STATE-BASED INDIVIDUAL MANDATE
FRAMING QUESITONS 3-5
DISCUSSION DOCUMENT
FEBRUARY 8, 2018

Framing Question 3. Should DC modify any current federal standards for coverage, exemptions, penalties or operations and should DC try to use tax penalties to help individuals purchase coverage, as in the Maryland proposal?

COVERAGE: Conform to federal coverage standards for meeting the individual mandate as follows:

	FEDERAL	MA	DC
Federal Programs (Medicare, Medicaid, FEHBP, VA, DOD, etc.)	✓	✓	Federal
QHP (individual and small group plans – includes ACA EHB and market reform rules)	✓	✓	Federal
Large Group plans	✓	Large group plans that meet specific benefit requirements and cost sharing limits. Plans that do not meet requirements may pursue deemed compliance if they are close.	Federal
High Deductible Health Plans that meet federal rules	✓	Only if satisfying certain consumer protections and coupled with a health reimbursement account.	Federal
Student Health Plans	✓	✓	Federal
Peace Corps, VISTA, AmeriCorps, NCCCC	✓	✓	Federal
Health Care Sharing Ministries	✓	✓	Federal
Tribal or Indian Health Service Plans	✓	✓	Federal

POTENTIAL COVERAGE DEVIATIONS: CONSIDER LOCAL NEEDS:

COVERAGE	PROS	CONS
Association Health Plans – Would meet individual mandate coverage requirement ONLY if AHP meets ACA individual and small group market rules, otherwise use case by case basis for determining compliance	Concerns regarding AHP's under the proposed rule by the Dept of Labor: – Opens the door to fraud and scams. AHPs have a long history of insolvencies, scams, and fraud. – Permits discrimination against women, older people, and people with pre-existing conditions. Exempts AHPs from essential health benefit requirements and ACA consumer protections such as guaranteed issue, single risk pool, and rating protections. – DC residents and small business employees will be at risk of losing health insurance. AHPs would be able to cherry pick the healthiest individuals and businesses out of DC's individual and small business marketplaces. This destabilizes and increases costs for DC's individual and small group markets. – The proposed rule creates new ambiguity on whether and to what extent AHPs would continue to be subject to regulation and oversight of states. AHPs looking to evade state laws can use ambiguities in the new regulations as a shield resulting in years of litigation. –	– Permit cheaper plan options that may be attractive to some. – Individuals/employers enrolled in an AHP may not recognize they or their employees will face a financial penalty. – No way to effectively require all AHP plans to warn individuals that the coverage won't meet the District's individual mandate. – Federal guidance is still a proposed rule, not final. It is based on WH Executive Order from November 2017.

Limited/Short Term Duration Plans – meet individual mandate coverage requirement if AHP meets ACA individual and small group market rules, otherwise use case by case basis	SAME AS ABOVE	SAME AS ABOVE – Was included in November 2017 WH Executive Order. Rulemaking is still pending.
ACA Grandfathered Plans – Meet individual mandate coverage requirement	– Maintain status quo of federal rule. – Education required to deviate from federal rule will be difficult.	– Require health insurance that includes the essential health benefits and other consumer protections that not all grandfathered health plans have. – Individuals and employers may find cheaper or equivalent cost health plans that meet ACA standards and protections, but have not looked.
DC Healthcare Alliance – meet individual mandate coverage requirement	– Approximately 16,000 people are enrolled who have no other option for affordable coverage – Consistent with the District's values to provide coverage for all	– Permits healthcare coverage that does not include all of the essential health benefits.
Case by Case consideration of qualifying – similar to MA	– Allows for flexibility in implementation.	– Additional operational review burden. – Could be used to undermine an individual mandate.

EXEMPTIONS FROM PENALTY – Those that are exempt, or can appeal to become exempt, from the individual mandate penalty. Conform to federal exemptions from meeting the individual mandate as follows:

	FEDERAL	MA	DC
Individuals/families below the federal tax filing threshold	Exemption	Exemption	Exemption
Incarcerated individuals	Exemption	Exemption	Exemption
Those not lawfully present	Exemption	?	Exemption
Citizens living abroad and certain noncitizens • Lived abroad at least 330 continuous days • U.S. Territory Residents • Certain Resident Aliens Living in U.S.	Exemption	?	Exemption
Hardship Exemption	Exempt through appeal to Marketplace (HHS administers for DC) and qualify based on circumstances such as eviction or foreclosure, shutoff of utilities, or sudden increase in expenses due to disaster, death in the family, domestic violence, or unanticipated family care..	Exempt through appeal to the MA Health Connector based on similar circumstances.	Exemption
Religious Conscience exemptions	Exempt through appeal to HHS	Exempt through appeal to State Department of Revenue	Exemption
Native Americans	Exemption	?	Exemption
During residency in another state	N/A	Exemption	Exemption

POTENTIAL EXEMPTION DEVIATIONS FROM PENALTY: CONSIDER LOCAL NEEDS:

COVERAGE	CONSIDERATIONS
Short term periods without health coverage	Consider exemption if uninsured no more than three consecutive months. Similar to MA rule. In DC coverage generally begins on first of the month so people are unduly penalized by the specific limitation in the federal law of "less than" three months Done by tax filer on tax form.
Individuals/families below a specific FPL threshold (ex. MA is 150% FPL)	Does not require the tax filer to request or apply for exemption. Consider a straight exemption of low income individuals and families that OTR could administer, or be a fallback if the tax filer did not claim the exemption.
Affordability Exemption	Consider: • A consistent level for an affordability exemption (feds at approx. 8%) • A sliding scale affordability exemption (similar to MA) • No affordability exemption and instead use one of the other options. Requires an application, review, and adjudication of appeals.
MD Proposal Component 1 – Prepayment at Open Enrollment	Consider exemption if person enrolls during open enrollment. May be administered through questions/attestations on the tax form.
MD Proposal Component 2 – Tax Time	Consider exemption for tax time enrollment. Would require direct coordination between OTR and HBX. Would require tax filer to agree to release of tax filing to HBX.
MD Proposal Component 3 – Down payment through escrow account	Would require OTR to maintain individual accounts for DC tax filers.

	Would require an operational structure where OTR provides funding to HBX or carrier directly to purchase insurance. Would not be effective given the District's highly transitional population.

PENALTY CALCULATION

	FEDERAL	MA	DC
Penalty	$695 per adult/$347.50 per child -- up to a cap of $2085 per family Or 2.5% of family income that is over the filing threshold Whichever is greater – Except that the penalty is capped at the national average bronze level health plan.	The amount is set by the MA Connector annually, the penalty is progressive with income, mirroring the availability of premium subsidies for lower income individuals. In 2017, the penalty varied from $252 for someone at 150.1-200% of poverty; to $1,152 a year for someone above 300% of poverty.	**Discussion:** – Federal penalty as the foundation? – Additional or different calculations?
Who it applies to	Adults and children	Only adults	**Discussion:** – Applies to all? – Applies to adults only?
Deductions in Penalty		Lessened by amount paid to Federal government	Lessened by amount paid to Federal government
Calculation	Monthly penalty calculation based on 1/12 of annual amounts.	Monthly penalty calculation based on 1/12 of annual amounts.	Monthly penalty calculation based on 1/12 of annual amounts.

Framing Question 4. Getting a plan ready for 2019 implementation may require that the initial program be as similar as possible to the federal law. If that is necessary, is it possible to consider refinements at a later time?

Given the discussion up to this point, are there specific policies that anyone believes are critical to an individual mandate recommendation but would need to be considered/implemented at a later date due to operational, cost, or other considerations? Or, if we prefer to remain silent on specifics, we could note that refinements may be appropriate over time as we see what happens in other states, etc.

Framing Question 5. How should funds be used that are collected through an individual mandate?

Reminder: As part of the work already completed by the ACA Working Group in 2017, this group included in its recommendation on the individual mandate fallback policy that: *"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."*

Similarly, Massachusetts places funds collected through their state-based individual mandate into the "Commonwealth Care Trust Fund" and it is used to help finance the states' APTC "state wrap" that further reduce premiums and cost sharing for Health Connector enrollees.

As part of a recommendation, should that point be reiterated?