DC Health Benefit Exchange Authority
Draft Executive Board Meeting Minutes
Wednesday, May 14, 2014
5:40 p.m.

Members present: Dr. Henry Aaron, Dr. Mohammad Akhter, Kate Sullivan Hare, Dr. Leighton Ku, Diane Lewis, Kevin Lucia, Chester McPherson, Khalid Pitts

Members absent: David Berns, Dr. Joxel Garcia, Wayne Turnage

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

There was a roll call of members present to confirm that there was a quorum. A quorum was met with five voting members present listed above (Dr. Akhter, Dr. Ku, Ms. Lewis, Mr. Lucia, and Ms. Sullivan Hare).

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

The minutes from the April 24th meeting were unanimously approved by roll call vote. Voting in favor were Dr. Akhter, Dr. Ku, Mr. Lucia, Ms. Sullivan Hare, and Ms. Lewis.

III. Executive Director Report, *Mila Kofman*

1. *Budget Hearing:* Ms. Kofman reported that on April 10th, the Health Committee held a budget meeting. The majority of the hearing was about the proposed broad-based assessment. Kaiser and Aetna testified in support, as did the Restaurant Association, the Young Invincibles, the DC Fiscal Policy Institute and others. Opposition testifiers included DCIF, AFLAC, ACLI and AHIP.

2. *Assessment Legislation:* Ms. Kofman reported that the proposed broad-based assessment authority was approved by the Council unanimously on an emergency basis.

Mr. Pitts entered the meeting.

3. *Budget Mark Up:* HBX's budget was marked up earlier in the day by the Health Committee. She was pleased to report that the recommendation is exactly as proposed. Another recommendation in the report includes HBX in the same

process that DISB is currently subject to with respect to the insurance trust fund bureau. Membership of the bureau is all insurance companies that do business in DC; the board is made up of a subset of those members. The board is accustomed to reviewing DISB's budget and it has authority to conduct independent audits of DISB. It hires an outside accounting firm, at its expense, to conduct audits of DISB's spending every couple years. We would be subject to same approach.

Mr. Aaron entered the meeting.

4. *New Member Services Staff:* The HBX staff has been reorganized, and we are hiring staff to deal with member issues, including successful enrollment. Some of the new team members were successful in-person assisters, so they are familiar with the system, and we welcome them to the team.

5. *Upcoming moves:* The move to permanent space, originally anticipated for June, has been delayed to August or September. The contact center also needs to be relocated. That is likely for that same time period.

Ms. Sullivan Hare asked the locations of the new venues. The HBX location is 1225 Eye Street, NW. The Contact Center is in the L'Enfant Plaza area.

Ms. Lewis asked if the present location could be extended. Ms. Kofman stated that the building will be torn down in December in December. DGS is working with the current landlord to ensure space until we move.

6. *Special Enrollment Periods:* CCIIO has named some additional SEPS and it is encouraging states to adopt similar SEPs. We have asked the Standing Advisory Board to review the federal marketplace SEPS and to make recommendations for the Board to consider. A meeting will be scheduled later in the month and we are hopeful recommendations will be made at the June meeting.

Mr. Lucia inquired whether HBX had flexibility to open up the definition. Ms. Kofman replied that yes, staff reviewed the federal marketplace triggers and researched what other states have done. That information will be presented to the Standing Advisory Board.

7. *Enrollment Update:* Ms. Kofman reported that she was very pleased with our age breakdown. In the individual market, 54% of covered lives are under age 35. The latest enrollment numbers are available on the website,

IV. Executive Board Finance Committee Report, *Henry Aaron, Chair*

The Committee met earlier in the month and reviewed logs of purchase orders. Dr. Aaron found it difficult to understand because grants are tracked separately and committed dollars are accounted for differently than spent dollars. We seem to be on target.

The Committee also discussed change orders with our IPS IT Contract. We will know which change orders actually represent new work outside the scope of the contract in order pay

properly. There is a process by which an interagency committee reviews change orders and if approved by the interagency committee, they come before the Finance Committee. We discussed the change orders that came through that process and we did approve them.

Ms. Sullivan Hare asked if we are on target. Are we below budget? Dr. Aaron replied that we are within budget. Another supplemental grant is possible, so the total amount is not known yet.

Ms. Kofman added that some of the grants went to sister agencies prior to HBX being in existence. So, that makes it even more complex. Our financials will look more "normal" after federal grant dollars are no longer in the picture.

V. Executive Board Research & Data Analysis Committee Report, *Dr. Mohammad Akhter*

Dr. Akhter reported that he, Dr. Ku and Dr. Aaron comprised the Committee. The Committee is working with staff. For enrollees through DC Health Link, we have telephone numbers or emails of 90% plus. The Committee is discussing a schedule for research. HBX staff statistician Stephen Haines has been very helpful in providing input so the Committee can research how many enrollees had insurance prior to ACA, and how many uninsured have we covered. Also, the Committee must deal with fundamental issues that come with research such as confidentiality and privacy. The Committee notes that as we partner with researchers in community, we must review conflict of interest standards carefully so to recuse ourselves when appropriate on research projects. Within the first to second week of June the Committee plans to hold a public meeting with all stakeholders to solicit input on a basic plan on how to proceed. The Committee wants to conduct a survey in time to inform our next open enrollment in November.

- Discussion Items

Review of Outreach and Enrollment Efforts During Open Enrollment, *Linda Wharton-Boyd, HBX staff*

Dr. Boyd presented a slide presentation of our outreach and media strategy for first enrollment period which was very successful. Our motto was simple – reach them where they live, work, play and pray. The beginning of the process was to educate and encourage. The second half was enrollment, enrollment, enrollment. "Don't Delay Enroll Today." In the final push in March, we capitalized on events we knew were successful.
The full presentation can be viewed here.

Mr. Lucia asked if we knew from the people who enrolled, what communication worked best. Dr. Boyd stated that the communications team was working on that with regard to the survey Dr. Akhter mentioned. Preliminarily, the one-touch enrollment center was probably the most effective and word of mouth in the community from trusted resources and the Faith Based initiative seemed successful. Moving forward for second enrollment period, we are looking at more storefronts rather than the libraries.

Dr. Ku stated that national reports have shown low enrollment among Latinos. Dr. Boyd stated that our one touch enrollment centers at Carlos Rosario had lines waiting to get in that were mostly Hispanic. One assister told her that not only was one touch enrollment center a win for enrolling Hispanics, it also brought together the three agencies and brought together our internal staffs as well.

Ms. Kofman clarified that was Dr. Ku asking if we've done data mining to ascertain ethnic information. She stated that data has been mined, but one-third of enrollees did not report that data, so we cannot rely on it. She is hoping the research committee's work will get a more accurate sense of other demographics on who enrolled besides age. Also, at a recent conference a panel talked about SBMs and what they will do next year without federal grants. There was consensus that states are looking at the more localized approach – which is interesting since that has been our approach since day one. We learned about not spending limited budget on advertising buys. Other states are now moving in our direction on the grass roots front which we've been doing all along. Mobile apps and improving the consumer experience were highlights and we have been doing that too.

Mr. Lucia asked as our budget tightens, how do we maintain our efforts? Dr. Boyd stated that we engage additional partners who already have networks to expand out outreach. Mr. Pitts asked whether our existing partners would keep working with us when funding goes away. Dr. Boyd said yes, to some extent. But we will have to look for creative ways to keep them engaged.

Ms. Kofman stated that when we do the series of surveys, we will find out how they got in – on their own, with a broker, with an assister and why? We will learn. We will not buy expensive cable time as there is no evidence that works. We do see other evidence of local events and this survey work will further help. She would love foundations to partner with us. Preliminary reports indicated that the WTOP PSAs with presidents of our three associations are talked about and seem to create a buzz. That seems a good way to keep our message out there.

- **Dental Plans Working Group,** *Leighton Ku, Chair*

  By way of background, last year the Board approved the variety of dental plans that could be submitted. It turned out all major medical plans embedded the pediatric dental essential health benefit. Then, when dental carriers wanted to sell stand-alone dental plans (SADPs) with pediatric dental benefits only, DISB did not approve any, taking the stance they were duplicative of benefits in the QHPs. Dental plans did not like that outcome and that was our major task this year. Other issues were addressed as well.

  The working group reached consensus two clusters of issues. Stand-alone dental are not on SHOP due to technical limitations. We will soon have the ability to add them. Questions of policy needed to be answered about their availability. Of course, our choices are limited by our IT capabilities. In general, the group decided to agree on things that can be accomplished with the IT system quickly.

One issue was the extent to which employers could offer dental plans to their workers. We recommended that employers be able to offer any number of plans to their employees. It is up to the employer, which could choose one, more than one, etc. The next question is what type of employer contribution methodology should be required? The group recommends a percentage of a reference plan if the employer offers multiple choices.

The third area is should an employer contribution be required? The group recommends no requirement of a minimum contribution. Again, this approach can be accomplished with our IT and it is typical that employers do not contribute – our recommendation is consistent with the norm.

Another issue had to do with the concern that pediatric dental is embedded with the medical benefits and consumers might not fully understand the extent of the benefits. So, there is great interest in more clarity about pediatric dental benefits on the DC Health Link website. The working group reached consensus on this issue.

The working group discussed two non-consensus areas. Should pediatric-only SADPs be available in the individual and SHOP markets? Dental plans want the Board to adopt a policy to require that QHPS offer at least some plans without embedded pediatric dental. Then consumers could pair QHPs with SADPs for pediatric dental coverage. The dental carriers think this approach provides more choice to consumers. The dental carriers say that they have better or different networks that major medical plans. The dental carriers also noted that some members are childless adults or couples and we are today requiring all to purchase pediatric dental benefits even though they don't have children.

The working group asked major medical plans about their reactions and asked if they would voluntarily drop pediatric dental from some QHPs. All the major medical plans think it is a good idea have pediatric dental embedded and they would not voluntarily offer some QHPs without pediatric dental. It means that everyone in the QHPs have a pediatric dental plan so that all children have that coverage.

The majority of the Working Group members agreed with the recommendation that we leave the current status quo – we will not impose requirements on major medical plans either way. It is their choice whether to embed or not. It appears they will still offer embedded pediatric dental benefits, but it is not a requirement. There is a division of views on this perspective. Major medical plans and consumers favored the recommendation while dental plans did not. It is a non-consensus item and we did offer dental plans the opportunity to provide a minority report. Delta Dental did submit a minority report on behalf of some dental carriers and it is included in the materials you have received.

The second non-consensus item is what should be done about deductibles in embedded dental plans? There can be just one overall (blended) deductible. If that is $5000, it is conceivable that a family that is healthy would have to consume $5000

in care before the child receives any dental benefit. Should there be a separate deductible for pediatric dental benefits in an embedded plan? Kaiser has no deductible, and CareFirst has $50 in network/$100 out-of-network. Aetna and United have plans with blended deductibles. The recommendation was to require a maximum separate dental deductible for embedded pediatric benefits. The Working Group discussed $50/$100 for individuals and $100/$200 for families. The recommendation is non-consensus because the major medical carriers did not express an objection, but they did not have time to consult with actuaries and colleagues on financial implications. So, they did not want to agree on the spot. Also, we realized it is too late to do for 2015 so we were proposing it happen in 2016.

- **Insurance Market Working Committee,** *Kevin Lucia, Chair*

Mr. Lucia explained that two non-consensus issues came to the Committee, comprised of himself, Dr. Aaron and Ms. Sullivan Hare. They are complicated issues and the Committee did not think it had all the data needed to fully explore the options.

The first issue was with respect to the majority recommendation of maintaining the status quo and allowing carriers whether to embed the pediatric dental essential health benefit in their QHPS. The vote was in favor, 2-1 with Ms. Sullivan Hare voting no. Mr. Lucia was sympathetic to the argument that having an embedded pediatric dental benefit is a good thing. On other hand, maybe someone wants to buy a stand-alone product. So, the Committee did want further discussion in understanding DISB's position.

Dr. Aaron also wanted to hear more about DISB's position. He thought there were two reasons that might be acceptable to allow pediatric SADPs. One is deductibles and the second is the network issue.

Ms. Sullivan Hare stated that childless adults pay for maternity benefits; we all pay for benefits we don't use. She could make the same argument for pediatric dental benefits. At the same time, there is a difference in dealing with networks and appeals. Medical plans are new in this field. Dental plans have expertise. Maybe at one point these two groups might merge, but we are not there now. Her concern is primarily on the SHOP side. Her husband provides 100 percent coverage for a health plan for his employees. As an employer they have never been able to offer dental because a group of five or more is required. On the SHOP side, if we agree with the recommendation, small businesses may be paying twice for dental coverage. The employer could pay for embedded pediatric dental and then offer stand-alone dental that is hopefully richer. But, you'd be charging them twice. Other states have allowed pediatric-only SADPs. The Committee needed more information. HBX could prohibit buyers with children from completing enrollment without purchasing pediatric dental coverage. She stated she will oppose the

resolution at this point. When it comes to SHOP, there absolutely needs to be the offering of stand-alone products. She also wanted to hear from DISB.

Mr. McPherson (DISB Acting Commissioner) stated there was no nefarious plan at DISB regarding the decision last year. Based on his discussions and research, all will concede that implementing ACA was quite a task. Some decisions were chosen to be pended because we didn't have the bandwidth to address them at the time. That does not mean it is a permanent decision. For the 2016 plan year that it is his view that choices be available. Any change cannot occur for 2015 because the carriers file rates and forms soon and DISB does not have the ability to conduct the robust assessment needed to support a change that quickly. DISB will certainly take into account the views of the Board and he does not envision any disagreements. From a general public policy perspective he believes there should be choices. He also must recognize the capabilities of the exchange so that the public is adequately informed of these products.

Mr. Lucia stated that the Committee's recommendation is to continue to allow major medical carriers to embed or not at their option. He thinks most will. To Ms. Sullivan Hare's point, he does not think the working group or the committee knew all the options out there that are being allowed now in other states. We need to spend time understanding the issues and really understand the value add, and do not make the decision hastily.

Mr. McPherson stated that from a consumer protection view, we should provide choices. We shouldn't be paternalistic. If the law provides for that option, we should do whatever we can to be supportive of what the law provides.

Dr. Ku stated that if we move forward with consensus recommendations, he is hopeful that stand-alone dental will be available in SHOP shortly. He expects they will be family plans and those plans have to provide pediatric dental. He noted that with adult dental plans, we don't regulate them at all. We are silent on the nature of benefits so he cannot necessarily say how robust the plans are or not. It is a very different market than the ACA. There are lifetime limits with most dental plans.

Ms. Sullivan Hare noted that we are asking people to pay twice for coverage in SHOP. Mr. McPherson asked whether family dental is only in the individual market. Ms. Kofman replied that we don't have a SHOP SADP option yet.

Mr. McPherson stated that pediatric dental is a requirement in ACA so we have to keep that exception. The ACA provides that it can be excluded.

Ms. Sullivan Hare stated that the Committee did have a discussion that if we were to have stand-alone pediatric dental, that we would not allow completion of check out until applicants had their children covered. Ms. Lewis said the staff must research whether we have the authority to arrange the benefits in a way that is being discussed. The Board should not encourage purchasing of coverage twice. She

asked how the offerings could be structured so we have options as Mr. McPherson suggests. Consumers should be able to buy major medical and dental and not have duplication.

Mr. Lucia stated that the Board needs more time and information to discuss the issue. Also, there are adverse selection questions and public policy questions. He would hope we maintain the status quo for this year, but we make an informed decision for next year.

Ms. Lewis agreed. The Board cannot do everything at once. We need immediate recommendations for 2015, but we can revisit for 2016.

Mr. Lucia continued with the second non-consensus issue. Should there a separate pediatric dental benefit deductible? He did not think anyone on the Board believes a single blended deductible is the appropriate public policy. However, he is sensitive to the fact that carriers are filing soon and more information is necessary for how a separate deductible will affect pricing and that will take time to gather. Our recommendation is to put carriers on notice that we are moving to a separate pediatric dental deductible in 2016 so people will know their kids can access to the dental benefits they need.

Mr. McPherson stated that he was struggling with this issue. If a family incurs significant dental costs and the plan does not have a separate dental deductible, the family might never receive any significant dental benefits. He stated we must be sensitive that we could have unintended consequences. One could potentially make people worse off. A family could have $6000 in dental and not meet the major medical deductible at all. Is that good public policy? Mr. Lucia stated that is the mapping out we need to think about.

Dr. Aaron stated that as far as the action item for 2015, it is pretty cut and dry that we need to maintain the status quo. For 2016 we agree there are complicated issues and we should restart that process. We aren't going to settle them tonight. He suggested that the Board approve the recommendations of the committee with strong consensus that these issues need to be looked at fresh and early so that no issues are left off for administrative reasons.

Dr. Ku thought that the dental group could reconvene in June to tackle the issues so any recommendations are timely.

VI. Public Comment

Kevin Wrege represents both Delta Dental and Aetna. Aetna is unwilling to un-embed pediatric dental benefits for its major medical plans voluntarily. He would reinforce Dr. Aaron's comments that Delta Dental is strongly supportive of a process to start this process early. IT questions are also important so that consumers are not confused. All choices should be available in the exchange.

Frank Kolb, Delta Dental Association, had statement for record (attached). The Association believes that SADPs bring choice and transparency to the exchange. The Association has a number of plans that spent time and effort and wanted to come into this market. The Association wants to participate in the working group to deliberate on these issues for 2016, particularly with regard to SHOP.

Kris Hathaway, National Association of Dental Plans stated that SADPs have over 400,000 in enrollments in dental plans in DC, with 200,000 of them in small group. She is excited to continue working with Dr. Ku and the working group.

Michael Hickey, MetLife, echoed the comments of his colleagues.

VII. Votes

Ms. Lewis called for a vote on Resolution 1, the consensus items from working group. The Resolution was adopted, with Dr. Aaron, Dr. Akhter, Ms. Sullivan Hare, Dr. Ku, Ms. Lewis, Mr. Lucia and Mr. Pitts voting yes.

Ms. Lewis called for a vote on Resolution 2, a non-consensus item, to maintain the status quo and allowing carriers to choose whether to embed, or not embed, pediatric dental benefits in their QHPs. The Resolution was adopted, with Dr. Aaron, Dr. Akhter, Dr. Ku, Ms. Lewis, and Mr. Lucia voting yes. Ms. Sullivan Hare and Mr. Pitts voted no.

Ms. Lewis called for a vote on Resolution 2, a non-consensus item, requiring a separate pediatric dental deductible starting in 2016 for QHPs that embed pediatric dental benefits. The Resolution was adopted, with Dr. Aaron, Dr. Akhter, Ms. Sullivan Hare, Dr. Ku, Ms. Lewis, Mr. Lucia and Mr. Pitts voting yes.

VIII. Closing Remarks and Move to Executive Session (contracting and personnel issues)

A motion was made to move into closed executive session pursuant to DC Code Sections 2-575(b) (2), (4) and (10) and 31-3171.11 to discuss personnel, legal advice and contracting matters. Upon a unanimous roll call vote of the members present, the meeting went into closed executive session. Dr. Aaron, Dr. Akhter, Ms. Sullivan Hare, Dr. Ku, Ms. Lewis, Mr. Lucia and Mr. Pitts voted yes.

Time is: 7:26 p.m.