DC Health Benefit Exchange Authority
Draft Executive Board Meeting Minutes
Wednesday, June 11, 2014
5:40 p.m.

Members present: Dr. Henry Aaron, Dr. Mohammad Akhter, Kate Sullivan Hare (by telephone), Dr. Leighton Ku, Diane Lewis, Kevin Lucia, Nikol Nabors-Jackson (by telephone), Khalid Pitts (by phone for part of meeting)
Members absent: Dr. Joxel Garcia, Chester McPherson, 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 six voting members present (Dr. Aaron, Dr. Akhter, Dr. Ku, Ms. Lewis, Mr. Lucia, and Ms. Sullivan Hare).

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

The minutes from the May 22nd and June4th meetings were unanimously approved by roll call vote. Voting in favor were Dr. Aaron, Dr. Akhter, Dr. Ku, Ms. Lewis, Mr. Lucia, and Ms. Sullivan Hare.

Ms. Lewis announced that Dr. Akhter is leaving the Board. She stated that Dr. Akhter has been very special and important to the exchange from its inception to now, and it is with real regret that she was announcing his departure. She stated that Dr. Akhter was the first chair, and his vision and driving force established the exchange and has been vital to its operation. She stated he had been steadfast in his support of the Affordable Care Act. After his chairmanship ended last summer, he continued to work tirelessly. He also chaired our Research Committee and that role is especially important and will improve our work to cover the uninsured. She stated that the Board is deeply indebted to Dr. Akhter for his work to cover all in the District. His foundation is what the Board will build on to expand coverage and provide health equity. On behalf of the Board, Ms. Lewis thanked Dr. Akhter greatly.

Dr. Ku noted that Dr. Akhter has served the city in so many ways for a much longer time period, having been the Department of Health director – and more than we've even realized over the years. Dr. Akhter is a wonderful citizen of the District.

Dr. Akhter stated that his tenure on the Board has been a great opportunity to learn; he got an extra masters education working with everyone on the Board and the staff; he learned so much about health care law. He stated there comes a point when you need to graduate and can't stay in school forever, and it was his time to graduate. He stated he would not going far, that he would be at Howard.

III. Executive Director Report, *Mila Kofman*

1) *Department of Human Services.* Ms. Kofman reported that Ms. Nabors-Jackson will be acting as head of DHS so we will officially be welcoming her to our board and she will be added to our information on the web.

2) *Enrollment.* Ms. Kofman reported that DC Health Link was still enrolling people. Persons with life events (baby, loss of job, etc.) have special enrollment periods and if you qualify for Medicaid or are a small business, you can enroll at any time. Present enrollment figures:
Individual Market – 11,582
SHOP - 13,598
Medicaid - 23,008
Total - 48,188 covered lives

3) *Dr. Akhter.* Ms. Kofman thanked Dr. Akhter for his leadership. She stated that he introduced her to all the Council Members, the Mayor and his team, and those introductions and investments have paved the way to our success. He taught a lot about being a board and being an executive director. He provided tremendous mentoring and guidance and she will greatly miss him.

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

Dr. Aaron thanked Dr. Akhter for his service on the Board. Dr. Aaron stated that over our time, he increasingly respected and valued his judgment. He stated that Dr. Akhter brought singular qualities skills to the Board not possessed by the other Board members and he will be missed.

1) *Supplemental Grant.* Dr. Aaron noted that CMS has transferred funds for our supplemental grant. The grant requested $8.6 million and we received $7.9 million.

2) *Additional Grant.* An application was filed on May 15 for principally IT needs. Follow up meetings with CMS will occur and by July we should know whether this grant is approved and for how much.

3) *Finances.* The Committee reviewed finances for the preceding month – mostly staff and purchase orders. No significant issues since May, but we will be spending for IT which we hope to report on in July

4) *Reporting.* Dr. Aaron stated that a large part of the meeting was devoted to what form the reports on the finances of the exchange should take so that it facilitates decision

making by the Board and understanding by the public. The Committee looked at other state marketplaces and how they presented data. Dr. Aaron stated he has been educated and surprised at how difficult it is to present data at this point in the life of the exchange, since we get money from different grants from CMS covering different periods of time for different categories of purposes, different timelines, different restrictions and furthermore, they are meant by use for other agencies of the District. This scenario has posed serious challenges in laying out the data. And accounting conventions within the District that complicate the matter further. The committee is looking to present data better in 2016 when we no longer have federal dollars. He praised the staff, who are working very hard to develop a comprehensible presentation format.

Mr. Lucia asked about seeing the budget for next year.

Ms. Kofman stated the budget had been approved by the Mayor and the Health Committee. It is part of the Council budget process, and upon approval by Council, it will then go to Congress for final passage. She also stated it is all public and on city council website. Staff will resend the link.

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

Dr. Akhter reported that the Committee had several staff meetings and one public meeting to lay out the agenda for the Committee. The Committee has reviewed confidentiality and security, which are key. This afternoon the Committee had a final discussion to lay out timelines. The first action in the following months will be a survey to inform us about the population who has enrolled in the exchange: who they are, where they live, were they previously insured, and how can the customer experience be improved. We will attempt to survey look at QHP and Medicaid enrollees, and also those who did not enroll. That will inform our next open enrollment. After that, longer term, we want to look at the access to care and cost. Third will be quality of care and the impact of health status.

Mr. Pitts joined the meeting via telephone.

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Ms. Lewis noted that since Dr. Akhter won't be on the Research Committee any more, we will need another Board member on it. Her understanding is Kevin Lucia is interested. Mr. Lucia said yes Ms. Lewis noted the committee structure could be resolved when the Committee meets next.

Dr. Ku inquired as to the timetable for replacing Dr. Akhter on the Board and the Mayor's involvement. Ms. Lewis replied that with regard to the two members who are up for reappointment, the mayor has their information. Ms. Kofman added that the Mayor decides so the timeline is his. Ms. Lewis noted that it does have to go to the City Council for approval.

VI. Discussion Items

- **DC Health Link Assister Program Update** – *Ikeita Cantu-Hinojosa, HBX Staff*

Ms. Cantu-Hinojosa stated that staff is very excited about the contributions of the DC Health Link Assisters over first open enrollment period. We are analyzing best practices, lessons learned and wanted to give you an update. The grantees were approved August 13, 2013. There were 33 organizations in the program. 22 of them ended April 30. The remaining 11 grant extend to Dec. 31, 2014. Given that next year's open enrollment extends to Feb. 15, 2015, we are partnering with the remaining grantees to see if they can serve through the extended open enrollment period. Most organizations agreed to the no cost extension. Lessons learned: the power of faith based organizations. We are also going to have a couple of the strong faith based organizations that closed out in April agree to continue on with us through the next open enrollment. We have a meeting tomorrow about next steps for our grantees for next open enrollment.

The grant administrator is still finalizing paperwork. But, it does appear that no group overspent and some are returning unspent funds which will enable us to apply those funds to the next open enrollment period.

We had 184 certified DC Health Link Assisters. Now we have 86 active assisters. The remaining 91 are now considered inactive mostly because their groups ended their grants. This does present an opportunity in that there is large experienced pool of people. Some of these assisters will rejoin in the fall, and some will contribute in other ways. Staff values their experience and we have hired five former assisters to serve as case managers and one to serve as a business support specialist. We are excited to have that expertise on board.

Training update: Whitman Walker and Families USA were our training team. It was a comprehensive five day, 30 hours training with daily exams and a comprehensive exam at the end. We also had monthly continuing education. That monthly process gave us a continuous feedback loop. The assister training experience is a model for the Certified Application Counselor (CAC) training, and it will also help us Call Center training.

Reporting tool (ART): Compliance was a major focus. Assisters had to electronically report all of their outreach and enrollment on a real time basis. We were able to adjust activity based on these reports. We are still in the process of comprehensive analysis, but here are some key points:

- Assisters did outreach to uninsured and hard to reach populations; the data shows the majority of people they helped were uninsured.
- Males are a population in need of assistance in DC. We highlighted that data early on and assisters improved their outreach to males based on our input.

The time spent on enrollments shortened over time which showed real improvement. The beginning of the program was education-heavy and enrollment ticked up towards the end. If we can speed up the education process, we can get to enrollment sooner.

- **Emergency and Proposed Rules, "Health Care Assessment Administrative Appeal"** – *Jenny Libster, HBX Staff*

Ms. Libster reported that staff had drafted proposed regulations after conducting research into the assessment issue. We need an appeal process in place to satisfy due process requirements. Staff drafted an emergency regulation and a permanent regulation as well. The Assessment rule went into effect May 22nd. She noted that there is not sufficient time for the full regulation process, due to the timing of the assessment and the Council schedule for summer recess.
If the Board adopts the emergency regulation, it becomes effective that date and expire 120 days later.

With regard to the proposed process, we have made this proposal available on our website for informal comment before we go into the formal rulemaking process, the same as we did for the assessment when it was a proposed rule.

Ms. Libster stated the regulation was modeled after the FFM process with regard to its user fees. First, the regulation sets forth the scope of what carriers can appeal. There are three categories: the classification as a health carrier, processing errors (typos and administrative errors), and contesting the incorrect application of the assessment methodology or a mathematical error. The regulation does not enable health carriers to appeal the ability to assess. Also, the appeal is limited in scope: in order to contest the amount of assessment, it needs to be at least 1 percent of the assessment. In essence only material problems can be appealed.

The filing deadline is appeal within 30 days of being assessed. This time period is a deviation from the federal process which allows 60 days. While it is shorter, 30 days is still fair.

The appeal must identify the category under which the health carrier is appealing, provide any supporting documentation at the time of appeal. The regulation clarifies that the health carrier shall not provide information already submitted to the Department of Insurance, Securities and Banking, i.e. the Annual Statement, as we have access to it through DISB.

Once an appeal is made, the Executive Director or her designee will review the appeal and then, look at any additional information that might be pertinent. If additional information is reviewed, it will be provided to the health carrier for comment. The health carrier must prove its case by a preponderance of the evidence. HBX must provide a written decision with 30 days. The decision is final and binding with no other method to appeal through this mechanism.

Dr. Aaron asked what happened if the Executive Director does not comply. Ms. Libster responded that the health carrier could seek remedies through court system. Ms. Kofman added that if written decision is 45 days later and there is clear violation of this rule and a carrier goes to court to challenge the validity of the decision, the carrier has our non-compliance with the timeline as a another complaint.

Dr. Ku asked whether anyone had asked for these reviews in the past. Ms. Libster replied this is new for HBX. Mary Beth Senkewicz noted that DISB has a longer process of appeals, but to her knowledge no carrier has ever appealed an assessment. DISB assesses all licensees for their own operating funds, they also collect for Ombudsman. Purvee Kempf added that one thing to note is that DISB rules are written more broadly because there are more types of appeals, such as revoking licenses. That is why DISB has a more detailed process since there is much more at stake. It makes more sense for us to look at the FFM than DISB which has so much more on their plate for their appeals process.

Mr. Lucia asked if the FFM process had the grace amount of 1%.Ms. Libster replied yes.

- **Standing Advisory Board – Consideration of additional exceptional circumstances to qualify for a Special Enrollment Period**, *Claire McAndrew, Vice Chair*

Ms. McAndrew reported that on May 30 the Standing Advisory Board met to consider additional exceptional circumstances that would permit a Special Enrollment Period (SEP) into DC Health Link coverage as recommended by staff of the DC Health Benefit Exchange Authority. Staff recommendations came from a review of exceptional circumstances that qualify individuals for an SEP in the FFM as well as SEPs that have been adopted by other states' marketplaces. The SAB approved the recommendations of the staff with some slight modifications, and the draft resolution before you reflects the recommendations of the SAB to the Executive Board. Ms. McAndrew noted that Alex Alonso, the DC Exchange Staff member who drafted the resolution, was present for policy questions.

She walked through the exceptional circumstances that the SAB recommends should qualify individuals in the District of Columbia for special enrollment into the health benefit exchange.

1) A natural disaster such as an earthquake, massive flooding, or hurricane prevented the consumer from enrolling during open enrollment or their special enrollment period. The triggering event shall be day of the disaster of the event, to include the last day in circumstances involving multi-day disasters.

2) A serious medical condition, such as an unexpected hospitalization or temporary cognitive disability prevented the consumer from enrolling during open enrollment or a special enrollment period for which they were otherwise eligible. The triggering event shall be based on the circumstances of the medical condition as determined by the Authority.

3) A DC Health Link system outage or an outage of federal or local data sources, around the plan selection deadline prevented a consumer from enrolling during open enrollment or a special enrollment period for which they were otherwise eligible. The triggering event shall be the day of the outage.

4) If a person is leaving an abusive spouse. The triggering event shall be the date the individual leaves the spouse.

5) If an individual receives a certificate of exemption from the individual mandate based on the eligibility standards described in 45 C.F.R. §155.605(g)(1) for a month or months during the coverage year, and based on the circumstances attested to, or changes reported under 45 C.F.R. §155.620(b), he or she is no longer eligible for an exemption within a coverage year, but outside of an open enrollment period. The triggering event shall be 30 days prior to the date of ineligibility for the exemption.

7) If an individual is a current COBRA enrollee, he/she shall have until November 15, 2014 to voluntary drop COBRA coverage and enroll in a DC Health Link plan.

8) If an individual is a member of AmeriCorps State and National, Volunteers in Service to America (VISTA), and National Civilian Community Corps (NCCC). The triggering event is either the day the individual begins or ends service with one of the three programs.

9) Getting divorced or legally separated. The triggering event is the date of the divorce or legal separation. Effective dates shall mirror those available based on marriage under 45 CFR §155.420(b)(2)(ii).

10) Entering into a domestic partnership or civil union. The triggering event shall be the date the partnership or union is entered into. Effective dates shall mirror those available based on marriage under 45 CFR §155.420(b)(2)(ii).

11) Being court-ordered to obtain health insurance coverage (a.k.a. "medical insurance coverage order"). This circumstance shall include when a person other than the applicant/enrollee is being ordered to obtain coverage for the applicant/enrollee. The triggering event shall be the date of the court order.

12) Losing access to employer-sponsored coverage because the employee is enrolling in Medicare. The triggering event is the date of the loss of coverage. Effective dates shall follow the rules under 45 C.F.R. 155.420(b)(2)(iv).

13) Losing access to COBRA because an employer that is responsible for submitting premiums fails to submit them on time. The triggering event shall be the date of the loss of coverage. The length of the SEP shall be based on circumstances as determined by the Authority. The effective date of coverage shall be based on circumstances as determined by the Authority with the intent of preventing gaps in health coverage for the consumer.

Ms. McAndrew noted a special focus on the COBRA open enrollment period. Because COBRA notices have been so weak, the federal marketplace made a special enrollment period allowance for COBRA and the SAB agrees with this as well.

Mr. Alonso stated there was a tweak to 13 – it isn't just that the employer pays, but the employer submits. The employer may fail to submit, but the former employee may have actually paid the employer. The tweaked language protects the consumer in both instances.

Mr. Lucia asked if any of the SEPs were different than the FFE. Mr. Alonso requested permission to finish technical corrections first. In number 4 and 13 typos were corrected, and

Numbers 5 and 6 had been consolidated since they are very similar and could be grouped together.

Dr. Aaron inquired whether civil union was a legal concept. Mr. Alonso replied yes. Also, domestic partnership is defined in DC law. Domestic partnership has been maintained despite same sex marriage because of sanguinity – people with inter-related financial relationships who are family members. Ms. McAndrew said the motivation behind the SEPs is maintaining existing insurance relationships.

Claudia Schlossberg for Wayne Turnage suggested adding the citation to the DC law for domestic partnerships and civil unions. The Board agreed to that change.

Mr. Lucia asked what defines "leaving the spouse"? Should the exchange be determining that? Mr. Alonso replied that the language was drafted with Dania Palanker from the National Women's Law Center and she advised this was the language to use in this circumstance. We can't say "separation" because it has a legal meaning. Dr. Ku thought it better to leave the language vague because the breadth of circumstances. Otherwise you will leave people out. Mr. Lucia asked whether it is up to the exchange to determine in these instances. Mr. Alonso replied yes.

Ms. Schlossberg asked whether there was cost to these workflows. Is there cost to implement these changes? Mr. Alonso replied that the overwhelming majority of SEPS and exceptional circumstances already apply. They really are exceptional.

Mr. Lucia stated he wanted to be most protective to consumers, especially in the domestic violence circumstance. Mr. Alonso stated that in the protective order situation, they ask for the date of last act of abuse. We did not want to be that limiting and were not comfortable with that approach. Ms. McAndrew stated it was unsuitable as well. The date of the last act could be months before a person gets the courage to leave. The intent was to be the most protective as possible. This language is a challenge, but the intent is to err on behalf of the fleeing spouse.

Mr. Alonso stated that the SEP was inspired by the federal marketplace, but its exceptional circumstance in this related instance was temporary, was 60 days and expired May 31, 2014. The SAB is recommending it based on a new IRS ruling that permits domestic abuse survivors to claim coverage as an individual. This SAP is much broader than that – it addresses domestic violence whenever it occurs. Dr. Ku suggested we might want to broaden it as well to include dependents. Mr. Alonso said that isn't needed. It already covers everyone in the household.

Mr. Lucia said that at Georgetown, he has been hearing about when someone isn't eligible for tax credits until their income drops to become eligible. If that person is already enrolled in full coverage, he or she can get an APTC. But, if people did not enroll because they couldn't qualify for financial help, and later income drops down, they don't get an open enrollment period. There is a push in advocacy organizations to get this addressed.

Ms. McAndrew agreed it is a concern. It was not discussed at the SAB.

Ms. Kofman related that the staff looked at FFM and other states for their exceptional circumstances. We used those facts to ask the SAB to make recommendations. That's what the SAB did. Her suggestion is that we bring this new idea back to SAB. She suggested voting on what's before us today and at next meeting after SAB has sought public input and considered the issue, then we can add more. They did unanimously endorse what is before the Board.

Mr. Lucia did not think we needed to go back to the SAB. He thought the issue was clear cut and it did not make sense. Ms. Kofman responded that the process we've always used is public input on policy questions. That's what the SAB did when they considered these. So, if the Board adds additional ones, the process is different from what we've used in the past.

Dr. Ku noted that in the past we decided against a special enrollment period for illnesses or pregnancy. Now, if income has dropped, you may have the same effect.

Ms. Lewis stated that we do have a process we've used and we should do that again. Mr. Lucia responded that has been the process, but we have made amendments at the Board. However, he was willing to follow the process.

Dr. Ku asked about item 7 – COBRA enrollee. Why is it limited to November 15, 2015? Mr. Alonso responded that the FFMs use July 1, CA California is July 15, Hawaii is July 1. The SAB went longer than anyone else.

Ms. McAndrew stated that this SEP is spurred by inadequate COBRA notices. The notices did not adequately advise people of their choices. The FFM's approach was to have a time limited special enrollment period. However, SAB wanted to go further since we're already in June. Problem was lack of notice and we thought random dates didn't make sense – and decided to go until open enrollment period. Ms. Libster added that the Department of Labor just issued the regulations on COBRA notices so this will be fixed soon.

Mr. Lucia asked when the SAB would meet again. Ms. McAndrew said it would be scheduled soon. Ms. Kofman stated there could be a phone meeting next week and then we could do a call of the board and make decisions.

VII. Public Comment

Kevin Wrege asked if the board or staff knows what the percentage will be yet for the first assessment and do you know when the invoices will be sent?

Ms. Kofman replied that the assessment will be around 1%; she said nothing between her testimony to the Council and now has changed. HBX is looking at mid-July for the assessment.

Mr. Wrege asked if someone could notify him when the final assessment percentage is set.

Ms. Senkewicz stated HBX has not negotiated the details with DISB yet, but she believes it is in the assessment notice. Ms. Kofman stated it would be posted on the website.

VIII. Votes

Mr. Alonso clarified that technical amendments will be made to the exceptional circumstances resolution.

It was moved and seconded to adopt the Health Carrier Assessment Administrative Appeal Emergency Rule: The motion passed unanimously with the following Board members voting yes: Dr. Aaron, Dr. Akhter, Dr. Ku, Ms. Lewis, Mr. Lucia, and Ms. Sullivan Hare.

It was moved and seconded to adopt the Resolution "To define additional "exceptional circumstances" permitting a Special Enrollment Period" with technical corrections: The motion passed unanimously with the following Board members voting yes: Dr. Aaron, Dr. Akhter, Dr. Ku, Ms. Lewis, Mr. Lucia, and Ms. Sullivan Hare.

IX. 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 and Mr. Lucia and voted yes.

Time is: 7:15 p.m.