ACA WG
09 22 2017
Notes

Roll Call

PRESENT

Leighton Ku
Jodi Kwarciany
Colette Chichester, Rob Metz
Katie Nichol
Patricia Quinn
Peter Rankin
Carolyn Rudd
Jnatel Sims, John Fleig
Tammy Tomczyk
Kevin Wrege, Kris Hathaway

ABSENT:

Donna Alcorn
Dave Chandrasekaran
Carl Chapman
Louis Davis, Jr.
Maria Gomez
Laurie Kuiper
Dania Palanker
Bonita Pennino
Margaret Singleton
Liam Steadman
Jenny Sullivan

Ku: Previously announced that no votes would be taken today due to the religious holidays. Votes will be taken at the next meeting.

Quick recap: We have been operating under assumption, that there will be no major changes to the ACA, which may prove to be wrong. The new Graham Cassidy bill, which has some very serious problems, may spell the end of the Exchange and at least would result in no funding for

some of these things. So far the assumption that there will be no major changes, but if this changes we may have a lot of work to do.

Today we are looking at some of the issues relating to affordability and reinsurance. Staff sent around some analyses.

Our next meeting is October 2nd at 4 p.m. At that time we should have a better idea of what is going on in Congress. We had hoped that some of the bipartisan discussions would bear fruit; the discussions have stopped for now, but may be revived in the future.

As we turn to reinsurance and market stability, the discussion is focused on individual market, and not on SHOP.

Debbie Curtis (HBX): Administration did pay September CSR payments. The Administration continues to say they are not sure they will pay them again, but each month so far they have been paid.

Affordability

Purvee Kempf (HBX): Starting with local reinsurance discussion.

Many states around the country, including the District, continue to support a permanent federal reinsurance program. What we are discussing is for a temporary purpose, looking to do something locally while there is no permanent federal reinsurance program. Whatever dollars we discuss, will be a question for Council and other District leaders to decide where to find funding while also looking at other programs. We are focusing on policy, and putting forth anything we think might be useful for District leaders to consider.

Based on previous discussion, we have taken a condition based reinsurance program off the table. We dug deeper into other types of reinsurance programs and asked Oliver Wyman to do an analysis. These calculations are back-of-the-envelope type estimates on the amount of dollars it would take for insurance premiums to come down by a certain percentage. The analysis is posted on our website.

The first two proposals are of the first type, bringing down claims for the carriers. Traditional reinsurance programs use attachment points. This is based on claims data per member and based on that claims data there would be reimbursements to carriers.

We are trying to estimate a 20% claims reduction, which could be a relative number of expected premium adjustments down, but not perfectly. The cost estimate is around $14.8 million – $17.7 million, based on 2018 data, projected forward. We know the numbers are not perfect.

The second type of reinsurance is based on aggregated data, not based on claims per member.

Both types are claims based and would result in a reduction in premium during the filing season. Neither of these would be able to be put into effect for plan year 2018; it would be for plan year 2019 because the legislation would need to be put into place. Then the carriers would know what to expect, then carriers would built it into their rates.

Curtis: Tammy is participating in this work group as an individual, and she is also working on the analysis as part of her work for HBX.

Tomczyk: Clarified that this work was not done by me but by a colleague. My role on the working group is not as a consultant to HBX but as an interested party.

Kempf: Regarding the pros of the proposal, claims by member, carriers have done this with already with the federal government in 2014, 2015 and 2016, so there is experience with this method. Also there is some ability to adjust the attachment point to hit the right number. There is an ability to cap payments and risk to the district.

Cons- there is a double counting that is hard to avoid. Carriers may get the benefits of both risk adjustment and reinsurance for the same members' claims.

Metz: Regarding double counting, are you referring to coding and the adjustment for high cost claims?

Tomczyk: If you have two carriers and first carrier attracts consumer that are sicker, if first reimbursed under reinsurance and then on top of that under risk adjustment carrier B has to transfer money to A.

Metz: My understanding is that the federal program, risk adjustment feeds into reinsurance.

Curtis: That only works when both programs are run by the federal government. The issue here is that one would be run by the federal government and the other locally.

Metz: How do you envision a claims-based program being operationalized?

Tomczyk: You trade off simplicity for precision. We wanted to keep it simple, hopefully with the assumption that it is temporary. If law would pass, and there were state program, would you want to invest in a complex program. I assume the local program could not interact with the federal risk adjustment program. Carriers would submit claims information with some amount of

run out from the end of the year, claims at member level, and then set the parameters of the program (e.g. will pay 80% of claims between $50,000 and $200,000). The calculation is relatively simple, and you should have a reconciliation process to validate claims.

Ku: Since time is short for some people maybe we should not get into the details and technical issues so we can discuss the policy issues. If there is interest in this idea, can have more technical discussion with the carriers in the future.

Kempf: We should remember that we cannot put all operational details into legislation, but it does make a difference what the operational details are. Let's have some of that discussion, even if off line, just to give you a sense of the program. It might not be necessary for each member of the working group. Whatever we do, our goal is simplicity, and to minimize cost for carriers and us.

Other cons, risk of misestimating. Going to be true in both of these programs because you are guessing what claims will be and who your consumers are. When carriers are filing rates, carriers will need to take this into account and build in some cushion when setting rate. Because of this risk, we would not see the full 20% reflected in District rates.

Kempf: 1332 waivers .We did verify that it would be cost prohibitive to do a 1332 waiver in the District. Noting that MN was working on an attachment point reinsurance program through a waiver, MN followed all advice from the federal government in creating its application for the waiver, but at the very end, MN was told that it would get a greater reduction in the basic health program and not the amount set forth in waiver application. MN governor is calling this a bait and switch. It shows the uncertainty of 1332 waiver process and the cost of doing one.

In both of these programs, the District would not recoup the costs from the federal government. We are relying on carriers to determine what the premium reduction would end up being.

Kempf: Second type – we would be reimbursing for claims at an aggregate level, based on the total claims volume for carriers. It is more simplified and predictable because doing at aggregate level. There would not be double counting. Flexibility allowed here in making adjustments to reimbursements. Also ability to cap the risk, e.g. District could set a total amount and put in measures to limit spending to meet that cap. Then a carrier would then see how much it is at risk if the District capped its risk.

The numbers are the same for both methods - $14.8 million – $17.7 million for 20% premium reduction. The cons are similar to the first method.
Administration is somewhat more simplified with the second approach. A lot of this data is already filed by the carriers, for example for the medical loss ratio (MLR) requirements. There

may be a way to use current filings, but some timing issues with the when the MLR data is filed. There may be the ability to use data that is currently being collected by carriers. There will be some questions about how to validate data.

Ku: What might help, what is the approximate level of reinsurance payments made by federal government.

Kempf: Federal government made reinsurance payments in 2014-2016.In aggregate, District carriers were paid $4.2 million in 2016 data in the individual market.

One of the purposes of reinsurance is to protect carriers from large unexpected losses. The range of carrier losses in 2016 was from $6.4 million to $11 million.

Ku: Let's move on to the other option. Helpful to talk about the scope of payments and losses we are talking about.

Kempf: The third type of program is direct premium reductions, sending money to the carriers to reduce premiums. Pros include a guaranteed reduction in premium. It could be worked out so that you are not supplanting the APTC amounts. Could make decision to allow someone to get this on top of APTC or not.

There is an ability to cap the risk if we want. Can set a dollar amount to be used for premium reduction. Carriers would make decisions based on who enrolls and how many. It could be coordinated with risk adjustment such that there is no double counting.

Timing – if we want to try to do something for plan year 2018, if concerned about the costs for next year and keeping people in the market. This is the one option that could be implemented for 2018.

Metz: Strongly disagree that implementable for 2018. Would require 834 change. Thinks this is the most complex to implement. Saying that if they expect carriers to provide this to consumers in the form of premium reductions, would need to implement data process to support this.

Kempf: If this is really is an operational hurdle, might not be able to implement for 2018. Would have a higher cost, relative to other types of reinsurance, because other types are focused on paying claims. Direct premium reduction is paying dollar for dollar on both claims and administration, whereas other types are just paying on claims, so not paying on administrative costs.

It would cost $17.4-$17.6 million to get a 20% premium reduction.

Large possibility of claims volatility depending on who enrolls.

We will take steps to set up operational meeting on premium reduction program.

Aside from operational discussion, are there strong preferences for one type of program vs the other?

Metz: We are supportive of a reinsurance program, but need to have discussion around operational concerns. Thinks they would be better off weighing in on which type is better between 1 and 2 in an operational discussion. Most concerns are regarding options 3.Would impact notices and 834s. Also customer education/awareness.

Curtis: MN is doing it now. Could Rob at CareFirst check with the blues carrier in MN about how it was working. Re notices, would just add a line to notices to account for the DC premium.

Sarah Bagge (HBX): Notices are not that hard to update but 834s could be.

Kempf: If there is a desire to do this in 2018, we might want to look at what MN has done.MN did this in 2017 and trying for an attachment point reinsurance program for 2018. We may want to consider this approach as an option, so we want have something in place in the more immediate future. Consumer will drop out of coverage during the year if they have an inability to pay, so this is something we should at least consider.

Once we have more operational information, we can try to send out to working group. At least we can raise it at another working group meeting.

CSR Wrap

Kempf: We had sent out information on types of these programs. One was implemented in MA prior to passage of the ACA. It had a subsidy program before the ACA. Second one was in VT.

Alex Alonso (HBX): Massachusetts had a Medicaid-based program prior to the ACA. Post ACA MA implemented the MA health connector. Program buys down for consumers up to 300% FPL. Use the federal subsidies and then have a state-specific subsidy that applies on top of federal program. For consumers some get down to a 0 premium. Highest is $128 per month.

Curtis: MA took old program and merged with ACA and are able to provide really strong subsidies to consumers in the state in a subset of their exchange. Includes a lot of federal waivers that pre-date the ACA. Complex administration that is not something we can likely replicate.

Alonso: Vermont has a subsidy wrap around. Not a tax credit. Uses ACA framework for APTC but then have a flat add-on to expected contribution rate. VT adjusts by 1.5 points bringing the expected contribution rates down by that amount for everyone.

Kempf: Explained that in DC a lot of consumers are eligible for subsidies, but they do not get any tax credit because premiums in DC are below the expected contribution rates. In DC, with an adjustment, people who are getting APTC in amount of 0 could then get something in subsidies. Would especially help lower income people and could possibly help younger people. Right now younger people in DC frequently do not see any benefit from APTC.

Alonso: Some people at 250% may be eligible but they do not get any APTC under current affordability standards.

Curtis: with APTC you have to reconcile with your taxes. The VT program is not something that needs to be reported or reconciled with the federal government or on state taxes. This is not something that would need to be repaid if there is a change of income.

Alonso: VT is up to 300% (APTC is up to 400%).

VT CSR program did not change anything for people below 200%. It created adjustments for people between 200%-300%. They increased AV for consumers that is fully covered by the states.

Kempf: State is making CSR payments more robust and making more people eligible for them.

Curtis: We have around 900 people getting APTC. 300 getting CSRs. More people in DC would be eligible but they are getting $0 on APTC. We could increase the number of people in DC getting a benefit. Where does the group want to focus? We know that affordability is an issue.

Nichol: Anything we can do to help with affordability is needed. Seeing people that are under 400% FPL with the choice of enrollment and the plan they choose is based on affordability and they are not getting APTC.

Ku: Would focus on lower end of the income scale. One thing that is concerning, we have a generous Medicaid program, so Medicaid is making coverage free for these consumers. But people not eligible for that coverage can be expensive. Big bump in costs for people just above the Medicaid eligibility levels. Go from paying nothing to having to pay maybe $150+ per month for insurance.

Metz: What would that change look like from a carrier perspective. An APTC wrap you are looking at 834 changes. If looking at CSR changes, this would require a substantial administrative lift.

Kempf: We did not think that this is something we could do for 2018. If we want to do this, we would have to be looking at 2019 or later.

Nichol: In talking about individual responsibility – who is paying this. In 2015 it was between 250-500 FPL. Where people may not be buying because of immigration status or affordability. Might want to use these figures as a data point.

Kwarciany: DC uninsured rates – seeing that highest uninsured rates in DC were between 138-400 FPL under the new census data. Above that you see lower uninsured.

Kempf: Data on people with household income $25,000-$50,000 pay the highest IVL mandate – have close to 3000 people paying IVL responsibility payments.

Curtis: Pointing out that in 2016 census data showing that cost is a factor in who is uninsured in the District.

Ku: Reminder: there have always been discrepancies among various data reports.

Curtis: What we are hearing here is that there is interest in trying to help. Meeting separately with carriers to see if there is a way to do this in a way that is not unduly burdensome or expensive. To Dr. Ku's point, if we can do this in a way to help people who are coming off of Medicaid, because there is a big cliff in DC for those people because federal subsidies do not fill that gap.

Kempf: We will see if we can put together some numbers based on where things are today.

Curtis: These will be playdoh numbers, not concrete, but we will do what we can.

Kempf: Deborah F was able to pull some information

Deborah Freis (OCFO): Spoke to OTR about adding reporting on the district tax form. Adding a line on whether they owed something to the federal government for individual mandate. Looking at $100,000 of upfront costs, including form printing, systems changes and communications from tax office. If took something to Council this year, would be a 2018 cost. $250,000 per year in additional staffing costs for each year after 2018. It is about $1.1 million over 4 years.

Kempf: Remember, we need base year plus three operating years to bring to Council.

Ku: Critical for Oct 2nd meeting, try to vote on some of these issues. Sent around draft language on three issues. Planning to try to vote on Oct 2nd and if there is time, may have some more discussion around reinsurance and subsidies. We will also know more about Graham- Cassidy by then.

Curtis: We will get together with the carriers and will try to send out more information or at least be ready for discussion next time.