ACA WG
1/30/18
Notes

Roll Call

Present
Leighton Ku
Jodi Kwarziany
Robert Metz
Colette Chichester
Robert Axelrod
Kevin Wrege
Liam Steadman
Justin Palmer
Margaret Singleton
Jenny Sullivan
Katie Nicol
Carolyn Rudd
Tammy Tomczyk
Peter Rankin
Jnatel Sims
John Xu

Absent
Dave Chandra
Dania Palanker
Carl Chapman
Donna Alcorn
Maria Gomez

Welcome
Leighton Ku: We've had a couple of meetings, now we'd like to begin to discuss some of the more serious options. We want to discuss those key issues. We want to have some more substantive contact about what should be done. Want to discuss some data right now.

Debbie Curtis (HBX): This convo will refer to a lot of the handouts we have today. We will wait on DHCF data until Alice gets here. Let's start with HBX enrollment data. The data we've been reporting during OE is plan selection data which is different than enrollment data. We've got about 76,000 in our SHOP market, around 17k in IVL so a total of about 94k people covered through DC Health Link. We have a predominately young exchange. The vast majority of ppl in our individual market are covered in self-only plans. Our SHOP market, similarly is broken down by age and that also seems to be on the younger side. We have a lot more family coverage through SHOP than IVL. Note that about 11k of SHOP are Congress.

Leighton Ku: OE is still happening.

Purvee Kempf (HBX): Call center is open. Let anyone you know in DC that they can still enroll -- Don't delay! Enroll today!

Leighton Ku: Jodi will talk about the uninsured in DC.

Jodi Kwarziany (Vice Chair): This is a straightforward and numerical guide on what uninsured rates in the district look like. At the top we see civilian noninstitutionalized pop refers to overall population. For 2009 and 2010, the numbers under 138 and up to 1999 are pulled into another chart below that. Throughout the census has become more interested in ACA data and how they determine their income levels. Looking at the graph, over time since 2010, 2011 we have seen a decrease in the rate of uninsured in the district. It shows us not only how the uninsured have fared, but gives us an idea of what we can anticipate without a mandate. For those above 200 of FPL.

Jay Melder (DMHHS): Is there any explanation for the slight up tick in uninsured rate from 2015 to 2016?

Jodi Kwarziany: I don't know.

Leighton Ku: Possibility for this income range, the under 138 FPL – they're all in Medicaid, unless there is an aberration that makes it more difficult for people to get Medicaid.

Deborah Fries: Doesn't that cover 138 – 199 pop?

Debbie Curtis: yes

Jodi Kwarziany: About 26,000 uninsured in DC. This includes people who are both eligible and not eligible for Medicaid.

Debbie Curtis: Great point. Not all of the uninsured are eligible. The other things I want to highlight is looking at DC we wanted to come up with something like our own CBO score to see what the impact would be of eliminating the mandate. We want to know what impact that would have in premiums in DC. Hope to have that info on Friday. DOH is pulling data together, data on uncompensated care. Hospitals are helping with that. With that, Alice will talk about enrollment in Medicaid.

Alice Weiss (DHCF): Referring to DC DHCF's Monthly Enrollment Report from Dec 2017. This is our most recent eligibility report. Monthly enrollment report we provide to medical care advisory committee. We have that meeting monthly. Initial interest was in alliance and childless adult pop. Most recent estimates are from the December meeting, and because of claims lag our most recent data are from August. Total enrollment in Medicaid is 258,000 individuals. Alliance program is 16,245 people. I also have John Wedeles on the phone, he's the associate director for division of analytics and policy. John - anything you want to add?

John Wedeles (DHCF) – No - I think you covered the high level for the report. We're happy to answer any questions you have.

Leighton Ku: Context here is that though we're meeting under HBX umbrella – effects will be broad, and include Medicaid. I'll kick it off with some questions for framing the discussion. I don't think we'll answer all of these today.

1. Is there support for a DC Mandate?
2. If so, should DC's mandate conform to the federal mandate or should DC create its own unique mandate?
3. Should DC modify any current federal standards for coverage, exemptions, penalties, or operations?
4. Getting a plan ready for 2019 implementation may require that the initial program be as similar as possible to the federal law. If that is necessary, is it possible to consider refinements at a later time?
5. Should DC try to use tax penalties to help individuals purchase coverage, as in the MD proposal?

Those are big questions I hope we'll be able to address in this meeting. At this point, I'll turn it over to Purvee to discuss the policy matrix.

Purvee Kempf (HBX): I'm going to walk you through the document called state based individual mandate discussion matrix. We developed this after the last meeting – there was a lot of information given to folks over the last couple of meetings. We will get through the document – if we don't finish this today, we'll continue on Friday.

What coverage meets the individual mandate?

Large group plans have specified requirements under federal law but not as many as QHP – they don't have mandates essential health benefits coverage. The reason is large group plans which are generally those with over 500 or 1000 – idea is that you have so many people that you're not going to leave out those basic coverage benefits like preventive care. Have to meet minimum actuarial value limit. In MA, they had additional cost-sharing and benefit requirements – our expectation is that most large group plans in MA also meet those guidelines.

High deductible health plans is an animal of the tax code. It's not about benefits its about high deductible - it's a tax savings vehicle. If you put money in that is has a tax preference that allows you to pay for your health care costs. Any out of pocket costs that may now be covered under your plan. Only satisfies MA requirement if the person actually opens the HSA account.

Student health plans meet individual mandate.

ACA grandfathered plans – If you had a plan before ACA and continued having that plan, you are grandfathered into the coverage requirements.

Debbie Curtis (HBX): I don't know if we have grandfathered plans in DC? Does DISB Know?

Howard Liebers (DISB): I'm not sure, I'll have to look into that.

Purvee Kempf (HBX): Alliance is on this list. Don't want us to forget to consider whether Alliance meets requirements. It does not as of now.

Amelia Whitman (DMHHS): I know that association health plans aren't on this list, but I would like to add that to list to discuss whether they are covered and how they are covered.

Purvee Kempf (HBX): Right now states can regulate them in specific ways. There are rules that came out, that if finalized would allow different entities to come together. Does not require a new association to exist – you can pull any group together just for the purpose of getting health insurance. Those plans would be regulated at the federal level as large group plans not as local or small or individual plans. However, they are allowing individuals and small groups to pull them out of their market and into the association health plan market. It's something we're looking very closely at. It will create a lot of confusion, and will open the door for a lot of abuse. Before ACA there were association plans that were 100% scams and people would pay into them and their claims wouldn't get paid and they would close down. Some states did try to regulate them, the way the proposed rule is written it's possible that states would be preempted from regulating state association plans. It's a useful thing to add, but important to note and consider that when you're an individual or small group and someone tells you they can get you into a large group plan it's hard to know whether that meets requirements. We should definitely add it. Also important to note there are no rating requirements for them.

Debbie Curtis (HBX): In MA because there are standards for what you have to be for qualifying for the mandate an association health plan that didn't meet those standards couldn't exist. It's a good example of how you can take action to get around those rules. Another thing we should bring up are short term duration health plans. Howard – I don't know if DISB has data about association health plans or short term duration plans, but would be interested in data about those?

Howard Liebers (DISB): We have info on short term limited duration plans. We don't have currently certification or licensing schema for association health plans like some other states do. They have to get certified by Dept of Insurance so we wouldn't have any info about the last group that came to us to be reviewed about whether or not they're subject to state regulatory authority. I'll pull data on short term limited duration plans.

Alex Alonso (HBX): Just to reemphasize Purvee's point -- even if association health plan fell under the definition of large group plan and we wanted to exclude it, I think the messaging is incredible important. Despite being regulated nationally, they do not meet the DC requirement, and putting out that messaging on our side and not relying on the insurer because these aren't the sort of plans that are serving the needs of the insured.

Jay Melder (DMHHS): Would there be any association plans that would meet our requirement or is this just a low insurance product?

Purvee Kempf (HBX): They could choose to meet whatever requirements they want but because they don't have to we expect that they won't. Maternity, mental health and prescription drugs are 3 big examples of what we expect could go away. And certainly on rating side – rating protections could go away.

Debbie Curtis (HBX): Emphasis is that they are marketing cheaper products. What we know when marketing products we know people look for cheaper opportunities. We see this today -- people get scammed from some nefarious products today.

Howard Liebers (DISB): There are diff forms association plans could take. Emphasis here is that it's a bunch of small groups coming together to look like a large group but then those groups can choose to self fund or they could still be fully insured by an insurance company that we still regulate – they just look like large group coverage.

Alice Weiss (DHCF): Isn't one of the issues that even if it looks like any other plan, but the fact is that there is an option for them to be regulated by DOL and there's no idea of what that regulation would look like.

Howard Liebers (DISB): If they're insured then we have the ability to regulate. States still can regulate to the extent that their fully insured by an insurer. If they self-fund then there is no insurance company licensed by us then it's just a 3rd party admin then we have less authority in these cases.

Leighton Ku (Chair): Because AHP are an unknown enemy they might be varying and some might seem good and comparable to this is part of the challenge that's in this. We don't know what they would look like at this point. We should look to DISB for recommendations about some of this. Even under some of the things we might not think are strong AHP they may provide better coverage than some of the other things on this list like health care sharing ministries.

Stan Dorn (Families USA): Not a question of AHP's it's a question of risk pools. That gets removed from the market and its not pooled together by the other plans. If they manage to have a lot of young and healthy people that will lower their premiums and hurt the rest of the marketplace. One approach to consider was in Jason Levitis proposed bill, it had two approaches:

1. For AHP to constitute MEC it must be part of the individual market regulations and SHOP regulatory framework if sold to small groups
2. Cannot be MEC unless meets criteria of today

Jason Levitis: I think the approaches that Stan mentioned can be really helpful. If there's something new that comes along we would still have ability to do that.

Purvee Kempf (HBX): Quick recap- I think basically idea you could use mandate requirement to help control proliferation of plans that don't meet basic standards and are pulling people outside of risk pools by requiring coverage standards that don't allow the skimpiness. If we were to do anything like that it would be critical some sort of education around it. Having admin

authority to allow some plans that are close to meeting MEC and allowing them to meet mandate through an application or something similar.

Leighton Ku: Let's move onto exemptions from penalty

Purvee Kempf (HBX): We use the word exemption broadly. Some of these categories are not subject to penalty and some are filing for exemption when they file their taxes. We've put them all in one chart for simplicity. They don't have to pay the mandate if they meet one of these pieces.

Short term periods without health coverage – under fed rules if you're uninsured for less than 3 consecutive months you are exempted, which means 2 months and 29 days but if you hit 3 months you are subject to the penalty, and you're subject for all 3 of those months. In MA, if you're uninsured for no more than 3 consecutive months you're exempt, so they let you hit the 3 month mark.

Debbie Curtis (HBX): And in DC our coverage doesn't start until the first day of the month after you apply. So if you're uninsured for 4 months, yes you get the penalty but remember the facts: if you lose your job in DC and apply for DC Health Link, if you really have no income you'd get Medicaid, if you have some income you may able to get help and an affordable plan for that time.

Alex Alonso (HBX): And those are people we want, we want people who are losing coverage – DC Health Link is here to serve them.

Leighton Ku: Some may also have COBRA.

Purvee Kempf (HBX): People don't always realize when they are unable to pay one month of coverage, but they don't have a grace period to pay. Unfortunately with open enrollment rules, if you don't pay you will get terminated and you won't be able to get back in unless you qualify for a special enrollment period (SEP). We try to tell people that if they don't have income they should go to Medicaid.

Also want to note we are going over what feds did and what MA did – we don't have to choose. DC can do something different in one or all of these areas.

Affordability exemption – You are exempt at fed level if cost of health care coverage either through ESC or lowest cost bronze plan net of APTC, if that would be more than 8.05% of your income then you are exempt from paying the penalty because at the federal level that is considered unaffordable.

Debbie Curtis (HBX): Only exempt if you apply for that exemption though. We saw a lot of people who qualified for that exemption but didn't apply. You can apply through Marketplace or on your tax form.

Alex Alonso (HBX): You have to apply on your tax return; it's not like the IRS checks your income for you. There's an exemption form and you would have to file the form to apply for the exemption.

Stan Dorn (Families USA): Is there any way we can do it automatically in DC?

Purvee Kempf (HBX): we don't have all the information to know if they're eligible for APTC, so we'd be asking IRS to do Medicaid and tax credit eligibility determination which they don't have all the info to do. Purpose of tax credit is to go get tax credit.

Jason Levitis: Just to add a little bit on this, I think the concern that was raised is right. I was at treasury until 1/2017 we were surprised and unsettled by the number of low income people who ended up paying the penalty- a bunch of people who were actually exempt. Instructions for tax reform wasn't clearly written so we did a lot of work to improve that. Our hope is that with improvements a smaller number of low income people are going to pay it. Could DC automate that more? Would depend what OTR says is feasible. It would be hard to do a Medicaid determination, but there are people who paid the penalty whose income was below the filing threshold. IRS sent them checks. It's worth giving thought to how we prevent accidental overpayment because those data do show a lot of that.

Purvee Kempf (HBX): That's super helpful. We won't have that data for a bit but its something that we would want to help fix to avoid that outcome in DC.

Debbie Curtis (HBX): MA addresses a lot of that problem by having 150% threshold by which people are subject to it. Is that a way to go in DC? You definitely avoid people paying who can't afford to pay if you have a threshold.

Alex Alonso (HBX): We have a relatively low number of people getting APTC, about 7-8% people in DC get APTC because of high Medicaid threshold. Of those who do get APTC tend to be folks that are low income below 215 % FPL and reason they don't get Medicaid is because they don't meet the 5 year bar to get Medicaid.

Robert Axelrod (Kaiser Permanente): So Debbie, you're suggesting a floor on income levels so OTR would be able to calculate it without doing Medicaid or APTC calc.

Debbie Curtis (HBX): I was not suggesting, just stating an option.

Purvee Kempf (HBX): What MA did on affordability exemption – they have a sliding scale of progressivity of what they expect of a percentage of your income that you should be spending. Info about this is in presentation from last week's meeting. Above 400% you're expected to spend 8.5 % of your income. This is something that health connector puts out every year. If you apply and get federal APTC and state subsidy, it will be affordable for you to get health insurance. So they're saying if you're at 250% FPL and you don't go get insurance, you will pay the penalty because we've made sure that you can afford insurance and you chose not to.

Alice Weiss (DHCF): Do you know how they build it out? Does it guarantee you paying above a certain level of your income for our premiums? How you dole that out matters from an implementation perspective.

Alex Alonso (HBX): They're figuring out what the affordability scale and based on that they're comparing it against a plan and in order to make that plan affordable they have to kick in a certain state subsidy. They marry the two each year. It's for individuals and families. Each plan is individually rated.

Purvee Kempf (HBX): Remember this affordability schedule exists whether you're in IVL or employed.

Hardship exemption – At fed level you appeal to the marketplace and for DC's marketplace all the marketplace had the option let HHS manage the hardship exemption so HHS does that for DC. You can qualify for this due to things like foreclosure.

Jay Melder (DMHHS): I'm assuming now that the mandate is gone, HHS would not be checking this exemption so we would have to do it?

Purvee Kempf (HBX): For now for the next year mandate still applies. In 2019, mandate goes to 0 so when filing 2019 taxes there will be no reason to apply for anything.

Rob Axelrod (Kaiser Permanente): They just made penalty to 0. Unclear what IRS would be doing, may be good to use federal rules to leverage that.

Purvee Kempf (HBX): Yes.

Referring to sample mandate calculations tables - shows you for individuals, for joint filers, and a couple filing who is paying the penalty and when what a penalty would be. We did it by income and every 50% FPL. Alex will walk you through it.

Alex Alonso (HBX): Purvee went over before how affordability test works, so affordability test is for after APTC is taken out. Annual amount on these tables assumes person is uninsured for the whole year. The 2.5% of MAGI for amount of your income that exceeds the filing threshold. Examples:

1) Somebody at 200% FPL age 30 we're assuming they're eligible for Medicaid so they wont be able to get APTC because 2.5% of their income is less than the flat penalty for one person which is 695 dollars. Because they're not eligible for APTC they have to pay the full cost of bronze plan. Cost of premium is more than 8.05% of income (its 10%) and they would be exempt under the affordability test.

2) At 500% FPL at age 60. At 2.5% of income that exceeds filing threshold is $1,248.75 and they're also paying the full cost because they're not eligible for APTC at 500% FPL because that cost 11.6% of income they're also eligible for affordability exemption and do not have to pay a penalty.

Purvee Kempf (HBX): A helpful thing to understand is that the premium tax credit gets generous as you get older and because of that you're not exempt because of the APTC. It makes insurance affordable and brings it under the 8.05%.

Alex Alonso (HBX): For all single filers and couples you're always going to see that between 250% and 400% because they're eligible for APTC, it will bring it in below 8.05% test.

Another example: 40y/o parents with 2 kids. This family is enrolling the entire family but at 250% or 300% the 2 kids will be eligible for Medicaid – parents will not. So cost for enrolling the two children in the private plan won't be accounted for when calculating APTC but they have to pay the full cost of the bronze plan according to the exemption rules so they would be eligible for the exemption. At 350% kids are getting APTC suddenly the cost drops and they're not eligible for exemption.

Stan Dorn (Families USA): Why can't we assume that kids on Medicaid are not enrolling in bronze plan because they have Medicaid and only count the cost of the Bronze plan for the parents?

Alex Alonso (HBX): That would be more logical but that's not the way the law works.

Debbie Curtis (HBX): When you say we shouldn't count the kids, you're making them subject to a penalty.

Jason Levitis: Rules are complicated but I'd be happy to wade through the regulations with someone.

Purvee Kempf (HBX): Alex can connect with Jason about how we set this up. Assumptions here are that the whole family went without health insurance. You can calculate what the penalty would be if one or two kids went without insurance. Penalties are per person. Let us know if you want to see specific examples. We'll continue this discussion and matrix at next meeting.

Leighton Ku: Given that its 11 we will adjourn. Debbie will discuss additional meetings.