November 6, 2017

Recommendations of the ACA Advisory Working Group to the District of Columbia Health Benefit Exchange Authority

This report is submitted by the Affordable Care Act (ACA) Advisory Working Group, chaired by Leighton Ku and vice-chaired by Jodi Kwarciany. The working group's charge was to identify local policy options to protect and strengthen ACA protections in response to potential changes through regulations, guidance or law at the federal level.

Background

The Affordable Care Act (ACA), also known as Obamacare, is often referred to as having been built on a three-legged stool. The first leg is an individual responsibility requirement to have minimum essential coverage (MEC), bringing the young and healthy into the health insurance market. The second leg are insurance market reforms and consumer protections such as guaranteed issue without any preexisting condition exclusions or higher rates based on health status. And, the third leg are affordability provisions such as tax credits, cost sharing reduction (CSR) payments, and cost sharing limits. All three are critical for a stable health insurance marketplace. Although Congress was unable to repeal and replace the Affordable Care Act during FY 2017, the Trump Administration has taken several actions that pose threats to the stability of the health insurance marketplace. For example, on January 20, 2017, President Trump issued an executive order telling executive branch agencies to grant "relief" from the ACA. Since then, additional executive orders, guidance, regulations, and executive actions have been aimed at undermining the ACA.

The goal of this working group was to develop recommendations for the District of Columbia that could mitigate the negative consequences of new Administration policies, in order to stabilize the market and continue to provide affordable coverage.

Individual Responsibility Requirement: The Administration has repeatedly sought repeal of individual responsibility requirement to have insurance coverage and has taken actions to reduce enforcement of the mandate. In the spring, the Internal Revenue Service (IRS) announced that if the line item on a person's tax return requiring health coverage was not filled out, the tax return would not be considered incomplete and would be processed. Although the IRS modified its position in October and said it would impose tax penalties on those without insurance coverage, there remains great uncertainty over the Administration's commitment to enforcing the individual responsibility requirement. Uncertainty can result in sharp premium increases and enrollee participation changes. The individual responsibility requirement is a critical component of the three-legged stool to provide stability on which the ACA is built.

Cost-Sharing Reduction Payments: Under the ACA, insurance carriers are required to provide reduced out-of-pocket costs to eligible low-income and Native American enrollees and the federal government reimburses carriers for those cost reductions. After making last minute decisions month-to-month on whether to continue making these payments – which destabilized marketplaces because of insurance carriers' inability to count on these funds being made available – the Trump Administration announced in October 2017 that no more CSR payments would be made. In fact, the Administration announced that it would not even reconcile payments that had already been made to carriers. But, if payments were found to be in excess of what carriers were due, carriers would need to reimburse the federal government for those excess payments. The last CSR payments were made in September 2017.

Outreach and Enrollment: Through regulation, the Trump Administration cut in half the federal marketplace's open enrollment period, from twelve to six weeks, which many fear will reduce enrollment. Because the District has a state-based marketplace (SBM), HBX is able to extend its open enrollment period this year. On June 14, 2017, the HBX Executive Board voted to maintain a full twelve week open enrollment period running from November 1, 2017 through

January 31, 2018 – as the District has had in the past. In addition, the Trump Administration slashed funding for outreach and enrollment. Federal outreach has been important in getting consumers to DC Health Link through healthcare.gov. The Trump Administration cut the federal marketing budget for open enrollment from $100 million to $10 million and cut funding for navigators in federal marketplace states by 60%. As we are located in the nation's capital, national news saturates the local news for our residents. Thus, past federal advertising was a real boon to the District, amplifying our local efforts and messages. Instead of federal efforts amplifying District efforts, they are now contradicting them and confusing District residents about the status of the ACA, their ability to enroll, and the length of the open enrollment period.

New Executive Order: On October 12, 2017, the Administration issued an executive order on association health plans (AHPs), short term insurance, and health reimbursement arrangements (HRAs). These measures have the potential to further harm private insurance markets.

These and potential future actions could undermine the success achieved so far in the District through our effective implementation of the ACA. As a reminder, the District's rate of uninsured has been cut in half since DC Health Link opened for business in October 2013, with the District ranking in the top three states in the nation for covering our uninsured – with more than 96% of District residents having coverage today.

Introduction

The ACA Advisory Working Group was formed in the summer of 2017 to develop policy recommendations for District policymakers to consider in light of the destabilizing effects of Trump Administration actions. Its charges were as follows:

> **1. Identify local policy options to strengthen the ACA protections assuming that the ACA is not repealed (or replaced).** The ongoing Administration actions are jeopardizing the stability of our health insurance marketplace, e.g. not enforcing the individual responsibility requirement, no commitment to reimburse cost sharing reductions. The focus here is affordability, consumer protections, and market stability.

2. If the ACA is repealed: identify local policy options. The focus primarily is private health insurance (small group and individual marketplace) – affordability, consumer protections, and market stability.

Charge #1 is focused on the Trump Administration's actions and potential future actions that are contributing to instability in the marketplaces and recommendations to counteract such actions.

Charge #2 is focused on recommendations if the ACA is repealed. At this point charge #2 is not relevant because the ACA repeal and replace bills considered by Congress this year failed to move forward. It is not clear if Congress will return to full scale repeal efforts this year. But if Congress is able to pass a bill to repeal core components of the ACA, the working group could be asked to reconvene to consider additional policy interventions.

Discussion

At the introductory meeting on August 2, 2017, Executive Director Kofman outlined the charges to working group participants. In outlining the charges, she noted that the intent of HBX is to combine these policy initiatives as put forth by this working group with a general clean-up bill that would revise District ACA-related laws to ensure they continue to operate as intended with regard to the state-based marketplace and consumer protection standards. These updates will also help ensure that these laws withstand potential harmful federal actions. In addition, she noted that the work of this working group would be intense and would require significant participation. Finally, she noted that if anyone who had signed up wanted to make clear that their participation would be as a non-voting member, they would be welcome to notify HBX staff and they will be designated as such.

Individual Responsibility Requirement

The individual responsibility requirement is a provision in the ACA designed to motivate people to maintain health insurance coverage, or pay a tax penalty on their federal taxes for remaining uninsured. It was first implemented in 2014 and individuals can qualify for exemptions. To qualify as insured, a person's coverage must meet "minimum essential coverage" (MEC) requirements spelled out in the ACA. Most private health coverage, including employer

sponsored insurance, Medicaid, and Medicare, qualify as MEC. Limited benefit plans, or "excepted benefits" under HIPAA, do not qualify as MEC, nor do so called "mini med" plans or limited duration plans.

Early in the Trump Administration, the IRS indicated that it would permit tax returns to be processed even if the line item asking about health coverage was left blank, as described on the IRS's ACA information webpage for tax professionals. That IRS action would result in someone without MEC avoiding the penalty. However, on October 14, 2017, the IRS released a statement that "[t]he IRS will not accept the electronic tax return until the taxpayer indicates whether they had coverage, had an exemption or will make a shared responsibility payment." As we have seen already with this Administration, positions and policies change, sending conflicting messages. There is no certainty whether the IRS will change positions again or what the IRS may actually do when tax returns are filed for tax year 2017.

Without a fully enforced requirement to have health insurance, younger and healthier people may not purchase coverage, leading to rate increases as the remaining pool of those with insurance through the individual market have a less healthy profile. The question is whether the District wants something in local law that would provide enforcement of an individual responsibility requirement.

The working group heard from HBX staff about the state-level individual responsibility requirement in Massachusetts (MA), which predates the ACA. After passage of the ACA, MA amended its law to ensure that people did not face a double penalty. Now, in MA, if a person is subject to the federal penalty, the amount of the federal penalty paid is deducted from the amount the person would owe to MA.

Staff outlined the options as follows:

> Option 1. Mirrors the federal individual responsibility requirement and only collects money at the local level if the federal requirement is not enforced (a "fallback").

Option 2. Is similar to the MA requirement – has a different penalty amount and different criteria, but deducts from collection the amount an individual has paid to the federal government under the federal ACA individual responsibility requirement.

The working group discussed operational and implementation issues. A representative from the Office of the Chief Financial Officer (OCFO) participated to provide technical advice. She informed the group that the Office of Tax and Revenue (OTR) would need to make IT changes and develop instructions, and make changes to the paper tax form, which are printed in August each year. Legislation would require an identified funding source for these operational costs over four years. A rough cost estimate provided by the OCFO representative is $1.1 million over four years, based on the implementation of other tax provisions that required similar operational changes. Compliance monitoring would be done at the District level and OTR could run a match against federal tax data. There are approximately 200,000 tax filers in the District. Given the operational steps that would need to be taken, the earliest a fallback could be implemented without retroactive application would be for tax year 2019.

Working group members discussed a new tax versus implementing a fallback requirement. Members of the working group thought it more palatable to talk about a fallback rather than implementing a new tax. Still, some consumer advocate members presented concerns over a potential new individual mandate. The working group coalesced around discussion of Option 1. Under this proposal, a District fallback would be in place if the federal government were not to enforce the federal requirement for individual responsibility.

There was some confusion about this provision and whether it was actually instituting a District individual responsibility requirement. Over a number of meetings it was clarified that it is not the intent of this working group to enact a new District individual responsibility penalty. This discussion is confined to actions the District can take to respond to potential actions by the Trump Administration that weaken enforcement of the ACA. If Congressional legislation were to pass that repealed the federal individual responsibility requirement, then this working group will need to reconvene because it would be likely that additional changes to the ACA were enacted as well. As the working group is focused on Charge #1, the policy described here is

simply the District effectively enforcing the federal individual requirement provision through a penalty via District tax returns if a person does not obtain minimum essential coverage and does not pay the tax penalty at the federal level. There is no triggering event for this fallback to become effective and it would apply to anyone subject to the individual responsibility requirement who did not have minimum essential coverage, did not have an exemption, and did not pay the federal penalty beginning in tax year 2019.

The working group also highlighted that the purpose of this fallback penalty on District taxes is not because members wanted a new revenue source for the District or that members wanted people to be forced to pay a new tax penalty. Rather, members want people to obtain health insurance. And, as the individual responsibility requirement is perceived as a key component of achieving that goal, the District would enforce the requirement if the federal government will not.

If, however, the District were to realize revenue from this recommendation, the working group agreed that the funds should be placed in an HBX-managed fund dedicated to market stability.

Cost-Sharing Reduction Payments

As stated above, insurance carriers are required to provide reduced out-of-pocket costs (deductibles, co-insurance, copayments) for health plan options to eligible low-income enrollees and Native Americans. The federal government reimburses carriers for those cost sharing reductions (CSRs). Individuals generally above Medicaid eligibility up to 250% of the federal poverty level (FPL) are eligible to receive CSRs in the individual market. The federal law included these CSRs because this population is the least likely to be able to afford the significant cost-sharing that is inherent in most individual market plans. In the District it is a relatively small group of individuals since Medicaid eligibility goes to 215% of FPL for childless adults, people are eligible for CSRs only up to 250% of FPL, and there are few Native Americans. HBX estimates that about $150,000/year is reimbursed to carriers in the District under this program and that at any given time, there are approximately 300 people receiving CSRs from carriers in the District.

As noted above, the Trump Administration has cut off any CSR reimbursements to the carriers after September 2017. While the number of people receiving CSRs in the District is low, the carriers are in agreement that writ large, it is extremely important that CSR payments be reimbursed. If reimbursement is not made, consumers will not see CSRs go away, as carriers are required to offer them to consumers, but the effect of carriers having to absorb those payments would force them to raise premiums to offset the losses. Even though the value of CSRs is small in the District ($150,000), the nationwide value of these CSR payments exceeds $7 billion and is forecast to be more in 2018 and beyond. If these expenses are not reimbursed, there will be a ripple effect across the insurance industry that could impact the District over time.

A question was posed to the working group: Should there be a District fallback if the federal government does not make the CSR payments? Working group members quickly coalesced around the position that the District should have a fallback if the federal government fails to make the CSR payments. While there is a minimal immediate impact here in the District on premiums, working group members thought it was an important statement of commitment to market stability that the District would reimburse carriers if the federal government fails to do so. In addition, carriers noted that it was an important example to set for other states as well as our local carriers operate in various regions, not just DC. Finally, it is an opportunity for the District to stand out as a leader.

While supportive of this action, working group members cautioned, however, that it is important to make sure a local District program is not administratively burdensome on HBX or District health insurance carriers. Given that the value of these payments is less than $150,000 a year, the working group agreed that they would not want to create a program that cost close to that to administer. Therefore, when developing this policy, District policymakers should ensure it is implemented in a time and manner that minimizes operational costs for carriers and District government.

Reinsurance

Reinsurance programs are designed to help meet unexpected expenses, e.g., when a small number of people have unusually expensive claims; a small number of unexpected claims can

create substantial losses for carriers. The federal reinsurance program in the ACA was established as a temporary program and expired after 2016. However, it is clear that a role for federal reinsurance is still needed as individual markets remain unstable with the ability of a few expensive cases to negatively impact rates severely. Everyone agreed that reinstating a robust federal reinsurance program would be the best option. In its absence, however, the working group began the discussion on local options.

Staff presented background information on reinsurance options. Many other states are trying to establish local reinsurance programs, some through section 1332 waivers. Section 1332 of the ACA allows states to waive certain provisions of ACA, use funds differently than under the ACA, and tailor a unique program to their local markets. Consumer protections cannot be waived, and there are also comparability requirements. Budget neutrality is required. States are able to achieve budget neutrality by lowering expenditures of advance premium tax credit (APTC) funds in their states by creating alternative programs. Waivers must be approved through state legislation and by the Centers for Medicare & Medicaid Services (CMS). Because the District has a robust Medicaid program that goes up to 215% of FPL for childless adults and even higher for parents and children, the District has low APTC eligibility/participation. Due to the low number of individuals receiving APTC, section 1332 waivers are not an option in the District. In addition, there is a danger that CMS could respond to a waiver application in a manner that undermines other programs in the state as was done by the federal government in response to the Minnesota waiver request. The working group agreed to consider a local reinsurance program that would not require a federal waiver.

The working group had a robust discussion about reinsurance in general. True reinsurance in concept is that helping with high cost enrollees will help control premium costs. Carriers are supposed to calculate premiums based on the risk profile of people who enroll. It cannot be predicted perfectly. A reinsurance program should reduce volatility and make rate filings more accurate.

The federal reinsurance program in effect for 2014, 2015 and 2016 was an attachment point model. An attachment point model picks a dollar amount (the attachment point) above which a

carrier's claims for an individual will be assisted by reinsurance at a certain level. For example, a reinsurance program could set the attachment point at $50,000. Reinsurance would kick in for claims for an individual above that amount. The reinsurance amount can also be capped, and the reinsurance would cease at the dollar amount chosen, for example, at $300,000. Also, the reinsurance amount can be a percentage of the full amount of claims between those two numbers – 80% of claims are reimbursed by reinsurance, or 50%, or 100%. For the federal program, the attachment point was $45,000 in years one and two and $90,000 in year three. It had a $250,000 cap for all three years. Payments were made by the federal government for claims between those amounts to offset that risk at 100%.

A second type of reinsurance is condition-based reinsurance. The reinsurance program identifies certain medical conditions and carriers are helped offset the risk of those medical expenses. Examples of conditions covered by the program include diabetes, HIV, and certain cancers. A person with a covered condition has his or her claims covered by the reinsurance program. The state of Alaska was awarded a section 1332 waiver for a condition-based reinsurance program this year.

A third reinsurance option is a direct premium subsidy program. Minnesota has such a program in place for 2017. Payments are made to carriers to reduce premiums for consumers across the board, without regard to income level or medical condition. One of the benefits of this type of program is that the money goes directly to premium reduction.

After this overview, carrier participants in the working group explained how the federal reinsurance program worked. Claims files were sent to CMS' EDGE server. It calculated the amount and sent it back to the carrier. Some type of discrepancy review was performed.

The working group discussed the relative merits of each proposal. As the goal of this working group is to create market stability as quickly as possible, the question of how much time it would take to develop each of these types of reinsurance was also discussed. With respect to the attachment point model, for example, it requires back-office work with claims data. A carrier representative raised the point that he did not see how a claims-based reinsurance program would

work without some technical infrastructure, unless HBX were to rely on carrier attestations.

With respect to a condition-based model, a carrier representative discussed the complexity of needing to determine when during the year it can be obtained, at the time of application or through the claims process. Also, the medical conditions would need to be identified, which is not an easy task. A condition-based program would probably require an appeals process. Such a process would be cumbersome. Ultimately, the working group agreed that picking and choosing which conditions to include was a politically risky endeavor, and removed condition-based reinsurance from consideration.

With respect to a direct premium subsidy, working group members noted that such a program would result in direct premium reductions and was the only proposal that could realistically be implemented in time for the 2018 plan year – if steps were taken very quickly to enact such a policy. However, a carrier representative raised concerns about a new subsidy program that carriers would have to administer and what administrative burden that might entail. It was agreed at that meeting that HBX staff and carrier representatives should have a separate discussion to walk through these complexities since it was at a level of detail that was cumbersome to discuss in the working group setting. After these discussions, HBX staff reported back to the working group that a direct premium subsidy program would not be administratively feasible to achieve for the 2018 plan year. However, the working group continued to consider a direct premium subsidy program for future years.

HBX asked Oliver Wyman (OW), its contract actuarial firm, to develop estimates on the cost of a reinsurance program and the pros and cons of a claims based reinsurance program versus a direct premium subsidy reinsurance program (Attachment One).

Traditional reinsurance programs use attachment points. The first type of program in the OW analysis was based on claims data per member and based on that claims data there would be reimbursements to carriers.

For a 20% claims reduction, the cost estimate is around $14.8 million – $17.7 million, based on

2018 data, projected forward.

The second estimate is also a claims based reinsurance program but is based on aggregated claims data, not on claims per member.

Both types are claims based and would result in a reduction in premiums reflected in the health insurance rate filing. Neither of these would be able to be put into effect for plan year 2018; it would be for plan year 2019 because legislation would need to be put into place and both carriers and HBX would need time to develop the systems to facilitate reinsurance. The carriers would know what to expect, then would build it into their rates.

Regarding claims by member, carriers have used this method already with the federal government in 2014, 2015 and 2016, so there is experience with the method. Also there is some ability to adjust the attachment point to hit the right number. There is also an ability to cap payments and risk to the District.

A negative point in the first proposal – member level claims data – is there is a double counting that is hard to avoid. Carriers may get the benefits of both risk adjustment and reinsurance for the same members' claims.

Another negative is the risk of misestimating. That risk is present in both of these programs because carriers are estimating what claims will be and who their consumers will be. When carriers are filing rates, they will need to take this risk into account and build in some cushion. Because of this risk, the full 20% would not be reflected in District rates.

Reimbursement for claims at an aggregate level is based on the total claims volume for carriers. It is more simplified and predictable because it is done at an aggregate level. There would not be double counting. This approach allows flexibility in making adjustments to reimbursements. This approach also has the ability to cap the risk, e.g. the District could set a total amount and put in measures to limit spending to meet that cap. Then a carrier would see how much it is at risk for if the District capped its risk.

A lot of this data is already filed by the carriers, for example for the medical loss ratio (MLR) requirements. There may be a way to use current filings. There may also be the ability to use data that is currently being collected by carriers. There will be some questions about how to validate data.

The cost numbers are the same for both methods – $14.8 million - $17.7 million for 20% premium reduction.

The federal government made reinsurance payments in 2014, 2015 and 2016. In aggregate, District carriers were paid $4.2 million in 2016 in the individual market. The range of carrier losses in 2016 was from $6.4 million to $11 million.

Finally, working group members discussed the direct premium reimbursement reinsurance program. Some carriers and other members suggested that such a program has the same goals as a traditional reinsurance program of reducing the risks and losses carriers may experience in a year. Also, costs could be higher in this program because the District would be subsidizing retention components such as the premium tax and ACA insurer fee.

Working group members agreed that the goal of risk and loss reduction of a claims based reinsurance program and its other benefits outweigh having a direct premium reduction program. The recommendation states that the District would implement a claims based reinsurance program, leaving flexibility for operational considerations in determining whether it is an attachment point program or based on aggregate claims. Carriers and HBX staff would need to continue to meet to discuss some of the operational considerations as a claims based reinsurance program is implemented.

CSR/APTC Wrap

The working group considered an additional add-on payment/local subsidy to supplement the federal CSR and APTC for which customers are eligible.

Early on, it became apparent that providing additional monies for CSRs in addition to the federal CSR payments would be difficult and expensive to implement for both the District and health insurance carriers. Additionally, it would not be cost-effective given the very small number of CSR eligible individuals in the District, as discussed above. That option was removed from consideration.

For APTC, those with incomes up to 400% of FPL can receive a federal APTC that is calculated based on an expected contribution rate (a certain percentage of income). People with a lower income will pay less of a percentage than people with higher incomes. The tax credit amount is the amount above the expected contribution that a household would have to pay to get the second-lowest cost silver plan. That amount is advanced and paid directly to carriers and the customer is billed by the carrier and pays the difference.

An initial key discussion was whether the working group members were interested in having a new APTC wrap program funded with local dollars provide financial help at levels that exceeded 400% of FPL, where the federal APTC program assistance ends. Working group members noted that a reinsurance program would reduce premiums for everyone, and that with a local subsidy wrap they were most concerned about affordability for those people transitioning out of Medicaid and into private insurance – where the price differential can be substantial. There was consensus to not go beyond 400% of FPL with a local subsidy wrap.

HBX reviewed various state programs. The working group quickly gravitated toward the Vermont program as the simplest, as eligibility would be based on the same factors used by the federal government for APTC but merely changes the expected contribution rate. The working group asked HBX staff to develop some options and estimates. The initial proposal put forth by HBX staff reduced the expected contribution percentage beyond the APTC levels for people up to 400% of FPL. It was designed to track with APTC and was modeled after Vermont's APTC

subsidy wrap program. It would operate with the same eligibility rules and calculation method as APTC, require no additional application by District residents, and would require no reconciliation at the end of the year for the local subsidy portion above APTC. There were three different options of generosity modeled: reducing the expected contribution rates by 1.5 percentage points, 1.75 percentage points, and 2 percentage points.

Consumer advocacy members and a District navigator raised the concern that this flat approach benefited people similarly as income increased. Members said that, in the District, our assisters and navigators have noticed that people who are turning down private coverage are those just above Medicaid eligibility – who find it very hard to afford the much higher costs of private health insurance compared to essentially no costs in Medicaid.

A representative from OCFO presented IRS data from 2015 showing that most of the federal individual responsibility payments made by District residents were by those in the income bracket just above Medicaid eligibility.

District of Columbia – 2015

Health Care Individual Responsibility Payment: 7,150 returns; $3.45 million collected

Size of Adjusted Gross Income	# of returns	$ collected
$0 - $24,999	2,380	665,000
$25,000 - $50,000	2,990	1,135,000
$50,000 - $75,000	1,010	655,000
Over $75,000	770	995,000

Source: https://www.irs.gov/uac/soi-tax-stats-historic-table-2

And a representative of the DC Fiscal Policy Institute presented data showing that the remaining uninsured are in a similar income band.

RATIO OF INCOME TO POVERTY LEVEL IN THE PAST 12 MONTHS	Population Estimate	Number Uninsured	Percent Uninsured
Civilian noninstitutionalized population for whom poverty status is determined	645,605	25,862	4.0%
Below 138% FPL	153,061	8,973	5.9%
138 to 199% FPL	43,493	2,810	6.5%
200 to 399% of FPL	128,987	8,867	6.9%
At or above 400% FPL	320,064	5,212	1.6%

Source: U.S. Census Bureau, 2016 American Community Survey 1-Year Estimates.

Based on this information, working group members requested that HBX staff model more scenarios to concentrate the support for that income level.

The revised APTC wrap proposal (Attachment Two) focuses on helping to make marketplace plans more affordable for those with incomes above the Medicaid eligibility level up to 400% of FPL, all of whom are already eligible for federal APTC levels. Since Medicaid has no premiums, a person whose earnings increase slightly above its eligibility level could now face a substantial premium payment, even with APTC payments. This can reduce participation for low- to moderate-income working people. The proposal seeks to aid District residents and to ease the transition from Medicaid to private health insurance.

It would be funded entirely through local funds. As in the initial proposal, it is based on the same eligibility rules and calculation method for APTC; no additional application is required; and there is no reconciliation on a person's tax forms as there is for APTC. A carrier would only bill an individual what is owed after APTC and the local subsidy is considered.

A carrier representative put forth a few concerns. First, the representative stated that the District should not implement a local subsidy if it would have unintended tax implications resulting in a reduction of APTC. The carrier requested assurances from two federal government agencies that the amount of money an individual received through a local APTC wrap would not be classified as income by the IRS and thus could not impact the amount of APTC the individual could receive from the federal government. HBX staff consulted with its contacts in the Vermont state government who administer Vermont's subsidy wrap program and reported that Vermont does

not report its premium assistance to the IRS, so this has not been in issue in Vermont. HBX staff also identified IRS guidance that states that governmental benefit payments from a public welfare fund based upon need is not taxable income.[1] A representative from OCFO confirmed that this was her understanding as well. All working group members agreed on the crux of the argument but recognized that federal assurances were not likely. The group coalesced around language that prohibits the implementation of the recommendation if the APTC wrap proposal would reduce the amount of APTC individuals could receive from the federal government.

Second, a carrier representative stressed that the recommendation should consider the cost to implement – if it costs more to implement than dollars given as a supplement, the program should not be implemented. The carrier representative stressed that it will be costly to implement due to the operational changes carriers would need to make to their systems. Also, the carrier representative suggested not committing to 2019 as a fixed implementation date as it is a long runway on implementation. Finally, it was raised that if carriers and HBX are going to be asked to invest in developing the ability to operate a program like this, it is important that the program be permanent. This is important not just because of the expense of developing it, but also for it to have the desired impact of creating market stability. Carriers would need to know the program will be there in future years for it to achieve a true stability function. The carrier representative stated that if the funding for the APTC wrap program, as implemented, is not sufficiently substantial or permanent, the proposal should stipulate that funding for the program should be redirected to the reinsurance program as a default. Some working group members pointed out that because the proposed APTC wrap program would help enrollees with incomes up to 400% of FPL, while the proposed reinsurance program would help carriers pay for high-cost claims from all enrollees, redirecting the APTC wrap funding toward reinsurance should not be construed as providing a comparable benefit to the population eligible for the APTC wrap program. Working group members asked the carrier to reconsider the default to focus monies on the reinsurance program in lieu of the local subsidy wrap and objected to this type of default because the two programs have different purposes. After further discussion, the working group reached an agreement to drop the default to have monies flow to the reinsurance program in lieu

[1] INTERNAL REVENUE SERV., Taxable and Nontaxable Income, Publication 525 (Jan. 23, 2017), *available at* https://www.irs.gov/pub/irs-pdf/p525.pdf, at 27.

of the local subsidy wrap. All members agreed that language should be added to represent the critical nature of having a multi-year program with significant funding and agreed to include the following text in the proposal's description of the APTC wrap program, "[A] substantial multi-year commitment to the funding of the local subsidy is required to justify the administrative cost to operationalize the program, and to properly inform consumers who will rely on the additional subsidy."

A representative from OCFO stated that the proposed language is appropriate for a recommendation. She added for clarification that appropriations are done year by year due to the District's Anti-Deficiency Act and that would need to be adhered to in legislative language.

Summary of Draft Legislation

At the October 27 working group meeting, HBX staff reviewed for working group members a summary of draft legislation that can be expected. First, if the HBX Executive Board advances market stability recommendations, HBX staff will then work with District policymakers to develop legislation.

Second, HBX staff reviewed that draft legislation would also include clean-up legislation of District code to preserve the protections of the ACA. The District implemented provisions of the ACA into District code years ago. A review of this code and proposed changes would focus on maintaining the state-based marketplace, DC Health Benefit Exchange Authority (HBX), and the District's insurance market rules and consumer protections (Attachment Three).

Third, the legislation would include a prohibition on back payment of premiums as reflected in a previous HBX Executive Board resolution enacted on June 14, 2017. Regulations promulgated by the federal government in April 2017 reinterpreted the ACA's guaranteed issue requirements to allow carriers to require payment of back premiums owed by an applicant during open enrollment or a special enrollment period if the applicant had previously been terminated by that carrier within the last 12 months for non-payment of premiums. Failure to pay these back payments would prevent enrollment at the carrier's option.

As noted by staff, HBX submitted formal comments to CMS opposing this proposed regulation. It is HBX's position that this regulation goes beyond statutory authority as the statute is clear that open enrollment is a time when people can freely apply for coverage. In addition, HBX staff noted that with our young population, this requirement would likely have the opposite effect than intended in the District. Rather than improve the risk pool, it could weaken the risk pool because young healthy people would be unable to afford the back payments. Finally, with two insurance companies in the individual marketplace, this provision could be perceived as discriminatory. HBX staff brought this issue to the working group for transparency as the HBX Executive Board has already voted to recommend that the Department of Insurance, Securities and Banking (DISB), or the DC Council if necessary, act to preclude carriers from denying a consumer open enrollment rights even if s/he owe back premium. This piece will be included in the legislative package that HBX plans to develop once the working group has completed its work. But, since the Board already approved it, the working group did not need to vote on it.

Recommendations

The ACA Working Group coalesced around the following recommendations for a vote:

ACA Working Group Market Stability Recommendations

The HBX ACA Working Group recommends the following policies in order to provide stability in response to actions, or inactions, at the federal level that are having a destabilizing effect on the local health insurance market and markets nationwide. A sustained and substantial commitment to these policies over multiple years can best achieve predictable premiums and consistent affordability. Such a commitment is also critical to support the operational investment necessary to implement these policies.

DISTRICT INDIVIDUAL RESPONSIBILITY FALLBACK POLICY

The District of Columbia will 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 and the taxpayer owes a federal penalty under the ACA. If the ACA penalty is paid at the federal level, no penalty is assessed on District taxes.

Any funds received through the local individual responsibility requirement will be placed in a new HBX managed fund to be used for the sole purpose of insurance market stabilization. This policy should be implemented in a time and manner that minimizes the operational costs for carriers and the District government.

This is not implementing an individual mandate in the District, this is a fallback to the extent there is a federal individual responsibility requirement and it's not enforced.

DISTRICT FALLBACK POLICY TO PAY COST-SHARING REDUCTION PAYMENTS TO THE CARRIERS IF THE FEDERAL GOVERNMENT FAILS TO MAKE SUCH PAYMENTS

The District of Columbia will pay carriers the equivalent of the Cost Sharing Reduction (CSR) payments due to carriers by the Federal Government under the Affordable Care Act where the federal government fails to make such payments.

This policy should be implemented in a time and manner that minimizes the operational costs for carriers and the District government.

LOCAL REINSURANCE PROGRAM

The District of Columbia will implement a local reinsurance program beginning in the 2019 plan year based on carriers' claim costs. The program will take into account the availability of federal reinsurance. This policy should be implemented in a time and manner that minimizes the operational costs for carriers and the District government.

Estimated Funding Required to Reduce Claims Costs*

10% Claims Reduction	$7.4 million to $8.8 million
20% Claims Reduction	$14.8 million to $17.7 million

Historical Federal Reinsurance Payment to Individual Market Carriers

2016	$ 4,238,057
2015	$ 6,049,699
2014	$ 4,288,060

* Projected on a 2018 plan year cost basis.

LOCAL DISTRICT SUBSIDY IN ADDITION TO FEDERAL APTC PAYMENTS

The District of Columbia will implement an annual local 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 (APTCs) for those under 400% of the federal poverty level. The subsidy would make premiums more affordable for those at or below 400% of the federal poverty level (FPL), providing greater assistance to those just above Medicaid levels phasing out as income increases up to 400% FPL by reducing the contribution percentage of individuals using local funds.

A substantial multi-year commitment to the funding of the local subsidy is required to justify the administrative cost to operationalize the program, and to properly inform consumers who will

rely on the additional subsidy. The subsidy would have the same eligibility rules and calculation method as Advance Premium Tax Credits, would not require an additional application for the subsidy, would not require reconciliation at the end of the year, would be provided directly to carriers, and should be implemented in a time and manner that minimizes the operational costs for carriers and the District government. This provision will not be implemented if it will lower APTC or constitute additional taxable income to the eligible consumer.

Estimated Funding Required*

- Current APTC population plus an additional 1,000-person increase = $2,698,402.15
- Current APTC population plus an additional 2,000-person increase = $4,073,107.10
- Current APTC population plus an additional 3,000-person increase = $5,447,812.04

*Projected for proposal below using proposed 2018 rates. Final rates were not available during consideration of the proposal.

Proposal

The ACA provides financial help for individual market premiums through Advance Premium Tax Credits (APTC). APTC amounts are based on specific contribution rates (a percentage of income). For example, in 2018, a household at 250% of poverty is expected to spend a maximum of 8.1% of its income on premiums. If the cost of a benchmark plan exceeds the expected contribution, APTC covers whatever the family would have to pay above that to purchase a benchmark plan. Individuals and families are ineligible for APTC if they are eligible for the Medicaid program. This proposed subsidy approach would reduce the ACA contribution percentage of individuals further using local funds as reflected below:

FPL Level	ACA Federal Contribution Rate for APTC	DC Adjusted Contribution Rate for DC Subsidy
Less than 133% FPL	2.01%	0%
133 to 150% FPL	3.02% to 4.03%	0%
150 to 200% FPL	4.03% to 6.34%	0%
200 to 250% FPL	6.34% to 8.1%	0 – 1.5%
250 to 300% FPL	8.1% to 9.56%	1.5 – 4.5%
300 to 400% FPL	9.56%	4.5 – 7.5%

Examples

The impact on a customer's total subsidy amount (APTC + state subsidy) varies based on income and the ages of the household members. This chart highlights how a state subsidy could increase financial help for premium reductions.

	2018 Monthly Premium for Second Lowest Cost Silver Plan (Full Cost)	**Consumer Portion of 2018 Monthly Premium for Second Lowest Cost Silver Plan (APTC Only)**	**Consumer Portion of 2018 Monthly Premium for Second Lowest Cost Silver Plan (APTC + State Subsidy)**
A single 32-year-old ($30,150 annually – 250% FPL)	$271.38	$208.37	$42.55
A family of 3 (ages 45, 42, and 14) ($71,470 annually – 350% FPL)	$959.31	$463.79	$374.52

Working Group Members

The ACA Advisory Working Group is comprised of representatives from health insurance carriers, broker agencies, medical providers, consumer groups, trade associations, actuaries, navigators, and consumers. Ten meetings were held, on August 2 and 30, September 7, 14 and 22, and October 2, 13, 27, 30 and 31, 2017 by conference call and in person. All meeting announcements and meeting materials were publically posted prior to the meetings allowing anyone from the public to join as well.

WORKING GROUP MEMBER	AFFILIATION
Leighton Ku, Chair	GWU Center for Health Policy Research
Jodi Kwarciany, Vice-Chair	DC Fiscal Policy Institute
Donna Alcorn	Rust Insurance Agency
Dave Chandrasekaran	Consumer Advocate, DC Health Link Consumer
Carl Chapman	AmeriHealth Caritas
Colette Chichester (Robert Metz)	CareFirst
Peter Rankin (Louis Davis, Jr.)	AARP
Maria Gomez (Christian Narro)	Mary's Center
Laurie Kuiper (Robert Axelrod)	Kaiser Permanente
Katie Nicol	Whitman Walker
Dania Palanker	Georgetown Center for Health Insurance Reforms
Patricia Quinn	DC Primary Care Association
Carolyn Rudd	DC Health Link SHOP Customer
S. Jnatel Sims (self-designated as non-voting member)	UnitedHealthcare
Margaret Singleton	DC Chamber of Commerce
Liam Steadman	DC Hospital Association
Jenny Sullivan	Consumer Advocate
Tammy Tomczyk (self-designated as non-voting member)	Oliver Wyman
Kevin Wrege (Kris Hathaway)	America's Health Insurance Plans

Staff Advisors & Support	
Debbie Curtis Purvee Kempf Sarah Bagge Alex Alonso Mary Beth Senkewicz Jennifer Libster Alexis Chappell Angela Franco	HBX
Howard Liebers Philip Barlow	DISB
Alice Weiss Yorick Uzes	DHCF
Deborah Freis	OCFO

Parentheticals note people who attended with or in place of working group members at times, but did not vote.

The working group members and HBX staff gratefully acknowledge the support work of our sister agencies during the working group's meetings.

VOTE

The recommendations were voted on en bloc at the October 31 meeting and were unanimously adopted. Fourteen members voted to approve the policy recommendations as proposed. There were no abstentions from voting or votes against the policy recommendations. Three members were absent.

Below is the vote tally:

WORKING GROUP MEMBER	VOTE
Leighton Ku	YES
Jodi Kwarciany	YES
Donna Alcorn	NOT PRESENT
Dave Chandrasekaran	YES
Carl Chapman	NOT PRESENT
Colette Chichester	YES
Peter Rankin	YES
Maria Gomez	YES
Laurie Kuiper	YES
Katie Nicol	YES
Dania Palanker	YES

Patricia Quinn	YES
Carolyn Rudd	YES
Margaret Singleton	YES
Liam Steadman	NOT PRESENT
Jenny Sullivan	YES
Kevin Wrege	YES

OLIVER WYMAN

Ryan Schultz

Oliver Wyman
411 East Wisconsin Avenue, Suite 1300
Milwaukee, WI 53202-4419
414-277-4608
Ryan.Schultz@OliverWyman.com

Ms. Mila Kofman
Executive Director
DC Health Benefit Exchange Authority
1225 Eye Street, NW, 4th floor
Washington, DC 20005

September 20, 2017

Review of Funding and Approaches to Reduce Individual Premium Rates

Dear Mila:

In this letter, we provide estimates regarding the level of funding that would have been required by the District of Columbia (the District) in order to develop a program that would have lowered 2018 premium rates in the individual market by amounts equal to 5%, 10%, and 20%. Additionally, we include a discussion of potential approaches which could be utilized to allocate funds to carriers in order to achieve the intended objective of lowering rates in the market.

Funding Required To Reduce 2018 Carriers' Claim Costs[1]

In this section, we provide estimated funding levels required to reduce carrier claim costs by 5%, 10%, or 20% (assuming carriers would correspondingly reduce premium rates by a similar percentage and no significant population shifts occur) as well as approaches which could be utilized to allocate funding to carriers in the event a program were created to do so.

Funding Required To Reduce 2018 Claim Costs	
5% Claims Reduction	$3.7 million to $4.4 million
10% Claims Reduction	$7.4 million to $8.8 million
20% Claims Reduction	$14.8 million to $17.7 million

#1 –Reinsurance Based on Claim Thresholds

A percentage of annual claims which fall between a specified lower and upper threshold for a given member is reimbursed to carriers.

Pros:

- **Carrier Familiarity** – Carriers would be familiar with a program such as this due to past experience with the federal Transitional Reinsurance program which was in place for calendar years 2014, 2015, and 2016.

[1] For demonstration purposes; it is our understanding that a claims based reinsurance program could not be implemented in time to impact carriers' 2018 individual market premium rates

- **Flexibility** – If desired, the parameters of the program can be adjusted up or down after the policy year end as needed to return the exact amount of any reinsurance funds back to participating carriers.

- **Ability to Cap Risk to the District** – If desired, risk to the District could potentially (e.g. if legally feasible based on the way in which the arrangement is written and communicated) be capped such that total payments to carriers do not exceed available reinsurance funds. It should be noted that this could result in carriers receiving lower payments (as a percentage of total claims) than initially expected and potential premium deficiencies, which could lead to carriers being more conservative in their development of rates.

- **Protection Against Claim Volatility Due to Large Claims** – If implemented in a way similar to that of the federal Transitional Reinsurance program with thresholds at higher claim amounts, carriers would have a level of protection against the most volatile and hardest to predict claims.

Cons:

- **"Double-Counting" with Risk Adjustment**- Carriers covering a higher than average percentage of members diagnosed with high cost conditions can have an advantage over other carriers in the market as they could be reimbursed for the cost of those members through both risk adjustment as well as reinsurance.

- **Risk of Misestimating** – Assumptions would be made for items such as projected membership, claims trends, and plan mix in the initial determination of both the required funding and the parameters to be used. In the event actual results are significantly different than the assumptions made, available reinsurance funds may be either too high or too low (to achieve the desired objective) and/or payments to carriers could be too high or too low (if parameters are not later adjusted).

- **Diminished Impact of Cost Management** - Carrier-specific cost management efforts (e.g. use of narrow networks, care management) would be somewhat diminished, as every $1.00 improvement in actual claim costs achieved would only actually result in an improvement in those costs net of the reinsurance payments (e.g. $0.80 in the scenario where claim costs are reduced 20%).

- **Reduced Federal Funding with no 1332 Waiver**– Lower premiums would lead to reduced federal funding (i.e. APTCs) financed with District funds, which likely could not be recouped without the approval of a 1332 waiver.

- **Timing of Implementation –** Could not be implemented for plan year 2018.

- **Reliance on Carriers to Implement Premium Rate Reductions –** The parameters and intended objective of the reinsurance program could be communicated, but it would ultimately be up to carriers to adjust their rates accordingly. In some cases, carriers may

incorporate some level of conservatism. One control on this may be the rate review process which is in place.

Administration:

- **Calculation of Funding Required and Choice of Parameters -** Initial analysis would be required to determine the level of funding required to achieve the desired objective (e.g. 20% reduction to claim costs) as well as to set the preliminary program parameters. Analysis would include projections of membership and claim costs. Data could be requested from carriers in order to enhance the accuracy of the analysis.

- **Calculation of Payments to Carriers -** Carriers would need to submit claim files to the District at the end of year (with some specified level of runout), providing total annual claim costs on a per member basis. The District would validate the information provided and calculate the amount to be paid to carriers using the established parameters. To the extent calculated payments are greater than or less than total available reinsurance funds, parameters could be adjusted and payments recalculated as necessary. Overall, the level of administration associated with the program could be relatively low, especially to the extent federal reporting data could be utilized to validate the accuracy of the claims information submitted by carriers.

#2 - Reinsurance Based on Total Annual Claim Costs Net of Risk Adjustment

Carriers are reimbursed a specified percentage of their overall annual claim volume net of risk adjustment payments/receipts.

Pros:

- **Simplicity and Predictability**– The reimbursement percentage can easily be set to produce the desired percentage reduction in claim costs.

- **Coordinated with Risk Adjustment** – Given that reimbursement would be based on claims net of risk adjustment payments/receipts, there would be no “double-counting” between the two programs.

- **Flexibility** – If desired, the reimbursement percentage can be adjusted up or down after the policy year end as needed to return the exact amount of any reinsurance funds back to participating carriers.

- **Ability to Cap Risk to the District** – If desired, risk to the District could potentially (e.g. if legally feasible based on the way in which the arrangement is written and communicated) be capped such that total payments to carriers do not exceed available reinsurance funds. It should be noted that this could result in carriers receiving lower payments (as a percentage of total claims) than initially expected and potential premium deficiencies, which could lead to carriers being more conservative in their development of rates.

Cons:

- **Risk of Misestimating Required Funding**– Assumptions would be made for items such as projected membership, claims trends, and plan mix in the initial estimation of required funding. In the event actual results are significantly different than the assumptions made, available reinsurance funds may be either too high or too low (to achieve the desired objective).

- **Diminished Impact of Cost Management** - Carrier-specific cost management efforts (e.g. use of narrow networks, care management) would be somewhat diminished, as every $1.00 improvement in actual claim costs achieved would only actually result in an improvement in those costs net of the reinsurance payments (e.g. $0.80 in the scenario where claim costs are reduced 20%).).

- **Reduced Federal Funding with no 1332 Waiver**– Lower premiums would lead to reduced federal funding (i.e. APTCs) financed with District funds, which likely could not be recouped without the approval of a 1332 waiver.

- **Timing of Payments** – Final payments for a given calendar year would likely not be calculated until after risk adjustment results are finalized by CMS, which occurs approximately mid-way through the following calendar year.

- **Large Claim Volatility**– This approach does not reduce the pricing risk of high cost claimants in the way an approach similar to that of the federal Transitional Reinsurance program would.

- **Timing of Implementation –** Could not be implemented for plan year 2018.

- **Reliance on Carriers to Implement Premium Rate Reductions –** The parameters and intended objective of the reinsurance program could be communicated, but it would ultimately be up to carriers to adjust their rates accordingly. In some cases, carriers may incorporate some level of conservatism. One control on this may be the rate review process which is in place.

Administration:

- **Calculation of Funding Required and Choice of Parameters -** Initial analysis would be required to determine the level of funding required to achieve the desired objective (e.g. 20% reduction to claim costs) as well as to set the preliminary program parameters. Analysis would include projections of membership and claim costs. Data could be requested from carriers in order to enhance the accuracy of the analysis.

- **Calculation of Payments to Carriers -** Carriers would submit claim files to the District at the end of year (with some specified level of runout), providing total annual claim costs. Additionally, resulting payments/receipts from the risk adjustment program would need to be confirmed. The District would validate the information provided and calculate

the amount to be paid to carriers using the reimbursement percentage intended. To the extent calculated payments do not equal total available reinsurance funds, the reimbursement percentage could be adjusted and payments recalculated as necessary. Overall, the level of administration associated with the program could be relatively low, especially to the extent federal reporting data could be utilized to validate the accuracy of the claims information submitted by carriers.

Funding Required To Directly Subsidize 2018 Premium Rates

In this section, we discuss estimated funding levels required to provide direct premium subsidies to members which would reduce premium rates by 5%, 10%, or 20% for ***non-subsidy eligible*** enrollees.

Funding Need To Subsidize 2018 Premium Rates	
5% Premium Reduction	$4.3 million to $4.4 million
10% Premium Reduction	$8.7 million to $8.8 million
20% Premium Reduction	$17.4 million to $17.6 million

#3 – Direct Premium Subsidies

The District would directly fund a specified percentage of premiums for individual market enrollees who are not eligible for APTCs. Subsidies from the district would be provided directly to carriers with enrollees being billed the reduced premium rates (i.e. net of the District subsidies).

Pros:

- **Guaranteed Reduction to Premium Rates**- Able to ensure that premium rates are reduced by a specified percentage.
- **No Reduction to Federal Funding** – Given that gross premium rates are not reduced, and premium subsidies are for enrollees who are not eligible for APTCs, federal funding to the District would not be reduced.
- **Ability to Cap Risk to the District** – If desired, risk to the District could potentially (e.g. if legally feasible based on the way in which the arrangement is written and communicated) be capped such that total subsidies to carriers do not exceed available reinsurance funds. It should be noted that this would likely result in carriers receiving total premium payments below gross levels and, therefore, potential losses, which could lead to carriers being more conservative in their development of rates.
- **Full Incentives to Manage Care Remain**– Impacts of cost management are not diminished under this approach.
- **Coordinated with Risk Adjustment** – Assuming that carriers incorporate anticipated risk adjustment payments/receipts into their rate development, there would be no “double-counting” between the two programs.

- **Timing of Implementation –** Could be implemented for plan year 2018.

Cons:

- **Risk of Misestimating Required Funding** – Assumptions would be made for projected membership and premium rates. In the event actual results are significantly different than the assumptions made (e.g. significant membership growth), available reinsurance funds may be too low to cover the direct premium subsidies.

- **Increased Cost to District Relative to Reinsurance Approach** – The District would be subsidizing retention components such as premium tax and the ACA Insurer Fee which would not subsidized under a claims reinsurance approach.

- **Potential for Non-APTC Premiums to Be Lower Than APTC Premiums?** – To the extent the District subsidies were significant (e.g. 20% of premium) it is not clear whether there would be the potential for premiums available to non-APTC members to be lower than those available to APTC members through the Marketplace, in particular at younger ages.

- **Large Claim Volatility**– This approach does not reduce the pricing risk of high cost claimants in the way a claims reinsurance approach similar to that of the federal Transitional Reinsurance program would.

Administration:

- **Calculation of Funding Required -** Initial analysis would be required to determine the level of funding required to achieve the desired objective (e.g. 20% reduction to premium rates for non-APTC enrollees). Analysis would include projections of membership and premium rates.

- **Calculation of non-APTC Premium Rates –** The carrier billing process would need to be modified such that amounts billed to enrollees are the premium rates net of District subsidies.

- **Calculation of Payments to Carriers –** The Marketplace would track and record amounts owed by the District to carriers. To the extent calculated payments are more than total available reinsurance funds, the amounts owed could potentially be reduced accordingly. In this case, the District could pay carriers at the end of the year after reconciling amounts owed vs. available reinsurance funds.

Limitations and Considerations of this Analysis

Key limitations and considerations associated with our analysis include the following:

- Values are based on estimates of future events; therefore, actual results may vary

- Estimates rely on information provided by DCHBX as well as other external sources. If the information used is inaccurate or has misinterpreted incorrectly, the underlying finding and conclusions may need to be revised.
- Estimates assume no shift in membership to or from the individual market, or between metal plans, as a result of any premium reductions.
- Cost estimates do not incorporate any estimated expenses associated with administration of the corresponding program.
- Calculated premium rate reductions assume carrier expenses with the corresponding program in place remain the same fixed percentage of premium as currently filed levels.
- Estimates are on a projected 2018 cost basis.

Please let me know if you have any questions related to this letter.

Thank you.

Sincerely,

Ryan Schultz, FSA, MAAA

Copy: MaryBeth Senkewicz, DCHBX
Purvee Kempf, DCHBX
Debra Curtis, DCHBX
Tammy Tomczyk, Oliver Wyman

Attachment Two

DRAFT State Premium Subsidy Wrap Option: Using Expected Contribution Rate Reduction Method

Background: The Affordable Care Act (ACA) provides financial help for individual market premiums through Advance Premium Tax Credits (APTC). APTC amounts are based on specific contribution rates (a percentage of income). For example, in 2018, a household at 250% of poverty is expected to spend a maximum of 8.1% of its income on premiums. If the cost of a benchmark plan exceeds the expected contribution, APTC covers whatever the family would have to pay above that to purchase a benchmark plan. Individual and families are ineligible for APTC if they are eligible for the District's Medicaid program. Medicaid eligibility in DC goes to 215% of poverty for childless adults and even higher for parents and children. Those eligible for Medicaid effectively pay nothing, but would pay a substantial premium for private coverage in the 216-400% range of the federal poverty level.

Subsidy Wrap Proposal: A proposed subsidy that would make premiums more affordable for those under 400% of the federal poverty level (FPL), providing greater assistance to those just above Medicaid levels phasing out at 400% FPL. This includes greater assistance to those individuals that are in the Medicaid 5 year bar – Medicaid's 5 year waiting period for lawful immigrants before they are eligible. This proposed subsidy approach would reduce the contribution percentage of individuals using local funds as reflected below.

FPL Level	ACA Federal Contribution Rate for APTC	DC Adjusted Contribution Rate for DC Subsidy
Less than 133% FPL	2.01%	0%
133 to 150% FPL	3.02% to 4.03%	0%
150 to 200% FPL	4.03% to 6.34%	0%
200 to 250% FPL	6.34% to 8.1%	0 – 1.5%
250 to 300% FPL	8.1% to 9.56%	1.5 – 4.5%
300 to 400% FPL	9.56%	4.5 – 7.5%

Local Subsidy Program Features

- Same eligibility rules and calculation method as Advance Premium Tax Credits
- No additional application
- No reconciliation at the end of the year for the local subsidy

Back of the Envelope Estimated Cost Projections[1]

- Current APTC population plus an additional 1,000-person increase = $2,698,402.15
- Current APTC population plus an additional 2,000-person increase = $ 4,073,107.10
- Current APTC population plus an additional 3,000-person increase = $5,447,812.04

[1] ASSUMPTIONS: a) We used proposed 2018 rates since rates have not been finalized. b) We used age/income mixes most likely to gain a state subsidy, based on current DC Health Link enrollment. c) We assume an increase in enrollment based on the more generous subsidies, particularly among those below 250% FPL.

Examples

The impact on a customer's total subsidy amount (APTC + state subsidy) varies based on income and the ages of the household members. This chart highlights how a state subsidy could increase financial help for premium reductions.

	2018 Monthly Premium for Second Lowest Cost Silver Plan (Full Cost)	**Consumer Portion of 2018 Monthly Premium for Second Lowest Cost Silver Plan (APTC Only)**	**Consumer Portion of 2018 Monthly Premium for Second Lowest Cost Silver Plan (APTC + State Subsidy)**
A single 32-year-old ($30,150 annually – 250% FPL)	$271.38	$208.37	$42.55
A family of 3 (ages 45, 42, and 14) ($71,470 annually – 350% FPL)	$959.31	$463.79	$374.52

BACKGROUND DOCUMENTS

Reference Table 1
Sample 2018 APTC for Single-Member Households (NO STATE SUBSIDY)

	Customer eligible to receive APTC in amount listed
	Customer not eligible to receive any APTC because premium for Second Lowest Cost Silver Plan is less than expected contribution level

FOR DEMONSTRATION ONLY: Actual APTC calculations may differ slightly.
ASSUMPTIONS: The Individual is a non-dependent tax filer and meets all other non-financial APTC eligibility

		Federal Poverty Level									
		200	216	225	250	275	300	325	350	375	400
Age	26	$ 109.73	$ 87.31	$ 73.91	$ 33.65	$ -	$ -	$ -	$ -	$ -	$ -
	27	$ 109.73	$ 87.31	$ 73.91	$ 33.65	$ -	$ -	$ -	$ -	$ -	$ -
	28	$ 115.28	$ 92.86	$ 79.45	$ 39.20	$ -	$ -	$ -	$ -	$ -	$ -
	29	$ 120.50	$ 98.08	$ 84.67	$ 44.42	$ 3.89	$ -	$ -	$ -	$ -	$ -
	30	$ 126.69	$ 104.27	$ 90.87	$ 50.62	$ 10.09	$ -	$ -	$ -	$ -	$ -
	31	$ 133.22	$ 110.79	$ 97.39	$ 57.14	$ 16.61	$ -	$ -	$ -	$ -	$ -
	32	$ 139.09	$ 116.67	$ 103.26	$ 63.01	$ 22.48	$ -	$ -	$ -	$ -	$ -
	33	$ 145.30	$ 122.87	$ 109.47	$ 69.22	$ 28.69	$ -	$ -	$ -	$ -	$ -
	34	$ 151.82	$ 129.40	$ 115.99	$ 75.74	$ 35.21	$ -	$ -	$ -	$ -	$ -
	35	$ 158.34	$ 135.92	$ 122.51	$ 82.26	$ 41.73	$ -	$ -	$ -	$ -	$ -
	36	$ 164.87	$ 142.45	$ 129.04	$ 88.79	$ 48.26	$ 4.07	$ -	$ -	$ -	$ -
	37	$ 171.39	$ 148.97	$ 135.56	$ 95.31	$ 54.78	$ 10.59	$ -	$ -	$ -	$ -
	38	$ 174.97	$ 152.55	$ 139.15	$ 98.90	$ 58.37	$ 14.17	$ -	$ -	$ -	$ -
	39	$ 178.57	$ 156.15	$ 142.74	$ 102.49	$ 61.96	$ 17.77	$ -	$ -	$ -	$ -
	40	$ 190.64	$ 168.22	$ 154.81	$ 114.56	$ 74.03	$ 29.84	$ 5.82	$ -	$ -	$ -
	41	$ 203.03	$ 180.61	$ 167.20	$ 126.95	$ 86.43	$ 42.23	$ 18.21	$ -	$ -	$ -
	42	$ 216.08	$ 193.66	$ 180.26	$ 140.01	$ 99.48	$ 55.28	$ 31.27	$ 7.25	$ -	$ -
	43	$ 229.46	$ 207.04	$ 193.63	$ 153.38	$ 112.86	$ 68.66	$ 44.64	$ 20.62	$ -	$ -
	44	$ 243.49	$ 221.06	$ 207.66	$ 167.41	$ 126.88	$ 82.69	$ 58.67	$ 34.65	$ 10.63	$ -
	45	$ 257.83	$ 235.41	$ 222.01	$ 181.76	$ 141.23	$ 97.03	$ 73.01	$ 49.00	$ 24.98	$ 0.96
	46	$ 272.84	$ 250.42	$ 237.01	$ 196.76	$ 156.24	$ 112.04	$ 88.02	$ 64.00	$ 39.98	$ 15.96
	47	$ 288.50	$ 266.08	$ 252.68	$ 212.43	$ 171.90	$ 127.70	$ 103.69	$ 79.67	$ 55.65	$ 31.63
	48	$ 304.82	$ 282.40	$ 268.99	$ 228.74	$ 188.21	$ 144.02	$ 120.00	$ 95.98	$ 71.96	$ 47.94
	49	$ 321.78	$ 299.36	$ 285.95	$ 245.70	$ 205.17	$ 160.98	$ 136.96	$ 112.94	$ 88.92	$ 64.90
	50	$ 339.40	$ 316.98	$ 303.57	$ 263.32	$ 222.79	$ 178.60	$ 154.58	$ 130.56	$ 106.54	$ 82.52
	51	$ 357.66	$ 335.24	$ 321.84	$ 281.59	$ 241.06	$ 196.86	$ 172.84	$ 148.83	$ 124.81	$ 100.79
	52	$ 376.58	$ 354.16	$ 340.75	$ 300.50	$ 259.97	$ 215.78	$ 191.76	$ 167.74	$ 143.72	$ 119.70
	53	$ 396.16	$ 373.74	$ 360.33	$ 320.08	$ 279.56	$ 235.36	$ 211.34	$ 187.32	$ 163.30	$ 139.28
	54	$ 416.71	$ 394.29	$ 380.88	$ 340.63	$ 300.10	$ 255.91	$ 231.89	$ 207.87	$ 183.85	$ 159.83
	55	$ 437.91	$ 415.49	$ 402.08	$ 361.83	$ 321.31	$ 277.11	$ 253.09	$ 229.07	$ 205.05	$ 181.03
	56	$ 460.10	$ 437.68	$ 424.27	$ 384.02	$ 343.49	$ 299.30	$ 275.28	$ 251.26	$ 227.24	$ 203.22
	57	$ 482.93	$ 460.51	$ 447.10	$ 406.85	$ 366.33	$ 322.13	$ 298.11	$ 274.09	$ 250.07	$ 226.05
	58	$ 506.75	$ 484.33	$ 470.92	$ 430.67	$ 390.14	$ 345.95	$ 321.93	$ 297.91	$ 273.89	$ 249.87
	59	$ 531.55	$ 509.12	$ 495.72	$ 455.47	$ 414.94	$ 370.75	$ 346.73	$ 322.71	$ 298.69	$ 274.67
	60	$ 557.32	$ 534.89	$ 521.49	$ 481.24	$ 440.71	$ 396.52	$ 372.50	$ 348.48	$ 324.46	$ 300.44
	61	$ 584.07	$ 561.65	$ 548.24	$ 507.99	$ 467.46	$ 423.27	$ 399.25	$ 375.23	$ 351.21	$ 327.19
	62	$ 584.07	$ 561.65	$ 548.24	$ 507.99	$ 467.46	$ 423.27	$ 399.25	$ 375.23	$ 351.21	$ 327.19
	63	$ 584.07	$ 561.65	$ 548.24	$ 507.99	$ 467.46	$ 423.27	$ 399.25	$ 375.23	$ 351.21	$ 327.19
	64	$ 584.07	$ 561.65	$ 548.24	$ 507.99	$ 467.46	$ 423.27	$ 399.25	$ 375.23	$ 351.21	$ 327.19

Reference Table 2
Sample 2018 APTC + State Subsidy for Single-Member Households

	Customer eligible to receive APTC + State Subsidy in amount listed
	Customer not eligible to receive any APTC or State Subsidy because premium for Second Lowest Cost Silver Plan is less than adjusted expected contribution level

FOR DEMONSTRATION ONLY: Actual APTC calculations may differ slightly.
ASSUMPTIONS: The Individual is a non-dependent tax filer and meets all other non-financial APTC eligibility

		Federal Poverty Level									
		200	216	225	250	275	300	325	350	375	400
Age	26	$ 237.17	$ 226.75	$ 220.21	$ 199.48	$ 154.25	$ 101.49	$ 65.69	$ 26.12	$ -	$ -
	27	$ 237.17	$ 226.75	$ 220.21	$ 199.48	$ 154.25	$ 101.49	$ 65.69	$ 26.12	$ -	$ -
	28	$ 242.72	$ 232.30	$ 225.76	$ 205.03	$ 159.80	$ 107.04	$ 71.24	$ 31.67	$ -	$ -
	29	$ 247.93	$ 237.51	$ 230.97	$ 210.24	$ 165.02	$ 112.26	$ 76.45	$ 36.88	$ -	$ -
	30	$ 254.13	$ 243.71	$ 237.17	$ 216.44	$ 171.22	$ 118.45	$ 82.65	$ 43.08	$ -	$ -
	31	$ 260.65	$ 250.23	$ 243.69	$ 222.96	$ 177.74	$ 124.97	$ 89.17	$ 49.60	$ 6.26	$ -
	32	$ 266.52	$ 256.10	$ 249.56	$ 228.83	$ 183.61	$ 130.85	$ 95.04	$ 55.47	$ 12.13	$ -
	33	$ 272.73	$ 262.31	$ 255.77	$ 235.04	$ 189.82	$ 137.05	$ 101.25	$ 61.68	$ 18.34	$ -
	34	$ 279.25	$ 268.83	$ 262.29	$ 241.56	$ 196.34	$ 143.58	$ 107.77	$ 68.20	$ 24.86	$ -
	35	$ 285.77	$ 275.35	$ 268.81	$ 248.08	$ 202.86	$ 150.10	$ 114.29	$ 74.72	$ 31.38	$ -
	36	$ 292.30	$ 281.88	$ 275.34	$ 254.61	$ 209.39	$ 156.63	$ 120.82	$ 81.25	$ 37.91	$ -
	37	$ 298.82	$ 288.40	$ 281.86	$ 261.14	$ 215.91	$ 163.15	$ 127.35	$ 87.77	$ 44.43	$ -
	38	$ 302.41	$ 291.99	$ 285.45	$ 264.72	$ 219.50	$ 166.73	$ 130.93	$ 91.36	$ 48.02	$ 254.13
	39	$ 306.00	$ 295.58	$ 289.04	$ 268.32	$ 223.09	$ 170.33	$ 134.52	$ 94.95	$ 51.61	$ 260.65
	40	$ 318.07	$ 307.65	$ 301.11	$ 280.39	$ 235.16	$ 182.40	$ 146.59	$ 107.02	$ 63.68	$ 266.52
	41	$ 330.47	$ 320.05	$ 313.51	$ 292.78	$ 247.55	$ 194.79	$ 158.99	$ 119.42	$ 76.08	$ 272.73
	42	$ 343.52	$ 333.10	$ 326.56	$ 305.83	$ 260.61	$ 207.84	$ 172.04	$ 132.47	$ 89.13	$ 279.25
	43	$ 356.90	$ 346.48	$ 339.94	$ 319.21	$ 273.98	$ 221.22	$ 185.42	$ 145.85	$ 102.50	$ 285.77
	44	$ 370.92	$ 360.50	$ 353.96	$ 333.23	$ 288.01	$ 235.24	$ 199.44	$ 159.87	$ 116.53	$ 292.30
	45	$ 385.27	$ 374.85	$ 368.31	$ 347.58	$ 302.36	$ 249.59	$ 213.79	$ 174.22	$ 130.88	$ 298.82
	46	$ 400.27	$ 389.85	$ 383.32	$ 362.59	$ 317.36	$ 264.60	$ 228.80	$ 189.22	$ 145.88	$ 302.41
	47	$ 415.94	$ 405.52	$ 398.98	$ 378.25	$ 333.03	$ 280.26	$ 244.46	$ 204.89	$ 161.55	$ 306.00
	48	$ 432.25	$ 421.83	$ 415.29	$ 394.56	$ 349.34	$ 296.58	$ 260.77	$ 221.20	$ 177.86	$ 318.07
	49	$ 449.21	$ 438.79	$ 432.25	$ 411.53	$ 366.30	$ 313.54	$ 277.73	$ 238.16	$ 194.82	$ 330.47
	50	$ 466.83	$ 456.41	$ 449.87	$ 429.14	$ 383.92	$ 331.16	$ 295.35	$ 255.78	$ 212.44	$ 343.52
	51	$ 485.10	$ 474.68	$ 468.14	$ 447.41	$ 402.19	$ 349.42	$ 313.62	$ 274.05	$ 230.71	$ 356.90
	52	$ 504.01	$ 493.59	$ 487.05	$ 466.33	$ 421.10	$ 368.34	$ 332.54	$ 292.96	$ 249.62	$ 370.92
	53	$ 523.60	$ 513.18	$ 506.64	$ 485.91	$ 440.68	$ 387.92	$ 352.12	$ 312.55	$ 269.21	$ 385.27
	54	$ 544.14	$ 533.72	$ 527.18	$ 506.45	$ 461.23	$ 408.47	$ 372.66	$ 333.09	$ 289.75	$ 400.27
	55	$ 565.35	$ 554.93	$ 548.39	$ 527.66	$ 482.43	$ 429.67	$ 393.87	$ 354.30	$ 310.96	$ 415.94
	56	$ 587.53	$ 577.11	$ 570.57	$ 549.84	$ 504.62	$ 451.86	$ 416.05	$ 376.48	$ 333.14	$ 432.25
	57	$ 610.37	$ 599.95	$ 593.41	$ 572.68	$ 527.45	$ 474.69	$ 438.89	$ 399.32	$ 355.97	$ 449.21
	58	$ 634.18	$ 623.76	$ 617.22	$ 596.49	$ 551.27	$ 498.51	$ 462.70	$ 423.13	$ 379.79	$ 466.83
	59	$ 658.98	$ 648.56	$ 642.02	$ 621.29	$ 576.07	$ 523.30	$ 487.50	$ 447.93	$ 404.59	$ 485.10
	60	$ 684.75	$ 674.33	$ 667.79	$ 647.06	$ 601.84	$ 549.07	$ 513.27	$ 473.70	$ 430.36	$ 504.01
	61	$ 711.50	$ 701.08	$ 694.54	$ 673.81	$ 628.59	$ 575.83	$ 540.02	$ 500.45	$ 457.11	$ 523.60
	62	$ 711.50	$ 701.08	$ 694.54	$ 673.81	$ 628.59	$ 575.83	$ 540.02	$ 500.45	$ 457.11	$ 544.14
	63	$ 711.50	$ 701.08	$ 694.54	$ 673.81	$ 628.59	$ 575.83	$ 540.02	$ 500.45	$ 457.11	$ 565.35
	64	$ 711.50	$ 701.08	$ 694.54	$ 673.81	$ 628.59	$ 575.83	$ 540.02	$ 500.45	$ 457.11	$ 587.53

Reference Table 3
Sample 2018 Monthly Consumer Premium for Second Lowest Cost Silver Plan
After APTC + State Subsidy[2]

		Federal Poverty Level									
		200	216	225	250	275	300	325	350	375	400
	26	$ 4.32	$ 14.74	$ 21.28	$ 42.01	$ 87.24	$ 140.00	$ 175.80	$ 215.37	$ 241.49	$ 241.49
	27	$ 4.32	$ 14.74	$ 21.28	$ 42.01	$ 87.24	$ 140.00	$ 175.80	$ 215.37	$ 241.49	$ 241.49
	28	$ 4.42	$ 14.84	$ 21.38	$ 42.11	$ 87.34	$ 140.10	$ 175.90	$ 215.47	$ 247.14	$ 247.14
	29	$ 4.52	$ 14.94	$ 21.48	$ 42.21	$ 87.43	$ 140.19	$ 176.00	$ 215.57	$ 252.45	$ 252.45
	30	$ 4.63	$ 15.05	$ 21.59	$ 42.32	$ 87.54	$ 140.31	$ 176.11	$ 215.68	$ 258.76	$ 258.76
	31	$ 4.75	$ 15.17	$ 21.71	$ 42.44	$ 87.66	$ 140.43	$ 176.23	$ 215.80	$ 259.14	$ 265.40
	32	$ 4.86	$ 15.28	$ 21.82	$ 42.55	$ 87.77	$ 140.53	$ 176.34	$ 215.91	$ 259.25	$ 271.38
	33	$ 4.97	$ 15.39	$ 21.93	$ 42.66	$ 87.88	$ 140.65	$ 176.45	$ 216.02	$ 259.36	$ 277.70
	34	$ 5.09	$ 15.51	$ 22.05	$ 42.78	$ 88.00	$ 140.76	$ 176.57	$ 216.14	$ 259.48	$ 284.34
	35	$ 5.21	$ 15.63	$ 22.17	$ 42.90	$ 88.12	$ 140.88	$ 176.69	$ 216.26	$ 259.60	$ 290.98
	36	$ 5.33	$ 15.75	$ 22.29	$ 43.02	$ 88.24	$ 141.00	$ 176.81	$ 216.38	$ 259.72	$ 297.63
	37	$ 5.45	$ 15.87	$ 22.41	$ 43.13	$ 88.36	$ 141.12	$ 176.92	$ 216.50	$ 259.84	$ 304.27
A	38	$ 5.51	$ 15.93	$ 22.47	$ 43.20	$ 88.42	$ 141.19	$ 176.99	$ 216.56	$ 259.90	$ 307.01
g	39	$ 5.58	$ 16.00	$ 22.54	$ 43.26	$ 88.49	$ 141.25	$ 177.06	$ 216.63	$ 259.97	$ 307.08
e	40	$ 5.80	$ 16.22	$ 22.76	$ 43.48	$ 88.71	$ 141.47	$ 177.28	$ 216.85	$ 260.19	$ 307.30
	41	$ 6.02	$ 16.44	$ 22.98	$ 43.71	$ 88.94	$ 141.70	$ 177.50	$ 217.07	$ 260.41	$ 307.52
	42	$ 6.26	$ 16.68	$ 23.22	$ 43.95	$ 89.17	$ 141.94	$ 177.74	$ 217.31	$ 260.65	$ 307.76
	43	$ 6.50	$ 16.92	$ 23.46	$ 44.19	$ 89.42	$ 142.18	$ 177.98	$ 217.55	$ 260.90	$ 308.00
	44	$ 6.76	$ 17.18	$ 23.72	$ 44.45	$ 89.67	$ 142.44	$ 178.24	$ 217.81	$ 261.15	$ 308.26
	45	$ 7.02	$ 17.44	$ 23.98	$ 44.71	$ 89.93	$ 142.70	$ 178.50	$ 218.07	$ 261.41	$ 308.52
	46	$ 7.30	$ 17.72	$ 24.25	$ 44.98	$ 90.21	$ 142.97	$ 178.77	$ 218.35	$ 261.69	$ 308.80
	47	$ 7.58	$ 18.00	$ 24.54	$ 45.27	$ 90.49	$ 143.26	$ 179.06	$ 218.63	$ 261.97	$ 309.08
	48	$ 7.88	$ 18.30	$ 24.84	$ 45.57	$ 90.79	$ 143.55	$ 179.36	$ 218.93	$ 262.27	$ 309.38
	49	$ 8.19	$ 18.61	$ 25.15	$ 45.87	$ 91.10	$ 143.86	$ 179.67	$ 219.24	$ 262.58	$ 309.69
	50	$ 8.51	$ 18.93	$ 25.47	$ 46.20	$ 91.42	$ 144.18	$ 179.99	$ 219.56	$ 262.90	$ 310.01
	51	$ 8.84	$ 19.26	$ 25.80	$ 46.53	$ 91.75	$ 144.52	$ 180.32	$ 219.89	$ 263.23	$ 310.34
	52	$ 9.19	$ 19.61	$ 26.15	$ 46.87	$ 92.10	$ 144.86	$ 180.66	$ 220.24	$ 263.58	$ 310.69
	53	$ 9.54	$ 19.96	$ 26.50	$ 47.23	$ 92.46	$ 145.22	$ 181.02	$ 220.59	$ 263.93	$ 311.04
	54	$ 9.92	$ 20.34	$ 26.88	$ 47.61	$ 92.83	$ 145.59	$ 181.40	$ 220.97	$ 264.31	$ 311.42
	55	$ 10.30	$ 20.72	$ 27.26	$ 47.99	$ 93.22	$ 145.98	$ 181.78	$ 221.35	$ 264.69	$ 311.80
	56	$ 10.71	$ 21.13	$ 27.67	$ 48.40	$ 93.62	$ 146.38	$ 182.19	$ 221.76	$ 265.10	$ 312.21
	57	$ 11.12	$ 21.54	$ 28.08	$ 48.81	$ 94.04	$ 146.80	$ 182.60	$ 222.17	$ 265.52	$ 312.62
	58	$ 11.56	$ 21.98	$ 28.52	$ 49.25	$ 94.47	$ 147.23	$ 183.04	$ 222.61	$ 265.95	$ 313.06
	59	$ 12.01	$ 22.43	$ 28.97	$ 49.70	$ 94.92	$ 147.69	$ 183.49	$ 223.06	$ 266.40	$ 313.51
	60	$ 12.48	$ 22.90	$ 29.44	$ 50.17	$ 95.39	$ 148.16	$ 183.96	$ 223.53	$ 266.87	$ 313.98
	61	$ 12.97	$ 23.39	$ 29.93	$ 50.66	$ 95.88	$ 148.64	$ 184.45	$ 224.02	$ 267.36	$ 314.47
	62	$ 12.97	$ 23.39	$ 29.93	$ 50.66	$ 95.88	$ 148.64	$ 184.45	$ 224.02	$ 267.36	$ 314.47
	63	$ 12.97	$ 23.39	$ 29.93	$ 50.66	$ 95.88	$ 148.64	$ 184.45	$ 224.02	$ 267.36	$ 314.47
	64	$ 12.97	$ 23.39	$ 29.93	$ 50.66	$ 95.88	$ 148.64	$ 184.45	$ 224.02	$ 267.36	$ 314.47

[2] ASSUMPTIONS: a) Used proposed 2018 rates since rates have not been finalized.

DRAFT LEGISLATIVE PACKAGE SUMMARY

ACA Working Group Meeting October 27, 2017

1. STATUTORY CLEAN UP

The District of Columbia implemented provisions of the Affordable Care Act into District code. A review of this code and proposed changes would focus on maintaining the State based marketplace, DC Health Benefit Exchange Authority (HBX), and the District's insurance market rules and consumer protections.

A review of the District code for cleanup would include the District's state based marketplace, eligibility and enrollment for marketplace coverage, open enrollment, eligibility for advance premium tax credit, cost sharing reduction, navigator requirements, exemptions to the individual responsibility requirement, metal levels, certification of qualified health plans including essential health benefits, cost sharing protections, actuarial value, network adequacy, waiting period limitations, quality rating, guaranteed issue, guaranteed renewability, pre-existing condition protections, nondiscrimination based on health status, prohibition of lifetime and annual limits, prohibition on rescissions, preventive services at no cost sharing, dependent coverage to age 26, and medical loss ratio.

2. DISTRICT PROHIBITION ON CARRIER REQUIREMENT TO PAY BACK PREMIUMS AS A CONDITION OF NEW ENROLLMENT

The HBX Executive Board passed a resolution June 14, 2017 recommending that the District of Columbia Department of Insurance, Securities and Banking act to prohibit the ability of carriers to require back premium payments as a condition of enrollment during an open enrollment period.

To protect residents, a change in District code to prohibit health insurance carriers from requiring an individual or employer to pay all past-due premiums owed to that carrier prior to enrollment is necessary. This would be for premiums owed for coverage in the prior 12-month period in order to effectuate coverage for that carrier during open enrollment or special enrollment periods.

3. MARKET STABILITY RECOMMENDATIONS

The HBX ACA Working Group recommendations are to provide stability in response to actions, or inactions, at the federal level that are having a destabilizing effect on the local health insurance market and markets nationwide. Such recommendations are reflected in a separate handout.

A sustained and substantial commitment to these policies can best achieve predictable premiums and consistent affordability. Such commitment is also critical to support the operational investment necessary to implement these policies.