third meeting, the Committee heard from numerous 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. In addition, the Committee asked HBX staff to develop recommendations taking into consideration staffing, capacity and feasibility.

At the fourth meeting last Friday morning, the Committee reviewed HBX staff DRAFT recommendations where committee members and the public were able to ask questions to fully understand the recommendations.

In the process of developing these recommendations, HBX staff have talked to DISB and each health carrier participating in the exchange marketplace numerous times to understand their operations and ability to implement different ideas that were presented by experts in the field.

The Committee is soliciting and encouraging comments on these recommendations. The recommendations and directions for submitting comments can be found on our website www.hbx.dc.gov under Executive Board Committee, Insurance Market Committee meeting materials. Comments are due by 12 noon on Tuesday, January 20, 2015.

The next Insurance Market Committee meeting will be an in person meeting at 1:00 p.m. on Wednesday, January 21, 2015. At that meeting the Committee will deliberate to consider the comments, take further public comment, amend the recommendations as appropriate, and vote on a set of recommendations.

The Committee needs to act quickly in order to have the recommendations in place for the certification process this current year (for plan year 2016). So once the Insurance Committee votes, Mr. Lucia will present the recommendations to the Board for a discussion and vote.

VII. Standard Plans Advisory Working Group Update, *Leighton Ku, Chair*

Dr. Ku reminded the Board members that it had previously adopted standard plan recommendations from the working group. The federal government recently issued a draft 2016 Actuarial Value (A/V) Calculator. The new calculator potentially alters the value of all the standard plans, but it definitely alters the bronze plan, raising the A/V above the maximum allowed (about 60% to 65%). The bronze plan, and all bronze plans in general, will therefore be skinnier. His intent is to quickly reconvene the working group and come back to the Board as soon as possible with alternative recommendations and modifications to the standard plans. If consensus is not achieved, then the Insurance Market Committee would be drawn into the process.

Dr. Aaron recollected that the standard bronze plan deductible was already near the maximum. Mary Beth Senkewicz, HBX staff, noted that to bring the bronze plan A/V down would require changes to more than just the deductible and maximum out-of-pocket (MOOP).

VIII. Research & Data Analysis Committee Report, *Leighton Ku, Chair*

i. "Covering the Uninsured through DC Health Link, Report on the First Year"

Dr. Ku reminded the Board members that an email survey had been conducted in late 2014 to try to determine how many people now in QHPs or Medicaid were previously uninsured. He used the survey and the 2013 American Community Survey to tabulate results. As of 2013, the census data showed about 42,000 uninsured in the District. The email survey showed that roughly one-quarter of people in QHPs and nearly half of those in Medicaid had been uninsured. That translates into about 18,000 people now with coverage were previously uninsured; that is roughly 43% of the 42,000 uninsured in 2013 now had coverage. However, he noted that it would take broader survey data to come up with numbers that are more comfortable for him. He bemoaned the fact that the report did not get much press. Ms. Kofman stated that it had been shared with Council staff and the Mayor's office. There was one television report on it.

IX. Discussion Item

a. Outreach use of Research & Data Analysis Committee Data – *Linda Wharton Boyd, HBX Staff*

Ms. Wharton-Boyd reported that outreach staff had reviewed the data reported by Dr. Ku and analyzed the outreach plan against the data. Wards 4, 5, 1 and 8 had the highest percentage of uninsured people. The outreach strategy was revised based on the information. Specifically, some outreach events were rearranged to focus on those wards.

Mr. Lucia asked about the in-person assister program, and were they funded this year? Ms. Kofman said yes, they were, and it is a very strong group. Some of the assisters will accompany Ms. Wharton-Boyd to the White House later this week for strategic planning around the Young Invincibles. They attend lots of enrollment events. They had updated training last week and have been very active and helpful with the enrollment efforts. They also staff the storefronts.

Mr. Lucia asked whether any of the assister organizations can continue to help once the federal dollars are no longer available by becoming certified application counselors (CAC). Ms. Kofman said many of the assister organizations have become CACs; many have funding from other sources. Ms. Kofman said she would update the Board on how many assister organizations have become CACs, how many are in the pipeline, etc.

Mr. Lucia asked if an individual could become a CAC. Ms. Kofman said no, a person has to be affiliated with an organization to be a CAC. The primary reason for that requirement is to protect the customers – since the counselor has access to personally identifiable information, the CAC organization is responsible for screening the individuals, conducting background checks, training the individual, and ensuring that the counselor is equipped fully to handle personal information appropriately.

Ms. Kofman said the take-home message was that we learned a lot from last year's open enrollment and the strategy was based on lessons learned. Dr. Ku's research enabled the team to re-focus the strategy on the wards with the most uninsured. Part of the new strategy this year was to open storefronts, which worked well for some states last year.

Mr. Lucia wondered how we could learn more about who the uninsured really are. Ms. Kofman said that there is no new data to shed light on that question; we rely on older reliable data. We do know that African-American men as a group have a higher rate of uninsured people, as do Latinos. Also, people under 40 are also in that group; hence the focus last year on the Young Invincibles.

Ms. Kofman noted that since people are deadline-driven, staff is expecting heavy volume in February and are preparing accordingly. Surveys from last year indicate that the tax penalty was not the primary reason people enrolled. While some messaging will be tied to the larger tax penalty this year, the messaging in general focuses on the positive aspects of getting coverage: you can access health care; it will save you from bankruptcy; it is affordable.

Ms. Hicks thought the messaging strategy was good. Her review of national data shows that the primary reason people have not had coverage in the past is not because they do not want it, it is because they could not afford it. People do not hear the tax penalty issue well. If we can get the message out there are good, quality plans available that are affordable, that can be a game-changer. Some messaging should also focus on the deadline. After open enrollment closes, she thought that the messaging should soften and focus on "life moments" – that people with a life change can still enroll.

Dr. Aaron was troubled that people may not correctly anticipate what the hit they will take until they do their taxes. He asked if it made sense to place an op-ed in the Post reminding people of the consequences. It would be a public service. The tax penalty might not be the primary motivation, but it is a motivation. People need to realize it is not chump change – there is a real and costly penalty.

Ms. Hicks noted that there have been some smaller articles in the Post on the issue, but no big feature. The problem is that the people we want to reach do not necessarily read the Post, and we need to figure out other ways to reach them and get the message out. Dr. Ku noted that the tax preparer companies are starting to advertise on the issue, and we should try to capitalize on their messaging.

X. Action Items

a. HBX Telecommuting Policy – *Diane Lewis, Business Operations Committee Chair*

Ms. Lewis reported that the Executive Board Business Operations Working Committee voted to approve Telecommuting Policies and Procedures on December 16, 2014. The Telecommuting Policies would establish a telecommuting program at the Authority, which would permit authorized employees to perform their duties at home or another work location. The program proposed under the Telecommuting Policies would provide employees with flexibility in their work place and better enable Authority employees to carry out the Authority's mission. These draft Policies are closely modeled on the District of Columbia Department of Human Resources (DCHR) Telecommuting General Information Guidance and policies developed by other DC agencies. The Telecommuting Policies are issued pursuant to D.C Official Code 1-612.01 and consistent with applicable law.

Jenny Libster, HBX Associate General Counsel, stated that briefly, the policy sets forth clear processes for requesting telework approval and sets standards for approving requests. The policy envisions that the Operations Committee, delegated by the Board, will play a role in approving requests.

Mr. Lucia asked the thought process behind the Board getting involved in approving telecommuting that is more than three days a week. He thought that should be within the purview of the Executive Director. Ms. Kofman said HBX wanted to have a similar process to regular city agencies. This process outlined is a parallel process to what the City Administrator does now.

b. HBX Board Reimbursement Policy – *Diane Lewis, Business Operations Committee Chair*

The Executive Board Business Operations Working Committee voted to approve Executive Board Compensation Policies and Procedures on January 8, 2015. The Board Compensation Policies would establish standards for Executive Board reimbursements for actual and necessary expenses incurred in the performance of official duties and set forth a process for requesting reimbursements. These Policies would apply to expenses incurred after the date of the adoption. These Policies are modeled on reimbursement policies applicable to District employees and Federal reimbursement policies set forth by the General Services Administration (GSA). The Board Compensation Policies are issued pursuant to D.C. Official Code 31-3171.05(f).

Jenny Libster said the policy sets forth clear categories of reimbursable expenses, including local travel (not subject to any prior approval, out-of-city travel (subject to prior approval by the Chair of the Executive Board), and a miscellaneous catch-all (prior approval by Chair if over $50). Processes for reimbursement are set forth as well.

Dr. Ku noted that the policy would be on a going-forward basis.

XI. Public Comment

No public comment was offered.

XII. Votes

a. HBX Telecommuting Policy. It was moved and seconded to approve the telecommuting policy. The motion passed unanimously with all voting members voting yes.

b. HBX Board Reimbursement Policy. It was moved and seconded to approve the reimbursement policy. The motion passed unanimously with all voting members voting yes.

XIII. Closing Remarks and Move to Executive Session

a. Pursuant to DC Codes Sections 2-575(b)(2), (4) and (14) and Section 3171.11, it was moved and seconded for the Board to move to executive session to discuss contracting, investigation, and litigation.

The public meeting was closed at 7:15 p.m.

XIV. Reconvene Public Session

The public session was reconvened at 8:15 p.m.

XV. Votes

Contracts:

Temporary Staffing Services – Ms. Kofman stated that the contract extension with MB staffing was for $118,508.40, bringing the purchase order to a total of $217,008.40. It is a fully HBX expense with no cost allocation. It was moved and seconded to approve the contract extension with MB Staffing. The motion passed unanimously with all voting members voting yes.

Operations Assistance -- Ms. Kofman stated that the contract with Optum was for not to exceed $465,465. It is a fully HBX expense with no cost allocation. It was moved and seconded to approve the contract with Optum. The motion passed unanimously with all voting members voting yes.

Curam Technical -- Ms. Kofman stated that the contract with eSystems, Inc., a Curam development firm, was for $252,000. It was moved and seconded to approve the contract with eSystems, Inc. The motion passed unanimously with all voting members voting yes.

Architectural Technical -- Ms. Kofman stated that the contract with Accenture was for $604,333. It was moved and seconded to approve the contract with Accenture. The motion passed unanimously with all voting members voting yes.

Oracle Software License - Ms. Kofman stated that the contract with Mythics, Inc was for an annual software license expense for $625,000. Cost allocation has been agreed to with DHS. It was moved and seconded to approve the contract with Mythics, Inc. The motion passed unanimously with all voting members voting yes.

XVI. Closing Remarks and Adjourn

The meeting was adjourned at 8:25 p.m.