Standing Advisory Board Meeting

DRAFT MINUTES

Date: September 17, 2015
Time: 3:00pm
Location: HBX Office and Conference Call
Call-In Number: 1-877-668-4493; access code 731 960 360

Name of Members: Chris Gardiner, Kevin Dougherty, Billy MacCartee, Dania Palanker, Jill Thorpe, Stephen Jefferson, Laurie Kuiper, Claire McAndrew

Members Present: Chris Gardiner, Billy MacCartee, Claire McAndrew

Phone: Stephen Jefferson, Laurie Kuiper, Dania Palanker

Members Absent: Kevin Dougherty, Jill Thorpe

Staff in Attendance: Mila Kofman, Robert Shriver, Debra Curtis, Holly Whelan, Alex Alonso, Shayla Hamlin, Candace Walls

I. **Welcome, Opening Remarks and Roll Call,** *Chris Gardiner, Chair*

Chair Chris Gardiner called the meeting to order at 3:08pm. A roll call of members present confirmed that there was quorum with six members present: Mr. Gardiner, Mr. MacCartee, Ms. McAndrew, Ms. Kuiper, Mr. Jefferson and Ms. Palanker

II. **Approval of Minutes,** *Chris Gardiner, Chair*

The Chair asked for questions or comments regarding minutes. It was moved and seconded to approve the minuets from June 3, 2015 meeting. The motion was unanimously approved by voice vote.

III. Discussion Items

Robert Shriver (Director for Marketplace Innovation, Policy & Operations):
We are really pleased to have Consumer Checkbook here with us today, because it really is a culmination of a couple years of work to deliver these new consumer support tools. We have a stakeholder driven process with HBX and the tools you will see today are a result of the work from the stakeholder groups and the HBX Executive Board. We have been rolling these tools out in phases. So far this summer we have rolled out our Doctor Directory for the individual market in beta form to allow consumers and health plans the opportunity to try it and see how it works. Since then it has been fully deployed. Now we have rolled out a Spanish language version of our Doctor Directory in beta form. The Doctor Directory is currently only available to the individual marketplace and we hope to have the SHOP directory completed soon. Today you are going to see a demonstration of the new DC Health Link Plan Match tool which is a multifunctional plan comparison tool. It has several features such as an out-of-pocket cost tool and a robust plan benefits comparison feature. The tool itself is not yet live to the public, but we will send a link out to the group so you all will be able to test it out.

Chris Gardiner: When do you expect it to be live for the public?

Robert Shriver: We are targeting Monday to make it available to the public, but we did want to give the Board members a chance to preview the tool. Today you will see an individual market tool, and as with the Doctor Directory, we are working on a SHOP tool that we expect to have live for the 2016 plan year. Now I'm going to turn it over to Consumers Checkbook.

Andrew Duff (Consumers, Checkbook): You may know us from Consumers Checkbook the magazine, but we are a non-profit organization that has been in business for over forty years and our mission has always been to help consumers make better informed choices when selecting services and services provider. The magazine started out rating plumbers, roofers, mechanics etc. and that work continues today, but we now also rate healthcare providers, healthcare services, health insurance plans, etc. For the past 35 years we have had a guide to federal employees for the federal employee health exchange, which is the first large scale exchange and for the past 12 years we've had an online tool for federal employees shopping for their health plans. With the new state-based exchanges and federally-facilitated exchange this tool made a lot of sense to use for these new exchanges. Now that you have a little background about our company I will walk you through how to use the tool shortly.

With the implementation of the Affordable Care Act millions of people have greater access to and greater choice in health plans. This increase in choice has introduced challenges to people shopping for health insurance. For example, should I pick the plan with a $300 premium and a $10,000 deductible or should I pick the plan with a $450 premium and a $4,000 deductible?

Consumers should also consider more granular health benefits, such as how much does it cost to see your primary care provider or how much do I have to pay if I have to go to the emergency room. The DC Health Link Plan Match tool gives consumers the most important information about selecting the best health plan for them and presents this information in a way that is easy to digest. It gives them information without having to become an expert in health insurance. The tool is designed for everyone to use regardless of knowledge about health insurance. We know people do not like shopping for insurance and get very confused when evaluating and comparing plans. We designed the tool to get people to the right answer quickly and painlessly. All they have to do is answer a few questions about themselves and family members and in a few seconds they see a list of all plans available to them with an easy to understand single dollar amount yearly out-of-pocket cost estimate for that plan. Our tool recently won the Robert Wood Johnson Plan Tool Challenge, which makes us very proud. Over the years we have improved the tool and we are always looking for feedback. We know the tool itself is a very powerful and useful tool for consumers.

Demonstration Begins:

Here is the tool welcome page. Users see a block of descriptive text and a short welcome video, which I will play in a moment. You will see throughout the site we offer a lot of explanations about the tool for those who like to read more and also offer these audio visual videos for those who understand better through that medium instead of reading text. (Welcome video was played.)

Two key things from the video is that the tool is designed for anyone to use regardless of insurance knowledge, so it removes some of the intimidation of shopping and comparing health plans. The other key point is that in just a few minutes you will get the information you need quickly.

Claire McAndrews: One thing I have heard is that continuously telling people that finding health insurance is difficult and confusing can be a bad message, because they already think that. So we do not want to reinforce that message. Have you thought about removing some of the negative messaging?

Andrew Duff (Consumers' Checkbook): Through consumer testing and research we have learned that consumers do not know how to compare plans. To some degree we would like to share the message that this is going to be easy for you, but we try not to say health insurance is horrible and this tool is the solution. Instead we say that regardless of your knowledge you will be able to help you.

Claire McAndrews: I was just wondering about the messaging, because it sounds a little negative.

Andrew Duff (Consumers' Checkbook): Thank you for that feedback. (Continuing with the demonstration of the tool.) Building a family profile (entered family members' ages, health, expected medical procedures (if any)). The question "in general, would you say the health of this person is" is a very strong predictor of health insurance cost along with age so it is very important to try to get people to answer this question. Expected medical procedures are procedures that any person would reasonably know in advance that they will need in the upcoming plan year. A pregnancy question and Indian/native Alaskan question is also asked because we also do a determination of Medicaid and APTC. On the next page you can see if you are Medicaid or APTC eligible. In this example this family was eligible for $176 per month APTC and the two children are eligible for Medicaid. The last question is about doctors you currently see or would like to see. This field is optional.

Billy MacCartee: When they are putting in their doctors it is not for a particular carrier. It is just any carrier. That doctor may participate in Aetna or Kaiser but not CareFirst. This doctor just happens to be in one of these plans.

Andrew Duff (Consumers' Checkbook): That is correct. The doctor information is coming from the Doctor Directory that we have on the DC Health Link site, so it is integrated with this tool. As long as the doctor shows up in any plan you will see that in the drop down list. We also have messaging that tells people to call the doctor's office to make sure the doctor is in the network and plans to be in the network for the upcoming plan year.

Billy MacCartee: Is that language in there?

Andrew Duff (Consumers' Checkbook): Yes, it is located right here in red.

On this plans results page we have every QHP available to this individual for this year on the DC Exchange. The first column is the total yearly cost estimate. A second column is the premium plus the out-of-pocket cost estimate for a family we entered. We know these costs are the best way to evaluate true health plan cost. We see people now using the monthly premium only because it is the only figure readily available to them. Then the next variable of concern to people is the maximum total out-of-pocket and deductible, which this column displays. In the next column you will see "cost in a bad year" - this aspect of the tool predicts what a bad year would look like for the family we entered. In red is an estimate of the percentage chance that a family like this one would have a bad year. Some people will pay more or less attention to risk or "cost in a bad year". In the last column we can see which of my doctors participate in the plans that a user maybe considering. On the left there are filter options: metal level, insurance

company, yearly cost estimate etc. We never want to start off by filtering because when you filter too early people may not see all the information when in fact they may want to see that information. For instance, if I filtered to see only my preferred doctors I may miss out on savings. We know that 60% of users will make a choice based on this information. We do have additional information for users to go into granular detail about the plans to make a choice. I can click on the SBCs for each plan and see the co-pays, which hospitals are in the network etc.

Claire McAndrews: Do those granular benefits display out-of-network benefits as well?

Andrew Duff (Consumers' Checkbook): Typically, we only have the in-network benefits, but in some cases we have the out-of-network benefits. These benefits are coming from the SERFF CCIIO data templates and the plan templates the carriers provide.

Claire McAndrew: There are some out-of-network benefits on the SBC right?

(Consumers' Checkbook): Yes. What prompts you to think of that?

Claire McAndrew: For example, we did a survey in my work place to assess how many people use out-of-network benefits and it was determined about 40% of us rely on some out-of-network benefit or service, so it is an important cost concern where I work to look at the out-of-network costs as well.

(**Consumers' Checkbook)**: How do you all do that?

Claire McAndrews: We just surveyed our staff.

(Consumers' Checkbook): No, I mean how do you all figure out the out-of-network costs? Do you all go through the SBC?

Claire McAndrew: We work with a broker, but even our brokers will just tell us that people should be going in-network for these benefits. So we surveyed our staff about why they are going out-of-network for these benefits and it was because there were long waiting lists to see in-network providers, or they can't find a provider. As everyone has heard me discuss, network adequacy is a concern, because people do have to go out-of-network. Therefore, I worry that out-of-network services are an important cost concern for people, because cost-sharing can be really high.

(Consumer Checkbook): It is very difficult to estimate out-of-network prices because of the balance billing issue. You have no idea what the provider's list price is going to be. At least with

SERFF templates you have some relative consistency regarding the allowed price. You get a benchmark from the SBC. If the benefit isn't covered you know what you are walking into.

Claire McAndrew: I haven't looked at the exchange plans specifically, but perhaps knowing the difference from a $3,000 out-of-network deductible and a $10,000 out-of-network deductible is important.

(Consumers' Checkbook): It is something we have definitely considered, but I am just pointing out that it is distinctly more complex than modeling the in-network benefits. We believed it was important to get to consumers some measure of cost, so we left that out.

Claire McAndrew: I know you have to provide the basic information and it is not just the balance billing it is knowing what the usual and customary price is.

(Consumers' Checkbook): Yes, we have to know what the price is in the first place.

Billy MacCartee: I like the tool so far from what we are seeing, but Claire is correct. What is happening is the coordination of benefits is becoming more complicated as more and more doctors do not take the insurance or the insurance company denied a claim. For instance, in my firm we see about five denied claims per day, so we have to help the consumers figure out what it is they have to pay or if the insurance carrier should be covering it. It becomes quite complex. I know it is hard especially with the balance billing and I know you guys had to start somewhere so you went with the in-network benefits.

(Consumers' Checkbook): In general people shopping here are the least educated about health insurance in the first place, because it is there first time or first time in a long time having health insurance. We try to strike a balance, so we try to limit the amount of information we give them and ask from them to make the experience something they can get through.

Debra Curtis (Deputy Director): I see all four of these happen to be HMOs, so do they even have out-of-network benefits and do you highlight or say that there aren't any out-of-network benefits if it is an HMO?

Andrew Duff (Consumers' Checkbook): We just list the out-of-network…

Debra Curtis (Deputy Director): If you click there is it going to say no out-of-network benefits?

Andrew Duff (Consumers' Checkbook): You will see the SBC, so whatever the plan offers.

Debra Curtis (Deputy Director): An improvement for the future might be if they are HMOs you can say up there that there are no out-of-network benefits.

Billy MacCartee: Or not even put that piece in there to be able to click because that can be confusing because HMOs do not have out-of-network benefits.

(Consumers' Checkbook): I think many people are still just wrestling with the idea of out-of-network and in-network and not even down the path of knowing what a network is. It is just balancing the level of information, so people can digest it.

Andrew Duff (Consumers' Checkbook): Thank you all for your feedback; it is very helpful. We also have a hospital directory and provide a few quality metrics on these hospitals.

Claire McAndrews: I do not know if it is worth having the hospitals that are in-network when the doctors may not be, because that is a big issue sometimes. It may not be for the exchange.

Billy MacCartee: I am not sure I understand the question.

Claire McAndrew: The hospital can be in-network, but that does not mean that every single provider that works there is in the network.

Debra Curtis (Deputy Director): They will give you an anesthesiologist that you did not ask for because you are unconscious who may not be in your network.

Claire McAndrew: Maybe that is too much information and I totally respect the balance of what information to provide.

Eric (Consumers' Checkbook): I am very interested in this and I am going to want to speak to all about this. Think of it this way, people want to know their degree of exposure. With in-network you know you are kind of capped and with out-of-network even though you may not know the price you might be able to say something or give a sense of exposure without providing too much information.

Andrew Duff (Consumers' Checkbook): Thanks for your feedback and we are always struggling with providing consumers enough information, without overwhelming them with information. Throughout the site people can print their results and save their information and come back to it. The last feature is the shopping cart feature. If you are browsing plans you can select a few plans, add them to the shopping cart and come back and look at those plans. That is all I have to show and I am happy to take any other questions.

Billy MacCartee: Then you can go directly in and it takes you back to those plans so you can sign up?

Andrew Duff (Consumers' Checkbook): Yes, so if you want to sign up right now we just direct them to the DCHL website.

Debra Curtis (Deputy Director): But if they click right there it will take them directly to the DCHL website, correct?

Andrew Duff (Consumers' Checkbook): Yes, and in the future we want to have an integrated link where you click on the plan and DCHL will already know that it is the plan you are interested in so the consumer has a more seamless process when signing up.

Billy MacCartee: This is similar to the tools we are seeing for the private exchanges.

Claire McAndrew: If someone is eligible for cost-sharing reductions based on your determination will they know to shop for a silver plan?

Andrew Duff (Consumers' Checkbook): We do not provide any messaging that states you have to at least choose a silver plan, but in general those plans will rise to the top of your list, because they will be the best value.

Claire McAndrew: And you were saying it would be reflected in the deductible as well?

Andrew Duff (Consumers' Checkbook): Yes.

Eric (Consumers' Checkbook): We expect that their income will be calculated correctly and get them to the right cost-sharing bracket and so expect them to end up in the right plan.

Chris Gardiner: Are there any other questions? Any questions on the phone?

Dania Palanker: When someone clicks if they want to determine if they are eligible for cost-sharing reductions, it seems if they are determined eligible for Medicaid that is the only option that displays, unless they go back to the beginning and start over. This concerns me for pregnant women who are using this tool during special enrollment who may be eligible for Medicaid, but may want to stay in their QHP, which they are legally allowed to do. It is tough for them to figure out which is the best plan once the child is born.

Andrew Duff (Consumers' Checkbook): Thank you for that feedback. The answer to the question now would be to have them go back and unclick the pregnant field and add a line for

the child or try without seeing if eligible for cost sharing reduction, but we can see how we can address messaging to help that consumer know.

Dania Palanker: And it seems like for pregnant women it was basing the determination of her current family size and not counting the unborn child, but for Medicaid purposes it is counted. So there may need to be a question if she is expecting one or more child, so that the family size is correct.

Andrew Duff (Consumers' Checkbook): We will continue to coordinate with the DCHL team to make sure we are handling that scenario appropriately.

Dania Palanker: Great. Thank you.

Chris Gardner: We will now move to the Executive Director report.

Mila Kofman (Executive Director): I apologize for being late and thanks for accommodating my schedule. We are excited about DCHL and the new consumer tools. We have been working with Consumers' Checkbook and excited about what they have done for us in terms of the doctor directory and health plan match tool. We do not think it will address all issues. Health insurance is difficult to understand, and as we heard around the table there is more room to make the tool even better. We think we will make a huge difference for people going through special enrollment periods now and when we go into open enrollment.

Just a note on the vacancy: as you know Dr. Padilla resigned. We have advertised the vacancy. We did not get an overwhelming response, but the Executive Board Operations Committee has reviewed candidates and will be making a recommendation to the full board at our Executive Board meeting on Monday, September 21. Debbie will send you an update as soon as that is complete. Also, we will be retroactively re-appointing Dania Palanker to a full term that will run until November 2018.

Upcoming open enrollment as you know is November 1, 2015 through January 31, 2016. If a person wants coverage to begin January 1st they have to enroll by December 15th. We also began sending out a notice about reporting any changes to DCHL, if anyone moved, had income changes, etc. Income changes are particularly important for APTC calculations. We are upgrading our IT system, and if we get the updated information by mid-October they can see the updated information in their accounts when they login during open enrollment. Additionally, if a person received APTC they have to file federal income tax. If they did not we have to find them ineligible for APTC. Unfortunately, we would like to do targeted outreach to this population, but we are unable to get a list from the IRS, so we are relying on everyone and you to get the word out.

Our October board meeting will include a thorough staff briefing on the OEP 3 Outreach Plan and we will get you all that briefing as well. In addition, as you may have seen in the press, plan rates for 2016 have been released by DISB. We had our own actuary, Oliver Wyman, perform an analysis as well and it was provided to DISB. We always advocate for the lowest possible rate for our customers and we do appreciate DISB's actions this year in accepting some of our recommendations and assumptions.

Claire McAndrew: In your opinion how did it go?

Mila Kofman (Executive Director): We are very pleased in general. For example, CareFirst PPO on the small group requested a 15.2% average increase and DISB approved 5.5%. When you look at all the proposed rates and approved rates there is certainly a considerable difference.

Claire McAndrew: How did it go on the individual side?

Mila Kofman (Executive Director): For example on the individual side CareFirst PPO requested a 14.5% average increase and only 4.6% was approved. It is important to recognize that even a one dollar increase in premium for some of our customers can create a financial hardship, and without scrutiny of rates the consumers could be charged rates that are higher than warranted. So we are pleased and will continue to advocate for our customers.

We have also made a decision on the DC Health Link Assister Program. There are eight grantee organizations. I think all of these have been with us from day one, so none of them should surprise you. We have Community of Hope, La Clinica del Pueblo, Mary's Center, Whitman-Walker Health, Unity Health Care, African Methodist Episcopal Church Second District Religious, Educational & Charitable Development Projects, Inc., Leadership Council for Health Communities and Young Invincibles. The total grants equate to $869,000 dollars. That in combination with 19 CAC designated organizations with 80 FTEs certified under that program we are in great shape going into the third open enrollment period. We are still in the process of selecting our Navigator organizations. There was a request for applications to be submitted and we should be ready to announce those organizations soon. Even though this process isn't closed we feel very confident going into the third open enrollment.

As you seen the census report yesterday the districts uninsured rate dropped by 20%. That is very good news for us. It reminds us we have to keep working, so we see a 100% drop. We will continue working and be creative so that every DC resident is covered.

Mr. Chair that completes my report.

Chris Gardiner: Any questions?

Claire McAndrews: When will the approved plans be able to be previewed on the site?

Mila Kofman (Executive Director): We are trying to figure out how long the preview period should be or if we should have one. It can make it difficult, because the number of SEPS per month. People may get confused with looking at 2015 and 2016 plans. We will look to other states and the federal marketplace for input and take your input to see how long the preview period should be or if we should even have one. I can tell you based on our experience from the last two open enrollment periods is that most people are deadline driven, so they wait to that last day.

Billy MacCartee: I can see it being confusing.

Claire McAndrews: Will the navigators or assisters be able to view the plans or be trained on the new plans? I know other states train on the new plans.

Mila Kofman (Executive Director): Rob left, but he could speak more to the upgrades to the system and the training for the brokers and assisters. On the plan choice all of our assisters have partners with brokers, so when a person is asking benefit questions most often the assister gets the broker involved. Therefore, it will be important to have everyone trained, especially starting with the brokers. Holly, can you maybe talk more about the training plan?

Holly Whelan (Deputy Director for Marketplace Innovation Policy and Operations): I cannot speak to the broker side, but the assisters have to go through annual training.

Mila Kofman (Executive Director): And is the product piece a part of the curriculum?

Holly Whelan(Deputy Director for Marketplace Innovation Policy and Operations): I am not sure.

Mila Kofman (Executive Director): We will have to follow up with you. Before I leave do you all have any other questions?

Chris Gardiner: Holly, we will now go to you for your recommendations on special enrollment periods (SEPs).

Debra Curtis (Deputy Director): Before Holly speaks, I just want to remind everyone on the Standing Advisory Board that we really appreciate the role that you have agreed to play and looking at these exceptional circumstances and making a determination. What we are trying to

do as staff is to come back to you with real life examples of where we can help people obtain coverage. With that, I will turn it over to Holly.

Holly Whelan (Deputy Director for Marketplace Innovation Policy and Operations): I will talk about two special enrollment periods up for discussion today.

The first exceptional circumstance SEP is about loss of job based coverage due to an employer's failure to pay premiums. When an employer fails to pay all or a portion of the premium, coverage terminates. Consumers already have access to a SEP when they lose employer sponsored coverage that is the SEP for loss of minimal essential coverage (MEC). However, we found that some people end up outside the 60 day window to elect new coverage because of loss of MEC, because they did not learn about that loss until the 60 day period ended. This exceptional circumstance is what we are working to address. We have seen it in a couple different situations. The first is with our own SHOP employers. We give the employer a 60 day grace period to pay premiums and if the employer fails to pay at the end of those 60 days, the insurance is terminated and covered employees lose their coverage. The problem is if you're an employee of that employer your 60 day window to elect new coverage is running concurrently with the employer's grace period, so when the grace period ends the employee has also reached the 60 day window to elect new coverage. We have seen this several times and that is why the SEP is needed.

The second circumstance is individuals who come to us who have had employer sponsored coverage not by SHOP, but a business outside of SHOP and for some reason they have lost coverage and have not learned about it before their 60 day window ended. We have not seen this happen a lot, but we have seen it a few times, generally around employer bankruptcy and that sort of thing. Our recommendation is to allow consumers a 60 day window to select coverage that begins on the date that consumers are notified of their loss of coverage.

Chris Gardiner: How will you know when people lost their coverage?

Holly Whelan (Deputy Director for Marketplace Innovation Policy and Operations): If it is a SHOP employer we could tell from our system. If it is a business outside of SHOP we would rely on the person to tell us.

Billy MacCartee: Is this providing them with another 60 days and when is their coverage going to be effective? Will it be retroactive back to the date they lost coverage or when they gave you notice?

Holly Whelan (Deputy Director for Marketplace Innovation Policy and Operations): It will give them 60 days from their notification.

Bill MacCartee: What if it was 70 days ago they were notified.

Debra Curtis (Deputy Director): It will not be retroactive coverage.

Holly Whelan (Deputy Director for Marketplace Innovation Policy and Operations): If you selected a plan today, September 17th….

Alex Alonso (Attorney Advisor): If you selected a plan today it would start on November 1st, because it follows the 15th of the month rule.

Chris Gardiner: So it is not a retroactive plan, so they are going to be stuck without coverage.

Alex Alonso (Attorney Advisor): It is similar to the normal loss of employer sponsored coverage and we are just pushing it forward, because the customer did not learn about the loss of coverage**.**

Holly Whelan(Deputy Director for Marketplace Innovation Policy and Operations): The coverage would actually be effective October 1st.

Alex Alonso (Attorney Advisor): Yes, you are correct.

Laurie Kuiper: And part of the requirement will be that they would have to pay those pass premiums due, right?

Debra Curtis (Deputy Director): No, this is something different. This is someone who lost employer sponsored coverage and are now coming to us on their own to get coverage.

Laurie Kuiper: Okay, I understand. I will also like to add that at Kaiser we have also seen instances where employers have not notified their employees that they were terminating their coverage and the employee does not find out until they go to the doctor. So I think this is a valuable SEP to have.

Billy MacCartee: It is valuable, but why aren't we giving these people an option to go back and get retroactive coverage?

Alex Alonso (Attorney Advisor): I think the important point to note is that the exchange is actually permitted to work with customers to establish a coverage effective date based on customers' circumstances. The last sentence of the SEP language states that 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.

Debra Curtis (Deputy Director): So we misspoke before and the correct way to say it is they get a 60 day window, but we will work with them individually to determine the effective date.

Alex Alonso (Attorney Advisor): Yes, that is correct.

Holly Whelan (Deputy Director for Marketplace Innovation Policy and Operations): The second SEP is the technical correction to COBRA Employer Non-payment. This is a correction to an exceptional circumstance that was already approved in June of 2014. As it is currently written this exception is not in compliance with federal law. Federal law indicates that a SEP window can be no more than 60 days in length, but how it was originally written it states that the length of the SEP will be based on the circumstances as determined by the Authority. We cannot say that, so we are suggesting three recommendations to this SEP. The first is to clarify that the triggering event for the SEP should be the date of the notice to the individual informing them of the loss of coverage. The second is clearly indicating that the consumer has 60 days from the notice of loss of coverage to elect a new plan. The third is a language change to amend the language to make it more comparable to the other SEP we looked at today, so amend the language to state it is not just if the employer fails to submit the premium on time, but also if the employer fails to submit all or a portion of the premium on time.

Chris Gardiner: I think they are both pretty straight forward to me and we can move to a vote.

Alex Alonso (Attorney Advisor): I just want to clarify Laurie, that for any retroactive coverage they will have to pay for those premiums.

Chris Gardiner: Do we have any members of the public on the phone who would like to address this issue?

IV. Votes

It was moved and seconded to accept the COBRA Employer Non-Payment Exceptional Circumstance SEP. The motion passed unanimously by voice vote.

It was moved and seconded to accept the Loss of Job-Based Coverage due to Employer Failure to Pay Premiums SEP. The motion passed unanimously by voice vote.

V. Closing Remarks and Adjourn

The meeting was adjourned at 4:22pm.