ACA WG
1/23/18
Notes

Roll Call

Present
Leighton Ku
Jodi Kwarziany
Colette Chichester
Robert Metz
Robert Axelrod
Kevin Wrege
Kristen Hathaway
Justin Palmer
Patricia Quinn
Katie Nicol
Tammy Tomczyk
Peter Rankin

Absent
Dave Chandra
Dania Palanker
Margaret Singleton
Carl Chapman
Jenny Sullivan
Donna Alcorn
Carolyn Rudd
Jnatel Sims

Welcome and Intro to Presenters
Leighton Ku (Chair): Welcome to special guests. We're continuing our discussion about what DC's response should be to loss of federal responsibility payment under the tax bill.

We have a strong meeting today with three presenters: 1) Audrey Gasteier who is chief of policy and strategy for MA connector. She's on the phone. MA helped kick all this off when it passed its own health reform law that became the base for the ACA. We've learned a lot from them, and Audrey will talk more about how the individual responsibility payment worked for MA. 2) Jason Levitis. He worked in the Treasury department under the Obama administration at implementing the individual mandate. He currently helps states like DC through consulting work. 3) Stan Dorn will talk about proposals from MD. He's arriving late so I'll introduce him later.

Presentation: MA's Experience with a State Individual Mandate
Slides are on the website.

Audrey Gasteier (MA Health Connector): Thanks for the opportunity to share. I'm joined by our General Counsel, Ed Deangelo, Director of Policy and Applied Research, Marissa Woltmann, and Steve Dukeman from our state's department of revenue. In the presentation we'll talk about the background to origins of mandate and policy components which are predominately governed by the Health Connector.

Background on MA individual mandate – it was a key feature of our landmark health reform passed in 2006. Was paired with other policy advancements – we established the Exchange, expanded subsidies for people up to 300% FPL and some others. Mandate was administered through state income tax process. Dept of Revenue led that effort. Mandate went into effect July 1, 2007, a little over 12 months between when law was passed. We worked with a lot of community based partners and businesses as we rolled out the mandate since it was a new concept at the time. Compliance with mandate has been very high and only applies to adults. For 2015, only 3% of adult tax filers reported that they did not have coverage that met state standards.

Policy components of our individual mandate fall into 3 buckets:

1. Coverage standards
2. Affordability standards
3. Penalty amounts and exemption standards

Ed will talk about coverage standards.

Ed Deangelo (MA Health Connector): We have minimum standards set by board of directors back in 07 and 08 and they have been updated once since the ACA was passed. The big areas that our standards deal with are what benefits have to be covered and cost-sharing; establishing ceilings for cost-sharing. Some plans/programs would meet categorical standards – Medicaid, Medicare, and others. Standards for cost sharing - deductibles are capped at 2000 or 4000 for family coverage. Prescriptions capped at 250 or 500. Also you can't have annual limits for any of the core benefits. We also have a list of core benefits that have to be covered; they're largely prescribed by the ACA. Some plans may deviate from that, but if they don't cover the core benefits they can't qualify as MEC. They will be deemed compliant if they can demonstrate that they have an actuarial value that is at least as good as the lowest cost bronze plan. We have a process where plans that fall in this bucket that don't meet the other standards can apply to be certified by stating their deviation and by providing an actuarial certification of an AV above 60% using federal AV calculator. That said, certain deviations are not permissible no matter what. High deductible health plans will meet min coverage standards if it's coupled with an HSA.

Marissa will talk about affordability standards.

Marissa Woltmann (MA Health Connector): We have an affordability schedule which is a tool to help people figure out if they'll have to pay a penalty for going without coverage. Each year our Board sets a percentage of income that it determines is reasonable for a family to spend on health insurance. If the family had access that met those standards but failed to enroll in it

they would have to pay a penalty. If the coverage cost more than what is considered reasonable they would not have to pay the penalty. We align our affordability with the premiums that we set for our plans. We have a program called connector care that supplements federal subsidies for premiums and cost-sharing.

Penalties -- Our penalties are progressive with income. Up to 300% FPL we use half of the subsidized premium that's available in those income brackets, and for people over 300% FPL we use half the cost of a bronze plan (or cat plan). MA HC adopted policy when federal mandate went into effect to deduct federal penalty amount from state level penalty so people weren't double penalized.

Hardships – People can be exempt from penalty on hardship grounds. Tax payers would go through the schedule HC tax form that asks about their coverage and if they get to the end and have a penalty, they can check a box saying they'd like to appeal the penalty and apply for a hardship exemption.

Reporting and Admin -- MA sends forms to customers to let them know how many months they've been covered – must be 15 days, not 1 like federal standard. They're also sent to Dept. of Revenue.

Audrey Gasteier (MA Health Connector): Wanted to touch on secondary benefits of having state level mandate. Outreach has improved. Also note for the purposes of the way people report on their tax reform, somebody with no coverage is the same as someone receiving employer-sponsored coverage so we treat them the same. We get great data from those who are paying penalty. Dept of Revenue sends out mailers that MA Health Connector develops to people who have been uninsured the entire year with messages that we think will help resonate. We're interested in doing deeper analysis to link someone who may have gotten a letter and someone who came to us and enrolled.

MCC applies to the entire market – 4 million adults in MA – about what they need to carry to not be penalized. EHC applies to non-group and small group market –it's a common benefits floor no matter where you get your coverage. Helped us determine the kind of coverage we find meaningful in our state.

Mandate not developed to generate revenue, but does. Generates 18 million on average on an annual basis. This money goes into Commonwealth Trust Fund – established as part of our law -- it includes employer contributions and revenue from tobacco tax. Funding from trust fund goes into funding a state wrap – ConnectorCcare. So that money goes back into making coverage affordable for people. All together when we tend to think about our coverage revenue in our state, we think about the mandate.

How did state react to mandate and continues to react? This is sort of a nonstory. Mandate rolled out in 2007 and I think people were braced for more controversy and push back, it got rolled out at the same time as a lot of other big pieces. Not a lot of tumult around rollout and that has continued to be the story.

Ex: when we revise regulations or revise affordability schedule, we don't hear much. With respect to hard data – polling data done by Boston Globe and Harvard Public Health School, there is pretty robust support for health reform in MA. Mandate is slightly less popular but still has enough support to keep it moving forward. Most recent data from this is from 2014.

Leighton Ku (Chair): Thanks Audrey, Ed and Marissa. Let's go to Jason.

Presentation: Considerations for an Individual Mandate for the District of Columbia
Slides are on the website

Jason Levitis: I'm here to talk about an approach that DC could take to implement an individual mandate. I'm going to run through a different approach than MA took - the federal mandate approach, taking the fed mandate and restoring it as the baseline approach that a state could start with to build off of. In broad outlines, the fed and MA are quite similar. Both implemented through tax system, have similar MEC and exemptions for low income people, and hardships and penalties, getting higher for higher income people. Both have reporting requirements for providers and coverage providers – saying who was covered and for what months and that goes to tax and revenue office. On the margin there are specific differences along all of those axes. Not here to tell you the federal model works better.

Reasons to consider starting with the fed mandate as a model and baseline:

1) It's familiar. Provides continuity given the short implementation timeline DC is going to face if mandate is implemented in 2019 or 2020. There are a lot of components to this that need to come together. Stakeholders are already familiar with fed rules so easier to go with something familiar, would maximize continuity while potentially departing in some places, I think offers some benefit. That's the main reason to consider.
2) Would simplify legislative drafting. Could implement fed mandate through process called conformity. For ex, 27 states define AGI by reference to federal AGI. It also simplifies implementation/incorporation of guidance.
3) Potentially also some political reasons. Re-imposing fed mandate payment does allow one to say we are maintaining the status quo instead of creating whole new set of winners and losers, which could lead to re-litigation of new rules.

There are 3 big components of fed individual mandate:

1) Definition of qualifying coverage
2) Exemptions
3) Penalty Calculation

Reporting requirements of fed mandate (there are 2 different ones):

1. Coverage reporting requirements that applies to insurers, coverage providers
2. Employer coverage requirements, and is a bit more complicated and includes info about offer that was made, how much people have to pay and which family members were offered coverage.

Note that third party reporting greatly increases compliance. Even if it isn't perfect, the fact that reporting exists seems to have a big impact on compliance. While fed mandate is repealed, reporting requirement is still on the books. So the simplest thing to do here, is to say the same info that is reported for the fed requirement can be used here. If that statement is already being sent to the individual, you don't have to send a second one as a state requirement.

Again sticking with fed system, issuers don't need to change anything. For example, 1 day of coverage vs. 15 day rules – insurers would have to change their systems to accommodate changes like that.

Changes need to be made to fed system about who is required to report because states don't have the authority to require Medicaid and Medicare to report to the state. So that will be a whole new reporting set up.

Procedures for granting exemptions:
Most exemptions claimed on tax reform – for some of them (specifically, hardship and religious) Congress made the judgement that the marketplace would be in a place to make the judgement call on those request, over the IRS. States should continue that.

Notification of uninsured about coverage options:
ACA includes requirement where IRS sends letters to people who say they didn't enroll informing them of coverage options. IRS did it for one year and stopped. Also, IRS has not been willing to share that info directly with states so they can do that outreach themselves. So there is definitely a real value that can be had out of having state mandate as MA touched on.

Some areas to consider optional changes to Fed/MA rules –

1) Addressing substandard plans
   Examples: Fed govt is considering loosening rules for AHP's grandfather plans which don't meet all the government requirements and undermines market by pulling healthier people out of individual market; Healthcare sharing ministries which are not a form of coverage -- they're a club a person can join where the group can promise to reimburse the member for healthcare costs -- ACA includes an exemption for people who are members of these groups; Employer market doesn't need to provide all the essential health benefits. So there is some flexibility here to adjust what qualifies. Here, you can say that 1) that's not coverage or 2) they can apply to be coverage.

   OR

   Require that certain types of coverage have to meet certain requirements to meet mandate. Ex: AHP could be MEC but has to meet certain specific ACA reforms. MA uses a combination of these.

2) Interaction with fed mandate penalty
   MA passed rule to avoid people having to double pay. If you're paying fed mandate you can take a credit against that for the state mandate. If federal mandate comes back, no one

double pays you can still get benefit of ppl paying the higher amount if it's higher than fed penalty.

3) Penalty amounts and exemption rules
   I think there's a technical flaw in the affordability exemption that I could talk more about later. Fed penalty is generally a little higher at low incomes and much higher at higher incomes, those are things you can dial.

Leighton Ku (Chair): Let's open it up for questions. Start with people on the phone.

Linda Wharton-Boyd (HBX): For MA, can you talk about the affordability message and the data that was acquired in order to shape the messaging? Specifically, which firms you used and which pieces of info you used?

Audrey Gasteier (MA Health Connector): We did not use a firm. We've done some polling, surveys to find out why people are uninsured and we find that people say it costs too much. So if you put info in a message about how affordable it is, they become interested. Predominantly low income people are uninsured and they would qualify for help or free coverage.

Robert Metz (CareFirst): Could you speak to how much of your discussion was put in legislation rather than regulation. I believe a lot of this is also in rule making.

Ed Deangelo (MA Health Connector): Basic structure was legislative, created obligation to have insurance if it was affordable or met standards. Then delegated to board to establish what was affordable and what was considered minimum standards. Categorically qualified coverage was listed in legislations. So actual standards themselves, caps, cost-sharing, was all by regulation and was adopted after notice and comment. Rules around waivers of penalty is also by regulation, so people can appeal their penalty. Religious exemption is a statute, not regulation. Affordability schedule is a sub regulatory process. Every year board establishes after public comment, a grid of what dollar figure is considered affordable for premiums at each income year. Biggest regulatory list was coming up with the minimum coverage standards, and was the densest.

Audrey Gasteier (MA Health Connector): We can send Chapter 58 statute and legislation. I wasn't here at the time but heard that one of the biggest sticking points was around inclusion of prescription drug coverage. Some of statutory language is both precise and open. All penalties are tagged to lowest cost plan you could get from the health connector.

Jason Levitis: Similar at federal level, but more is written into statute. Affordability schedule is statute. In terms of coverage standards that are included in MA min coverage standards -- the ACA doesn't include those. ACA made the market rules apply separately.

Alice Weiss (DHCF): How many tax payers are paying the penalty in MA? Do you know what percentage of tax payers would be eligible for a plan?

Audrey Gasteier (MA Health Connector): We can do that, but we don't have it handy, but for a frame of reference there are about 4 million adult tax filers in the state.

Alice Weiss (DHCF): With respect to affordability schedule, how did you arrive at those percentages of income and wondering if you've heard push back or concern for the upper end of that being unaffordable?

Audrey Gasteier (MA Health Connector): We keep our affordability schedule in line with our subsidized premiums. They were developed hand in hand at the outset as well. Things that went into determining what we would charge our lower income residents were the cost of other plans – we tried to figure out what people could pay. Tried to figure out what other essentials cost like housing and food and how much people had left over to spend on healthcare. Since board approved standards they have stayed stable. As part of transition to ACA we shifted to a percentage of income schedule which allows for progressivity. It's a bit funky where we try to align for the dollar amount that we charge for a premium. We do a little retro engineering to make sure that premiums are affordable for everyone in a given bracket which helps drive those percentages now. Between 300-400% FPL we're looking at numbers that are in the 7%ish range.

Kristen Hathaway (AHIP): Were there smaller items that you weren't expecting when you got into the implementation phase, anything you didn't' foresee that surprised you?

Audrey Gasteier (MA Health Connector): One of the dimensions of MCC certification for plans seeking certification, there started to be a theme having to do with benefits applying to everyone included on the plan -- we would see maternity benefits for dependent of subscriber not being covered. That was an out of the box violation for us we didn't expect to see.

Ed Deangelo (MA Health Connector): We had a couple of years to design the whole tax reporting process. Biggest uncertainty for not knowing the numbers – how many appeals there would be and how long it would take to process those. Uncertainty more than things that surprised. In a way, surprised by high level of compliance we got without friction.

Steve Dukeman (MA Office of Tax and Revenue): We built a solution that would allow carriers to send us data but had a lot of small carriers where that tech was beyond them, which was an unanticipated problem for us. Communicating with multiple carriers systems was a big challenge.

Jason Levitis: Echo Steve's concern about communication between systems. We had IRS systems that are very old and getting those systems to talk to the marketplace systems, each with its own set of systems was our biggest challenge. Constant source of entertaining challenges, dealing with entrenched institutional habits.

Leighton Ku (Chair): Comes up any time any state comes up with a tax. You have a tax in DC but there's not an equivalent tax in VA – was there evidence in MA that people fled after this tax was imposed?

Audrey Gasteier (MA Health Connector): We have never seen any evidence of that. In all of our many policy conversations with so many stakeholder groups – that kind of question bubbled up in 2012 when MA and NY convened stakeholder group to debate whether to keep state mandate on books. We did. Could argue MA mandate is more stringent than fed mandate in some ways. I don't think people who wanted to make that argument had any evidence that that happened.

Leighton Ku (Chair): This came up in CBO analysis when they were anticipating impact. Why would there be a reduction in Medicaid since Medicaid is already free? Did mandate affect Medicaid participation?

Audrey Gasteier (MA Health Connector): It was more like a rising tide that lifted everything up. Everything happened all at once in MA – the whole convo in MA was about health coverage. Medicaid enrollment did grow, and we thought that with Medicaid expansion which took people out of subsidized coverage and put them into Medicaid, there was even more growth in Medicaid. People are more interested and more likely to come forward when there is a mandate. All those tools working together do make a difference.

Leighton Ku (Chair): My recollection is that ESC also rose during that period. Reasonable to assume you take the mandate away and the reverse happens. Jason, you mentioned the tax bill did away with mandate by lowering penalty to 0 but there is still a fed reporting requirement. Do people still expect IRS or Treasury to enforce that given climate of Trump admin?

Jason Levitis: I would not be surprised to see IRS try to do away with that requirement. The sense I continue to have, IRS is really insulated from the changes that we've seen in other places. You saw this with the silent return saga – first said they wouldn't take them, then that they would, now they won't again. As states look at mandates, there are other uses to federal mandate to consider. Decent case that fed mandate should be maintained. Even if it were to go away, insurers and providers have already built the system to do this kind of reporting so it would be easier for them to continue this and send it to a different place.

Debbie Curtis (HBX): So we should be using the fed reporting but drafting it into local statute so if it goes away at fed level we're still protected; that's the safest scenario.

Alex Alonso (HBX): In order to get catastrophic coverage if you're 30 years or older you would have to have an exemption from the individual mandate – one thing that was going to be removed but didn't passed Senate. Was not removed when penalty was zero'd out, so presumably you would need an exemption to get a catastrophic plan.

Jason Levitis: At fed level, catastrophic plans haven't been as meaningful a thing as it has in some states. It's not always cheaper than a bronze plan, which may create space to do things differently. When faced in a situation like that where remaining statutory structure doesn't fit together I wouldn't be shocked if the federal government came up with a new set of rules saying we're not going to administer hardship exemptions anymore, but here are alternate rules for people to get cat plans.

Patricia Quinn (DCPCA): Was legislation around cost containment linked to individual mandate and insurance reform or were they separate?

Audrey Gasteier (MA Health Connector): Several years after chapter 58, the state passed a cost containment law that established the health policy commission which was designed to monitor cost containment and hold state to a benchmark, and they do a lot more. They were independent mechanically and completely, but I do think that one follows the other. It was a big part of political dialogue around passage of chapter 58 which focused on expansion and people were scared about costs. Let's bring everyone in, expand coverage, and then really try to tackle cost. They were independent. Over time, there are hopes that the type of policy recommendations that will influence the type of coverage that we offer.

Jodi Kwarziany (Vice Chair): The decision to exempt children from MA mandate is a departure from fed mandate – was there an intended welcome mat effect?

Ed Deangelo (MA Health Connector): At the point the law was passed CHIP was in place, so a lot of kids were already covered. Some sense that uninsured children were less likely to be in the population of uninsured. Coverage rate prior to Chapter 58 was 99%. Because insurance mandate applied to adults, the idea was that if you get adults insured, children would also be insured. We didn't want to pile penalty onto families. There was also a feeling that children didn't need to be a target for this because of CHIP expansion. Created a subsidized plan for adults already up to 300% FPL.

Leighton Ku (Chair): Concluding presentations about MA. Turning to Stan Dorn – Senior fellow at Families USA. Talking about proposals that have come up in MD. Want to talk data after, but may have to wait until next meeting.

Presentation: Health Insurance Down Payments Would Cover Thousands of Uninsured in Maryland

Fact Sheet is on the website.

Stan Dorn (Families USA): Thanks Leighton. This is the approach we are pursuing in MD. Basic goal as with individual mandate requirement is to encourage healthy people to enroll and keep premiums low for people who lack subsidies. We're hoping this approach were thinking about will help enroll healthy people. There are 4 components/intervention points for enrollment retention we're talking about in MD and they may be modular (some may fit MD better than DC or vice versa:

1. Pre- payment – If a customer went without insurance over the course of the last year, they could use a calculator to determine what their penalty would be next year. Then they could take that payment and use it to enroll insurance. This pre-payment is subtracted from taxes when they file.
2. Tax time – this is all layered on top of a state mandate. The tax form would do 3 things: 1) ask if customer is insured 2) If yes, ask if you're willing to share your information so we can send you mailers and 3)let people just pay the penalty without having it go toward health insurance

3. Down Payment – If customer didn't use the payment to enroll during OE at tax time we let them know that they have X amount to go toward health insurance and if they don't use it they lose it
4. Retention – Could divide the credit lump sum into a 12 payments – 1 for each month. We use this to retain consumer – helps keep them in the market because part of the monthly payment is already covered

We're trying to use the fallacy of sunk cost to our advantage. We are learning at lightning speed; this proposal is in flux so some things could change, but we think this idea is going to help a lot of Marylanders get enrolled or Medicaid where they didn't have health coverage before.

Leighton Ku (Chair): Any questions from people on the phone?

Unknown: What's the temp from a political perspective in MD?

Stan Dorn (Families USA): A lot of people understand we need to keep the mandate. Message is that we're not penalizing people; we're helping people get health insurance. We've gotten very positive reactions from a lot of legislators in MD. Governor has said he's interested in seeing more.

Jacqueline Watson (DOH): From a health literacy perspective, what do you think are people's ability to navigate what you just said? From a first listen, sounds extremely complicated.

Stan Dorn (Families USA): The description I provided are the policy mechanics of the proposal – the mechanics are complex just as the ACA's are complex. There are a million layers that are very complicated and confusing. Yes, we would make it more complex by implementing this. Resources we have in place to translate the complexities of ACA are a huge component of this. We would need to break it down into digestible components. It's simple to say, you can get health insurance now instead of paying a penalty. I don't expect that it would be widely understood in year 1.

Robert Metz (CareFirst): I agree that we need to take the money from mandate in order to help people afford coverage and it seems that the question is how. We had discussions to use that for state subsidy wrap and reinsurance, and we know that we could bake that into rates for 2019. Do you have data to support what the rate impact would be of this proposal?

Stan Dorn (Families USA): Penalty payments could not go toward reinsurance in 2019. Basic question you're raising is if a MD household owes money – is it better for them to use that money to afford coverage or go into reinsurance. We've seen how reinsurance works, but we haven't seen how this works so we are trying to simulate this. We know that premiums are high in individual market because people don't enroll so were trying to change that.

Robert Metz (CareFirst): Money for reinsurance should be looped through to help people afford coverage – do we give it back to people or does it get sprinkled on to top?

Debbie Curtis (HBX): To be clear, the ACA WG recommendations were reinsurance AND an APTC wrap that specifically targeted people especially when they are coming off of Medicaid in DC.

Leighton Ku (Chair): We are passed 1 pm. Next meeting is at 9:30 next Tuesday. Any last minute announcements?

Purvee Kempf (HBX): If anyone has questions, send them to us. We'll try to have data at the next meeting. We'll kick next meeting off with data and talking about underpinnings.

Leighton Ku (Chair): I'd like to suggest a slight modification to that plan. Can we have staff work on an initial proposal for state individual mandate, with some basic concepts, just as a place holder to activate a discussion. I'm mindful that some people may need to go back to their colleagues to get consensus.

Alice Weiss (DHCF): We've heard a lot and I think it would be helpful to see a policy matrix with different options and choices and what rational would be for making a particular choice. It would be helpful to have more discussion about the plausible options that could work for our unique needs in the district.

Purvee Kempf (HBX): We'll go ahead and do that.

Leighton Ku (Chair): Adjourning. See you all at the next meeting.