DC Health Benefit Exchange Authority

Standing Advisory Board Meeting

MINUTES

Date: **Thursday, May 18, 2017**
Time: **4:00 PM**
Location: **1225 Eye Street NW, 4th Floor, Board Conference Room**
Call- in Number: **1-650-479-3208; access code 732 765 280**

Members Present: Chile Ahaghotu, Dave Chandrasekaran, Kevin Dougherty, Chris Gardiner, Laurie Kuiper, Billy MacCartee, Claire McAndrew, Dania Palanker
Absent: Jill Thorpe

I. **Welcome, Opening Remarks and Roll Call**, *Chris Gardiner, Chair*

Mr. Gardiner called the meeting to order at 4:05 p.m. A roll call of members present confirmed that there was a quorum with eight members present (Dr. Ahaghotu, Mr. Chandrasekaran, Mr. Dougherty, Mr. Gardiner, Ms. Kuiper, Mr. MacCartee, Ms. McAndrew, Ms. Palanker).

Mr. Gardiner stated that the Standing Advisory Board (SAB) was meeting to review the final *"Patient Protection and Affordable Care Act; Market Stabilization* (Market Stabilization rule) issued by the Centers for Medicare & Medicaid Services in April 2017. There is state flexibility provided in some parts of this regulation and HBX staff has asked us to review it with them and provide our guidance where there are decisions to be made. The staff will then develop that guidance into a resolution to be considered by the HBX Executive Board at their upcoming meeting on June 14, 2017.

II. **Approval of Agenda**, *Chris Gardiner, Chair*

It was moved and seconded to approve the agenda. The motion passed unanimously, with Dr. Ahaghotu, Mr. Mr. Chandrasekaran, Mr. Dougherty, Mr. Gardiner, Ms. Kuiper, Mr. MacCartee, Ms. McAndrew and Ms. Palanker voting yes.

III. **Approval of Minutes**, *Chris Gardiner, Chair*

It was moved and seconded to approve the minutes of November 3, 2106. The motion passed unanimously, with Dr. Ahaghotu, Mr. Mr. Chandrasekaran**,** Mr. Dougherty, Mr. Gardiner, Ms. Kuiper, Mr. MacCartee, Ms. McAndrew and Ms. Palanker voting yes.

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

ACA UPDATE: The House passage of the American Health Care Act (AHCA) was a serious disappointment. We await the Congressional Budget Office (CBO) scoring for the House-passed bill with the expectation that it will be released next week. Having those facts is important for the Senate as it tries to grapple with this issue. What happens next is far from clear.

WORKING GROUP ON LOCAL POLICY INTERVENTIONS: Ms. Kofman said HBX was establishing a new working group, whose purpose would be to review the AHCA and the CBO score to consider the issues and possible policy interventions to preserve the gains made here locally. HBX will be posting information about the working group on our website and we anticipate the first meeting in about two to three weeks. Board member Dr. Leighton Ku has agreed to chair the working group, and Jodie Kwarciany of DC Fiscal Policy Institute will vice-chair. We are looking for volunteers to join the group.

2018 HEALTH PLANS THROUGH DC HEALTH LINK: Carriers have filed their initial rates and forms for their plan year 2018 health plans in the individual and small group markets with the Department of Insurance, Securities and Banking (DISB). DISB is reviewing the filings. HBX also has its own outside actuaries reviewing the filings and providing feedback to DISB. HBX always advocates for the lowest possible premiums for our customers.

BROKER QUOTING TOOL: Today, we announced a new broker quoting tool on our website that makes it easier for brokers to help determine the best plans for prospective and current small business clients. It is in beta form, and we will adjust the tool as we get feedback before finalizing it.

HBX 2018 PROPOSED BUDGET: Our budget oversight hearing took place on May 10th. It was a very good hearing. Also, the Health Committee had a markup yesterday, and there were no changes to our budget.

MASSACHUSETTE UPDATE: HBX is in a partnership with the Massachusetts Health Connector (MHC). We are replacing MHC's IT technology supporting its SHOP. We are on track to use DC Health Link technology for MHC on August 1.

ENROLLMENT DATA: At each Executive Board Meeting, we release updated enrollment data. That is posted on our website under each meeting. To provide a brief update, we currently have approximately 18,500 people currently enrolled in our Individual Marketplace and nearly 70,000 enrolled through SHOP (of which approximately 11,000 a Congress).

V. **Discussion Item**

a. Presentation on the Centers for Medicare and Medicaid Services (CMS) Final Rule on Market Stabilization and decision points for HBX -- *Mila Kofman, Executive Director & other HBX staff*

Ms. Kofman handed this item off to Debbie Curtis, Senior Deputy Director.

PAYMENT OF BACK PREMIUM

Ms. Curtis said that the Market Stabilization rule has several provisions on which HBX wanted SAB feedback.

Guaranteed availability – CMS has re-interpreted guaranteed availability and now says that carriers are permitted to require payment for past due premiums from an old plan before consumers can enroll in new coverage during an open enrollment period. The provision is permissive as to carriers, but the rule also notes that the practice could be prohibited by state law.

Ms. Curtis noted that Howard Liebers, of the Department of Insurance, Securities and Banking (DISB) had been scheduled to participate in the meeting, but had been called out on an emergency and was unable to participate. Mr. Liebers told Ms. Curtis that DISB believes a provision in the DC Insurance Code protects consumers from paying for more than 60 days' of back premiums.

Ms. Curtis noted that in its comment letter, HBX said it believes the provision violates the ACA and is unlawful. The ACA provides that carriers accept all eligible individuals during open enrollment, not all eligible individuals except those with unpaid back premiums. Also, CMS did not provide any facts to support this reinterpretation. HBX staff looked at 2016 terminations, and 58% of terminations for nonpayment were 34 or younger, which is younger than DC Health Link's overall population. HBX believes that to require payment of back premiums, a potentially significant sum of money, will discourage enrollment of our younger population. That situation could damage our risk pool by making it older and less healthy.

The question for the SAB is, is there an action we should take? CMS says specifically it is subject to state law.

There was some discussion among the Board members about how long a person would actually accumulate back premiums, with some members thinking it would only be 30 days. Ms. Kofman understood the discussion, but advised that terminations are not always accomplished by the carriers within the expected time frames, for legitimate reasons.

Mr. MacCartee asked what the carriers in our market do with respect to this issue. Ms. Kuiper said Kaiser has not done this in the past, but is evaluating the steps that would be necessary to implement it.

Ms. Kofman said staff had talked to the carriers and it is not a common practice. They are in the same position as Kaiser, evaluating what would be necessary should the carrier decide to implement it.

Dr. Agaghotu asked if outstanding bills (i.e. back premium) could be subject to collection. Ms. Curtis said that option exists today – in other words, carriers can already take customers to collections for non-payment.

Ms. Palanker said she dislikes the reinterpretation of the law, and would support recommending to DISB that it not allow the practice. She listed her concerns:

- Notice issue. People may make a binder payment, not knowing it is applied to past due premium. After January 1, the person might go for medical services and discover s/he does not have coverage.
- People may stop paying and think that their coverage is therefore terminated. There are any number of reasons a person might stop paying, such as becoming eligible for Medicaid or employer-sponsored coverage.
- There could be a dispute about payment, the consumer saying it was paid and the carrier saying it was not paid. There is no process to work that out.
- In the individual market, we only have two carriers. That fact limits options and will force people into another carrier.

Mr. Gardiner said it seemed to him that the carrier can always go through the collection process. There is no reason a person should not be able to get coverage during open enrollment.

Ms. Curtis asked if the Standing Advisory Board was coalescing around a recommendation to DISB to not allow the practice. Ms. Kuiper asked if the recommendation was to amend DC law since earlier it was said there is a law in place to limit collection of back premium to 60 days.

Mary Beth Senkewicz, Associate General Counsel and Policy Advisor, said there is a law on the books as Ms. Kuiper stated, in the DISB portion of the Insurance Code. However, she said it was a in a section about reinstatement of a policy. She did not think that DISB would disagree that CMS exceeded its authority with this reinterpretation. What DISB is looking at is that what CMS did is really about reinstatement of a policy. Ms. Senkewicz said she could make an argument that the issue at hand is not about reinstatement of a policy, but rather is about the availability of guaranteed issue of a new policy during open enrollment. In her mind, what DISB has said is interpretive. She was comfortable with the recommendation because it is a different scenario.

Mr. Dougherty asked about to whom the recommendation would go. Ms. Curtis said the SAB would recommend to the Executive Board, who would then take up the recommendation.

<u>OPEN ENROLLMENT PERIOD</u>

Ms. Curtis said the regulation shortens the open enrollment (OE) period for the upcoming OE period to November 1 – December 15 (versus November 1 – January 31). State flexibility is available – CMS said that states could use a special enrollment period (SEP) to change the date. The question for the Board is whether HBX should take advantage of the flexibility and extend the OE period to align with what has been the OE period since plan year 2014.

Ms. Curtis offered some background. When the Contact Center contract and budget were developed, we never thought of a shortened OE period. Staffing requirements are very different for a six week OE than for a three month OE. Another consideration is that from November into December, HBX has Congress coming through for its OE, and 1200 small employer groups renewing within the same time frame. We simply do not have the time to make a shorter OE period work. We inquired and both Maryland and Virginia will be using the shortened period. We would not be the only state considering extending the period. We checked with our carriers, and the worst thing to do would be to extend OE in some unfamiliar way from the way it has operated since 2014.

Mr. Gardiner asked what the major impediment to shortening the period. Ms. Curtis said the administrative burden was one impediment. Also, it is right around the holidays, and people are used to the longer period. We have not had time to plan for it. The switch to a shorter OE period was originally scheduled to be in effect for plan year 2019 coverage, and we are planning how to educate the public about the change during the 2018 plan year.

Ms. Kofman clarified that "administrative burden" included extra costs, such as staffing up the Contact Center for more concentrated call volume. That would be quite costly. Without adding staff, wait times at the Contact Center could become unreasonably long. Also, there might be a need for temporary workers for HBX due to the overload.

Rob Shriver, Director, Marketplace Innovation Policy & Operation, said that we have traditionally had two peaks in Contact Center activity: December 15 for 1/1 coverage; and a larger peak around January 31 for 3/1 coverage. He is concerned that operational concerns not only about cost, which is significant, but that a shorter open enrollment period could result in fewer customers. We need more time to figure out how we do not lose new customers with a shorter open enrollment period.

Mr. MacCartee said that as a broker, the broker community always pushes the carriers for more time so clients can have more time to consider options and gain more understanding.

Ms. McAndrew said that aligns with the consumer perspective that they need more time to enroll and be educated. It also aligns with the exchange's commitment to making enrollment as easy as possible for the consumer. She would support the longer OE period.

Ms. Kuiper asked if the extension would be for one year. Ms. Kofman said it was a one-time extension allowed by the federal regulation. We will plan ahead for shortened OE period the next year.

SEP CHANGES

i. Pre-enrollment Verification. Before a person can be found eligible for SEP enrollment, all documents must be verified. Flexibility to SBMs is provided clearly. The staff recommendation is to maintain the status quo. We require verification for some SEPs but not others. Our data shows that our SEP population is younger than our OE population. Age being a proxy for health, we are

concerned that potentially onerous pre-verification requirements can result in the younger and healthier not signing up. We believe the result in the District would destabilization of our risk pool, resulting in increased premiums. Our recommendation is to not change how we implement SEPs. Since there would be no change, no vote is necessary. Does anyone have any concerns?

Ms. Palanker stated she strongly supports the staff recommendation.

ii. Certain SEPs. This piece of the regulation says that if you are pregnant, or get married, you can usually enroll in a different plan. The change now is that you are restricted to the same metal level. It reduces your choices. You could not switch to a different metal level until OE. No state flexibility is provided. However, CMS recognized that there may be technical issues with changing to the new rule. HBX does have technical challenges in implementing this change, as it would require IT re-building. HBX cannot implement at this time. CMS allows for technical difficulties, so no vote is needed; we have technical challenges.

Ms. Kofman said we will have to do it at some point in the future. Mr. Gardiner asked when it can be implemented? Ms. Kofman said the IT piece is complicated and a heavy lift. We will work through it, but we have other IT priorities. This change was an unplanned for financial surprise, and it is a big lift.

iii. Flexibility regarding Delayed Effective Dates. When someone has problems enrolling, we used to have a lot of flexibility around the effective date. The regulation now limits that flexibility to one month. We have no other flexibility so we will implement this provision.

iv. SEP due to Marriage: The Obama Administration implemented a policy that when you moved to a new state, you had to show that you had minimum essential coverage (MEC) for 60 days prior. We complied with this requirement through self-attestation on the website's SEP application process. The regulation requires that for people who qualify for a SEP due to marriage, that one of the couple must have had MEC for 60 days prior to marriage to qualify for this SEP. HBX will implement a similar self-attestation requirement for this SEP as we've done for moving into the District in order to comply with this provision.

v. Actuarial Value. Under the ACA, actuarial value (AV) of the metal plans was +/- 2%. The allowed variation recognizes that it is hard to hit the number precisely. Last year, the Obama Administration expanded the bronze AV +5/-2%, since carriers were sometimes having difficulty making the plans weak enough for bronze. The new rule says you can go down to a negative 4 (-4%). States can require the older narrower AVs.

Ms. Senkewicz reported that the rate filings for plan year 2018 show that in the individual market, we have one gold plan at 76.2% and a silver at 67.2%. In SHOP, we have a gold at 76.4%, two silvers at 66.5% and 66.2%, a two bronze at 64.6% and 65%. What we do not have, as expected, is a bronze at 58%, since that is virtually impossible to attain.

Ms. Curtis said staff is inclined to watch it and see if it impacts our marketplace. If it does, we may need to take action in the future.

Ms. Palanker said she has some concerns. When the Standard Plans Working Group worked on standard plans for 2018, we were aware of the bronze flexibility, but not the other levels. A gold plan at 76.2% is significantly lower than 80%. She does not think those two plans are comparable, but people may assume comparability due to the label gold. She would rather not allow it.

Ms. Kuiper said Kaiser was comfortable with the recommendation to watch the market. She asked if it was a DISB or HBX decision. Ms. Curtis said you could probably go either way. Ms. Senkewicz noted that the requirement to offer metal level plans is in the HBX portion of the Insurance Code. She also noted that carriers are still required to offer a standard plan, if offering at that metal level, in addition to any variations.

ESSENTIAL COMMUNITY PROVIDERS AND NETWORK ADEQUACY

Ms. Curtis said that the rule was that a network had to have 30% of its providers be ECPs; that has been changed to 20%. It does allow states to require a higher percentage. CMS used to have some standards on network adequacy; now CMS is deferring to the states. Right now, DISB has a group that is working on network adequacy standards for the District. Ms. McAndrew serves on that group.

Ms. McAndrew said the group is working through the NAIC model act and adding some specificity for the District. The purpose is to set standards for network adequacy, for provider directory availability, accuracy and audits, and for ECPs. The types of standards relate to quantitative measurable standards for network adequacy in access times and access to public transportation, provider ratio requirements, access plans, and ECP access. The proposed result will be enactment as a DISB regulation.

Ms. Curtis said since DISB is moving forward, staff inclination is to follow the DISB process but take no further action at this time. Board members agreed.

VI. Public Comment

No public comment was proffered.

VII. Vote

a. Recommendations for the Executive Board on HBX decision points regarding the Market Stabilization rule

Back Premium

It was moved and seconded to recommend that DISB act to prohibit the ability of carriers to require payment of back premium as a condition of enrollment through open enrollment. The motion carried,

with Mr. MacCartee, Dr. Ahaghotu, Mr. Dougherty, Ms. McAndrew, Ms. Palanker and Mr. Gardiner voting yes. Ms. Kuiper abstained.

Open Enrollment Period

It was moved and seconded to recommend that HBX add an SEP for December 16, 2017 – January 31, 2018 to the upcoming OE period. The motion carried unanimously, with Ms. Kuiper, Mr. MacCartee, Mr. Chandra, Dr. Ahaghotu, Mr. Dougherty, Ms. McAndrew, Ms. Palanker and Mr. Gardiner voting yes.

VIII. **Closing Remarks and Adjourn**, *Chris Gardiner, Chair*

Mr. Gardiner noted that Mr. Chandrasekaran was absent for the vote on the back premium recommendation and would have voted yes. The meeting adjourned at 5:08 p.m.