Health Benefit Exchange Authority Executive Board Meeting[i]
MINUTES

Date:	January 10, 2024
Time:	5:37 PM
Location:	Via Zoom/By Video or Conference Call Only
Meeting Link:	https://rb.gy/q6klrs password: 3a+$FTq4

Members Present: Henry Aaron, Leighton Ku, Diane Lewis, Khalid Pitts, Gabriela Mossi, Ayanna Bennett, Karima Woods

Members Absent: Ramon Richards, Tamara Watkins, Wayne Turnage, Laura Zeilinger.

Welcome, Opening Remarks and Roll Call
Diane Lewis, Chair

A roll call confirmed a quorum with 5 voting members present (Dr. Aaron, Dr. Ku, Ms. Lewis, Ms. Mossi.

Approval of Agenda
Diane Lewis, Chair

One change to the agenda was announced and that was that the Board would not be convening in closed session today. It was moved and seconded to approve the draft Agenda. The motion passed with Dr. Aaron, Dr. Ku, Ms. Mossi, and Ms. Lewis voting yes.

Approval of Minutes
Diane Lewis, Chair

It was moved and seconded to approve the Draft November 8, 2023 Minutes. The Chair noted that there was a correction on page 10. The figure $400,000 should have been $100,000 to accurately reflect the amount of the prior award to the Telecommunications Development Corporation for outreach support. It was moved and seconded to approve the draft Minutes. The motion passed with Dr. Aaron, Dr. Ku, Ms. Lewis and Ms. Mossi voting yes.

Discussion Items

Dania Palanker, Chair, Standard Plan Working Group

DC Health Link Standard Plans for PY 2025 to lower cost-sharing for cardiovascular disease.

Dania noted that she was coming back to the board after having received values from the updated AV calculator and direction from the Board for the Standard Plans Advisory Group. The working group was charged to make recommendations to modify the standard plans for the plan year 2025 for the individual, and shop markets, to eliminate cost sharing for cardiovascular disease. They initially met seven times once a week between September 12 and October 24, 2023 by video or conference call. The draft federal AV calculator has been issued now, and that was taken into consideration for these changes.

They had a renowned cardiologist give a presentation about the high financial burden of forgoing or delaying cardiovascular disease care. They also received some expert advice and data analyzed by the Whitman Walker Clinic that reviewed guidelines and made proposals. After running the 2025 draft plan through the new AV calculator, the 2024 calculator, the bronze plan was the only plan that needed modifications to have a no cost share for cardiovascular disease generics.

We had reached a non-consensus decision that we come back to you as the least bad option to bring the bronze plan within the de minimis AV range. The bronze generic copay would go from 25 dollars to thirty dollars. In addition, in the release of the 2025 draft AV calculator, on November 15, the bronze and silver plans were in the de minimis AV range, but the platinum and gold were not, therefore the standard plan working group discussed and deliberated on options to bring those plans into the Actuarial Value compliance. The working group wanted to incentivize going to a primary care provider rather than a specialist.

They did clarify that the labs for cardiovascular services would be covered at zero-dollar cost sharing irrespective of setting and that it didn't matter if ordered by a primary care or specialist.

H. Aaron - How do doctors get classified as specialists or general? Or as non-specialists is it at their discretion? Does it require board certification? Is it voluntary?

M. Kofman - Staff did research after you posed that question. We talked to as many health plans as we could. So essentially, the bottom line is once doctors have all of their certifications, most of the time when they're in network, they contract. You know, a specialist under their allowable practiced areas and certifications. But sometimes they actually contract with health plans to provide primary care. So that all just varies, and sometimes health plans to meet their network adequacy requirements, where there aren't enough primary care, physicians, traditional, family doctors in the area will ask certain specialists to contract with a health plan to provide primary care and serve in that capacity. The doctor has to have all the right qualifications to be in the network as a particular specialist, and I don't know if Dr. Bennett wants to say anything else about that. She may have a perspective I haven't yet offered or correct anything.

A. Bennett - That sounds right. A set of services that would define primary care, which is coming in for ambulatory issues and allowing it to be a wide range of things. If you are restricting yourself to an

organ, I don't think you get to call yourself primary care. But there are obstetricians or others who will act as primary care for women or if their specialty is a subgroup. So I agree. I don't think much of the time we debate it too much. But yes, it's a set of services but there are specialists who will do that set of services in some circumstances.

L. Ku - Correct me if I'm wrong, I spoke to Mary Beth and Mila about this. My impression is that ultimately, we're allowing the carriers to make the decision in these cases of how they're determining if you're a cardiologist or you are counted as a primary care or internist as opposed to as a specialist, when all is said and done, it's a messy area to decide who is what? Under which purposes. Given that people are not always board certified in one way or the other when they're counted as the specialist within a specialty. But that to the extent that there are rules that we already have that apply to copays for primary care versus specialty. That made some sense to just leave it within the discretion of how the plans are making these decisions, rather than trying to sort of set up new rules and interpretations that might get us into more hot water.

D. Palanker - I would just note that I think we are doing that in some way by having it because we're having this connected to the services that are getting to visits that are already getting or one would expect are getting coded or getting the primary care treatment because that's how the cost sharing is applying right now. The insurers are already splitting the cost sharing. So of a difference between the primary care and the specialist care. I don't know if we need it to be zero dollars for specialists.

H. Aaron – Are we satisfied that the incentives we have created are the right ones, are patients satisfied? Do we have any evidence on that? I think Leighton probably had the right answer. People work it out and we should let them work it out. Health plans together with their physicians. But it raises, I think a cautionary note about distinguishing payments based on specialty status. I'm not saying we shouldn't do it, but no harm, no foul. Let's proceed.

Dr. Ku – expressed his appreciation to D. Palanker for serving as chair of the working group.

M. Kofman - If I can just pile on Dania has been helping us since 2013 and served on many working groups. I just want to say how much we all appreciate everything that you've done, as DC residents to help us be successful. And we hope that after a little bit of a break from us, you will miss us and have the capacity to come back and continue to help us reach even greater heights. So, thank you. I really appreciate it.

D. Lewis – added additional remarks stating the Board's appreciation for her service.

Mila Kofman, Executive Director

Carahsoft Technology Corporation for Salesforce licenses.

This first was reviewed by the finance committee, and they approved moving this for approval to the full board. This is renewing the Salesforce license, which is used to keep track of cases when there are customer service issues and to renew the license through Carahsoft Technology Corporation, Uh, the total approval. We are seeking approval for $394,794. That includes what the Massachusetts

Health Connector pays, which is about $27,300, and the rest is paid by HBX. So the total amount requested for your approval is $394,794, which is again to renew, the Salesforce licenses for the year.

Diane Lewis, Chair

Consider Appointments for the Standing Advisory Board from the Executive Board Operations Committee.

As the Chair of the Board Operations Committee, D. Lewis presented a resolution to reappoint three members and to appoint two new members to the Standing Advisory Committee. The Chair stated that the Board Operations Committee approved these last week on January 3.

The three reappointment candidates for Executive Board consideration are Dock Winston, Margarita Dilone, and Rebecca Barson.

- Dock Winston was initially appointed in 2019. His most recent term expired November 2022 but he has continued to serve pursuant to the terms of the HBX Establishment Act. His reappointment would be for a term expiring November 2026.

- Margarita Dilone was initially appointed in 2019. Her most recent term expired November 2023 but she has continued to serve pursuant to the terms of the HBX Establishment Act. Her reappointment would be for a term expiring November 2027.

- Rebecca Barson was initially appointed in 2019. Her most recent term expired November 2023 but she has continued to serve pursuant to the terms of the HBX Establishment Act. Her reappointment would be for a term expiring November 2027.

- All would like to continue serving. In addition, all three members are active, involved participants who are well-versed in the ACA and HBX policies.

Two members of the Standing Advisory Board resigned this year - Jodi Kwarciany and Rob Metz.

Therefore, two new candidates were selected for Executive Board consideration. These are Claire Heyison and Jennifer Valentine.

- Claire Heyison's appointment would be for a term expiring January 2028.

- Jennifer Valentine's appointment would be for a term expiring January 2028.

Finally, one Standing Advisory Board member, Dania Palanker, was recommended by the Board Operations Committee for reappointment on January 3rd. However, she informed us that she would not be seeking reappointment. Dania is an expert in the qualification category for disease and demographic-specific advocacy groups and also satisfied the qualification categories of health insurance consumer and health care consumer interest advocacy. We sincerely appreciate Dania's commitment to assisting HBX in its mission, notably bringing her substantial expertise to our benefit

as well as serving as Chair of the Standard Plans Working Group. The Operations Committee will review replacement candidates and make a recommendation to the Board at a future date.

The resolution before you will be to reappoint the three individuals and appoint the two new individuals.

L. Ku – would you say a word about who Claire and the other new person?

M. Kofman – I can answer that. Claire is at the Center on Budget and Policy Priorities. And she was one of your former colleagues I think, Dr. Ku. I don't know if she worked with you personally or not, but she was at GW at the Center on Budget and Policy Priorities. She focuses on the Affordable Care Act and all issues related to the ACA. So we're very excited that as a District resident, she can fulfill this role as a consumer advocate and lend us that voice.

Jennifer Valentine is with Kaiser Permanente Mid-Atlantic and she's on the financial side, but she's been involved in implementing the Affordable Care Act for the Permanente Group. She is intimately involved in implementing the HealthCare4ChildCare program. She knows DC Health link, both the group side and the individual side, so she's as Board Chair Lewis said, she is fulfilling the health plan vacancy that was prior held by CareFirst. So, we're very excited that both are DC residents and can lend their voice and their expertise to the Standing Advisory Board.

Public Comment

Chair Lewis asked for public comments. No public comments were offered.

Vote

Resolution – PY25 Standard Plans Lowering Cost Sharing for Cardiovascular Disease. The Chair noted the presence of Board Member Khalid Pitts, and Commissioner Karima Woods who had joined at the beginning.

It was moved and seconded that the Board approved the resolution. After the following discussion, resolution was approved with Dr. Aaron, Dr. Ku, Mr. Pitts, Ms. Mossi, and Chair Lewis voting yes.

Discussion

L. Ku - At some point we've now actually gotten to the point where some of these changes we've made have actually been implemented that in principle we could sort of try to evaluate some of them, some of the insulin and diabetes cost sharing changes. You know, it really would be nice to see if we could introduce something to promote some, some active evaluation of that. I had a doctoral student this year who was interested in doing evaluation of insulin caution reductions and basically could not find the data to do this analysis, you know, so we can figure out some ways to make some of those things possible. I think it'd be a useful contribution to the field.

M. Kofman – When the social justice working group deliberated about how to measure the impact whether or not any of this makes a difference, the working group didn't want to be prescriptive and

some of the health plans have already had similar initiatives, benefit design changes, they were trying out and some other jurisdictions. So the working group consensus was, leave it to the plans to design, a way to measure the impact. So, the health plans are supposed to be doing that. It's very much unclear to HBX staff what, in fact, have the health plans been able to do at least with the diabetes coverage changes, one of the things that at the staff level, we're working on, is bringing in some external expertise, who can follow up with experts who can follow up with the health plans to understand better. The health plans are evaluating the benefit change and what they're finding is that we don't have the expert contracted yet but we hope in the next month or two that that all will be set and will be able to get some good information from the health plans.

Deputy General Counsel Alex Alonso noted that Board Member Pitts had written twice in the chat that his vote should be recorded as yes on this item.

Carahsoft Technology Corporation for Salesforce licenses

It was moved and seconded that the Board approved the contract. The contract was approved without further discussion, with Dr. Aaron, Dr. Ku, Mr. Pitts (via chat), Ms. Mossi, and Chair Lewis voting yes.

Appointments for the Standing Advisory Board

It was moved and seconded that the Board approved the appointments. The appointments were approved without further discussion, with Dr. Aaron, Dr. Ku, Mr. Pitts, Ms. Mossi, and Chair Lewis voting yes.

Executive Board Finance Committee Report
Henry Aaron, Chair

He stated that the committee met twice, December 4 and January 4. With all three of the committee members present. Theye approved the Carahsoft Technology Corporation contract, which was approved. At the time of the finance committee meeting on January 4, they had not yet received the signed FY 24 Memorandum of Understanding for HealthCare4ChildCare. But subsequently, they did receive it so that's all locked up. They reviewed the monthly budget tracker and spending report for December and with staff help for January, as is the norm nothing disturbing stood out. The Finance Committee will review the Capital Reserve Policy to inform any decisions to move money into the Reserve. The committee is urging that a revised Reserve be indexed by a suitable amount to ensure that HBX is keeping up with inflation and a given nominal number and to avoid losing purchasing power that nominal number will be adjusted with the rate of inflation. Not certain whether that's going to require board approval, but the committee is recommending it. Notice was received about the city-wide audit and the committee looks forward to receiving the final report shortly. None of the assets in the Reserves are maturing at this time, so no decision had to be made about how to invest the proceeds from those assets that will mature in the future. Will take care of that when and as those assets mature.

Executive Director Report
Mila Kofman, Executive Director

The Health Committee has announced that on February 14th at 9:30 will be our Performance Oversight Hearing. And as always, HBX staff are drafting answers to the questions we've received ahead of the hearing, and I'll be testifying. There is no budget hearing date set yet. Usually, the board chair, Diane Lewis and I both testify on the budget, but performance oversight, it's just me in the hot seat.

Just a reminder about open enrollment deadlines. We are still in open enrollment. And if residents want February 1 coverage, they have to enroll by January 15, so that's in five days from today. After that, they can still enroll, but it will be March 1, effective date for their coverage. And on deadline days, we have extended our call center hours so that we will be there to answer any questions that residents may have about enrolling.

As always, we focus our outreach strategies on specific target populations. We have residents who have not given us permission to ping the IRS in order for the resident to receive a lower premiums in terms of APTC. So, we have called an email, then we have a special Outreach campaign to those residents. We have residents who are young adults, aging off their parent's plan, so we have a special campaign to reach those residents to make sure that they set up their own account and enroll if they are still DC residents. We continue to have one touch events, once a week, they are in person at Carlos Rosario, and once a week, they are virtual by appointments and those continue to be very successful. Our Outreach events in the community include participation in various action weeks: Hispanic Latino Week of Action, LGBTQ+ Week of Action, Young Adults Week of Action, events around MLK birthday celebration. We also participate and in some cases host various events with others, like our business partners, the Chamber and Community Health Centers and others. In terms of open enrollment summary and there's data that we're posting like we do every year. But just to give you a sense of customers who have already effectuated their coverage. That means not only do they select a plan, but they actually pay the first month's premium. So that's what I'm giving you. And those numbers are usually lower than people who selected a plan. Sometimes people select a plan, but then end up getting a job and they no longer need a plan, an individual plan for us so they don't pay for it. So, effectuated data is lower than plan selection data.

We have 14,248 individual Market customers who have effectuated their coverage, paid their their first month's premium. Out of that 11,234 were existing customers who we renewed into the plan they had in 2023. Same plan for 2024. Other existing customers 1,332 actively shopped and either switched carriers, switched the metal level or switched their plan. All of those were renewed into their new plan and they paid the first month's premium and then we had 1,682 new customers who also paid their first month's premium. On the SHOP side, we currently have 5,267 employers that includes small businesses and non-profits covering 86,639 people. So overall we continue to hover around a hundred thousand paid customers. That's our enrollment.

Just as a reminder, the flexibility that we had for small businesses of not meeting contribution and participation requirements during the Covid Public Health Emergency has now ended. And so earlier this year, our team started to reach out to employers who did not meet the established participation requirements, which is two-thirds of their eligible employees have to participate in the health plan or the 50 percent premium contribution requirements. So, the team has reached out to 41 groups, and some of those groups we moved to one one coverage, which is where they can continue to have

flexibility. Other groups either contribute more to the premium now, so they kept their renewal or planned to change when they renew. A few employers went out of business. So we did lose a few groups.

Medicaid unwinding continues to be a very robust effort that is requiring lots of staff resources. We continue to participate in the forums that DHCF has established to continue to educate the community about Medicaid, losing Medicaid and what to do when you are at risk of losing Medicaid and where you can come, DC HealthLink to get private coverage. We also continue to rely on our DC Healthlink Assisters for direct outreach to people who lose Medicaid coverage, who are likely eligible for DC Healthlink, our Assisters call and email those folks. And in addition to that, we sent a gazillion emails to those folks ourselves directly, and we also text them. And we've had very successful text responses. People let us know through text, if they want to be called for help enrolling. They also let us know if they have other coverage which is also helpful.

So just a little bit of data around that. To date from May through December, we've had 279 households that are likely eligible for D.C Healthlink coverage that we received from DHCF and Medicaid agency. And we sent close to 2,000 emails, close to a thousand texts, and almost all have been assigned to our DC Healthlink Assisters for follow-up. Based on all of those efforts, we've enrolled 38 households, 41 people, 36 into individual and family coverage and 5 into our small group coverage. We've enrolled 17 households back into Medicaid, and 22 households reported that they had other coverage and did not need DC Healthlink coverage. So overall, our conversion rate for households is about 28 percent and we're very happy with that, that includes people who are back in public coverage, Medicaid are now covered through us as well as people who told us they have other coverage.

Healthcare4Childcare. There's great news to report. We have now surpassed 50 percent enrollment mark for eligible facilities. And in fact, through January 1 enrollment, we have out of 336 eligible facilities and that's conservative, some are actually not eligible, but that's being conservative. We've enrolled 176 into group coverage, which is 52 percent, and we have nine additional facilities lined up for February 1 coverage.

So, we are aggressive in our outreach. We appreciate our grantees helping us. We have learned through a survey we've done of those who've enrolled. This is very preliminary, that most facilities points of contact, employers, their workers learn about us through email, not the in-person visits, not the calls that we do, but emails and not only our emails but also emails from OSSE, the Office of the State Superintendent of Education. So, we've been very fortunate that OSSE has been such a strong outreach partner to us and those emails are actually being read by this community and people are taking action. So we are very pleased with where we are now with Healthcare4Childcare.

Just as a reminder, two big policy shifts for that program, the program now pays for gold coverage. In 2023 it paid for silver coverage, and also employers can keep both their DC residents and non-DC residents enrolled as a group. We no longer require D.C residents to enroll in individual coverage. We did that initially for a number of policy reasons, but it turns out that employers and employees wanted more flexibility. So, those are the two major policy shifts for 2024.

On the federal front, on November 15th, CMS released two important proposals that we commented on, one is the 2025 Notice of Benefits and Payment Parameters proposed rule. And another one which Dania mentioned, which is the draft Actual Value, 2025 calculator, and we submitted comments to both. On December 19th, the Biden Administration, the U.S Department of Labor released a proposed rule on Association Health Plans. As you recall, the prior Administration back in 2018 finalized a rule allowing associations to circumvent the Affordable Care Act requirements that apply to the small group and individual market carriers and protections for consumers. And it was an end run around the Affordable Care Act essentially. Congress didn't repeal it. So, the prior Administration attempted to do it through this rule, We were very engaged and opposed the prior rule because we support the Affordable Care Act protections. We became one of the three lead states, in addition to New York and Massachusetts who organized a court challenge to the prior Administration's rule. And if you recall, we won in the District Court and the prior rule was paused in its implementation, and it had been on appeal for all of these years. So, the bottom line is, we are thrilled. We and advocates and other state officials and other states are thrilled with the proposal that the Biden Administration issued to completely rescind the prior administration's AHP rule, and we're also thrilled that they're contemplating memorializing their prior guidance from decades worth of guidance which essentially says that ultimately, if you sell to small businesses, you have to make sure all consumer protections apply. If you sell to individuals, individuals maintain their consumer protections even when they get coverage through an association. So we also support that obviously that has been on the books and the principle that was reflected in regulatory guidance for decades. And I remember it when HIPAA was first being implemented from 1997. We will continue to be very engaged and active organizing folks who agree with these positions and agree that this proposal makes the ACA stronger. I look forward to drafting our comments and staying engaged on that front.

Switching gears to our eGFR campaign. If you recall the National Kidney Foundation changed its guidelines to eliminate race from the eGFR calculation. Unfortunately, not all labs have adopted the new calculation so we have a consultant who's helping us as we are trying to figure out what we can do to help labs who have not yet adopted the new calculation to remove race which had many implications including contributing to Black Americans not being put on the kidney transplant list in the priority that they should have had. And also wrong dosing for treatment of kidney disease. Those are at least two of the negative implications that the prior calculation had. So, we're trying to figure out how we can help move that along to get all the labs to modify and update their calculation. And we have had several discussions with Dr. Bennett and her team about what can be done locally. But of course, many or the most labs that our health plans contract with are not here in DC, it's nationwide coverage. So it's really important for us to focus on both fronts and we appreciate all the help that Dr. Bennett and her team have been giving us to understand this area better.

Finally, my last update is really just remind everyone that we have now scheduled the Board's strategic planning meeting for May 1 which is a full day and then May 2, which is a half day. At that meeting the Board will take a look at many, many things in our past, and then looking forward, help set direction for staff, in terms of our focus areas and our approach. So, we look forward to the strategic planning session. That concludes my report. I'm happy to take any questions.

Closing Remarks and Adjourn
Diane Lewis, Chair

The meeting was adjourned as of 6:37 pm on Wednesday, January 10, 2023. The next regular meeting is scheduled for March 13, 2024. It was announced that if the Board decided to meet prior to that time, notice will be provided in accordance with the Open Meetings Act.

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[i] This meeting is governed by the Open Meetings Act. Please address any questions or complaints arising under this meeting to the Office of Open Government at opengovoffice@dc.gov.