ACA WG
2/1/2018
Notes

Roll Call

Present
Leighton Ku
Jodi Kwarziany
Colette Chichester
Robert Axelrod
Kevin Wrege
Dania Palanker
Justin Palmer
Patricia Quinn
Katie Nicol
Carolyn Rudd
Peter Rankin
Maria Gomez

Absent
Dave Chandra
Margaret Singleton
Carl Chapman
Jenny Sullivan
Donna Alcorn
Tammy Tomczyk
Jnatel Sims

Welcome
Leighton Ku (Chair): Last week we began talking through the individual mandate discussion matrix. We're going to continue that today. Purvee will lead the discussion where we left off.

Purvee Kempf (HBX): Penalty Calculation -- I'll walk through how the structure existed with fed mandate and then how MA structured it. We will need to determine the penalty amount itself. At the fed level penalty is 695/adult and half of that per child up to a cap of 2085/family or 2.5% of family income that is over the filing threshold. Families will pay whichever is greater. Penalty is capped at the national average bronze level health plan. The policy is set up to make people ask whether they want to pay the penalty or buy health insurance. In MA – the penalty amount is set by the MA connector annually, and the penalty is progressive with income mirroring the availability of premium subsidies for lower income individuals. Every 50% FPL, there is a different penalty amount. Important to remember the penalty for both fed and MA is actually assessed by month, so if you're uninsured for 4 months you pay 4/12 of the penalty.

Debbie Curtis (HBX): Other thing to think about, we are in a different situation than the federal government because we've had a penalty in place for the last 4 years that people have gotten used to. So we're not starting from scratch.

Alex Alonso (HBX): Running numbers using the same methodology that the feds use it would be $3,084 for one person. You would double that for a couple. For families it maxes out at 5 people, so it would be $15,420. Note on that is that this max doesn't really come into effect once you run the numbers, people never meet this cap.

Leighton Ku (Chair): How does the DC average level compare to national average level?

Alex Alonso (HBX): The average monthly bronze plan in DC was $257/person*12 which gives you $3,084. Numbers for national average were similar.

Leighton Ku (Chair): In the end, in order to sell this it may be helpful to tell people you'd be paying what you would have paid under the fed penalty. If the national level was lower than DC we may want to choose national level.

Jason Levitis: Concern about continuing to go with the national level is that the IRS is likely to stop publishing the national average bronze premium so DC may not have all the info they need to calculate the national average. Looks like in 2016 national average bronze plan was $2,676. I don't have 2017 or 2018 but it would probably be similar or maybe a tad higher.

Jay Melder (DMHHS): Is there data or studies that show us how the mandate expanded coverage in DC or nationwide?

Purvee Kempf (HBX): There are studies of the opposite that look into what would happen without the mandate, for example the CBO analysis and Academy of Actuaries we distributed at first meeting. It would be difficult to single out the effect of just the mandate since it went into effect alongside other ACA policies like Medicaid expansion, creation of health insurance exchanges, etc.

Leighton Ku (Chair): There was research that came from MA that tried to look at that. And found that yes, the mandate itself had an effect. And with ACA research there were econometric studies that tried to control for so many events happening at once that basically said they were all having positive effects. Just from history though there's research and a basis that these things have positive effects which is why CBO and others conclude more would be uninsured and premiums would go up without mandate.

Purvee Kempf (HBX): CBO statistic was that 4 million would lose health insurance by 2019 and 13 million by 2027 across the country. Average premium in IVL market would go up by about 10% in most years of the decade with no changes of ages of people purchasing insurance.

Debbie Curtis (HBX): The other thing we are trying to do is get analysis from our actuaries that would look at what would happen if DC did nothing, premium wise.

Jay Melder (DMHHS): I get the premium stuff, I was curious about coverage rates. Want to make the case that mandate helps to expand coverage.

Amelia Whitman (DMHHS): Would it be possible for them to expand their study about what would happen to premiums to also looking at coverage levels?

Purvee Kempf (HBX): They don't have data to do that but we could see if there is a coverage loss estimate that they have attached to IVL and SHOP market.

Stan Dorn (Families USA): Majority of coverage losses were in Medicaid and large group coverage. A lot of Medicaid people would not sign up if they didn't have the nudge of the mandate to apply in the first place. And also workers wouldn't take up coverage from employer without mandate. Based on MD experience, it's also important to talk about impact of premiums for people who have insurance. There's the CBO 10% impact but also need to think about effect of premiums from Trump admin attack on IVL market. The state mandate is an essential part of protecting DC from those attacks. I think it's important to communicate that to Mayor when selling this.

Jay Melder (DMHHS): To the point about behavioral nudge for folks that are eligible for Medicaid, we should explore value of an economic penalty to some of our low income folks vs. another action we could take for those groups who may qualify for Medicaid.

Stan Dorn (Families USA): It's not a nudge that comes from the penalty – what happens with mandate is all kinds of people who were not subject to penalty came forward and to their surprise found out they were eligible for no cost coverage.

Purvee Kempf (HBX): Behavioral nudge is one way to say something specific urged you to do something vs. the overall expectation that people need to have health insurance. It's a different type of component its more of an education outreach messaging that's getting to them, not the consequences.

Leighton Ku (Chair): There is a lot of research that shows for example, wear a seatbelt or you'll get a ticket. Now most people wear seat belts because there is this new norm that they are supposed to do this. So we want to have a clear message that the norm is to get health insurance.

Jason Levitis: Going back to the premium impact of this, Purvee noted CBO found 10% increase in IVL market and Stan talked about how other threats from fed gov't could increase premiums more, another thing to keep in mind is that when you have more uninsured people you end up with more uncompensated care and health providers have to increase the costs for everyone in all the markets. Last thing, I found the 2017 national average bronze plan premium- $3,264. Higher than DC.

Purvee Kempf (HBX): Back to discussion matrix. Who does penalty apply to? Fed penalty applies to everyone. MA penalty only applies to adults.

Debbie Curtis (HBX): MA explained that they were already at such a high insured rate for kids they didn't have the need to apply penalty to kids.

Alex Alonso (HBX): We have very good coverage levels for kids based on our CHIP expansion.

Debbie Curtis (HBX): Do you know what the percentage of children covered in DC is?

Eugene Sims (DHCF): 98% covered

Debbie Curtis (HBX): One of the things that's true about health insurance is that when you get one person in a family covered, you can often get the rest and vice versa.

Purvee Kempf (HBX): So question might be what percentage of kids were covered before ACA?

Maria Gomez (Mary's Center): It was high. Having children covered generally helps the adult. If the child can go first the family follows, not the reverse. We had a deep penetration with children before ACA.

Amelia Whitman (DMHHS): Children's coverage rates barely changed with the ACA, but adults increased significantly.

Purvee Kempf (HBX): Helpful to know repeal of mandate may not have an effect on children's coverage. Jodi talked about that last week too.

Jodi Kwarziany (Vice chair): Our most recent census data from between 2015 and 2016 showed that our children's rate dipped slightly which was kind of significant, but it's still well above 95%. I can get a breakdown by age above and below CHIP age.

Alex Alonso (HBX): CHIP age is 18 but we also use CHIP dollars toward adult coverage to carry that coverage up to 221% FPL for parents. 19 and 20 y/o are also at 221%.

Purvee Kempf (HBX): Back to matrix. Deductions in penalty – MA subtracts fed penalty from MA penalty so people don't double pay. Fed mandate was zero'd out it wasn't completely repealed. It's possible that in the future the dollar amount is changed to be above 0 and if that ever happens we would want to consider deducting federal payment on DC taxes.

Penalty calculation – For both fed and MA they are calculated monthly. That's across the board and that's something we would also want to consider.

Jay Melder (DMHHS): Do we have something that shows us behaviorally what the right amount for a penalty is?

Debbie Curtis (HBX): No, some people will tell you the ACA penalty is too low. People are all over the place with that. It's very uncertain what the proper level is.

Purvee Kempf (HBX): Is there anyone who has any thoughts on the penalty amount?

Jason Levitis: I agree that there is really no clear evidence. If people are interested you can compare fed schedule to MA schedule and you would find that the federal penalty is higher for people at lower incomes, then it grows and then the MA penalty is higher in the middle then fed mandate goes up because its capped at full cost of premium and MA is capped at half cost of premium, so it really varies.

Colette Chichester (CareFirst): Are we all working from the same premise that the fed penalty at least is the floor?

Jay Melder (DMHHS): I'm fine with that for conversation's sake, but I'd like to have evidence.

Leighton Ku (Chair): We know schedules change over time. There were larger effects for people to get covered when the penalty went up. Unanswered question is: would insurance coverage go up if the penalty were even higher? We know that largest penalties will have an impact, but also saying that having insurance is the norm does get some effect. The law still says now, yes you are supposed to get health insurance but it has been widely assumed that the mandate completely went away.

Debbie Curtis (HBX): We heard from Jason his thoughts about how building on fed mandate as the norm and that's one argument, and then there is MA who does the penalty more progressively. We don't have a lot of numbers that specifically say which is the right way.

Leighton Ku (Chair): Yeah and my gut reaction and in the first year the simplest thing to do is try to emulate the fed law as much as possible so we are not changing procedures. Part is that we need to sell it to policy makers and to customers and the other part is how you implement it. My thought is that simpler is better for now and we can always change things down the line.

Deborah Fries (OCFO): I just did some calculations on the federal data from 2015 to help inform the debate. I think the more relevant cap is the 2.5% of family income and not the bronze level amount. In 2015, 7,000 people paid the penalty but less than 1,000 of those people were making over $75k. So for the majority of people making less than $75k they paid 2.5% of their income which was 1875. The Bronze level cap wouldn't apply for most people here.

Jay Melder (DMHHS): I think part of the role of this working group has to be how to explain why this is the right thing to do and not just what the best way to do it is.

Alex Alonso (HBX): The reason we put the sample mandate calculations together was to see that at the lower incomes that the flat rate is what you pay, then as income goes up people start to pay 2.5%, but no one was capping out at bronze plan.

Debbie Curtis (HBX): Also need to remember part of this discussion is that some of these people will be exempted.

Amelia Whitman (DMHHS): For those lower income people who are paying 695 rather than 2.5% because that's more than 2.5% of their income -- that seems regressive to me. Just because the federal mandate would be easier doesn't mean that it aligns with DC values.

Colette Chichester (CareFirst): I think we were just thinking about the fed mandate as a floor but not being punitive in that sense.

Jacqueline Watson (DOH): Maybe we could call it a foundation. We can always build on it in terms of what is best for DC.

Purvee Kempf (HBX): Let's talk about the Maryland Proposal – there are 4 components and we don't have to use all of them. No legislative language at this time so there are a lot of open areas here. Components are:

1. Prepayment – During open enrollment, a person who thinks they may have to pay a penalty can use that money to purchase insurance
2. Tax time – A person who owes the penalty and is uninsured can choose to have the MD connector use that money to purchase health insurance mid –year ONLY if the cost of the premium (with APTC) is going to be less than the penalty.

Debbie Curtis (HBX): Maryland has a high number of people who get APTC because in MD Medicaid goes up to 138 % FPL whereas in DC we go up to 215% for childless adults and 319% FPL for kids. So this could impact DC differently.

Purvee Kempf (HBX): It may, but we are talking about insurance premiums in DC which are different than MD. We have a lot of young people in DC whose premiums are low and it's possible that the penalty could cover the insurance premiums so even without APTC the penalty could cover the premiums. There are a lot of variables to run examples but we could do a few.

Leighton Ku (Chair): Is it possible to build a calculator on DC Health Link website to help people know whether the penalty is greater or less than their expected monthly premium?

Debbie Curtis (HBX): Yes we would have to do that.

Purvee Kempf (HBX): Idea here is not that someone knows their penalty. They would have to check a box to let MD know if they want to see if they could get health insurance instead. In the proposal as its structured, it's the tax folks who ask the person if they can share their info with the connector and the connector would reach out to the person about insurance.

Colette Chichester (CareFirst): This sounds operationally complex and I want to steer the conversation back to something the committee has already considered. We agree with Stan in that we want the penalty to go into helping people get insurance and in order to get something done by 2019 we've already talked about the APTC wrap and the reinsurance program. We are making a sidestep that I don't know is in the best interest of DC at this point since it may not be applicable at this point.

Jay Melder (DMHHS): I agree wholeheartedly with that. Don't need to dig down to operations but we should just talk about goals and strategies.

Stan Dorn (Families USA): It seems to me that the biggest bang for the buck is the prepayment option where the operational details are that the exchange has to confirm that the consumer wants to apply prepayment. It changes the calculus for consumer that I think would be very valuable. The other thought I want to talk about is the tax time piece. Nationally there is a lot of Medicaid uninsured who files their tax returns. One of the big benefits we will get is on the Medicaid side. When people let us know that we can use their info to reach out to them we're in a much better place to get them enrolled. So the 2 pieces I see having the biggest benefit for DC are prepayment and tax time Medicaid enrollment.

Debbie Curtis (HBX): That is a nuance that tax time Medicaid enrollment which could get at the point that Jay raised about values. If we have a penalty but you are eligible for Medicaid, then instead of paying a penalty at tax time you get Medicaid.

Amelia Whitman (DMHHS): I just want to notes I'm looking at KFF data from 2016 that suggests that 51% of our uninsured are below 200% FPL. And according to this 36% are under 100% FPL and another 15 % are between 100% and 200%.

Stan Dorn (Families USA): Yes and some research we did also suggest that more than ½ of the Medicaid eligible uninsured nationally file income tax returns. I don't know where you get more eligible uninsured than you do at tax time.

Jason Levitis: Under fed rules virtually everyone who is eligible for Medicaid is exempt from the penalty. This is not widely known. This is not something we widely publicized because we wanted people to think they needed to go out and get covered. If you have something like Stan is talking about where someone doesn't have to pay the penalty and you could funnel them into Medicaid that would help.

Debbie Curtis (HBX): I want to say though that data show that in 2015 in DC for individual returns up to 25k of income (which for an individual you're eligible for Medicaid) 2,380 of those returns paid the individual mandate at federal level.

Jason Levitis: That's right. There was a lot of accidental overpayment and I would urge any state that was trying to do an individual mandate to try to prevent what happened at fed level.

Debbie Curtis (HBX): do you know when updated 2016 data becomes available?

Jason Levitis: It should be within the next couple of months. As you know the release of federal data has become unreliable.

Alex Alonso (HBX): To follow up on what Jason was saying everyone under 240% are eligible for exemption but if they file and 2400 did in DC and we had a way that they could apply that penalty in a prepayment way, for all of those penalties its always going to be 695 and they're not going to get APTC because they will be eligible for Medicaid. Divide 695 by 12 and that's not going to cover a premium.

Debbie Curtis (HBX): But they won't have to pay anything because they'll get Medicaid. If your income is X and you're eligible for Medicaid they don't have to pay a penalty and they get Medicaid.

Jodi Kwarziany (Vice Chair): If there is a way that we can do that I think it would be worth it. There are people who encourage lower income folks to file their taxes so in some ways we are pushing people into this and without some kind of ping to alert them that they don't have to pay we are going to keep seeing this problem.

Leighton Ku (Chair): By the time you file your taxes with your income, that year has already elapsed by 2 months, so it's hard to do that on a current basis.

Stan Dorn (Families USA): In MD at tax time we ask people if they are currently uninsured and we ask them if we can share their data with the exchange to see if you're eligible for low cost or free health insurance. And then the Exchange contacts the person because we would need to know an attestation of current monthly income.

Debbie Curtis (HBX): It does become complex though because its 3 months after the last year. We need to keep thinking about that I don't think we will resolve it right now.

Purvee Kempf (HBX): Last two pieces of MD proposal --

3. Down Payment – where the penalty isn't going to cost of their premiums for the rest of the year it goes into a fund
4. Retention – then all that money from the fund is sent out incrementally to carriers to retain those customers

In down payment for future penalty we need to remember a lot of people move in and out of DC. The amount of effort it would take to keep track of individual tax payers may not be worth the operational cost.

Jaqueline Watson (DOH): It's a noble idea and undertaking to try to cover as many people as possible but at this point it seems cumbersome. I think we table it for now and then come back later to see if there is a way to do this in DC at a different time. Maybe MD can go ahead and then we have some data.

Debbie Curtis (HBX): Just to add on that, the IRS was supposed to be doing promotion for people who end up paying the penalty but they really didn't, but that is an easy no brainer for us to do.

Patricia Quinn (DC Primary Care Association): I want to go on record about the MD proposal and say that DCPCA is very interested in this because what's being proposed goes beyond the penalty and tries to pull theses people in the market.

Maria Gomez (Mary's Center): I ditto what Patricia said.

Jason Levitis: One more consideration to put out there – there's a lot to be said in terms of the incentive to enroll here, I think there is a lot to be said for the behavioral economics of the lost version where

people don't want to lose money. And there is also some potential that people could decide that if they don't use the money the first go around they can use it later, which is another incentive to consider.

Stan Dorn (Families USA): Don't think about the MD package as a whole. Some parts may work for DC and some may not.

Purvee Kempf (HBX): Operational considerations –
Implementation timing – fed mandate goes to 0 starting in 2019. People think it's already gone. There is an idea of doing something through federal conformity – which means doing something where you can cross reference the federal structures so agencies don't have to put out huge swaths of guidance. They're relying on the structure that's already in place. This does not mean you can't change some pieces of it. So there is some plausibility for getting something in place by 2019 by way of conformity. Still would require something getting into DC law. We need operational steps to happen. For example: we'll need changes to the tax form. Deborah let us know that OTR needs to make changes to tax form in the summer because that's when they print them.

Deborah Fries (OCFO): Target for form change is August 2019. That's when they print the form so all changes would need to be finalized by then.

Jason Levitis: Also issuers right now are designing plans and figuring out what to offer in 2019 and employers need to determine what to offer and there are systems that need to be setup to track who has coverage. So I think those things really present the greatest time pressure. So if what's considered MEC now is still in place for 2019 then that would make that easier, but if those change then it would take time for other partners to adjust.

Purvee Kempf (HBX): Rate filings for all plans (not just exchange plans) start May 1, so if we are hoping to see a change in premiums that's when that happens. Changing plan structures take a lot of time so all of that needs to happen as early as possible. The more changes we make to the federal rules the longer it would take to implement.

Operational cost – OTR and HBX are going to have costs to implement a policy like this. If there is an exemption process, we would have to implement that. Costs for OTR start in 2018 and on both sides there will be both personnel and non-personnel costs. If there are revenues from the individual mandate, they aren't there in 2018, they would come in after the 2019 tax filing season.

Reporting & Education & Outreach – important to note that if there is outreach we want to be sure is a component, like if we want OTR to share who is uninsured with other agencies, that's important to build in. Under fed rules we would have to require tax forms and reporting to continue and come to the District Office of Tax and Revenue. In MA, MA tax department maintains the tax data they don't share it with MA connector, but it is the Massachusetts Connector that develops materials that the tax department sends out to those folks.

There should also be costs associated with a marketing campaign to make sure we message these changes and make sure people know what we're doing so they don't just drop their insurance. For HBX, that

wouldn't be a new cost for us as we do this outreach and education now – but we'd just add this message to those materials and efforts.

Leighton Ku (Chair): Last section of matrix I hope people can read on their own. Over the next couple of meetings I hope we can have discussions about where we want to go from here so we can see where the consensus of this group is on these subjects.

Purvee Kempf (HBX): We can put a discussion document together for the next meeting so that we have something to build off of.

Leighton Ku: Adjourn.