Health Benefit Exchange Authority Executive Board Meeting

FINAL MINUTES

Date: June 13, 2016
Time: 5:00 PM
Location: 1225 Eye Street NW, 4th Floor, Board Conference Room
Call- in Number: 1-877-668-4493; access code 733 720 095

Members Present: Henry Aaron, Kate Sullivan Hare (via telephone), Nancy Hicks, Leighton Ku, LaQuandra Nesbit (via telephone), Khalid Pitts (via telephone), Tamara Watkins (via telephone), Laura Zeilinger (via telephone)
Members Absent: Diane Lewis, Stephen Taylor, Wayne Turnage

I. **Welcome, Opening Remarks and Roll Call,** *Henry Aaron, Vice Chair*

Vice-Chair Henry Aaron called the meeting to order at 5:05 pm. A roll call of members confirmed that there was a quorum with five voting members present (Dr. Aaron, Ms. Sullivan Hare, Dr. Ku, Ms. Hicks, and Ms. Watkins).

II. Approval of Agenda, *Henry Aaron, Vice Chair*

It was moved and seconded to approve the agenda. The motion passed unanimously, with Dr. Aaron, Ms. Sullivan Hare, Dr. Ku, Ms. Hicks and Ms. Watkins voting yes.

Mr. Pitts entered the call.

III. Approval of Minutes, *Henry Aaron, Vice Chair*

It was moved and seconded to approve the May 11, 2016 minutes. The motion passed unanimously, with Dr. Aaron, Ms. Sullivan Hare, Dr. Ku, Ms. Hicks, Mr. Pitts and Ms. Watkins voting yes.

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

NEW CMS GUIDANCE
Ms. Kofman reported that the Federal government has issued several new regulations and guidance in the last several weeks. The information that is most relevant to HBX:

- On May 18, 2016, the U.S Department of Health & Human Services (HHS) Office for Civil Rights issued a final regulation on the Affordable Care Act's Section 1557 nondiscrimination provision, which extends certain provisions of existing civil rights laws to certain health programs and activities, including state-based exchanges. Jennifer Libster, Associate General Counsel and Policy Advisor, provided a brief review of notable provisions in this final regulation.

  Ms. Libster said that the final regulation extended certain civil rights protections based on race, color, national origin, sex, age and disability (protected classes) to certain health programs and activities, including the offering of health-related insurance. State-based exchanges are pointed out as a covered entity. Generally the effective date is July 18, 2016, but some provisions have a farther-out effective date.

  Covered entities need to provide notices that they do not discriminate on the basis of protected classes. The notices must tell the consumer that certain services, such as language access services, are available free of charge, and must tell consumers how they can access those services. Also, language access taglines must be provided in the top 15 languages by state, instructing how to access language access services.

  The regulation provides standards for language services, and lays out standards for what staff can provides oral translation services to consumers. An example is staff must be fluent in both English and the non-English language, and have the requisite specialized vocabulary, such as insurance terminology.

  Dr. Ku asked if it applied to HBX staff, or to provider staff as well. Ms. Libster replied that the regulation applies to a broad range of entities, and definitely to HBX staff. HBX could use the standard to designate certain staff in various languages. Whether a specific provider is covered is a complicated answer. Generally the regulation applies to entities receiving federal health care dollars, such as Medicare and Medicaid.

  Covered entities are required to set up grievance processes so a consumer can complain about potential discrimination to the entity. Any complaints must be addressed promptly.

  Dr. Aaron asked if HBX had received any complaints of discrimination. Ms. Kofman replied no. The notice requirement goes into effect 90 days after July 18, so sometime in md October. Once the notices contain the "we do not discriminate" language, consumers may be prompted to file a complaint if he or she feels that HBX discriminated against him or her.

  A discussion ensued about existing laws that provide similar protections in the employment arena.

  Ms. Kofman said that HBX will be engaging in initiatives to ensure compliance, such as HBX has done for other federal regulations as they become final. Self-audit is a tool that HBX has used successfully in the past. That tool has resulted in the past in shifting resources to ensure compliance in an area self-identified as weaker than we need to be.

Dr. Ku noted that language assistance has been the law for many years in many areas, but has never really been tested due to lack of resources. Ms. Kofman stated that for HBX, the Contact Center has bilingual staff, and has access to the DC language line. HBX piggy-backs on the existing city contract for that access. HBX hires bilingual staff as well – we have staff members who are native speakers of Spanish, Amharic, French and Vietnamese. For outreach events, HBX uses business partners and navigators and assisters who are bilingual when we anticipate needing them, depending on the event. We also have language line assistance at enrollment events.

- On June 10th, the tri-Agencies (HHS, Labor, and Treasury/IRS) issue proposed regulations to address several issues related to excepted benefit plans, and lifetime and annual limits for large group plans where the essential health benefit package is not required. These regulations do not impact qualified health plans offered through our marketplace, but impact other carrier offerings.

- On May 10th, CMS issued guidance extending an alternative process related to the availability of APTC for consumers that failed to reconcile in their taxes, and other eligibility reenrollment processes.

- On June 1st, HHS issued limited guidance to help identify potential non-compliance with mental health parity requirements. We will work, and coordinate compliance efforts, with the Department of Insurance, Securities and Banking (DISB) as these requirements apply to QHPs and other major medical coverage sold outside of exchanges.

- On May 26, 2016, CMS issued new guidance that reverses position on the application of waiting periods for pediatric orthodontia in QHPs. QHP issuers will be required to eliminate waiting periods on these benefits for the 2018 plan year. Staff will review if this necessitates a change in HBX's standard plan offerings, and if so, it will be referred to the Standard Plans Working Group. The elimination of waiting periods may have an effect on actuarial value. Dr. Ku thought it would probably not have much of an effect, because a certain level of malocclusion is required for medically necessary orthodontia. Cosmetic orthodontia is not covered.

GSA FOLLOW UP:

An HBX team had another meeting with people from the General Services Administration (GSA). GSA will provide training on GSA systems. Also, since District agencies are essentially agencies with regard to the GSA, active discussions on taking advantage of GSA-negotiated services will continue.

PRODUCT CHOICES AT EACH METAL LEVEL:

In the last two years, HBX has required that carriers offer standardized benefit plans in addition to other products designed by the carriers, and carriers have had a wide range of products. To ensure that there is sufficient range of products, HBX will have a stakeholder process to review plan offerings at each metal tier, as well as standard benefit design at each metal tier, for Plan Year 2018.

Dr. Aaron asked if the standard plans were some of our most popular. Ms. Kofman stated that among new enrollees and those who actively shopped at renewal, about 35% chose a standard plan.

BROKER UPDATE:

The Producer Advisory Committee met on June 7, 2016.

- Demo of new GA/TPA Portal—very well received
- Discussed a refreshment of the Preferred Broker Program proposal; got great feedback and will keep working with the Committee and report back to the Board
- Trained over 150 brokers across three in-person training sessions hosted at our headquarters (on 3/17, 5/2, and 6/2). Training is available online at any time for brokers who prefer online or were unable to attend one of the in-person training sessions
- 51 new brokers added to the DC Health Link ranks since this effort began, for a total of 676 brokers certified to sell individual or SHOP coverage, or both, through DC Health Link.

PRESCRIPTION SEARCH TOOL DEMONTRATION:

Consumers' CHECKBOOK is working to add a prescription search tool to the Plan Match tool they have already built for DC Health Link. It will offer an easy way for customers to see which health plans cover their prescriptions. Customers will be able to check up to 10 drugs at once. They will be able to see details about the drug benefit. For example, is it pre-deductible or not subject to the deductible, and how much of a copay or coinsurance will they be charged for a particular drug.

HBX staff has seen an initial demonstration of the tool and offered some feedback. We will be scheduling demos with the Research Committee and Standing Advisory Board in the next four to six weeks, and then with the full Board.

Dr. Aaron said that when he looks up a drug on WebMD or Mayo Clinic, he gets information about contraindications. He asked if the tool would provide similar information. Ms. Kofman said not in the first generation approach so far, but she would follow up with Consumers' CHECKBOOK on both price and needed technology.

Ms. Kofman noted that the carriers will be test driving the tool before it goes live as well.

Dr. Ku asked if there were any privacy concerns with consumers inputting drugs they take. Ms. Kofman said the tool is anonymous – it has no idea who the consumer is that is using the tool.

MARKETING COMMITTEE MEETING UPDATE:

The Committee met by telephone in early June to plan activities for the next couple of months. Some of the discussion involved devoting more outreach and education on the SHOP side. The people that attend the meetings are pretty diverse and we get good participation from our business partners and assisters.

MISCELLANEOUS

Ms. Kofman will be presenting at the upcoming AHIP conference. The topic is our creative outreach and enrollment activities.

Recent events Ms. Kofman attended with Ms. Hicks and HBX staff:

- Greater Washington Hispanic Chamber of Commerce Annual Dinner
- Chamber of Commerce Awards
- Restaurant Association Metropolitan Washington Annual event

She gets the opportunity at these events to speak with small businesses and speak about DC Health Link.

ENROLLMENT DATA:

HISTORICAL DCHL CUSTOMERS SERVED	
PROGRAM	**LIVES**
QHP	35,536
SHOP	28,603
Medicaid	161,911
TOTAL	**226,050**

** Totals as of June 5th, 2016 and include future coverage start dates.*

Effectuated Covered Lives as of June 5, 2016: 17,918
Effectuation Rate: 73%

V. <u>Finance Committee Report</u>, *Henry Aaron, Chair*

Dr. Aaron reported that the Finance Committee met on Tuesday, June 7th with all three committee members (Diane, Khalid and himself) joining by telephone.

Assessment Regulation Update: The permanent regulation related to the HBX assessment is pending before the Council. It will be deemed approved as of June 30th if no action is taken by Council. If deemed approved, the regulation will be published in the *DC Register* in July. It becomes effective upon publication. Once effective, DISB can subsequently send out the assessment letters.

SMART Audit Update: CMS requires an annual audit which it refers to as the SMART Audit (State-Based Marketplace Annual Reporting Tool). It consists of three parts: an independent financial audit; an independent programmatic audit; and an attestation questionnaire. This year's SMART audit is due June 20th. Staff informed the Committee that the independent financial audit component is fulfilled using the District's CAFR audit which was completed earlier this year. The programmatic audit was completed June 1. Both documents are posted on the HBX website. The attestation questionnaire will be completed by staff and submitted by June 20th.

There was some discussion of whether this SMART audit should come to the Finance Committee because the Committee already reviewed the financial audit and the rest was programmatic. The members of the Finance Committee decided that all audits should come to the Finance Committee as that keeps one Committee informed of all audits.

Financial Review: The Committee reviewed FY 16 expenditures to date and noted that expenditures are as expected. In addition, the Chief Financial Officer provided updated information on assessment collections and balances.

VI. Research & Data Committee Report, *Leighton Ku, Chair*

Dr. Ku reported that the Customer Survey is making progress. There are surveys of four distinct populations. All surveys are in the field or data collection is completed. The Committee received a briefing last Thursday from the Center for the Study of Services (CSS also known as Consumers' CHECKBOOK) which is conducting the survey for us.

People enrolled in Private Health Plans: Field work was completed May 20th on this survey. It was conducted both via email and telephone interviews with approximately a 13% response rate (13.2% for email/13.5% for telephone). CSS did a brief walk through of preliminary finds for the Committee last week. However, the data analysis is not complete, the Committee asked CSS to sort the data a number of additional ways, and CSS still needs to weight it as well. Given these limitations, there is no data to share at this time.

People found eligible for Medicaid: The survey was conducted via email only, it had a 12.6% response rate, field work was completed June 1st, but data is not yet compiled.

People who applied, but did not enroll in coverage: This survey is still in the field, it should be completed by July 1st and it is being conducted both by email and telephone.

Employers offering coverage to their employees through DC Health Link: The survey was conducted via email only, it is still in the field, and data collection will be completed by the end of the month.

VII. Insurance Market Committee Report, *Henry Aaron, Chair*

Dr. Aaron reported that the Insurance Market Committee met on June 6 to discuss Network Adequacy. The full agenda and documents are posted on the HBX website. The meeting lasted two hours. Network adequacy includes:

1. The sufficiency of a health plan network to provide all covered benefits;
2. Accuracy of provider directories;
3. Inclusion of essential community providers; and
4. The problem of surprise billing -- Surprise billing is a situation where a person has treatment at an in-network facility but receives care from an out of network provider typically not chosen by the individual such as an anesthesiologist or radiologist.

HBX staff reviewed federal regulations on network adequacy and standards adopted by this board to-date including the Network Adequacy Working Group recommendations adopted by the executive board in 2013, the adoption of updated network adequacy certification requirements in 2015, the review of provider directories – through a "secret shopper" review -- conducted by the Standing Advisory Board in 2014, and the deployment of the all-plan doctor directory powered by Consumers' CHECKBOOK.

After the staff presentation, Jolie Matthews, Senior Counsel for Life and Health, National Association of Insurance Commissioners (NAIC), presented the recently amended and adopted NAIC Model Law on Network Adequacy.

She described three provisions from that draft. The full model law was circulated and available to all attendees. This model was developed and negotiated by an NAIC working group with the input of insurers, consumer and patient advocacy groups, providers and other stakeholders. The Model law was adopted unanimously by the NAIC in November of 2015.

Ms. Matthews emphasized that the model represented a fair amount of compromise among the various interest groups in the amendment process. Unanimous agreement meant there was agreement through a political process. The view of HBX staff and the Committee was that the fact that this was a negotiated package has political significance. Deviations from that agreement should only be undertaken with the greatest of caution.

In federal network adequacy regulations, HHS encouraged states to adopt the new NAIC model.

Finally, Claire McAndrew, vice-chair of the Standing Advisory Board highlighted a few states with laws on network adequacy including provider directories and surprise billing. Among her review, she noted Florida and New York's recent passage of surprise billing laws, Maryland's and Colorado's passage of network adequacy standards, and Georgia, Maryland, and California's provider directory laws.

Stephen Taylor, Commissioner of DISB and HBX board member, and Philip Barlow, Associate Insurance Commissioner for Insurance attended. Commissioner Taylor stated that DISB is moving forward with the Model Law, actively reviewing authority to adopt the NAIC Model law by regulation which would be a faster approach than through legislation.

After public input from people in attendance in person and by phone, the Committee discussed the issues. On the recommendation of Ms. Kofman, the Committee asked that the Standing Advisory Board (SAB) review the NAIC Model law, consider laws passed by other states, and provide recommendations to HBX. It is an important step forward and, in a way, SAB is our local analogue to discussions and negotiations that happened at NAIC. Speaking for himself, Dr. Aaron was looking forward to the SAB recommendation. He believes that the Model has a presumption in its favor, and any recommended modifications to the Model should be undertaken with care and strong justification.

The SAB is expected to report back to the Insurance Market Committee. The meetings of the SAB will be posted online on the HBX website.

Dr. Aaron went on to say that this discussion is really important, and it is clear that there is a lot of work needed. For example, directories are not accurate, and people received nasty surprise bills. This is the next generation of issues that the HBX should be considering.

Dr. Ku asked where the Model ended up on surprise billing. Purvee Kempf, General Counsel and Chief Policy Advisor, said for emergency room care, any service is treated as in network. Emergency is narrow, however. If a consumer goes to a hospital for a procedure, there is a requirement that the consumer be notified there may be an out-of-network provider involved. If a consumer receives a surprise bill that exceeds $500, a mediation process occurs between the carrier and the provider, the result of which could be an in network charge, a reduced charge, or the full bill.

VIII. Public Comment

No public comment was proffered.

IX. Closing Remarks and Adjourn, *Henry Aaron, Vice Chair*

The meeting was adjourned at 6:10 p.m.