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Report to the Mayor and Council of the District of Columbia on Financial Sustainability from the District of Columbia Health Benefit Exchange Authority

This report is submitted by the District of Columbia Health Benefit Exchange Authority ("Authority"), pursuant to the requirement set forth in the Health Benefit Exchange Authority Establishment Act of 2011(D.C. Official Code § 31-3171.16(b)) which requires that the Executive Board of the Authority "prepare a plan that identifies how the Authority will be financially self-sustaining by January 1, 2015," and further requires the plan "be certified by an independent actuary as actuarially sound and shall be submitted to the Mayor and Council not later than December 15, 2013." This report fulfills that requirement.

Introduction

Consistent with the Affordable Care Act and District law establishing the Health Benefit Exchange Authority (the Health Benefit Exchange Authority Establishment Act of 2011 D.C. Official Code § 31-3171.1 *et seq.*) this report details how the Authority intends to maintain financial sustainability beginning January 1, 2015. It provides background information on the Affordable Care Act, details the policy development process used by the Authority to reach a recommendation for financial sustainability, explains how the recommendation will be operationalized, and includes the required actuarial certification. The recommendation is to conduct a broad-based assessment of all health insurance premiums in the District from non-group, small group, large group and Medicaid managed care organization (MCO) carriers each year.

ACA Background

The Affordable Care Act makes grant funds available to all state-based exchanges, including the District's, to assist them in planning, establishing and operating their own state-based marketplaces. These funds must be spent before January 1, 2015. The ACA requires that state-based marketplaces must be financially self-sustaining beginning January 1, 2015. ACA § 1311(a)(4)(B); 45 CFR §155.160(b).

Therefore, the requirement to be financially self-sufficient by January 1, 2015 is both a federal and a District requirement for the Authority. The D.C. Official Code § 31-3171.03(e)(2) provides that the Authority may collect assessments only to the extent of "reasonable projections regarding the amount necessary to support the operations of the Authority."

Policy Development Process

WORKING GROUP PROCESS: Consistent with the public process the Authority used to develop policy recommendations, the Authority established a Working Group on Financial Sustainability

in April 2013. Authority Executive Board Member Leighton Ku chaired this group. Standing Advisory Board Member Jill Thorpe was vice-chair. Additional volunteer working group members included people representing consumers, insurance carriers, brokers, and others. Below is a list of the Financial Sustainability Working Group Members who regularly participated and took part in the consensus recommendation presented to the Authority.

Susan Walker, Consumer Advocate
Bill Simmons, Group Benefit Services
Diane Marcus, Insurance Broker
Laurie Kuiper, Kaiser Permanente
Randy Sergent, CareFirst
Deborah Chollet, Mathematica Policy Research
Regina Woods, MedStar
Katherine Stocks, Goldblatt Martin Pozen
Dave Chandra, Center on Budget and Policy Priorities
Justin Palmer, (no additional information provided)
Wes Rivers, DC Fiscal Policy Institute
Matthew Grace, First Financial Group

The Executive Board asked the Financial Sustainability Working Group to review and discuss potential Exchange revenue sources and to recommend which source(s) the Exchange should use to support its operations. The Working Group received a background paper before its first meeting (available in the Financial Sustainability Report to the Executive Board of the Authority here) that was prepared by Wakely Consulting Group (a firm that performed the role of facilitator for this working group).

That report outlined various revenue sources which included:

- Qualified Health Plan (QHP) Enrollment – user fee (or surcharge) on premiums administered through the Exchange
- All Insured Premiums – assessment on insurance premium revenue (individual, small group, and large group markets)
- Health Care Market – assessment on all benefits, including self-insured plans, or hospital revenue and other private medical claims as a way to reach all medical benefits
- Public Funding Source – e.g. tobacco tax, soda tax, or general tax revenues

The Report made clear that the Authority's annual operating costs were still being projected. It provided illustrative examples of operating costs to show the relative impact of the various revenue approaches. For example, if the annual operating budget in 2015 is $25 million, an assessment on premiums generated from a QHP enrollment user fee of 15.91% would be necessary to fund Exchange operations. If the assessment applied to all District health insurance carriers (similar to the assessment used by the Ombudsman program today to fund its operating

expenses), a .87% assessment would fund operations.

It is important to note that the operating expenses of the Authority will vary from year to year. Thus the percentage assessment will vary from year to year, whatever the base. The Authority is developing its budget for fiscal year 2015. Once that process has been completed, the Authority will provide additional information to the Mayor and the Council regarding the fiscal year 2015 assessment.

The Working Group members quickly concluded that a broad-based assessment is preferable. Some of the health carrier representatives initially withheld their agreement. One carrier agreed that a broad-based approach is preferable to Exchange-only user fees, but preferred that the Exchange be funded through existing resources. The carrier also wanted to consider assessing the self-funded plans. The committee considered a provider tax, but determined it to be politically unfeasible. Another method to reach the self-funded plans is through assessment of reinsurance and stop-loss carriers, and was included in the recommendation if feasible. The public funding source was dismissed as being unrealistic.

The Working Group met in-person on April 17 and April 30, 2013 and by conference call on May 9, 2013. At the third meeting, Working Group members endorsed a consensus recommendation that was presented to the Executive Board in a report from the Working Group dated May 23, 2013. The Working Group's recommendation was as follows:

> **Recommendation:** To the extent that it is feasible to use the existing 2% premium tax and/or .3% DISB operating assessment to support the Exchange, these revenues should be used. If this is not feasible or if additional funds are needed, a broad-based assessment on all health insurance premiums is the preferred revenue source. Specifically:
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> 1. HBX [the Authority] staff should, in consultation with other District officials, determine if there will be unanticipated collections from the existing health insurance tax and assessments that can be used to support the Exchange Authority and that this is consistent with the legislative requirement that the Authority be "financially self-sustaining."
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> 2. If this is not feasible, or if additional revenues are needed, the preferred source of revenue is a broad-based assessment of health insurance premiums, including Non-group, Small Group, Large Group and Medicaid MCO premiums, written in the District.
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> 3. If feasible and cost-effective, this should also include assessments on reinsurance and stop-loss insurance policies.

This recommendation was presented to the Executive Board on June 6, 2013 and a resolution approving it was adopted unanimously.

ADDITIONAL PROCESS

Once the Committee's resolution was approved by the Board, Authority staff needed to resolve several open questions within the recommendation.

USE OF EXISTING PREMIUM TAX:
The largest existing revenue source is the 2% premium tax on insurers, which is assessed annually and is used to fund the Department of Health Care Finance which operates the District's Medicaid program. One carrier thought that the increase in premiums that will be generated because the number of insured persons will increase might cover the cost of operating the Exchange. However, actuarial projections prepared by Wakely indicate that the premium tax will increase by only $1.6 million in 2015 and $500,000 more in 2016, for a total of $2.1 million because of increased insurance coverage. That amount would cover only a fraction of the Authority's operating expenses.

Additionally, Wayne Turnage, Director of the Department of Health Care Finance (DHCF), and a non-voting member of the Executive Board of the Authority, provided a brief report via email to the Executive Board on July 29, outlining how DHCF is financed and stating that any use of existing premium tax for new purposes would seriously jeopardize DHCF's financing. (Attachment One) The Authority's Executive Board Finance Committee met with Director Turnage on September 12, 2013 to discuss his report and reached consensus that Director Turnage's points were persuasive and that the existing premium tax should not be considered a resource for funding the Health Benefit Exchange Authority's operating expenses.

MEDICAID MCO PREMIUM ASSESSMENT:
Also on September 12, 2013the Authority's Executive Board Finance Committee, with Director Turnage attending as a nonvoting member, , the Committee discussed the inclusion of Medicaid managed care plans within the broad-based assessment as recommended by the Financial Sustainability Working Group and adopted by the Executive Board. The committee members agreed including those plans in a broad-based assessment would broaden the assessment base and that it would not jeopardize DCHF's financing. The Finance Working Committee agreed to retain the assessment of the Medicaid managed care plans in the financial sustainability plan. According to projections by Wakely, including the Medicaid MCOs to the list of health carriers subject to the assessment would add an additional $678 million to the premium base in 2015.

REINSURANCE AND STOP LOSS POLICIES:
Authority staff researched assessment of these policies for practicality and feasibility. Actuarial projections prepared by Wakely showed that assessment of reinsurance and stop loss carriers would bring little revenue and would decrease the broad-based assessment by only .01 %. The Department of Insurance, Securities and Banking (DISB) stated it was impractical to assess these carriers as DC entities could easily reinsure with out-of-state carriers, thereby avoiding the assessment.

Operationalizing the Assessment

As adopted by the Executive Board, the Financial Sustainability Working Group and the Finance Working Committee recommended a broad-based assessment of all health insurance carriers in the District to assure the lowest percentage assessment possible for the Authority's future funding. The Authority's enabling legislation, D.C. Official Code § 31-3171.03(e)(1), states that the Authority "is authorized to charge, through rulemaking: (A) User fees; (B) Licensing fees; and (C) Other assessments on health carriers selling qualified dental plans or qualified health plans in the District, including qualified health plans and qualified dental plans sold outside the exchanges." Pursuant to subsection (e)(1) above, the Authority intends to adopt a rule that provides for the imposition and collection of a licensing fee by assessing all health insurance carriers in the District. The Authority believes its enabling legislation authorizes the proposed assessment and that this legislation authorizes the Executive Board to impose the broad-based assessment market-wide as recommended by the Working Group. If the Council finds additional authorization is necessary for the broad-based market-wide assessment, the Authority will request such legislation.

The proposed rule will be sent to the Council, pursuant to D.C. Official Code § 31-3171.17(b), "for a 30-day period of review." The rule will operationalize the assessment for funding Authority operating expenses for fiscal year 2015 and beyond.

The Executive Board asked Authority staff to work with DISB to understand its current process of assessing insurers. In addition to the 2% premium tax discussed above, DISB now assesses certain carriers twice a year: once to fund the Ombudsman program, and once to fund DISB's operating expenses. The assessments are based on the previous year's premiums. Once annual operating expenses are determined through the budgeting process, DISB notifies the appropriate carriers and requires payment within 30 days. (The amounts for each carrier are determined based on the carrier's market share of premium dollars.)

The Authority plans to conduct its assessment in the same manner as DISB funds its operations. The Authority's assessment percentage will be based on its projected operating expenses and the previous year's total health insurance premium dollars, and each health insurance carrier will be assessed based on its market share of premiums. The Authority anticipates the first assessment will be imposed within the first six months of 2014.

Authority staff recommended that the Authority assess the carriers using the DISB process. Since DISB already performs these functions, there is no reason for the Authority to duplicate what DISB easily does routinely. Under the recommended arrangement, the Authority and DISB will work cooperatively through a Memorandum of Agreement that will enable DISB to perform the assessment and transfer the funds to the Authority.

A DISB staff member noted that many health insurance carriers pay the minimum assessment of $100 for the Ombudsman program because they have little premium volume.

To minimize administrative hassle, Authority staff recommended that the assessment apply only to health insurance carriers with annual premiums of at least $50,000. This threshold for assessment reduces the number of carriers to be assessed from 830 to 158, thereby saving the Authority the administrative burden of collecting small amounts of money from nearly 700 carriers that do little or no business in the District presently.

The staff recommendations above are adopted in this report.

Actuarial Certification

As required by D.C. Official Code § 31-3171.16(b)(2), this Financial Sustainability Plan has been "certified by an independent actuary as actuarially sound." (Attachment Two)

Conclusion

As required by law, the Authority has devised a plan that will make it financially self-sustaining by January 1, 2015. The Authority considered a wide range of options for achieving financial self-sustainability. It decided to levy a licensing fee and collect a broad-based assessment on all health insurance premiums in the District from non-group, small group, large group and Medicaid MCO carriers for any given calendar year. The assessment will be a percentage of the health insurance carrier's premium. The Authority will adopt a rule setting the assessment process. The Authority and DISB will work cooperatively through a Memorandum of Understanding that will enable DISB to perform the assessment and transfer the funds to the Authority. The plan adopted by the Authority will ensure the financial self-sustainability of the Authority for the foreseeable future.

Attachment One

Email from the Wayne Turnage, Director, the Department of Health Care Finance for the District of Columbia to the DC Health Benefit Exchange Authority Executive Board, 7/29/2013

A few months back, the Board discussed the possibility of using the existing premium tax to generate revenue for the Exchange. As indicated below, such a policy shift would create serious budget problems for DHCF and I use this email to officially register my opposition to the proposal.

The Role of Healthy DC in DHCFs Annual Budget

Overview

Established in 2007, the Healthy DC and Health Care Expansion Fund (Healthy DC) supports the Healthy DC Program and other medical assistance programs administered by the Department of Health Care Finance (DHCF). Funds are provided through a combination of premium / provider taxes and other payments. DHCFs budget is balanced in part by the use of the funds from the Healthy DC fund. ***Any reduction in the amount of Healthy DC funds allocated to DHCF would create a spending pressure for the agency.***

Background

The Healthy DC and Health Care Expansion Fund (Healthy DC) was established in 2007 to support the Healthy DC Program and other medical assistance programs administered by DHCF. There are three primary revenue sources for the Healthy DC fund:

1. A 2% premium tax on all of the private (Non-Medicaid and non-Alliance) health insurance policies written in DC (however, only 75% of the tax is allocated to the Healthy DC Fund)
2. A 2% premium tax on the Medicaid Managed Care plans; and
3. An annual $5 million contribution from CareFirst.

In FY2012, the total revenue collected for the Healthy DC Fund was $39 million. The amounts collected, by revenue source, are below:

FY 2012 Revenue (in millions)	
Revenue from Private (Non-Medicaid/Alliance) Plans	$20.1
Revenue from Medicaid & Alliance Plans	$13.9
CareFirst Contribution	$5.0
TOTAL	**$39.0**

DHCF builds the tax into the capitation rates paid for the Medicaid and Alliance plans. For the Medicaid portion, 70% is funded by the federal government.

The Healthy DC establishment act gives DHCF the authority to use Healthy DC funds for other medical assistance programs administered by the agency. Specifically, DHCF uses Healthy DC funds for the Medicaid program, the Alliance program, and to support the agency's Health Care Reform and Innovation Administration (HCRIA). In FY14, the Healthy DC funds are allocated as follows:

FY 2014 Healthy DC Budget (in millions)	
Medicaid MCOs (non-federal match)	$20.5
Alliance MCOs	$14.4
HSCSN (non-federal match)	$3.8
Health Care Reform & Innovation Adm. (non-federal match)	$0.3
TOTAL	**$39.0**

DHCF is able to use Healthy DC Funds as the "local match" for the Medicaid program and HCRIA. As a result, DHCF is able to draw down an additional $56.7 million in federal funds.

Impact of Reducing Healthy DC Funds on DHCF

DHCFs FY14 is predicated on the inclusion of $39 million in Healthy DC Funds. These funds generate an additional $56.7 million in federal funds that are accounted for in DHCFs budget. As outlined in the chart above, the funds support activities that are essential to the agency: the administration of the Medicaid and Alliance programs and the activities related to the HCRIA. ***Elimination of the Healthy DC funds, in part or total, will create a local budget deficit of up to $39 million. Further, DHCF would jeopardize the $56.7 million in federal funds that are generated through the Healthy DC funds, creating a nearly $100 million dollar deficit for the agency. DHCFs inability to meet federal obligations under the Medicaid could further put at risk additional federal funding, creating an impact well beyond $100 million.***

Attachment Two

(To be provided prior to final publication)