Health Benefit Exchange Authority Executive Board Meeting
FINAL MINUTES

Date: June 8, 2015
Time: 5:30 PM
Location: 1225 Eye Street NW, 4th Floor, Board Conference Room
Call- in Number : 1-877-668-4493; access code: 736 557 379

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

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

Vice-Chair Henry Aaron called the meeting to order at 5:36 pm. A roll call of members present confirmed that there was a quorum with five voting members present (Dr. Aaron, Ms. Sullivan Hare, Ms. Hicks, Dr. Ku and Mr. Lucia).

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, Ms. Hicks, Dr. Ku and Mr. Lucia voting yes.

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

It was moved and seconded to approve the May 11, 2015 minutes. The motion passed unanimously, with Ms. Hicks, Ms. Lewis, Mr. Lucia and Mr. Pitts voting yes.

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

- **WORKING GROUP on 51-100:** Ms. Kofman reported that earlier in the day, DISB issued a data request to the District's large group carriers, requesting demographic and other information regarding the large group market. Mr. Lucia had chaired a working group on this topic and concluded that further research was necessary. The data request is a follow up from the working group to collect that information, including how benefits might differ from those traditionally offered in the small group market and the various rating structures used to set rates for this cohort. Information gathered will be taken back to the working group.

- **SMART AUDIT:** Starting this year, CMS is requiring an annual programmatic and financial audit on state based marketplaces. HBX completed the bulk of the audit earlier in the spring, but had until May 29, 2015 to submit its independent external programmatic audit. That work was completed last week by Bert Smith (our auditors) and submitted to CMS on time.

- **CMS IT CONSULT:** Last Friday, May 29th HBX hosted an all-day meeting with CMS. This meeting is a key component for CMS permitting ongoing use of federal funds for IT. The meeting was a great success.

- **CMS guidance on 1311 grants:** Guidance on the use of 1311 grant funds was issued today. There had been a number of questions from states and the OIG on the use of federal grants in the out years. As time progresses, it gets tricky to delineate between implementation activities and operations and maintenance activities. Ambiguities still exist so HBX will continue to work with CMS to ensure compliance with spending guidelines.

- **CMS meeting at end of July on sustainability**: CMS is hosting a state-based marketplace (SBM) meeting in northern Virginia at the end of July. The focus will be on financial sustainability. CMS has asked HBX to assist with the agenda.

  Dr. Aaron said he had read that the Hawaii exchange is failing. Mr. Lucia said he understood the Hawaii Board voted to transition to the federal platform but maintain SBM status, as does Oregon, Nevada and New Mexico.

- **Outreach:** Ms. Kofman stated that HBX outreach efforts do not cease when open enrollment closes. The Restaurant Association of Metropolitan Washington recently hosted a dinner awards event. There was a photo booth that printed the pictures with DC Health Link information on it. Also, one of their members served a vegan juice – beats, ginger, mint – in DC Health Link cup, and the drink was tweeted by a Washington post food critic. Ms. Kofman congratulated Whitman Walker for the opening of the 1525 14th Street Clinic and was pleased to participate in the ribbon cutting for that event.

- **ENROLLMENT DATA:** cumulative data that show the number of people who have enrolled in private coverage or been determined eligible for Medicaid through DC Health Link since October 1, 2013.

Through June 7, 2015:

QHP: 22,889 people
Medicaid: 83,465 people have been found eligible for Medicaid; and
SHOP: 19,124 people enrolled (includes Congress).
DC Health Link has served **125,478 to date**

Ms. Sullivan Hare asked if we knew how many people were covered presently, how many had APTC, etc. Ms. Kofman replied that HBX is figuring out how to collect and report that data accurately. The problem is the lag time between when a customer pays and HBX receiving the effectuation file from the carrier, and a similar lag with respect to terminations. She characterized the effort as a work in progress and acknowledged that the process is not where it needs to be, but that all states are dealing with these issues.

Dr. Ku stated it would be helpful to have coverage information as of a certain point in time. Since HBX went through a reconciliation process in issuing the 1095As, it was possible in theory.

Dr. Nesbitt asked if there was a regular process by which HBX, for example, reviewed the data on a monthly basis. Ms. Kofman said federal law requires the carriers to report to HBX when there is a change, such as termination for nonpayment. Each carrier partner has diffident capabilities and IT systems, and we work with each carrier to give them as much flexibility as possible, particularly when systems issues are involved. Eventually the carriers and HBX will reach a place where such reporting is routine and fast, and the back end reconciliation happens quickly as well.

Dr. Aaron asked what happens when the same person shows up more than once. Ms. Kofman stated that the HBX data system nets out duplicates. If a person received an SEP, then wanted to change plans, that person only shows up once in the system.

Chris Gardiner, Chair, Standing Advisory Board, asked what happens when someone does not pay, and the provider still has to provide services. Ms. Kofman said that question had arisen early and has to do with the grace period provided for enrollees with APTC, HBX said at the time it would monitor the issue. She is unaware of any complaints in that regard, but stated she would check with DISB.

Dr. Nesbitt said she would like to see data on an aggregate basis, from an evaluative perspective. If we are going to be able to notice a trend, how quickly will we be able to see that with aggregate data.

Dr. Aaron thought Dr. Nesbitt's question was important and said the Research Committee might want to take it on.

Ms. Kofman said that after the first open enrollment HBX conducted surveys and had good data on the impact of the ACA after open enrollment. The data spurred HBX to concentrate on different areas of the city for outreach. HBX is in the process of issuing an RFP for a commercial survey firm to dig deeper into our customers, for example, finding out who was truly uninsured previously. Ms. Hicks suggested adding a few marketing questions to the survey to discover how people found out about DC Health Link.

Dr. Nesbitt asked if the data was broken down by residence in the District. Ms. Kofman said no, the eligibility for businesses is that the business be in the District. Dr. Ku said HBX has zip code information and can figure out where people live.

Ms. Kofman reminded the Board that it had previously asked about the number of SEP enrollments. From April 1 until now, a total of 1,184 people enrolled through an SEP.

V. **Finance Committee Report,** *Henry Aaron, Vice-Chair*

Dr. Aaron reported that the Finance Committee met on June 4.

BERT SMITH AUDIT: Ms. Kofman discussed Bert Smith's programmatic audit in detail. The audit report was submitted to CMS to fulfill a component of the new CMS annual audit called the SMART Audit.

FEDVIP: Staff also informed the Committee of new information from OPM on the issue of assessing dental and vision coverage under the Federal Employees Dental and Vision Insurance Program (FEDVIP). After an

ongoing review of preemption issues, OPM determined that HBX is preempted and therefore cannot assess FEDVIP coverage. HBX is taking steps to issue a refund to one carrier that informed HBX it paid an assessment in 2014 on this line of business.

CMS IT CONSULT: Staff also updated the Committee on the IT Consult visit that Ms. Kofman also highlighted in her executive director's report. This visit is an important component of federal authorization for use of federal grants for IT implementation expenses.

ASSESSMENT APPEALS EMERGENCY REGULATION: Staff informed the Committee that they are working on a staff-draft of proposed emergency regulations for appeals by carriers subject to the HBX assessment. Because of the status of the legislation, HBX needs to promulgate emergency regulations again this year. The staff-draft will be posted by the end of the month for public comment and should be ready for discussion at our July 13th Executive Board meeting.

UPCOMING PROCUREMENTS: Ms. Kofman also informed the Committee that additional procurements will be coming for Finance Committee consideration – and then to the full board – later this month. We've already scheduled a second board meeting in June (Monday, June 15 at 1 pm, this meeting will be by telephone only and it is posted on our website) and it is likely that in addition to the planned business of voting on the 2017 Essential Health Benefit package – which will be discussed later at this meeting – we will have some procurement items.

FINANCIAL REVIEW: We were presented with the monthly HBX expenditures by HBX Staff and noted that expenditures are as expected.

Ms. Sullivan Hare asked how much the refund for the FEDVIP assessment totaled. Ms. Kofman said it was approximately $1.5 million.

VI. Discussion Items

a. Review of 2nd Open Enrollment Period Evaluation Summit

i. Linda Wharton-Boyd; HBX staff

Ms. Wharton-Boyd reported that HBX had held a meeting after open enrollment closed with all its partners to review open enrollment practices and determine which had worked well, and to brainstorm outreach ideas. She reported that the meeting had been successful. Her presentation can be found here.

b. Review of 2015 Business Partnerships

i. Linda Wharton-Boyd; HBX staff

Ms. Wharton-Boyd reported that HBX had reviewed its business partners' activities, and reported that the partners' activities had increased substantially. Her presentation can be found here.

Ms. Hicks stated that one of the things that was successful this last open enrollment period was the local events that strengthened all of HBX's partnerships. Ms. Hicks thought that in terms of messaging, the tax penalty for 2015 will be significantly higher than in 2014, which might be an incentive for some to buy insurance. She also thought positive messages were very helpful.

Ms. Kofman stated that what we have learned is that our army on the ground that helped us succeed is the in-person assisters (IPAs) and the business partners. Both pay dividends with actual enrollment and the earned media surrounding the local events that result in higher awareness. She stated that HBX has always had to be very creative in an expensive media market. She said both the IPA and business partner budgets were as lean as they can be. She expected to maintain the funding of those programs at their present level. She would like to keep the assister groups that are still with us (we pared down the list after the first open enrollment) on board. The guidance received today from CMS is very helpful in that any activities on new enrollment may be funded by grant money.

Ms. Hicks noted that the District is a magnet for young people just out of school and we have a constant influx of new residents that have not heard our message. She thought newcomers would be a good pool from which to draw new applicants.

c. Recommendation for the Essential Health Benefits (EHB) Benchmark Plan for 2017

i. Chris Gardiner, *Chair, Standing Advisory Board*

Mr. Gardiner reported that pursuant to the ACA, the first benchmark plan selected for the individual and small group market in the District of Columbia was the largest small group plan, a CareFirst PPO plan. In early 2013, the HBX Executive Board created an Essential Health Benefit Plan Working Group to help with policy decisions around the EHB package. The key decisions were: Prohibiting benefit substitution, banning day or visit limits on mental health services, defining habilitation based on the National Association of Insurance Commissioners' definition and ensuring applied behavioral analysis is included under habilitation for treatment of children with autism. These policies were then enacted by the Council.

The federal government notified DISB in early May 2015 that the states may select a new EHB benchmark plan for 2017 by May 31, 2015. DISB obtained an extension until June 30, 2015for the District to select the new 2017 benchmark plan.

The 2017 EHB benchmark plan is based on plans as of March 31, 2014. Federal guidance identifies allowable plans and a state can choose from the 10 options: one of the three largest small group plans; the largest non-Medicaid commercial HMO plan; one of the three largest FEHBP plans; and one of the three largest DC government employer plans. The Standing Advisory Board was asked to review the potential benchmark plans and make a recommendation to the Executive Board.

The Standing Advisory Board first met to review the benchmark options on May 23, 2015. HBX and DISB staff researched plan options, drafted a chart to summarize and compare benefits among the plans, and briefed the Standing Advisory Board at the May 23 meeting. The Board also asked for public comment. Two members of the public testified and provided written testimony. After a review and discussion of the ten plans, the Board asked staff to research coverage of benefits in more detail in the following areas: habilitative services; rehabilitative services, home health care services; durable medical equipment; and hospice services.

The Standing Advisory Board met again on June 3, 2015 to review the additional research. The Board also received a report from Dania Palanker, a Standing Advisory Board member who had researched the prescription

drug formularies. The Board reviewed written comments received directly and the ones received through DISB in response to DISB's public comment request.

Unlike with other questions where HBX offers staff recommendations when requested by the Board, HBX Staff did not have a recommended approach. Through a robust discussion, the Standing Advisory Board narrowed the EHB benchmark choices to the three small group plans. The FEHB plans and the DC government employer plans were eliminated as the variation from EHB was too great. The large group commercial HMO plan was then eliminated due to limits on rehabilitative services that the Board considered consumer unfriendly. The largest small group plan as of March 31, 2014 was a CareFirst PPO plan and was the most similar to the existing benchmark.

In the absence of compelling evidence to change the nature of the benchmark plan; recognition that all three small group plans were very similar as they already met the 2012 EHB standard; and recognizing that minimizing marketplace disruption is beneficial, the Board reached a unanimous decision selecting the CareFirst BluePreferred PPO plan, the largest small group plan as of March 31, 2014.

The unanimous consensus decision from the Standing Advisory Board is to recommend that CareFirst BluePreferred PPO plan be selected as the 2017 EHB benchmark plan.

Dr. Aaron noted that the EHB benchmark is about the services a QHP must cover. Carriers can cover additional services, but must cover those on the EHB list. Cost-sharing is a different topic, determined by carriers to fit with a certain metal level.

Dr. Ku asked how much the SAB looked beyond the benefit tables and into the specific benefits actually covered. Mary Beth Senkewicz, Associate General Counsel and Policy Advisor, stated that she had looked through the exclusions and limitations, the definitions, and the charts. She stated she had dug deep into the plan documents to see the actual benefits. Dania Palanker of the SAB had done a similar review of the formularies for Plans A-C. She and Ms. Palanker both concluded that the exchange plans are very similar, as they should be, since they all cover the 2012 EHB.

Debra Curtis, Senior Deputy Director for Policy & Programs, also noted that SAB members themselves had also reviewed the material in some depth, as was evidenced by the questions they asked. Ms. Kofman stated that there was also some back and forth between the carriers and DISB staff to verify some interpretive questions. DISB was quite helpful in the process.

Ms. Sullivan Hare asked about United and why no United plans were on the list of potential benchmark plans. Ms. Kofman said that the list of potential plans was determined by CMS based on enrollment as of March 31, 2014.

Dr. Aaron emphasized that the SAB membership is very diverse, and the recommendation is unanimous. He noted that all the documents before SAB are posted and the Executive Board will be voting in about two weeks.

Dr. Ku asked if picking a new EHB benchmark would be a periodic exercise. Ms. Kofman expected so, and hoped that HHS would provide much more time for the states to consider the EHB benchmark in the future.

VII. Public Comment

No public comment was proffered.

VIII. Closing Remarks and Adjourn, *Henry Aaron, Vice-Chair*

The meeting was adjourned at 7:03 p.m.