Health Benefit Exchange Authority Executive Board Meeting

FINAL MINUTES

Date: Wednesday, December 9, 2015
Time: 5:30 PM
Location: 1225 Eye Street NW, 4th Floor, Board Conference Room
Call- in Number: 1-877-668-4493; access code: 733 351 801

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

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

Chair Diane Lewis called the meeting to order at 5:37 pm. A roll call of members present confirmed that there was a quorum with five voting members present (Dr. Aaron, Ms. Hicks, Dr. Ku, Ms. Lewis and Mr. Lucia).

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

It was moved and seconded to approve the agenda. The motion passed unanimously, with Dr. Aaron, Ms. Hicks, Dr. Ku, Ms. Lewis, and Mr. Lucia voting yes.

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

It was moved and seconded to approve the November 9, 2015 minutes. The motion passed unanimously, with Dr. Aaron, Ms. Hicks, Dr. Ku, Ms. Lewis, and Mr. Lucia voting yes.

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

JANUARY 1 COVERAGE DEADLINE

Ms. Kofman reported that December 15, 2015 is the deadline to sign up for 1/1/2016 coverage. A number of community events have been planned around the deadline. All are posted on the website. Also, some of our DC Health Link Assister organizations will have extended hours. However, the Call Center will not be open for extended hours. Data shows it is not necessary nor is it cost-effective.

Mr. Lucia asked about call volume. Ms. Kofman stated many calls are received but the volume is down in general due to the improved IT and consequent improved customer experience.

ENROLLMENT STATISTICS

a) Cumulative numbers (since our launch through 12/7/15)

- 28,196 people have enrolled in individual market coverage through DC Health Link
- 23,813 employees have obtained SHOP coverage through DC Health Link
- 137,283 people have received Medicaid eligibility determinations through DC Health Link

b) Open enrollment (statistics as of 12/7/15)

- We have passively renewed 14,726 individual market customers.
- 389 customers have actively changed health plans.
- And we've enrolled 1,294 brand new individual market customers.
- 38 of our new enrollees are APTC eligible, and 1,256 are full pay

Ms. Kofman acknowledged that the APTC number was very low. Mr. Lucia asked whether we knew if the hard-to-reach, still uninsured population, was APTC eligible. Ms. Kofman said a large chunk will be eligible for Medicaid.

c) Plan selection information:

- Active renewals saw a 4% decrease in premiums (on average) over 2015 rates. Passive renewals saw a 3% increase in premiums (on average) over 2015 rates.

Dr. Aaron asked if these numbers referred to premium only, and not the total cost to the consumer. Ms. Kofman said yes. Dr. Ku said people are looking for lower premiums. Dr. Aaron stated that could be a good or bad thing. Ms. Hicks said that on the whole, the fact that consumers are getting some value from shopping is a positive news point. She wondered if other exchanges were seeing the same types of savings. Mr. Lucia said that for example, last year on Rhode Island everyone shopped and a significant number of consumers chose lower premium plans. Dr. Aaron said that there is abundant evidence that consumers over-weight premium cost only, and that consumers do not always make the right choices. Mr. Lucia pointed out that now DC Health Link has a tool to help better decision-making by consumers. Dr. Aaron agreed that was a good point.

Ms. Kofman stated that after December 15, HBX will follow up via survey with those that actively shopped and ask them if they used the Consumers Checkbook tool (DC Health Link Plan Match) and what motivated them to change plans. Regarding use of tool, Ms. Kofman related that it was anonymous. Dr. Ku thought that in theory we should be able to know if those who actively shopped clicked on the tool. Dr. Aaron noted that the discussion underscored a theme he stresses, that we need to do research. He thought we could identify the active shoppers without violating their privacy, perhaps secure their cooperation, and find out if the choices made through

shopping improved their position, which would be extremely helpful. Ms. Kofman reiterated that we will have more information after we conduct the survey.

- 487 (out of 1,294) of our new enrollees selected a standard plan (37.6%). 145 (out of 389) of active renewals selected a standard plan (37.3%).

Ms. Kofman noted this information was preliminary. The numbers run across all the standardized plans.

Ms. Kofman reported that of the few new APTC customers, 65% are choosing more than the 85% default percentage for APTC. (She noted that this information will be more meaningful at the end of open enrollment, since there are so few new APTC customers.) Seventeen percent chose more than the default, and four percent chose less than the default. A small percentage is still being reviewed.

SPECIAL OUTREACH TO AETNA CUSTOMERS

Ms. Kofman reminded the Board that Aetna is not participating in the individual market beginning next year. The Contact Center has begun calling these customers, in addition to an email campaign. If the Contact Center reaches an affected individual on the telephone and the individual wants to continue coverage, the Contact Center has a "live" handoff to a broker ready to assist the customer.

OTHER OUTREACH

Certain customers are losing their APTC for the 2016 plan year. Outreach to all those customers has occurred. We use a very general script since we do not know if the customer filed taxes, the lack of which would trigger a loss of APTC.

Dr. Ku asked about the general news reports that United may be pulling out of exchanges. Have we heard anything about United? Ms. Kofman responded that United will stay in our SHOP. Most of the contemplated withdrawals are in the individual markets, not SHOPs. Ms. Hicks noted that United also walked back a bit from the reports after the news broke. She thought it was a bit of a cry of alarm that carriers needed help on the risk corridor front. She noted that Aetna and Wellpoint made strong statements about how the exchanges will be good for their businesses.

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

Dr. Aaron reported that the Finance Committee met on December 3rd for its regular monthly meeting.

PROPOSED ASSESSMENT REGULATION: HBX Legal staff informed the Committee that the informal comment period had closed for the assessment regulation. As a reminder, the Board has reviewed this regulation multiple times when they were passed as emergency rules. The process is now beginning to adopt a permanent rule. Based on comments received and experience gained through the past assessment process, staff are recommending only one minor substantive change which is to add fraternal benefit societies to the list of lines of coverage not subject to the assessment. This change is consistent with the District's insurance code and will have almost no financial impact. ACLI is the only organization that commented formally on the proposed rule. The

proposed permanent rule will be discussed later during this meeting. The Board is scheduled to vote on the proposed rule and move it forward to publication in the DC Register and the formal comment period.

GRANT EXTENSION UPDATE: Staff informed the Committee that CMS has formally approved the no-cost extensions extension of the three grants. To be clear, these are not new funds being provided by CMS, but it does permit the ongoing use of the awarded funds into 2016 when they would otherwise have expired. These extensions are important as it means we will have federal grant funds to continue our IT development work into 2016.

FY 17 STAFF PROPOSED BUDGET: HBX Staff walked the Committee through the budget presentation that will be delivered here shortly and the Committee recommended forwarding the proposed budget to the Executive Board. The Board will hear more on the budget from Mila shortly.

FINANCIAL REVIEW: Staff informed the Committee that closure of FY 15 expenses is wrapping up over the next couple of weeks so we will have a full accounting of FY 15 at our January Meeting. We also reviewed FY 16 expenditures and noted that expenditures are as expected.

Ms. Lewis noted for the record that Kate Sullivan Hare and Laura Zeilinger both entered the meeting.

VI. Insurance Market Committee

Mr. Lucia reminded the Board that one year ago, the Board had adopted updated exchange certification standards. Also, there has been quite a bit of activity around network adequacy standards, including an updated model from the national Association of Insurance Commissioners (NAIC). Mr. Lucia stated that he intended to call a meeting of the Insurance Market Working Committee after the first of the year to hear about the updated standards and how they were working out in practice. He also hoped to hear about the updated NAIC model and begin a discussion on that topic.

VII. Discussion Items

a. Consider reappointments for the Standing Advisory Board (SAB) from the Executive Board Business Operations Working Committee – *Diane Lewis, Business Operations Working Committee Chair*

Ms. Lewis stated that we have before us a resolution to appoint three members to the Standing Advisory Board. These are reappointments of three individuals currently serving on the Standing Advisory Board to new four-year terms that will expire in November 2019. Each of the Standing Advisory Board members has been an active participant and the Board Operations Committee recommends their reappointment. The three members are: Jill Thorpe, Kevin Dougherty, and Billy MacCartee.

As a reminder, Jill Thorpe is an expert in digital health, and she and her husband own a small business in the District.

Kevin Dougherty is on the staff of the Multiple Sclerosis Society and is an outspoken voice for people with chronic conditions, people with disabilities, and consumers in general.

Billy MacCartee is a health insurance broker.

Dr. Ku said that Ms. Thorpe was now working for a law firm, Manatt. Ms. Lewis stated HBX staff was aware of her recent change in employment.

Ms. Lewis stated that the vote would be taken after public comment.

b. FY 2017 Proposed Budget (link to power point presentation of budget)– *Mila Kofman, Executive Director*

Ms. Kofman stated that as last year, HBX staff had looked at its needs internally to develop the proposed budget for FY 2017. The Finance Committee had been briefed to get its feedback, and the Standing Advisory Board held a public meeting to review the staff proposed budget and provide feedback. She then walked through a power point presentation of the budget (link above) and answered Board Members questions as she walked through the presentation.

The total budget request is slightly over $34 million, a small growth from the prior year's budget of $32.5 million. As is usual, the majority of the budget is for IT and Marketplace Operations. Slide 6 shows the significant changes from FY 2016. A 10% reduction in the Maximus contract for the Contact Center had been achieved. The MOA amount with ESA has been adjusted more than $1.2 million downward. IT changes now allow HBX to perform some eligibility verifications on its own, so long as it does not involve Medicaid income eligibility.

Dr. Aaron noted that the total shown on Slide 6, "Significant Changes," makes it look like the budget is going down as the total is minus $1.6 million, when in fact the budget is increasing by about $1.6 million. Ms. Kofman noted that salaries and fringe (including new FTEs) accounted for a lot of the difference. Dr. Aaron thought that the significant changes should include more items to show the entire picture more fully, from a presentation standpoint. Ms. Kofman agreed.

Dr. Ku noted that revenues are part of any budget equation. At some point, the federal funds would run out. Eventually the budget should somehow reflect assessment revenues. Ms. Kofman stated that the estimated assessment revenue for FY 2017 will be about $30 million. Since there will still be some grant funding in 2017, so she would like to maintain the assessment at 1%.

Ms. Hicks stated if more carriers came on board, would that help reduce the assessment? Ms. Kofman said no, it would be newly insured people that would increase the premium volume, which is the basis for the assessment.

Slide 9: Ms. Kofman noted the Marketplace Operations' proposed budget was $12.1 million, including 4.5 new FTEs. The following slides show details of the Marketplace Operations budget. Ms. Kofman noted that most of the functions were required by the ACA.

Mr. Lucia asked how the cost allocation for the Contact Center is calculated. Ms. Kofman said that originally, it was 2/3 HBX and 1/3 Medicaid. DHS has a vendor in place that is studying the allocation in detail based on underlying data. Until that work is completed, there is an agreement in place to use a 50/50 cost allocation formula. Based on initial HBX staff review, particularly of enrollment numbers, HBX believes that the cost allocation will ultimately look much different. She noted that in other states that have completed detailed cost allocation review, it has come out about 93% Medicaid. Mr. Lucia noted that was consistent with a recent presentation he had seen. Mr. Lucia asked if that included employers. Ms. Kofman said yes. Mr. Lucia noted that more employers were coming through SHOP.

Dr. Aaron asked whether Medicaid received federal matching funds for these administrative expenses. Ms. Kofman said the Medicaid piece is quite complicated and the federal match depends on the function performed. For example, eligibility functions draw a 90% match. For administrative functions, the match is 50/50.

Slide 13: Ms. Kofman noted that the consulting services for $275,000 were related to quality initiatives that will be forthcoming from CMS. She noted that HBX does not have an internal person who is expert at quality issues. Mr. Lucia noted that nationally there were not many quality experts and SBMs might be lining up to retain them.

Slide 16: On premium aggregation, Dr. Ku asked if the price was based on volume. Ms. Kofman said no, the contract had been renegotiated to a flat price. The original contract was per member per month, which led to greater exposure for HBX. Dr. Aaron asked what would happen if the vendor declared it could not perform at the flat rate. Ms. Kofman said HBX could issue an RFP. Dr. Aaron noted that HBX retained the risk if the vendor walked.

Ms. Zeilinger had asked how the budget reflected the change in shared services as those changes evolved. Ms. Kofman said imperfectly. For example, there are certain notices that HBX only issues, and some that are Medicaid only, and some that are shared. Invoices are tracked, and based on best information, the budget reflects HBX's share, both its own alone plus cost allocated for shared services.

On slide 18, Ms. Kofman noted that she had received a new price from DCHR for HR Support Services. The correct figure is $169,000, not $163,000 as listed.

Slide 19: Ms. Kofman said that the $350,000 for Community Outreach and Marketing included $170,000 for Metro ads that can be seen on city busses. She noted the Navigator program was an ACA requirement. She asked the Board to increase the Consumer Education and Outreach budget amount by $500,000 for Outreach and Enrollment. She was specifically concerned about the present in-person assister (IPA) program that is funded 100% by federal grants that will become unavailable. It is presently funded at $870,000. Ms. Kofman said HBX learned that many people need in person assistance for

coverage. Many people do not have a computer or smartphone and need one-on-one interaction. Within many communities, culturally the way to do business is in person. The IPA program provides good value. HBX is still in discussion with sister agencies and other community members to find other sources to fund this program, but nothing solid has developed. This item generated the most concern when the proposed budget was presented to the Standing Advisory Board. Therefore, Ms. Kofman was requesting the additional funds for the IPA program.

Mr. Lucia asked why the request was for $500,000 when the current level was $870,000. Ms. Kofman said part of the strategy was to get as many certified application counselors (CACs) on board as soon as possible. The CAC organizations do not require HBX funding. She is hoping to have the same number of bodies on the ground as before. Also, HBX is still working with sister agencies and exploring grant opportunities to help in funding the IPA program. She noted that there is a strong belief among SBMs that the federal government needs to rethink its approach to the IPA program. The federal government has provided millions of dollars to states that use the federal marketplace for outreach with no corresponding funding to SBMs. The SBMs think there are equity and public policy arguments to be made that states continue to have the need for IPA assistance. The need for that outreach enrollment does not go away. The SBMs plan to discuss the issue with the federal partners and ask for grant assistance for the IPA program.

Mr. Lucia said he wanted to be sure not to shortchange the program. If we need more, we should be upfront about it. His understanding is that "boots on the ground" is the only way to find the hard-to-reach populations. He would support asking for whatever we need for the program. Ms. Kofman said she thought that the combined efforts, including discussions with the Medicaid agency, since so many of the uninsured left in the District will ultimately get on to Medicaid, will be sufficient for the IPA program.

Dr. Aaron returned to the presentational issue he had raised earlier. The budget will increase by $2 million. Ms. Kofman previously stated that the bulk of that was for added personnel costs. The "Significant Changes" slide should be amended to reflect all changes above a set threshold, with a Miscellaneous item to cover the rest of the changes, to avoid any confusion. The total on the Changes slide should equal the amount of the budget increase.

Delicia Moore of the CFO's office, who is assisting HBX while we are minus a Chief Financial Officer, noted that the budget as sent to Council reflects all the changes. Ms. Kofman said she thought Dr. Aaron's point was an excellent one and she would revise the presentation to reflect his comments, while still retaining the overall big picture and not losing that with too many words and figures on individual slides.

Dr. Ku said what he noticed was that staffing was increasing by 19 FTEs, about a one-quarter increase. IT staff is more than doubling, with shifting contractors to FTEs, which can ultimately stabilize the staff and save money.

Ms. Hicks said what struck her was that the increase in budget was fairly modest. She wondered if we knew about other SBM budgets and what they were doing in this regard. Ms. Kofman said it was hard to

compare apples to apples due to cost allocations in the other states. The other piece that made it hard was the differences in vendor contracts across the SBMs. Anecdotally she said that discussions with her counterparts on things like the Call Center contracts enabled HBX to get better deals with certain vendors.

Mr. Lucia said many outside organizations had tried to do comparisons and it was very difficult. The variances in cost allocations, and hidden costs underneath the contracts, made it hard.

Ms. Hicks noted that Consumer Education and Outreach had no allocation for outside communications help. Ms. Kofman said it had been struck from the budget. She also noted that Ms. Hicks provided some help with her professional expertise for which HBX used to pay.

Mr. Lucia wondered if there was a way to leverage our partners who now make more money because of the ACA. For instance, before the ACA, carriers in the individual market had to spend a lot on outreach. Are they paying less now? Ms. Hicks commented that consumers, particularly the newly-insured, needed to be educated on health insurance literacy, among many other categories. It seemed to her that the carrier partners should make a concerted effort to keep their customers engaged in their health coverage, and it should not fall solely with HBX. Ms. Kofman said the HBX team had been trying to think creatively on how to engage all people in the community and no one was off the list of being approached for help. For example, the pharmaceutical industry directly benefits from people being insured, whether through Medicaid or private coverage.

Dr. Ku said the natural history of things such as Medicaid expansion and Medicare Advantage is that the toughest part is the beginning where people are being asked to do something they have never done before. Things get better over time. The community becomes aware of what is available for help. It does not mean that we stop efforts to reach people.

Ms. Kofman agreed, and underscored the need for continued education and outreach to help the newly insured use their coverage. For example, many newly insured do not understand deductibles and copays, and do not know that preventive benefits are covered with no out-of-pocket cost to the insured. Also, some covered people are still using the emergency room for primary care. Effective consumer education will ultimately lead to better outcomes and hopefully, system savings. Ms. Hicks noted that there could be second and third wave of better health outcomes. She said that a recent study, she thought of Medicaid expansion states, showed an increase in mammograms and diabetes care among previously uninsured persons.

Ms. Zeilinger said it was hard to crosswalk the budget presentation to the shared services numbers that both agencies were using. Ms. Kofman said it was a reminder that she will instruct staff to work with DHS staff to ensure everyone was on the same page. Ms. Moore said the Office of the Chief Financial Officer was working on both budgets to ensure cost allocation was properly reflected on both budgets.

Dr. Ku said it might be prudent to include an estimate of the savings anticipated on IT due to increasing FTEs to replace contractors. Ms. Kofman agreed.

c. Assessment Appeals Regulation – *Jenny Libster, HBX Staff*

Ms. Libster stated that the proposed Notice of Rulemaking for the assessment was before the Board. The Board has seen the rule a number of times as it has been passed before on an emergency basis. The proposed Notice of Rulemaking was for the permanent rule. One change is to exclude fraternal benefit organizations from the assessment. That exclusion amounted to about $2,455 annually. Approval by the Board would move the Notice to publication in the DC Register for a 30 day comment period. Thereafter it would go to Council for a 30 day review period.

Dr. Ku said the Notice lays out the basis for the assessment. He asked where it said what the rate was. Ms. Libster said it was not stated in the Notice. Ms. Kofman stated that every year, she had pledged to keep the assessment at 1%. Since the assessment comes from health carriers and is passed through on premiums, she did not want to raise the assessment if not necessary.

VIII. **Public Comment**

No public comment was proffered.

Ms. Sullivan Hare asked if anyone on the Standing Advisory Board (SAB) received coverage through DC Health Link. Ms. Kofman said she would need to ask permission of the SAB members to state that publicly. Ms. Sullivan Hare thought it was helpful to have advisers who received coverage through DC Health Link. Ms. Lewis said moving forward, it can be a consideration when a SAB vacancy occurs.

A discussion ensued about how HBX solicited feedback from real customers and took that feedback into account when planning IT upgrades.

IX. Votes

a. Resolution -- Standing Advisory Board Reappointments

It was moved and seconded to approve the SAB reappointments. The motion passed unanimously, with Dr. Aaron, Ms. Sullivan Hare, Ms. Hicks, Dr. Ku, Ms. Lewis, and Mr. Lucia voting yes.

b. FY 2017 Proposed Budget

It was moved and seconded to approve the FY 2017 Proposed Budget. The motion passed unanimously, with Dr. Aaron, Ms. Sullivan Hare, Ms. Hicks, Dr. Ku, Ms. Lewis, and Mr. Lucia voting yes.

c. Assessment Appeals Regulation

It was moved and seconded to approve the Assessment Appeals Regulation Assessment Appeals Regulation. The motion passed unanimously, with Dr. Aaron, Ms. Sullivan Hare, Ms. Hicks, Dr. Ku, Ms. Lewis, and Mr. Lucia voting yes.

X. <u>Closing Remarks and Move to Executive Session (TBD),</u> *Diane Lewis, Chair*

Pursuant to DC Codes Sections 3171.11and 2-575(b)(4), it was moved and seconded for the Board to move to a closed session to discuss litigation. The motion passed unanimously, with Dr. Aaron, Ms. Sullivan Hare, Ms. Hicks, Dr. Ku, Ms. Lewis, and Mr. Lucia voting yes.

The meeting was adjourned at 7:32 pm.