Health Benefit Exchange Authority Executive Board Meeting
DRAFT MINUTES

Date:	**Friday, January 30th, 2015**
Time:	**2:00 PM**
Location:	**By Conference Call only**
Call- in Number:	1-877-668-4493; access code: 737 707 248

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

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

Chair Diane Lewis called the meeting to order at 2:04 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 noted that HBX is reaching out to the new directors for the Department of Human Services, Laura Zeilinger, and Department of Health, Dr. LaQuandra Nesbitt, so they can participate with the HBX Board.

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

Debra Curtis, Deputy Director for Policy & Exchange Programs , requested that two items be removed from the agenda: executive session; and reconvening after executive session. It was moved and seconded to remove the two items as requested. The motion passed unanimously, with Dr. Aaron, Ms. Sullivan Hare, Ms. Hicks, Dr. Ku, Ms. Lewis, Mr. Lucia, Mr. Pitts voting yes. It was moved and seconded to approve the revised agenda. The motion passed unanimously, with Dr. Aaron, Ms. Sullivan Hare, Ms. Hicks, Dr. Ku, Ms. Lewis, Mr. Lucia, Mr. Pitts voting yes.

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

It was moved and seconded to approve the minutes of the January 12, 2015 Board meeting. The motion passed unanimously, with Dr. Aaron, Ms. Sullivan Hare, Ms. Hicks, Dr. Ku, Ms. Lewis, Mr. Lucia, Mr. Pitts voting yes.

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

a) Enrollment

Ms. Kofman reported on DC Health Link enrollment October 1, 2013 through January 27, 2015:

Total people served:	76,996
Individual market:	19,987
SHOP:	15,662
Eligible for Medicaid:	41,347

Dr. Ku asked if these numbers were cumulative. Ms. Kofman responded yes, these numbers reflect people that have or did have coverage. Dr. Ku asked for current information. Ms. Kofman supplied the following numbers for the current open enrollment period:

Individual market passively renewed:	13,342	
Active renewals:	1,344	
		784 changed plans
		551 changed metal levels
		147 changed carriers
New individual market entrants:	3,316	

Ms. Kofman further reported on outreach events through February 8, designed to encourage enrollment before the last week of open enrollment.

b) Hearing Update

Ms. Kofman reported that on the day prior, the Health and Human Services Committee of the Council held a hearing on the HBX' permanent legislation on financial sustainability, Bill 21-8, introduced by Council Member Yvette Alexander. She reminded the Board that last year, Council unanimously passed temporary and emergency legislation that was identical to Bill 21-8. Several of DC Health Link's customers testified in support of the bill, talking positively about the experience, how much having coverage meant to them, and how they saved money. Additionally, three business partners (Restaurant Association Metropolitan Washington, DC Chamber of Commerce, and Greater Washington Hispanic Chamber of Commerce) testified in support of the bill, citing the need for a stable funding source for the exchange. The DC Fiscal Policy Institute, Kaiser Permanente and the DC Primary Care Association also testified in support of the bill. America's Health Insurance Plans (AHIP) and the American Council of Life Insurers (ACLI) testified against the bill.

c) 1095As

The 1095A is an Internal Revenue Service (IRS) form that HBX is required to provide to individual market customers, detailing coverage dates and APTC amounts provided to the customer, if applicable. Ms. Kofman reported that approximately 13,000 had already been mailed, and the last 250 were mailed earlier in the day, thus meeting the federal deadline. She stated that HBX staff performed extensive quality checks for accuracy. They will be made available electronically in about 10 days. She said she would send a sample copy to Board members.

d) Clarification of Contract Information

The Board had previously approved a contract with Optum. Ms. Kofman clarified for the record that the contract is with an Optum wholly-owned subsidiary, the Lewin Group.

V. **Discussion Items**

a. Standard Plans Working Group update – *Leighton Ku, Chair*

Dr. Ku reported that standard plans at the four metal level tiers had been approved by the Board previously. However, the federal actuarial value (A/V) calculator changed, resulting generally in a 1%-2% increase in the A/V of the plans, but increasing the bronze standard plan by far more, such that the approved standard bronze plan was out of compliance. The Standard Plans Working Group had met, discussed sample A/V calculations, and was making the following recommendation: add a separate $250 drug deductible, and increasing the maximum out-of-pocket (MOOP) to the limit, $6,850. These changes result in a 61.3% A/V.

He also noted that the working group wanted the standard plans to be comparable to popular plans, and it cannot be certain how the carriers might tweak the plans. The standard plans might wind up not being in the lower half of the price range. He wanted the Board to be apprised.

The revised bronze plan is posted on the HBX website and would be voted on at the next regularly scheduled Board meeting on February 9, 2015.

Dr. Ku also reported that he had been asked about the naming convention for the standard plans. The working group does not make a recommendation in this regard. He had consulted someone with marketing experience who suggested “value plan” or something similar.

Ms. Sullivan Hare noted the Maryland early filing date for forms. She wondered if carriers would file the DC standard plans in Maryland. Dr. Ku thought perhaps; Ms. Kofman pointed out that the EHBs might be different. Ms. Sullivan Hare thought HBX should coordinate with the Maryland exchange to accomplish true comparability of price. Also, she objected to the term “value plan” since it suggests a monetary advantage.

Ms. Hicks stated that HBX needed nomenclature for the standard plans that would avoid consumer confusion. She suggested that the Marketing and Consumer Outreach Working Committee might be able to make some suggestions. Ms. Lewis thanked Ms. Hicks and looked forward to any recommendations.

Dr. Ku stated that he had been asked about cost-sharing reduction (CSR) variations for the standard plans. He stated that since so persons were involved in a CSR plan, that question was not addressed.

b. Recommended Updates to Qualified Health Plan Certification Requirements – *Kevin Lucia, Chair, Executive Board Insurance Market Committee*

Mr. Lucia reported that the Insurance Market Working Committee had recommendations for updating some certification requirements for Plan Year (PY) 2016. In 2013, a QHP Issuer Certification Process Working Group developed recommendations, adopted by the Board, which imposed an attestation standard for issuer certification. At the time, the working group recommended revisiting the process. The Insurance Market

Working Committee had five public meetings devoted to discussion of developing amended standards for network adequacy, rate review, quality and nondiscrimination. Recommendations were developed and circulated for comment, revised per some comments, and were being presented for approval by the Board at the next regularly scheduled Board meeting on February 9, 2015.

On network adequacy, previously carriers have attested that they meet the standard: a sufficient number and type of providers to deliver services without unreasonable delay, including mental health, substance services abuse and essential community providers. The recommendations are as follows:1) require carriers to use the new CCIIO template on network adequacy; 2) the Department of Insurance, Securities and Banking (DISB) will update its complaint tracking system as necessary to track network adequacy complaints; 3) carriers shall provide data to Consumers Checkbook for the unified provider directory; 4) carriers shall list a telephone number and email address in the provider directory for consumers to report inaccuracies; 5) carriers shall take corrective action to correct any inaccurate information within 30 days' notice of inaccuracy; 6) carriers shall take steps to improve accuracy of the provider directory by doing one of the following: regular self-audit of the directory; validate provider information if no claim has been received within the past two years; or any other action approved by DISB; and 7) carriers shall continue to provide access plans to HBX.

Mr. Lucia reported that these recommendations can be handled by the carriers and HBX and DISB staff.

On rate review, the recommendations clarify that HBX will continue to do what it has done for the last two years, which is HBX will receive the rate filings, and the HBX consulting actuaries will review the filing and assumptions and report to HBX. HBX will continue to work with DISB to avoid duplication of effort in this arena.

Purvee Kempf, HBX staff, clarified that the same process means that the carriers will reply to questions from DISB. The consulting actuaries' questions are funneled through DISB to the carriers.

On quality, presently HHS is working on ways to measure quality. HHS is developing and testing a quality rating reporting system and a quality improvement strategy, is implementing a consumer experience survey, and is requiring carriers to work with patient safety organizations. The recommendation is that HBX use the federal standards. Also HBX will establish a link to NCQA's public report cards for health plans.

Mr. Lucia noted that once the federal standards are final, HBX can go above and beyond the standards; however, for the moment the recommendation is to use the federal standards.

Ms. Sullivan Hare commented that once the federal standards are final, carriers will be busy adapting, and she is cognizant of that fact; she noted that the initial working group there was a strong feeling that HBX might want to look at some high priority areas, such as maternal child health, HIV, diabetes and smoking cessation. Mr. Lucia agreed, noting that the first step will be to determine where the federal standards land. At some future point HBX might want to delve deeper into certain areas.

Ms. Lewis noted that the recommendations presume added support from DISB in implementation. Mr. Lucia responded that DISB has been consulted fully and understands and accepts it's enhance role.

On nondiscrimination, presently DISB does conduct form review, and uses the available CCIIO tools. The recommendation is that carriers provide full consumer-facing documents, e.g. evidence or certificate of coverage, for public posting. Mr. Lucia noted that this recommendation will allow researchers to review plans for discriminatory benefit design. He noted that DISB has receives zero complaints on this issue. Also, DISB will consider providing examples of potentially discriminatory benefit design language as guidance.

Dr. Ku asked about the timing of HHS surveys. Ms. Kempf said she would provide that information.

Mr. Lucia thanked the HBX and DISB staff, and the stakeholders, for their hard work and input.

VI. Public Comment

No public comment was proffered.

VII. Closing Remarks and Adjourn

The meeting was adjourned at 2:57 p.m.