ACA Working Group
1/19/2018
Notes

Roll Call

Present
Leighton Ku
Jodi Kwarziany
Colette Chichester
Robert Metz
Robert Axelrod
John Vu
Kristen Hathaway
Dania Palanker
Justin Palmer
Carl Chapman
Patricia Quinn
Katie Nicol
Tammy Tomczyk
Peter Rankin
Jnatel Sims
Maria Gomez
Jacqueline Watson

Absent
Donna Alcorn
Dave Chandra
Margaret Singleton
Jenny Sullivan

Welcome, Charge, and Past ACA WG Recommendations
Leighton Ku (Chair): We're convening the ACA working group on behalf of the DCHBX. For those who joined us last year thanks for coming back, and for those that are new, thanks for your efforts. This is an intro meeting. Main focus is expressed in Mayor Bowser's charge to HBX Board.

The Mayor's charge is posted on the website:

> *The repeal of the Affordable Care Act (ACA) individual mandate will lead to an increase in premiums and loss of coverage for millions across the country and thousands here in the District. While I continue to call on the federal government to expand access to health care coverage, it is clear that the current Congress and administration refuse to show leadership on this issue. I ask that the HBX Board reconvene the ACA working group, with the charge of recommending actions the District government should take to protect*

coverage gains and ensure affordable health coverage for individuals and small businesses. I am requesting that the working group consider whether there are actions DC should take in light of the repeal of the individual mandate.

Jay Melder (DMHHS): Mayor provided 4 additional points that she wants this group to consider:

1. Assess the impact of the repeal on insurance markets in the District and access to affordable coverage options for District residents
2. Assess the impact of the repeal on our government agencies' operations and budgets
3. Assess the impact of the repeal on the healthcare delivery system in the District of Columbia
4. Make recommendations to mitigate the impact of the repeal on the District of Columbia, including financial and policy/legislative analysis

Leighton Ku (Chair): We have a broad group of people representing DC agencies, we'll get some insights from this group and from parties that will be affected by this. I want to recognize Jodi Kwarziany, our Vice Chair, to address work that was done in part 1 of working group.

Jodi Kwarziany (Vice Chair): As many recall, our group put forward 4 recommendations for DC Government to consider to mitigate effects of federal level action prior to repeal. The recommendations are on our website.

The 4 recommendations were:

1. Implement and collect an individual responsibility requirement penalty for taxpayers beginning for 2019 where the federal government fails to enforce the federal Affordable Care Act individual responsibility requirement
2. Pay carriers the equivalent of the Cost Sharing Reduction (CSR) payments due to carriers by the Federal Government under the Affordable Care Act where federal government failed to make such payments
3. Implement a local reinsurance program beginning in the 2019 plan year based on carriers' claim costs
4. Implement an annual local District subsidy beginning for plan year 2019, or if not practicable, as soon as possible thereafter, that would be in addition to federal Advance Premium Tax Credits for those under 400% of the federal poverty level

Leighton Ku (Chair): Thanks Jodi. These were forwarded to HBX exec board and approved unanimously. Since then, the tax bill snuck up on us. The mandate is in place this year but will disappear in 2019 and DC (along with a number of other states) is considering what should be done because of that.

Debbie sent you a copy of both the CBO report and American Academy of Actuaries analysis on potential effects of mandate repeal. Both indicate that repealing the individual mandate would reduce coverage. After several years they expect 13 million more to be uninsured, with losses to Medicaid, the exchange, and other private insurance coverage. And there's an expectation that

premiums would rise by 10%, so there are strong implications that insurance markets would suffer. These days one never knows what's coming down in terms of legislation about CSR or reinsurance, or questions like if CHIP will be reauthorized, so our agenda may change somewhat over time.

In addition to some of these things, there's been speculation that CBO made the numbers up. I've heard this from conservatives that there is widespread disagreement about these numbers. The answer is that since Massachusetts created its own version of individual mandate there have been a number of studies that have been done about that by well-respected researchers who agree that, in fact, the creation of the mandate expanded insurance and helped control premiums. So we infer over time if the mandate goes away those effects will reverse and we'll see a reduction in insurance coverage. None of the estimates talk about DC specifically, so to the extent that we can keep about those things, we should. There will be a lot more analysis on this. Other comment I want to make is as a DC resident. Just today I was talking with one of my colleagues who is younger and she has health insurance and expects to retain it so supports an individual mandate, but knows that she may become uninsured or unemployed and likes having the exchange as an option for insurance. For a lot of people in DC and some at a young age, income is tight. The purpose of the individual mandate is to provide further incentive for these people to retain health insurance. So there's a risk that some would opt to go without insurance and we could see some of the effects that CBO talked about in our healthcare system at many levels. With that, I'll stop and see if others have thoughts. I'll turn to Jodi first.

Member Perspectives

Jodi Kwarziany (Vice Chair): I echo Ku's concerns. From my perspective at DC Health Policy Institute, where you see issues in health you really see the ripples in many other areas of people's lives, like affordable housing, homelessness, education, and so on. I'm concerned from a health perspective that if people are losing health coverage it may be affecting other aspects of their lives. Want to bring the holistic approach to the table. I also want to share the views of Jenny Sullivan and Dave Chandra. Jenny is supportive of this group coming together and interested in further analysis and wondering if we can learn from Maryland's down payment approach. Dave is also supportive. He felt strongly both as a consumer rep and as a person who uses DCHL to get coverage of what this impact could have on premiums in DC. He wants DC to look into a DC-wide mandate, feeling that local government did have capacity to take this on and that DC can do the level of educational outreach needed to inform consumers about that.

Leighton Ku (Chair): Let's open it to the floor to see what other folks have to say about this. Start with folks on the phone.

Maria Gomez (Mary's Center): Thanks for bringing the group together and inviting me. MC runs 3 community health centers in DC and some in MD and what we are seeing is something that is very scary -- convergence of a lot of issues. ACA has allowed them to get preventive care they need. Things like family planning for women. There are concerns about no preventive services for catching cancer and other chronic illness' early. We know ACA has had an impact on catching things so early and makes things less expensive. Young people also say I'll just stay out of it, if I need services I'll just go to places like MC to get healthcare. This is a problem for MC's bottom line. People who aren't insured often can't pay and have other bills to worry about.

But once they come to see us we have to treat them regardless of if they're able to pay or not. Result on bottom line will be big. For those folks that are on Medicaid and also on the ACA there are a lot of concerns and rumors about Medicaid going away, or maybe not covering certain things. Third issue is about immigrants. Convergence of all these issues has a lot of people scared. Every day at our centers we need to do training with front desk staff because people come in and start crying, and these are people that have insurance. They have anxiety about the ACA or Medicaid going away along with immigrant issues. I want to say that this whole thing has such an amazing ripple effect on people's lives.

Leighton Ku (Chair): Thanks Maria. Mary's Center is at the front line for helping a lot of needy people. We salute you for all the wonderful work you do. Another thing that's stuck is community health funding. This needs to get resolved. It wasn't in last version of the continuing resolution the House just passed.

Rob Axelrod (Kaiser Permanente): We share a lot of concerns that have already been discussed. Repeal of mandate will result in loss of coverage and higher premiums. No mandate means those who bought coverage because of mandate will drop out. There will be less healthy folks which means that spreading claims cost means higher cost per person and higher premiums. Since DC combines individual and SHOP we think there will be volatility in rates in both markets. We liked the piece by the American Academy of Actuaries.

Kristen Hathaway (AHIP): Also EO coming out could really impact the risk pool, so agree that we'll see a whole lot of issues come to a head here.

Leighton Ku (Chair): Just want to say DC has done great job and has one of the lowest uninsured rates in the country. So we've made tremendous progress and I think that's part of the underlying concern. We want to continue to move forward, not backward.

Dania Palanker (Georgetown Center for Health Insurance Reform): Want to echo the insurer research things that Leighton said; research is not necessarily DC specific but without mandate we take the risk of increasing premiums and destabilizing individual market, which would be a shame. DCHL has been such a success and it would be a real shame to lose some of the progress we've made. We've reduced health insurance disparities and gotten young people enrolled. We need to find ways to keep that going. We now know people need to have an incentive to enroll. From conversations I've had with other insurers before the mandate was repealed, they were saying there would be real concern about whether they would participate in market or what would happen to stability of market if penalties went away.

Alice Weiss (DHCF): Joined the call echoes concerns of others. HBX and Medicaid are walking hand in hand down this road as we think about coverage options for DC residents. We have some policy choices to make about programs we offer here in DC (Medicaid, Alliance). To follow up on what Maria said, we will continue to support coverage for people in DC so most people in DC should have access to meaningful coverage options and shouldn't have to go without (we hope). We want to stay in touch with Mary's Center or other organizations if they're hearing that low income people aren't enrolling in Medicaid or alliance.

Leighton Ku (Chair): Though we are convening on behalf of HBX, we do recognize that Medicaid and DHCF are likely to be affected by this and that ESI and other private insurance in general will also be affected. Mandate applies across the board.

Patricia Quinn (DC Primary Care Association): When thinking about a local mandate and supporting a local mandate, it needs to be closely linked to robust coverage options. Part of why we could say yes was because of expansive Medicaid programs that DC has invested in. For anyone that's focused on any kind of safety net population the idea that we have a mandate and some poor people would be accountable to that is highly problematic. Having Medicaid and alliance is critical, coverage has to be affordable and if that stops happening that's when we would have to back away from a mandate, if that stops happening.

Jacqueline Watson (DOH): I'm new to the WG and have a question about numbers just to orient myself here - how many people are covered currently through HBX? And are those DC residents?

Debbie Curtis (HBX): We have about 18,000 people on average in our individual market. They're all DC residents. That number varies throughout the year. Individual market is not a static market – it changes all the time when people move in and out of DC for work, school, etc. We do also have a large self-employed pop in DC so those people stay in the market. On small business side, we have 76,000 covered lives on small group side. Congress covers abut 11,000 of those. SHOP includes employers with 50 or fewer employees. We have the biggest small group exchange marketplace in the country. On the SHOP side, not all covered lives are DC residents. They're all employed in DC.

Leighton Ku (Chair): What are the numbers for Medicaid and Alliance?

Alice Weiss (DHCF): About 260,000 on Medicaid. I'll need to check on the Alliance population. Last time I checked between 12,000--15,000.

Patricia Quinn (DCPCA): Has HBX done any analysis of what you project the impact to your programs will be? We have national data that makes those guesses. Can we get an estimate of premium increase change?

Debbie Curtis (HBX): That's our goal to figure out. We're working on that right now, to develop that kind of analysis.

Leighton Ku (Chair): Some aspects on premium increases are tricky because we're talking about 2019 and there will be issues of healthcare cost increases that naturally go on between now and then. Also tough for insurers to make projections because of so much uncertainty, so many actions taken by HHS and Trump admin has made it a scary time for insurers and of course they have to worry about their bottom lines. DISB monitors and regulates rates but the expectation is that there will be increases. Again, this is another area we've been fortunate because we have low uninsurance rates so we've been pretty successful in keeping rates down and growth moderated.

Collette Chichester (CareFirst): Mandate was key underpinning of ACA and seeing that eroded does cause a lot of concern on insurer side. We are interested in best possible way to have a stable risk pool. Removal of mandate removes a lot of healthy people from the risk pool, which makes it an older and sicker and more expensive risk pool. Mandate shares responsibility across populations so you can have an affordable product to offer to consumers. We worry about affordability. Premiums will go up we're guessing 10-15% right now. That may change.

Purvee Kempf (HBX): On 10-15% to clarify – is that because of the mandate alone, not counting general healthcare cost going up?

Debbie Curtis (HBX): So increases, you're estimating, would be greater than the 10-15% in 2019 if we include general healthcare costs going up.

Collette Chichester (CareFirst): Correct.

Katie Nicol (Whitman Walker Health): We are a FQHC and specialize in HIV and LGBTQ healthcare. Much of our population is people who have multiple chronic illnesses. We have insurance navigation teams that predate the ACA who help people assess what their insurance needs are. We know that removing barriers to payer issues will increase access to healthcare. With ACA we saw shift of health outcomes of our patients because they're able access to healthcare. Jodi really hit the nail on the head. The impact of no access to healthcare will bleed into social determinates and a decrease in access will affect health outcomes of our most vulnerable populations. Mandate removal and premium increases and cost sharing increase makes it difficult to access quality health care for our patients.

Peter Rankin (AARP): We represent the 50+ pop. They pay 3x as much for coverage between 50-65. As a result of a loss of this mandate 4 million people in this group would be uninsured. Cost is a big factor for us. I'd like to see data from DC for the 50-65 population – how much they use HBX and what the impact could be of cost and loss of coverage there? I think that'd help mobilize our members and get us keyed in for DC specifically.

Jnatel Sims (UHC): UHC doesn't sell IVL policies in DC but as a member of carrier community we're interested in market developments so we continue to have an interest in the ACA WG.

Jay Melder (DMHHS): A lot of this work is about trying to make sure that access to health care is affordable, that we have a healthy mix of beneficiaries. Since we have healthcare partners in the room, are there tactics we can take to reduce healthcare costs in general rather than just the cost of insurance?

John Vu (Kaiser Permanente): We think premiums will increase and members will lose coverage. Insurers will lose money and so I support efforts to stabilize DC market.

Maria Gomez (Mary's Center): In response to Jay. Believe me: there are a lot of hours spent on that. DHCF, DCPCA, and CHC's are working hard to make that happen. Honestly, we are all

doing our best to make sure that we cut costs and one way is to make sure that CHC get support to make sure preventive care is available so people aren't ending up in hospitals.

Justin Palmer (DC Hospital Association): We have concerns across a lot of areas, especially about the Medicaid population because they're a large payer group in DC. The earlier we get people into care the more we reduce costs. ER care is one of our highest costs. We have concerns for commercial payers and really anything that destabilizes the market or increases rates. DC has done a great job at lowering uninsured rates but also uncompensated care. And anything that reduces enrollment will start spiking uncompensated care back up. Anything that upsets SHOP markets also concerns us. We're invested in making sure that people have coverage and that people get care when they need it.

Closing Remarks and Looking Ahead

Leighton Ku (Chair): I'd like to turn to scheduling. I think we'll need 3 or 4 meetings or more. Let's lay out the time table to get a sense of the urgency to move promptly. Because this involves tax policy we need to have these known to tax payers and administrators both in the Office of Tax and Revenue and also for administrators of hospitals and insurers. A specific thing is that insurers submit rates for 2019 in May. Our goal is to have recommendations to go forward to Executive Board at their meeting on 2/21. At our meeting next week, we will have some speakers. Who are we going to have?

Debbie Curtis (HBX): We have Audrey Gasteier from Massachusetts. She'll talk through MA's individual mandate and why it did that and how it benefited them. Then Jason Levitis will present. He was at Treasury for many years and helped implement individual mandate there. He will talk through how the Federal mandate can work at state level. So those two perspectives are 1) a state that did it on their own and 2) how to build on what federal law does. Last we have Stan Dorn from Families USA who will talk about MD's proposal in lieu of federal mandate. I'll circulate presentations in advance.

Purvee Kempf (HBX): If you have other questions about data or anything else email me and Debbie and we'll see if we can pull answers together. Bring questions to presenters next week.

Leighton Ku (Chair): As a reminder, in general if you have questions use Debbie as a POC. In addition, to the extent that you have an initial sense of you or your organization's reaction to options about what to do, let us know. An obvious one is to take federal rules and implement them at District level instead. MD has talked about down payment option. Let us know if you have other thoughts or ideas. The expectation is to come up with actual recommendations to vote on and send up. Consensus is the goal, especially from a group like this.

Alexis Griffin (EOM Budget): I don't think we have until the recommendation time to make a budget suggestion, so we'll need a plug for FY 19 budget. Budget is submitted March 23. Mayor is starting to look at budget next week. The sooner we can get a plug for the budget the better.

Jay Melder (DMHHS): Well I do think we have budget recommendations from previous working group.

Debbie Curtis (HBX): To be clear, (and Deborah Fries helped us get those numbers) when we were talking about that it was very different from operationalizing an individual mandate. My thought is that we will need help from OCFO and Tax and Revenue to figure out what it will cost to do this. This will need to be a different conversation.

Deborah Fries (OCFO): We'll go back and look at what we talked about then.

Leighton Ku (Chair): Do people have estimates about how much revenue has been collected by federal government for mandate, and estimates of the amount of revenue that will need to shift over?

Purvee Kempf (HBX): Earlier recommendations were based on 2015 data. That was the most recent data we had.

Debbie Curtis (HBX): I don't know if Treasury has released 2016. Info from report shows 7,150 returns and $3.45 million collected by federal government. In 2015, mandate was much lower. Was $95 per person, its now $695 or more per person. When we see 2016 numbers its going to be much higher. IRS holds this data and makes it hard to get. Also, report info is what federal government got from DC filings.

Deborah Fries (OCFO): If DC is considering penalty on par with higher number, then that data under the higher penalties will be more useful.

Leighton Ku (Chair): The number of filers who are uninsured should be in the ball park of what we saw before. The real difference will be level of revenue per person.

Debbie Curtis (HBX): If you take less than 4% of our pop, it's about 27,000 who are probably uninsured. Of those, some don't pay taxes or are not here legally so they are exempt.

Leighton Ku (Chair): Adjourning. Look forward to hear back from you next Tuesday.