KENTUCKY HEALTH BENEFIT EXCHANGE ADVISORY BOARD

Meeting Minutes

March 7, 2024

Attendance: Sharon Clark Shaun Orme attended as proxy, Ryan Sadler; Harry Hayes, Dr. Joe Ellis, Martha Mather, John Mark Fones, David Roode, Whitney Allen

Deputy Secretary Carrie Banahan welcomed the board to the meeting and confirmed all had received a copy of the meeting minutes from the previous meeting. Deputy Secretary Banahan asked for a motion to accept the minutes with Harry Hayes offering a motion to accept and Ryan Sadler made a second to the motion. Minutes were adopted.

The first agenda item was an update from the Kentucky Health Benefit Exchange. David Verry provided a recap on Open Enrollment using the CMS reported numbers. This showed 75,000 enrolled during open enrollment. New consumers doubled from last year. There was a 62% increase in people identifying as African American or black and a 78% increase in those identifying themselves as Hispanic. There was also an increase of 43% in those who had assistance from licensed insurance agents. David reported Kentucky was slightly under the curve from the national snapshot of individuals receiving assistance from agents or navigators. David stated people are more likely to stay enrolled and more likely to understand their health coverage and more likely to use their health coverage if they have the assistance of a of an agent or an or a navigator.

David reminded the Board members that the unwinding special enrollment period was still an option for people, even if they lost their coverage in May or June.

David shared that the paper application was in the process of being translated. This will include the paper application for both Medicaid and QHP, being translated, with options in English, Spanish, and ten additional languages including Arabic, Somalis, Swahili, Chinese, French Creole, and Ukrainian.

David further reported there are enhancements to the Agent Portal Dashboard being implemented that will allow agents access to more dynamic data reports and streamlining of the remote ID proofing process.

David mentioned the feedback received from Open Enrollment debriefing sessions, which was constructive. He further explained The Tiger Team, which is a team led by staff member Tyler Little and a team of contractors conducting outreach via to those who lost their Medicaid coverage. These calls were planned as two calls, on two separate days, during different times, in an effort to reach residents. David reported a large success rate of contact. Deputy Secretary Banahan asked if there was a count of the number of calls made or contacts made from this effort. Tyler Little reported there had been

roughly 12,000. This was from a list with over 60,000 with the effort ongoing. David next reported the exchange had helped 81,000 with some type of change in information over the course of a year. More information to be provided in the following month on the midyear Federal Poverty Level changes. Overall, David reported robust and impressive numbers. Deputy Secretary Banahan asked if residents receive a notice when the FPL changes result in moving from an issuers QHP into their MCO plan. David stated he would review and provide additional information on this question. David did confirm residents do receive a notice to confirm their correct income before any changes are made. David Roode asked for confirmation that the numbers displayed were only for QHP enrollment. David Verry confirmed stating that Medicaid enrollment is in the 1.5 million range.

Helen Dawson provided an update on Medicaid unwinding. Updated numbers were shared and Helen explained that CMS reporting includes updated statuses on pending cases following the 90-day processing period. The 90-day processing period for cases means cases were further processed for reinstatement or income verification etc. This explained the difference in numbers reported monthly versus post 90-day period. Helen shared that the CMS reports of case activity are hosted on the DMS webpage. The report displays the number of members who have been reinstated, or responded to an RFI, to be reinstated from their original termination date. Helen reported these numbers increase weekly. Outreach priority is to help members understand they have a 90-day window for reinstatement. Helen said the numbers she shared were also shared during the monthly stakeholder calls with additional details and encouraged those interested to join those meetings.

David Roode asked when the unwinding will end. Helen stated that with the flexibilities in place, the Medicaid unwinding special enrollment period will continue through December 31, 2024. Most people will be back to a normal schedule by June, but there are two specific populations that were given extensions. LTC waiver members and long-Term Care facility residents will have two additional months until August. Further, children were awarded 12 months continuous coverage starting in October, meaning the first child renewals will resume in the fall 2024. There is a communication plan, working with the Department of Education to make sure that family members and schools are aware of children renewals.

Karla Burton provided a kynector outreach update. Karla said the team had traveled across the state to hold debrief sessions with kynectors. Five sessions were help across three contracted agencies. A survey with 95 responses had been utilized to capture information to guide discussions. The sessions included scenario-based work about best practices. Karla provided some metrics to display 65% of kynectors found information on the website to be most helpful, with the webinar being a close second. The Friday Fun facts newsletter and the monthly kynector were also identified as helpful tools for information. Survey responses showed 93% of kynectors felt supported during OE. 91% of those surveyed used the incident tracker, and 89% of kynectors surveyed visited the website for support and resources during open enrollment. Karla shared a map showing the three contracted agencies territories. Contracted agencies are KIPDA, Community Action Kentucky and Primary Care Association. The visits resulted in 32 key takeaways that will guide future enhancements and improvements for upcoming open enrollment periods. There were approximately 150 kynectors that participated in the sessions. Pictures were shared of kynectors participating in public events.

Martha Mather provided the Behavioral Health subcommittee meeting update. She announced the next Behavioral Health Subcommittee meeting will be held March 20th at 9:00 AM.

Whitney Allen provided the Education and Outreach subcommittee update. Whitney shared the subcommittee met Monday, February the 26th with a cultural competency overview provided by Danita Coulter, the HealthEquity branch director. This was an overview and discussion of plans the branch has for the educational curriculum, and ways the kynectors can provide feedback and then receive training once developed. The Medicaid application and other document translations were discussed. The next subcommittee meeting will be held Monday, March 25th.

The Qualified Health Plan subcommittee updates were delayed until the next Advisory Board meeting.

David Verry updated that the Agent Navigator Subcommittee meeting focused on creating a task force to work on a campaign for the family glitch fix, with the possibility of having two agents and two kynectors come up with a more direct way to address that problem. Issues with agent commissions being paid was discussed but that issue has been resolved. The importance of HSA's and plans that support HSA, was also discussed. David mentioned Whitney Allen and her subcommittee are also discussing this topic and expect more information in the coming months.

Deputy Secretary Banahan opened the floor to any questions or discussion items. Dr. Joe Ellis stated he had noticed that the Department of Insurance testified in the legislature on HB 186. Dr. Ellis asked for clarification about whether this was a cost analysis or a new legislative defined benefit for qualified health plans.

Shaun Orme responded that federal law requires each state to have an essential health benefit benchmark plan, and that includes the benefits required by federal law and any state mandated benefits adopted before 2012. If a state enacts a mandated benefit that exceed the benchmark plan, then the state is required to pay back a cost defrayal either to the enrollee or the plan, who has to in turn refund that back to the enrollee, either through a reduced premium or a rebate for the utilization of that mandated benefit.

Shaun explained there hadn't been any new mandates passed until the 2023 legislative session which required coverage of biomarker testing. Since Kentucky had no mechanism in place to issue cost defrayal payments, HB 186 established a mechanism for the state to make payments for mandated benefits that exceed the benchmark plan.

Dr. Joe Ellis also asked about a different bill that appeared to talk about the health care workforce and wanted to better understand its purpose. Shaun was not familiar with the bill mentioned and asked for a bill number. Shaun asked Dr. Joe Ellis to email him the information on the bill for follow-up.

Deputy Secretary Banahan announced the next meeting was scheduled for April 4th. Noting this is often a spring break week. Ryan Sadler made a motion to change the next meeting date to May. The Advisory Board approved with the next meeting to be held the first Thursday in May.

Meeting was adjourned.