ACA WG
2/7/2018
Notes

Roll Call

Present
Leighton Ku
Jodi Kwarziany
Robert Metz
Robert Axelrod
Bill –
Dave Chandra
Kristen Hathaway
Dania Palanker
Liam Steadman
Patricia Quinn
Katie Nicol
Tammy Tomczyk
Peter Rankin
Jnatel Sims
John Fleig
Maria Gomez

Absent
Dania Palanker
Carl Chapman
Donna Alcorn
Patricia Quinn

Welcome, Opening Remarks
Leighton Ku (Chair): I hope by the end of tomorrow's meeting we will have fleshed out what this Working Group wants to recommend. People will have an opportunity to talk to colleagues to get them up to speed and at following meetings we will take votes and finalize our policies. Turning over to Debbie to review additional data.

Debbie Curtis (HBX): First, we have a Department of Health summary on Hospital uncompensated care. Thanks to Dr. Jacqueline Watson for pulling this together. There are 3 major tables. First shows uncompensated care before 2010 (before ACA took effect). Table 2 shows 2011 and that was after the Medicaid expansion begun. Table 3 shows 2015 which is a more full effect after ACA.

The next two charts are the amount of total uncompensated care provided by DC 2010 – 2015. In the first one we can see that uncompensated care went down by 60%. That's a very important representation of the impact the ACA has had in DC. To me, this is a picture of what having the

ACA in DC has meant to us. Second chart breaks it down by charity care and bad debt. There are distinctions. I don't think they matter as much for our purposes.

Jodi Kwarziany (Vice Chair): I've prepared additional data on the uninsured. Previously we'd looked at uninsured by FPL and this takes it a step further and gives us a better sense in talking about exemptions for certain age or income categories. Also groups that are not taking up coverage or who we may see not enrolling in post mandate repeal world. In 2016 we still have some groups with relatively high uninsured rates. People with incomes at 400% FPL and above make up more than ½ of all DC residents. So those skew our overall results. For those under 200% even though there are coverage options available (Medicaid) some may not take them up or know that they are available. Might also be confusion around by uninsured rates are going up. 18-64 age group has higher rates of uninsured but if you compare where we are now with 2009 there are consistent coverage gains. Lowest rates of uninsured is in our 65+ group. Any questions?

Alice Weiss: Our approval for the DC Medicaid expansion was in 2010. I think we implemented it in 2010 but effect wasn't seen until FY2011.

Jenny Sullivan: 200-299% group for kids, what's happening with their uninsured rate?

Jodi Kwarziany: This graph is scaled, but I don't know what's going on there.

Alice Weiss: I don't have any insights into that either and I remain interested in our ability to do the job we need to in order reach eligible kids in DC. Most national studies are not consistent with this. We do a good job of enrolling eligible people; they have our coverage rate at around 98%. I do have questions about accuracy of ACS's surveys for the small region like DC. A couple outliers can throw out samples for the year. Not sure if it represents trend or not.

Debbie Curtis: As promised, we asked our outside actuaries, Oliver Wyman, to conduct an analysis of the impact of the federal repeal of the individual responsibility payment. I'll Turn it over to Ryan Schultz from Oliver Wyman to walk through it now.

Ryan Schultz: Referring to Oliver Wyman study called Impact of Repeal of the Individual Mandate. This summarizes what we did to look at the impact of the mandate in DC. We used results from our national micro simulation model, which was calibrated based on known enrollment data. Specifically, results we used were changes that were being projected due to repeal of mandate by age and FPL. In DC, the ACA individual market skews younger and there is little membership in DC that gets APTC. And both of those are drivers in how we expect people to react to the repeal of the mandate. Using January 2018 data for market by age and FPL and applying the deltas we came up with estimates for how we expect mandate to affect DC's market.

RESULTS - Will result in reduction of enrollment 15.1% or 2500 covered lives. Claims cost increase by 7.2%, is on a per member/per month basis and excludes a change in rates that would otherwise occur. We have some alternative measures – first is the CBO estimates who estimated that premiums would go up by 10% nationwide. They are revising their methodology to show the

impact will be less. KFF tracking survey asked enrollees in the IVL market if they would drop coverage if mandate were repealed. Those results are summarized in the letter.

Debbie Curtis: Highlighted the tables in 3 and 4 that break out the age of people who will drop coverage, which is illustrative for us. Looking at poverty levels, the majority of people that will drop will be those that pay full price because that's the majority of our marketplace. But the 200-300% range those are people who would get APTC.

Purvee Kempf: One other thing to note, analysis Oliver Wyman did not look at coverage loss for Medicaid or SHOP market.

Alice Weiss: Is there any way we could get more information about impact to Medicaid as a result of mandate repeal?

Debbie Curtis: Our actuaries can't do that because they're doing this based on our enrollment data.

Leighton Ku (Chair): Ryan in your general micro simulation model, have you looked at general trends for Medicaid or ESC? CBO said those are supposed to decline too, is that what your model is indicating?

Ryan Schultz: Our model is heavily focused on the IVL market, and I wouldn't expect to be able to pull results about these other markets.

Debbie Curtis: We can pretty much assume that people on Medicaid thought this applied to them based on the IRS data -- a significant number of people paid because they never got exemptions.

Leighton Ku (Chair): Evidence in MA that after they involve their mandate employer sponsored coverage and Medicaid numbers went up. In addition, there were things that showed having health insurance helped improve life in other areas.

Alice Weiss (DHCF): I'm trying to better understand the effects of the individual mandate and the penalty and the collaboration that DC Health Link and other partners took to propel enrollment. I think there are a lot of factors in play that have helped boost Medicaid enrollment other than the penalty.

Leighton Ku (Chair): Referring to his summary of evidence document entitled What is the Evidence of the Effects of the ACA's Individual Mandate and of it's Repeal? There was outreach and related activities going on that helped with that. When you think about the mandate going away, there will be publicity around that too. Hopefully we will continue to do the effective outreach that we are. There could be confusion if people are being told at the national level "no more mandate" but it is still going on in DC. A couple other noteworthy things – I looked at what was going on with premiums in SHOP market between 2013 and 2016 and basically Employer sponsored coverage premiums, which tend to be a little higher in DC, nonetheless the increase for both single and family premiums was lower than the nation at large in SHOP market. Which

tells me that some of the things we've been doing in DC to stabilize market may have bled into employer market. If mandate goes away, the reverse could be the case. I've done an analysis on the skinny repeal bill and eliminated employer mandate. Implementation of that bill would have caused the loss of 700 jobs by 2020 and 1200 jobs by 2026 in the District. Not the same as the mandate going away, but shows that there are broader effects both in the healthcare sector and outside it.

Alexis Griffin (EOM): We got numbers when we were talking about reinsurance around what would happen if the premiums increase by 15% and 30%.

Purvee Kempf: That was before the repeal of the mandate. This analysis by Oliver Wyman talks about the claims cost increase just in relation to the mandate. There are other reasons that the cost of premiums will go up. They tend to rise naturally, so as insurers put together their filings they will take a lot of factors into account. That's why those numbers were at 15% and 20% there is no doubt that there would be an increase beyond this 7.2%.

Debbie Curtis: At a previous meeting, Colette said that CF was predicting a 10-15% increase based on the mandate alone, which is different than the 7.2% that Oliver Wyman is presenting. But those have to be approved by DISB so a lot of uncertainty. Blue Cross BlueShield foundation expected 13% increases based on repeal of the mandate.

Alexis Griffin (EOM): Would be great to see a study based on a lower number, like 7.2% increase. We've seen research on 15% and 30%.

Bill Wehrle (Kaiser Permanente): From our perspective, it's really hard to narrow it down because it's not something any of us have experience with. Couple comments: 1) I don't think 7% is unreasonable and 15% may not be either. 30% seems steep. When we look at this we see a magnifying impact over time. Maybe the 15 and 30 estimates are taking more factors into account.

Alexis Griffin (EOM): There were some options given about how reinsurance would affect the increases, but the only two increases are 15% and 30%.

Debbie Curtis (HBX): Well, what we did was we estimated what it would cost to do reinsurance with a 15% premium increase and 30% premium increase. We were just doing estimates on how much a reasonable reinsurance would cost. It was not an attempt to estimate the cost of the mandate repeal. We assumed premium increase of 15% and you would invest X amount and bring rates down y. It was just an estimate.

Robert Metz (CareFirst): In terms of IVL mandate estimates. Each carrier will have a different estimate because they have different populations.

Leighton Ku (Chair): When we sent the budget office some other estimates,that was assuming the IVL mandate was in effect. In addition to those 15-30% increases, we'd expect rates to go up an additional 7.2%. And then if we maintained a DC mandate it would go back down 15 % or whatever, but these are all just smart guesses.

Jay Melder (DMHHS): Rate increases for CF alone were 19.6% (IVL) and 15.3% (SHOP)

Purvee Kempf (HBX): We are going to move to the Framing Questions document 1-2. We've had a number of meetings where we were in the weeds. We want to take this back up a level. First framing question – "What is the Evidence of the Effects of the ACA's Individual Mandate and its Repeal?" This is about what the evidence is around why the mandate went into effect and what it did for this county. Second question – "Is there support for a mandate in DC?" This is a qualitative question about how we think about this. We tried to distill the comments down into pros and cons. We didn't capture everything so I encourage folks to not use this as the only thing to reflect on. Here are some of the key parts and please jump in and let us know how these affect you or your organizations.

Pro #1 – it protects the ACA. This is really about the position DC has taken around the ACA where we've established an Exchange and expanded Medicaid. Con #1 – Is the penalty necessary? It may not be because DC has a very low uninsured rate. Also we may be seeing more of the effects on the Medicaid side.

Robert Metz: I don't think it's unnecessary. There is 15% of the IVL market that would exit and that premiums would increase. I contend with the idea that it's unnecessary.

Alice Weiss: When you look at the population that's helped by the marketplace in the Wyman study as many as 95% of people in marketplace have incomes over 400% and if we compare them to people who are at lower incomes. We still have work to do on Medicaid.

Alex Alonso (HBX): It's not that 95% of the people enrolled in the marketplace had income over 400% FPL. They just assumed that those people had income over 400% because they are not getting assistance.

Rob Metz: That's a coverage loss estimate. It's that 95% of the people that would exit the market have those incomes.

Ryan Schultz: We're showing 95% is at 400+% FPL and that's because they're not getting APTC, not necessarily because their income is that high.

Debbie Curtis (HBX): There are people who come through and don't want to seek assistance and so they pay full price for their coverage even though they would otherwise be eligible for Medicaid or help.

Purvee Kempf (HBX): Not all of these people are over 400%, these are people who are not getting APTC.

Bill Wehrle: On the statement that it's unnecessary. What frustrates me is that I don't think the supporting statement backs that up. The coverage rates of DC is not relevant to whether a mandate is an effective tool or not. Question is, is it effective enough to make it necessary? We would argue it is.

Leighton Ku (Chair): The pros and cons are a rhetorical device to help the discussion. My intuitive guess is that most of the people in the room favor a DC specific mandate, but want to make sure we cover all our bases.

Amelia Whitman: I just want to add, on the pros side we're estimating that 1.3% of the coverage gains is due to other things like the individual mandate, not exclusively the mandate. Other things - private insurance coverage did not change? We're operating on the assumption based on Oliver Wyman data that there will be changes in the IVL market, who knows if there was a redistribution of private coverage.

Bill Wehrle: I'm trying to reconcile that with the table from Oliver Wyman study and it doesn't add up.

Alice Weiss: Relative uninsurance rates of higher income folks that we are helping through marketplace are much lower than the uninsurance rates that we are seeing for the adults in the lower income group.

Leighton Ku: Everything that people have said about survey data could apply there. I would expect that our private insurance rate probably did increase. The bulk of our insurance gains were due to Medicaid growth.

Purvee Kempf: Pro #2 - Maintaining the status quo – the DC mandate can protect insurance coverage. DC taxpayers that go without coverage will pay the same that they did in 2018. Public (across nation) is undivided. MA instituted individual mandate. Experience of MA is relevant to DC since pre-reformed MA and pre-reformed DC both had low uninsured rates.
Con #2 – health insurance may not be affordable – can we require people to buy health insurance that's not affordable? Question comes down to what is affordable – different for everyone and can also be a perception among people.

Kris Hathaway (AHIP): Timeline. Filings coming out in May. Huge questions around what will happen with the executive order. We need to get this in before we know. Another con could be the timeline that we're working with.

Purvee Kempf: If you can't get something in place for 2019, for rates for 2019, then that may not be something we want to consider.

Leighton Ku (Chair): Would be really nice to have some legislation to adopt something in April or so? As you know, we want to have recommendations by 2/21.

Dave Chandra: Just wanted to mention that there is a process to pass emergency legislation, so it would take effect sooner.

Jodi Kwarziany: I think the timeline can go both ways. If we decide to go forward with this, that will put us on a tight timeline. If we do nothing, the magnitude will grow.

Robert Metz: Affordability is a concern for us. Using that state mandate funding to help make coverage more affordable and reduce costs for everyone is an idea we had from the recommendations that we came up with at the last recommendations from this Working Group. We already have and we have an idea of the work that we need to do to support it.

Dave Chandra: Were those supposed to be in lieu of the mandate?

Debbie Curtis (HBX): In addition to. Those were from our last ACA Working Group Recommendation that was approved by the HBX Executive Board in November 2017.

Purvee Kempf: Pro #3 – Retains coverage gains. Con #3 – Politically based opposition

Jay Melder (DMHHS): Can I ask a question about the first ACA Working Group – there were some consumer advocates who had a concern about the mandate. Do we have a collection of those concerns from consumers that we can discuss?

Debbie Curtis: We should ask Patricia with DCPCA to talk more about that tomorrow. As recall what she raised, from her perspective, the mandate is not DCPCA's primary concern. They are worried about fact that they're not getting paid from the federal government. She was also concerned because they hadn't dealt with this at an organizational level board meeting. I think making sure coverage is affordable is their number one priority – Once reinsurance and APTC wrap were paired together she was part of the consensus.

Katie Nicol (Whitman Walker): We were looking at 2015 data about those that paid the most for the penalty and where that fell and that in and of itself likely those who paid the penalty would be eligible for another program if we were able to adjust it with the APTC wrap.

Debbie Curtis: We had initially proposed what Vermont did with their wrap and Katie noted that we didn't want to give people at 400% FPL the same amount of help as people who are coming off of Medicaid. So we revised that recommendation to apply more to lower income folks.

Bill Wehrle: On the wrap part – does that need a waiver?

Debbie Curtis: No, it's state money doing state things. We're not asking the feds for anything.

Leighton Ku (Chair): We have so few people on APTC in DC that we are able to do a wrap. Would be difficult in another state.

Dave Chandra: I think it's true that in DC we have fewer people who are QHP eligible going to FQHCs but there are some. If there are people who as a result of the mandate repeal would drop insurance, I believe that as a DC Health Link individual market consumer I want people to keep buying insurance to keep costs down for everyone. We would have needed to talk about those things even if the feds hadn't repealed the individual mandate. By keeping a mandate in DC we are just maintaining the status quo and preserving the positive trends we've been seeing in DC.

Jodi Kwarziany: I think to a lesser degree there were concerns about outreach and if we could do robust enough outreach in DC to let people know we had a mandate in DC then it could work.

Robert Metz: Structuring of the mandate itself and what the penalty amounts are will also get to that issue of affordability in a way that we couldn't before.

Purvee Kempf: Pro #4 – Keep premiums down, Con #4 – Confusion among taxpayers that individual mandate exists in DC, when repealed at federal level.

Katie Nicol: One thing to consider, as we are with HBX as an assister entity, this would be funded by HBX which is good so that we maintain a clear message as multiple organizations spreading that message. In looking at this, it will be critical to maintain that as a way to educate DC residents and making sure that they continue to be a leader. We would need to make sure people know they need to have insurance as part of the DC individual mandate.

Purvee Kempf: Right now our education and outreach does include a mandate. We ask all of our partners to do this – our business partners and assisters. We try to get to a broad base of folks in making sure that mandate message is getting across to everyone.

Alex Alonso (HBX): When feds were implementing the mandate, they were supposed to do outreach to people to let them know that they had options available. They did this once. We know if we had a local mandate, we would now be able to be in charge of that outreach.

Alexis Griffin: would that have a substantial cost impact?

Debbie Curtis: In MA as an example their Department of Tax and Revenue did not turn over any info to the Exchange. The Exchange developed their materials and the Tax Department mailed those. So there could be some cost for Office of Tax and Revenue in DC on this. In 2015 (latest Treasury data that is available) approximately 7,000 people in DC paid the mandate so we would be able to reach out to them. This is an area we can expand coverage.

Deborah Fries: People who come into the IVL market aren't just choosing between having insurance and not having insurance – they're choosing between taking a job or not taking a job.

Debbie Curtis: So if premiums go up, people may not be able to forego employer sponsored coverage and we'd be confining entrepreneurship. Ice cream Jubilee, whose owner started as a DC Health Link individual market customer, is a prime example of that.

Alice Weiss: Any conversation of the operational cost of implementing this?

Deborah Fries: We did an initial cost estimate for the piggy back option of the fed mandate. Where you had this additional line item on the tax form and most of the cost have to do with outreach. Now OTR has to receive a form and accept that form, but there will be some startup costs. Once there is more form about what you're recommending I can get better estimates.

Leighton Ku: We would expect that revenue would offset those costs but those data are very helpful.

Debbie Curtis: Its also important to remember that we won't have revenue coming in in the first year.

Alice Weiss: From a budgeting perspective, it's done by agency. Even if there were revenues coming in it wouldn't offset costs for OTR. When we discussed revenues we talked about them going to the HBX stabilization fund so not sure if they could go to OTR.

Debbie Curtis: So, we need to come to a conclusion about what we're recommending and then Deborah will work with OTR to do that work.

Leighton Ku: A placeholder would be that we should assume that we are trying to maintain the federal standards. That should get us started.

Purvee Kempf: Let's touch base at tomorrow's meeting that allows Deborah to have enough info to start working with OTR. Last couple pros and cons. Pro #5 – Mitigates an increase in uncompensated care, Pro # 6 – Keeps any reinsurance program focused Con #5 – Idea that fed rules would be a regressive tax – 5,370 returns for households making under 50k included a payment of a penalty. Jason Levitis, formerly with the US Department of Treasure, shared with us in his presentation that they looked at this data and they changed the instructions for the following year hoping to clarify for those folks that most of those people are eligible for an affordability exemption. We don't have access to data past 2015 data.

Bill Wehrle: Did you want to note here somewhere something about the DC wrap? Reinsurance is one thing the penalty funds could be used for. They could also be used to fund a DC wrap.

Alexis Griffin: Have we talked about using revenue for operational costs?

Purvee Kempf: Any of the moneys that were generated I think folks think it's important to put that money back into reinsurance or the subsidies, which helps with affordability and reinsurance to stabilize premiums to keep people in. It's still an open question though.

Bill Wehrle: You're funded by carrier assessments. If you took the money for operation of a simple reinsurance program and whatever that did to reduce the assessment on carriers could be reflected on premiums, so if we are paying 4% instead of 5% that could be reflected in premiums.

Leighton Ku: Our assessment is a broad assessment from all health carriers as opposed to those just within the exchange.

Alex Alonso (HBX): Whatever we got from penalty payments, if you took any of that money away to reduce the cost of premiums through wrap or reinsurance, whatever you took away is just taking away from affordability if you used it for operations.

Bill Wehrle: I'm suggesting I think it would have the same effect as reinsurance.

Alex Alonso (HBX): But because our assessment is so broad it would have a very marginal effect, because there are few carriers in DC exchange, so it would benefit a lot of carriers and not us.

Amelia Whitman (DMHSS): Also want to just say that the mandate would be for everyone in DC not just those in the individual market. There could be a number of things that we could put that money into.

Debbie Curtis: Also want to note with less than 4% of people uninsured, we're not talking a big pot of money here.

Robert Metz (CareFirst): From a marketing perspective, it would be easier to generate support for the mandate if we say that penalty funds are going directly back into the market to help people.

Debbie Curtis (HBX): We will go into questions 3, 4, and 5 tomorrow morning.

Leighton Ku (Chair): Adjourn.