The Committee on Health, to which Bill 20-240 was referred, reports favorably thereon and recommends approval by the Council.

I. BACKGROUND & NEED

The stated purpose of Bill 20-240 is to amend the Health Benefit Exchange Authority Establishment Act of 2011 to promote meaningful choice, provide enhanced benefits, and build a competitive private insurance marketplace for the residents and small business owners of the District of Columbia by not limiting the number of qualified health plans in the Exchange, requiring plans at different metal levels, standardizing at least one plan option at each metal level to promote meaningful choice, creating one large marketplace, and defining habilitative services.

The Health Benefit Exchange Establishment Act of 2011 (Bill 19-002) was enacted in March 2012 to provide the necessary authority for the District to establish its own health exchange under the Patient and Protection Affordable Care Act. The Health Benefit Exchange Establishment Act, codified at D.C. Code §31-3171.01 et seq., established a seven-member
Health Benefit Exchange Authority Board to govern the exchange, provided the board with the 
authority to hire staff and seek grant funding, created a standing advisory board to inform the 
executive board’s decisions regarding the operation of the exchanges, and set the requirements 
for qualified health plans, individuals, and carriers on the exchange.

Of the 50 states and the District of Columbia, 17 states enacted legislation to establish a 
health insurance exchange, and 7 elected to enter into a partnership with the federal government 
whereby they run the consumer assistance and/or plan management function of the exchange, 
while the U.S. Department of Health and Human Services performs the remaining marketplace 
functions. The remaining 27 states defaulted to a federally-facilitated exchange. The state-based 
exchanges were afforded the flexibility in determining the role of their marketplace with respect 
to contracting with health plans, constrained primarily by Affordable Care Act requirements to 
contract with health plans meeting the minimum federal requirements for qualified health plans. 
State exchanges also retained flexibility in determining whether they will operate as “clearinghouse” and contract with all qualified health plans, or becoming an “active purchaser” by pre-selecting health plans and negotiating premium prices with certain health plans. The 
District joined 7 other jurisdictions in establishing a clearinghouse structure for its state-based 
exchange.

Bill 20-240 amends the Establishment Act to include the requirements for the plans sold 
inside and outside of the exchange, policies for the exchange beyond the requirements of the 
Affordable Care Act, and the rules for individual and small group participation in the exchange 
marketplace. The bill was introduced on April 11, 2013 by the Chairman at the Request of the 
Mayor, and reflected the consensus of the Exchange Authority’s Executive Board after obtaining 
input from its standing advisory board and various policy working groups that had been charged 
with providing recommendations on the policies reflected in the legislation.

This multi-tiered approach was used to establish the District’s exchange policies since its 
inception. Prior to the implementation of the initial Establishment Act, the Mayor created a 
Health Reform Implementation Committee (HRIC) and charged it with making 
recommendations to the Mayor on the implementation of the PPACA. The HRIC held 
stakeholder engagement sessions throughout the District regarding the initial formation of an 
exchange and its governing board, which included consumer advocates, insurance providers, 
health care providers, and residents. Once the Health Benefit Exchange Authority Board was 
established, 15 advisory working groups were created to address various policy decisions and 
legislative recommendations that had to be made on an accelerated basis by October 1, 2013, 
including network adequacy requirements, plan offerings, and the essential health benefits 
package. Many other jurisdictions employed similar policy working groups to create the 
foundation of their respective exchanges.

Throughout this process, in 2013, the Committee on Health held numerous public 
oversight roundtables on the implementation of the exchange to maintain an ongoing public 
dialogue with board members regarding its operations and the status of its legislative 
recommendations, which were eventually reflected in Bill 20-240. Due to the accelerated
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timeframe that the Committee had to consider and vote on Bill 20-240 so that carriers could submit their plans to DISB for approval and the Health Benefit Exchange could act quickly to pull together the final pieces of the District’s Exchange by October 1, the Committee postponed a formal hearing on the legislation and moved emergency and temporary versions1 of the bill, having the benefit of already hearing a large amount of testimony about Bill 20-240 at the Committee’s roundtables. The emergency and temporary versions of the bill were passed unanimously.2 On January 29, 2014, the Committee held a hearing on Bill 20-240, and heard a far less robust discussion about the Exchange’s policies and legislative recommendations than took place at the 2013 roundtables. Accordingly, the Committee Print reflects consideration of the comments received by the Committee throughout the entire process.

The Committee has retained the majority of the structure of the emergency and temporary versions of the Bill 20-240 and strongly recommends the adoption of the Committee Print by the District of Columbia Council, as follows:

“Metal Level” defined - section 2(a)  
Metal Level is defined as the bronze, silver, gold, and platinum levels of coverage established by the federal health reform law, the Affordable Care Act.

“Navigator” defined – section 2(a)  
Navigator is defined as the entities described in section 1311(i) of the Federal Act.

“Standardized plan” defined – section 2(a)  
Standardized plan is defined as a plan with defined benefits and cost sharing as determined by the executive board for the Authority.

Bronze Plan Required - section 2(b)(1)(A)(i)  
Requires insurers to offer a qualified health plan at the bronze metal level in the District’s exchange marketplace. This is in addition to the federal requirement that insurers offer a qualified health plan at the silver and gold metal level.

Accurate Attestations - section 2(b)(1)(A)(iii)  
Requires insurer accuracy in any confirmations made as a part of its filing for certification to participate in the District’s exchange marketplace. The attestations include having an adequate provider network and having a

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2 Bill 20-0301, the “Better Prices, Better Quality, Better Choices for Health Coverage Emergency Amendment Act of 2014” (June 4, 2013); Bill 20-0302 (June 26, 2013)
plan structure that does not discriminate against specific groups such as those with cancer or women.

Standardized Plans - section 2(b)(1)(A)(iii)
Requires insurers to offer one or more standardized qualified health plan in each metal level in which an insurer is participating to allow for an apples-to-apples shopping experience for individuals and small businesses. The Executive Board of the DC Health Benefit Exchange Authority will approve such plans for 2016.

Mental Health Parity and Addiction Equity - section 2(b)(1)(C)
Ensures that treatment for mental health and substance use disorders is on par with medical benefits in all qualified health plans offered in the District’s Exchange marketplace. Mental health parity includes prohibiting day and visit limitations on behavioral health services for mental health or substance use disorders, unless the carrier has similar limitations for medical benefits.

Prescription Drug Formularies - section 2(b)(1)(C)
The drug formularies for qualified health plans offered in the Exchange marketplace shall have one or more drugs in each category and class (that would be the greater of one drug or the number of drugs covered in each category and class by the District’s base benchmark plan).

Coverage of Essential Health Benefits - section 2(b)(1)(C)
All qualified health plans in the District’s Exchange marketplace will cover the benefits equivalent to the District’s defined essential health benefits package with no substitutions.

Maximum Plan Choice - section 2(b)(2)
The District’s Exchange marketplace will not limit the number of qualified health plans offered for purchase.

Offering Additional Benefits - section 2(b)(3)
Qualified health plans being offered in the District’s Exchange marketplace have the option of including additional benefits that are not in the essential health benefits such as infertility treatment or acupuncture services.

“Habilitative Services” Defined - section 2(b)(3)
Federal law requires coverage of “habilitative services” as part of an essential health benefit package. The legislation defines habilitative services as health care services that “help a person keep, learn, or improve skills and functioning for daily living,” including, but not limited to,

Establishing a Competitive, Transparent Marketplace - section 2(c)
- All individuals and families who are uninsured will be able to purchase coverage and, if eligible, receive tax credits to reduce costs, solely in the District’s Exchange marketplace starting January 1, 2014;
- Small businesses (50 or fewer full-time equivalent employees) that do not currently offer health benefits to workers but wish to begin to do so will be able to purchase coverage and, if eligible, receive tax credits to reduce costs, solely in the District’s Exchange marketplace starting January 1, 2014;
- Small businesses currently offering health benefits to workers that wish to continue to do so will have the option of renewing coverage outside the District Exchange marketplace in 2014, or to purchase coverage in the marketplace; and
- Small businesses seeking to establish, renew, or change coverage options in 2015 or later will do so in the District’s Exchange marketplace.

Grandfathered Health Plans - section 2(c)
The requirements in this legislation do not apply to plans that meet federal requirements as “grandfathered health plans” allowing individuals and businesses to maintain coverage in place prior to March 23, 2010.

Sale, Solicitation and Negotiation by Insurance producers – section 2(c)
DC-licensed producers may sell any qualified health plan in the Exchange after completing DC Health Link training approved by the Authority. Producers shall be compensated directly by the health carrier.

II. LEGISLATIVE CHRONOLOGY

April 15, 2013  Bill 20-240, the "Better Prices, Better Quality, Better Choices for Health Coverage Amendment Act of 2013" is introduced by Chairman Mendelson at the request of the Mayor.

April 19, 2013  Notice of Intent to Act on Bill 20-240 is published in the D.C. Register.

April 30, 2013  Bill 20-240 is referred to the Committee on Health.

December 20, 2013 Notice of Public Hearing is published in the D.C. Register.

December 27, 2013 Revised Notice of Public Hearing is published in the D.C. Register.
January 29, 2014  The Committee on Health held a Public Hearing on Bill 20-240.

March 26, 2014  The Committee on Health meets to mark-up and vote on the report and committee print of Bill 20-240.

III. POSITION OF THE EXECUTIVE

No executive witness testified at the hearing on Bill 20-240. Health Benefit Exchange Authority Chair Diane Lewis and Executive Director Mila Kofman testified in strong support of Bill 20-240.

IV. RESPONSE TO ADVISORY NEIGHBORHOOD COMMISSIONS RESOLUTIONS

There were no official Advisory Neighborhood Commission resolutions presented as testimony for the record.

V. WITNESS LIST

1. Wes Rivers  Policy Analyst, DC Fiscal Policy Institute
2. Dania Palanker  Senior Counsel, Health and Reproductive Rights, National Women's Law Center
3. Susan Walker  Volunteer, D.C. Coalition on Long Term Care
4. Angela Franco  Greater Washington Hispanic Chamber of Commerce
5. Eric Vicks  Associate Director of Policy & Advocacy, District of Columbia Primary Care Association
6. Barbara Lang  President and CEO, DC Chamber of Commerce
7. Diane C. Lewis, MPA  Chair, District of Columbia Health Benefit Exchange Authority Executive Board
VI. IMPACT ON EXISTING LAW

Bill 20-240 would impact existing law by amending the District of Columbia Health Benefit Exchange Authority Establishment Act of 2011 to define key terms, establish the minimum requirements for plans offered on the District of Columbia Health Insurance Exchange, establish the terms of participation of small group and non-group persons, and insurance brokers in the exchange marketplace.

FISCAL IMPACT

The attached fiscal impact statement from the Chief Financial Officer states that funds are sufficient in the FY2014 budget and proposed FY 2014 through FY 2017 budget and financial plan to implement the proposed legislation.

VII. BILL ANALYSIS

Section 1: States the short title of Bill 20-240.


Section 3: Adoption of the Fiscal Impact Statement.

Section 4: States the Act will take effect following Mayoral approval and Congressional review.

VIII. COMMITTEE ACTION

On Wednesday, March 26, 2013, the Committee on Health met to consider Bill 20-240, the "Better Prices, Better Quality, Better Choices for Health Coverage Amendment Act of 2013". The meeting was called to order at 3:26 p.m., and Bill 20-410 was the first item on the agenda. After ascertaining a quorum, Chairperson Alexander asked if there was any discussion, and no discussion ensued. Chairperson Alexander then moved the print and report separately, with leave for staff to make technical and editorial changes. The vote on the print and report was
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unanimous (Chairperson Alexander and Councilmembers Grosso and Bonds voting “aye.” Councilmembers Orange and Catania were absent). The meeting adjourned at 3:35 p.m.

IX. ATTACHMENTS

1. Bill 20-240 as introduced.
2. Copies of written testimony.
4. Legal Sufficiency Memorandum.
5. Comparative Print of Bill 20-240.
6. Committee Print of Bill 20-240.
ATTACHMENT 1
To: Members of the Council  
From: Nyasha Smith, Secretary to the Council  
Date: April 15, 2013  
Subject: Referral of Proposed Legislation

Notice is given that the attached proposed legislation was introduced in the Office of the Secretary on Monday, April 15, 2013. Copies are available in Room 10, the Legislative Services Division.


INTRODUCED BY: Chairman Mendelson at the request of the Mayor

The Chairman is referring this legislation to the Committee on Health.

Attachment

cc: General Counsel  
     Budget Director  
     Legislative Services
The Honorable Phil Mendelson  
Chairman, Council of the District of Columbia  
John A. Wilson Building  
1350 Pennsylvania Avenue, N.W., Suite 504  
Washington, DC 20004  

Dear Chairman Mendelson:

I am transmitting the proposed bill entitled the “Better Prices, Better Quality, Better Choices for Health Coverage Amendment Act of 2013” (“Bill”). The purpose of the Bill is to amend the Health Benefit Exchange Authority Establishment Act of 2011, D.C. Official Code § 31-3171.01 et seq., to promote meaningful choice, provide enhanced benefits, and build a competitive private health insurance marketplace for the residents and small business owners of the District of Columbia.

Specifically, this Bill assures that the District’s Exchange marketplace will promote choice by allowing an unlimited number of qualified health plans in the Exchange while requiring health plans to be “meaningfully different” from one another. This standard will serve to protect residents and businesses from a confusing flood of look-alike policies. The Bill also requires carriers to offer options at the bronze, silver and gold levels of coverage so that District residents will have a choice of plans to fit their needs and their budgets. It requires at least one standardized plan option at each level by each insurer, in addition to other plans, to promote an easy-to-shop consumer experience. Finally, the Bill creates one large, competitive marketplace that provides individuals, small businesses, and their employees with the same clout as large companies, while providing a transition to phase this requirement in over the next two year period. The large marketplace is critical to ensure real price competition and to expand choices by allowing individuals and small businesses to choose from all insurers and all health insurance products through the Exchange Web portal.

Accordingly, I urge the Council to act favorably and expeditiously on the proposed Bill. In order to facilitate a timely response to any questions you may have, please have your staff...
contact Purvee Kempf, Deputy General Counsel and Chief Policy Advisor, DC Health Benefit Exchange Authority, at (202) 741-0900.

Sincerely,

Vincent C. Gray

Vincent C. Gray
A BILL

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

Chairman Phil Mendelson, at the request of the Mayor, introduced the following bill, which was referred to the Committee on ____________________

To amend the Health Benefit Exchange Authority Establishment Act of 2011 to promote meaningful choice, provide enhanced benefits, and build a competitive private insurance marketplace for the residents and small business owners of the District of Columbia by not limiting the number of qualified health plans in the Exchange, requiring health plans to offer plan options at the bronze, silver and gold metal levels, developing at least one standardized plan option at each metal level to promote meaningful choice, creating one large marketplace that provides individuals, small businesses, and their employees the same leverage as large companies, and defining habilitative services to include keeping or improving functioning, including treatment of autism.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the “Better Prices, Better Quality, Better Choices for Health Coverage Amendment Act of 2013”.

Sec. 2. The Health Benefit Exchange Authority Establishment Act of 2011, effective March 2, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 et seq.) (“Act”), is amended as follows:

(a) Section 2 of the Act (D.C. Official Code § 31-3171.01) is amended as follows:

(1) A new paragraph (18) is added to read as follows:
“(18) "Metal level" means the bronze, silver, gold, and platinum levels of coverage as defined in section 1302(d)(1) of the Federal Act."

(b) Section 10 of the Act (D.C. Official Code § 31-3171.09) is amended as follows:

(1) Subsection (a) is amended as follows:

(A) Sub-subparagraph (5)(B)(i) is amended by striking the phrase “at least one qualified health plan at the silver level and at least one plan at the gold level” and inserting the phrase “at least one qualified health plan at the bronze level, at least one qualified health plan at the silver level, and at least one qualified health plan at the gold level” in its place.

(B) Paragraph (7) is amended by striking the period at the end of the paragraph and inserting a semi-colon in its place.

(C) New paragraphs (8), (9), (10), (11), (12), and (13) are added following paragraph (7), to read as follows:

“(8) Provide accurate attestations as required in the initial certification process;

“(9) Offer one or more standardized plan(s) as approved by the Executive Board for the Authority, at each metal level in which the carrier is participating, in addition to other plans the carrier may offer;

“(10)(A) Offer plans subject to a meaningful difference standard.

“(B) The meaningful difference standard is as defined in Chapter 1, section 4(ii) of “Affordable Exchanges Guidance” dated March 1, 2013, by the Centers for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services in the U.S. Department of Health and Human Services, or as may be defined by the Executive Board for the Authority;
“(11) Comply with the Mental Health Parity and Addiction Equity Act of 2008 as applied to the Federal Act, including, but not limited to, covering behavioral health inpatient and outpatient services for mental health and substance use disorders without day or visit limitations;

“(12) Provide a drug formulary that includes, at a minimum, the greater of either the number of drugs listed in each category and class found in the District’s base-benchmark plan formulary, or the minimum number of drugs, by category and class, as established by the Center for Consumer Information and Insurance Oversight in the Centers for Medicare and Medicaid Services at the U.S. Department of Health and Human Services; and

“(13) Provide benefits identical to the essential health benefits package as defined by the District without benefit substitution.”

(2) Subsection (b) is amended as follows:

(A) Paragraph (2) is amended by striking “or”.

(B) Paragraph (3) is amended by striking the period at the end of the paragraph and inserting “; or” in its place.

(C) A new paragraph (4) is added to read as follows:

“(4) On the basis of the number of qualified health plans being offered.”

(3) A new subsection (g) is added to read as follows:

“(g) A qualified health plan may provide additional services that are not in the essential health benefits package required in paragraph (a)(1), only if such services are eligible for claims submission and reimbursement.”

(c) A new section 10a is added to read as follows:

“Sec. 10a. Distribution of individual and small group health benefit plans.
“(a) A carrier that offers individual or small group health benefit plans shall offer such
plans solely through the District’s American Health Benefit Exchange, as established pursuant to
§ 31-3171.04(a) subject to the following transition:

“(1) Individual health benefit plans with plan years beginning on or after January
1, 2014, shall be offered solely through the District’s American Health Benefit Exchange;

“(2) On or after January 1, 2014, small group health benefit plans offered to any
small business that was not insured as of December 31, 2013, shall be offered and issued solely
through the District’s American Health Benefit Exchange;

“(3) Small group health benefit plans offered to or renewed by any small business
that was insured as of December 31, 2013, may be issued or renewed during calendar year 2014
through existing distribution channels with the same carrier or a new carrier, except that such
plans shall meet the qualifications for certification of a qualified health plan as provided in § 31-
3171.09; and

“(4) On or after January 1, 2015, all small group health benefit plans shall be
offered and issued or renewed solely through the District’s American Health Benefit Exchange.

“(b) “Habilitative services” are defined as health care services that help a person keep,
learn, or improve skills and functioning for daily living, including, but not limited to, applied
behavioral analysis for the treatment of autism spectrum disorder.

“(c) The requirements of this section shall not apply to grandfathered health plans as
defined in section 1251 of the Federal Act.”

Sec. 3. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal
impact statement required by section 602(c)(3) of the District of Columbia Home Rule Act,
Sec. 4. Effective Date.

This Act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto), a 30 day period of Congressional review as provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; Pub. L. 93-198; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of Columbia Register.
MEMORANDUM

TO: Lolita S. Alston  
   Director  
   Office of Legislative Support

FROM: Janet M. Robins  
      Deputy Attorney General  
      Legal Counsel Division

DATE: April 8, 2013


This is to Certify that this Office has reviewed the above-referenced draft legislation and has found it to be legally sufficient. If you have questions regarding this certification, please do not hesitate to contact me at 724-5524.

Janet M. Robins
Title: Better Prices, Better Quality, Better Choices for Health Coverage Amendment Act of 2013

“Metal Level” defined - section 2(a)
Metal Level is defined as the bronze, silver, gold, and platinum levels of coverage established by the federal health reform law, the Affordable Care Act.

Bronze Plan Required - section 2(b)(1)(A)
Requires insurers to offer a qualified health plan at the bronze metal level in the District’s exchange marketplace. This is in addition to the federal requirement that insurers offer a qualified health plan at the silver and gold metal level.

Accurate Attestations - section 2(b)(1)(C)
Requires insurer accuracy in any confirmations made as a part of their filing for certification to participate in the District’s exchange marketplace. That includes having an adequate provider network and having a plan structure that does not discriminate against specific groups such as those with cancer or women.

Standardized Plans - section 2(b)(1)(C)
Requires insurers to offer one or more standardized qualified health plan in each metal level in which an insurer is participating to allow for an apples-to-apples shopping experience for individuals and small business. The Executive Board of the DC Health Benefit Exchange Authority will approve such plans for 2015.

Meaningful Difference in Plan Offerings - section 2(b)(1)(C)
Requires all qualified health plans offered by a single insurer to be meaningfully different from one another to protect residents from being confused or overwhelmed by a flood of “look-alike” policies.

Mental Health Parity and Addiction Equity - section 2(b)(1)(C)
Ensures that treatment for mental health and substance use disorders is on par with medical benefits in all qualified health plans offered in the District’s Exchange marketplace. This includes prohibiting day and visit limitations on behavioral health services for mental health or substance use disorders.
Prescription Drug Formularies - section 2(b)(1)(C)
The drug formularies for qualified health plans offered in the Exchange marketplace shall have one or more drugs in each category and class (that would be the greater of one drug or the number of drugs covered in each category and class by the District’s base benchmark plan).

Coverage of Essential Health Benefits - section 2(b)(1)(C)
All qualified health plans in the District’s new Exchange marketplace will cover the benefits equivalent to the District’s defined essential health benefits package with no substitutions.

Assuring Maximum Plan Choice - section 2(b)(2)
The District’s Exchange marketplace will not limit the number of qualified health plans offered for purchase.

Offering Additional Benefits - section 2(b)(3)
Qualified health plans being offered in the District’s Exchange marketplace have the option of including additional benefits that are not in the essential health benefits such as infertility treatment or acupuncture services.

Establishing a Competitive, Transparent Marketplace - section 2(c)
- All individuals and families who are uninsured will be able to purchase coverage and, if eligible, receive tax credits to reduce costs, solely in the District’s Exchange marketplace starting January 1, 2014;
- Small businesses (50 or fewer full-time equivalent employees) that do not currently offer health benefits to workers but wish to begin to do so will be able to purchase coverage and, if eligible, receive tax credits to reduce costs, solely in the District’s Exchange marketplace starting January 1, 2014;
- Small businesses currently offering health benefits to workers that wish to continue to do so will have the option of renewing coverage outside the District Exchange marketplace in 2014, or to purchase coverage in the marketplace; and
- Small businesses seeking to establish, renew, or change coverage options in 2015 or later will do so in the District’s Exchange marketplace.

“Habilitative Services” Defined - section 2(c)
Federal law requires coverage of “habilitative services” as part of an essential health benefit package. The legislation defines habilitative services as health care services that “help a person keep, learn, or improve skills and functioning for daily living,” including, but not limited to, applied behavioral analysis for the treatment of autism spectrum disorders in children.

Grandfathered Health Plans - section 2(c)
The requirements in this legislation do not apply to plans that meet federal requirements as “grandfathered health plans” allowing individuals and businesses to maintain coverage in place prior to March 23, 2010.
COUNCILMEMBER YVETTE M. ALEXANDER, CHAIRPERSON
COMMITTEE ON HEALTH ANNOUNCES A PUBLIC HEARING

on

Bill 20-240, the "Better Prices, Better Quality, Better Choices for Health Coverage Amendment Act of 2013"

Wednesday, January 8, 2014
11:00 a.m., Room 412, John A. Wilson Building
1350 Pennsylvania Avenue, N.W.
Washington, D.C. 20004

Councilmember Yvette M. Alexander, Chairperson of the Committee on Health, announces a hearing on Bill 20-240, the "Better Prices, Better Quality, Better Choices for Health Coverage Amendment Act of 2013". The public hearing will be held at 11:00 a.m. on Wednesday, January 8, 2013 in Room 412 of the John A. Wilson Building.

The stated purpose of Bill 20-240 is to amend the Health Benefit Exchange Authority Establishment Act of 2011 to promote meaningful choice, provide enhanced benefits, and build a competitive private insurance marketplace for the residents and small business owners of the District of Columbia by not limiting the number of qualified health plans in the Exchange, requiring health plans to offer plan options at the bronze, silver and gold metal levels, developing at least one standardized plan option at each metal level to promote meaningful choice, creating one large marketplace that provides the same leverage as large companies, and defining habilitative services to include keeping or improving functioning, including autism.

Those who wish to testify should contact Melanie Williamson, Legislative Counsel, at (202) 741-2112 or via e-mail at mwilliamson@dccouncil.us and provide their name, address, telephone number, organizational affiliation and title (if any) by close of business on Monday, January 6, 2013. Persons wishing to testify are encouraged, but not required, to submit 15 copies of written testimony. If submitted by the close of business on Monday, January 6, 2013, the testimony will be distributed to Councilmembers before the hearing. Witnesses should limit their testimony to four minutes; less time will be allowed if there are a large number of witnesses.

If you are unable to testify at the hearing, written statements are encouraged and will be made a part of the official record. Copies of written statements should be submitted to Ms. Melanie Williamson, Room 115 of the Wilson Building, 1350 Pennsylvania Avenue, N.W. Washington, D.C. 20004. The record will close at 5:00 p.m. on Wednesday, January 22, 2013.
COUNCILMEMBER YVETTE M. ALEXANDER, CHAIRPERSON
COMMITTEE ON HEALTH ANNOUNCES A PUBLIC HEARING

on

Bill 20-240, the "Better Prices, Better Quality, Better Choices for Health Coverage Amendment Act of 2014"

Wednesday, January 29, 2014
11:00 a.m., Room 412, John A. Wilson Building
1350 Pennsylvania Avenue, N.W.
Washington, D.C. 20004

Councilmember Yvette M. Alexander, Chairperson of the Committee on Health, announces a hearing on Bill 20-240, the “Better Prices, Better Quality, Better Choices for Health Coverage Amendment Act of 2014”. The public hearing will be held at 11:00 a.m. on Wednesday, January 29, 2014 in Room 412 of the John A. Wilson Building. Please note that this hearing notice has been revised to reflect a change in the date of the hearing.

The stated purpose of Bill 20-240 is to amend the Health Benefit Exchange Authority Establishment Act of 2011 to promote meaningful choice, provide enhanced benefits, and build a competitive private insurance marketplace for the residents and small business owners of the District of Columbia by not limiting the number of qualified health plans in the Exchange, requiring health plans to offer plan options at the bronze, silver and gold metal levels, developing at least one standardized plan option at each metal level to promote meaningful choice, creating one large marketplace that provides the same leverage as large companies, and defining habilitative services to include keeping or improving functioning, including autism.

Those who wish to testify should contact Melanie Williamson, Legislative Counsel, at (202) 741-2112 or via e-mail at mwilliamson@dccouncil.us and provide their name, address, telephone number, organizational affiliation and title (if any) by close of business on Monday, January 27, 2014. Persons wishing to testify are encouraged, but not required, to submit 15 copies of written testimony. If submitted by the close of business on Monday, January 27, 2014, the testimony will be distributed to Councilmembers before the hearing. Witnesses should limit their testimony to four minutes; less time will be allowed if there are a large number of witnesses.

If you are unable to testify at the hearing, written statements are encouraged and will be made a part of the official record. Copies of written statements should be submitted to Ms. Melanie Williamson, Room 115 of the Wilson Building, 1350 Pennsylvania Avenue, N.W. Washington, D.C. 20004. The record will close at 5:00 p.m. on Wednesday, February 12, 2014.
COUNCILMEMBER YVETTE M. ALEXANDER, CHAIRPERSON
COMMITTEE ON HEALTH ANNOUNCES A PUBLIC OVERSIGHT ROUNDTABLE

on

Bill 20-240, the “Better Prices, Better Quality, Better Choices for Health Coverage Amendment Act of 2013”

Wednesday, January 29, 2014
11:00 a.m., Room 412, John A. Wilson Building
1350 Pennsylvania Avenue, N.W.
Washington, D.C. 20004

WITNESS LIST

Public Witnesses

1. Wes Rivers
   Policy Analyst, DC Fiscal Policy Institute

2. Dania Palanker
   Senior Counsel, Health and Reproductive Rights, National Women’s Law Center

3. Susan Walker
   Volunteer, D.C. Coalition on Long Term Care

Health Benefit Exchange Board

1. Diane C. Lewis, MPA
   Chair, District of Columbia Health Benefit Exchange Authority Executive Board

2. Mila Kofman, JD
   Executive Director, District of Columbia Health Benefit Exchange Authority Executive Board
Chairwoman Alexander and other members of the committee, thank you for the opportunity to testify today. My name is Wes Rivers, and I am a Policy Analyst with the DC Fiscal Policy Institute. DCFPI engages in research and public education on the fiscal and economic health of the District of Columbia, with a particular emphasis on policies that affect low- and moderate-income residents.

I am here today to support "The Better Prices, Better Quality, Better Choices for Health Coverage Amendment Act of 2013." DC Health Link helps ensure that residents who buy individual insurance and small employers have access to a range of high-quality health plans. The DC Fiscal Policy Institute supports the transition to a competitive health insurance market under DC Health Link, which has already begun to foster transparency and choice for District consumers. I would also like to applaud the staff of DC Health Link for their efforts to engage the community. While no major roll-out is flawless, DC Health Link has been quick to respond to problems and has upheld the District's reputation as a national leader in providing quality and affordable health care to all of its residents.

Since last October, the new online shopping portal has given small businesses and individuals an easy way to shop for health plans and to get help to pay for them. The marketplace acts as a clearinghouse of options, helping individuals decide what plan is best for them. DC Health Link also helps make health insurance more affordable to both individuals and small businesses as the place they go to apply for federal tax credits and other subsidies.

DC Health Link creates real transparency and competition, allowing consumers to know exactly what they are getting with a specific plan and to compare features across plans, side-by-side. The online portal allows for stronger monitoring and enforcement of both local and federal plan standards. With all four major carriers participating in a transparent marketplace, insurers have had to compete based on price and quality of their products. Stronger competition has led to three District carriers lowering their prices from their initial rate filings, with one of those insurers lowering premiums twice. One insurer added dental benefits to make benefit packages competitive with the three other carriers.

DC Health Link has also resulted in improved choice for individuals, small businesses, nonprofits, and employees. In the past, individuals and very small employers often faced few, if any, plan
choices they can actually afford. Today, DC Health Link offers 267 health plans for small businesses and 34 plans for individuals and families. The online portal also permits small businesses to expand choice even further by allowing their employees to choose from a wide range of insurance carriers, instead of the common practice of offering just one or a few plan options.

DC Health Link will need a large and diverse pool of consumers in order to keep downward pressure on prices. Particularly, DC will need young adults to purchase coverage because they are a fairly healthy population and have avoided getting insurance in the past. Without them, the health insurance market will consist largely of people with poor health conditions, creating higher demand for medical services and increasing the cost of insurance. DC is off to a good start — more than 15,000 people have signed up for individual or employer health coverage through the marketplace so far, with 37 percent of those new enrollees being between the ages of 26 and 34.

Finally, DC Health Link staff have performed commendably to incorporate community feedback into their policy and procedures and to improve the consumer experience. Technology problems have persisted across the country and, while DC has had some issues, quick responses by staff and a strong network of consumer assisters have mitigated many enrollment issues. As open enrollment continues, DC Health Link is using the experiences of brokers and assisters to inform quality improvement.

Given the success of DC Health Link in improving the quality, affordability, and accessibility of health plans sold in the District, DCFPI urges the DC Council to approve the permanent version of this legislation. The legislation includes a transition period for small businesses — allowing them to purchase plans outside the exchange until 2015. That gives time for the Exchange Authority to assess and improve the market structure and the information technology needed to give residents and small businesses the optimal experience. DCFPI supports the transition to a unified District marketplace under DC Health Link and we urge the Council to do the same.

Thank you for the opportunity to testify, and I am happy to take any questions.
DC Health Link- DC Council Hearing

Good morning Councilmember Alexander and members of the Committee on Health. My name is Angela Franco, and I am the President and CEO of the Greater Washington Hispanic Chamber of Commerce, representing over 460 members from the DC metropolitan area. We believe that a diverse and growing regional economy not only provides opportunities for business, but also provides opportunities for people.

Since July 15 of 2013, the GWHCC has partnered with DC Health Link to inform and educate small Hispanic businesses based in Washington, DC.

Given that the Chamber’s vision is to build a stronger business network for the competitive future of the region, our partnership with DC Health Link fits with our mission to promote and facilitate the success of Hispanic and other minority-owned businesses and the communities they serve through networking, education, and advocacy.

We have been working hand-in-hand with the leadership at DC Health Link to make sure that both businesses and the Hispanic community of the District of Columbia are accurately informed and aware of the new health legislation and how the law may impact them.

The Chamber has Partnerships with the following organizations to raise awareness among their network:


The Chamber has implemented our outreach strategic plan in several stages.

First stage: Information and Education

To inform and educate Hispanic small businesses based in Washington DC, GWHCC’s marketing strategy has focused on four approaches:

1. **Going door-to-door**: The Chamber has focused its outreach efforts on the neighborhoods with the highest Hispanic small business concentration - Ward 1 and Ward 4. GWHCC physically walks these neighborhoods and visits businesses to inform them about DC Health Link.

   We have visited 325 small businesses
2. **Information Sessions:** To maximize our efforts, GWHCC has partnered with key organizations, associations, and businesses to host information sessions. We have hosted **31 educational seminars reaching 1,028 people** in association with: The office of Councilmember Bowser, the Mayor's Office on Latino Affairs, the Latino Economic Development Center, Stephanie Cohen of Golden & Cohen, Margarita Dilone of Crystal Insurance, Mary's Center, Andromeda, La Clinica del Pueblo, Haydee's Restaurant, El Alero Restaurants, BB&T, Fiesta Travel, the Adams Morgan BID, El Tamarindo Restaurant, the DC Latino Caucus, the Spanish Catholic Center, Consulate of Mexico, Consulate of Colombia, and commercial attaches of the Latin American embassies.

3. **Events:** As a Chamber, we host multiple networking and business development events each month at which we always communicate pertinent information to our members and prospective members. Since July, we have reached over **1,990 additional people through 24 events.**

4. **Social Outlets:** The Chamber has used various social media vehicles to promote DC Health Link. We registered **1,200 followers on our social media outlets and 83,000 people have visited our website.** We have sent press releases, videos, USPS mailings, and e-mail blasts. We have also held TV and radio interviews, as well as published newspaper articles to promote the benefits of DC Health Link.

**Second Stage: Education and Enrollment**

When open registration began on October 1, 2013, the Chamber proceeded to the second stage, in which education and enrollment have been the main goal. **All our presentations and education sessions afford DC Health Link the opportunity to directly contact Hispanic business owners, their employees and the community.** The sessions are also enhanced by an assister and/or broker to whom we have referred potential clients.

To schedule education and enrollment sessions, the Chamber is partnering with the Mayor's Office on Latino Affairs, the Latino Economic Development Center, Hispanic Embassies, consulates, religious organizations, and Hispanic associations, as well as preparing for a large enrollment day during our annual Business Expo on March 19, 2014. The enrollment day at the Expo will include participation from the four insurance companies providing policies through DC Health Link.

We strongly believe that the ACA is not just a law but an important social breakthrough. We are committed to working with DC Health Link to reach our goal, which is to make sure our Hispanic small business community has access to health care and a higher quality of life.
Council of the District of Columbia

HEARING on

“Better Prices, Better Quality, Better Choices for Health Coverage Amendment Act of 2013”
January 29, 2014

Committee on Health
The Honorable Yvette Alexander, Chairperson

By

Eric Vicks
Associate Director of Policy and Advocacy
District of Columbia Primary Care Association Performance Oversight Hearing on Department of Mental Health 1.29.14
Good afternoon, Chairperson Alexander and distinguished members of the committee. My name is Eric Vicks, Associate Director of Policy and Advocacy for the DC Primary Care Association (DCPCA). DCPCA represents historic, safety net, community-based primary care providers and other key stakeholders who are committed to our mission of creating a health care system in the District of Columbia that allows for everyone to be covered and everyone to be cared for. As we set out to achieve health equity in the District through action and innovation, I am here today to focus my testimony on the “Better Prices, Better Quality, Better Choices for Health Coverage Amendment Act of 2013”.

Chairperson Alexander, as the previous roundtables have shown, the rollout has not been without some difficulties. What is extremely encouraging is the responsiveness of DC Health Link to address identified concerns. DC Health Link has worked with many organizations such as DCPCA to create a system to educate on and enroll District residents in available plans. As issues have arisen, it has been our experience that DC Health Link has been quick to address them.

WHY DC HEALTH LINK’S ONE BIG MARKETPLACE IS WORKING IN DC

DC Health Link’s One Big Marketplace is working because, it offers consumers real choice. Currently, DC Health Link offers 267 health plans for small businesses and 34 plans for individuals and families. For the first time, individuals and the smallest of District businesses have multiple choices for affordable health coverage. Employees of small businesses now have a greater choice of health plans and the businesses themselves are freed from the administrative burden associated with trying to provide choices for their employees.

DC Health Link Offers Affordable and Competitive Health Plans:

The requirement that all insurers have to display their prices and health plan information on a single website portal has fostered competition among carriers. This competition has caused
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Council of the District of Columbia

HEARING on

"Better Prices, Better Quality, Better Choices for Health Coverage Amendment Act of 2013"
January 29, 2014

Committee on Health
The Honorable Yvette Alexander, Chairperson

By

Eric Vicks
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**DC Health Link Offers Affordable and Competitive Health Plans:**

The requirement that all insurers have to display their prices and health plan information on a single website portal has fostered competition among carriers. This competition has caused
three of the four District carriers to lower their prices from initial rate filings, one insurer lowered premiums twice in order to become competitive. Consumers can now make clear choices based on price and quality. Consumers have the comfort of knowing that they are receiving the best rates available even if they don’t work for the largest employers; which was not the case just a year ago.

**DC’s Marketplace Has Attracted a Large and Diverse Pool of Consumers that Will Increase Competition and Continue to Put Downward Pressure on Costs:**

To date, over 20,000 people have signed up for health coverage using DC Health Link. This includes a sizable population (37%) of younger consumers in the 26 to 34 age group; those who were previously less likely to be insured. This is also the group deemed necessary to make this system work. If the District continues to enroll a large and diverse mix of residents, DC Health Link will continue to be stable with affordable prices in the future.

We are fully in support of the passage of permanent legislation supporting DC Health Link. I am confident that working with the committee and stakeholders, DC Health Link will continue to build upon its success.

Thank you for this opportunity to testify. I would be happy to answer any questions you may have.
Testimony of Barbara Lang  
President and CEO, DC Chamber of Commerce

Before the Committee on Health

Wednesday, January 29, 2014

Good morning Councilmember Alexander and other members of the DC Council. I am Barbara Lang, President and CEO of the DC Chamber of Commerce. I am pleased to be here today to represent the 1700+ members of the Chamber, the hundreds of thousands of employees they employ. The DC Chamber of Commerce represents businesses large and small. At the Chamber, we truly work hard to make living, working, playing and doing business in the District of Columbia a much better proposition for all of our residents. It is in that vein that I appear before you today to state our support for Bill 20-240, the Better Prices, Better Quality, Better Choices for Health Coverage Amendment Act of 2013.

My testimony today will focus on the status of the DC Health Exchange in lieu of the specific provisions of Bill 20-240. Since July of last year, the DC Chamber has embraced its partnership with DC Health Link. From providing small business education sessions, local outreach and disseminating relevant information, our partnership with the Health Benefit Exchange Authority has been a success. Over the past six months, we have conducted extensive outreach and educational forums to expose small businesses to the new online health insurance marketplace. We have reached out to businesses in every Ward by physically visiting businesses, meeting with ANCs and citizens and civic associations. We have hosted educational sessions at local libraries throughout the District. We have also successfully partnered with non-profits associations to bring Health Link to their members. And of course, we leverage our own DC Chamber connections by providing businesses key information at our many events.

In fact, in just a few days, we are hosting one of our monthly in-person education sessions at the District Department of Consumer and Regulatory Affairs Small Business Resource Center. We have forged a successful partnership with DCRA to bring Health Link to our businesses, where they already do business with the District. The forum, titled, DC Health Link: The New Health Law and Small Business is an hour and a half long session that educates small businesses on DCHealthLink.com and will guide businesses to compare and purchase health plans and take advantage of tax credits that cover up to 50% of the cost of employee health insurance. We work with employers to see that they can see all available plans and comparison shop price, coverage, and other plan offerings. Additionally, we will clarify compliance and regulation questions during this event.
We are currently focusing on finalizing applications for 2014 plans and bringing in businesses that are skeptical of the process. We have faced significant challenges over the last 6 months in both educating businesses about the Health Link and addressing concerns over website functionality. We understand that there are still a few issues, but the DC Exchange is in a far better position than other Exchanges in the region.

As we look forward into 2014, the Chamber is expanding the enrollment, education and technical aspects of our partnership with Health Link. While we hosted a few enrollment days to get employers signed-up, we were more focused on outreach in 2013. This year, we plan to host enrollment days twice a month, once at our offices and also at DCRA. Our enrollment days will include access to brokers and in-person assistors, who are experts in getting businesses enrolled. Businesses must be organized and informed well before starting the online enrollment process. Therefore, we are expanding our education efforts to include step by step guidance for businesses to become enrolled.

While the Chamber cannot by law enroll, businesses in Health Link, we can and do provide crucial support services to get a business through the process. Another initiative for 2014 is for the Chamber to provide technical assistance to businesses seeking to become enrolled. We have learned the many nuances of getting enrolled and are focused on keeping a business from frustration in the process. There are 6 steps to becoming enrolled, including motivating employees to go online and choose a plan. We have found that employers need clear timelines and checklists, supported by technical assistance to become enrolled.

We will continue to maximize the 2014 enrollment period as we transition into encouraging plan renewals for 2015. The DC Chamber is committed to providing relevant information on healthcare reform and to serve as a primary resource for understanding how the government's implementation of the new healthcare law will impact business.

I thank you for the opportunity to testify and am able to answer questions at this time.
Chairperson Alexander, Members of the Committee, my name is Diane Lewis and I am the Chair of the Executive Board of the DC Health Benefit Exchange Authority. Thank you for the opportunity to appear before you today.

I’m here to urge the Council to pass and make permanent the Better Prices, Better Quality, Better Choices for Health Coverage Amendment Act of 2013, which, as you know, was unanimously approved by the Council on a temporary basis last June.

There is no doubt from any of us on the Executive Board of the DC Health Benefit Exchange Authority that this legislation has been essential to the successful launch of DC Health Link and that it will be even more important for its future.

The key provision in this legislation is the creation of “one big marketplace” for individual and small group health insurance in the District. That means that all individual health insurance sold in the District is now sold through DC Health Link. After a transition period in 2015, all small group policies will also be sold through DC Health Link.

One big marketplace is vitally important because it establishes one, consistent set of rules for the sale of health insurance to individuals, families and small businesses in the District. On top of that, DC Health Link provides the only way for consumers and small business owners to see each of the plan offerings on-line and truly compare apples-to-apples among their choices. By requiring all products to come through DC Health Link, we’re also able to ensure strong participation by insurance companies in this new marketplace so that consumers have access to the types of products at prices that they can afford. That participation is vitally important because financial help in the form of federal tax credits is only available for products sold
through state exchange marketplaces. We certainly don’t want to create a two-tiered system in the District that limits those who need financial help to fewer choices.

Having a health insurance exchange with the participation of major insurers, numerous options for consumers, strong provider networks, and a competitive environment that drives down prices is the goal for each and every state exchange nationwide. I am pleased to report that DC Health Link has achieved that goal—and that is in large part due to this legislation’s creation of one big marketplace.

With the strong support and collaboration of the Council, the Mayor, our sister agencies in District government, our dedicated staff at the Authority, and our DC Health Link Assisters who are our “boots on the ground” across the District, we had a successful launch of DC Health Link on October 1.

That success has been carried forward into quality, affordable health insurance that is now in effect for thousands of DC residents, owners and employees of our small businesses. Here in the District thousands of people have signed up for affordable quality coverage through DC Health Link.

Both as Chair of the Authority and as a DC resident, I am proud of our efforts to-date. As of Friday, January 10, 2014, 20,290 people have enrolled through DC Health Link in private health plans and Medicaid. We will release updated data on a monthly basis so our next release will be in early February.

While we are pleased with our enrollment success, we also acknowledge that there is much work to be done. Enrolling people who need coverage is our top priority.

I am truly honored to be part of the historic effort of implementing the ACA and making affordable, quality health insurance a reality for thousands of people in the District of Columbia. Swiftly enacting permanent legislation to maintain one big marketplace in the District’s individual and small group health insurance market will be key to our ongoing success. I thank you and the other members of this committee for your ongoing support. It is my pleasure to turn things over to Mila Kofman, Executive Director of the DC Health Benefit Exchange Authority.

Again, thank you, Madam Chair, for the opportunity to testify today.
Chairperson Alexander and members of the Committee, my name is Mila Kofman. I am the Executive Director of the DC Health Benefit Exchange Authority and it is an honor to be here.

I am testifying in strong support of Bill 20-240, "The Better Prices, Better Quality, Better Choices for Health Coverage Act of 2013." This bill would make permanent the temporary legislation passed by the Council this past summer.

When you held a hearing on this bill in May 2013, more than 50 witnesses came to share their perspectives on this legislation, overwhelmingly showing strong support for the legislation. These included national and local groups who worked for many years to get health coverage reforms passed and were strong supporters of the Affordable Care Act. Witnesses also included national experts like Alice Rivlin and others who understand insurance markets. The temporary bill was passed unanimously. Today, I am here to ask you and all the members of the Council to vote to make it permanent.

Last May, I testified that the District had the power to establish a truly competitive, consumer-driven private health insurance marketplace for residents and small business owners ensuring access to high quality, affordable coverage. The Better Prices, Better Quality, Better Choices for Health Coverage Act of 2013 did that.
Chairperson Alexander and members of the Committee, my name is Mila Kofman. I am the Executive Director of the DC Health Benefit Exchange Authority and it is an honor to be here.

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Last May, I testified that the District had the power to establish a truly competitive, consumer-driven private health insurance marketplace for residents and small business owners ensuring access to high quality, affordable coverage. The Better Prices, Better Quality, Better Choices for Health Coverage Act of 2013 did that.
Through this legislation, the District created real price competition. In our market, price transparency and competition has benefited people and small businesses. Also, the legislation ensured that consumers purchasing through the marketplace have access to all health insurance products sold by insurers. The legislation also helped ensure that health insurance coverage through the Marketplace includes broad provider networks, nationwide networks as well as comprehensive Metro-area networks.

Looking at other states, it is clear that without legislation creating one big marketplace, consumers in many cases face high premiums, limited coverage options, and limited provider networks. Permanent legislation is necessary to ensure that the District continues to have competitively priced coverage, real choices, and coverage with comprehensive networks.

As you know the District’s new on-line health insurance marketplace -- called DC Health Link -- opened for business on October 1, 2013. Bloomberg news reported that we were one of only four jurisdictions nationwide to successfully open the morning of October 1. Since then we have enrolled more than 20,000 people.

I strongly believe that this success is due in large part to the enactment of the legislation and that is why it is critical that the Council make it permanent.

**Price Competition**

The creation of one big marketplace has been vital to creating real competition resulting in more affordable premiums for individuals and small businesses.

All prices and products are transparent in one place on-line – DCHealthLink.com.


Insurers know that when a consumer sees all prices, the consumer is in the driver’s seat. They also know that prices must be competitive and low enough to attract buyers. The temporary legislation created real competition in prices. And as a result, people and small businesses have benefited.

We know that our rates are competitive. Brokers have told us that they can find better deals now for their small business clients through DC Health Link. One small business
owner told me that they are saving over $1000 a month. They have a platinum level plan (the most expensive level of coverage) through DC Health Link.

Importantly, permanent legislation is necessary to ensure that rates remain affordable and that policies are priced competitively.

**Broad choices of insurers, coverage and networks**

Unlike other jurisdictions with state-based or federal marketplaces, all major insurers are offering coverage through DC Health Link. Aetna, CareFirst BlueCross BlueShield, and Kaiser Permanente are offering coverage through the DC Health Link individual marketplace. These and United HealthCare are offering coverage through DC Health Link’s small business marketplace.

There is a product for everyone, fitting a small business' and an individual's needs and different budgets. In the small business marketplace, insurers are offering 267 different products—HMOs, PPOs, zero-deductible plans, and HSA-compatible high deductible coverage, plans with broad nationwide provider networks and robust local and regional networks—and full employer choice that allows each small business to offer its workers a choice of insurers, plans, and different levels of coverage. Small businesses, like large employers, can finally offer their employees choices.

There are 34 insurance plan choices (31 comprehensive plans and 3 catastrophic plans) in the individual marketplace.

Importantly, small group and individual plans have broad nationwide and local METRO-area provider networks. Products sold through DC Health Link are similar to what has traditionally been offered commercially in the District.

Fortunately, the District’s Marketplace offers to consumers and small businesses a choice of coverage from all major insurers in the District, many different coverage options, and comprehensive provider networks. This is different than the experience in many other states. For example, in one state that has a great individual marketplace, only one insurer is offering coverage to small businesses through their SHOP marketplace and that coverage is only available in two counties in the entire state. In another state with a federal marketplace, although five insurers offer coverage to individuals and families through the marketplace, only one offers coverage in all parts of the state.

In contrast, each of the insurers here in the small group marketplaces offer networks that expands beyond the District. Aetna, CareFirst BlueCross BlueShield and United all offer nationwide plan options. Kaiser Permanente, an HMO which by definition has a regional network, opened a significant number of their plans to their networks everywhere they do business across the country.

One of the strongest endorsements of our success in the District is that the Federal Government chose DC Health Link as the marketplace for insurance coverage for all
Members of Congress and their designated staffs. DC Health Link closely resembles the Federal Employees Health Benefit Plan, which has broad choices. Our marketplace – with four major insurers participating and offering broad choices with comprehensive networks – was selected as the best option for Members of Congress and their designated staff nationwide.

And in December, President Obama enrolled through DC Health Link’s individual marketplace.

The choice of all major insurers, a broad variety of different health insurance products, and nationwide and comprehensive local provider networks all result from the private market parameters established through the legislation -- Better Prices, Better Quality, Better Choices for Health Coverage Act of 2013.

Without permanent legislation, we can assume that our experience is likely to be similar to what other jurisdictions have experienced -- a lack of competition and high premiums, consumers and businesses with fewer options, and coverage with inappropriately narrow networks. Instead of having one big marketplace where all businesses and consumers have lots of affordable quality options, absent permanent legislation, we may have few coverage options for people who need premium reductions, while people able to pay full price would have broad choices. Insurers could decide not to offer coverage through the Marketplace or to offer only a few options. We need permanent legislation to ensure that all consumers and small businesses in the District continue to have access to all major insurers, all products, and comprehensive provider networks.

Conclusion

In conclusion, I strongly support Bill 20-240 and urge you to make “The Better Prices, Better Quality, Better Choices for Health Coverage Act of 2013” permanent. Although today I focused on one major provision, the bill has many consumer protections. It reflects the significant work done by many diverse stakeholder policy working groups that developed consensus policies and policy options where consensus was not possible and reflects recommendations from the Standing Advisory Board. The bill reflects the work of hundreds of people who were working group members and many more who participated in these groups. With more than 50 public meetings and professional assistance from nationally recognized experts like Jon Kingsdale (the first executive director of the Massachusetts Connector), these policy committees of diverse stakeholders including consumer and patient advocates, small business owners, insurers, brokers, physicians and other providers have compromised and reached consensus. The bill reflects their work. Their efforts have enabled us to be here today with a successful start to a new era in health insurance in the District.

While we are proud of our record to date, we know there is much more to be done. We are improving our website on an on-going basis and decisions are informed by the experience of our customers, brokers and DC Health Link Assisters.
In conclusion, thank you Councilmember Alexander, and all Members of the Council, for your ongoing, strong support for DC Health Link. I truly believe that for us to continue our successful start, permanent enactment of “the Better Prices, Better Quality, Better Choices for Health Coverage Act of 2013” is vital. Without it, there is a real danger of coverage not being priced competitively and therefore premiums skyrocketing. And there is a real danger of choices that exist today disappearing, leaving consumers with very few options.

Thank you for the opportunity to testify. I urge the Council to approve “the Better Prices, Better Quality, Better Choices for Health Coverage Act of 2013” with the important consumer protections as well as the one big marketplace for all.
The District of Columbia Association of Health Plans and its member plans have been actively engaged in the District’s efforts to implement the federal mandates of the federal Affordable Care Act (ACA). In that regard, representatives of our member plans have provided ongoing technical support to help make the transition for Individual market consumers into an Exchange-only environment. DCAHP member plans have spent hundreds of staff hours resolving issues related to the Exchange enrollment process. In short, our member plans have helped the District develop the most effective, efficient and accessible Exchange possible.

The Association would like to respectfully offer the following comments and amendments to Bill 20-240 for your consideration and adoption:

**Exchange Operations and Market Rules**
While the District’s Exchange experienced less publicized operational issues than those highlighted in the neighboring jurisdiction of Maryland, its implementation process has had challenges. All health insurance plans have highly efficient and automated enrollment processes which help to make getting coverage easy for consumers. Since October 1, much of the enrollment interface between the Exchange and the health plans has had to be done manually. Manual processing creates significant opportunity for errors and slows the processing for both health plans and consumers. There continue to be problems with the enrollment process for individual consumers, including the inability of the Exchange to process change request such as consumers adding new family members to policies.

DCAHP member plans have seen very little Exchange enrollment activity in the small employer market segment, excluding members of Congress and their staff members. We believe the Council took the correct action in delaying mandatory Exchange enrollment for small employers. We would recommend that the Council extend to 2016 the option for small employers to purchase products directly from health plans. The extension of time for small employers to enroll solely through the Exchange should provide sufficient time for the Exchange to develop and test the enrollment portal for this consumer group.

**Proposed Market Operation Amendment:**

Sec. 10a. Distribution of individual and small group health benefit plans.
"(a) A carrier that offers individual or small group health benefit plans shall offer such plans solely through the District's American Health Benefit Exchange, as established pursuant to section 5(a) subject to the following transition:

"(1) Individual health benefit plans with plan years beginning on or after January 1, 2014, shall be offered solely through the District's American Health Benefit Exchange;

"(2) On or after January 1, 2014, small group health benefit plans offered to any small business that was not insured as of December 31, 2013, shall be offered and issued solely through the District’s American Health Benefit Exchange;

"(3) Small group health benefit plans offered to or renewed by any small business that was insured as of December 31, 2013, may be issued or renewed during calendar years 2014 and 2015 through existing distribution channels with the same carrier or a new carrier, except that such plans shall meet the qualifications for certification of a qualified health plan as provided in section 10; and

"(4) Unless the Council acts by October 1, 2015 to change the date that all small group health plans shall be offered, issued, or renewed through the District’s American Health Benefit Exchange, on or after January 1, 2016, all small group health benefit plans shall be offered and issued or renewed solely through the District’s American Health Benefit Exchange.

"(b) The requirements of this section shall not apply to grandfathered health plans as defined in section 1251 of the Federal Act."

Financial Sustainability
Federal law requires the Exchange to be financially self-sustaining beginning in 2015. During the working group process, members of DCAHP urged the Exchange to adopt an approach including using existing revenue, user fees, health plan assessments and general revenue. While the Exchange did adopt a broad-based assessment on health insurers, it is limited only to health insurers. DCAHP member plans currently pay multiple assessments and taxes. These assessments increase the cost of providing health insurance in the District and impact the cost of coverage to District insurance consumers. We believe the Council should establish the Exchange financial sustainability plan in law based on the following principles:

• While we applaud and strongly support the DC Exchange Authority for proposing a funding methodology that is fairly broad-based, DCAHP commercial members believe the base for the assessment should be expanded even further. Unless prohibited by Federal rule or law, we believe the only sustainable way to fund the Exchange is by casting a wide net. We recommend that you reconvene the Financial Sustainability Working Group in 2015, to identify additional funding sources including general fund revenues.

• DCAHP encourages the Authority to leverage Medicaid Federal matching dollars to the extent the Exchange handles Medicaid/CHIP administrative functions and/or authorizes Navigators to assist with enrollment into those programs as well as secure District general fund revenues to support the Exchange.

• We recommend that the assessment plan establish a ceiling on the maximum assessment rate of no more than .5 percent of gross receipts so as to ensure the Authority’s operations costs remain reasonable. For consistency, the proposal should specify that the assessment will not begin before 2015, and indicate when during the year the Authority will issue a Notice of Assessment. Further, all funds collected should include a transparent plan, including the
creation of an industry oversight board similar to the Regulatory Trust Fund Board, to show and monitor how the funds will be allocated to specified Exchange activities.

• Finally, the fees or assessments used to finance the Exchange should be considered a state tax or assessment as outlined in the Affordable Care Act and its implementing regulations, and should be excluded from health plan administrative costs for the purpose of calculating medical loss ratios or rebates, to the full extent allowed by federal regulation.

Proposed Assessment Amendment:

(b) Section 4 (D.C. Official Code § 31.3171.03) is amended as follows:

(1) Subsection (c) is amended as follows:

(A) The following phrase is inserted at the end of the subsection: “The funds obtained from any assessments on health carriers under this chapter will not be commingled within the Fund, and separate accounts will be maintained within the Fund to properly allocate assessment revenue and expenditures to health carriers.

(2) New subsections (f), (g), (h), (i), (j) and (k) are added to read as follows:

“(f) Beginning in calendar year 2015, the Authority shall enter into a Memorandum of Understanding with the Department of Insurance Securities and Banking to assess annually each commercial health carrier doing business in the District an amount based on a percentage of its direct gross receipts for the preceding year. The Authority shall establish in each assessable year the assessment rate, not to exceed .5% of the direct gross receipts. In no event shall the amount assessed exceed the amount budgeted by the Council.

“(g) The Department of Insurance Securities and Banking shall compute the assessment on behalf of the Authority for each commercial health carrier and send the health carrier this information in a “Notice of Assessment”. Each commercial health carrier shall pay the amount stated in the Notice of Assessment within 30 days of the mailing date of the Notice of Assessment.

“(h) The annual billing cycle for the assessment established by this chapter shall be the fiscal year of the District of Columbia.

“(i) All commercial health carriers subject to assessments in accordance with this chapter shall be members of the District of Columbia Regulatory Trust Fund Bureau, organized and maintained by such health carriers at their own expense, for the purpose of advising the executive board of the Authority annually as to the need for the proposed assessments, the fairness of the proposed assessments, and any other matters with respect to the administration of the Fund. The executive board shall submit to the Regulatory Trust Fund Bureau annually, in advance of the Mayor's budget submission to the Council, a detailed budget showing how the proposed assessments are to be expended.

“(j) Any health carrier aggrieved by an assessment may appeal under procedures established in § 101 of Title 26 of the District of Columbia Municipal Regulations (26 DCMR 101). In addition, the Regulatory Trust Fund Bureau may appeal to the Authority or the Mayor the entire annual assessment or a specific expenditure or category of expenditure, in accordance with the procedures
established in 26 DCMR 101, if it believes the assessment is not in accordance with this chapter or applicable laws.

“(k) Upon a vote of the Regulatory Trust Fund Bureau taken in accordance with its bylaws, the Regulatory Trust Fund Bureau, at its own expense, may annually arrange for an independent audit of the expenditures made in any fiscal year by the Fund. The Authority, the Commissioner, the Department of Insurance, Securities, and Banking, and all other elements of the Government of the District of Columbia shall cooperate with such an audit and shall make available all documents and records reasonably necessary to the conduct of the audit.”

Prompt Payment
Under the District’s prompt payment statute, DC Code 31-3132, carriers must pay or deny a claim within 30 days of receiving a “clean” claim. However, ACA provides for a 90-day grace period for premiums due from individuals who receive a subsidy through the Exchange. During this grace period, claims must be paid for the initial 30 days, but payment on claims may be suspended for the remaining 60 days and ultimately denied if premiums are not paid in full during the grace period. The District should revise its prompt pay statute to account for this new 60-day period of suspended claims by allowing the 30-day period for processing a claim to be suspended while a claim is “suspended” under the federal rule.

Proposed Prompt Pay Amendment:

Add new (g) to DC Code 31-3132

(g) A carrier may suspend processing and payment of a claim when permitted under 45 C.F.R. § 156.270. Any period of time during which the processing or payment of a claim is suspended under 45 C.F.R. § 156.270 shall not be included when computing the time periods in subsections (a) through (f) of this Section.

Open Enrollment
District law currently mandates provision of an open enrollment product that provides coverage for high-risk members who are unable to secure underwritten coverage in the commercial individual market. See DC Code 31-3514. Because ACA requires guarantee issue, bars medical underwriting and provides for specified open enrollment periods during which individuals can purchase insurance, the District’s open enrollment requirement should be repealed.

Proposed Open Enrollment Amendment:

Repeal DC Code 31-3514.
As we discussed, please make members of the DC Council Committee on Health aware that Kaiser Permanente does not agree with the following advocacy point raised in the written testimony that was submitted by DCAHP in February of this year on B20-240 Better Prices, Better Quality, Better Choices for Health Coverage Amendment Act of 2013:

- Kaiser does not agree with the DCAHP recommendation that the Council delay until 2016 mandatory Exchange enrollment for small employers. We strongly believe the DC Exchange should stay the course with regard to the SHOP Exchange and require mandatory enrollment for small employers in 2015.

Thanks,
Laurie Kuiper
ATTACHMENT 3
MEMORANDUM

TO: The Honorable Phil Mendelson
   Chairman, Council of the District of Columbia

FROM: Jeff DeWitt
       Chief Financial Officer

DATE: March 25, 2014


REFERENCE: Bill 20-240, Committee Print shared with the Office of Revenue Analysis on March 21, 2014

Conclusion

Funds are sufficient in the FY 2014 through FY 2017 budget and financial plan to implement the bill.

Background

The bill contains a number of amendments to the "Health Benefit Exchange Authority Establishment Act of 2011" designed to address issues of health insurance choice, benefit levels, and market competitiveness in the District’s private health insurance marketplace ("DC Health Link"). These amendments include:

- Defining plan metal levels, and requiring insurers to offer a qualified health plan at the bronze metal level through DC Health Link (this exceeds the federal requirement that insurers offer qualified health plans at the silver and gold metal levels);
- Requiring insurer accuracy in any attestations made as a part of their filing for certification to participate in DC Health Link;
- Requiring insurers to offer at least one “standardized” qualified health plan in each metal level by 2015;
- Requiring that all qualified health plans offered by a single insurer be meaningfully different from one another (to protect residents from being confused or overwhelmed by a flood of “look-alike” policies);

1 Effective March 2, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 et seq.).
The Honorable Phil Mendelson

- Ensuring that all qualified health plans on DC Health Link are fully compliant with mental health parity guidelines;
- Ensuring that the prescription drug formularies for qualified health plans offered on DC Health Link have one or more drugs in each category and class;
- Requiring that all qualified health plans on DC Health Link will cover the benefits equivalent to the District’s defined essential health benefits package with no substitutions;
- Allowing DC Health Link to carry an unlimited number of qualified health plans, and allowing those plans to carry services beyond the essential health benefits;
- Building a functioning and competitive insurance marketplace by determining deadlines for uninsured individuals and small businesses to purchase or change health coverage solely through DC Health Link;
- Defining habilitative services;
- Grandfathering health plans that meet federal requirements and were in place prior to March 23, 2010; and
- Requiring brokers who want to sell private health insurance on DC Health Link to complete training developed by the Health Benefit Exchange Authority (“the Authority”).

Financial Plan Impact

Funds are sufficient in the FY 2014 through FY 2017 budget and financial plan to implement the bill.

The only provision of the bill that could impact the Authority’s operations is the one requiring brokers who want to sell insurance through DC Health Link to complete training developed by the Authority. The Authority has already partnered with the National Association of Health Underwriters to develop and offer the training. Currently, the Authority is paying the 2014 training fees for brokers operating in D.C. who have resident licenses in D.C., Virginia, or Maryland from money earmarked for this purpose. Beginning in 2015, brokers will need to pay for the training themselves.2 Because the Authority is already providing brokers training and the bill does not require the Authority to pay training fees, this portion of the bill does not have a fiscal impact.

The rest of the bill’s provisions clarify how private health insurers will operate in the health insurance marketplace and do not change the staffing and resource requirements for the District; therefore, they do not have an implementation cost.

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2 According to Purvee Kempf, Deputy General Counsel and Chief Policy Advisor of the D.C. Health Benefit Exchange Authority.
ATTACHMENT 4
MEMORANDUM

TO: Councilmember Yvette Alexander

FROM: V. David Zvenyach, General Counsel

DATE: March 26, 2014


The measure is legally and technically sufficient for Council consideration.

The proposed legislation would amend the Health Benefit Exchange Authority Establishment Act of 2011 by requiring health carriers to offer at least one standardized, qualified health plan at bronze, silver, and gold levels in addition to any other health plans the carrier may offer. Bill 20-240 also defines habilitative services as related to the essential health benefits benchmark plan.

Bill 20-240 provides that carriers offering individual or small group health benefit plans shall offer such plans solely through the American Health Benefit Exchange ("Exchange"), subject to specific transitioning time frames. Bill 20-240 provides that if the Council does not act by October 1, 2014, all small group health benefit plans will be offered and issued or renewed solely through the Exchange. Finally, the proposed legislation provides that a licensed insurance producer may sell any qualified health plan offered in the Exchange, after satisfactorily completing training developed and provided by the Health Benefit Exchange Authority, and the insurance producer will compensated directly by a health carrier for the sale.

I am available if you have any questions.

s/ V. David Zvenyach
ATTACHMENT 5
DIVISION V. LOCAL BUSINESS AFFAIRS

TITLE 31. INSURANCE AND SECURITIES

SUBTITLE IV. HEALTH AND RELATED INSURANCE

CHAPTER 31D. HEALTH BENEFIT EXCHANGE

D.C. Code § 31-3171.01 (2014)

§ 31-3171.01. Definitions

For the purposes of this chapter, the term:

(1) "American Health Benefit Exchange" means an entity established pursuant to § 31-3171.04, and section 1311(b) of the Federal Act.

(2) "Authority" means the District of Columbia Health Benefit Exchange Authority established by § 31-3171.02.

(3) "Commissioner" means the Commissioner of the Department of Insurance, Securities and Banking, as established by § 31-102.


(5) (A) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.
(B) The term "health benefit plan" does not include:

(i) Coverage only for accident or disability income insurance, or any combination thereof;

(ii) Liability insurance, including general liability insurance and automobile liability insurance;

(iii) Coverage issued as a supplement to liability insurance;

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance;

(vii) Coverage for on-site medical clinics; or

(viii) Other similar insurance coverage, specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, approved August 21, 1996 (110 Stat. 1936; 42 U.S.C. § 201, note) ("HIPAA"), under which benefits for health care services are secondary or incidental to other insurance benefits.

(C) The term "health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate of insurance, or contract of insurance, or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits;

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(iii) Other similar, limited benefits specified in federal regulations issued pursuant to
HIPAA.

(D) The term "health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate of insurance, or contract of insurance, and there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(i) Coverage only for a specified disease or illness; or

(ii) Hospital indemnity or other fixed indemnity insurance.

(E) The term "health benefit plan" does not include the following if offered as a separate policy, certificate of insurance, or contract of insurance:

(i) A Medicare supplemental policy as defined in section 1882(g)(1) of the Social Security Act (42 U.S.C. § 1395ss(g)(1));

(ii) Coverage supplemental to the coverage provided under 10 U.S.C. § 1071 et seq.; or

(iii) Similar supplemental coverage provided to coverage under a group health plan.

(6) "Health carrier" means an entity subject to the insurance laws and regulations of the District that contracts, or offers to contract, to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including:

(A) An accident and sickness insurance company;

(B) A health maintenance organization;

(C) A hospital and medical services corporation; or
Committee on Health
Comparative Print: B20-240
March 26, 2014

1 (D) Any other entity providing a health benefit plan.

2 (7) "Health professional" shall have the same meaning as provided in § 3-1201.01(8).


4 SA "Metal level" means the bronze, silver, gold, and platinum levels of coverage as defined in section 1302(d)(1) of the Federal Act.

5 SB "Navigator" refers to the entities described in section 1311(i) of the Federal Act.

6 (9) "PHSA" means the Public Health Service Act, approved July 1, 1944 (58 Stat. 682; 42 U.S.C. § 201 et seq.).

7 (10) "Qualified dental plan" means a limited-scope dental plan that has been certified in accordance with § 31-3171.09.

8 (11) "Qualified employer" means a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the Small Business Health Options Program Exchange ("SHOP Exchange"), and, at the option of the employer, some or all of its part-time employees; provided, that the employer:

9 (A) Has its principal place of business in the District and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or

10 (B) Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in the District.

11 (12) "Qualified health plan" means a health benefit plan that has a certification validating that the plan meets the criteria for certification described in section 1311(c) of the Federal Act.
and § 31-3171.09.

(13) "Qualified individual" means an individual, including a minor, who:

(A) Is seeking to enroll in a qualified health plan offered to individuals through the Authority;

(B) Resides in the District;

(C) At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

(D) Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

(14) "Secretary" means the Secretary of the United States Department of Health and Human Services.

(15) "SHOP Exchange" means a Small Business Health Options Program Exchange established pursuant to § 31-3171.04, and section 1311(b) of the Federal Act.

(16) (A) "Small employer" means a single employer that employed an average of not more than 50 employees during the preceding calendar year.

(B) For the purposes of this paragraph:

(i) All persons treated as a single employer under section 414(b), (c), (m), or (o) of the Internal Revenue Code of 1986 (26 U.S.C. § 414(b), (c), (m), or (o)) shall be treated as a single employer.

(ii) An employer and any predecessor employer shall be treated as a single employer.

(iii) All employees shall be counted, including part-time employees and employees who
are not eligible for health benefit coverage through the employer.

(iv) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that employer is reasonably expected to employ in the current calendar year.

(v) An employer that makes enrollment in qualified health plans available to its employees through the SHOP Exchange and would cease to be a small employer by reason of an increase in the number of its employees shall continue to be treated as a small employer for purposes of this chapter as long as it continuously makes enrollment through the SHOP Exchange available to its employees.


(18) “Standardized plan” means a plan with defined benefits and cost sharing as determined by the executive board for the Authority.

§ 31-3171.09. Health benefit plan certification

(a) To be certified as a qualified health plan, a health benefit plan shall, at a minimum:

(1) Provide the essential health benefits package described in section 1302(a) of the Federal Act; except, that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in subsection (e) of this section, if:

(A) The Authority has determined that at least one qualified dental plan is available to
supplement the plan's coverage; and

(B) The health carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Authority, that the plan does not provide the full range of essential pediatric dental benefits and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the exchanges;

(2) Obtain prior approval of premium rates and contract language from the Commissioner;

(3) Provide at least a bronze level of coverage, as determined by § 31-3171.04(a)(11), unless the plan is certified as a qualified catastrophic plan, meets the requirements of section 1302(e) of the Federal Act, and will only be offered to individuals eligible for catastrophic coverage;

(4) Ensure that the cost-sharing requirements of the plan do not exceed the limits established under section 1302(c)(1) of the Federal Act, and if the plan is offered through the SHOP Exchange, the plan’s deductible does not exceed the limits established under section 1302(c)(2) of the Federal Act;

(5) Be offered by a health carrier that:

(A) Is licensed and in good standing to offer health insurance coverage in the District;

(B) (i) Offers at least one qualified health plan at the bronze level, at least one qualified health plan at the silver level and at least one qualified health plan at the gold level, through each component of the Authority in which the health carrier participates;

(ii) For the purposes of this subparagraph, the term "component" refers to the SHOP Exchange and the exchange for individual coverage within the American Health Benefit Exchange;
(C) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the exchanges and without regard to whether the plan is offered directly from the health carrier or through an insurance producer;

(D) Does not charge any cancellation fees or penalties in violation of § 31-3171.04(c); and

(E) Complies with the regulations established by the Secretary under section 1311(d) of the Federal Act and any other requirements as the Authority may establish; and

(F) Provides accurate attestations as required in the initial certification process;

(G) Offers one or more standardized plans that meet the criteria developed by the executive board for the Authority, at each metal level in which the carrier is participating, in addition to other plans the carrier may offer; and

(H) Offers plans subject to the meaningful difference standard, as defined in section 4(ii) of Chapter 1 of the Affordable Exchanges Guidance, dated March 1, 2013, by the Centers for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services in the U.S. Department of Health and Human Services, or as may be defined by the executive board for the Authority.

(6) Meet the requirements of certification pursuant to the authority provided in this chapter and by the Secretary under section 1311(c) of the Federal Act, and rules promulgated pursuant to this chapter or the Federal Act, which include:

(A) Minimum standards in the areas of marketing practices;

(B) Network adequacy;

(C) Essential community providers in underserved areas;
1. (D) Accreditation;
2. (E) Quality improvement;
3. (F) Uniform enrollment forms and descriptions of coverage; and
4. (G) Information on quality measures for health benefit plan performance; and
5. (7) Be determined by the Authority that making the plan available through the exchanges is
   in the interest of qualified individuals and qualified employers.
6. (8) Comply with section 512 of the Paul Wellstone and Pete Domenici Mental Health
   Stat. 3881), as applied to the Federal Act, including covering behavioral health inpatient and
   outpatient services for mental health and substance use disorders without day or visit limitations;
7. (9) Provide a drug formulary that includes, at a minimum, the greater of either the
   number of drugs listed in each category and class found in the District’s base-benchmark plan
   formulary, or the minimum number of drugs, by category and class, as established by the Center
   for Consumer Information and Insurance Oversight in the Centers for Medicare and Medicaid
   Services at the U.S. Department of Health and Human Services;
8. (10) Provide benefits identical to the essential health benefits benchmark plan, as
   defined in federal regulations promulgated pursuant to section 1302(a) of the Federal Act, as
   defined by the District without benefit substitution.
9. (b) The Authority shall not withhold certification from a health benefit plan:
   (1) On the basis that the plan is a fee-for-service plan;
   (2) Through the imposition of premium price controls by the Authority; or
(3) On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the Authority determines are inappropriate or too costly.

(4) On the basis of the number of qualified health plans being offered.

(c) The Authority shall require each health carrier seeking certification of a plan as a qualified health plan to:

(1) Submit a justification for any premium increase before implementation of that increase, and prominently post the information on its publicly accessible website;

(2) (A) Make available to the public, in the format described in subparagraph (B) of this paragraph, and submit to the Authority, the Secretary, and the Commissioner, accurate and timely disclosure of the following:

(i) Claims payment policies and practices;

(ii) Periodic financial disclosures;

(iii) Data on enrollment;

(iv) Data on disenrollment;

(v) Data on the number of claims that are denied;

(vi) Data on rating practices;

(vii) Information on cost-sharing and payments with respect to any out-of-network coverage;

(viii) Information on enrollee and participant rights under title I of the Federal Act; and

(ix) Other information as determined appropriate by the Secretary.
(B) The information required in subparagraph (A) of this paragraph shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act;

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual’s plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider and make this information available to the individual through a website that is publically accessible, and through other means for individuals without access to the Internet; and

(4) Promptly notify affected individuals of price and benefit changes, or other changes in circumstances that could materially impact enrollment or coverage.

(d) The Authority shall not exempt any health carrier seeking certification as a qualified health plan, regardless of the type or size of the health carrier, from District licensure or solvency requirements, and shall apply the criteria of this section in a manner that assures a level playing field between or among health carriers participating in the exchanges.

(e) (1) The provisions of this chapter that are applicable to qualified health plans shall also apply, to the extent relevant, to qualified dental plans except as modified in accordance with the provisions of paragraphs (2), (3) and (4) of this subsection or by regulations adopted by the Authority.

(2) The health carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits.
(3) The plan shall be limited to dental and oral health benefits, without substantially
duplicating the benefits typically offered by health benefit plans without dental coverage and
shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary
pursuant to section 1302(b)(1)(J) of the Federal Act, and such other dental benefits as the
Authority or the Secretary may specify by regulation.

(4) Health carriers may jointly offer a comprehensive plan through the exchanges in which
the dental benefits are provided by a health carrier through a qualified dental plan and the other
benefits are provided by a health carrier through a qualified health plan; provided, that the plans
are priced separately and are also made available for purchase separately at the same price.

(f) The Authority shall take the information required by subsection (c)(1) of this section, along
with the information and the recommendations provided to the Authority by the Commissioner
under section 2794(b) of the PHSA, into consideration when determining whether to allow the
health carrier to make plans available through the exchanges.

(g) A qualified health plan may provide additional services that are not in the essential
health benefits package required in subsection (a)(1) of this section, if the services are eligible
for claims submission and reimbursement.

(h) For purposes of the essential health benefits benchmark plan, as defined in federal
regulations promulgated pursuant to section 1302(a) of the Federal Act, the term “habilitative
services” includes health care services that help a person keep, learn, or improve skills and
functioning for daily living, including applied behavioral analysis for the treatment of autism
spectrum disorder.
New Section 10

10a. Distribution of individual and small group health benefit plans.

(a) A carrier that offers individual or small group health benefit plans shall offer such plans solely through the American Health Benefit Exchange, as established pursuant to section 5(a) subject to the following transition:

(1) Individual health benefit plans with plan years beginning on or after January 1, 2014, shall be offered solely through the American Health Benefit Exchange;

(2) On or after January 1, 2014, small group health benefit plans offered to any small business that was not insured as of December 31, 2013, shall be offered and issued solely through the American Health Benefit Exchange;

(3) Small group health benefit plans offered to or renewed by any small business that was insured as of December 31, 2013, may be issued or renewed during calendar year 2014 through existing distribution channels with the same carrier or a new carrier, except that such plans shall meet the qualifications for certification of a qualified health plan as provided in section 10; and

(4) Unless the Council acts by October 1, 2014 to change the date that all small group health plans shall be offered, issued, or renewed through the American Health Benefit Exchange, on or after January 1, 2015, all small group health benefit plans shall be offered and issued or renewed solely through the American Health Benefit Exchange.

(b) The requirements of this section shall not apply to grandfathered health plans as defined in section 1251 of the Federal Act.
10b. Sale, solicitation, and negotiation by insurance producers.

(a) An insurance producer that is licensed in the District and authorized by the
Commissioner to sell, solicit, or negotiate health insurance pursuant to the Producer Licensing
seq.), may sell any qualified health plan offered in the American Health Benefit Exchange, after
satisfactorily completing training developed and provided by the Authority.

(b) An insurance producer shall be compensated directly by a health carrier for the sale of
a qualified health plan offered in the American Health Benefit Exchange.
ATTACHMENT 6
A BILL

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

To amend the Health Benefit Exchange Authority Establishment Act of 2011 to promote meaningful choice, provide enhanced benefits, and build a competitive private insurance marketplace for the residents and small business owners of the District of Columbia by not limiting the number of qualified health plans in the Exchange, requiring plans at different metal levels, standardizing at least one plan option at each metal level to promote meaningful choice, creating one large marketplace, and defining habilitative services.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Better Prices, Better Quality, Better Choices for Health Coverage Amendment Act of 2014".

Sec. 2. The Health Benefit Exchange Authority Establishment Act of 2011, effective March 2, 2012 (D.C. Law 19-94; D.C. Official Code § 31-3171.01 et seq.), is amended as follows:

(a) Section 2 (D.C. Official Code § 31-3171.01) is amended as follows:

(1) New paragraphs (8A) and (8B) are added to read as follows:

"(8A) "Metal level" means the bronze, silver, gold, and platinum levels of coverage as defined in section 1302(d)(1) of the Federal Act.

"(8B) "Navigator" refers to the entities described in section 1311(i) of the Federal Act."
(2) A new paragraph (18) is added to read as follows:

“(18) “Standardized plan” means a plan with defined benefits and cost sharing as determined by the executive board for the Authority.”.

(b) Section 10 (D.C. Official Code § 31-3171.09) is amended as follows:

(1) Subsection (a) is amended as follows:

(A) Paragraph 5 is amended as follows:

(i) Subparagraph (B)(i) is amended by striking the phrase “at least one qualified health plan at the silver level and at least one plan at the gold level” and inserting the phrase “at least one qualified health plan at the bronze level, at least one qualified health plan at the silver level, and at least one qualified health plan at the gold level” in its place.

(ii) Subparagraph (D) is amended by striking the word “and” at the end.

(iii) New subparagraphs (F), (G), and (H) are added to read as follows:

“(F) Provides accurate attestations as required in the initial certification process;

“(G) Offers one or more standardized plans that meet the criteria developed by the executive board for the Authority, at each metal level in which the carrier is participating, in addition to other plans the carrier may offer; and

“(H) Offers plans subject to the meaningful difference standard, as defined in section 4(ii) of Chapter 1 of the Affordable Exchanges Guidance, dated March 1, 2013, by the
(B) Paragraph (7) is amended by striking the period at the end and inserting a semicolon in its place.

(C) New paragraphs (8), (9) and (10) are added to read as follows:

“(8) Comply with section 512 of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, approved October 3, 2008 (Pub. L. No. 110-343; 122 Stat. 3881), as applied to the Federal Act, including covering behavioral health inpatient and outpatient services for mental health and substance use disorders without day or visit limitations;

“(9) Provide a drug formulary that includes, at a minimum, the greater of either the number of drugs listed in each category and class found in the District’s base-benchmark plan formulary, or the minimum number of drugs, by category and class, as established by the Center for Consumer Information and Insurance Oversight in the Centers for Medicare and Medicaid Services at the U.S. Department of Health and Human Services;

“(10) Provide benefits identical to the essential health benefits benchmark plan, as defined in federal regulations promulgated pursuant to section 1302(a) of the Federal Act, as defined by the District without benefit substitution.”.

(2) Subsection (b) is amended as follows:

(A) Paragraph (2) is amended by striking the word “or”.
(B) Paragraph (3) is amended by striking the period at the end and inserting the phrase “; or” in its place.

(C) A new paragraph (4) is added to read as follows:

“(4) On the basis of the number of qualified health plans being offered.”.

(3) New subsections (g) and (h) are added to read as follows:

“(g) A qualified health plan may provide additional services that are not in the essential health benefits package required in subsection (a)(1) of this section, if the services are eligible for claims submission and reimbursement.

“(h) For purposes of the essential health benefits benchmark plan, as defined in federal regulations promulgated pursuant to section 1302(a) of the Federal Act, the term “habilitative services” includes health care services that help a person keep, learn, or improve skills and functioning for daily living, including applied behavioral analysis for the treatment of autism spectrum disorder.”.

(c) New sections 10a and 10b are added to read as follows:

“Sec. 10a. Distribution of individual and small group health benefit plans.

“(a) A carrier that offers individual or small group health benefit plans shall offer such plans solely through the American Health Benefit Exchange, as established pursuant to section 5(a) subject to the following transition:

“(1) Individual health benefit plans with plan years beginning on or after January 1, 2014, shall be offered solely through the American Health Benefit Exchange;

“(2) On or after January 1, 2014, small group health benefit plans offered to any
small business that was not insured as of December 31, 2013, shall be offered and issued solely
through the American Health Benefit Exchange;

"(3) Small group health benefit plans offered to or renewed by any small business
that was insured as of December 31, 2013, may be issued or renewed during calendar year 2014
through existing distribution channels with the same carrier or a new carrier, except that such
plans shall meet the qualifications for certification of a qualified health plan as provided in
section 10; and

"(4) Unless the Council acts by October 1, 2014 to change the date that all small
group health plans shall be offered, issued, or renewed through the American Health Benefit
Exchange, on or after January 1, 2015, all small group health benefit plans shall be offered and
issued or renewed solely through the American Health Benefit Exchange.

"(b) The requirements of this section shall not apply to grandfathered health plans as
defined in section 1251 of the Federal Act.

"Sec. 10b. Sale, solicitation, and negotiation by insurance producers.

"(a) An insurance producer that is licensed in the District and authorized by the
Commissioner to sell, solicit, or negotiate health insurance pursuant to the Producer Licensing
seq.), may sell any qualified health plan offered in the American Health Benefit Exchange, after
satisfactorily completing training developed and provided by the Authority.

"(b) An insurance producer shall be compensated directly by a health carrier for the sale
of a qualified health plan offered in the American Health Benefit Exchange.".
Sec. 3. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 602(c)(3) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(3)).

Sec. 4. Effective date.

This act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto), a 30-day period of Congressional review as provided in section 602(e)(1) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(e)(1)), and publication in the District of Columbia Register.