Health Benefit Exchange Authority Executive Board Meeting

FINAL MINUTES

Date:	**Wednesday, September 10, 2014**
Time:	**5:30 PM**
Location:	**1100 15th St, NW, 8th Floor Conference Room**
Call- in Number:	1-877-668-4493; access code: 736 284 385
	Approximately 45 minutes after going into Executive Session, the public meeting will reconvene at this number: 1-877-668-4493; access code 735 066 166

Members present: Dr. Henry Aaron (by telephone), Deborah Carroll, Dr. Leighton Ku, Diane Lewis, Kevin Lucia, Kate Sullivan Hare, Chester McPherson, Wayne Turnage (by telephone)

Members absent: Dr. Joxel Garcia, Khalid Pitts

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

There was a roll call of members present to confirm that there was a quorum. A quorum was met with four voting members present (Dr. Aaron, Dr. Ku, Ms. Lewis, and Mr. Lucia).

II. Approval of Draft Agenda

Ms. Lewis asked if there were any changes to the draft agenda. There were none. It was moved and seconded that the agenda be approved. The motion was unanimously approved by roll call vote. Voting in favor were Dr. Aaron, Dr. Ku, Ms. Lewis, and Mr. Lucia.

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

Ms. Lewis asked if there were any changes to the draft minutes. There were none. It was moved and seconded that the agenda be approved. The motion was unanimously approved by roll call vote. Voting in favor were Dr. Aaron, Dr. Ku, Ms. Lewis, and Mr. Lucia.

IV. Executive Director Report, *Mila Kofman, Executive Director*

1) *New Staff Members.* Ms. Kofman introduced two new members of the HBX staff: Adam Hudson, Public Information Officer, and Joan Hummons, Contact Center Manager. Mr. Hudson has experience as a reporter and on the Hill; Ms. Hummons has several decades experience managing contact centers in both the public and private sectors.

2) *New Office Space*. Ms. Kofman reported that the new HBX space would be at 1225 Eye St. NW, Ste. 400, and the Contact Center will be moving to 955 L'Enfant Plaza. Once the dates are finalized, Ms. Kofman will let the Board know.

3) *Enrollment Numbers*. Ms. Kofman reported the most recent enrollment numbers:

   Individual Market – 14,402
   SHOP - 14,289
   Medicaid - 29,192
   Total – 57,883 covered lives

V. Finance Committee Report, *Dr. Henry Aaron, Chair*

The Finance Committee met on September 4, 2014 for its monthly meeting, except the Finance Committee did not meet in August.

1) *NO COST EXTENSIONS OF GRANTS:* The District has three active grants from CMS. We have already received a no cost extension through 2015 for our most recent grant and are in the process of obtaining one-year extensions on each of the other grants. These extensions are necessary because, as we know, IT functionality had to be right shifted, so we are still building. CMS has recognized this issue across the country and has been considering and approving no cost extensions in other state based exchanges as well.

2) *DEPARTMENT OF HEALTH SERVICES MEMORANDUM OF AGREEMENT:* HBX has finalized an MOA with DHS that will result in DHS receiving $19 million from our CMS grants to fund ongoing IT needs.

3) *FINANCIAL UPDATE:* HBX Staff reviewed spending for the preceding two months (as we did not have an August Finance Committee meeting). Spending has been for staff and ongoing purchasing orders. There are no significant new spending items since our last report.

4) *ASSESSMENT:* We have moved forward on implementing the assessment. A Memorandum of Understanding was signed with DISB in mid-July to conduct the assessment on our behalf. Notices were mailed to the affected health carriers on August 18 and 19. Health carriers may appeal for limited reasons under the Carrier Assessment Administrative Appeal Rule. The appeal deadline is Sept. 17. The due date for the invoice is Sept. 30. We are slated to collect $25.3 million from the assessment.

VI. Annual Board Officer Elections, *Diane Lewis, Chair*

- *Nominations and Vote for Chair, Vice-Chair, Treasurer/Secretary of the Executive Board*

Mr. Lucia nominated Ms. Lewis to serve as Executive Board chair; Dr. Aaron seconded. Dr. Ku nominated Dr. Aaron to serve as Executive Board vice- chair; Ms. Lewis seconded. Mr. Lucia nominated Mr. Pitts to serve as Secretary-Treasurer; however, he was not present and had not given previous assent as required in the Bylaws.

Ms. Sullivan Hare entered the meeting.

Ms. Lewis called for a roll call vote on her nomination as Chair of the Executive Board. Voting in favor were Dr. Aaron, Ms. Sullivan Hare, Dr. Ku, Ms. Lewis, and Mr. Lucia.

Mr. McPherson entered the meeting.

Ms. Lewis called for a roll call vote on the nomination of Dr. Aaron as Vice-Chair of the Executive Board. Voting in favor were Dr. Aaron, Ms. Sullivan Hare, Dr. Ku, Ms. Lewis, and Mr. Lucia.

Mr. Lucia nominated Khalid Pitts to serve as Secretary-Treasurer. However, he was not present and had not presented an affirmation of the nomination as required by the Bylaws. Action on Secretary-Treasurer was deferred until later in the meeting.

Kudos and congratulations were extended to the returning officers.

VII. Discussion Items

- **Rate Review Presentation** , *Kevin Lucia, Chair, Executive Board Insurance Market Committee*

Mr. Lucia noted that the Insurance Committee had received a private briefing from Oliver Wyman, the consulting firm hired by HBX to review the rates submitted by the carriers for 2015 exchange plans. He stated that it was clear to him that the Board needed to learn more and understand its role with respect to plans and rates. He stated he would first call upon Purvee Kempf, General Counsel to the HBX, to provide background on the statutory provisions surrounding rates and Exchanges. Next he had asked Commissioner McPherson to provide an overview of the rate review process in the District. Last he would ask Oliver Wyman to give a high level overview of the initial rates filed for 2015 on the Exchange.

Ms. Kempf stated she would provide the legal background regarding review of rates and the Board's role with respect to rates. She stated that overall the ACA has numerous provisions regarding the review of premium rates. First is that States must evaluate rate increase requests and ensure they are based on reasonable cost assumptions and solid evidence. She stated this was the role that DISB performs in reviewing rates as the regulatory authority. Second, there are specific provisions in the ACA relating to the Exchanges and their role in reviewing and assessing premium increases. In general, exchanges must make available health plans that are in the interests of individuals and small businesses. Specifically, the ACA states that the Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase, and the Exchange shall take this information into consideration when determining whether to make such health plan available through the Exchange. Additionally, the Board members have specific duties as well. They shall have the responsibility and duty to meet the requirements of this chapter [HBX enabling legislation], and the Federal Act, to serve the public interest of the individuals and small businesses seeking health care coverage through the exchanges, and they shall have all the powers necessary to carry out the functions authorized by the Federal Act. Ms. Kempf stated that overall, the big picture is that there are two bodies in the District that have a role with respect to premium increases, rate review and justification. One is the regulatory body, DISB, and the other is this new entity, the HBX, that are required to review premium increases and to ensure there is a justification for those premium increases.

Mr. McPherson noted for the record the opinion was that of the General Counsel to the HBX, and with which DISB disagreed.

Dr. Aaron inquired what aspect of Ms. Kempf's presentation he disagreed with.

Mr. McPherson stated that the purview of the Commissioner is to approve rates in the District of Columbia. The HBX enabling legislation at DC Code sec. 31-3171.09 provides that the Exchange is authorized to approve plans, and one of the requirements for the plans is to obtain the prior approval of premium rates and contract language from DISB. In looking at the justification language, he was not aware of any interpretation that says in

addition to having the Commissioner approve rates, the plans are required to provide any additional information to the Exchange Board, and he would like the Exchange to provide him with that guidance. Until such time, it is his view that his purview is to approve rates, which he will do; he does not intend to cede or abdicate that responsibility to the Board.

Dr. Aaron asked Ms. Kempf if there was anything Mr. McPherson said that was at odds with what she described. Ms. Kempf said in order to clarify the matter, it might be helpful to refer to the section of the ACA that has the requirements related to premium rate review. She referred to sec. 1311 (e)(2) of the ACA and read the following:

> *PREMIUM CONSIDERATIONS.— The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange shall take this information, and the information and the recommendations provided to the Exchange by the State under section 2794(b)(1) of the Public Health Service Act (relating to patterns or practices of excessive or unjustified premium increases), into consideration when determining whether to make such health plan available through the Exchange. The Exchange shall take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the States.*

Ms. Kempf stated what the Exchange is required to do is to take the information from insurance companies regarding justifications for rate increases into consideration, and take the information from the state under 2794(b)(1) regarding the rate approvals and any recommendations from DISB into consideration, when making determinations regarding certification of qualified health plans.

Mr. McPherson stated he would not tell the Exchange how to do its job, or how to interpret its law, but he would tell the Board where the line is in the sand. He is of the view that the authority and role of the Commissioner and the appropriateness of the decisions to be made to by the Commissioner have been called into question. No one, including his staff, is privy to the decision he will make on rates. He continues to maintain that the discussions about rates, appropriateness of rates and the rates to be approved are premature. Once he makes a decision he will inform the Exchange. He states that the Exchange is a separate Board and he does not intend to tell the Board what to do in the approval and certification process as that is the Board's prerogative and purview.

Dr. Aaron asked for a modification: that it is our responsibility not just our purview. He also stated that Mr. McPherson is a member the Exchange Board as well. He hoped for the benefit of collegial exchange of views so the Exchange can do its job as called for under the statute. Mr. McPherson replied that there had been a collegial and great working experience until last Tuesday when the legitimacy of the Commissioner and the agency was publicly called into question. Dr. Aaron replied that last Tuesday's telephone conversation was not a public meeting. The Insurance Committee was seeking to have an exchange of views and not infringe in any way on the clear authority of DISB to approve rates of insurers. He hoped to continue in a collegial vein.

Mr. Lucia stated that in hearing the language of the federal statute it was the Board's job to certify plans and it was pretty specific that the Board members need to be engaged and thoughtful in their roles. Mr. McPherson stated that again, he would not tell the Board how to do its job. Mr. Lucia asked whether Mr. McPherson agreed with what he had said. Mr. McPherson replied that it was a legal interpretation that lawyers have to produce. He stated the issue is, it is a federal statute. Are those provisions optional for states to adopt in their organic statute? Were those provisions adopted by the District? There are a host of legal interpretations that we could take forever to discuss. Mr. McPherson did not want to get into what the Board perceives its role to be based on the guidance received from its counsel. He wanted to make clear what his role is and what he intends to do. Mr.

Lucia stated it was an important question for the Board to understand its role and responsibilities and until he hears otherwise from the Board's analysis, the Board needed to go with the idea that the Board has a responsibility to engage on access to coverage, affordability of coverage and adequacy of coverage in any way that is permissible under federal and state law. He did not think the Board had a choice. Mr. McPherson reiterated that he was not going to get into a dispute over what the Board's jurisdiction is as that was for the Board with its counsel's advice to decide.

Ms. Carroll opined that it might be an appropriate time to request a legal opinion from the Office of the Attorney General, the official decision-maker on legal questions in the District.

Mr. Lucia stated that what the Board is doing right now is educating itself on what its role is. The Board will hear more about the rate review process in the District. Mr. Lucia did not think anyone on the Board truly understands the rate review process; few people in the country do. He stated that the Board had hired consulting services (Oliver Wyman and sister company Mercer) on this matter and the Board needed to hear what the consultants found. He stated the Board would not be taking any action at this meeting on this matter. The Board paid for consultants to help the Board understand about rates, and this was an opportunity for the Board to educate themselves.

Dr. Aaron asked if the Board could hear from Oliver Wyman. Mr. Lucia replied that he hoped to hear more from DISB about the rate review process itself. Dr. Ku interjected that he thought Ms. Carroll's idea was a plausible one. One issue that creates some interesting issues is that unlike most states, because of the District's decision to unify the market, one could think that DISB has overall regulatory role and the Board has a special role with respect to plans on the Exchange, but here they are one and the same and it creates some interesting tensions. Dr. Ku agreed with Mr. McPherson that much of this is in some way it is premature. We do not know what the Commissioner's recommendations are, nor has the Board had the opportunity to hear what the issues are well enough to know how the Board should react. He agrees it is worth understanding there are some differences of opinion and potentially some ways to resolve them. He thought having further information, such DISB's perspective on rate review and Oliver Wyman's analysis, was reasonable.

Ms. Carroll noted that she was one of the few people around in the early days of talking about setting up the Exchange. One of the key drivers in early decision-making was leveraging existing infrastructure to keep costs down. Rate review was one in particular that it was thought DISB could handle and not something that HBX would do and establish a whole team to establish a rate review process when there is an agency that already performs that function and has the statutory authority to do so. Mr. Lucia stated to make clear, he did not think anyone at the meeting was suggesting that DISB would not be the regulator of rates. In fact, in order to be an effective rate reviewer as determined by CMS, that function has to be with DISB. It is about our role in the input regarding rates, as a Board advocating for the most competitive rates for the residents of the District. It has never been about the regulatory authority of DISB – that is not the question here or anywhere in the country. The question is in understanding how the Board interacts with that process and provides input to that process. Also, the Board certifies plans. In that role, the Board has the responsibility to look into the access, affordability and adequacy of coverage before it certifies plans.

Mr. Lucia invited Mr. McPherson to discuss the rate review process in the District.

Mr. McPherson stated that he would present a high level overview. He also stated he was not an actuary. The mechanics of the rate review process is the purview of professional actuaries hired by DISB. Companies make a determination whether to enter the marketplace, and what plans and products would they like to offer for a certain plan year. The companies design the plans and take into consideration all their assumptions driven by their business decisions. They take into consideration the size of the market they would like to capture, the MLR (medical loss ratio) requirement, whether to make contributions to surplus; they take into consideration a

whole slew of variables they use to design their plans. No two companies are the same. Some companies have deep-pocketed parents who can continue to treat them as loss leaders for market purposes, some are not-for-profit. They come in all spectrums and they design their plans based on their business judgment. Those plans are submitted to DISB and the actuaries come into play.

Mr. McPherson was not certain the ratio of credentialed actuaries in insurance departments across the country, but DISB has three credentialed actuaries on staff, and two are assigned exclusively to health. Also, the head of the Insurance Division at DISB and thus the supervisor is a credentialed actuary. It is the job of the actuaries to review assumptions submitted by the companies that support the rate and ask questions. If the actuary determines that based on the data submitted, based on experience, based on the risk profile, that there are issues or concerns that ranges are out of regional or national norms, the actuary requests further information from the company. His guide to the staff is to perform a rigorous regulatory review. The statutory requirement is that rates not be excessive, inadequate or unfairly discriminatory. DISB has a very delicate balancing act. It has to ensure that there is access to the marketplace, that the rates approved are competitive and affordable and at the same time such rates will not lead to the inadvertent demise of the company because then there will be market disruption. Those are two very important delicate balancing acts and are the guidelines behind the rate review process. The actuaries go through their exercises, they engage the company actuaries, and they request additional information. Some information will be satisfactory and some will not.

For 2014, DISB had the benefit of two independent actuarial reviews. This was done purposefully because DISB recognized the impact of the ACA – that it brought to the marketplace some significant changes and DISB was unsure it had all the necessary talent in-house to deal with those changes appropriately. For the 2015 rates currently under consideration, the Exchange offered to pay for Oliver Wyman as an independent outside resource to DISB. An independent outside resource does not necessarily mean that every recommendation or issue raised will be agreed to by DISB. These are professionals. Actuaries have a significant level of judgment to exercise, just like lawyers. Two lawyers can review a case and come to different conclusions, and two judges can hear the same facts and rule differently. It would be foolhardy to deny that discretion exists. So this year DISB received the input of Oliver Wyman and to the best of Mr. McPherson's knowledge, a significant number of issues were raised by Oliver Wyman. For the record, DISB appreciates the input of Oliver Wyman. However, of the x number of issues raised, DISB had y number of issues with which it had a difference of opinion. A number of those issues have been reconciled, remedied or reduced.

Ultimately, Mr. McPherson said the staff the actuaries will make a recommendation to him. His practice is to meet with his team, review the rates that were filed and the actuaries' recommendations, and the team has a robust discussion. His recollection is that in SHOP, two carriers filed for reduced rates and one filed for an increase. There he asks his actuaries to explain to him why one carrier is filing for a 10% average decrease, another for a 9% average decrease, and another for a 10% average increase. One answer is insurers filing for a rate decrease realize either (1) they were priced too expensively or (2) they are adjusting their formula to be more competitive. Even then the insurer requesting a decrease may be more expensive than the insurer that requested an increase in rates. If Mr. McPherson is satisfied that the staff actuaries have exercised appropriate discretion they are qualified to make, and balancing his regulatory mission and duty, then he will make decisions accordingly. He stated that final stage has not yet occurred. It is a dynamic process and the insurers respond to comments based on where they perceive themselves to be and they will use as much time as possible to make small tweaks because ultimately they want to be competitive.

Mr. Lucia asked where we are in the process. Mr. McPherson's commitment is to have the decision made by Friday. He met with the staff on this past Tuesday. After rigorous discussion, Mr. McPherson had some issues he wanted the actuaries to explore further. They are scheduled to meet on Friday to hopefully go through the final review.

Mr. McPherson asked Philip Barlow, Associate Commissioner for Insurance, if DISB had given the insurers a deadline. Mr. Barlow replied that they do not tell the insurers anything about dates until they are done with the review.

Mr. McPherson noted that DISB wants the insurers to submit competitive rates and does not want to arbitrarily set a deadline. But there is a practical implication as well since the rates have to be sent to the Exchange to process the rates and have them available to the public. He is aiming for Friday but he has been told that some last minute changes would be coming in even then, but he wants to get them done by Friday.

Dr. Aaron stated that Mr. McPherson explained the process quite well and it will presumably come to an end on Friday, when the Board's responsibilities ensue. He asked whether it was Mr. McPherson's understanding that after he approves a rate, the Exchange is obliged to accept as final the rates he has approved, in which case the Board can then approve or disapprove plans at the rate he has approved. Mr. McPherson said that was his understanding. There are about five requirements for plan certification, and one of them is the prior approval of premium rates and contract language from DISB.

Dr. Ku asked if it was Mr. McPherson's view that DISB approves a rate, then the Board's option is to say we do not like the rate for a particular plan and exclude the plan? Mr. McPherson responded that he had not spent much time thinking about next steps by the Exchange but had focused his time and energy on the rate review process and not causing any inadvertent delays for the Exchange. He may have an opinion but did not think it appropriate to offer them as to what he thinks the Exchange should do. But since the premiums and contract language have been approved by the Commissioner, that part of the certification requirement has been met.

Mr. Lucia said that typically, if there was a possibility of going lower on rates, it is a red flag to DISB regarding the solvency of the company. Mr. McPherson replied that it is a delicate balance. It is not rates alone. If rates are inappropriate, there is the possibility of market disruption because if rates are not sustainable to that company, it can go down and then you have another set of problems to address. If the Commissioner approves a rate that a company does not think is sustainable for the company, it can decide to exit the market.

Dr. Aaron asked which of the carriers in the market Mr. McPherson felt might be in a delicate financial condition. Mr. McPherson stated he would not respond, because it would be inappropriate as a regulator for a variety of reasons, including that he has a regulatory matter before him concerning one of the carriers.

Mr. Lucia then called upon Oliver Wyman for a presentation. Tammy Tomczyk apologized for not being at the meeting in person. She is a health actuary with Oliver Wyman, and has been working on ACA projects almost exclusively for the past four years. Oliver Wyman (OW) and the sister company Mercer were retained by the Exchange to assist with an independent actuarial review of the filed rates for 2015 in both the individual and small group markets. She related that she performs work like this in 11 other states, sometimes directly for the state, and other times for CCIIO in states that do not have effective rate review programs.

Ms. Tomczyk began with a brief overview of the Oliver Wyman process. Slide 3, keeping in mind that DISB is the regulator, they were hired to assist DISB who has many filings to review in a short period of time. OW worked collaboratively with DISB identifying assumptions or areas of the filing that required additional support. OW provided the information to DISB, at which time DISB decided which issues it wanted to investigate further with the carriers and ask for additional support. Throughout the process they had many conversations with DISB to provide clarifying information on OW's opinion so DISB could understand their opinion. At the conclusion of the process OW will provide a final report as to each of the filings providing their analysis and opinion.

Slide 5 – Ms. Tomczyk clarified that while people are accustomed to four carriers, Aetna, CareFirst, Kaiser and United, rate filings are required to be at the legal entity level so there are more than four carriers reflected. Slide 5 is a high level overview of the increases the carriers requested, and their independent analysis of the information provided to them. It is not what DISB might approve. She noted that as stated previously, there is a lot of discretion and assumptions that go into rate-setting, it is not always black and white and therefore there is no right or wrong answer in many cases. If you gave these filings to 10 different actuaries, you would probably get 10 different answers, but hopefully most of those answers fall within a reasonable range. The left half of the slide shows the weighted average increases requested in the original filing over 2014 rates. The right side reflects OW's independent analysis of the original filing and additional materials that have come in since the original filing, and what the increase would be if OW had calculated it.

Ms. Sullivan Hare asked for the breakdown of the corporate entities and the products associated with them. Mr. Barlow replied:

CareFirst BlueChoice is the CareFirst HMO
GHMSI is the CareFirst PPO
Aetna Health Inc. is the Aetna HMO
Aetna Life Insurance Company is the Aetna PPO
UnitedHealthcare Insurance Company is the United PPO
Optimum Choice is the United HMO that operated in the Exchange last year and continues in 2015
UnitedHealthcare of the Mid-Atlantic is the United HMO that is new to the Exchange in 2015

Because UnitedHealthcare of the Mid-Atlantic is new, the -1.2% is the difference between the original filing and the OW calculated rate. There is nothing in 2014 to which to compare it.

Slide 6 is a sampling of rates that would be offered in the individual market for someone purchasing silver coverage based either from the rates that were filed originally or the rate produced from the OW analysis. On the top portion of the slide are the rates for the lowest cost silver plan, and the bottom is platinum. Because there are not standardized benefit packages in the District, the actual underlying benefits could be slightly different, but she would not expect them to be more than 1% of the actuarial value of the plan. The first three columns are the monthly premiums for a 27 year old and the columns to the right are for a 55 year old, and in both cases the difference in the monthly rates from the filed premium and the OW calculation.

Slide 7 is the same but for a family of four. OW assumed a husband and wife both age 40 and two dependent children under the age 21.

Slides 8 and 9 are similar summaries of rates for the small group market. (There are more legal entities operating in the small group market.) The rates are for an individual person of that age covered in the group plan. On this slide OW used gold and platinum because those tiers have the majority of members in the small group market.

Slide 10 is a fictitious example of a small group. It underlies the rates displayed on Slides 11 and 12. Slide 11 is for gold and Slide 12 is for platinum.

Dr. Aaron asked in reviewing rates, one way of reaching a final price would be an add factor for additions to reserves. Does OW have any information that any of the carriers in the District have reserves in a delicate position that would justify an addition to reserves in the rates?

Ms. Kofman stated that much of the information the OW has is confidential and part of the ongoing regulatory process. She would prefer that Ms. Tomczyk not answer. Dr. Aaron understood, but he believed it is a factor

that the Exchange should consider in approving plans. Ms. Kofman stated that OW was not asked to opine on the financial condition of any of the carriers.

Mr. Lucia noted that even small percentage changes resulted in significant dollar changes in premium. He was particularly struck by the small group market numbers. In some cases it is as great as $5,000. Small percentages do matter.

Ms. Sullivan Hare noted that for a small business, an extra $700 means a laser printer, an additional computer or an upgrade to telephone. A few hundred dollars makes a difference to a small employer. She is very concerned about the rate increases in the small group plans. She appreciated the analysis.

Ms. Carroll asked whether a smaller premium resulted in nickel-and-diming covered persons on their coverage. Mr. Barlow stated that in the short term he did not think so. Rate changes are reflective of changes in the underlying experience. In the long run, if a carrier is charging rates that are not supported, it would tend to cut back on services.

Ms. Carroll asked what the effect of the assessment had on premium. Mr. Barlow stated that the assessment, as with all expenses, are allowed to be included in the rates. The 1% assessment is reflected in the rates. Ms. Tomczyk agreed. None of the differences between filed rates and the OW calculations is due to the assessment.

Mr. Lucia said OW was serving as the rate reviewer in some states and probably does work for companies. He asked what OW's national experience shows. Ms. Tomczyk noted that OW works for CCIIO in five states and for the state in six states. Some of those states have actuaries on staff as does DISB. The state regulator always makes the decision. Similar to Mr. McPherson's earlier comments, the state decides which issues it agrees with raised by OW and which it does not. Where the state does not employ actuaries, the state relies heavily on OW's analysis. OW's reviews and analyses are typically limited to rate development as it was here. OW typically does not provide opinions on solvency and contributions to surplus because both of those require a much deeper review beyond the information that is in the rate filings. With regard to their national experience, because of the volume of filings they review and rate development in other states they provide for carriers, they have a wide view of how states approach different aspects of the ACA. They have helped some states develop effective rate review programs. With respect to these District filings and more specific to each individual filing, each filing must stand on its own and is reviewed on its own based on the information and support that is provided in the filing. Every assumption in the filing should be supported. There are a range of reasonable assumptions and sometimes the filing did not reveal the reason the company actuary chose one point within a reasonable assumption over another. Once more information was provided, in some cases OW thought the assumption was reasonable. In other cases, with the additional support, OW disagreed, which leads to the difference in the filed rate and the OW calculation.

Dr. Ku said OW does this in other states. In some cases the discrepancies are significant and in some cases less so. He asked if this is this consistent with what OW sees in other states? The District is a small market and has a small number of carriers.

Ms. Tomczyk replied she thought Dr. Ku was asking if the District was an outlier and she said no. Typically they are not as wide as one of the OW conclusions is in this presentation. Sometimes OW concludes the rate should be higher. Even in these filings OW might conclude that one assumption should be higher but cumulatively it should be lower.

Dr. Aaron asked in general, OW works in a large number of states. Does OW see a pattern that in some states the filed rates are consistently closer to OW calculations than in other states? He stated does OW see systematic differences in insurance regulation.

Ms. Tomczyk said yes and no. Their reviews are independent. In some of the states OW works for, particularly in states that have fewer carriers, they work closely with the carriers and over time the carriers have learned what type of support OW is looking for. The underlying requirements are set to some degree by the ACA, and states have some variations that must be taken into account. Overall, however, the process is similar.

Mr. Barlow added that when DISB identifies changes to a rate filing, carriers update the rate filing. The presentation by OW is looking at the original rate filing because that is publicly available. DISB is reviewing the updates.

Ms. Sullivan Hare asked if the final result would be somewhere between the originally filed rate and the OW analysis. Mr. Barlow responded likely some would be about the same, but others might be higher or lower. Mr. McPherson reiterated that OW is providing its independent opinion. Their recommendations are not etched in stone. As Ms. Tomczyk said, 10 actuaries can produce 10 different outcomes. Mr. McPherson reiterated that DISB would be making the decision.

Ms. Sullivan Hare noted that last year DISB had the benefit of two consultants. Mr. Barlow affirmed they were OW and Novarest. Ms. Sullivan Hare wondered if they found things that were overlooked or reconsidered? She was happy to hear the consultants had frequent contact with DISB. She asked about another set of eyes on the filings. Mr. McPherson stated that OW was another set of eyes on the filings. Mr. Barlow stated that as Ms. Tomczyk had noted, this is a new process for everyone. The more DISB works with the carriers, they get an understanding of how the process works, state actuaries get a better understanding of how the carrier works, and the longer state actuaries continue to work with carriers, the more straightforward things become. Everything is up in the air at the moment because the ACA introduced new elements to the process. He stated it has been helpful to have multiple sets of eyes on the filings and particularly helpful to have people who look at filings from other jurisdictions.

Ms. Sullivan Hare asked when the rates are finalized, will the Board have the opportunity to hear what they will be, or will DISB just make an announcement? Mr. McPherson stated his commitment was to share the rates with the Board before they went public. He will not seek the approval of the Board before approving the rates. Ms. Lewis said that was not the expectation.

Mr. Lucia thanked everyone for their presentations and said they were very helpful. He stated that he was of the opinion that the Board has been asked by the Mayor to advocate for consumers and provide access to adequate coverage and affordable coverage. He stated the Exchange will not work unless there is managed competition that is working correctly. The rate review process and DISB's authority to review and approve rates is important, but the Board has a role as well. The Board is learning about that role and how to interact with the process. Mr. McPherson said it could be argued that the Board has had input into the process because it secured the services of OW. He said OW has represented the Board's interests much more dynamically than if he came to a Board meeting and asked for the Board's feedback. Mr. McPherson emphasized that there is a line and that the Board should understand the respective roles of DISB and the Board, and how he viewed that the Board has had direct and indirect input into the process.

Mr. Lucia stated that Mr. McPherson had been very collaborative with OW and had respected their input. As a member of the Board, he repeated that the Board has a responsibility to ensure that the system helps consumers get easy access to coverage. Mr. Lucia is of the opinion that the Board has a real role in the affordability issue. The Board will learn more about its role as the process moves forward. The Board advocates on behalf of consumers and the Board hired a firm with a national reputation to help give insight and provide an independent analysis. He is glad that Mr. McPherson values OW's input and he hopes that the OW input finds its way fully into the final premiums.

Dr. Aaron added that Mr. McPherson makes a good point. He receives input from a variety of sources, his own actuaries and OW, and he forms a judgment about what the final rate should be. The Exchange receives input from a variety of sources including the actuarial firm and other sources of information, then it decides how to evaluate the information and exercise its responsibilities under the statute. He noted a certain parallelism as respects DISB and the Exchange.

Ms. Lewis thanked everyone for engaging in the conversation that was critical to the Board. At the end of the day, the Board's concern is with access to health care, and while insurance is not the only issue in that regard, it is a key issue. Mr. McPherson plays a critical role, and the Board is pleased that he has been willing to engage in the conversation. She noted that the issues are new to everyone, and the Board is working through how we think about it, what the issues are and how we ultimately make those final decisions.

- **Update to HBX Procurement Policies and Procedures** , *Leighton Ku, Executive Board Operations Committee and Jennifer Libster, HBX Staff*

Dr. Ku reported that the Procurement Policies and Procedures are an action item. After the Board was formed, we realized the Exchange's procurement authority was somewhat different from other city agencies. Policies were established two years ago with the help of experts. Two years have passed, and the Exchange realizes that the Exchange procures many services, and particularly IT services. Exchange staff reviewed the past procurements of the Exchange, federal regulations and District law and other agencies' regulations and best practices. The staff made recommendations to the Operations Committee, the Committee reviewed them and made comments to staff. Staff then met with the Office of Contracting and Procurement (OCP), and received input from OCP on the draft.

Dr. Ku noted that there are a variety of procurement mechanisms, some that are competitive and some that are sole source, small versus large, etc. A worthwhile clarification is that inter-governmental transfers are permitted. A new policy is with respect to unsolicited proposals, where a suggestion that is worthwhile comes in and the Exchange does not want to exclude the entity that made the suggestion. Pilot programs have been added for a new service or method that existing procedures do not address. The key decision person at the initial level is the Executive Director or her designee. The overall rules about what goes to the Finance Committee, the Board and the Council remain the same.

Jennifer Libster, Associate General Counsel and Policy Advisor, added that flexibility consistent with other agency practices has been added, such as exemptions from competitive procurement requirements where there is only one way to procure certain goods and services. The simplified small purchases limit has been increased to $100,000, or less from $75,000, or less. Modifications to contract approval and reporting were made to clarify the language. The Executive Director reporting to the Board annually has been replaced with the Chief Financial Officer reporting on a regular basis. Transparency language was strengthened, such as requiring posting all competitive solicitations on the website, and publishing basic information on contract awards.

Language has been added to ensure that HBX performs basic checks, such as vendor clean hands. Staff has been doing a clean hands check; now it has been added to the policies and procedures. For emergency procurements only, a verbal agreement may be entered into, followed up by a written contract in three business days. In response to a question, Ms. Kempf clarified that this provision is consistent with District practice, and had been approved by OCP. It applies only in a true emergency situation which is very limited. Ms. Kofman noted that the revised policies and procedures reflect a lot of input from a variety of sources such as other District agencies, other instrumentalities, other states, federal practice, and including review by OCP General Counsel.

- **Secretary-Treasurer Nomination Discussion**

After a discussion and a review of the Bylaws, it was determined that the election for Secretary-Treasurer would need to occur by the end of the month via conference call.

VIII. Public Comment

Ms. Lewis asked if there was public comment on the updated Procurement Policies and Procedures. There was none.

Ms. Lewis asked if there was any other public comment. Kevin Wrege (representing Aetna) stated that he had not learned of any issue regarding rates and Oliver Wyman review until earlier in the afternoon from his client. He believed the OW slides were posted to the website about one hour before the meeting. He stated that there appeared to be a public disagreement between two agencies about interpretation of federal and District law, and the authority of both agencies regarding rates. Mr. Wrege stated that his client has a significant financial stake in the outcome of the process. He requested a meaningful public opportunity for input about who has authority, who has input and what that input would look like. He did not know the timeframe for any Board decision. The legal and policy implications of the discussion warrant public input and deliberative consideration by the Board. He requested that such a process occur before any Board decision that would run contrary to the rate review practices that have been within the Commissioner's purview prior to the Exchange. He also requested that any change to such prior practices not occur for the rates presently before the Commissioner for approval.

Ms. Lewis attempted to move to closed session. Mr. Wrege interrupted, asking for a response to his request. Ms. Lewis stated there was not any action before the Board. Any action would come from the Insurance Committee. Mr. Lucia stated no recommendations had been made. Mr. Lucia noted the time element involved in that rates needed to be approved in a matter of days and then loaded into the exchange by the carriers. He questioned where the public comment would occur on a process that strikes him as a major policy issue that may affect 2015 rates.

Mr. McPherson said it was in his purview to approve rates and forms, and to the best of his knowledge that issue had been resolved. Ms. Lewis and Mr. Lucia agreed.

Mr. Wrege then asked if the rate impact as shown in the meeting would not impact the rate approval process by DISB or the Board. Mary Beth Senkewicz, Associate General Counsel and Policy Advisor, responded by stating that public comment is allowed on any rate proposal. Mr. Barlow agreed. Mr. Lucia stated that is required under federal law. Ms. Senkewicz stated the Board hired an actuarial firm, it commented, and now it is up to DISB. Mr. Barlow stated that filed rates are public. What was new for Mr. McPherson was sharing that DISB was engaged with the actuaries that were hired by the Exchange. He has strong reservations about that process. While he believes the input of the actuaries was valuable, different actuaries have different opinions. His concern is that this process which previous to now and which occurred last year was part of DISB's deliberative process has now been made public.

Ms. Kempf pointed out that there is no action before the Board and therefore no public comment item in this regard. Mr. Wrege said he had asked due to overall misunderstanding of the next steps. He asked does the Exchange intend to take any action on rates that would be contrary to the Commissioner's decision on approval. Ms. Senkewicz stated she did not understand the question as the Exchange cannot take any action on rates once the Commissioner approves a rate. Ms. Kempf emphasized again that there was no action item before the Board at this time.

IX. Vote

Adoption of Updated HBX Procurement Policies and Procedures

It was moved and seconded to adopt the Updated HBX Procurement Policies and Procedures. The motion was unanimously approved by roll call vote. Voting in favor were Dr. Aaron, Ms. Sullivan Hare, Dr. Ku, Ms. Lewis, and Mr. Lucia.

X. Closing Remarks and Move to Executive Session

Ms. Lewis noted that pursuant to DC Code Sections 2-575(b)(2), (4) and (10) and 31-3171.11 the Board would move to a closed session to discuss contracting, rates, personnel and litigation. It was moved and seconded to move to closed session. The motion was unanimously approved by roll call vote. Voting in favor were Dr. Aaron, Ms. Sullivan Hare, Dr. Ku, Ms. Lewis, and Mr. Lucia.

XI. Reconvene Public Session

Ms. Lewis announced the Board was reconvening into public session at 8:33 p.m. Three consulting contracts were on the agenda.

Ms. Kofman stated that the Board would be asked to approve to send three contracts to Council. Earlier in the summer the online solicitation process was used to solicit CBEs for IT consuming work. All three will be cost-allocated with DHS to reflect IT work on the Exchange.

The total contract amount for Obverse is $6,967,052. The total contract amount for Vantix is $6,753,501. The total contract amount for Analytica is $1,749,707.

1. Obverse Corporation Inc. It was moved and seconded to adopt the Obverse Corporation Inc. contract. The motion was unanimously approved by roll call vote. Voting in favor were Ms. Sullivan Hare, Dr. Ku, Ms. Lewis, and Mr. Lucia.

2. Vantix. It was moved and seconded to adopt the Vantix contract. The motion was unanimously approved by roll call vote. Voting in favor were Ms. Sullivan Hare, Dr. Ku, Ms. Lewis, and Mr. Lucia.

3. Analytica, LLC. It was moved and seconded to adopt the Analytica LLC contract. The motion was unanimously approved by roll call vote. Voting in favor were Ms. Sullivan Hare, Dr. Ku, Ms. Lewis, and Mr. Lucia.

XII. Closing Remarks and Adjourn

Ms. Lewis adjourned the meeting.

Time: 8:38 p.m.