DC Health Benefit Exchange Authority

Standing Advisory Board Meeting

FINAL MINUTES

Date:	Thursday, May 21, 2015
Time:	3:00 pm
Location:	1225 Eye Street NW, 4th Floor, Board Conference Room
Call-In Number:	1-877-668-4493; access code 738 905 618

Names of members: Chris Gardiner, Billy MacCartee, Claire McAndrew, Dania Palanker, Jill Thorpe, Kevin Dougherty, Stephen Jefferson, Laurie Kuiper, Luis Padilla, Jill Thorpe

Members Present: Chris Gardiner, Kevin Dougherty (via phone), Billy MacCartee(via phone), Stephen Jefferson(via phone), Dania Palanker, Laurie Kuiper, Claire McAndrew, Luis Padilla, M.D., Jill Thorpe (via phone)

Members Absent: None

I. **Welcome, Opening Remarks and Roll Call,** *Chris Gardiner, Chair*
Chair Chris Gardiner called the meeting to order at 3:05pm. A roll call of members present confirmed that there was a quorum with eight members present: Mr. Gardner, Mr. MacArtee, Ms. McAndrew, Ms. Palanker, Mr. Jefferson, Mr. Dougherty, Ms. Kuiper and Dr. Padilla.

II. **Approval of Minutes,** *Chris Gardiner, Chair*
Time was given to review the minuets from the previous meeting. The Chair asked for questions or comments regarding minutes. It was moved and seconded to approve the minutes from 2/26 meeting. The motion was unanimously approved by voice vote.

III. **Executive Director Report,** *Mila Kofman, Executive Director*
Ms. Kofman opened her remarks by giving a quick update on the budget hearing that took place on April 28th. Ms. Kofman stated that the hearing went very well. She appreciates all those who came to testify and supported us. The second item is that later this month CMS will be doing a site visit at HBX.

Chris Gardiner, Chair: Was the budget approved?

Mila Kofman: A markup of the budget was done and the health Committee approved our proposed budget. And with the Chair's permission, she moved into the topic for today.

IV. Discussion Item

Mila Kofman: In the tradition of being transparent, we want to have a very transparent stakeholder driven process in order to make a recommendation about which benchmark plan will be selected. Unfortunately, the federal government gave very little notice that the states could select their own benchmark plan; therefore we only have a couple of weeks to complete this process. By July 1st we have to notify the District of the new EHB plan. If a state does not act to select a new EHB, the federal law automatically defaults it to the largest small group plan in the state. What that has meant for the HBX staff is that we have had very little time to pull documents and really do an in-depth analysis of the plans. In an ideal world we would like 6-8 months and hire an outside group to do an in-depth analysis and then make a decision. We will do our best to answer all questions that you all might have today and follow up with answers if we can't answer them now.

Billy MacCartee: Mila, you may want to explain why we have a bench mark plan and what it is for.

Mila Kofman: The ACA has a minimum standard of what health insurance has to include. Before the ACA plans could be very limited in nature and now they have to have a basic level of coverage. In each category there is a minimum standard. Remember, cost-sharing, deductibles, co-insurance and copayments are not a part of the discussion today. What will be discussed today is the actual benefit. The scope of work is to select a new EHB benchmark plan from the 10 plans required by federal regulations. We have the chart before us, more detailed information posted online and on hand today our staff and others will walk through these options. The focus today will be to start a discussion of these options. After the Standing Advisory Board members have asked their initial questions, we will open it up for public comment. We look forward to a robust discussion. We will not take any votes today. We will return at a later date after people have had time to digest our discussion today and we may need to do some follow up homework for you. We hope to come to a consensus and take the recommendation to the board by Monday, June 8th. The board will have time to review the information and comments and will vote by phone. The decision will be conveyed to the District who will then let the federal government know. Now we will turn to Howard Liebers from DISB to give some basic information about the plans.

Howard Liebers (DISB): Thank you Director, Mr. Chair, and members of the board. I appreciate everyone's patience with us given the amount of work that needs to be done with a short amount of time. I believe we have most if not all the information to make a decision. I would like to thank Dustin Schaefer on our staff for his help. A notice has gone out earlier today saying that we have begun this process and will be having this meeting and will be accepting comments until May 31st.

Mila Kofman: And Howard that the comments will be shared with the SAB?

Howard Liebers: All comments that we receive will be shared with SAB so they can make their recommendation to the board.

We had requested a 30 day extension from the federal government and it was granted. I believe only 15 states to date have concluded this process. Maryland had their public meeting two weeks ago. If we are looking at our existing plans in the District certainly by law they have to cover the essential health benefits, but as complaints come into DISB we look to see if they are in regards to essential health benefits. To my knowledge, very little, if any, have come in. CCIIO published a bulletin about the three largest plans. If we don't make a decision we will default to the largest small group plan. Currently, the largest small group 9plan in the District is a CareFirst PPO plan offered through their company GHMSI and called the Blue Preferred PPO $1000.

We must keep in mind that adding new benefits in excess of what our current benchmark plan has will have an effect on premiums. It would increase premiums at all metal levels. The District has not passed any new mandates since we have first established our Essential Health Benefit Package in 2012. Some states have mandates above and beyond and the states have to find a way to cover those costs. Again, this doesn't have anything to do with co-pays, co-insurance, deductibles etc.; it is really about the cost of the provision of an additional benefit.

Debbie Curtis (HBX Staff): Is it important if people have complaints that the submit those to DISB and how do they do that?

Howard Liebers: Absolutely submit those complaints. DISB has an online form that can be filled at www.disb.dc.gov or a number consumers can call. DISB also collaborates with HBX on complaints. Earlier this year we met with HBX on QHP certification updates. As part of that process we added guidance to our carrier reference manual about non-discrimination. During that process talked a lot about the complaint process. DISB is currently exploring ways tease out EHB and discrimination complaints.

Dania Palanker: Is the carrier reference manual available on your website?

Brendan Rose (HBX Staff): It is available on the HBX website under the carrier tab.

Claire McAndrew: Do you talk to the ombudsman office and do those complaints get to DISB?

Howard Liebers: We try to connect the contact center, DISB, and ombudsman office to collect complaints.

Claire McAndrew: Did the ombudsman office hear anything specific to this topic?

Debbie Curtis: I will follow up with the ombudsman's office to see, but we have not heard anything**.**

Howard Liebers: I will give it over to Marybeth to discuss the 10 different plan options.

MaryBeth Senkewicz (HBX Staff): I will talk about the 10 options. DISB has documents posted on its website and HBX has documents posted on our website as well. Let me start with the regulation:

> **45 CFR §156.100 State selection of benchmark.**
>
> Each State may identify a single EHB-benchmark plan according to the selection criteria described below:
>
> (a) *State selection of base-benchmark plan.* The options from which a base-benchmark plan may be selected by the State are the following:
>
> (1) *Small group market health plan.* The largest health plan by enrollment in any of the three largest small group insurance products by enrollment, as defined in §159.110 of this subpart, in the State's small group market as defined in §155.20 of this subchapter.
>
> (2) *State employee health benefit plan.* Any of the largest three employee health benefit plan options by enrollment offered and generally available to State employees in the State involved.
>
> (3) *FEHBP plan.* Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by aggregate enrollment that is offered to all health-benefits-eligible federal employees under 5 USC 8903.
>
> (4) *HMO.* The coverage plan with the largest insured commercial non-Medicaid enrollment offered by a health maintenance organization operating in the State.

(b) *EHB-benchmark selection standards.* In order to become an EHB-benchmark plan as defined in §156.20 of this subchapter, a state-selected base-benchmark plan must meet the requirements for coverage of benefits and limits described in §156.110 of this subpart; and

(c) *Default base-benchmark plan.* If a State does not make a selection using the process described in this section, the default base-benchmark plan will be the largest plan by enrollment in the largest product by enrollment in the State's small group market.

In looking at the chart that I've provided, plans A, B, and C as of March 31, 2014, are the three largest plans in the District. Plan A is the BluePrefered PPO, Plan B is CareFirst HealthyBlue Advantage HMO and Plan C is a Kaiser HMO. Plan D is a CareFirst HMO that is a large group product. The first three are the small group products. Plans E, F, G, are the three FEHBP plans. Plan E is the Blue Cross Blue Shield FFS Standard HMO, Plan F is the Blue Cross Blue Shield FFS Basic HMO and Plan G is the Government Employee Health Association (GEHA) plan. For those plans I will note that because they are the FEHBP plans they are not required to cover DC mandated benefits. Plan H is the DC employee Aetna HMO Plan. Plan I is the DC employee Aetna PPO plan and Plan J is the DC Employee Kaiser HMO plan.

Plan A is the largest small group plan and is very, very similar to the existing benchmark plan. I have not gone through the plan word by word but it is very similar to the benchmark. This is for information only. I will also note that here in the District, through resolution and then codified, that we have added three things that may not appear in other states.

First is the definition of habilitative services. We revised the definition as part of our working group process when we developed the EHB to eliminate the age restriction and adopt the NAIC definition of habilitative services. We have received a few comment letters in regards to the issue, but the writers of letters may not be aware of what we have done. Second, for mental health services (that includes substance abuse treatments) we don't allow day limits for services. Also in the District we don't allow substitution of benefits.

Debbie Curtis: To clarify, that means all those things exist in our bench mark plan now, right Marybeth.

Mary Beth Senkewicz: Yes.

I will note that Kaiser in plan C covers bariatric services but not covered by CareFirst in Plans A and B. Mastectomy bras are covered in Kaiser but not listed in CareFirst. I can't say that CareFirst doesn't cover these things in plan A and B, but they are not explicitly listed as Kaiser does. So Plans A, B, and C are very similar as they should be. The benefits that should be included are ambulatory patient services, emergency coverage, hospitalization, maternity/newborn care,

mental health, substance use disorders, behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, pediatric services, including dental and vision and prescription drug formulary. I will also note before HBX existed and EHB's were adopted we had to pull in dental from FEDVIP. I think that is good for an overview and will allow for questions.

Kevin Dougherty: Marybeth you referred to a definition of habilitative services, can you read that?

MaryBeth Senkewicz: Let me just read the exact definition. "For purposes of the essential health benefits benchmark plan, as defined in federal regulations promulgated pursuant to section 1320(a) of the Federal Act, the term "habilitative services" includes health care services that help a person keep, learn, or improve skills and functioning for daily living, including, but not limited to, applied behavioral analysis for the treatment of autism spectrum disorder." That exact language is found in plans A, B and C.

Mila Kofman: This definition was the consensus from a working group back in the winter of 2013.

Debbie Curtis: Correct, it was enacted of March 22, 2013.

Dania Palanker: I noted a few things when I reviewed the plans. The CareFirst plans had exclusions for maintenance therapy. Specifically for the Kaiser plan an exclusion of chiropractic services, but narrowed that as it relates to spinal manipulation. I want to know if spinal manipulation is considered a chiropractic service. I want to make sure it is covered.

Laurie Kuiper: As I work for Kaiser, I asked some colleagues to be on the phone, can you answer that?

Kaiser staff on phone: Not at this time, but we will investigate.

Debbie Curtis: I read it very consistent with Medicare which only covers spinal manipulation as the solo chiropractic service they will cover.

Dania Palanker: In the Kaiser plan, family planning was in brackets but doesn't it have to be included for employers that seek a religious exemption?

MaryBeth Senkewicz: That is correct.

Dania Palanker: I saw that Plan D covers infertility.

MaryBeth Senkewicz: Yes, but it is very limited.

Debbie Curtis: To read precisely what they cover, they say that benefits are provided for medically necessary, non-experimental/investigational artificial insemination (AI) procedures and associated services (including intrauterine insemination). As conditions of coverage, it requires: 1) prior authorization of the treatment must be obtained from CareFirst Blue Choice;. 2) Benefits are limited to six attempts per live birth; 3) The Member is responsible for the copayment or coinsurance for AI stated in the schedule of benefits; and 4) Coverage is subject to the exclusions listed in the Exclusions and Limitations section at the end of this description of covered services.

Chair Gardiner: Any other questions board members?

Claire McAndrew: When I look through a number of the plans there are times that services like for hospice and home health, Kaiser is more specific with limits. For example, hospice covers 180 days and CareFirst just says covered. Is there a difference or we just don't have detailed information from CareFirst?

Dustin Schaeffer: Kaiser is more descriptive than CareFirst. If there is something specific we can research we can reach out to the carrier and get those answered.

Mila: Please look up for hospice care and home health and report back. Thank you.

Claire McAndrew: I don't want anyone to do a lot of work if it is not going to be a deciding factor, but don't want to ding Kaiser because they are more descriptive.

Laurie Kuiper: I want to confirm that I heard correctly and plan A is similar to the existing essential health benefit benchmark plan.
MaryBeth Senkewicz: Yes

Claire McAndrew: In regard to habilitative services and rehabilitative services Kaiser is very descriptive and CareFirst is not.

Mila Kofman: Is there anyone on the phone from CareFirst?

CareFirst Representative on the Phone: I'm checking to see if anyone is on the phone from our marketing team and get an answer for you.

Chair Gardner: We will now take comments from the public**.** We will start with people in the room

V. <u>Public Comments:</u>

Daneen Grooms, American Speech Hearing Language Association (ASHA)
We are very supportive of the HHS definition of habilitative services. The HHS definition makes specific reference to PT, OT, speech language pathology. Please make sure habilitative services aren't based on age. HHS also clarified that issuers can't impose limits on habilitative services that are less favorable than those imposed on rehabilitative services. For example, if there unlimited rehabilitative visits then it should be unlimited for habilitative visits. It is not appropriate to have unlimited services for children, but limit adults. There is still value in receiving those services. I found some information from CCIIO and the current benchmark doesn't cover hearing aids. We would like the plan to cover hearing aids and the state wouldn't have to pay for the mandate. Plans A, B and D meet the new HHS definition of habilitative services.

Mila Kofman: I don't think I understood you. If we include hearing aids the state doesn't have to pay for the mandate? Can you send a link to your authority for that position?

Daneen Grooms: Yes. There is a hyperlink in my comment letter to the actual page in the regulation.

Laurie Kuiper: Does the regulation refer specifically to covering hearing aids?

Daneen Grooms: No, it does not, but a hearing aid is an example of a habilitative service. We think it is a medically necessary device for those with hearing loss.

Tim Nanof (also with ASHA): It is not specifically in the regulation itself. However, hearing aids are used as an example in the description of the regulation. It is specifically cited to describe a benefit that provides hearing aids to children under 19 should not have an age limitation.

Clarie McAndrew: Please repeat what you said for plans A, B and C.

Daneen Grooms: We believe Plans A, B and D are most comprehensive with respect to habilitative services.

Claire McAndrew: Do any of the plans cover hearing aids?

Daneen Grooms: I did a quick look and I didn't find that they did.

Claire McAndrew: Do any of the plans cover rehabilitative benefits more generously the habilitative services?

Daneen Grooms: I did a quick look and did not find anything initially.

Mila Kofman: It would be very helpful if you can look at the three largest plans and the HMO and point out where it leads you to think it will limit services of habilitative services and hearing aids.

Claire McAndrew: Is your analysis that plan A, B, and D are the best for rehabilitative services based on other documents you had to look at?

Tim Nanof: No. We are working from what we have here.

Claire McAndrew: Do you have further information about plan A and B.

Tim Nanof: No, not at this time. However, we think that the Kaiser exclusion for assistive technology for habilitative and rehabilitative services does not comport with the federal regulation.

Chair Gardiner: Any other questions or comments in the room, any other comments from those on the phone?

Jill Thorpe: I want the record to show that I have been on the phone since 3:20.

Debbie Curtis: I want to recap what we owe back. We are going to touch base with the ombudsman's office and see if it has had any complaints or wants to weigh in on the topic. DISB will help us find out the limits, if any, to hospice, home health, rehabilitation, habilitation, and medical devices in the CareFirst Plans.

Dania Palanker: I will do some research on the formularies. The overall numbers look pretty similar. We are going to look at some categories and classes that may raise some concerns. If the board has a class or condition that they want me to specifically to look at let me know.

Mila Kofman: Thank you Dania for looking at the formularies. One other thing our team will follow up on is the reference to new federal guidance. And update our chart to see if the guidance trumps any definitions. We appreciate this board and your discussion in looking at all the options. At the staff level, I do want to note that we thought completely changing the benchmark from what people are used to will create unintended consequences.

Laurie Kuiper: What are the follow up steps again**?**

Mila Kofman: We will get all the information we owe back to you, have a call to make a consensus recommendation to the board, and give the recommendation to the board on June 8th. The Board will have time to ask questions and look at comments and later that month the board will vote on which plan to use.

VI. Closing Remarks and Adjourn- Chris Gardiner, Chair

Thanks to the board, staff and the public for their work on this. The meeting was adjourned at 4:12pm.