DRAFT MINUTES

NH HEALTH EXCHANGE ADVISORY BOARD

June 12, 2015

Board Members present: Evelyn Aissa, Christine Alibrandi (conferenced in), Scott Baetz, Sharon Beaty, Dianne Chase, Nancy Clark, Russell Grazier, Beth Roberts and Tim Soucy

Board Members unable to attend: Lisa Guertin and Lisa Morris.

Agency Representatives: DHHS Healthcare Program Specialist, Deborah Fournier; and NHID Life, Accident and Health Legal Counsel, Jennifer Patterson.

Co-chair Scott Baetz called the meeting to order at 9:05 a.m. and, after giving a warm welcome to the group, asked for approval of the April 10, 2015 minutes. Everyone approved and the meeting and agenda continued.

DHHS – Deb Fournier

Deb told the group that the New Hampshire Health Protection Program (NHHPP), New Hampshire's version of the Medicaid expansion, exceeded 40,000 enrollees this week and that preparation for its Premium Assistance Plan (PAP) component continues very robustly. Scott thanked Deb and moved on.

NHID- Jennifer Patterson

Jenny introduced Michael Wilkey from the NH Insurance Department (NHID) to report on the Qualified Health Plan (QHP) review process. First, Michael reiterated the timeline for reviewing the QHPs. Staff members are currently reviewing all forms and filings. As of June 1st, rate increase information for those products with proposed rate increases of 10% or more is posted on the healthcare.gov website. Consumers wishing to comment on the proposed increases can do so through the Department's website: www.state.nh.gov/insurance. Michael noted that by August 25, all information for 2016 plans must be transferred to CMS.

On June 5, 2015 the NHID held the first of two public information sessions on healthcare provider networks (network adequacy) for health and dental plans before a large group of interested parties. Michael explained that in 2014 there was one carrier (Anthem); in 2015 there were five carriers, one of which left this year (Assurant); and in 2016 there are five carriers-- a new carrier (Ambetter from NH Healthy Families—offered by Celtic Insurance) is now offering policies. For health coverage in 2015 there were 60 different plans, and in 2016 there are 81 different plans. For dental plans for 2014 and 2015, there were 3 carriers and for 2016 there are four carriers – the newest Dentegra Insurance Company-- and within the dental group there are

15 different plans, 8 individual and 7 small group dental plans. In all, this means that staff went from reviewing 300 plans to reviewing 400 plans, including those on and off the exchange. Michael mentioned that the change in small group size from 50 to 100 beginning January 1, 2016 has an effect on the number of plans. Michael wrapped up his discussion by letting the group know that every hospital is in at least two carriers' networks, most in three or more, and that all this information is available on the NHID website.

Co-chair Scott Baetz thanked Michael and his staff, and commented that there is an astounding amount of information available to the public on the Department website. Michael added that sometime this year there should be a new updated website for the Department.

Jenny Patterson continued the NHID update and talked about the selection of the 2017 Essential Health Benefit (EHB) benchmark plan. On May 19th the Joint Legislative Health Reform Oversight Committee selected the EHB benchmark for 2017 from the list of potential benchmark plans the federal Centers for Medicare and Medicaid Services (CMS) gave to the state. The Oversight Committee selected the Matthew Thornton Blue plan as the benchmark; this plan was previously selected in 2012 as the benchmark for 2014-16. Jenny explained that under the Affordable Care Act (ACA) there is a cost to the state if a state-mandated benefit is not included as part of the EHB benchmark; thus, it makes sense to select a plan in the small group market as the benchmark, because these plans include state mandates. The NHID has conveyed the state's benchmark choice to CMS; the next step will be for the federal agency to adopt all of the states' EHB benchmarks through formal rulemaking

Discussion ensued on this topic. Russell Grazier asked if there was any significant change from the current benchmark. Al Couture from the NHID replied that we will need to supplement the benchmark plan to add certain benefits that are required under the ACA but aren't included in the plan; these include pediatric dental and vision services. Christine Alibrandi asked when the NHID will make the decision about pediatric dental. Michael Wilkey replied that the NHID is waiting for more information before deciding. Christine Alibrandi asked whether the state planned to stay with the FedVIP (one of the federal employee plans) for the dental benchmark. Michael replied that the state didn't anticipate any change but haven't been given full information on the federal plans yet by CMS.

Next on the agenda was King v. Burwell, a case now pending before the U.S. Supreme Court, and its potential effects in New Hampshire. Scott asked Jenny Patterson to explain this, as suggested at the last meeting. Jenny told the group that, depending on how the case comes out, there could be a substantial impact in New Hampshire, as the advance premium tax credits for lower- and moderate-income people could be eliminated in New Hampshire if the King plaintiffs win. The plaintiffs contend that the tax credits are only available in states that have established their own state-based exchange, while the IRS has adopted a rule under which the tax credit is available in every state. The decision will be issued by June 29, because the Supreme Court's term ends on that date.

There are some issues that are specific to New Hampshire. The same statute that created this Board also prohibits New Hampshire from establishing a state based exchange. Thus, if the Court's decision eliminates the subsidies except in state based exchanges, the legislature would have to pass a new law if it wanted to preserve them. One option might be a bill like HB 548, which was introduced in the New Hampshire legislature this year, but did not pass. HB 548 goes through the federal exchange law (section 1311 of the ACA) and allocates the functions an exchange must perform in a way that is consistent with how our partnership exchange works now, with the federal government maintaining the website and administrating the tax credits, and the state performing the plan management and consumer assistance functions. HB 548 was voted down as premature, but some of the ideas in the bill could be revived if the Court strikes down the subsidies.

Scott Baetz commented that the subsidies seem to be critically important for the success of the ACA, and that it is frustrating that people who don't want the law to succeed would bring a case that would have such a large effect on others. If states have to build their own websites now, after the federal site has become operational, it would not make sense. As the small business representative, he would like to see less chaos, not more. Nancy Clark noted that that this type of situation was unfortunately not unexpected in a political election year.

Tim Soucy asked who King and Burwell are. Jenny replied that Burwell is the U.S. Secretary of Health and Human Services, and King and the other three plaintiffs are residents of Virginia who do not want to be subject to the individual mandate.

Russ Grazier said that as a consumer representative the lack of stability that this case could cause is very disappointing.

Beth Roberts noted that as a carrier, regardless of whether or not you were supportive of the law in the beginning, it would be a shame and a waste to start over at this point.

Sharon Beaty stated that hospitals and other providers are appalled at what could happen if subsidies are lost.

Scott Baetz then asked Aaron Holman to give Covering New Hampshire's update. Aaron told the group that the grant funding that supports the consumer assistance work is scheduled to expire at the end of December of this year. The marketplace assisters (MPAs) will nevertheless be working during the next open enrollment period. The New Hampshire Health Plan (NHHP), which is currently in charge of the consumer assistance function, is talking about transition plans, including decentralizing management of the MPA program, so the existing MPAs can tie in to groups that will continue to exist after the funding ends.

Aaron noted that from an intellectual property perspective, there is value in preserving the name Covering New Hampshire, as it is a trusted source of information. Scott asked about the operational elements for the website. Aaron responded that these include the plan comparison

tool, the find a broker tool, and the find an assister tool, all of which would need to be maintained and updated. Evelyn Aissa asked whether the MPAs would be working throughout the next open enrollment period. Aaron replied that it depends on the status of the NHHP and on whether there can be a no-cost extension of the grant beyond December 31. Evelyn and Scott commented that Covering New Hampshire has done a phenomenal job and is a huge asset to the state.

The time and location of the board's next meeting was discussed. The next meeting is scheduled for July 10th at 9:00 a.m. at Delta Dental. The outcome of King v. Burwell will determine whether we have the meeting in July.

Discussion then opened up, with Tim Soucy asking where we are with Medicaid Expansion. Deb Fournier from DHHS responded that legal authority exists for the Premium Assistance Program (PAP) to operate through the end of 2016. The program will not be directly affected by the King v. Burwell case, but if premiums go up there could be an impact on the cost-effectiveness of the program as coverage will be through QHPs. In terms of reauthorization beyond 2016, this was proposed in the Governor's budget, but was not included in the House or Senate version of the budget. The Committee of Conference on the budget starts this afternoon.

Beth Roberts commented that carriers had to set QHP premiums based on the risk status of both the PAP population and the private market enrollees. If federal subsidies for private market enrollees end, carriers will need to change their premiums based on the PAP population being predominant, as those losing subsidies would likely drop coverage. Thus, everything is at stake with King v. Burwell.

Deb agreed – the impact will be on 80 thousand people, not just the 40 thousand people already in the individual market, but also the 40 thousand in the PAP program. Tim Soucy asked what happens to the 40 thousand on PAP if the program is not reauthorized. Sharon Beaty commented that that it is horrifying from a provider perspective to think about Medicaid expansion unravelling. Deb Fournier reiterated what Commissioner Toumpas said last week, that personal stories make a difference, and that talking to legislators is a big help.

Jennifer Patterson informed the Board about a letter from a consumer with concerns about some healthcare.gov glitches, and wishing the Board met at a time other than in the work day to take public comment. The NHID will reply to the person, but wanted the Board to be aware of the comment. Scott suggested that the person write a letter to the Board, and said he could be available to talk to the person if there were small business issues. Russ said he'd be glad to be a contact for individual market issues.

Public comment continued with Marie Brownell who is a health insurance producer. She is very concerned about the lack of communications between carriers and the healthcare.gov website. She finds it frustrating that the client hears from the Marketplace before she does, or when the client's coverage is cancelled for not paying premium. The Marketplace has had difficulty

recognizing her authorization to speak on consumers' behalf. Dianne Chase, the Board's producer representative, noted that she has had similar problems. She has spent a lot of time on appeals where if she had known of the issue earlier, no appeal would have been necessary.

Marie also noted that some consumers were not aware that if their coverage lapsed due to nonpayment, they could not reenroll without a qualifying event.

Michael Wilkey encouraged consumers to come to the Insurance Department with issues, and that once we get involved, we can hold the carrier responsible for complying with the contract. There is not much to be done regarding nonpayment by the consumer, however.

Michael also mentioned that the NHID can bring these issues up with CMS. Sharon Beatty then asked whether, before the ACA, producers were notified when people did not pay their premiums. Beth Roberts said that different carriers had different policies on this.

Christine Alibrandi suggested we ask CMS to attend the next meeting if the King v Burwell decision is anything other than the subsidies being upheld.

And that was the end of the meeting!! Meeting ended at 10:20 a.m.