ACA Working Group
2/8/2018
Notes

Roll Call

Present
Leighton Ku
Jodi Kwarziany
Robert Metz
Robert Axelrod
Bill Wehrle
Dave Chandra
Kristen Hathaway
Kevin Wrege
Dania Palanker
Liam Steadman
Patricia Quinn
Katie Nicol
Peter Rankin
Jnatel Sims
John Fleig

Absent
Margaret Singleton
Carl Chapman
Jenny Sullivan
Donna Alcorn
Carolyn Rudd
Tammy Tomczyk
Maria Gomez

Welcome and Opening Remarks

Jodi Kwarziany (Vice Chair): Thanks for joining the HBX ACA WG. We are going to continue the discussion we started last week. Leighton is running a few minutes late so I am kicking us off today.

Purvee Kempf: Wanted to open up by giving folks an opportunity to make comments on the discussion we had yesterday around first framing questions. We will go ahead and jump in to the next part of the discussion – framing question 2. Should DC mandate conform to the federal mandate or create its own unique mandate? This is an implementation, operation and timing question. Even if we choose to conform we can make specific deviations. Pros and cons are listed on the discussion document. Yes, local mandate should conform to federal mandate – Ease of implementation, taxpayers and tax preparers already understand it, and there's some flexibility to customize rules in accord with local needs and preferences. No, DC should develop its own –

A complete locally devised mandate gives DC full control over all aspects of the mandate, DC can work with state neighbors such as MD to pass something comparable for regional consistency, and feds could retract all federal regulations and guidance. Want to get thoughts on this.

Jason Levitis: Re: federal guidance going away, the way that imposing state law through conformity works. There is rolling conformity where when fed law changes state law is automatically updated to match fed law and then there is point in time conformity where state says state rules should be federal rules as of x date. The recommendation I have is to use point in time conformity and use the date December 15, 2017 because that was after all the most recent helpful guidance on the mandate was promulgated but before repeal happened. That way even if Congress were to completely repeal the federal mandate or IRS were to change rules through regulation, that would not then affect the rules in DC. They'd be tied to those rules as of 12/15/17.

Dave Chandra: I think Jason's comments make sense. They would have a matching state requirement to federal unless something were to happen to federal requirement then state requirements kick in. Would be a safeguard.

Debbie Curtis: Also want to say we want to have language like MA had after the feds acted, in case the feds come up with a penalty in the future we don't want people to get double hit.

Rob Metz (CareFirst): How many of these decisions are we trying to make in the working group? There are so many details of the mandate.

Purvee Kempf: If you think back to the first ACA Working Group recommendation we had where we discussed affordability and stability provisions. We can have very detailed discussions, the recommendation itself will be at a higher level. It will be about whether DC wants to implement an individual mandate. The other things that would need to be in there would be anything anyone in the working group needs to see in there so we can get to a consensus. But the point of the conversation is for the folks who will be operationalizing and implementing this. If things need to be changed, we need to be flexible with our recommendations.

Debbie Curtis: The other thing for everyone to be thinking about is the power of this working group is that all of you are making a recommendation on something. So if there are key components that you want to see all the way through please mention them.

Patricia Quinn (DCPCA): Can you remind me the timeline?

Debbie Curtis (HBX): Timeline matters. Rates are filed in May and we need to have action before that to impact rates so our timeline is really to try to wrap this up next week.

Kris Hathaway (AHIP): We need to be practical when looking at this question. With MD, we may not be able to reach conformity. As much as we want conformity we need to consider practical implications of proposals.

Leighton Ku: My hope is that by today we can end the discussion to some of the questions that Purvee has been asking. We'll have another meeting Monday and Wednesday to take recommendations to board on 2/21. Then it goes to Mayor. Does Deborah have any comments around operational thoughts?

Deborah Fries: The OTR work will come on the back end. If you think you are going to have more regulations because DC wants to do their own thing ,HBX will need to come up with that and then I can bring you more substantial estimates.

Howard Liebers: Operationally, DISB would have the resources to draft regulations on this. The desire at this point is to try to conform with the federal requirements as closely as we can. We might be the most appropriate agency for drafting the rules around what type of coverage qualifies since we regulate the whole insurance market.

Alice Weiss: From DHCF's perspective, I don't think there will be substantial operational costs. Biggest things will be issues we talked about with the mandate to the extent we are exempting populations who are Medicaid eligible or at that income level we want to make sure that we are communicating in alignment with other agencies. Options on the table focused on reinvestment in coverage to make it more affordable, I want to see if we can add that as an option for this group.

Purvee Kempf (HBX): Let's jump into the next document - framing questions 3 – 5. There are things we will go through that are at such a level of detail we shouldn't' worry about making decisions on, but there are other parts that people may feel strongly about and that's what we need to hear.

Coverage that qualifies individual mandate – plans that qualify and other plans that do not. Gray shaded chart are non-controversial. I think we would want to include all of these as coverage that qualifies.

Next part of chart – we laid out a handful of options DC needs to consider. Association health plans/limited short term duration plans – these would meet the individual mandate coverage requirement only if the AHP or duration plan meets ACA individual and small group market rules. Otherwise you would use a case by case analysis to see if they meet requirements. Reason for this is the executive order put out in November that allows additional flexibility and we've seen a proposed rule put out by DOL around this that opens the door to scams. One way to prevent proliferation of AHP's would be to say that they don't meet minimum essential coverage – which means they don't mean the individual responsibility requirement. These AHP plans will be permitted to discriminate by age, gender and health status. If AHP's cherry pick out healthy people into their large group risk pool this destabilizes our risk pool, and I note that people who move in the AHP's if they get sick or have healthcare costs could prospectively come back into our market when they have needs. Cons of doing nothing around AHP's—permit cheaper plan options which could be attractive to some, people may not know they would have to pay a penalty when they enroll in a AHP, no effective way to warn people that AHP coverage won't meet DC individual mandate and federal guidance is still a proposed rule, not final. I really want to see how important folks think this is to exclude this.

Debbie Curtis: When thinking about this – it's always harder to undo something once it's happened. If nothing is included here, and AHP's pop up, it's much harder to undo that.

Howard Liebers: I think there is an interest to figure out the most appropriate way to address the proposed rule. Some states have tighter restrictions around certification and licensure of AHP's, so at least in the interim we can say if you have a policy that was issued or renewed prior to 2/1/18 to make sure that those people don't have to pay a penalty because up until now they've thought their coverage was fine.

Leighton Ku: Thanks Howard. I don't think it's clear how much the federal regulation when it comes out, how much it might preempt states' insurance authority. So an alternative here, we need to realize there is no ability for the federal government to preempt state rules on taxation so that adds in a second layer of guarantee. Therefore, if an AHP meets qualifications as of 12/15 then that would apply and then we can consider exceptions thereafter.

Bill Wehrle: AHP and short term health plans do not exempt you from the penalty. I don't think we would want to write a rule in DC that would reverse that. You would be making that sort of coverage compliant when it isn't.

Jason Levitis: Let me lay out what the current legal landscape is. It's different between short term coverage and AHP's – short term coverage is not minimum essential coverage (MEC) under federal law today. Concern there is that even though it's not MEC it was still popular among people who may not have known it wasn't MEC which is why Feds took action to limited duration to 3 months. Trump admin could extend that back out to a year, which would make it more attractive. Fed mandate has never made short term coverage has never been MEC. AHP's are MEC under the ACA, but issue there is which ones are allowed to exist at all. Currently there are limits around which individuals and small employers can be in AHPs which helps protect integrity of ACA system which is to say that individual market and short term market has to have a single risk pool that is all community rated and subject to market rules that help keep premiums low for everyone. Concern about what the fed proposed rule is it would break down those barriers so that AHP's can now be offered to individuals and small employers such that you would have leakage between the markets that could undermine the individual and small group market. To extent that AHP is allowed right now, yes we want to allow those to continue because it seems to be working. Question is, are we going to attempt to limit their spread?

Dania Palanaker: There is a potential that state's abilities to regulate AHP's will be preempted. It's a huge concern that these could be sold to people who don't know that they're not MEC. They don't have a min value requirement or offer mental health or maternity care. Worst case scenario is AHP selling plans that only cover preventive services. This would be a great way to limit that ability. People could end up buying these plans and not realizing how skimpy they are. Other piece is segmentation from the market – we don't want to pull people who are enrolled in DC Health Link into substandard plans and then go back to DC Health Link when they get sick. My concern is allowing a case by case basis if they don't meet the requirements. If we have that, there needs to be very strict requirements about what is able to be considered. We don't want a situation later where some leadership in DC begins to approve AHP as MEC –hard to undo.

About short term duration plans – I don't think we should allow these to meet the mandate. I haven't seen a plan that meets those requirements. Would create some confusion – if people hear that a short term plan meets the mandate then it would be easier for bad players to enroll people.

Howard Liebers: We've looked at the 2 markets in DC for short term limited duration policies. Most of the policies have been withdrawn from filings in DC and we contacted the carriers that still had products filed with us and there are no enrollment in short term duration policies in DC that we are aware of. We don't think they should be considered MEC. On AHP, we've reviewed filings with the DOL. Currently they don't have to file with us. We're aware of about 20-25k enrollees in AHP's now.

Debbie Curtis: Is that just small group?

Howard Liebers: It's not clear who they are, but when they file they have to report covered lives. They admitted to us that they had small groups so they're trying to figure out if the coverage were going to be offered in the small group.

Leighton Ku: I've met someone in DC who has told me that they had a short term plan, so there is at least one person in DC who has one.

Debbie Curtis: We've had customers try to get an SEP after losing a short term plan. They may not be licensed in DC but there's all kinds of ways to get around that.

Dania Palanker: They're supposed to get approval and register with the state, but sometimes they don't. Sometimes they're selling them as indemnity plans, which makes it even worse cause on top of everything else they have daily limits.

Robert Metz: I think we are all in agreement that short term duration plans should not meet MEC, so we can move on from that. In terms of case by case requirements, it depends on whether those plans meet the EHB requirements. If a plan meets the ACA requirements but doesn't fall into one of these buckets when it should be considered to qualify.

Bill Wehrle: We wouldn't support that because that is only one aspect of the risk selection that can happen. Even if they have all of the same benefits, they invite people to segment off based on health status and age. So we would not recommend exceptions. If you are going to have people comply with the mandate you have to have coverage that meets ACA requirements then the plans we offer should meet requirements.

Purvee Kempf: One of the questions that we will talk about later, is which things can we add on later. This may be one of those things. We don't need to determine now if we want to move forward with case by case consideration. Another thing to do is have some specific requirements, but that leaves them out of the risk pool and that is a real fact as far as when premiums are set and how that will affect cost.

Kevin Wrege: Do we have any sense of when the final rules will be at the federal rules? Will they preempt?

Debbie Curtis: Comments are due March 6 and then they have time to review those. When final rule comes out is in their control so we will see what they actually do. With regard to what qualifies as MEC, we will always have the authority to define that, so this is an opportunity to act.

Purvee Kempf: Along the lines of what Howard was saying about AHP's, since they are already considered MEC we should consider that that is fine but not having an allowance for other type of AHPs that could come along after a proposed rule becomes final, and then you all would continue to look at it with the Department of Insurance and we'll figure out where to go from that.

Howard Liebers: We're looking at the registration and licensure of requirements of other places and trying to figure out if this rule will preempt those states or not and if not then we have an interest in establishing a strict review in DC.

Leighton Ku: So you're suggesting that AHPs that are currently accepted in DC continue to be acceptable. All new AHP's would be subject to review.

Debbie Curtis: I hear Howard talking about what the Department of Insurance wants to do to regulate AHPS in the future which is different than do we want AHP's to meet the mandate? Grandfathered one would meet and future ones would not.

Alice Weiss: Caveat -- I thought I heard Jason and KP suggest that we should qualify that, its not just AHP's that existed before the date that we make this decision should meet the mandate, its AHP's that met the criteria to be considered MEC would meet the requirement.

Howard Liebers: Yes, that's right.

Dania Palanker: However things get crafted, I'd be nervous about grandfathering the AHP because we don't want an AHP that changes their benefits that somehow becomes remaining grandfathered. We want to make sure we're not grandfathering that in if someone is getting it as an IVL or SHOP employee. I'm nervous about how that ends up getting worded. I expect there are some associations now that improved their plans to meet MEC and may try to crop those if we grandfather others in.

Jason Levitis: There have been some good points here including some that I haven't considered in terms of if you had an AHP that was totally compliant but it was all yoga instructors, that could be a problem for the market. I think we agree on where we need to go but there's tech work that needs to happen to work this through. I'd volunteer to help draft some specific rules with others about this.

Amelia Whitman: There is a way to draft that language to say that grandfathered plans qualify but not allow those rules to apply to new plans.

Howard Liebers: We've done policies before where plans should be issued or renewed as opposed to grandfathering a product in.

Purvee Kempf: Let's move on to ACA grandfathered plans and DC Healthcare Alliance. On grandfathered plans there do seem to be grandfathered plans in DC and they meet MEC requirements. Does anyone have interest in changing that in a DC mandate?

Robert Metz: We have about 9,000 grandfathered plans. That's not the entire market. Even carriers that exited the market may have grandfathered plans.

Purvee Kempf: Ok, let's move on to DC Alliance 16k are enrolled that conceivably have no other option for affordable coverage and whether it aligns with DC values to have that qualify as MEC. On flip side, you're permitting coverage that doesn't meet those requirements. It's not a robust plan.

Alice Weiss: What I'm concerned about there are a lot of people who may be purchasing QHPs out of pocket because they're concerned that Alliance doesn't meet current requirements and that they would be subject to a penalty. The reason we have these programs in place is because it's a DC value to ensure that we're providing healthcare access to everyone in need regardless of citizenship or immigration status and I fear that the way this has evolved is undermining that goal. Although Alliance offers a more limited benefit than Medicaid carves out mental health services, those can be sought through DBH. It's not as comprehensive as Medicaid, but it's a solid option that many people rely on and not allowing it to be considered MEC would disadvantage a lot of people who I think we as the District have intended to provide coverage for for free.

Leighton Ku: Since Alliance is for low income people, if you don't exclude it preferentially creates a disadvantage for them. Most if not all are undocumented or within the 5-year bar for Medicaid so should be exempt from the penalty. But I think it helps to put out a clear message that the Alliance is safe as far as the individual mandate goes.

Katie Nicol: Can I also make a point of clarification on ICP because I think it's got the same benefits as Medicaid, but it does not meet MEC?

Alice Weiss: I don't know. It is a Medicaid lookalike and I think the intention is for it to be Medicaid.

Bill Wehrle: What is the income limit Alliance?

Alice Weiss: 200% FPL

Bill Wehrle: What if the policy was to exempt those up to 200% FPL you would take care of those people.

Alice Weiss: Need to remember that Medicaid eligibility for parents and caretaker relatives is higher, childless adults its 210% with another 5% set a side. May be difficult to set a specific number.

Leighton Ku: I think it's also helpful to tell people in Alliance that Alliance qualifies as MEC. Regardless of the income, because eligibility requirements are always confusing for people.

Debbie Curtis: To clarify, I think Leighton is saying Alliance folks shouldn't be exempt but that Alliance qualifies as MEC.

Purvee Kempf: Although most of those people are exempt under federal law under affordability exemption we know that they don't know that they are exempt. Messaging and outreach around the mandate is what makes them go out and look for coverage. There is potentially another benefit of having everyone feel like they need to get MEC and if we say Alliance is MEC it may be helpful to pull people into the market.

Debbie Curtis: Does anyone feel that the Alliane shouldn't count? It sounds like we're in agreement about this.

Bill Wehrle: The only question is whether it could become a place where people above those income levels would start to go.

Purvee Kempf: I'ts fully funded by DC program. It would be very expensive and difficult to change those eligibility requirements.

Let's talk about exemptions from the penalty –

We conform to federal exemptions, and assume that a lot of that is noncontroversial, so let's talk about potential deviations. I want to focus on what you think is meaningful to have in our recommendations.

Short term period without health insurance – we want to consider exemption if uninsured for no more than 3 months (similar to MA).

Individuals/families below a specific FPL threshold - If we want the simplicity of people not having to apply for an affordability exemption, we could set it at a FPL threshold and OTR would give them the exemption even if they didn't take it.

Affordability exemption – we would need to determine as a percentage of income how much people should have to spend on health insurance. Requires an application, review, and adjudication. These are done right now by HHS, so that would be additional operational costs.

This is also where you want to consider MD idea of including MD components which are about how to use whatever we put into law to ensure that we are getting people to use penalty money to get coverage. So you may be getting to same incentive and purpose with MD components that

you are with some of the other options. MD components are prepayment, tax time, and down payment through escrow account.

I believe the discussion should steer around the threshold, affordability exemption, and MD components and if you're ok with flexibility on these then we need to hear that.

Robert Metz: I think you raised a good point, an exemption for people below a certain threshold and also having an affordability exemption are getting at a lot of the same goals that the MD components are and I think CF would look at those options as opposed to MD ones. MD proposals would be complex, not help timeline and not help market as quickly.

Bill Wehrle: I think we would also be supportive of that. The one thing you lose is that people won't be pushed to go sign up for Medicaid which is not insignificant. Yesterday we saw charts that show the drop in uncompensated care and you will lose some of that if you aren't being pushed to go sign up for Medicaid.

Jodi Kwarziany: I was thinking about how we can create a more streamlined exemption process. Thinking about how many people were supposed to be exempt but ended up paying. We need to have a central place for people to go in order to apply for exemptions – can be confusing with IRS, exchange, diff websites and timing. Need to centralize this process.

Debbie Curtis: That's super important, I think Jason can talk about how the feds were thinking about this. We should have those conversations separately because its more implementing than what exemptions are.

Kris Hathaway: You just want to make sure there are no loop holes.

Katie Nicol: Right now the feds are doing all the exemptions for DC so one thing to consider is that HBX would have to implement this and figure out what that's going to cost.

Debbie Curtis: We would absorb that cost.

Leighton Ku: It also depends on what peoples incomes are. Presumably some of that could be covered by OTR.

Alex Alonso: Affordability can be applied for during the year. Once you lose that exemption you get a SEP mid year.

Leighton Ku: Jason, do you have any sense at fed level what proportion of people qualified as a result of the affordability exemption. It's so complicated I wonder if people applied regardless of eligibility.

Jason Levitis: Biggest source of confusion is that under fed rules virtually everyone who is Medicaid eligible is exempt from mandate. Reason it's complicated is your required contribution is based on the full unsubsidized premium (because they're eligible for Medicaid and can't get APTC) which is highly unaffordable. A lot of people didn't realize that. I think that Medicaid

goes up to 215% and 319% for kids and 226% for parents and caretaker relatives. Given that Medicaid eligibility goes up so high in DC you are not going to lose people from paying the mandate. If you put in a low income exemption you won't change who owes a penalty what you will change is who realizes they owe a penalty. That comes with pros and cons because you don't want people to pay, but maybe you want people to think they would have to pay if they don't enroll.

Alex Alonso: We do know that we could lose people from the penalty because we know that people paid the penalty had they applied for affordability exemption would have qualified. So if we put in a flat exemption those people wouldn't be subject to penalty in the first place.

Jason Levitis: Yes, you would lose out on accidental payments but I don't think that accidental payments is something that we want.

Alex Alonso: But those accidental payments could lead to pushing those people into coverage like Medicaid which could reduce uncompensated care.

Alice Weiss: Given that ¾ of people who paid for penalty could be eligible for Medicaid. And given the absence of data around that it was the mandate and not all the outreach work that was done around enrolling, I'm not convinced the penalty is the reason the people came in the door. Plus hospitals in DC are actively applying patients for Medicaid when they are seen. Do we feel comfortable penalizing people who are the lowest income in DC? Despite the fact that they were exempt evidence shows a lot of people paid in 2015 and I don't think It's consistent with DC values generally.

Alex Alonso: I think Leighton is correct that it may not be a very high operational burden to process affordability exemptions but it does take time to handle those calculations. By doing a flat exemption we would reduce the need for us to do that.

Purvee Kempf: For folks considering a flat exemption -- 150% around 18k for an individual, 24k for 2 people and 37 k for 4 people. At 200% - 24k individual 32k for 2 people, and 49k for fam of 4, just to give you an idea of who those folks are. Do people have feelings around doing a flat FPL exemption. If you have thoughts it's helpful for us to understand as a group. Do we want in addition to afford exemption or in lieu of it?

Katie Nicol: If we have a flat 200% FPL exemption, I think we need to not only think of that but also how we can get those people connected to coverage. So if we want Alliance to meet MEC that's going to include this whole other population that wasn't before and I hope the outcome is not just the penalty part but that there is a way to connect people to coverage and get them enrolled. That was one component of the tax time for MD plan granted operations for that are complex but what's great about that, though they're looking at the exemption they're also looking at getting people enrolled.

Jacqueline Watson: Something that will happen in tandem is an investment in health literacy where there is a campaign the Mayor has funded. A large component of this is making sure that we are educating people about how to get people into the system.

Alex Alonso: You could still have a reporting requirement on that tax return about whether that person had coverage or not we just would not be assessing a penalty so we could still have data and OTR could do that outreach.

Debbie Curtis: And hopefully OTR could work with us so we could fashion the materials and work with DHCF Medicaid to create all those materials.

Alex Alonso: Difference with having a flat penalty is that it's not requiring an application. It's a much cleaner process.

Leighton Ku: Worth considering that because taxes are done on an annual basis, Medicaid eligibility is done on a monthly basis there are funny discrepancies between annual income and monthly income. I don't think it's that easy with info on a tax return to determine eligibility for Medicaid. If we decided to impose an income limit that it is one that OTR could implement easily with info on the tax form.

Dania Palanker: I would add that we would hate to have a situation of someone who is 1% above the limit and thought they didn't have to pay the limit. That is not something that would be easy for people to understand. I think there may be multiple options that someone could get the exemption earlier in the year and if they didn't, filing at tax time is a follow up. I want people to get covered but not hurt because they misestimated by $200, or whatever.

Alice Weiss: Idea of having a checkbox on your tax form may be helpful here because one key issue is privacy of tax info. Once received by tax agency it can't be sent anywhere else. I think MD and MA later did this but you can put a checkbox on the tax form that says I'm interested in sharing my info to determine my eligibility for health insurance. I hear Leighton's concern about the household changes but you could have another checkbox saying that you're interested in applying for coverage to help streamline that.

Leighton Ku: This is like when school begins every year, there is an option for kids who apply for reduced price lunches to also apply for Medicaid.

Purvee Kempf: Does OTR have a mechanism to share information?

Deborah Fries: No, don't think so.

Purvee Kempf: Helpful to learn from MD on this one about using their tax form to get info to them about health insurance options.

Leighton Ku: By the time they are filing their taxes the year has lapsed so last year's income doesn't apply for this year's eligibility. This would just be about getting them into the system as opposed to determine eligibility.

Purvee Kempf: So what I heard on this piece is that we should do both. If we have a threshold we should also have an affordability exemption so that you have the comfort level for people

who apply for the affordability exemption and don't have to worry about if their income changes. And I heard that we definitely want to do something around using this as a point in time to figure out how to get info about getting insurance to people who are still not covered.

Deborah Fries: Whether this only applies to only adults or children could inform threshold limit. If we exempt children, we don't need to align with Medicaid because kids levels are higher.

Rob Metz: From a political perspective, push back is that federal mandate is a regressive tax that forces people to purchase coverage that's not affordable.

Purvee Kempf: I heard a general consensus that we need to ensure that this isn't regressive or applying to our lowest income folks, so we can write this part broadly and allow some flexibility about how it's implemented. Once we start having more specific convos with OTR about this, if a flat line exemption is helpful, we can put that in but leave it more general knowing that we want to have an exemption for our most vulnerable populations.

Leighton Ku: I propose that we have an income exemption level around 200% FPL recognizing how that gets done might end up varying because of complexities around monthly vs annual income, and also have with that the options for affordability exemptions and hopefully that would reduce the number of people who need to apply for an affordability exemption.

Alice Weiss: Could we align the threshold with Medicaid to protect those people?

Leighton Ku: Only thing I'm concerned about there is that there are different Medicaid levels for adult and children. I don't think OTR assessment of income to align with how Medicaid assesses it.

Purvee Kempf: Let's go to penalty calculation. First question is about who it applies to and the penalty itself. It's a complicated formula and would be easier to implement the federal rules, we could put out the bronze levels each year as a cap. Do people want to exempt kids?

Bill Wehrle: I think we support the federal approach for simplicity and it is regressive in the sense that it's based on income. Problem with exempting kids across the board is you're taking away the incentive for parents to enroll them in coverage regardless of income. Our focus should be on family's resources regardless of anything else. If we have an exemption around 200% FPL that's a better way to approach it than saying kids don't have to have coverage.

Rob Metz: Fed mandate should be treated as a floor. The $695 minimum payment becomes irrelevant if we around 215% FPL because $695 is about 2.5% of income at 215% FPL.

Jason Levitis: The 2.5% ignores children, that is a percent just based on income. I think fed approach is not simplest but it's designed to take into account all the members of your family on one hand and also ability to pay on the other hand.

Alice Weiss: Also an operational issue for tax preparers if we change fed rules.

Purvee Kempf: Tax preparers will have to use that structure to their DC tax form calculations. If ever the number from 0 goes to something, we would be aligned with the fed structure. Given that the penalty helps you already take into account the family and income levels for exemptions, do we really need to exempt children? One of the reasons MA did that is because they had a different structure well before ACA. Given ACA does that through structure of penalty and affordability exemption, do we have a need to exempt children, assuming we do the 200% FPL threshold?

Katie Nicol: I know Alice is working to figure out ICP in conjunction with Alliance and what that looks like, since ICP is same population as the DC Healthcare Alliance, I just want to make sure that they aren't paying. Many of them are tax filers. We want to consider ICP for reference at the same time we are considering Alliance.

Alice Weiss: The affordability piece we just discussed which is if we make it flat and relatively lower, need to remember that Medicaid and CHIP is at 319% FPL. I'm assuming we wouldn't want to impose a penalty for kids who are eligible for Medicaid, CHIP or ICP.

Purvee Kempf: Maybe there is something for us to consider around a set threshold because you always have someone who is maybe eligible for a program that may be paying a penalty. A recommendation that's broader may be the way to go so we can work through those difficulties as it works its way through.

Alex Alonso: To the degree you have a nuclear family which includes kids it accounts for the fact that kids are CHIP eligible and make that family with non-Medicaid eligible parents and CHIP eligible kids, they are eligible for the affordability exemption. So if we had both the flat and affordability exemption that would account for the issue Alice raised.

Purvee Kempf: Let's move on to framing question 4 – getting ready for 2019 implementation may require we have something simpler and that we could consider refinements at a later time. If there are specific policies that we want to consider but won't be in place by 2019, we should talk about those here. If you want a nod to it in the recommendation this is where we want to include that.

Last framing question 5 – How should funds be used? As a reminder as part of part 1 WG this group included in its recommendation on the individual mandate policy fallback policy that any funds received through the individual responsible requirement will be placed in a new HBX managed fund that will be used for the sole purpose of insurance market stabilization. In MA funds go to state APTC wrap. Should we reiterate something like this?

Rob Metz: CF would strongly support reiterating that any funds collected from the mandate would be used to help consumers afford coverage, and might call out the two programs reinsurance and APTC wrap. Would make it easier to sell.

Leighton Ku: Thanks. I am asking the staff some recommendations based on what we have heard and will like to think we could get it out immediately but hopefully before Mondays 9:30

meeting. I expect we will try to proceed with votes on Monday or Wednesday. If you can't be here for either meeting email Debbie.

Adjourn.