Health Benefit Exchange Authority Executive Board Meeting

MINUTES

Date: November 8, 2023
Time: 5:30 PM
Location: Via Zoom or Conference Call Only

Members Present: Henry Aaron, Leighton Ku, Diane Lewis, Khalid Pitts, Gabriella Mossi.
Members Absent: Ramon Richards, Tamara Watkins, Wayne Turnage, Laura Zeilinger, Karima Woods, Ayanna Bennett.

Welcome, Opening Remarks and Roll Call

Diane Lewis, Chair

A roll call confirmed a quorum with 5 voting members present (Dr. Aaron, Dr. Ku, Ms. Lewis, Khalid Pitts, Gabriela Mossi).

Approval of Agenda

Diane Lewis, Chair

It was moved and seconded to approve the draft Agenda. The motion passed with Dr. Aaron, Dr. Ku, Mr. Pitts, Ms. Mossi, and Ms. Lewis voting yes.

Approval of Minutes

Diane Lewis, Chair

It was moved and seconded to approve the September 13, 2023 draft Minutes. The motion passed with Dr. Aaron, Dr. Ku, Mr. Pitts, and Ms. Lewis voting yes. Ms. Mossi abstained.

Executive Board Business

Election of Officers

Brian Flowers - The by-laws allow for any HBX board member, either voting or non-voting, to nominate a voting board member for an officer position. Voting board members may nominate themselves. To be considered for the vote, a person who is nominated must accept the nomination either orally or by writing sent to and published by another board member. Once all nominations have been heard and accepted, there will be a vote. Elections shall be made by majority vote. Abstentions are not permitted.

For the position of **Chair,** Diane Lewis was nominated, and the nomination seconded. Her nomination was approved unanimously. Dr. Aaron, Dr. Ku, Mr. Pitts, Ms. Lewis, Ms. Mossi, voting yes.

For the position of **Vice-Chair,** Dr. Henry Aaron was nominated, and the nomination seconded. His nomination was approved unanimously. Dr. Aaron, Dr. Ku, Mr. Pitts, Ms. Lewis, Ms. Mossi, voting yes.

For the position of **Treasurer/Secretary,** Khalid Pitts was nominated, and the nomination seconded. His nomination was approved unanimously. Dr. Aaron, Dr. Ku, Mr. Pitts, Ms. Lewis, Ms. Mossi, voting yes.

Discussion Items

> DC Health Link Standard Plans for PY 2025, to lower cost-sharing for cardiovascular disease – *Dania Palanker, Chair,* Standard Plan Working Group and Mary Beth Senkewicz, HBX.

Dania Palanker: The standard plan working group was charged with making recommendations to modify the standard plan year for plan year 2025, in the individual, and Shop markets to eliminate cost sharing for cardiovascular disease as the next step in the Social Equity Recommendations related to the standardized plans. As a group, we met seven times once a week between September 12th and October 24, 2023 by video or conference call and we met knowing that the federal Actuarial Value calculator for plan year 2025 has not yet been issued. So, this was not the coming together once the AV calculator is out to make any changes. First, coming together, before that period, to move forward with the Social Justice and Health Equity recommendations on cardiovascular disease. So, we had two sort of experts uh provide their expertise to us during the part process. First, Whitman Walker Institute, analyzed publicly available information on cardiovascular disease, including clinical guidelines. And they conducted qualitative interviews with medical and mental health providers to advise us on the

clinical treatment scenario conditions that would basically assist us with plan designs and help us understand some of the clinicians.

We also had a renowned cardiologist give a presentation to one of our meetings. He opined about the high financial burden linked to foregoing or delaying cardiovascular disease care in heart disease patients. He also advised on the most common risk factors and discussed troubling disparities in cardiovascular disease among District residents based on race and ethnicity. We also had looked at the basis for our work list of cardiovascular disease generic drugs that could potentially be offered for no cost sharing, which does come out in our recommendation that were used by the Massachusetts connector standard plans and that was validated by Whitman Walker Institute.

We ran the scenarios using the 2024 Actuarial Value calculator and we're do anticipate the 2025 AV calculator will be out soon, with no definition of what soon may mean. And after running these 2025 proposed plans at different options through the 2024 calculator, we ran a few scenarios, and we came to coalesce around the proposed plan design and like changes, but the bronze plan was a plan that would need modifications at no cost sharing. This was the first time that we have come to this point. I think really, within the standardized plan trying to adopt the reduced or eliminated cost sharing for certain individuals to improve health equity. And what we found with that, including the cardiovascular disease generics at no cost pushed the plan outside of the de minimus range of the AV calculator for the bronze plan. Basically, it made that it'd be too high. And so, you know, we did work with our actuaries and together as a group to try to come up with solutions for this and generally speaking from our work and in the past and confirmed by our actuary, that the most bang for the buck basically comes with in adjusting things to bring things within AV limits is usually by increasing deductibles and maximum out-of-pocket limits.

We also discussed that a major objective of our standardized plans was to keep as many services as possible, not subject to the deductible, and I've been connected to that as a desire to not increase the deductible too much. And so, our actuarial consultants ran the proposed plans through the Platinum with the including, at this point, the cardiovascular disease generics and services, at no cost share and the Platinum gold and silver plans were made within the respective, de minimus AV ranges, and so no changes were necessary for those. And we then discussed three alternatives, that could bring the bronze plans with the de minimis, AV range of under 65 percent. And one of these was to raise the maximum of the pocket by 250 dollars which would be up to ninety-four hundred dollars. The other was to increase the generic drug copay from 25 to 30. So that's up five dollars. And then the final was to increase cost sharing across multiple categories. So primary Care visit by 10, specialist by 20, office visit mental health, substance use by 10 the same as PCP and that those three options would bring things within the correct Actuarial value. And so we had our deliberations and I want to note that I don't think anybody wants to raise cost sharing on the bronze, so this isn’t something we were actively trying to do. We were looking at a recommendation that if the Board is going to move forward with the next steps in the equity plan design, then we're making the recommendation of what changes should be made in order to reduce or eliminate cost sharing.

We had a non-consensus recommendation that in order to slow the generic copay for the bronze plans would increase from 25 to 30 dollars. And I do want to note that, you know, it was discussed that this was basically the least bad of the options rather than you know as I noted rather than something that we are not looking to raise cost sharing and it leaves the most wiggle room when the new AV calculator comes out.

And we have to come back because we will have to come back to rewrite all of the plans and no matter what when the calculator comes back. There was a discussion of the appropriateness of the drug classes and drugs within those classes. There are other proposed drugs that should be within those services. There was also we talked about the reality that the way the AV calculator is built makes the generics play a really large piece. So, making a small change in cost sharing in the generics makes a very large change. And, although it was a non-consensus decision, they're all but one member, and that member being a carrier coalesced around option two, which is to raise the cost sharing by five, don't pay by five dollars on generic drugs. And the carrier that did not agree, I do want to make sure we know their concerns. They noted that generic drugs are one of the most important plan benefits preventing and managing chronic conditions broadly not just cardiovascular disease, and that the increased cost share for tier one drugs will be the highest among those standardized plan changes in the bronze Tier in Virginia, Maryland. And you say the carrier also expressed concern that the changes were that upward pressure on premiums for standard plans and potentially drive the populations that would most benefit from being able to purchase the plan, and also raised concerns about some of the equity impact for those with other health conditions to be in that plan. So that was the non-consensus recommendation.

There was consensus about some other pieces so that to add language to the grid for clarity around the diabetes supplies and medications. And that the select drug classes, select agents within the drug classes, and the select list of hypertensive medications within the drug classes, is defined by the carrier. Like that, we use that language from the diabetes to be for the cardiovascular, sorry to be clear. And we also recommended removing some pieces from the table around PCS canine inhibitors and anticoagulants. I'm happy to address questions.

Mary Beth Senkewicz
Dania, Let me just add one more piece. If you said it, I apologize. But in addition to the generic drugs at zero, we'll also run through the calculator and is also at zero and per the Whitman Walker report, our Primary Care Cardiac Rehabilitation Medical nutrition therapy were also recommended in the report and those who are also run at zero. And as Dania noted, it was the generic drugs that really drove this particular AV calculator within bronze. The addition of those services did not move the calculator more than .02, depending on the plan. So, it was basically de minimus.

Dania Palanker: Just note three things so you all know that we did deliberate, we could talk about whether we should move forward without the generic drugs. And, given the expertise we were given was that the generics are a huge component of this and that's why at this point they

are in with no cost sharing even though that then has the effect of needing to increase on the Bronze. We talked about doing a reduced versus no cost sharing for the generic drugs or other services and recognized within that there would be administrative difficulties, so that it did not seem like it was really an achievable option for this plan. We talked about a smaller increase in co-pays on generic drugs, that wasn't enough.

Mary Beth Senkewicz: The generic drugs, it could only it was 22.50 from 25 was all it could be reduced to state to get it to within range so that was virtually no reduction.

Dania Palanker: The final thing is we did very briefly talk about like, would it be a potential to have no cost sharing on drugs to treat cardiovascular disease in the gold on the platinum, gold, and silver tiers. But then having different plan design in the bronze and concerns about that were first, that it would be very confusing if we were trying to explain to people about the equity plans and then there might be confusion and enrollment in the bronze plan expecting it to have full benefit and the other was, there's a real concern about the inequities given that the bronze plan being the least expensive, probably therefore, you know, has a higher rate of people with lower incomes, who may already have a more difficult time affording care. Because of that, and that it did not seem to make sense to have a less generous equity plan design for that group, but I did want to raise those as things we were considering as we were trying to find out, if there was really another option to move forward.

Chair Lewis: Thank you Donia. Any questions?

Leighton Ku: I have a couple of questions, one that might help with clarification because I must admit, when I initially heard this plan, you say we're going to eliminate co-pays for cardiovascular generics. So, if someone has a heart attack or any heart bypass surgery, holy smokes, that's really expensive. We're going to eliminate cost sharing for that. Can you clarify and I think when we give publicity about this, we should clarify the things that you are recommending for eliminating cost sharing for. Typically speaking are sort of on the chronic care side of things. They do not include acute care or most cardiovascular events. So you have a heart attack. You know, you need to go to the emergency room and maybe you need to have bypass surgery or interventional cardiology, you still will rack up fair amount of cost sharing for that. It is these things that typically speaking are relatively inexpensive, chronic care things, like the anti-hypertensive statins, those sorts of things that we're providing, we're eliminating cost sharing for, and not the actual care or treatment.

Certainly though, no services where an actual cardiologist, it's all primary care services. I think that as I saw it was being be eliminated and so in fact it's worth clarifying. When we say primary care, does that mean if a cardiologist is providing regular treatment? Is that primary care, or does it only mean that it has to be a primary care physician? Meaning, like a family or general practitioner, who's providing that service. As compared to a cardiologist who also may provide primary care as part of cardiology. So that's one thing. The other thing is that some of the things that you are recommending eliminating cost sharing for, particularly I'm thinking of the tobacco use things. Under the Affordable Care Act, they're already supposed to be zero co-pay. There's

no cost sharing for those. So, I'm not entirely sure why we were eliminating cost sharing for some of those services, what they're supposed to be zero cost sharing anyway,

Mary Beth Senkewicz: I'll start backwards cardiologists are not included. We had specific discussions, the initial report from Whitman Walker did not include cardiologists, and we discussed that. And we decided to stick with the same approach as diabetes, which is primary care and that type of focus, prevention focus. So, for that you are correct. You were correct. You saw the drugs, etc.

Leighton Ku: But I note that in many cases, cardiologists would say that they are internal medicine.

Mary Beth Senkewicz: Well, that's probably a fight for a different day Leighton, but the way we have it cardiologists are not listed within the Whitman Walker report. They were specifically deleted. They were listed at first and they were deleted.

Leighton Ku: I just think that's the kind of thing you're going to need to clarify at some point.

Mary Beth Senkewicz: Okay, we can make a note of that since we do have to revisit it. I mean obviously this is step one as you know we always have to go back and do this drill twice when the AV calculator comes out so that's an excellent point, we thank you for that. On the tobacco cessation, yes that was also listed in the Whitman Walker report but as HBX staff noted to the working group, you are correct, tobacco cessation is already covered under the Affordable Care Act under the preventive care stuff. So that essentially is already taken care of.

Leighton Ku: In that regard, that's why I don't quite see why we're including it in here since it's already taken care of. I don't mind.

Mary Beth Senkewicz: Okay. Maybe I was unclear. It was in the Whitman Walker report, but we can clarify on the next go round that, we discussed that tobacco cessation is already covered. Whitman Walker, just still had it in the report, you know, based on the research, the clinical research it had done it,

Leighton Ku: Obviously, smoking is huge risk factor for cardiovascular disease. But again, the main thing that I'd say is you need to make it much clearer that you are talking about these sorts of preventive and chronic care things as opposed to acute care because otherwise people will think the way that you've described it so far and all the things that Donia was saying with no intended disrespect for Dania, would make people think if I have a heart attack zero copay. When I go to the emergency room, when I need bypass surgery, when I need a heart transplant, no cost sharing. And that's not what we're doing at all.

Mary Beth Senkewicz: You're correct.

Leighton Ku: This is the cheap stuff. And it's good, important preventive and chronic care things. But they are on the lower cost side of things, with a possible, exception of a couple of things like CAT scans and so on.

Henry Aaron: Lower costs per person, not necessarily lower cost in the aggregate.

Leighton Ku: Yes, you're right. Lower cost for one maybe lower cost in the aggregate too.

Henry Aaron: You may be right, but I don't know that to be the case.

Leighton Ku: You could be right. I don't know how much the cost in the aggregate is versus per person. But I mean, you know, as someone who takes some of these medications, I do realize that, you know, lots of the medications you're talking about, statins and some of the hypertensives. I mean, they cost a few bucks a month or so they're pretty cheap.

Henry Aaron: Lots of people use them.

Dania Palanker: I also want to remind that because of the way insurers process claims they, you know, for the generic drugs, they can't isolate and only cover the drug about cost sharing if they're connected to a specific diagnosis. And if some of the drugs are being used, you know, for something that would not necessarily fit within the diagnostic that we are targeting with cardiovascular today, we will probably have to kind of make sure that's clear to people as well, maybe some are used for certain people with dysautonomia and that maybe doesn't actually fit into this pool, but would end up people still getting the drugs without cost sharing. So, that's just sort of a reality of how our insurance claim system works in the U.S.

Henry Aaron: We're dealing with his proposal, I take it is in effect discouraging people from using specialists and encouraging them to use general internal medicine. Because if cardiologists are still subject to cost sharing, whereas ordinary internal medicine is not, there are gains and losses there. And I think this is among a whole host of very important questions we need to look at quite carefully. This is one of them. As a matter of policy, do we want to set up financial incentives for people to see general physicians rather than specialists for something like cardiac disease.

Leighton Ku: But where specialty care could be entirely appropriate.

Henry Aaron: Exactly. That's the question that I'm not for pulling this back. Let's proceed. But I think having done, I and partly to a very significant degree I've been educated as to the enormous amount of work and care the committee that Donia is either chair or co-chair of at the present time has put into this issue and I think it's important that we honor that effort. But as we move ahead, I think this should be added to the list of questions that we're going to be considering more broadly in general.

Leighton Ku: Could check with any cardiologist maybe other than Bill Borden about how they'd react to a potential exclusion of cardiologists.

Mary Beth Senkewicz: Doctor Borden presented it to us and then we did a few follow-up questions but that specific question, he was focused more on the generic drug aspect and keeping that subject to zero co-pay to eliminate as many cost barriers as possible.

Leighton Ku: Right? And I know Bill and you know, he's a great doctor. I don't even necessarily know that he actually thinks of himself as a cardiologist as compared to a general internist. But anyway, again, it's just one of these things I can see that among some, you know, I've seen these professional things come up. Because the another thing that I'm concerned about is right now, we've dealt with certain sorts of medications and treatments. And you know what do about you know, sort of new treatments or treatments that are related but not in this. For example, my recollection was a couple of years ago, there was a new medication that people were talking about actively that they thought would be a very good medication for heart attacks. It would prevent heart attacks, on the other hand, they were expensive. Have our people talking about the notion if this medication became widely used on one hand, it could be good for prevention and care for heart attacks. On the other hand, could be wildly expensive. I think there was some medication that began with an RE or RI or something like that. But it's not on one of the lists that you have. But again could they in some manner shape or form be classified. I guess the gist would be that you're naming certain specific medications, you know. Maybe the point is you need to have a reservation that we have the ability to come back and reevaluate in the event of new medications for new treatments.

Chair Lewis: To move the discussion because I think the committee is going to still have to look at this again is the reality that they're going to have to go back and look at things once we get the AV Calculator. And so, I think this will be part of what those considerations will be going forward. And just more generally I think we want to look more broadly at some of these policy decisions that have these kinds of implications. So, I would add that to our list of discussion points.

Leighton Ku: Then I won't belabor the point anymore.

Chair Lewis: Moving to the second item, the **Fiscal Year 2025 HBX Proposed Budget.**

Mila Kofman: Before I attempt to share my screen with you to walk you through the staff proposed budget. I just want to be clear, that before you today as an action item is a resolution that has been posted publicly and you all have which is to adopt the zero-cost sharing for the services and medication types that Dania and Mary Beth laid out for that Committee to reconvene once the AV calculator comes out to rerun everything through the AV calculator and potentially make adjustments. But importantly the resolution identifies two specific options for

the Standard Plan working group once they reconvene to consider, one is to stay within the AV limits for the bronze level, which is the problem here, either to look at raising maximum out of pocket protection by 250 dollars or increasing the cost of generic prescription medication by five dollars. So, I just wanted to be clear that is the resolution before you that you'll be voting on after I'm done with my discussions for your consideration.

Mila Kofman: I'm going to give you a very high-level walkthrough based on the feedback you have given me in prior years. This is the staff proposed budget for FY 25. You have all seen it, and it's been publicly posted. So, if you have any specific questions, then please ask me, but I'm going to try to limit myself to five minutes.

The staff for FY 25 is proposing a budget of approximately $41.7 million. And for assessment purposes, that's 38.4 million. I do want to highlight that we project decreasing the necessary assessment on health carriers to 0.80, should you approve this budget and it passes through the Mayor's office and the DC Council. As a reminder for FY 24, our assessment is 0.825 percent. So, this would be a decrease for assessment purposes for FY 25. I want to highlight for you some of the drivers for FY 25 and give you a comparison with the FY 24 approved budget. Essentially costs grew a little bit by subdivisions and a lot for other divisions. I do want to note for Consumer education and Outreach, there's no change in that. For Agency Management Operations, there's a slight increase as cost of goods and services increased.

Now, the Divisions called Partnerships and Marketplace Operations, and Health Coverage and Innovation is a more transparent way that we are presenting what we used to call MIPO, Marketplace Innovation, Policy and Operations. Partnerships and Marketplace Operations is mostly our shop, and also includes our Massachusetts Partnership. Health Coverage and Innovation is most is mostly our individual Marketplace and it also includes our Health Care for Child Care Program. The cost driver, there of the increase in the budget is mostly all call center costs increasing and I'll walk you through that slide specifically so you can see the drivers there. IT costs are projected to increase, a lot of that increase includes services. And we did have a slight increase in Agency Financial Operations, mostly because one of the positions was reclassified to a lower grade position by the CFO District-wide. This slide just walks you through how we get from the proposed budget, to what we actually assess ending out under revenues and, sources of payment for either staff or services.

I'm just going to keep going. This is just to give you a visual of where most of our spending goes or most of our resources are IT and then combined Health Coverage and Innovation with Partnerships and Marketplace Operations. I'm just going to go straight to the contact center to make sure you see what's driving the contact center proposed budget. So, as you can see, the cost of Salesforce licenses and other software has increased. What we used to get for very little cost or sometimes free we now have to pay for. An example of that is Salesforce development and

maintenance. The nearly 125,000, there is something that we didn't have in prior years and now we have it. So, the FY 25 budget reflects that.

Also an increase in our contact center service contract to ensure that we don't lose staffing levels at our contact center. Staffing levels are really important to keep hold times low. No, one likes to wait an hour and a half to get help. And so, keeping staffing levels at certain levels at the contact center helps us with making sure that we serve all residents and employers. I'm not going to now go through anything else, because everything else is pretty stable and consistent with prior years. And just stop and before I switch out of this sharing mode, I'll just ask if there are any questions about the staff proposed budget.

Leighton Ku: Quick question. So, I noticed the contract service budget goes up by 50 percent. So, is that an increase in personnel? Is it increase in the sort of labor rates or some combination thereof?

Mila Kofman: Um you the service contract question,

Leighton Ku: It goes up from 3 to 3.5 million. So that's more than a 50% increase.

Mila Kofman: That is the cost of the vendor which reflects all of their costs, including how many bodies they actually will have staffing the contact center? It's not our HBX staff. We pay a vendor. And that contract is mostly the cost of them having personnel to answer the phones.

Leighton Ku: Are there more personnel or if their labor rates are going up or they're charge for service?

Mila Kofman: Everything is going up including the number of people we want to have at the contact center. We want to maintain a certain number of people both during open enrollment and during the rest of the year. So, because we want to maintain more people that drives costs.

Telecommunications Development Corporation for Outreach Support – *Mila Kofman, Executive Director*

Mila Kofman: I'll move on to the next two items that you'll be asked to vote on. The first is Telecommunications Development Corporation, which we call TDC and we're requesting an increase in their contract, from 100,000 to 135,000. TDC is a district certified small business enterprise. I'll note that they have been helping us from day one with our outreach event planning and supporting those events.

And through a recent competitive process, we awarded them a contract for $400,000. We've discovered that we actually need more help than that and we're asking for an increase of 35,000 to that base year contract to make it 135,000 base year from October 1, 2023, from this point. In addition to the base year, we're asking 135,000 approval, which is 35,000 higher than we initially

thought for both option year one and two, and this went to the Finance Committee first, and they approved moving this to the full board for your consideration.

Joe Winn for eGFR Campaign – *Mila Kofman, Executive Director* presented the contract.

Mila Kofman: The next item that I'll be asking for your approval for is a contract we have with Joe Wynn. This base year started October 1, and we are asking for an increase from 100,000 to 145,000 for this one-year contract. I should say not base year but one year contract.

We've retained Joe to help us with our effort, focus on eGFR, which is the kidney function lab test. The clinical guidelines for eGFR were updated by the National Kidney Foundation, several years ago. Unfortunately, we learned that despite the fact that the Kidney Foundation and clinical groups said that race should be taken out of the eGFR calculation, many labs around the nation have yet to do so. And so, we wanted as part of the social justice work and the recommendations that you the board adopted a couple of years ago, we wanted to influence the pace of adopting the new eGFR that eliminates race. Having race in the calculation, not only keeps people from getting transplants when they should be getting transplants, when I say people, I mean black Americans, but it all still influences dosing and medication that patients receive when eGFR is adjusted for race and it results in black patients not getting the type of medication and correct dose that they need. So, there are lots of implications. We wanted to influence that process and Joe Wynn, who used to work for the major health major plans in the nation has left that work and is helping us pilot our effort. He's developing a campaign for us to influence how quickly labs will adopt this new eGFR -- the current eGFR test. So, again, we're asking for a $45,000 increase right now. His work with us is budgeted for a hundred thousand and we want to increase that to 145,000 for the entire fiscal year, and I'll note that the funding for this is coming from our partnership with DISB. You may recall that they have a grant from CMS, a state flexibility grant so the work for this will be, we're looking to fund through that grant. I think we're still waiting for all the proper approvals but we're working mostly with DISB to get those.

I'm happy to take any questions you may have about any of these contract approvals, and we did ask the Finance Committee to review this, and that committee recommended that we move this for full board approval.

Chair Lewis: Any questions?

Public comment

Chair Lewis: Are there any public comments. No public comments were offered.

Vote

DC Health Link Standard Plans for PY 2025, to lower cost-sharing for cardiovascular disease.

One of the agenda items is the DC Health link standard plan for plan year 2025 to lower cost sharing for cardiovascular disease. There's a draft resolution before you on this subject. Is there a motion to improve the resolution on DC Health link standard plan for plan year 2025?

Henry Aaron: This refers to the reduction in cost sharing, not to the means by which we will presumably after the new calculator is available have to make a decision about how to pay for this. It's just about the reduction in cost sharing, is that correct?

Chair Lewis: That's my understanding.

Mila Kofman: Yes, it includes the two options that the insurance committee discussed. Right? Right. So, the two options increase maximum out of pocket by 250 dollars or increase generic drugs by five dollars.

Henry Aaron: We're not choosing between them.

Mila Kofman: You're not choosing between them, you're not choosing. You've put both options into the resolution or the scam plans. Working room to consider.

Henry Aaron: Let me be clear that should a decision, I'm not suggesting it will occur, but should it appear that some other method of paying for this additional cost be desirable based on the new AV calculator, I am hoping that this motion does not foreclose us from considering such alternatives. I'm not recommending anything. But I just don't want to see us nailed down, the payment mechanisms to these two items only before we know exactly what the arithmetic tells us.

Mila Kofman: Right. Exactly. And I mean, maybe the AV will come out in a way where no change is needed.

Henry Aaron: Yes, that would be glorious. Yeah,

Mila Kofman: So essentially, I'm confirming that you're not saying the standard plan design will have to change what you are saying is it will have to change to eliminate the cost sharing for those things that both Donia and Mary Beth outlined for a primary care services particularly generic drugs and a few other services. So that is a commitment.

Henry Aaron: We're spending the money. We're not deciding where we're going to get the money to spend, all right?

Mila Kofman: But you are, but you are saying that two options, two of the three options that the standard plan working group identified, you are only asking the standard plan working group to look at those two, not the third one, you took the third one off the table. So different scenarios if the AV calculator says – it comes out in a way that no changes are necessary to pay for the changes, we're not making those changes. If however, changes are necessary, you've said your

two preferred options are the stand plans working group can potentially come up with other better ways, in which case, you can consider, you know, a better option. But what you're clearly saying is the third option that the working group came up with you're not keen on.

Henry Aaron: Let me rephrase what I would support, which is not three. That is the limit of the decision. One or two or if something else comes in and looks good, we're not excluding that from consideration. So it's simply, we're deciding that it isn't the third option. We're accepting the general aversion of the working group, I think, which we share also. We understand the administrative difficulties associated with it. So, we're saying to the carriers, you don't need to worry about three.

Mila Kofman: Yes, I think the resolution supports that, okay?

Leighton Ku: So, I have some questions too. Well since we don't know what the new AV calculated will be, it is conceivable that there might be things that are going to have repercussions for the silver and gold or platinum plans too. And so obviously at that point, the standard plan working group would have to sort of come up with new evaluations for those things. So, you know the truth, be known, until that new AV calculator comes out, we don't know what all the options are and so we're still resolving, giving them some discretion. Or, you know, new wiggle room with new options. As long as we are giving them that discretion. I guess I also hope that they would think, can they come up with a better way of determining things like this notion of primary care versus specialists and getting a sense of are we going to have problems because of that, which I don't think was clearly resolved. And I'm finally noting we do have one of the plans that sort of still disagrees with this in general, and that has sort of been disagreeing with the whole approach all along and so, Where do we have a sense of would that plan? Have they said, if we go ahead and approve this. Are they going to come along with it or there are going to be negative repercussions on their part? Or, would they say we'll pull out?

Mila Kofman: Yeah, we have not heard that from the health plan. Saying, if we move forward on this plan design, they would leave DC's Market.

Henry Aaron: Do we have any indication from the medical profession if there's a DC, an umbrella organization for physicians in the District, Do we have any impression as to how whether they have seen this change and what they may think of it?

Mila Kofman: Mary Beth, I don't know if you want to comment on that. Did we lose Mary Beth. Dania had had a hard stop. I can't answer that question. I just don't know how many stakeholders were consulted on this in addition to the ones that Mary Beth and Dania outlined, the clinical experts that Whitman Walker spoke with, and then the cardiologist that one of Leighton's colleagues, who's a nationally known expert on this particular area.

Leighton Ku: I mean, you know, I don't mind the resolution as it stands, understanding the standard plan working group is going to have to come back and look at some of these things and they're willing to sort of consider some of these issues we've discussed, and as necessary make

some modifications. I think that's appropriate. So it's not as though, we're thinking that all they have to do is look at the standard plans, if bronze is okay, then it's copacetic, we go ahead, but just, you know, there may be other changes, and I think we all assume that there may need to be other changes. I just don't want to sort think that we've done the entire job right now.

Mila Kofman: Yeah, it's always the case, every year and like when you shared this last year, you recall, we had to come back and go at it several times.

Leighton Ku: Right. So, as long as we understand, That there are those, you know there's several preliminary things as opposed to the final thing that we are not foreclosing what the standard plants working group might look at and it we're actually asking them to think about some of these issues then I'm okay with this as it stands. Yeah.

Mila Kofman: And the major issue being adding cardiologists to covering cardiologists at no cost. Just like primary care and internists.

Leighton Ku: And how we try to deal with that issue. In general, I mean again the boundaries between cardiology and internal medicine is not clear cardiology is often considered one part of internal medicine.

Mila Kofman: Yeah, I think you made very clear points and I know Mary Beth was taking notes to get some of that clarified, and certainly when they have to reconvene once the draft calculator comes out, they'll have to talk through all of that and rerun everything at all levels to see where we have to make adjustments to pay for what we want to do.

Leighton Ku: Yeah, so as long as those things are understood and they'll be taking these issues into consideration the next time they have to meet that, you know. I'm good with this. Otherwise I'd like just to add in those sorts of things formally into the resolution, but you know, if it's understood then there's no need.

Mila Kofman: Do you have language that you want us to add into the resolution? Or would you just prefer to move it? As is with the expectation that once the calculator comes out they'll be more clarity.

Henry Aaron: I would like to move it as is with the proviso that if things emerge from future discussions before the final decision has to be made, we won't be told that we've decided this issue and it's not, it can't be reopened for administrative reasons. I think this is an area of sufficient importance where we have, I think expressed our intent which is to try and improve access to general, uh, what I'll call general cardiology -- preventive cardiology for DC residents covered by our plans. But I do think this could be a hornet's nest. As a kind of illustration of, if you will, tinkering with medical practice through rate reimbursement in a way that the medical profession might find objectionable. I think we need to explore that before putting our feet in cement on this. I'm sorry. I understand that this has received extensive consideration, we in the insurance committee discussed some of the issues we're discussing now didn't come up, at least I

didn't understand, as part of that discussion. And I just think we need to move a bit more cautiously here. So let's declare our intent with respect to the elimination of cost sharing for cardiology administered by general physicians. It's more than a sense of a meeting. But it's short of a firm resolution which we're embedding in stone. I don't know exactly what that means, but I don't want us to move ahead and make an avoidable mistake.

Chair Lewis: Mila, can we be certain that the sense of the board will go forward with the resolution as the group has to, we know they're going to have to come back and look at everything and once the AV calculator comes in.

Mila Kofman: Yes, I thought you were going to say, can there just be a sense of the board without anything being written and was possible?

Chair Lewis: I think the sense of the board is clear.

Leighton Ku: How about this, I'm willing to write up something very brief, and within half an hour after this meeting, it means that we've expressed some of those concerns. And then the other concern that I have is I really would like to have a clearer sense of where Kaiser stands on this. And what are the repercussions from their perspective?

Mila Kofman: Okay. So, what would you like to do? Would you like to move forward with some form of a resolution?

Leighton Ku: So, a resolution, I'm willing to write some simple things, sort of a proviso, I'm happy to sort of draft them pretty soon after this. But they'll be simple, it's along the lines of generally speaking, we support the concept, we'd like to make sure that there's a little more background checking and some of these issues since the standardized plan committee is going to have to come back and reevaluate anyway.

Mila Kofman: So okay, so let me just rephrase. Do you want to vote on anything right now?

Khalid Pitts: It does not look like we're going to be able to, Leighton's got to write something up and I didn't realize that there's other questions since it's gone the through traps from the committees that I don't think we're ready to vote on something, I think with what Leighton and that Hank raised, I'd like to know what's wrong with my motion to move forward but I have I'd like to make sure they are satisfied in terms of what it looks like first before we can move forward voting on something.

Mila Kofman: You will not be able to vote in private, meaning at whatever vote you take, on whatever you vote on, will have to be done in a public meeting and, you know, we'll have to post it ahead of time. So, I'm just trying to, I'm just asking, logistical question that I'm still not clear on. Do you want to amend this resolution to include the extra language, and go ahead and vote on it? Or do you not want to vote, wait, until Leighton drafts something up and then at your next public meeting or, I think the next one is scheduled for January?

Hank Aaron: Wait a second, I think what you described Mila is the right thing to do, but the next meeting shouldn't be in January. It should be in a week or 10 days. Leighton and you should work together to draft, see whether you can come up with language, that makes sense to you from an administrative standpoint and that pays proper respect to the working group's efforts which I think deserve praise, and that have some bite to them. I'm not sure that's going to be possible, but I think it's worth a try. Leighton's willing to do it. If you're willing to do it, we could meet next week. Uh, find a time when we can all get together, we as board members, I think should be sure that we do make time to get together because this is not a minor matter.

Leighton Ku: I'm even willing to go with the motion of if we approve it just as long as there's administrative sense, at the administrative level of HBX, you understand the issues and are willing to give these additional instructions or requests to the standard plan committee. That would be okay with me too, but so if that's okay, we don't need to delay the vote. I wanted to approve it as long as there's that sense that that information will be conveyed to them, particularly since Dania and Mary Beth are not here at the moment.

Mila Kofman: All right. I'm just adding that into the resolution now, and if I don't finish, I know you have executive session, then we will come back into public session. So, I'm just adding it into the resolution that's been posted the new language additional request for standard plans. This is under be it resolved -- additional requests for standard plans, working group consideration of adding cardiologist.

Leighton Ku: Well, to inquiries about the effect of not including cardiologists in it. And then again, sort of that sense of do we know for the plan that doesn't agree, where exactly do they stand, how vital of an issue is this to them?

Mila Kofman: Well, I think we have a representative of Kaiser Permanente, I'm not sure, but the issue you're asking is will Kaiser Permanente pull out if we go forward with this. So, like a yes, or no, if the representative wants to speak but I can tell you when a plan decides to pull out of a market, it's usually based on extensive corporate decision making consideration, many considerations, and it's usually not based on one change in benefit design that happens in a market.

So, if the intent of this particular plan was to pull out, we would have heard about it and I'm sure our colleagues at DISB would have heard about it. So you know, I don't want to put anyone on the spot from Kaiser Permanente to talk about this issue, but clearly, you know, they have a perspective on coverage design. They have a perspective on many things and sometimes we agree, sometimes, we don't agree and that actually happens on many issues with our health plans. Sometimes we're on the same side sometimes, we're not. And you know, policy decisions, we don't always have to agree on. But that doesn't necessarily drive a carrier to leave a particular market. So, you want me to add it into the resolution?

Leighton Ku: Yes

Mila Kofman: Whether or not a plan is going to leave the market over this?

Henry Aaron: No.

Chair Lewis: No

Leighton Ku: Not phrased that way. But again the point is that it'd be nice, if before we have, what is our ultimate final vote, we have a clear sense. Of that issue you're right, I tend to think you're probably right. But, you know, I do know that Kaiser has had objections in the past and so I, you know I can't honestly say is this going to push them further than I don't want?

Henry Aaron: I think we ought to let Kaiser tell us their intent, rather than say, raising with them, the possibility, they could turn the operations of DCHBX into turmoil. They know their business. If there are mortal concerns, they'll let us know. We don't need to go around asking them whether this is that critical an issue. I think what Mila was saying is it would be quite out of character for an insurer to jump ship based on this sort of a decision. And as I'm thinking about it and looking at it, I have to believe that's got to be true. There's just so much more involved here than this issue. The idea that they're teetering on the edge of departing is not something I want to contemplate, and I don't want them to contemplate it.

Mila Kofman: Yeah. And can I just add to that we've heard the concern about, you know, using a benefit design to address cost barriers that impact communities of color disproportionally. We've heard this concern and we frankly have appreciated, at a staff level, the engagement that Kaiser Permanente has given us. They've helped to make this whole process better every year. Now we've heard this concern from day one even when we were considering type 2 diabetes and year after year, Kaiser Permanente has been 100% committed to making DC's Market work, and work better for patients, in fact, in their rate filings they price their products at a loss, to keep them more affordable. So, even though every year we've changed the benefit design, in a way that Kaiser Permanente, didn't like, after we did that, the plan, you know, still showed their commitment to D.C residents and employers through their rate filings, essentially pricing at a loss. So I give you that as a concise and specific example of the commitment that we've had from Kaiser Permanente on this front and many other fronts. And of course, we partnered with the health plan to feedback that legislation and you know have partner our number of initiatives. So, I think like, you're, you know, you're raising the right questions. But I think with respect to this effort, we're not going to see a plan pull out, especially one with Kaiser Permanente's history and commitment in the DC Market. I'm cognizant of time, we have to get votes in before we lose members while we still have a quorum. And I need your direction on the budget and the other contracts.

I've added language into this resolution as we spoke. So, now under the be it resolved clause, under that clause, I've added additional request for standard plans working group, consideration of adding cardiologists' visits for no cost sharing, getting a sense of the specialist community on

cost sharing and considering other options to stay within AV. That captures the essence of the discussion I think.

Henry Aaron: It does. Okay.

Mila Kofman: All right with that Amendment. Anyone wants to make a motion.

Henry Aaron: So moved as amended by you Mila.

Chair Lewis: All in favor.

Hank Aaron, Leighton Ku, Khalid Pitts, Gabriela Mossi voted in favor.

Chair Lewis: Next is the fiscal year 2025, HBX proposed budget. Is there a motion to approve the Fiscal Year 2025 HBX Proposed Budget

Henry Aaron: So moved

Leighton Ku: Second.

Chair Lewis: Roll call Henry Aaron. Yes. Leighton Ku. Yes. Gabriela Mossi. Yes. Diane Lewis. Yes. Khalid Pitts. Yes. Tamara Watkins Ramon Richard. The budget is passed

Telecommunications Development Corporation for Outreach Support contract.

Chair Lewis: Is there a motion to approve.

Henry Aaron/Leighton Ku: It was moved and seconded to approve the Telecommunications Development Corporation for Outreach Support contract. The measure was approved unanimously by roll call vote. Dr. Aaron, Dr. Ku, Mr. Pitts, Ms. Lewis, Ms. Mossi, voted yes. The contract is passed.

Joe Winn for eGFR Campaign.

Chair Lewis: Joe Winn for the eGFR campaign, is there a motion to approve?

Leighton Ku: So moved

Chair Lewis: Do we have a second.

Henry Aaron: Yes.

The measure was approved unanimously. Dr. Aaron, Dr. Ku, Mr. Pitts, Ms. Lewis, Ms. Mossi, voted yes.

Move to Closed Session

Diane Lewis, Chair

It was moved pursuant to D.C. Official Code Sections 2-575(b)(4), (10), and 31-3171.11 to convene in closed session to discuss personnel matters and obtain legal advice. The motion was approved unanimously by roll call vote. Dr. Ku, Mr. Pitts, Ms. Lewis, Ms. Mossi, voted yes.

Resumption of Public Meeting

Diane Lewis, Chair

The public session was reconvened.

Executive Director Report

Mila Kofman, Executive Director

Mila Kofman: We are in an open enrollment period which started November 1st and here in DC runs through January 31st. We've extended our DC Health Link, contact center hours, We have 27 health plans to choose from, some are as low as $13 a month. Thanks to the inflation reduction act on the shop side, we have 188 health plans for 2023. Our shop renewals just as a reminder, our largest renewal month for shop is December. Congressional open enrollment will begin November 13th and that runs through December 11th.

This past weekend, we had a very successful open enrollment kickoff event at MLK Library. The theme was hip-hop to health stepped to the beat of quality, affordable health insurance. In addition to myself, Congressman Norton, Council Health Committee Chair Henderson and Director Jackie Reyes from the Mayor's Office all spoke. It was well attended. We had enrollments of both individual enrollments and shop enrollments. So, we're really excited about that. Auto renewals went well. We Auto renewed close to 14,000 people in the individual Market. Again, as a reminder, we are targeting our Outreach campaign starting with emails and phone calls specifically to certain Target populations, like folks who didn't give us consent to check the IRS to requalify them for HTC. We're reaching out to those folks, including young people aging off parents plans, we have a special reach out to those folks. We do this every year. So this is just a reminder, we continue to run those campaigns.

Our CMS Readiness review was October 5th and October 10th. We received approval for our enrollment. Medicaid unwinding is going as expected, I would say. Just to give you a sense of our numbers so far between May and October, we received 468 cases from Medicaid that covers 833 people. We reviewed each case, and in fact we sent back for redeterminations about 216 cases, which is close to 46 percent. Because those folks are likely still eligible for Medicaid coverage and our sister agency, the Medicaid agencies are working on those real determinations.

We've sent several thousand emails to the other folks to let them know about us. We've texted, and we've assigned many of those cases to our sister agencies for further outreach. We have enrolled 30 people that

includes both individual coverage and small group coverage. In addition to that, we enrolled nine people into Medicaid out of that population and fortunately people told us that they actually have other coverage somewhere else.

Shifting gears, Health Care for Childcare is, is going very well and out of 371 potentially eligible facilities, we have now enrolled 168. We currently cover more than 1,200 people, which is pretty exciting.

I'm going to jump through major policy changes as a reminder for Health Care for Childcare. We are moving to Gold coverage. Right now we pay for silver coverage and starting in 2024, we will be paying for Gold coverage. That's a major policy decision that the deductibles and cost sharing for Gold are much lower than for Silver and that will make care more affordable. I think I will close with that. Madam Chair, thank you very much, and that's good news. Thank you so much. That concludes our business for today, the meetings.

Closing Remarks and Adjournment

Diane Lewis, Chair

Chair Lewis: That concludes our business for today. The meeting was adjourned at 7:32 pm. The next meeting is scheduled for January 10, 2024.