Standing Advisory Board Meeting

FINAL MINUTES

Date:	Wednesday, June 3, 2015
Time:	3:00 pm
Location:	By Conference Call Only
Call-In Number:	1-877-668-4493; access code 739 617 521

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

Members Present: Chris Gardiner, Kevin Dougherty, Billy MacCartee, Dania Palanker, Laurie Kuiper, Claire McAndrew, Luis Padilla and Jill Thorpe (joined late).

Members absent: Stephen Jefferson

Staff in attendance: HBX Staff: Mila Kofman, MaryBeth Senkewicz, Debra Curtis, Rob Shriver; DISB Staff: Howard Liebers.

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

Chair Chris Gardiner called the meeting to order at 3:05pm. A roll call of members present confirmed that there was quorum with seven members present: Mr. Gardiner, Mr. MacCartee, Ms. McAndrew, Ms. Palanker, Mr. Dougherty, Ms. Kuiper and Dr. Padilla.

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

The Chair asked for questions or comments regarding minutes. It was moved and seconded to approve the minutes from the May 21, 2015 meeting. The motion was unanimously approved by voice vote.

III. **Discussion Item**

Mila Kofman (Executive Director): This is a continuation of the in-person meeting the Standing Advisory Board had to look at the essential health benefit benchmark plan and the options that the federal government is allowing states to exercise when selecting a new EHB benchmark plan for plan year 2017. Our staff did a walk-through of the options permitted by HHS for the District's consideration. Members of the Standing Advisory Board had follow up questions that required additional research by staff here as well as our partners at DISB, so I'm going to turn this over to Mary Beth to walk us through what we have been able to find and the outstanding research questions.

Mary Beth Senkewicz (Associate General Counsel and Policy Advisor): Thank you Madam Executive Director. Please note that we emailed a chart to you with further details based on the in-person meeting. The Board had requested more detail on habilitative services, rehabilitative services, home health, durable medical equipment and hospice care. DISB sent out the appropriate emails and I forwarded the responses to you from CareFirst and Kaiser. However, I thought it would be visually easier to walk through a chart. I will note that the full chart of these additional benefits is pretty much what we expected. When you look at it in detail, all these plans, particularly A, B and C, are current exchange plans and are very close to each other. There is some deviation in plan D, which is a large group HMO product. I would note that under plan D you see that in the 2014 plan, habilitative services were not covered and they have visit limits on rehabilitative services. I would point out that if we adopt a benchmark plan that doesn't cover habilitative services we would need to supplement that plan by adding habilitative services. I would also note that plan D has visit limits, and if that plan was to be picked as the benchmark plan those limits could stay. Under the new rule habilitative benefits have to be as generous as the rehab benefits. If rehab contains visits limits then habilitative services would be limited too. I noticed plans A, B and C don't contain visit limits and already cover habilitative services. I will note that I think plan B and C standards are similar to plan A, which is the CareFirst PPO plan. Plans A and B use the terminology "subject to improvement" and plan C, the Kaiser Plan, says "limited to restoration of a physical function." In my view those are functionally equivalent.

On the bottom of page two, I do note on durable medical equipment (DME), limitations on DME are implemented differently by Kaiser and CareFirst. Kaiser uses a definition of durable medical equipment, which they define as intended for repeated use, primarily and customarily to serve a medical purpose, generally not useful to a person in the absence of illness or injury and meets plan criteria for medical necessity and excludes prosthesis, which is fairly standard. CareFirst's DME limitation is limited to the least expensive medically necessary DME adequate to meet the

member's medical needs. It is just a different approach from plans A and B to plans C. In hospice services, beginning on the bottom of page three, I do note that in plan D, the large group HMO does not cover PT, OT, speech and respiratory therapy required to maintain the comfort and manage the pain of the terminally ill member nor does it cover palliative drugs. In Plans A and B, CareFirst did not specifically list nutritional guidance and home visits within a service area. Those are the major differences that my review has indicated. I'm happy to take any questions.

Chair Gardiner: Are there any questions from board members?

Dania Palanker: Mary Beth under your understanding of the requirement for rehab and habilitative services to be in parity, if we remain in plan A or if we pick something like plan B would those thirty visit limits under habilitative services have to go away?

MaryBeth: Looking at Plan A or plan B there are no limit visits on rehab services, so you are correct that the thirty visit limit on habilitative services will have to be deleted.

Debra Curtis (Senior Deputy Director for Policy & Programs): If I can just clarify for everyone. You used the term that they have to be in parity, but just to be clear the new federal regulations that just came out do not say that they need to be in parity. They say that there cannot be limits on coverage for habilitative services and devices that are less favorable than any such limits on rehab. The way the regulation is written they can have a more open set of benefits for habilitative services than they do on rehab, but cannot do vice versa and that's in the federal regulation. I just want to remind everyone based on the other memos that we sent out we did clarify with CMS that our statutory definition is absolutely consistent with the federal standard, but note the federal standard is the floor. The federal standard has more specificity in it, which is encompassed by our definition already and we believe that CCIIO agrees, but the plans will need to recognize that the federal regulations are what they are going to have to follow and so that means that habilitative benefits have to be at least as good, if not better than, the rehab benefits. Starting in 2017 it will be inappropriate for plans to combine habilitative and rehabilitative limitations. They are going to have to be separate benefits offered by the plan and again that is federal regulation and that will apply in the District of Columbia.

Kevin Dougherty: Can I presume staying with the rehab services the difference between plans A and B. You used the language coverage is subject to improvement. Can I presume the same language applies to Plan B?

MaryBeth: Kevin thank you. I failed to mention that. No it does not. Plan A accomplishes that through the definition of rehabilitative services. That's where you get subject to improvement or the condition has to be subject to improvement. Plan B doesn't contain that same definition. There is no definition for rehabilitative services in plan B, so as far as I could find it doesn't have that limitation.

Dania Palanker: However, my understanding is that if it weren't covered under rehab because it is not subject to improvement that fits the definition of habilitative.

MaryBeth: That could very well be Dania. Good point.

Dania Palanker: So it seems like that difference only exists for physical therapy, occupational therapy, and speech therapy, which both are also habilitative services.

MaryBeth: Right.

Chair Gardiner: Any other questions?

MaryBeth: I would just note plan A by CareFirst is the same type of plan that is our benchmark that currently exists.

Debra: The other outstanding question from May 21st was from Claire McAndrews. She asked whether the ombudsman's office here in the District of Columbia has recommendations or specific benefit complaints that they have received. We have reached out to the ombudsman and we have not gotten any specific information from them regarding benefit complains within DC Health Link.

Dania Palanker: I want to go back to the rehab in plan B. Under exclusions in plan B it does include conditions not subject to improvement, so they do have that same language. So that means A and B are the same?

Debra: Right.

Chair Gardiner: So is that true for the three types of services?

Mary Beth: Yes, for habilitative services they have to be subject to improvement. That's the general distinction. I'm sure Kevin and Claire know more about this than I do, but generally speaking rehab is restoring functions that you have lost and habilitative is allowing you to stay where you are.

Chair Gardiner: Any other questions or comments board members?

Chair Gardiner: Do we have any members of the public on the phone?

Chair Gardiner: Seems not. Mila is there anything you would like to add?

Mila Kofman: No there is nothing from our end. We do need a recommendation from the Standing Advisory Board on which option to select and I would like to bring that recommendation to the Executive Board for it to consider. There is a board meeting on Monday, so if you are prepared to take a vote on what you would recommend that would be very helpful for us.

Claire McAndrew: Even though there are no members of the public on the phone now, I just want to recognize the groups that sent in written comments. At the last meeting we heard from the American Speech Language Hearing Association (ASHA), and we also received additional comments from the Acupuncture Society of the District of Columbia. I took a look at their comments and found them very helpful. I know they are not online with us now, but they raised some very important concerns. I know the Acupuncture Society recommended a specific plan. Their recommendations were not among the small group plans, which for me is concerning because they are plans that don't cover District mandated benefits. However, I do hear their concerns and if they are on the line I would recommend that they work with Council to share their concerns there. Similarly, ASHA brought up some really important points, including points the staff raised in regards to needing to bring habilitative services in compliance with the federal definition and making sure it is not more restrictive than rehabilitative services. I know they also had concerns that none of the plans covered hearing aids, which I hope is something we can look at in future years and something they can address with Council as well. I just thought it was important to recognize that we did have groups from the outside that really helped us think through these benefits and I really appreciate their input.

Mary Beth: Claire, thank you very much.

Chair Gardiner: Does the staff have a recommendation?

Mila Kofman: We do not. The HBX staff doesn't have a recommendation for you. We are looking for you all to make the recommendation without our input except for providing the research. The people on the Standing Advisory Board represent diverse stakeholders understanding the needs of the community, patient needs, health plan

needs, provider needs and physicians' needs. That's why in large part HBX staff did not want to come up with a recommendation. You all are much closer to the community by the nature of the stakeholders you represent, so we really would like your recommendation around this.

Chris Gardiner: Okay. Members of the board do you feel like we are in a position to make a recommendation at this time?

Dania Palanker: I think we can start the conversation by taking a number of plans off the table. The letters above D can be taken off the table in part because we do not have all the details on the plans. I just don't think it is proper to pick a plan that we really don't know what is in the benchmark. I also think we can at least take D out of consideration because of the limits in the rehabilitative services. I feel there is no reason to add thirty day limits to those if they are not in plans A, B and C. I think it is really great that DC does not have those limits and a really great part of our EHB, so I would hate to add those limits.

That brings us to the small group market plans, which are also similar to what our current benchmark is. I think they are very similar, and even though plan C is a different carrier, the carrier had to provide the EHB that was based on CareFirst, which is plan A and B. I will also mention for those who have not read both of my emails that I did do an analysis of not all but some of the formularies. I looked at some of the categories and classes that are used by USP to compare plans for EHB purposes and they were very similar. I thought that there were some significant differences, but I realized that those were all drugs administered by healthcare providers. So the drugs that would be covered under the full prescription formulary are instead covered under the medical benefits because the consumer does not go to the pharmacy, but receives the drug from the doctor or the clinic. I'm sure someone who looks through will find some categories that offer a little more coverage under one than the other, but they are very similar.

Billy MacCartee: I agree that I like the options of either A, B or C, and agree with your assessment of at least narrowing them down to those three options.

Claire McAndrew: The way I approached this is that there are benefits to staying with the same plan or similar plan in terms of minimizing disruption with our agencies in terms of how oversight is done, how easy it is to maintain in our system and for consumers in regards to consistency. However, if for consumers there was a compelling reason to switch to a different plan to offer better coverage I would want to pursue it. I think what we should be assessing right now is if there is a compelling

reason based on the evidence we have seen to move to a different plan, or are we seeing that there isn't much difference between plans A, B and C and therefore it is an advantage to maintain the coverage that is as consistent as possible with what we have now. Dania has done a lot of research and I'm not sure that there are differences between plans A, B, and C that are so drastic that warrant any kind of switch, but I don't know if I have the expertise like Dania or Kevin. If you have anything you seen to indicate that there is a reason to switch to B or C, I would want to know that, but as of now I'm not sure that there is a reason to disrupt something as close to what we have now, because there could be some costs in logistically doing that, but if someone does see a reason that indicates we should switch I certainly would want to know.

Kevin Dougherty: I agree with you Claire and like the way you framed that. From a neurological point of view for people with a neurological diseases I could not find a difference either and for that reason sticking with plan.

Dr. Luis Padilla: To chime in from a provider perspective, I couldn't find a difference either. Claire I totally agree with you and there ought to be a very compelling reason for us to want to disrupt the continuity of the benchmark. In my review of all the material that has been presented I don't see any reason to switch right now.

Billy MacCartee: I agree with the assessment and agree with sticking with plan A.

Jill Thorpe: I will speak from a consumer perspective. I have a CareFirst plan and I'm quite pleased and agree with the consensus that is developing on this phone call.

Chair Gardiner: Laurie, do you have an opinion?

Laurie Kuiper: I agree with all of the comments that have been made. I think it make sense to maintain the current plan. It will be less disruptive and facilitate administration and I think we are perfectly fine with that.

Chair Gardiner: It seems we have consensus. Do we have a motion?

It was moved and seconded to select as the benchmark, Plan A, the current benchmark.

Mila Kofman: Chris, just to clarify that plan A is closest to the current and it is not actually the current plan.

Chair Gardiner: But we do have to make a choice?

Mila Kofman: Yes, but I just wanted to make sure folks understood that it is not exactly the same but it is the closest to the plan we have now.

Chair Gardiner: Mila, is one of our choices to simply stick with what we have?

Mary Beth: No.

Dania Palanker: Because all the current plans have to provide the current EHB, it should be at least as good as the 2015 benchmark. It can't have any benefits lower than the existing benchmark, because it wouldn't have been approved due to not complying with the law.

Chair Gardiner: We have a motion on the floor to select plan A and it has been seconded. Any questions, comments or debates on the motion?

IV. Votes

Mr. Gardiner asked for a vote on recommending to the Executive Board that plan A be the essential health benefit benchmark plan for plan year 2017. The motion passed unanimously by voice vote.

V. Closing Remarks and Adjourn

The meeting was adjourned at 3:33 p.m.