April 6, 2018

Recommendations of the Reconvened 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 first met in 2017 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. In November 2017, the ACA Advisory Working Group reached consensus on four insurance market stability and affordability policy recommendations. Pursuant to a January 10, 2018 charge from Mayor Muriel Bowser, the working group reconvened to address the repeal of the individual responsibility requirement in the Tax Cuts and Jobs Act enacted on December 22, 2017 (Appendix A). The charge follows:

> *The repeal of the Affordable Care Act (ACA) individual mandate will lead to an increase in premiums and loss of coverage for millions across the country and thousands here in the District. While I continue to call on the federal government to expand access to health care coverage, it is clear that the current Congress and administration refuse to show leadership on this issue. I ask that the Health Benefit Exchange Authority Board reconvene the Affordable Care Act (ACA) Working Group, with the charge of recommending actions the District government should take to protect coverage gains and ensure affordable health care coverage for individuals and small businesses. I am requesting that the Working Group consider whether there are actions the District of Columbia should take in light of the repeal of the individual mandate.*

ORIGINAL ACA WORKING GROUP RECOMMENDATIONS: The ACA Working Group was first formed in the summer of 2017 and made its first recommendations in November 2017. During this time, Congress debated repealing and replacing the ACA with various proposals – none of which were enacted. Thus, the ACA Working Group focused at that time on efforts the District could take to protect our individual and small group health insurance marketplaces from potential negative consequences of federal actions, including regulations and guidance that could undermine coverage.

The working group reached consensus on four major policies as follows:

1. A locally funded reinsurance program to stabilize the District's individual health insurance and lower premiums for everyone;
2. The creation of a local subsidy program that would be in addition to federal premium tax credits to make health insurance more affordable for those who qualify for federal advance premium tax credits (generally those individuals and families just above Medicaid eligibility levels up to 400% FPL);
3. Fallback enforcement of the federal individual responsibility requirement; and
4. Fallback cost sharing reduction payments by the District to health insurance carriers if the federal government does not make payments.

To see the see full recommendations please view the November 6, 2017 ACA Working Group Report which can be found on the HBX website here: https://hbx.dc.gov/sites/default/files/dc/sites/hbx/event_content/attachments/ACA%20Working%20Group%20Report%2011.6.17%20FINAL%20w%20attachments.pdf)

ACA WORKING GROUP OVERVIEW

The Tax Cuts and Jobs Act of 2017, enacted on December 22, 2017, terminated the ACA's individual responsibility payment (also referred to as the individual mandate) by reducing the tax penalty to $0, effective January 1, 2019. In light of this, and pursuant to a charge from Mayor Muriel Bowser, the ACA Working Group convened for a second time beginning January 19, 2018 to develop recommendations the District of Columbia should take to protect coverage gains and ensure affordable health coverage for individuals and small businesses in the District in light of the repeal of the individual responsibility requirement.

The ACA Working Group is comprised of representatives from health insurance carriers, medical providers, consumers, small business representatives, brokers, actuaries, and navigators (full list of members later in the report). Eight meetings were held, on January 19, 23, and 30, and February 2, 7, 8, 12, and 14, 2018 by conference call and in person. Prior to the meetings, all meeting announcements and meeting materials were publically posted here: https://hbx.dc.gov/page/affordable-care-act-aca-working-group-2018-meeting-materials.

This report is a compilation of the ACA Working Group's consideration of the Mayor's charge and was compiled after completion of its work. It is designed to supplement the public record on the HBX website which has audio recordings of each meeting, meeting summaries, and all documents distributed.

It is also important to note that time was of the essence for this working group. In order to implement policies that protect coverage gains in the District, any such policies need to be enacted as quickly as possible for several key reasons. First, health insurance carriers file their 2019 proposed rates in May of 2018 with the District's Department of Insurance, Securities and Banking. The charge from Mayor Bowser is to recommend actions "*the District government*

should take to protect coverage gains and ensure affordable health care coverage for individuals and small businesses." The most effective way to meet that charge is to enact policy changes that impact the initial rate filings of health insurance carriers on May 1, 2018. Second, if the District is to consider enacting its own individual responsibility requirement, it would be a change to the District's tax code which would require changes to tax forms and instructions in time for the 2020 filing season (for 2019 taxes). In addition, District residents will need advance notice of the new individual responsibility requirement – especially because the open enrollment period occurs in advance of the 2020 filing season (for 2019 taxes). Finally, implementation of an individual responsibility requirement also includes reporting responsibilities for health insurance carriers and they'll need ample time to comply with any such requirements. These factors were clearly recognized by the working group members and work was completed quickly to best ensure the ability for District policy makers to implement any ACA Working Group recommendations in time to meet these deadlines.

ACA WORKING GROUP INITIAL MEETING

On January 19, 2018, when the working group reconvened, it was presented with the charge from the Mayor to recommend actions the District government should take to counteract the repeal of the federal individual responsibility requirement. In addition to the charge, a representative from the Mayor's office shared four additional points the Mayor asked the working group to focus on:

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

Members of the Working Group then shared their perspectives on the federal individual responsibility requirement and potential impacts from the repeal of it.

Working group members discussed that the individual responsibility requirement was a provision in the ACA that was key to the success of the ACA as it helped to expand coverage and control premiums. Without a fully enforced requirement to have health insurance, younger and healthier people may not purchase coverage, leading to rate increases as the remaining risk pool of those with insurance through the individual market have a less healthy profile. Robert Axelrod (Kaiser Permanente), Kris Hathaway (AHIP), Colette Chichester (CareFirst), and Dania Palanker (Georgetown Center for Health Insurance Reforms) all discussed the destabilizing effects of the repeal on the insurance markets including increases in premiums and a less healthy risk pool.

Members also discussed that when people have issues with access to health care there may also be negative ripple effects in other areas of their lives. Jodi Kwarciany (DCFPI) discussed how lack of health coverage can lead to issues in employment, housing, and other parts of a person's

life. Katie Nicol (Whitman Walker Health) echoed those concerns and noted that with the ACA, Whitman Walker Health saw a shift in health outcomes because patients had better access to health care. Other members shared similar thoughts, noting how the ACA had improved health outcomes for many people, especially for the District's highest need populations. Justin Palmer (DC Hospital Association) also noted how DC had done such a great job of reducing not only the uninsured rate in the District, but also the level of uncompensated care and expressed concern for commercial payers and anything else that stands to destabilize the market or increase rates.

Members also noted that having health insurance gives people access to preventive care they need to catch illness early and prevent more expensive treatment later on. Maria Gomez from Mary's Center, a federally qualified health clinic in the District, expressed concern that more young people would drop out of the market if coverage became too expensive, and would go to places like Mary's Center for care. People who aren't insured accrue healthcare costs regardless of their ability to pay. Often these populations seek coverage from local healthcare clinics like Mary's Center who serve populations regardless of their ability to pay. The uncompensated care costs fall on places like Mary's Center to cover. She also discussed that loss of preventive care can result in increased pregnancies, STDs, and hamper early detection of hypertension, diabetes and other chronic illnesses, increasing health care costs overall.

At the conclusion of the meeting, it was emphasized that the goal of the working group is to ultimately reach consensus around any recommendation and that the contributions of working group members would be critical to developing a recommendation that comprehensively represents the broad stakeholder perspectives in the District. Again, the need to act quickly, to provide time for policymakers to implement any recommendations to impact 2019 health insurance premiums was also noted.

Given the short implementation timeline the District faces if the individual responsibility requirement is to be implemented starting January 1, 2019, working group members agreed that the simplest option would be to mirror the federal individual responsibility requirement as a baseline approach to build from. Starting with the federal individual responsibility requirement as a model maximizes continuity while still providing opportunities to depart in some places. It would also simplify legislative drafting. In his presentation, Jason Levitis (State Health and Value Strategies and former US Department of Treasury staff) suggested the District could implement the federal individual responsibility requirement through a process called conformity, where the state references and adopts federal regulations and guidance already in place while making targeted changes. Finally, it was noted that the federal individual responsibility requirement is familiar to District residents and building on that structure best maintains the status quo. Taxpayers and tax preparers already understand it. Recognizing that the working group had the potential to deviate from the federal individual responsibility requirement in some places, the group coalesced around adopting federal rules as a starting point.

IDEAS FOR IMPLEMENTING A LOCAL INDIVIDUAL RESPONSIBILITY REQUIREMENT

At the second working group meeting, the working group heard three presentations on varying approaches to the implementation of an individual responsibility requirement:

- **Massachusetts's Experience with a State Individual Responsibility Requirement:** Audrey Gasteier, Ed DeAngelo, and Marissa Woltmann, Massachusetts Health Connector. The state of Massachusetts (MA) implemented an individual mandate as part of the state's landmark health reform in 2006. As such, it predates the ACA's individual responsibility requirement and includes some differences from the federal law for the District to consider. Another parallel with Massachusetts is that prior to implementing their state law, the state already had high health insurance coverage rates – which is also true of the District (Appendix D).

- **Lessons from the Federal Individual Responsibility Requirement:** Jason Levitis, State Health and Value Strategies. Jason led ACA implementation at the US Treasury Department until January 2017 and shared the approach of the federal government's implementation of an individual responsibility requirement as a feasible model and starting point for the District. He also continued to participate in the ACA Working Group meetings and provided expert technical assistance throughout the process on how the federal requirement works and how a state could adopt an individual responsibility requirement locally (Appendix E).

- **Maryland's Proposal for Health Insurance Down Payments:** Stan Dorn, Families USA. Stan has worked closely with a coalition in Maryland on an approach to respond to federal repeal of the individual responsibility requirement. He shared the Families USA working proposal for Maryland and described pieces of this model to the working group for consideration. The Down Payment model consists of components that would allow consumers to use penalty dollars to purchase coverage as well as connect and potentially enroll consumers who may be subject to the penalty to coverage at tax-time (Appendix F).

As a follow up to the presentations, HBX staff developed an individual responsibility requirement discussion matrix in addition to five framing questions to help frame the discussion and organize the policy components of each aforementioned presentation (Appendix H and I). The group completed a walkthrough of the discussion matrix and HBX staff developed two additional discussion documents which combined the five framing questions and specific policies from the Federal, MA and MD approaches that the District may want to conform to or deviate from (Appendix P and Q). Working from the framing questions discussion document, the group considered which policy components would ultimately be included in the recommendation.

THE SUCCESS OF ACA IN THE DISTRICT – HOW WE ARE COVERING THE UNINSURED:

The District is a national leader in protecting and improving the health of our residents. 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. The ACA created an unprecedented opportunity here in the District to achieve near universal coverage. When the District began implementation, there were 42,000 residents without any health coverage – either public or private health insurance. And, thousands of people were underinsured. The ACA created a significant opportunity for nearly all District residents to have affordable, quality health insurance coverage.

The most recent uninsured data shows that the District's uninsured rate dropped from 7.2% in 2009 to 4% in 2016, with approximately 26,000 uninsured residents in the District today (Appendix K). The gain in coverage is related to effective implementation of the ACA and the District's early expansion of Medicaid. As of January 25, 2018 there are 94,024 people covered through DC Health Link (Appendix J). Of those, 17,453 are enrolled in private health plans in the individual and family marketplace and 76,572 enrolled through the small business marketplace.

On the Medicaid side, the District of Columbia Department of Health Care Finance (DHCF) reported in December 2017 that the District ensures 258,000 individuals and families through the District's Medicaid program with 83,525 of those covered as a result of Medicaid expansion under the ACA (Appendix G).

Coverage gains in both private and public insurance markets have significantly lowered the amount of total uncompensated care provided by District of Columbia hospitals. Data gathered by The State Health Planning and Development Agency from the District of Columbia Department of Health found that between 2010 and 2015 total uncompensated care provided by District hospitals decreased by 60% (Appendix M). Altogether, these data provide a very important representation of both the impact the ACA has had in the District and what having meaningful coverage means for District residents.

IMPACT OF AN INDIVIDUAL RESPONSIBILITY REQUIREMENT ON HEALTH COVERAGE

As the District of Columbia considers the possibility of creating a state-level individual responsibility requirement, an important question to answer is what is known about the effect of the repeal of the individual responsibility requirement. The Congressional Budget Office (CBO) analyzed the impact of repealing the federal individual responsibility requirement and found that the impact would be a 10% average increase in premiums in the individual markets across the country (Appendix B). Those retaining coverage would tend to be less healthy and older, while those dropping coverage would be younger and healthier. Thus, average insurance premiums for

those remaining insured would rise because the risk pool becomes less healthy overall. CBO also estimated repealing the federal individual responsibility requirement would lead 4 million Americans to lose coverage in 2019, rising quickly to 12 million in 2021 and 13 million by 2025.

The American Academy of Actuaries agreed that insurance premiums would rise and cautioned Congress against repealing the individual responsibility requirement, noting that, *"Eliminating the mandate without implementing an alternative means to drive enrollment among healthy individuals would likely result in a deterioration of the risk pool due to lower coverage rates among lower-cost individuals who could defer purchasing insurance until a health need arose. Premiums would increase as a result, reducing affordability and eroding pre-existing condition protections."*

They went on to warn that the rise in premiums could result in insurer losses and solvency concerns, and could drive more insurers to withdraw from the market which could lead to severe market disruption and loss of coverage among individual market enrollees. They concluded that strong alternative mechanisms to encourage enrollment and/or significant market stabilization provisions would be needed to counteract the negative consequences of the elimination of the individual responsibility requirement (Appendix C).

At the request of the DC Health Benefit Exchange Authority, actuaries from the Oliver Wyman consulting firm provided estimates of the effects of the repeal of the federal individual responsibility requirement for the District of Columbia, drawing on its national micro-simulation model and data about the composition of DC Health Link beneficiaries. The firm found the repeal would result in a decrease in the District's 2019 individual ACA enrollment of about 15.1%, or about 2,500 covered lives. It also estimated that repeal would lead to an increase in average claim costs in the individual ACA market equal to 7.2% per member per month. Insurance carriers would have to increase premium rates to cover those costs, although insurance representatives in the working group mentioned that their internal estimates of the impact could be higher. Colette Chichester (CareFirst) estimated that CareFirst premiums would rise between 10-15% as a result of the repeal of the federal individual responsibility requirement alone, not including the general increase of health care costs over time. Oliver Wyman did not include estimates about the employer market or Medicaid because they lacked comparable data about the composition of those beneficiaries, but agreed that the repeal would have negative effects in those markets too (Appendix N).

In addition to these materials, ACA Working Group Chair Leighton Ku, Professor and Director of the Center for Health Policy Research at the George Washington University Milken Institute School of Public Health, compiled a summary in response to the broader framing question, what is the evidence of the effects of the ACA's individual responsibility requirement (Appendix R). What follows are research examples from that memo.

Research from Harvard and MIT based on 2014 data that found while the primary effects of the ACA on insurance coverage were caused by changes in Medicaid eligibility and the creation of subsidies for health insurance by the exchanges, about 30% of insurance expansions were likely attributable to other causes, including social perceptions of the individual responsibility requirement. The study noted that although there were exemptions from the tax penalties for

those with lower incomes or hardships, it is not clear how well the public understood these policy details. They also note that effects were likely to rise in later years, as tax penalties rose substantially after the first year of ACA implementation.

An economic analysis conducted by Leighton Ku in July 2017 of the Senate's "skinny" repeal bill, which mostly proposed to repeal the ACA's individual and employer mandates. This analysis estimated that the losses in federal funding caused by that bill would reduce overall employment in the District by 714 jobs in 2020 and 1,191 in 2026 (and overall losses of 67,000 jobs nationwide in 2020 and 131,000 by 2026). These losses were driven by reductions in Medicaid and premium tax credit revenue in the District. While that bill differs somewhat from the change enacted in the tax law, it demonstrates the harmful negative economic impact of repeal on the District

Much of the evidence about the effects on the individual responsibility requirement relies on findings from Massachusetts, which instituted an individual mandate in 2006 as part of its state's health reform. Research indicates that the MA mandate resulted in overall increases in insurance coverage and in lower insurance premiums. In addition, there were health care savings as preventable hospital admissions declined and length of stay fell, although there were no overall increases in hospital costs. Overall, Massachusetts' health reform helped reduce economic problems, including reduced past due debt, improved credit scores and reduced personal bankruptcies.

This evidence presented in the memo by Leighton Ku was bolstered through the discussion with the ACA Working Group by officials from the Massachusetts Connector representatives. During that presentation, Connector representatives indicated that there is no evidence that the state's individual responsibility requirement has had any significant adverse effects on the state's economy or employment. The experience of Massachusetts is particularly relevant to the District, since both pre-reform Massachusetts, as well as the District, had relatively strong insurance coverage levels (compared to other states). In addition, both states have relatively generous Medicaid coverage and strong employer sponsored coverage.

These data suggest that loss of the federal individual responsibility requirement poses significant risks to the District, its residents, the insurance market and health care providers. Creating a District replacement for the discontinued federal individual responsibility requirement could help prevent those losses. If a District replacement is comparable to the federal law, this could be accomplished without creating serious new burdens for District residents.

The group members also discussed in various meetings the potential support and opposition to a local individual responsibility requirement. In supporting a local individual responsibility requirement, members noted it protects the ACA, maintains the status quo, retains coverage gains, keeps premiums from increasing as a result of the repeal, mitigates an increase in uncompensated care and would keep any reinsurance money focused. In opposing, members discussed the debatable level of necessity, that health insurance may not be affordable, politically based opposition, the difficulty in overcoming the confusion with the federal requirement being repealed, and the regressive nature of the tax penalty. The discussion document from the February 7, 2018 meeting captures these considerations in greater detail.

COVERAGE STANDARDS

The working group turned to a discussion of what types of health coverage could meet a local individual responsibility requirement. Using the federal coverage categories as a starting point, HBX staff prepared a matrix to guide the discussion (Appendix Q). Currently, the federal individual responsibility requirement can be met by having healthcare coverage that includes coverage through federal programs (Medicare, Medicaid, FEHBP, VA, DOD, etc), Qualifying Health Plans (individual and small group plans), large group plans, high deductible health plans, student health plans, Peace Corps, VISTA, AmeriCorps, NCCCC, Health Care Sharing Ministries, and Tribal or Indian Health Service Plans. The group generally agreed these are mainly non-controversial and should continue to be considered qualifying coverage under a District mandate. However, it was caveated that the District doesn't have experience with some of these products, like health care sharing ministries, and the group noted that the District would need to monitor such products if they become available and determine if reconsideration of their status becomes warranted.

Next, members of the working group raised the pending November Executive Order from President Trump that called on his Administration to take steps to make changes to expand access to Association Health Plans and short term limited duration plans. In response to that executive order, the Department of Labor issued proposed regulations that would loosen rules defining Association Health Plans (AHP). Another regulation is anticipated pursuant to the Executive Order that would loosen the rules with regard to short term limited duration health plans as well. Under the federal individual responsibility requirement, AHPs meet the minimum essential coverage requirement. Working group members considered the pros and cons of excluding AHP's and short term duration plans from meeting the coverage requirements for a local individual responsibility requirement under new and looser federal regulations.

Association Health Plans. The working group had a robust discussion about AHPs and specifically discussed whether AHPs should be considered qualifying coverage. Some noted that if the AHP met the ACA individual and small group market rules before the proposed rule was issued it should meet the coverage requirement, otherwise AHP's could be considered on a case by case basis for determining compliance. Members discussed that in Massachusetts, health plans that do not meet their minimum essential coverage requirements, but still provide robust coverage overall, could apply to the Health Connector for special designation as an Minimum Creditable Coverage Compliant plan for a specific plan year. Members warned that if the proposed rule were to become final, there would be potential for fraud, scams, and proliferation of low quality AHPs that do not meet minimum essential coverage (MEC) requirements, and also permit discrimination against women, older individuals, and those with preexisting conditions. The proposed rule also exempts AHP's from consumer protections such as guaranteed issue, single risk pool, and rating protections. Dania Palanker (Georgetown Center for Health Insurance Reforms) spoke at length about how AHPs could hurt District residents. People could end up buying these plans without realizing how skimpy they are. She also warned that segmentation of the market could lead to people leaving DC Health Link for substandard plans until they get sick and then try to rejoin the market in order to obtain the benefits they need. She emphasized the concern that the proposed rule will preempt states from continuing to protect their consumers. William Wehrle (Kaiser Permanente) stated their opposition to a case

by case designation process and the importance of a unified risk pool. Howard Liebers, a representative from the Department of Insurance, Securities, and Banking (DISB), mentioned that they are looking at the registration and licensure requirements in other states and were still determining if this proposed rule would preempt states from effectively regulating AHPs. Given that exact details as to how the proposed rule will be finalized cannot be known, including whether states will be preempted from protecting residents from potential negative consequences, working group members determined that excluding AHPs as defined under looser consumer protections from meeting the individual responsibility requirement could protect District consumers and should be considered as a safety net against the proliferation of substandard plans in the wake of this proposed federal regulation.

There was discussion about whether current AHPs should be grandfathered to meet a local individual responsibility requirement. There was some confusion about this point. HBX clarified that there were two considerations here: whether AHP's in the future under the new rule meet local coverage requirements, and what we should do about current AHP's that exist. Jason Levitis (State Health and Value Strategies and former US Department of Treasury) added that the District could use point-in-time conformity to mirror the federal guidelines as of a certain date. Jason also suggested using December 15, 2017 as the point-in-time to conform to federal rules since it includes helpful federal guidance on the individual responsibility requirement and is before the federal provision was repealed. Working group members appreciated this insight and agreed that using point-in-time conformity could feasibly work for the District. The District could continue to explore other state actions that are not preempted under a new final AHP rule to minimize the proliferation of harmful AHPs. But making a decision under the local individual responsibility coverage requirements to only permit AHPs that meet individual and small group insurance market rules, as was required of AHPs as of December 2017, is a safety net for District residents. HBX noted that the group's recommendation would be broad enough to leave room for flexibility during implementation, and noted that the discussion was helpful and illustrative of how the District intends to protect its residents in light of harmful guidance from the federal government.

Short term limited-duration health plans. Under current regulations, short term limited-duration health plans cannot provide more than three months of coverage. The reason for that regulation is that these policies do not have to meet the ACA standards but many consumers buying such plans did not understand their limitations and left many of their medical needs unmet. Now, it is expected that the federal Administration will issue proposed regulations to lift the three month limitation on these plans. That will return massive confusion to consumers. Jason Levitis (State Health and Value Strategies and former US Department of Treasury) clarified that short term limited-duration health plans do not meet minimum essential coverage requirements under the federal individual responsibility requirement. For all of these reasons, the group agreed that short term limited duration health plans should continue to be excluded from meeting the individual responsibility requirement if the District adopts one.

DC Healthcare Alliance. Currently under the federal law, DC Healthcare Alliance does not meet the individual responsibility requirement. Alice Weiss, a representative from the District of Columbia Department of Health Care Finance (DHCF), raised concerns that individuals enrolled in the Alliance may be paying the federal shared responsibility penalty. She went on to note that

the reason we have the program in place is because it's a District value to ensure that we're providing health care to all low-income residents. Patricia Quinn with DCPCA and Katie Nicol with Whitman Walker Health noted concern over the Alliance benefits package not being comparable to Medicaid or qualified health plans. Alice Weiss responded that while the Alliance program doesn't cover some key benefits, like mental health, the District does provide other ways for enrollees to access those needed services. Given that the Alliance is a program that approximately 16,000 District residents rely on and that they don't have other affordable coverage options available to them, the group discussed having enrollees of the Alliance program be exempt from an individual responsibility payment if the District adopts such a policy. This would be an alternative to designating the Alliance as minimum essential coverage, but have the same operational effect for those that may be subject to the penalty. The group agreed that the Alliance is an important District coverage option that many people rely on. Given that, exempting its enrollees from the individual responsibility payment would be important if the District adopts its own such requirement.

Immigrant Children's Program. The Immigrant Children's Program (ICP) is a District program that is a Medicaid lookalike. The District has not sought clarification from the federal government as to whether the program meets the MEC requirements of the ACA, but as its benefits mirror Medicaid, it most certainly should. Katie Nicol of Whitman Walker Health and Alice Weiss (DHCF) asked the group to consider including ICP as coverage that meets the individual responsibility requirement. Since ICP includes the same benefits as Medicaid, the group was in support of including ICP as minimum essential coverage.

EXEMPTIONS

The working group discussed which exemptions from the federal individual responsibility requirement the District should conform to if it decided to adopt a local requirement. Federal exemptions include, but are not limited to, an exemption for individuals/families below the federal filing threshold, incarcerated individuals, those not lawfully present, citizens living abroad, the hardship exemption, religious conscience exemption, and an exemption for Native Americans. These were non-controversial exemptions the group agreed should be included in a District individual responsibility requirement. In addition, the group easily agreed that a local individual responsibility requirement can only apply when someone is a resident of DC and months individuals reside in another state would be exempt, similar to District individual taxes.

Discussions around exemptions also included thoughts about borrowing components from Maryland's proposal as presented by Stan Dorn of Families USA. The group noted that there is much to learn from Maryland and that the District may want to include provisions from their plan that use tax filings to bolster outreach and help get people enrolled in health coverage at tax-time. Members were interested in these ideas as they focused on connecting people in the District to meaningful coverage.

Short term periods without health coverage. Under the federal individual responsibility requirement, the federal government grants an exemption for individuals and families who are uninsured for less than three consecutive months (i.e. 2 months and 29 days), whereas

Massachusetts offers an exemption to individuals and families who are uninsured for no more than three consecutive months. The group chose to deviate from federal law on this and allow people to hit the three-month mark and still qualify for this exemption. District coverage generally begins on the first of the month so people are unduly penalized by the specific limitation in the federal law of "less than" three months. This exemption must be done by the tax filer on the tax form, and will require some messaging to ensure that people know to apply for it.

Affordability exemption. The federal government includes an affordability exemption for those who can show that they don't have an affordable coverage option. The federal government's affordability exemption applies if the cost of coverage, either employer-sponsored insurance or the lowest cost bronze plan net of APTC, is more than 8.05% of their income. To administer this, the District would need to determine as a percentage of income how much people should have to spend on health insurance. This exemption would require an application, review, and adjudication. Right now, affordability exemptions are assessed by HHS, so there would be additional operational costs associated with implementation of this at the local level. HBX noted that it could make determinations and administer this exemption. The working group agreed that the District would mirror the federal government threshold level of affordability, currently 8.05%.

Individuals/families below a specific FPL threshold. In addition to the affordability exemption, the group considered an exemption for individuals and families below a specific Federal Poverty Level (FPL) threshold, such as 200% of FPL, to ensure low income District residents are not subject to the penalty without the need for an application under the affordability exemption. Some members suggested we use Medicaid levels as a threshold, but the group was concerned it would be difficult to determine which level to use since there are different Medicaid levels for adults and children and it would not be easy to determine that on tax forms. In discussions around this exemption the group was presented 2015 data that showed 2,380 tax households, with incomes up to $25,000, paid the shared responsibility penalty. Alice Weiss of DHCF noted that approximately three-quarters of those tax households that paid the penalty may have been eligible for Medicaid and felt that penalizing people who are at the lowest income levels in DC is not consistent with District values.

The working group discussed the need to strike a balance between exempting District residents and providing an incentive for them to enroll in a plan. Jason Levitis noted that marketing around the affordability exemption at the federal level may have been limited in part because they wanted people to seek out coverage and enroll. He also mentioned that lack of clarity about the rules likely contributed to accidental overpayment by some Americans, which led them to need to amend their tax returns. Members of the working group understood that the central purpose of the individual responsibility requirement is to incentivize enrollment in health coverage, and also helps support market stability and affordability. But the group also determined that it would not be consistent with District values to impose a regressive penalty on District residents, or enforce a penalty on low income residents by not making them aware of exemptions they may rightfully claim. This led the group to discuss the importance of outreach and education around the District implementing an individual responsibility requirement. They noted that outreach and education would be crucial, particularly with the federal requirement ending in 2019.

Overall, the group felt that creating an exemption for the Districts low income residents was important. It could prevent accidental overpayments and also create a much simpler process for administering the exemption since individuals would not be required to complete an application to receive the exemption – they would claim it on their tax filing. Given that determining the specifics would require further collaboration with OTR and DHCF, the group settled on the idea that a broad recommendation regarding an exemption for people below a specific FPL or Medicaid and CHIP thresholds, with the specific policy to be worked through during drafting. They felt this was the appropriate response since additional facts were needed to develop a workable policy.

As part of this discussion, Jason Levitis (State Health and Value Strategies and formerly with the US Department of Treasury) noted that when Treasury analyzed the data of who paid the individual responsibility payment in 2015, they, too, were concerned about the high number of tax households that paid the penalty who would likely have qualified for an exemption. In response to the data, Treasury revised the tax instructions/forms and consumer aides developed to help tax filers, accountants, and tax preparers with properly applying for and claiming exemptions. New tax data is not available yet that shows the impact of those changes. Those materials should be reviewed as the process moves forward in the District.

Connecting People with Coverage: The group also considered borrowing from Maryland's idea of including components that would connect people to coverage at tax time. Katie Nicol (Whitman Walker Health) and Patricia Quinn (DC Primary Care Association) noted their support for the Maryland proposal as it really sought to connect people to coverage. The group considered the idea of having a checkbox on the tax form that individuals could check to allow the Office of Tax and Revenue (OTR) to share their information with HBX, or alternatively, have HBX develop materials that OTR could mail to individuals, as Massachusetts did. As with the previous exemption, the group came to a general consensus that this part of the recommendation should be written broadly to allow some flexibility around how it is implemented.

PENALTY STRUCTURE

The working group discussed the penalty structure for a District individual responsibility requirement and quickly coalesced around the idea that for purposes of implementation, it would be simpler to follow the federal rules closely. To assist in this discussion, HBX staff put together sample 2018 penalty calculations using the federal structure for a variety of ages and income levels (Appendix L). This chart included calculations to determine whether customers would face a penalty or qualify for the affordability exemption under federal standards. Some general findings from the chart included that Medicaid eligible customers would be eligible for an affordability exemption because they would not be eligible for APTC to help make the cost of an Exchange plan more affordable; customers who received APTC would not be eligible for the affordability exemption because their APTC ensured that the lowest cost bronze plan was affordable according to federal standards; and the penalty cap of the average bronze plan cost did not play a factor in the calculations because for most households up to 1000% FPL, the penalty

amount was below that cap. Regardless of the affordability exemption, anyone can apply for a hardship exemption where special circumstances exist such as a natural disaster or home fire.

Penalty. The group considered what the penalty amount should be. The federal penalty is $695 per adult/$347.50 per child, up to a cap of $2,085 per family or 2.5% of family income that is over the filing threshold, whichever is greater. In both cases, the penalty is capped at the national average bronze level health plan. Although the federal calculation is complex, tax preparers have already been trained and tax prep software has already been developed to calculate it. And if the federal government ever changed the penalty amount from $0 to something else (reinstating the federal penalty), the District would be aligned with the federal government, which would minimize confusion around how to implement the penalty. The group agreed on mirroring the federal penalty to maximize ease of implementation.

Who the penalty applies to. The group considered if the penalty should apply to both adults and children as in the federal individual responsibility requirement. The group discussed Massachusetts' decision to exempt children from their state mandate. Bill Wehrle (Kaiser Permanente) noted that he was in support of following the federal rules as not to de-incentivize parents from enrolling their children into coverage. He agreed with other members who expressed concern that the federal penalty was regressive as it's based on income, but felt that implementing a 200% FPL threshold exemption (or something similar to that) was a more effective way to get at preventing overpayment for low income individuals and families, rather than sending a message that children don't need to have coverage. Given that the group had previously determined they wanted to include a new low-income exemption, they determined it was not necessary to exempt children from the District individual responsibility requirement.

Preventing the Risk of Double Payments. In the event that the federal government increases the federal penalty amount to something other than $0 at some point in the future, the working group determined the District should mirror Massachusetts' model to prevent double payment. Like Massachusetts' penalty, the District penalty would be lessened by the amount paid to the federal government.

Calculation. The group also determined that like both Massachusetts and the federal government, the District should also calculate the penalty by month, i.e. the monthly penalty calculation will be based on 1/12 of annual amounts.

OTHER POLICY CONSIDERATIONS

With respect to the important priority of recommending a policy that could be ready for January 1, 2019 implementation, working group members noted that the recommendation developed from this group would be broad enough so that some further refinements could be made in the development process. Implementing an individual responsibility requirement through federal conformity allows the District to rely on the structure that's already in place at the federal level, but still customize in specific instances. Such a structure would still require operational work by the Office of Tax and Revenue and others.

ACA Working Group members Katie Nicol (Whitman Walker Health), Patricia Quinn (DCPCA), and Maria Gomez (Mary's Center) all expressed strong support for parts of Maryland's proposal and noted that they would be interested in seeing additional provisions from that proposal, like the pre-payment and tax-time pieces, in the District individual responsibility requirement down the road. The pre-payment piece of Maryland's proposal would allow customers who go without health insurance to determine what their penalty amount would be for the last year and use their penalty payment to purchase insurance. The tax-time piece would give consumers the opportunity to share their information so we could reach out to them about coverage options. Stan Dorn from Families USA emphasized that tax-time is the number one time to identify the uninsured and potentially get them enrolled. Members of the Working Group agreed that tax-time does present a great opportunity to enroll uninsured people in the District. Group members also discussed where the Maryland proposal would not be as effective in the District. For example, the District's individual market may have more turnover and maintaining individual accounts, like escrow accounts, with paid penalties that could be used in the future would be overly burdensome without great benefits. Rob Metz (CareFirst) also discussed the concerns and effects on the risk pool of letting individuals enroll in health insurance at tax time after they failed to enroll during open enrollment. The group discussed whether the tax-time piece could even be implemented in the District by January 1, 2019. Representatives from OCFO noted that tax forms are printed in the summer, and if the District were to implement Maryland's idea to connect people to coverage at tax time, the District would need to include an additional section on the tax form allowing people to give OTR permission to connect them to HBX or Medicaid, and that change would need to be on the form before August. The working group also discussed the importance of timing for insurance partners. Insurance companies start rate filings in May 2018. If the District is hoping to prevent an increase in premiums due to the loss of the federal responsibility requirement, the District will need to act quickly so insurers can take them into account when estimating premiums for 2019. In the end, the group determined that these specific Maryland components would not be ripe for inclusion in a local individual responsibility requirement for 2019 but could be assessed in the future, particularly if Maryland moves to implement such a policy and DC could learn from such implementation.

Vice-Chair of the working group, Jodi Kwarziany also noted that the District should continue to think about how it can streamline the exemption process, suggesting that the District should establish some centralized place residents can go to understand the individual responsibility requirement, the exemptions, and more. It can be confusing to know where to go and how to apply given the many agencies involved at both the state and federal level.

The working group also agreed that whatever ended up in District law should be accompanied by a rigorous outreach and marketing campaign, informing District residents, taxpayers, and tax preparers of new rules. District residents need to know the policy in advance of January 1, 2019 so they don't just drop coverage. HBX agreed that it will continue to work with sister agencies, community partners and businesses to get the word out about a local individual responsibility requirement like it does with the federal requirement.

The working group also discussed operational costs at length. OTR and HBX are going to have costs to implement the individual responsibility requirement. There will be both personnel and non-personnel costs the agencies would have to absorb. HBX made clear that any additional

expenses for HBX will be absorbed in its budget. For example, the robust outreach and education campaign already conducted includes information on the federal individual responsibility requirement. So, emphasizing a District individual responsibility requirement is not really a new responsibility. The message would need refining. Representatives from both agencies agreed ongoing discussions outside of the working group would be needed to further estimate additional costs.

There was also significant discussion about the importance of ensuring that funds raised through the individual responsibility payment go back into insurance market stabilization and affordability programs. Rob Metz (CareFirst) noted several times that it strengthens the case for the individual responsibility requirement if people know the funds are being used to ensure affordability. Others, including Kris Hathaway (AHIP), also weighed in that the recommendation being put forth in this second reconvening of the ACA Working Group should build on and accompany the recommendations already provided on insurance market stability and affordability. While the individual responsibility requirement is a key component of coverage – it is equally important that coverage be affordable. Group members agreed that a recommendation on the individual responsibility requirement should be accompanied by a local reinsurance program and a local premium subsidy wrap to the federal advance premium tax proposed earlier by this working group but would supplant the individual responsibility requirement fallback.

RECOMMENDATION

ACA WORKING GROUP RECOMMENDATION

District of Columbia Individual Responsibility Requirement
For Consideration on February 14, 2018

The federal government repealed the federal individual responsibility payment, effective January 1, 2019, in the Tax Cuts and Jobs Act of 2017. That action puts affordable private and public health care coverage at risk including coverage through state individual and small group insurance markets. It also poses risks to District patients, health care providers, and to the District economy. In response, Mayor Bowser asked the DC Health Benefit Exchange Authority to: "*reconvene the ACA Working Group to recommend actions the District government should take to protect coverage gains and ensure affordable health coverage for individuals and small businesses*."

The ACA Working Group recommends that the District of Columbia fill the void left by the federal government by enacting an individual responsibility provision requiring District residents to maintain qualifying health coverage or pay a penalty on their District taxes, unless they quality for an exemption. The ACA Working Group intends that District taxpayers pay no more, and in some cases less, than they would under federal law that applies in 2018. For the 96% of District residents who are insured today, this recommendation presents no change if they remain covered.

The ACA Working Group recommends the District's individual mandate mirror the federal mandate as of December 15, 2017 with changes to enhance protections for District residents and promote District values. These changes include: ensuring that the DC Healthcare Alliance enrollees are exempt from the mandate; clarifying that the Immigrant Children's Program meets coverage requirements; protecting against future association health plans that would undermine coverage in the District; exempting low-income individuals and families from the penalty; conducting outreach and education to connect uninsured residents with health coverage options; and preventing District residents from ever facing a double penalty.

Coverage Changes

District residents and businesses will be further protected by clarifying the Immigrant Children's Program meets the individual mandate and exempting the DC Healthcare Alliance enrollees from the individual mandate. There is a pending federal regulation to loosen the rules regarding association health plans that could undermine the District's private health insurance market. The District's individual mandate will be designed to protect against these risks by excluding from the definition of qualifying coverage future association health plans that may be permitted under these looser rules. However, to prevent disruption of existing coverage, association health plans that meet the requirements in place under federal law as of December 15, 2017 will meet a District mandate.

Exemption Changes

District residents will be further protected by exempting low-income individuals and families, such as those under 200% of the federal poverty level or at Medicaid or other public program eligibility levels. The District will also better protect residents by clarifying that they will not be penalized for short lapses in coverage of three months or less.

Outreach and Education Changes

The District will use the tax filing process as an opportunity to conduct outreach and education regarding health coverage options for those that are uninsured.

Penalty Changes

If the federal government reinstates a federal individual responsibility payment, District residents will not be subject to double penalties.

This policy should be enacted in time to impact premiums for 2019 and become effective January 1, 2019. Implementation of a District penalty should be coupled with significant outreach and education to begin upon enactment. The key to success is maintaining strong DC Health Link partnerships with assisters, brokers, business associations, and carriers and working closely with health care providers, government agencies, elected officials and other stakeholders. Over time, refinements to the District's individual mandate should be considered to maintain its effectiveness.

This recommendation supplements the HBX Executive Board and ACA Working Group November 2017 recommendation for local policy interventions to protect market stability and affordability in the District's health insurance marketplace. This recommendation amends the individual responsibility fallback provision in the previous recommendation [LINK].

WORKING GROUP MEMBERS

WORKING GROUP MEMBER	AFFILIATION
Leighton Ku, Chair	GWU Center for Health Policy Research
Jodi Kwarciany, Vice-Chair	DC Fiscal Policy Institute (DCFPI)
Donna Alcorn	Rust Insurance Agency
Dave Chandrasekaran	Consumer Advocate, DC Health Link Consumer
Carl Chapman	AmeriHealth Caritas
Colette Chichester and/or Robert Metz	CareFirst
Peter Rankin and/or Louis Davis, Jr.	AARP
Maria Gomez and/or Joan Yengo	Mary's Center
Laurie Kuiper, Robert Axelrod, and/or William Wehrle	Kaiser Permanente (KP)
Katie Nicol	Whitman Walker Health 9WWH)
Dania Palanker	Georgetown Center for Health Insurance Reforms
Patricia Quinn	DC Primary Care Association (DCPCA)
Carolyn Rudd	CRP Inc., DC Health Link SHOP Customer
S. Jnatel Sims (self-designated as non-voting member)	UnitedHealthcare
Margaret Singleton	DC Chamber of Commerce
Jackie Bowen, Liam Steadman and/or Justin Palmer	DC Hospital Association
Jenny Sullivan	Consumer Advocate
Tammy Tomczyk (self-designated as non- voting member)	Oliver Wyman
Kris Hathaway and/or Kevin Wrege	America's Health Insurance Plans (AHIP)

Parentheticals note people who attended with or in place of working group members at times, but each organization got only one vote.

Staff Advisors & Support	
Debbie Curtis Purvee Kempf Alexander Alonso Sarah Bagge Julia Garcia	HBX
Howard Liebers and/or Philip Barlow	DISB
Alice Weiss, Eugene Simms, Melanie Williamson	DHCF
Deborah Freis and/or Kevin Lang	OCFO

Jay Melder and/or Amelia Whitman	DMHHS
Desiree Hoffman and/or Declan Kingman	EOM, Office of Federal and Regional Affairs
Alexis Griffin	EOM, Budget
Jacqueline Watson	Department of Health

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

The working group members and HBX staff also gratefully acknowledge the ongoing technical assistance provided by Jason Levitis, available through the Robert Wood Johnson State Health & Value Strategies Initiative and former US Treasury Official, Stan Dorn with Families USA, and Audrey Gasteier, Ed DeAngelo, and Marissa Woltmann from the Massachusetts Health Connector.

VOTE

A vote on the recommendation was held on February 14, 2018. The recommendation was unanimously adopted. Fourteen members voted to approve the policy recommendation as proposed. Three members were not present.

Below is the vote tally:

WORKING GROUP MEMBER	**VOTE**
Leighton Ku	YES
Jodi Kwarziany	YES
Colette Chichester	YES
Robert Axelrod	YES
Dave Chandrasekaran	YES
Kris Hathaway	YES
Dania Palanker	YES
Justin Palmer	YES
Margaret Singleton	YES
Carl Chapman	NOT PRESENT
Jenny Sullivan	YES
Donna Alcorn	NOT PRESENT
Patricia Quinn	YES
Katie Nicol	YES
Carolyn Rudd	YES
Peter Rankin	NOT PRESENT
Maria Gomez	YES

Appendix A

January 10, 2018

Mayor Muriel Bowser
Mayoral Charge to HBX Board

The repeal of the Affordable Care Act (ACA) individual mandate will lead to an increase in premiums and loss of coverage for millions across the country and thousands here in the District. While I continue to call on the federal government to expand access to health care coverage, it is clear that the current Congress and administration refuse to show leadership on this issue. I ask that the Health Benefit Exchange Authority Board reconvene the Affordable Care Act (ACA) Working Group, with the charge of recommending actions the District government should take to protect coverage gains and ensure affordable health care coverage for individuals and small businesses. I am requesting that the Working Group consider whether there are actions the District of Columbia should take in light of the repeal of the individual mandate.

Appendix B

Congressional Budget Office

NOVEMBER 2017

Repealing the Individual Health Insurance Mandate: An Updated Estimate

The Affordable Care Act (ACA) includes a provision, generally called the individual mandate, that requires most U.S. citizens and noncitizens who lawfully reside in the country to have health insurance meeting specified standards and that imposes penalties on those without an exemption who do not comply. In response to interest from Members of Congress, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have updated their estimate of the effects of repealing that mandate. As part of repealing the mandate, the policy analyzed would eliminate the penalty that people who have no health insurance and who are not exempt from the mandate must pay under current law.

The analysis underlying this estimate incorporates revised projections—of enrollment in health insurance, premiums, and other factors—made as part of the usual process CBO follows to update its baseline projections. This report updates a budget option published in December 2016 and is not based on specific legislative language.[1]

The Results of CBO and JCT's Analysis

CBO and JCT estimate that repealing that mandate starting in 2019—and making no other changes to current law—would have the following effects:

- Federal budget deficits would be reduced by about $338 billion between 2018 and 2027 (see Table 1).
- The number of people with health insurance would decrease by 4 million in 2019 and 13 million in 2027 (see Table 2).
- Nongroup insurance markets would continue to be stable in almost all areas of the country throughout the coming decade.
- Average premiums in the nongroup market would increase by about 10 percent in most years of the decade (with no changes in the ages of people purchasing insurance accounted for) relative to CBO's baseline projections.

Those effects would occur mainly because healthier people would be less likely to obtain insurance and because, especially in the nongroup market, the resulting increases in premiums would cause more people to not purchase insurance.

If the individual mandate penalty was eliminated but the mandate itself was not repealed, the results would be very similar to those presented in this report. In CBO and JCT's estimation, with no penalty at all, only a small number of people who enroll in insurance because of the mandate under current law would continue to do so solely because of a willingness to comply with the law. If eliminating the mandate was accompanied by changes to tax rates or premium tax credits or by other significant changes, then the policy analyzed here would interact with those changes and have different effects.

For this analysis, CBO and JCT have measured the budgetary effects relative to CBO's summer 2017 baseline, which underlies the Concurrent Resolution on the Budget for Fiscal Year 2018.[2] In that baseline, the ACA's other provisions, including premium tax credits and

1. See Congressional Budget Office, *Options for Reducing the Deficit: 2017 to 2026* (December 2016), www.cbo.gov/publication/52142.

2. See Congressional Budget Office, *An Update to the Budget and Economic Outlook: 2017 to 2027* (June 2017), www.cbo.gov/publication/52801. For additional information about the baseline presented in that report, see *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027* (September 2017), www.cbo.gov/publication/53091.

Table 1.

Estimate of the Net Budgetary Effects of Repealing the Individual Mandate

Billions of Dollars, by Fiscal Year

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	Total, 2018–2027
Change in Subsidies for Coverage Through Marketplaces and Related Spending and Revenues[a,b]	0	-4	-9	-19	-23	-24	-25	-26	-27	-28	-185
Medicaid	0	-5	-9	-16	-20	-22	-24	-26	-28	-29	-179
Change in Small-Employer Tax Credits[b,c]	0	*	*	*	*	*	*	*	*	*	*
Change in Penalty Payments by Employers[c]	0	0	0	*	*	*	*	*	*	*	1
Change in Penalty Payments by Uninsured People	0	*	5	5	5	5	5	6	6	6	43
Medicare[d]	0	1	2	4	5	5	5	6	7	7	44
Other Effects on Revenues and Outlays[e]	0	*	-2	-6	-8	-8	-9	-9	-10	-10	-62
Total Effect on the Deficit	**0**	**-8**	**-13**	**-33**	**-40**	**-44**	**-47**	**-49**	**-51**	**-54**	**-338**
Memorandum:											
Total Change in Direct Spending	0	-7	-14	-30	-36	-40	-42	-44	-46	-49	-307
Total Change in Revenues[f]	0	1	-2	3	4	4	5	5	6	6	31

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Estimates are based on CBO's summer 2017 baseline.

Changes in budget authority would equal the changes in outlays shown.

Except as noted, positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

Numbers may not add up to totals because of rounding.

* = between -$500 million and $500 million.

a. "Related spending and revenues" includes spending for the Basic Health Program and net spending and revenues for risk adjustment.

b. Includes effects on both outlays and revenues.

c. Effects on the deficit include the associated effects that changes in taxable compensation would have on revenues.

d. Effects arise mostly from changes in payments to hospitals that treat a disproportionate share of uninsured or low-income patients.

e. Consists mainly of the effects that changes in taxable compensation would have on revenues.

f. Positive numbers indicate an increase in revenues; negative numbers indicate a decrease in revenues.

Table 2.

Effects of Repealing the Individual Mandate on Health Insurance Coverage for People Under Age 65

Millions of People, by Calendar Year

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Change in Coverage Under the Policy										
Medicaid[a]	0	-1	-2	-4	-4	-4	-4	-5	-5	-5
Nongroup coverage, including marketplaces	0	-3	-4	-5	-5	-5	-5	-5	-5	-5
Employment-based coverage	0	*	-1	-2	-2	-3	-3	-3	-2	-2
Other coverage[b]	0	*	*	*	*	*	*	*	*	*
Uninsured	0	4	7	12	12	12	12	13	13	13

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Estimates are based on CBO's summer 2017 baseline. They reflect average enrollment over the course of a year among noninstitutionalized civilian residents of the 50 states and the District of Columbia who are under age 65, and they include spouses and dependents covered under family policies.

For these estimates, CBO and the staff of the Joint Committee on Taxation consider individuals to be uninsured if they would not be enrolled in a policy that provides financial protection from major medical risks.

Numbers may not add up to totals because of rounding.

* = between -500,000 and zero.

a. Includes noninstitutionalized enrollees with full Medicaid benefits.

b. Includes coverage under the Basic Health Program, which allows states to establish a coverage program primarily for people whose income is between 138 percent and 200 percent of the federal poverty level. To subsidize that coverage, the federal government provides states with funding that is equal to 95 percent of the subsidies for which those people would otherwise have been eligible.

cost-sharing reduction (CSR) subsidies in the marketplaces that the legislation established, are assumed to remain in place.[3]

In the budget option presented last year, CBO and JCT examined the same policy starting a year earlier and relative to CBO's March 2016 baseline: They estimated that the policy would reduce federal budget deficits by $416 billion between 2018 and 2026 and increase the number of uninsured people by 16 million in 2026.

The differences between the budgetary effects shown here and those estimated in December 2016 stem from several sources. The current estimate relies on updated baseline projections related to the federal costs of subsidizing health insurance. This estimate also incorporates CBO and JCT's expectation that individuals' and employers' full reaction to the elimination of the individual mandate would phase in more slowly than the agencies previously projected. (The agencies have incorporated that expectation in all estimates for legislative proposals related to the mandate that they have prepared after the 2017 budget reconciliation process ended in September.) And this estimate includes an interaction with Medicare, whose "disproportionate share hospital" payments to facilities that serve a higher percentage of uninsured patients would be affected.[4]

In addition to updates to the baseline, which occur on a regular cycle, CBO and JCT sometimes make major

3. After consultation with the Budget Committees, CBO has not changed its baseline to reflect the Administration's announcement on October 12, 2017, that it would stop making payments for CSRs. The Balanced Budget and Emergency Deficit Control Act of 1985, which specifies construction of the baseline, requires that CBO assume full funding of entitlement authority. CBO has long viewed the cost-sharing subsidies as a form of entitlement authority—that is, legal authority for federal agencies to incur obligations and to make payments out of the Treasury for specified purposes. On that basis, in the agencies' initial cost estimate for the ACA and in all subsequent baseline projections, they have recorded the CSR payments as direct spending (that is, spending that does not require appropriation action). For a related discussion, see Congressional Budget Office, *The Effects of Terminating Payments for Cost-Sharing Reductions* (August 2017), www.cbo.gov/publication/53009.

4. That interaction, which would add costs totaling $44 billion over the 2018–2027 period, was not included in the December 2016 estimate because, as is often the case with budget options, it followed a simplified method. However, during 2017, the interaction with Medicare has been included in estimates of the effects of major changes to policies affecting health insurance.

methodological changes to improve their estimates. Accordingly, the agencies have undertaken considerable work to revise their methods to estimate the effects of repealing the individual mandate. CBO's Panel of Health Advisers and experts at the American Enterprise Institute, the Office of the Actuary in the Centers for Medicare & Medicaid Services, the RAND Corporation, and the Urban Institute, along with other sources, have provided valuable information during that process.[5] However, the evidence available to inform CBO and JCT's work on that issue is limited. Because that work is not complete and significant changes to the individual mandate are being considered as part of the budget reconciliation process, the agencies are publishing this update now without incorporating major changes to their analytical methods.

However, the preliminary results of analysis using revised methods indicates that the estimated effects on the budget and health insurance coverage would probably be smaller than the numbers reported in this document. The agencies are continuing to work on those methods, and they expect to complete and publish an estimate including and explaining the revisions at some point after the current budget reconciliation process is complete or along with a future update to the baseline.

Uncertainty Surrounding the Estimates

CBO and JCT's estimates of this policy are inherently imprecise because the ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other affected parties would respond to it are all difficult to predict. The responses by individuals in the short term to a policy that would repeal the mandate are uncertain, for example.

The policy's nonfinancial effects—changes in people's tendency to comply with laws and attitudes about health insurance and their greater responsiveness to penalties than to subsidies—amplify its financial effects in CBO and JCT's analysis. The amplification from those nonfinancial effects is harder to project. In large part because of the difficulty in projecting that amplification, different organizations' estimates of the effects of repealing the mandate have varied. The effects could be smaller than those presented here: Some organizations have recently published such smaller estimates that appear to ascribe lesser effects to nonfinancial factors.[6] Alternatively, the nonfinancial effects of the mandate might grow over time—as the effects of many provisions of the tax code appear to have done after their implementation and as could occur if awareness and enforcement of the mandate changed. Under that circumstance, the effects of repealing the mandate could be larger over time.

CBO and JCT's baseline projections are also uncertain, and revisions to them would alter interactions and change the estimates of the effects of eliminating the mandate. For example, if there are no payments for CSRs, premiums in the marketplaces would probably be higher than projected in the baseline. (The Administration has halted those payments, but the baseline projections used in this estimate incorporated the assumption that they would continue.) Premiums that are higher than those in the baseline projections would tend to boost the budgetary savings under this policy by increasing the estimated per-person savings from people no longer enrolling in nongroup coverage. As another example, subsidized enrollment in the marketplaces might be lower than projected in the baseline, which would tend to decrease the budgetary savings under this policy.

Despite the uncertainty, some effects of this policy are clear: For instance, the federal deficit would be many billions of dollars lower than under current law, and the number of uninsured people would be millions higher.

5. For additional information, see Alexandra Minicozzi, Unit Chief, Health Insurance Modeling Unit, Congressional Budget Office, *Modeling the Effect of the Individual Mandate on Health Insurance Coverage* (presentation to CBO's Panel of Health Advisers, Washington, D.C., September 15, 2017), www.cbo.gov/publication/53105; and Congressional Budget Office, "Panel of Health Advisers" (accessed November 7, 2017), www.cbo.gov/about/processes/panel-health-advisers.

6. Those estimates were for the early years of policies that would have initially repealed the individual mandate and later made many other changes. See Office of the Chief Actuary, Centers for Medicare & Medicaid Services, *Estimated Financial Effect of the "American Health Care Act of 2017"* (June 2017), https://go.usa.gov/xnTzU; and Linda Blumberg, Matthew Buettgens, and John Holahan, *Implications of Partial Repeal of the ACA Through Reconciliation* (Urban Institute, December 2016), http://tinyurl.com/y6vkugs4.

This report updates CBO and JCT's estimate of the effects of a budget option that CBO published in December 2016. Susan Yeh Beyer, Kate Fritzsche, Jeffrey Kling, Sarah Masi, Kevin McNellis, Eamon Molloy, Allison Percy, Lisa Ramirez-Branum, and Robert Stewart prepared the report with guidance from Jessica Banthin, Chad Chirico, Holly Harvey, and Alexandra Minicozzi and with contributions from Ezra Porter and the staff of the Joint Committee on Taxation. Theresa Gullo, Mark Hadley, Robert Sunshine, and David Weaver reviewed the document; John Skeen edited it; and Casey Labrack prepared it for publication.

An electronic version is available on CBO's website (www.cbo.gov/publication/53300).

Keith Hall
Director

Appendix C

AMERICAN ACADEMY *of* ACTUARIES

Objective. Independent. Effective.™

December 12, 2017

The Honorable Kevin Brady
Chairman, Committee on Ways & Means
1102 Longworth Building
Washington D.C. 20515

The Honorable Richard Neal
Ranking Member, Committee on Ways & Means
1139E Longworth Building
Washington D.C. 20515

The Honorable Orrin Hatch
Chairman, Committee on Finance
219 Dirksen Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Committee on Finance
219 Dirksen Building
Washington, DC 20510

Re: Potential Adverse Consequences of Eliminating the Affordable Care Act's Individual Mandate

Dear Chairman Brady; Chairman Hatch; Ranking Member Neal; and Ranking Member Wyden:

On behalf of the Health Practice Council (HPC) of the American Academy of Actuaries,[1] I would like to offer comments related to including a provision to eliminate the Affordable Care Act's (ACA) individual mandate as you work to reconcile the House and Senate versions of H.R. 1, the *Tax Cuts and Jobs Act*. When considering this legislation, policymakers should consider the potential adverse consequences of eliminating the mandate, including increases in premiums and the number of uninsured, unless adequate alternative mechanisms or market stabilization provisions are implemented. In addition, the HPC has concerns about the bill's inclusion of an elimination of the individual mandate being motivated as a means to offset revenue reductions in your efforts to provide tax cuts and reform the tax code. We appreciate this opportunity to comment on the unique actuarial concerns involved in this issue. The mission of the American Academy of Actuaries is to inform public policy deliberations in a nonpartisan, objective way.

Eliminating the individual mandate would lead to premium increases.
The individual mandate is an integral component of the ACA. It helps support the law's pre-existing condition protections—the provisions that prohibit insurers from denying coverage or charging higher premiums based on health status. The mandate helps encourage the young and healthy, as well as the old and sick, to obtain coverage, thus achieving the balanced risk pool required to keep premiums affordable and stable. In practice, its financial penalty is usually low as a share of premiums, many individuals are exempt, and enforcement is weak. Nevertheless, the mandate, especially in conjunction with the premium- and cost-sharing subsidies, likely increases enrollment above what it would otherwise be. Eliminating the mandate without implementing an alternative means to drive enrollment among healthy individuals would likely result in a deterioration of the risk pool due to lower coverage rates among lower-cost individuals who could defer purchasing insurance until a health need arose. Premiums would increase as a result, reducing affordability and eroding pre-existing condition protections.

[1] The American Academy of Actuaries is a 19,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

Changes made to eliminate the mandate after premiums are finalized could weaken insurer solvency.
Premiums for a given year reflect insurers' expectations regarding the composition of the risk pool for that year. Premium rates for 2018 have already been finalized. If the individual mandate were to be eliminated for 2018, a deterioration in the risk pool profile would result; premiums would be too low and would no longer match the costs of those covered. This could result in insurer losses and solvency concerns.

Increasing risks could cause an increase in insurer withdrawals from the market.
Increased uncertainty and instability regarding future enrollment, premium rates, and risk pool profiles if coverage incentives are eliminated would increase the risk of insurers incurring losses. Insurers would likely reconsider their future participation in the market. This could lead to severe market disruption and loss of coverage among individual market enrollees.

Strong alternative mechanisms to encourage enrollment and/or significant market stabilization provisions would be needed to counteract an elimination of the mandate.
Without any offsetting actions, eliminating the individual mandate would result in lower enrollment, a deterioration of the risk pool, and higher premiums. Expanded availability of short-term duration policies and association health plans could exacerbate these results by reducing the barriers to non-compliant coverage. To offset these results, alternative mechanisms to the mandate that would encourage ACA plan enrollment among young and healthy individuals or other market stabilization provisions (e.g., external reinsurance funding) would be needed. Notably, while making cost-sharing reduction reimbursements to insurers, as would be provided for through separately-introduced legislation, would offset premium increases due to the prior termination of those payments, it would not offset premium increases due to an elimination of the mandate.

Primary consideration should be given to the consequences of eliminating the individual mandate on premiums, coverage rates, and the stability of the insurance market. These issues are not appropriately considered when such proposals are added to unrelated legislation as a "pay-for" to enable other priorities.

As the conference committee proceeds on reconciling the House and Senate versions of the *Tax Cuts and Jobs Act*, the American Academy of Actuaries' Health Practice Council strongly encourages you to consider the adverse consequences of eliminating the individual mandate. We would welcome the opportunity to discuss our concerns with you in more detail. If you have questions or would like to meet with us, please contact David Linn, the Academy's senior health policy analyst, at 202-785-6931 or linn@actuary.org.

Sincerely,

Shari Westerfield, MAAA, FSA
Vice President, Health Practice Council
American Academy of Actuaries

cc: Members of the U.S. Senate
Members of the U.S. House
U.S. Governors

Appendix D

MASSACHUSETTS HEALTH CONNECTOR
the right place for the right plan

Massachusetts's Experience with a State Individual Mandate

ED DEANGELO
General Counsel

AUDREY MORSE GASTEIER
Chief of Policy and Strategy

MARISSA WOLTMANN
Director of Policy and Applied Research

Webinar for DC Health Link
January 23, 2018

Massachusetts Individual Mandate: Overview of Webinar Topics

- Background on Massachusetts individual mandate origins
- Policy components of mandate:
  - Affordability schedule
  - Coverage standards
  - Penalties
- Appeals and hardships
- Reporting and administration
- Other uses of mandate:
  - Outreach
  - Common benefits floor
  - Revenue
- Public perceptions
- Questions?

Background on MA Individual Mandate

Massachusetts has been administering its own individual mandate since July 1, 2007. It was included as a part of Massachusetts's own health reform law, passed in 2006.

- In 2006, Massachusetts enacted a comprehensive package of landmark health care reforms designed to expand health coverage.
- Among these reforms was a requirement that adult state residents enroll in affordable health coverage or face a penalty. The Massachusetts Health Connector and the Department of Revenue (DOR) have worked together since then to implement this "individual mandate."
- The individual mandate reflected the guiding principle of shared responsibility that governed the Commonwealth's first-in-the-nation health reform effort.
- The mandate went into effect on July 1, 2007, coupled with a comprehensive public awareness campaign.
- In 2015 (the most recent year for which we have tax data), only 3% of adult tax filers reported not carrying coverage that met state standards.

Policy Components of Individual Mandate

The individual mandate is made up of three primary policy components. These elements are largely governed by statute and by regulations set by the Board of Directors of the state's health insurance exchange, the Health Connector.

- First, it includes coverage standards, known as Minimum Creditable Coverage, which an individual's health coverage must meet in order for them to avoid a penalty.
- Second, it requires that the Health Connector Board of Directors define affordability standards to avoid penalizing uninsured individuals whose available insurance options are deemed too costly.
- Third, it defines penalty amounts and exemption standards.
- Some policy details were defined in statute, others have been left to regulatory processes to establish

Coverage Standards

In order to satisfy the individual mandate requirements, state residents must enroll in a health plan that meets Minimum Creditable Coverage ("MCC") standards.

- Some plans are deemed categorically compliant with MCC, per statute:
  - Medicaid (MassHealth)
  - Medicare
  - Qualified Health Plans, as certified for sale by the Health Connector
  - Military and veterans' coverage
  - Federal employee health plans
  - Peace Corps, VISTA, AmeriCorps, and National Civilian Community Corps Coverage
  - Federally qualified high deductible health plans (HDHPs) provided they are coupled with a health savings account or health reimbursement account
  - Student health plans
  - Tribal or Indian Health Service plans
  - Health Care Sharing Ministries

Coverage Standards (Cont'd)

For plans that are not defined as categorically compliant, standards set in MCC regulations related to cost sharing must be met in order to be considered compliant.

- MCC-compliant plans must encompass a broad range of services, and they apply to all members covered by the plan.
- Further, MCC regulations prohibit annual benefit limits on core services and set out parameters for out of pocket spending.
- Compliant plans must cap deductibles at $2,000 for individual coverage and $4,000 for family coverage, with separate prescription drug deductibles capped at $250 for individual coverage and $500 for family coverage.
- The maximum out of pocket amount for a compliant plan may not exceed the maximum defined by the U.S. Department of Health and Human Services each year. (In 2018, this is $7,350 for an individual, and $14,700 for a family.)

Coverage Standards (Cont'd)

For plans that are not defined as categorically compliant, standards set in MCC regulations related to covered benefits must be met in order to be considered compliant.

- Ambulatory services, including outpatient, day surgery and related anesthesia
- Diagnostic imaging and screening procedures, including x-rays
- Emergency services
- Hospitalization
- Maternity and newborn care, including pre- and post-natal care
- Medical/surgical care, including preventive and primary care
- Mental health and substance abuse services
- Prescription drugs
- Radiation therapy and chemotherapy

Note: Differences from EHB are de minimus – on benefits covered, they specifically relate to habilitative services.

Coverage Standards (Cont'd)

Plans that do not meet the exact MCC standards prescribed in regulation can still pursue and be deemed compliant, if approved by the Health Connector.

- If a plan does not precisely meet certain standards outlined in regulation but still provides robust coverage overall, the Health Connector has a process by which a plan sponsor can apply for and receive designation as an MCC-compliant plan.
- Certain deviations from regulatory requirements will not – as a policy matter -- be considered, such as failure to provide a broad range of services, imposition of lifetime limits, or failure to provide services (such as maternity care) to all dependents.
- The Health Connector generally receives several hundred such applications per year.

The Affordability Schedule

The affordability schedule determines whether an individual must pay a penalty for not having Minimum Creditable Coverage (MCC).

- Supports consumers as they make choices about coverage and their household budgets by defining the maximum amount they would be expected to contribute toward coverage or face a penalty
- Does not require employers, issuers or other coverage providers to offer plans deemed affordable by the schedule or subject them to penalties if individuals fail to enroll in the affordable coverage they offered
- The Health Connector has historically aligned base enrollee premiums for subsidized individuals up to 300% of the federal poverty level (FPL) with the state's affordability schedule, such that Massachusetts's ConnectorCare program, which supplements ACA subsidies with state-funded premium and cost sharing subsidies, is considered affordable, but it is not required to do so under the law
- Does not affect the assessment of a federal penalty for failing to enroll in coverage

2018 Affordability Schedule for Individuals

CY 2018 Affordability Schedule: INDIVIDUALS					
Income Bracket				Monthly Dollar Amount	
% of FPL	Bottom	Top	Monthly Affordability Standard	Bottom	Top
0 - 150%	$0	$18,090	0%		
150.1 - 200%	$18,091	$24,120	2.90%	$44	$58
200.1 - 250%	$24,121	$30,150	4.20%	$84	$106
250.1 - 300%	$30,151	$36,180	5.00%	$126	$151
300.1 - 350%	$36,181	$42,210	7.45%	$225	$262
350.1 - 400%	$42,211	$48,240	7.60%	$267	$306
Above 400%	$48,241		8.05%	$324	

Note: The state also develops schedules for couples and families that are based on the same amounts.

Penalties

State residents determine if they owe a penalty for not complying with the state individual mandate when they file their state income tax return.

- Since 2008, penalties for non-compliance with the state's individual mandate have been set at half of the lowest cost Health Connector plan available to the individual, pursuant to the formula set by statute.
- The penalty schedule is published by DOR in a Technical Information Release (TIR) and reprinted in the state income tax form.
- The penalty is imposed if an individual has more than three consecutive months without insurance.

Penalties (Cont'd)

State penalties for failing to obtain insurance are progressive with income, mirroring the availability of premium subsidies for lower income individuals.

- Individuals below 150% FPL are not assessed a penalty for not carrying health coverage, since they have access to a zero dollar enrollee contribution plan through ConnectorCare

Massachusetts Individual Mandate Penalties - 2017					
Income category	150.1-200% FPL	200.1-250% FPL	250.1-300% FPL	Above 300% FPL - Age 18-30	Above 300% FPL – Age 31+
Penalty	$21/month $252/year	$41/month $492/year	$62/month $744/year	$74/month $888/year	$96/month $1,152/year

- Beginning in 2014, Massachusetts allowed for the "netting out" of any owed federal penalty from any owed state penalty, in order to avoid "double penalizing" any residents.

Appeals and Hardship Waivers

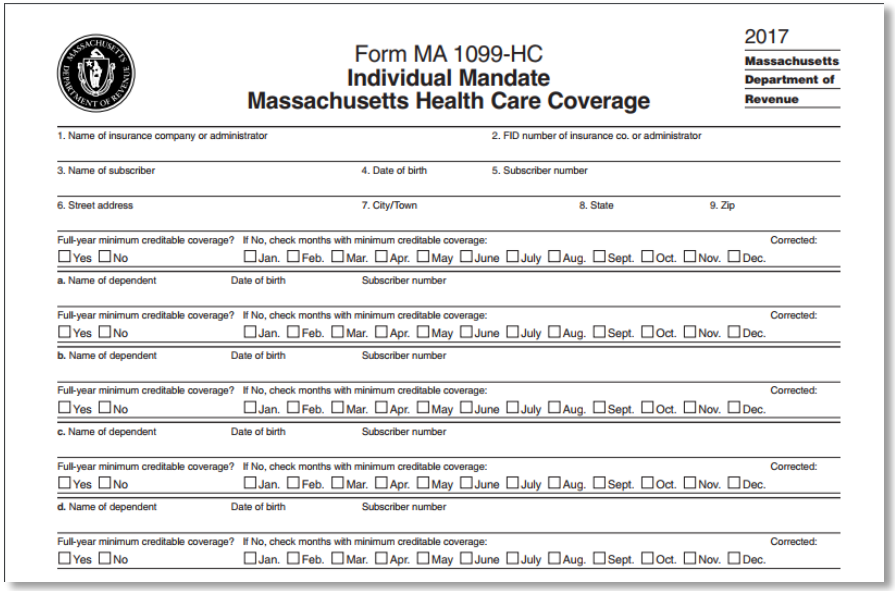
The Health Connector administers and sets rules for hardship waivers and appeals.

- Exemptions from the mandate are available for individuals who claim a sincerely held religious belief as the reason for remaining uninsured.
- Additionally, the Health Connector can waive the penalty if the individual appeals claiming a "financial hardship." A hardship includes 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.
- Appeals are heard by independent hearing officers engaged by the Health Connector. On average, the Health Connector has reviewed ~2,400 hardship appeals each year since 2007
  - The numbers have declined in recent years, to an average of approximately 1,300, probably because persons subject to the federal credit could offset their state penalty, if any, thus reducing the number of people who were subject to a state penalty.

Reporting and Administration

Coverage reporting to operationalize and enforce the mandate requires activity on the part of plan sponsors/employers, health plans, and residents.

- Plan sponsors (employers) or health plans must send enrollees evidence of each month during the calendar year in which they were enrolled in MCC for at least 15 days.
  - This report is known as the 1099-HC and is sent in January for individuals to use when filing their state income tax returns
- As a practical matter, 1099s are usually sent by health plans (or third party administrators of self-insured plans) rather than the employer.



Form MA 1099-HC
Individual Mandate
Massachusetts Health Care Coverage

2017
Massachusetts Department of Revenue

1. Name of insurance company or administrator
2. FID number of insurance co. or administrator
3. Name of subscriber
4. Date of birth
5. Subscriber number
6. Street address
7. City/Town
8. State
9. Zip

Full-year minimum creditable coverage? ☐Yes ☐No
If No, check months with minimum creditable coverage: ☐Jan. ☐Feb. ☐Mar. ☐Apr. ☐May ☐June ☐July ☐Aug. ☐Sept. ☐Oct. ☐Nov. ☐Dec.
Corrected:

a. Name of dependent — Date of birth — Subscriber number

Full-year minimum creditable coverage? ☐Yes ☐No
If No, check months with minimum creditable coverage: ☐Jan. ☐Feb. ☐Mar. ☐Apr. ☐May ☐June ☐July ☐Aug. ☐Sept. ☐Oct. ☐Nov. ☐Dec.
Corrected:

b. Name of dependent — Date of birth — Subscriber number

Full-year minimum creditable coverage? ☐Yes ☐No
If No, check months with minimum creditable coverage: ☐Jan. ☐Feb. ☐Mar. ☐Apr. ☐May ☐June ☐July ☐Aug. ☐Sept. ☐Oct. ☐Nov. ☐Dec.
Corrected:

c. Name of dependent — Date of birth — Subscriber number

Full-year minimum creditable coverage? ☐Yes ☐No
If No, check months with minimum creditable coverage: ☐Jan. ☐Feb. ☐Mar. ☐Apr. ☐May ☐June ☐July ☐Aug. ☐Sept. ☐Oct. ☐Nov. ☐Dec.
Corrected:

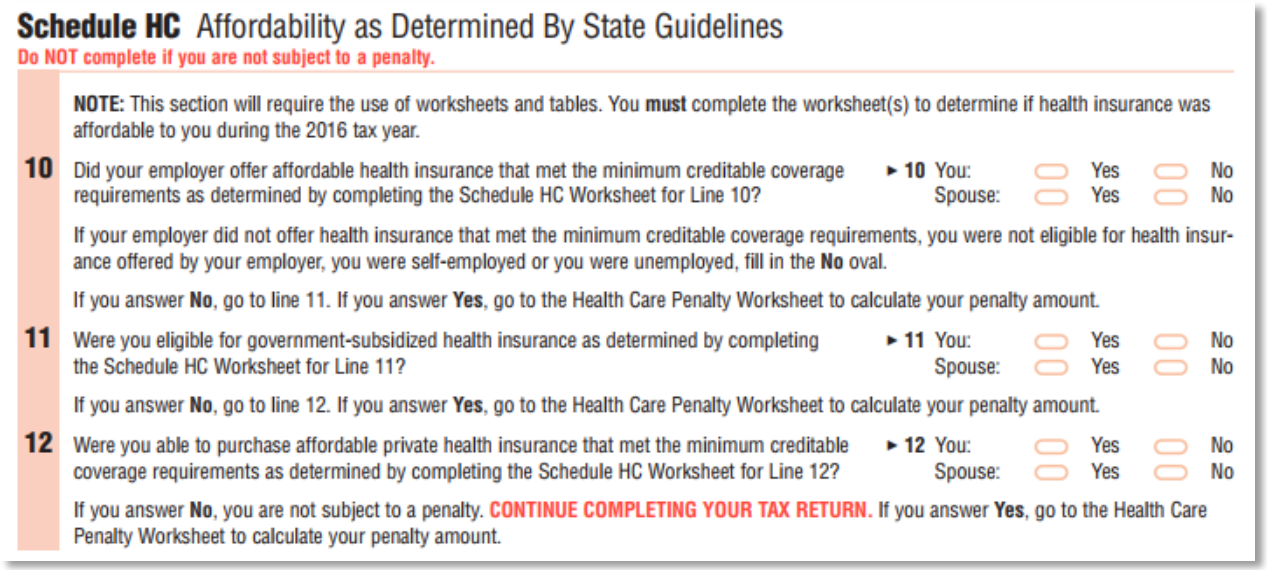
d. Name of dependent — Date of birth — Subscriber number

Full-year minimum creditable coverage? ☐Yes ☐No
If No, check months with minimum creditable coverage: ☐Jan. ☐Feb. ☐Mar. ☐Apr. ☐May ☐June ☐July ☐Aug. ☐Sept. ☐Oct. ☐Nov. ☐Dec.
Corrected:

Taxpayer Process

The state income tax return includes a "Schedule HC" that helps taxpayers report coverage, determine penalties that may apply to gaps in coverage, and request an appeal of any penalty owed.

- On the Schedule HC, uninsured taxpayers determine whether affordable coverage was available to them through an employer, through the subsidized ConnectorCare program, or on the unsubsidized non-group market
- Worksheets are provided to answer affordability questions and to calculate the penalty



Schedule HC Affordability as Determined By State Guidelines

Do NOT complete if you are not subject to a penalty.

NOTE: This section will require the use of worksheets and tables. You **must** complete the worksheet(s) to determine if health insurance was affordable to you during the 2016 tax year.

10 Did your employer offer affordable health insurance that met the minimum creditable coverage requirements as determined by completing the Schedule HC Worksheet for Line 10? ▸ **10** You: ◯ Yes ◯ No Spouse: ◯ Yes ◯ No

If your employer did not offer health insurance that met the minimum creditable coverage requirements, you were not eligible for health insurance offered by your employer, you were self-employed or you were unemployed, fill in the **No** oval.

If you answer **No**, go to line 11. If you answer **Yes**, go to the Health Care Penalty Worksheet to calculate your penalty amount.

11 Were you eligible for government-subsidized health insurance as determined by completing the Schedule HC Worksheet for Line 11? ▸ **11** You: ◯ Yes ◯ No Spouse: ◯ Yes ◯ No

If you answer **No**, go to line 12. If you answer **Yes**, go to the Health Care Penalty Worksheet to calculate your penalty amount.

12 Were you able to purchase affordable private health insurance that met the minimum creditable coverage requirements as determined by completing the Schedule HC Worksheet for Line 12? ▸ **12** You: ◯ Yes ◯ No Spouse: ◯ Yes ◯ No

If you answer **No**, you are not subject to a penalty. **CONTINUE COMPLETING YOUR TAX RETURN.** If you answer **Yes**, go to the Health Care Penalty Worksheet to calculate your penalty amount.

Other uses of the individual mandate

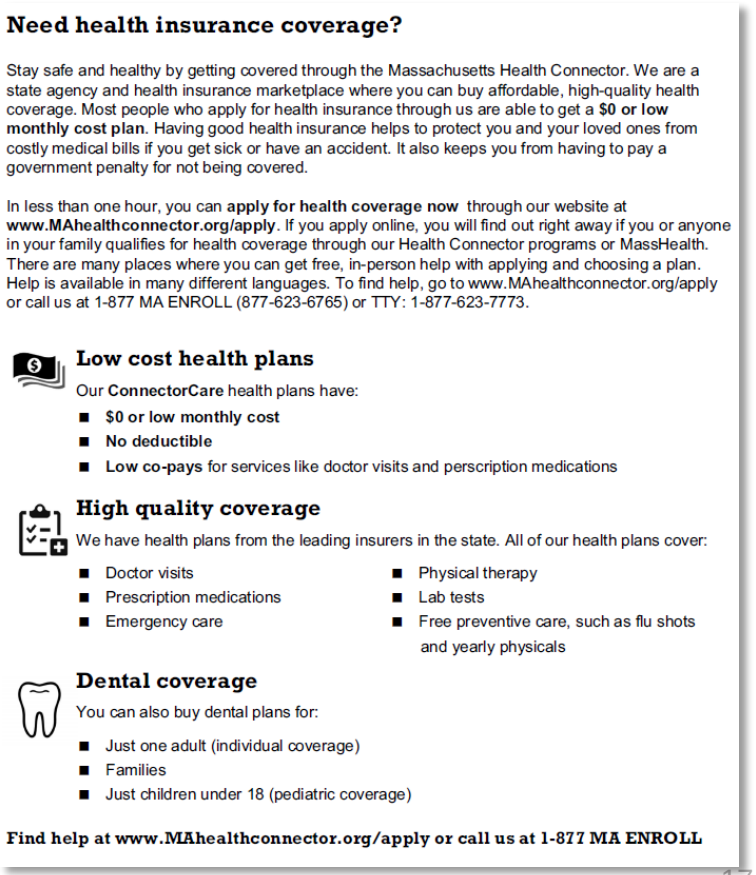
Outreach Uses of State Mandate

Administration of a state-level individual mandate has afforded Massachusetts the opportunity to analyze and use detailed administrative data on health insurance coverage of its residents.

- Analyses of state tax data has allowed the Health Connector to better understand the demographics of adult tax filers who remain without coverage. These insights have allowed us to further tailor our outreach and communications to the uninsured

- Starting in 2015, Massachusetts began sending direct mail to individual tax filers who reported being without MCC to provide them practical information about how to get coverage, allowing the ability to move from proxy-based general outreach to targeted outreach

- In December, the Commonwealth sent a mailing (see right) to ~129K residents who had reported full-year uninsurance during 2016



Need health insurance coverage?

Stay safe and healthy by getting covered through the Massachusetts Health Connector. We are a state agency and health insurance marketplace where you can buy affordable, high-quality health coverage. Most people who apply for health insurance through us are able to get a **$0 or low monthly cost plan**. Having good health insurance helps to protect you and your loved ones from costly medical bills if you get sick or have an accident. It also keeps you from having to pay a government penalty for not being covered.

In less than one hour, you can **apply for health coverage now** through our website at **www.MAhealthconnector.org/apply**. If you apply online, you will find out right away if you or anyone in your family qualifies for health coverage through our Health Connector programs or MassHealth. There are many places where you can get free, in-person help with applying and choosing a plan. Help is available in many different languages. To find help, go to www.MAhealthconnector.org/apply or call us at 1-877 MA ENROLL (877-623-6765) or TTY: 1-877-623-7773.

Low cost health plans

Our **ConnectorCare** health plans have:

- **$0 or low monthly cost**
- **No deductible**
- **Low co-pays** for services like doctor visits and perscription medications

High quality coverage

We have health plans from the leading insurers in the state. All of our health plans cover:

- Doctor visits
- Prescription medications
- Emergency care
- Physical therapy
- Lab tests
- Free preventive care, such as flu shots and yearly physicals

Dental coverage

You can also buy dental plans for:

- Just one adult (individual coverage)
- Families
- Just children under 18 (pediatric coverage)

Find help at www.MAhealthconnector.org/apply or call us at 1-877 MA ENROLL

Common Benefits Floor

MCC has allowed Massachusetts to promote and encourage the concept of a minimum benefits floor across market segments. As market rule changes are being proposed federally, Massachusetts's MCC standards give us an extra policy tool to help ensure coverage standards are not eroded.

- Our mandate requires all adults to carry coverage that meets certain standards, whether they obtain their coverage in the non-group market, from a public program, or through their employer.
- Massachusetts's MCC standards include required covered services that are nearly identical to the ACA's Essential Health Benefits (EHB) package.
- MCC standards also include limitations on cost-sharing, many of which are equivalent to ACA's consumer protection standards applying to insured plans.
- An individual who receives health coverage through a large employer's fully-insured or self-insured plan must also meet MCC standards in order to avoid a penalty. Because individuals are responsible for obtaining MCC-compliant coverage or paying a penalty, all employers have an interest in ensuring that their workers have access to compliant coverage, whether or not their plans are subject to EHB or similar standards.
- We are looking at the role MCC can play in preserving market stability in light of recent/forthcoming federal proposals stemming from the president's Executive Order on Association Health Plans and Short-Term Limited Duration Plans.

Ability to Reinvest Penalty Revenue in Affordable Coverage

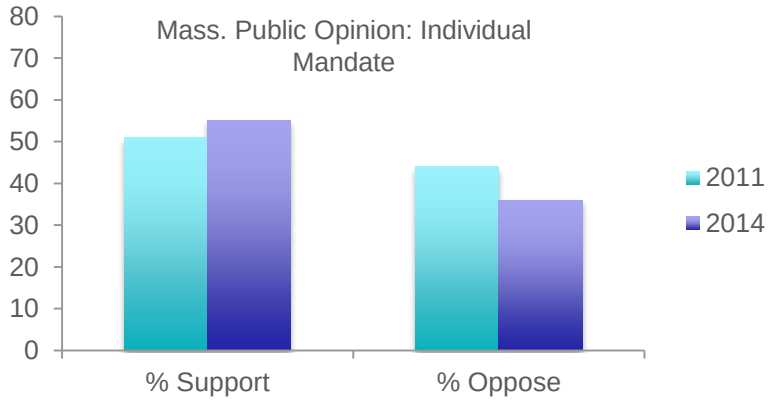
While revenue generation is not the purpose of the state's individual mandate, penalty revenue helps the state fund affordable coverage programs.

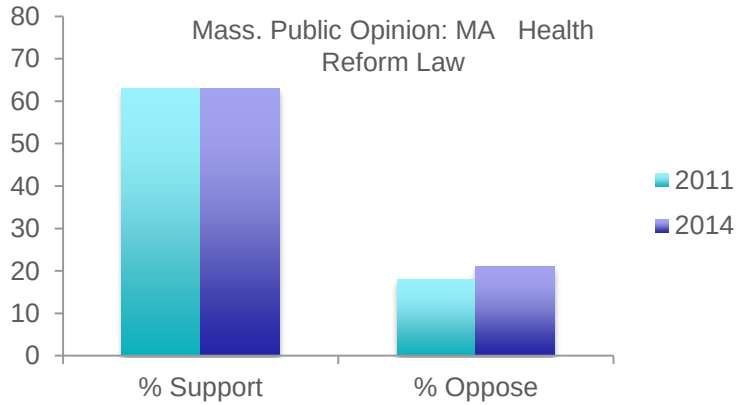
- Overall, the individual mandate penalizes roughly 50,000 taxpayers per year and has generated on average $18M per year in revenue
- Penalty revenue goes to the Commonwealth Care Trust Fund (CCTF) and is used to pay for "state wrap" subsidies that are used to further reduce premium and cost sharing for Health Connector enrollees, augmenting APTC and – prior to October – federal CSR
  - Our CCTF also draws from other sources of revenue (e.g., employer contributions, tobacco tax revenue)
- State investments in affordable coverage for low-income residents has helped our state reach high levels of insurance coverage (now ~97.5% of residents covered, per most recent US Census data)

Market Support and Public Perceptions

The Massachusetts carrier market is broadly supportive of the mandate, and the mandate has not proven to be particularly controversial among the Massachusetts public.

- The Massachusetts individual mandate was introduced in 2007 with relatively little commotion
- It has become seamlessly woven into the fabric of our health care landscape
- Support for MA health reform as an overall construct has remained high
- We receive minimal public comments when we adjust policy features of the mandate, and rarely encounter complaints on the mandate as a concept





Source: Boston Globe/Harvard School of Public Health, PUBLIC PERCEPTIONS OF THE MASSACHUSETTS HEALTH INSURANCE LAW, May 27 – June 2, 2014

Questions?

Additional Information and Contact Information

Contact information:

Ed DeAngelo
EDeAngelo@state.ma.us

Audrey Morse Gasteier
Audrey.Gasteier@state.ma.us

Marissa Woltmann
Marissa.Woltmann@state.ma.us

Reports and data:

The Massachusetts Individual Mandate: Design, Administration, and Results: https://www.mahealthconnector.org/wp-content/uploads/Individual-Mandate-Report-Nov2017.pdf

More reports and data: https://www.mahealthconnector.org/about/policy-center/reports-publications#individualmandatedata

Appendix E

Considerations for an Individual Mandate for the District of Columbia

Jason Levitis
State Health and Value Strategies
January 23, 2018

About Jason Levitis:

Jason Levitis, Levitis Strategies LLC. Jason is a health policy expert focusing on the Affordable Care Act's (ACA) tax measures and state innovation waivers. Until January 2017 he led ACA implementation at the U.S. Treasury Department. He currently provides technical assistance to states on behalf of State Health and Value Strategies. He is also a senior fellow at Yale Law School's Solomon Center for Health Law and Policy, and a non-resident fellow at the Brookings Institution. He is a resident of the District of Columbia.

About State Health and Value Strategies:

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's Woodrow Wilson School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.statenetwork.org.

General Approach

Implement through DC Income Tax

- Single line on tax return

Use Federal Law as Starting Point

- Maximizes continuity and eases compliance amid short implementation timeline
- Simplifies legislative drafting and incorporation of Federal guidance
- Reduces re-litigation and “winners and losers”

Adjust for State Context and Policy Preferences

- Modify for State legal framework and terminology
- Make specific policy changes as desired

Key Components

I. Individual Mandate

- Definition of qualifying coverage
- Exemptions
- Penalty calculation

II. Reporting Requirement for Certain Coverage Providers

- Requires only nominal effort on top of Federal reporting
- Federal programs exempted

III. Procedures for Granting Certain Exemptions

- DCHBX grants exemptions for hardship and religious conscience

IV. Notification of Uninsured about Coverage Options (optional)

Potential Changes to Federal Rules

Addressing Substandard Plans

- May require consumer protections (like Mass.) or simply exclude
- May include/exclude AHPs, health sharing ministries, grandfathered plans, certain employer coverage

Interaction with Federal Mandate Penalty

- May allow credit for Federal penalty in the event it is reinstated to avert any possible double-payment (like Mass.)

Change penalty amounts and exemption rules

Contact Information and Resources

Contact information:

Jason Levitis
jason.levitis@gmail.com

Model Legislation:

http://www.statenetwork.org/resource/model-legislation-for-state-individual-mandate/

Appendix F

FAMILIESUSA.ORG

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

HEALTH CARE for All
MARYLAND CITIZENS' HEALTH INITIATIVE

Health Insurance Down Payments Would Cover Thousands of Uninsured Marylanders

By Stan Dorn

While the federal government attempts to repeal coverage gains achieved through the Affordable Care Act (ACA), Maryland is leading the way on innovative solutions to help more people obtain quality, affordable health insurance. Although Congress has ended federal enforcement of the ACA's individual mandate, Maryland lawmakers propose to reverse this sabotage, transforming the expiring individual mandate into insurance down payments that help the uninsured get coverage, while lowering costs for people who buy their own insurance today.

This proposal helps Marylanders, both with and without insurance. Thanks to the ACA, the proportion of Marylanders without health coverage fell from 11.3 percent in 2010 to 6.6 percent in 2015. Far too many Marylanders remain uninsured, however, including more than 200,000 people who qualify for Maryland Health Connection (MHC) coverage. Many are eligible for federal financial assistance because their jobs do not provide health benefits and they earn too little to afford insurance on their own. They include real estate agents, farmers, carpenters, child care workers, sales men and women, and other hard-working Marylanders. This proposal helps them combine insurance down payments and federal financial assistance to sign up for coverage, often available at no additional cost. Many of the uninsured who enroll will be young and healthy adults who improve the risk pool, helping stabilize the market and lower premiums.

Here's how it works:

1. When they file state tax returns starting in 2020, uninsured Marylanders will receive notice that, unless they would rather pay a penalty and get nothing back, their money will be used as a down payment to help them buy health insurance.
2. For many uninsured consumers, MHC already offers health insurance that costs no more than the down payment plus federal tax credits for which the consumers qualify. If MHC finds that a consumer can enroll in such a plan at zero additional cost, the consumer is enrolled.
3. If MHC cannot find a zero-cost plan, the consumer's payment is held in an interest-bearing, "escrow" account to buy insurance during the next open enrollment period. When that period starts, MHC reaches out to the consumer and explains the health insurance options that the down payment could help purchase.
4. If the consumer does not select a plan by the end of open enrollment, MHC checks to see whether a zero-cost plan has become available. If so, the consumer is enrolled in that plan by default.
5. The consumer can use the down payment only through the end of open enrollment. After that, a "use it or lose it" rule applies, and unused down payments go into a health insurance stabilization fund.
6. Medicaid will cover uninsured Marylanders whose tax returns demonstrate Medicaid eligibility.

Appendix G

District of Columbia Department of Health Care Finance
Monthly Enrollment Report - December 2017

Enrollment, Aug 2016 through Aug 2017

Medicaid Enrollment Totals	2016-08	2016-09	2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	2017-07	2017-08
Total Medicaid Enrollment	**242,390**	**244,064**	**244,399**	**245,089**	**246,791**	**248,740**	**250,127**	**252,083**	**253,173**	**254,291**	**255,310**	**256,514**	**257,978**
Fee-For-Service (FFS) Enrollment	**64,958**	**64,736**	**63,350**	**63,045**	**62,844**	**63,403**	**62,962**	**62,822**	**61,948**	**61,500**	**60,507**	**60,011**	**60,091**
Total Managed Care Enrollment	**177,432**	**179,328**	**181,049**	**182,044**	**183,947**	**185,337**	**187,165**	**189,261**	**191,225**	**192,791**	**194,803**	**196,503**	**197,887**
AmeriHealth Caritas District of Columbia	94,328	95,096	95,813	96,048	96,779	97,231	98,068	98,991	99,705	100,454	101,239	101,960	102,396
MedStar Family Choice	48,187	48,951	49,594	50,097	50,800	51,368	52,058	52,838	53,699	54,350	55,088	55,685	56,315
Trusted Health Plan	29,389	29,753	30,105	30,357	30,832	31,230	31,545	31,924	32,326	32,509	33,008	33,394	33,720
Health Services for Children with Special Needs (HSCSN)	5,528	5,528	5,537	5,542	5,536	5,508	5,494	5,508	5,495	5,478	5,468	5,464	5,456
Medicaid Eligibility Groups	**2016-08**	**2016-09**	**2016-10**	**2016-11**	**2016-12**	**2017-01**	**2017-02**	**2017-03**	**2017-04**	**2017-05**	**2017-06**	**2017-07**	**2017-08**
Infants and Children	**83,108**	**83,924**	**83,996**	**84,110**	**84,566**	**85,337**	**86,143**	**86,979**	**87,474**	**88,064**	**88,501**	**88,973**	**89,509**
Medicaid Children	**72,959**	**73,965**	**74,280**	**74,518**	**74,996**	**75,047**	**75,863**	**76,718**	**77,224**	**77,707**	**78,067**	**77,789**	**77,616**
Infants up to Age 1	5,358	5,447	5,437	5,396	5,389	5,417	5,462	5,485	5,480	5,474	5,469	5,509	5,402
Age 1-5	21,798	22,119	22,230	22,296	22,425	22,534	22,773	23,056	23,266	23,511	23,637	23,710	23,837
Age 6-14	29,950	30,387	30,550	30,698	30,983	30,961	31,277	31,683	31,949	32,153	32,388	32,281	32,235
Age 15-18	9,614	9,780	9,891	9,993	10,076	9,970	10,118	10,202	10,239	10,254	10,249	10,015	9,840
Youth, Age 19-20	6,239	6,232	6,172	6,135	6,123	6,165	6,233	6,292	6,290	6,315	6,324	6,274	6,302
CHIP Children	**10,149**	**9,959**	**9,716**	**9,592**	**9,570**	**10,290**	**10,280**	**10,261**	**10,250**	**10,357**	**10,434**	**11,184**	**11,893**
Infants up to Age 1	46	47	45	45	35	39	40	37	34	31	34	35	31
Age 1-5	1,621	1,572	1,545	1,521	1,519	1,627	1,616	1,626	1,619	1,621	1,619	1,697	1,770
Age 6-14	5,296	5,244	5,147	5,115	5,123	5,565	5,622	5,617	5,626	5,690	5,728	6,082	6,483
Age 15-18	3,186	3,096	2,979	2,911	2,893	3,059	3,002	2,981	2,971	3,015	3,053	3,370	3,609
Adults	**140,983**	**141,797**	**142,105**	**142,684**	**143,913**	**145,101**	**145,693**	**141,824**	**142,385**	**142,920**	**143,330**	**143,935**	**144,621**
Pregnant Women	**559**	**572**	**556**	**538**	**533**	**515**	**535**	**532**	**534**	**534**	**525**	**517**	**509**
Parent/Caretaker Relatives	**32,518**	**32,931**	**33,060**	**33,170**	**33,312**	**33,692**	**34,039**	**34,437**	**34,671**	**34,909**	**35,054**	**35,187**	**35,382**
Aged, Blind, Disabled	**43,069**	**42,989**	**42,927**	**42,887**	**42,858**	**42,762**	**42,691**	**42,688**	**42,565**	**42,514**	**42,492**	**42,512**	**42,660**
Supplemental Security Income (SSI) Recipients	**29,079**	**29,022**	**29,015**	**29,031**	**28,970**	**28,964**	**28,937**	**28,935**	**28,815**	**28,801**	**28,711**	**28,729**	**28,823**
Total Long-Term Care	**7,928**	**7,953**	**7,932**	**7,940**	**7,946**	**7,906**	**7,888**	**7,923**	**7,946**	**7,940**	**8,032**	**8,031**	**8,066**
Institutional/Long-Term Care	3,390	3,375	3,368	3,351	3,325	3,294	3,238	3,219	3,202	3,156	3,182	3,150	3,151
DD Waiver	1,719	1,727	1,724	1,726	1,740	1,736	1,741	1,743	1,745	1,754	1,750	1,741	1,746
EPD Waiver	2,819	2,851	2,840	2,863	2,881	2,876	2,909	2,961	2,999	3,030	3,100	3,140	3,169
Expansion/Non-Disabled Adults	**77,842**	**78,277**	**78,513**	**78,985**	**80,022**	**80,915**	**81,232**	**81,764**	**82,096**	**82,355**	**82,610**	**83,038**	**83,525**
0-133% FPL	65,044	65,347	65,508	65,785	66,617	66,879	66,987	67,260	67,117	66,917	67,107	67,601	68,080
134-210% FPL	12,798	12,930	13,005	13,200	13,405	14,036	14,245	14,504	14,979	15,438	15,503	15,437	15,445
Qualified Medicare Beneficiary (QMB)	**10,004**	**10,032**	**10,116**	**10,163**	**10,195**	**10,193**	**10,249**	**10,254**	**10,251**	**10,253**	**10,330**	**10,415**	**10,523**
Dual Eligibles (QMB Plus)	**16,790**	**16,806**	**16,837**	**16,856**	**16,902**	**16,917**	**16,974**	**21,953**	**21,941**	**21,901**	**21,959**	**22,045**	**22,225**
Age 0-20	7	7	8	8	7	6	5	18	18	18	14	16	17
Age 21-64	5,884	5,869	5,881	5,858	5,840	5,853	5,896	8,583	8,558	8,526	8,570	8,591	8,654
Age 65+	10,899	10,930	10,948	10,990	11,055	11,058	11,073	13,352	13,365	13,357	13,375	13,438	13,554
Incarcerated Individuals	**1,509**	**1,537**	**1,461**	**1,439**	**1,410**	**1,385**	**1,317**	**1,327**	**1,373**	**1,406**	**1,520**	**1,561**	**1,623**
Children	70	62	63	62	60	57	51	51	53	48	55	65	67
Adults	1,439	1,475	1,398	1,377	1,350	1,328	1,266	1,276	1,320	1,358	1,465	1,496	1,556
Locally Funded Programs	**2016-08**	**2016-09**	**2016-10**	**2016-11**	**2016-12**	**2017-01**	**2017-02**	**2017-03**	**2017-04**	**2017-05**	**2017-06**	**2017-07**	**2017-08**
Alliance	**15,188**	**15,271**	**15,348**	**15,462**	**15,442**	**15,581**	**15,615**	**15,686**	**15,699**	**15,893**	**16,132**	**16,159**	**16,245**
Immigrant Children's Program (ICP)	**3,275**	**3,292**	**3,307**	**3,340**	**3,368**	**3,460**	**3,495**	**3,586**	**3,614**	**3,612**	**3,617**	**3,657**	**3,675**

DHCF Annual Enrollment Growth: Aug 2016 - Aug 2017

FFS Growth:	-7.49%
Managed Care Growth:	11.53%
Alliance Growth:	6.96%
ICP Growth:	12.21%

Annual Growth Rate Highlights

Medicaid Children:	6.38%
CHIP Children:	17.18%
DD Waiver:	1.57%
EPD Waiver:	12.42%
0-133% FPL:	4.67%
134-210% FPL:	20.68%

Source: This report was prepared by DHCF's Division of Analytics and Policy Research. Enrollment data was obtained from the D.C. Medicaid Management Information System (MMIS) Recipient Package.

Appendix H

Framing the Discussion

1. Is there support for a DC mandate?

2. If so, should DC's mandate conform to the federal mandate or should DC create its own unique mandate?

3. Should DC modify any current federal standards for coverage, exemptions, penalties or operations?

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?

5. Should DC try to use tax penalties to help individuals purchase coverage, as in the Maryland proposal?

Appendix I

STATE-BASED INDIVIDUAL MANDATE DISCUSSION MATRIX

I. COVERAGE STANDARDS

What coverage meets the individual mandate?

	FEDERAL	MA	NOTES
Federal Programs (Medicare, Medicaid, FEHBP, VA, DOD, etc.)	✓	✓	
QHP (individual and small group plans – includes ACA EHB and market reform rules)	✓	✓	
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.	
High Deductible Health Plans that meet federal rules	✓	Only if satisfying certain consumer protections and coupled with a health reimbursement account.	
Student Health Plans	✓	✓	
Peace Corps, VISTA, AmeriCorps, NCCCC	✓	✓	
Health Care Sharing Ministries	✓	✓	
Tribal or Indian Health Service Plans	✓	✓	
ACA Grandfathered Plans	✓	?	
Alliance (DC specific)	**NO**	**N/A**	

II. EXEMPTIONS FROM PENALTY

Who is exempt, or can appeal to become exempt, from the individual mandate penalty?

	FEDERAL	MA	NOTES
Individuals/families below the federal tax filing threshold	Exemption	Exemption	
Incarcerated individuals	Exemption	Exemption	
Those not lawfully present	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	?	
Short term periods without health coverage	Exemption if uninsured less than three consecutive months (i.e. 2 months and 29 days would be fine)	Exemption if uninsured no more than three consecutive months	
Individuals/families below 150% of FPL		Exemption	
Affordability Exemption	Exempt if the cost of coverage (either ESI or the lowest-cost bronze plan, net of APTC) would be more than 8.05% (the percentage is indexed annually). The exemption may be claimed either from the Marketplace based on projected income or on the tax return.	Exemption on a progressive basis where the premium is over a percentage of income. MA develops an affordability schedule annually. Note, MA offers state subsidies wrapping federal APTC making coverage more affordable.	

	FEDERAL	MA	NOTES
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.	
Religious Conscience exemptions	Exempt through appeal to HHS	Exempt through appeal to State Department of Revenue	
Native Americans	Exemption	?	
During residency in another state	N/A	Exemption	

III. PENALTY CALCULATION

	FEDERAL	MA	NOTES
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.	
Who it applies to	Adults and children	Only adults	
Deductions in Penalty		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.	

IV. MARYLAND PROPOSAL

MD's proposal allows the uninsured individual to convert their penalty into a payment for coverage during open enrollment, at tax time, or the following year. MD Proposal Components:

1. **Prepayment:** During open enrollment, a person who anticipates owing an individual mandate penalty can use that money to purchase/renew health insurance instead of paying that penalty on their taxes.
2. **Tax Time:** A person who owes the individual mandate penalty and is uninsured can choose to have the MD Connector use that money to purchase health insurance coverage for the individual mid-year **ONLY** if the cost of the health insurance (with APTC) for the remainder of the year would be less than the premium.
3. **Down Payment:** If at tax time the penalty cannot cover the cost of health insurance coverage, the money can be held in an escrow account to be used toward health insurance in the next open enrollment period. If not used, person moves, get employer sponsored insurance, etc. the money goes to the health insurance stabilization fund.

4. **Retention:** All down payment money is divided by 12 months and payments are made incrementally. If person gets ESI or other coverage or stops making their payment and gets terminated, the remainder of the money goes into the health insurance stabilization fund.

V. OPERATIONAL CONSIDERATIONS

Operational considerations if DC adopts an individual mandate based on the federal law verses the MA law verses the MD proposals.

	Federal	**MA**	**MD**	**NOTES**
Implementation Timing	Possible for 2019 using federal conformity. Even with conformity, DC has the options to make some changes specific to DC.	Unlikely for 2019	Not for 2019	
Operational Cost	OTR/HBX to estimate	OTR/HBX to estimate	OTR/HBX to estimate	
Reporting	If federal reporting is maintained, use their reporting. Alternatively, mimic federal requirements.	OTR would need to develop state reporting requirements.	Unknown	
Education and Outreach	The ACA requires the IRS to send a notification to each household that pays a penalty (though IRS has not fully complied). That notice directs the individual or family members to the Exchange in order to obtain coverage. DC OTR could provide similar outreach and education.	Starting in 2015, the MA tax department sends mailings to individuals who report being uninsured. The MA Health Connector has designed these mailings and provides information directly relevant to their marketplace. DC OTR could provide similar outreach and education.		

VI. USE OF FUNDS COLLECTED THROUGH THE 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.

Appendix J

DC HEALTH BENEFIT EXCHANGE AUTHORITY
Paid Enrollment Summary for February 2018 (Totals Differ from Plan Selection reports)
As of January 25th, 2018

PROGRAM	TOTAL
Individual	17,453
SHOP	76,572
TOTAL	**94,025**

INDIVIDUAL - AGE	TOTAL
< 18	1,711
18-25	970
26-34	5,866
35-44	3,743
45-54	2,585
55-64	2,458
65+	120
TOTAL	**17,453**

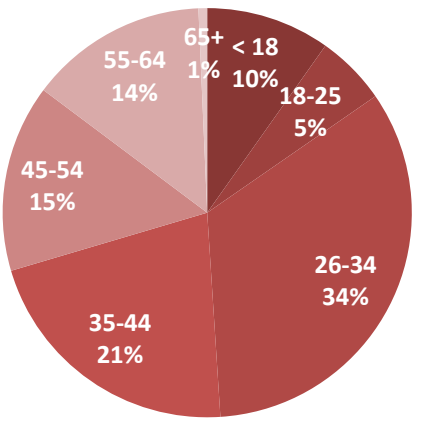
INDIVIDUAL - HOUSEHOLD	TOTAL
Self	12,290
Family	5,163
TOTAL	**17,453**

SHOP - AGE	TOTAL
< 18	14,222
18-25	8,268
26-34	18,940
35-44	13,801
45-54	10,799
55-64	8,253
65+	2,289
TOTAL	**76,572**

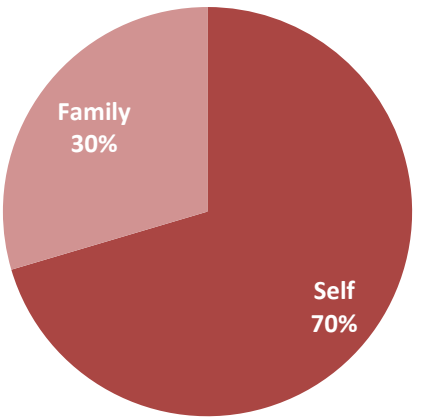
SHOP - HOUSEHOLD	TOTAL
Self	31,754
Family	44,818
TOTAL	**76,572**

SHOP - PROGRAM	TOTAL
Small Group	65,736
Congress	10,836
TOTAL	**76,572**

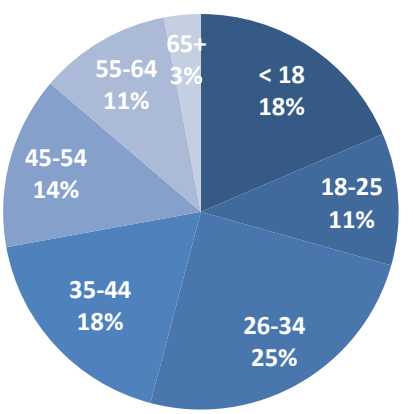
INDIVIDUAL - AGE GROUP



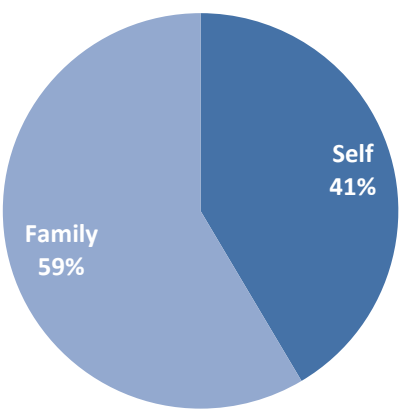
INDIVIDUAL - HOUSEHOLD TYPE



SHOP - AGE GROUP



SHOP - HOUSEHOLD TYPE

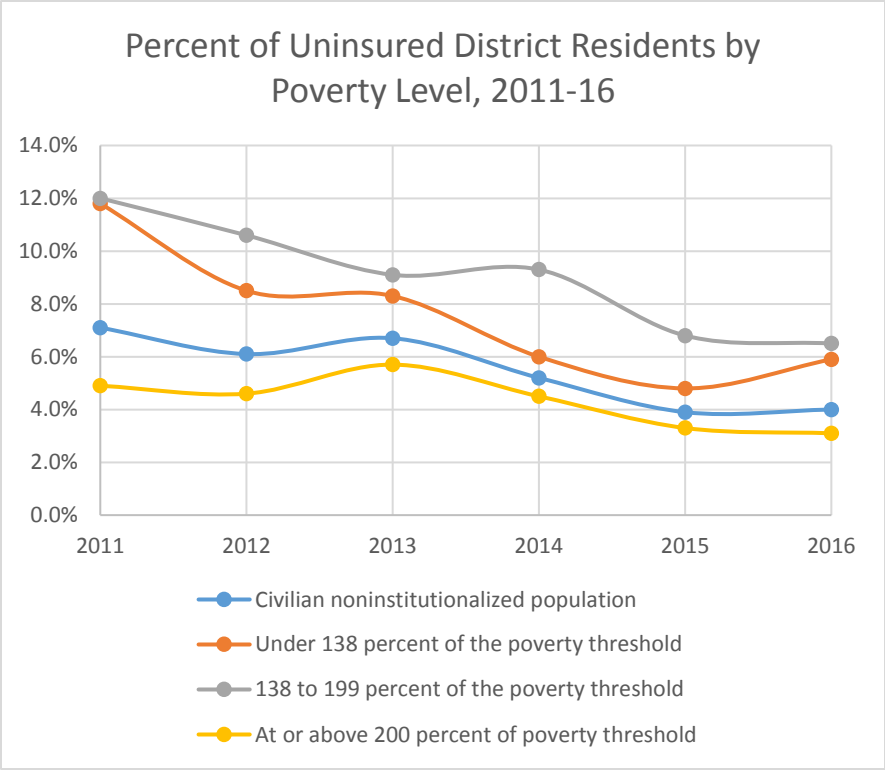


**** All values represent current paid covered lives, including February 1st start dates.***

Appendix K

Uninsured Rates in the District of Columbia by Poverty Threshold, 2009-2016

RATIO OF INCOME TO POVERTY LEVEL IN THE PAST 12 MONTHS	PERCENT UNINSURED BY YEAR							
	2009	2010	2011	2012	2013	2014	2015	2016
Civilian noninstitutionalized population	**7.2%**	**7.8%**	**7.1%**	**6.1%**	**6.7%**	**5.2%**	**3.9%**	**4.0%**
Under 138 percent of the poverty threshold	N/A*	N/A*	11.8%	8.5%	8.3%	6.0%	4.8%	5.9%
138 to 199 percent of the poverty threshold	N/A*	N/A*	12.0%	10.6%	9.1%	9.3%	6.8%	6.5%
At or above 200 percent of poverty threshold	6.0%	7.0%	4.9%	4.6%	5.7%	4.5%	3.3%	3.1%



**Prior to 2011, the U.S. Census grouped poverty thresholds differently. See below for estimates.*

RATIO OF INCOME TO POVERTY LEVEL IN THE PAST 12 MONTHS	2009	2010
Civilian noninstitutionalized population	**7.2%**	**7.8%**
Under 100 percent of poverty threshold	8.5%	8.8%
100 to 199 percent of poverty threshold	11.0%	9.8%
At or above 200 percent of poverty threshold	6.0%	7.0%

Source: "Selected Characteristics of Health Insurance Coverage in the United States" & "Health Insurance Coverage Status", American Community Survey 1-Year Estimates, United States Census Bureau, 2009-2016

Appendix L

SAMPLE MANDATE CALCULATIONS

SINGLE TAX FILER (age 30)

Modified Adjusted Gross Income	% Federal Poverty Level	Annual Individual Mandate Penalty	Annual Lowest Bronze Premium (w/APTC)	Exempt from Federal Individual Mandate	Premium Cost as a % of Income
$ 12,060.00	100	$ 695.00	$ 2,596.56	YES	21.53%
$ 18,090.00	150	$ 695.00	$ 2,596.56	YES	14.35%
$ 24,120.00	200	$ 695.00	$ 2,596.56	YES	10.77%
$ 30,150.00	250	$ 695.00	$ 1,989.12	NO	6.60%
$ 36,180.00	300	$ 695.00	$ 2,596.56	NO	7.18%
$ 42,210.00	350	$ 796.50	$ 2,596.56	NO	6.15%
$ 48,240.00	400	$ 947.25	$ 2,596.56	NO	5.38%
$ 60,300.00	500	$ 1,248.75	$ 2,596.56	NO	4.31%
$ 72,360.00	600	$ 1,550.25	$ 2,596.56	NO	3.59%
$ 84,420.00	700	$ 1,851.75	$ 2,596.56	NO	3.08%
$ 96,480.00	800	$ 2,153.25	$ 2,596.56	NO	2.69%
$ 108,540.00	900	$ 2,454.75	$ 2,596.56	NO	2.39%
$ 120,600.00	1000	$ 2,756.25	$ 2,596.56	NO	2.15%

SINGLE TAX FILER (age 40)

Modified Adjusted Gross Income	% Federal Poverty Level	Annual Individual Mandate Penalty	Annual Lowest Bronze Premium (w/APTC)	Exempt from Federal Individual Mandate	Premium Cost as a % of Income
$ 12,060.00	100	$ 695.00	$ 3,249.96	YES	26.95%
$ 18,090.00	150	$ 695.00	$ 3,249.96	YES	17.97%
$ 24,120.00	200	$ 695.00	$ 3,249.96	YES	13.47%
$ 30,150.00	250	$ 695.00	$ 1,875.24	NO	6.22%
$ 36,180.00	300	$ 695.00	$ 2,891.88	NO	7.99%
$ 42,210.00	350	$ 796.50	$ 3,249.96	NO	7.70%
$ 48,240.00	400	$ 947.25	$ 3,249.96	NO	6.74%
$ 60,300.00	500	$ 1,248.75	$ 3,249.96	NO	5.39%
$ 72,360.00	600	$ 1,550.25	$ 3,249.96	NO	4.49%
$ 84,420.00	700	$ 1,851.75	$ 3,249.96	NO	3.85%
$ 96,480.00	800	$ 2,153.25	$ 3,249.96	NO	3.37%
$ 108,540.00	900	$ 2,454.75	$ 3,249.96	NO	2.99%
$ 120,600.00	1000	$ 2,756.25	$ 3,249.96	NO	2.69%

SAMPLE MANDATE CALCULATIONS

SINGLE TAX FILER (age 50)

Modified Adjusted Gross Income	% Federal Poverty Level	Annual Individual Mandate Penalty	Annual Lowest Bronze Premium (w/APTC)	Exempt from Federal Individual Mandate	Premium Cost as a % of Income
$ 12,060.00	100	$ 695.00	$ 4,769.88	YES	39.55%
$ 18,090.00	150	$ 695.00	$ 4,769.88	YES	26.37%
$ 24,120.00	200	$ 695.00	$ 4,769.88	YES	19.78%
$ 30,150.00	250	$ 695.00	$ 1,610.04	NO	5.34%
$ 36,180.00	300	$ 695.00	$ 2,626.68	NO	7.26%
$ 42,210.00	350	$ 796.50	$ 3,203.16	NO	7.59%
$ 48,240.00	400	$ 947.25	$ 3,779.64	NO	7.84%
$ 60,300.00	500	$ 1,248.75	$ 4,769.88	NO	7.91%
$ 72,360.00	600	$ 1,550.25	$ 4,769.88	NO	6.59%
$ 84,420.00	700	$ 1,851.75	$ 4,769.88	NO	5.65%
$ 96,480.00	800	$ 2,153.25	$ 4,769.88	NO	4.94%
$ 108,540.00	900	$ 2,454.75	$ 4,769.88	NO	4.39%
$ 120,600.00	1000	$ 2,756.25	$ 4,769.88	NO	3.96%

SINGLE TAX FILER (age 60)

Modified Adjusted Gross Income	% Federal Poverty Level	Annual Individual Mandate Penalty	Annual Lowest Bronze Premium (w/APTC)	Exempt from Federal Individual Mandate	Premium Cost as a % of Income
$ 12,060.00	100	$ 695.00	$ 6,996.48	YES	58.01%
$ 18,090.00	150	$ 695.00	$ 6,996.48	YES	38.68%
$ 24,120.00	200	$ 695.00	$ 6,996.48	YES	29.01%
$ 30,150.00	250	$ 695.00	$ 1,221.60	NO	4.05%
$ 36,180.00	300	$ 695.00	$ 2,238.24	NO	6.19%
$ 42,210.00	350	$ 796.50	$ 2,814.72	NO	6.67%
$ 48,240.00	400	$ 947.25	$ 3,391.20	NO	7.03%
$ 60,300.00	500	$ 1,248.75	$ 6,996.48	YES	11.60%
$ 72,360.00	600	$ 1,550.25	$ 6,996.48	YES	9.67%
$ 84,420.00	700	$ 1,851.75	$ 6,996.48	YES	8.29%
$ 96,480.00	800	$ 2,153.25	$ 6,996.48	NO	7.25%
$ 108,540.00	900	$ 2,454.75	$ 6,996.48	NO	6.45%
$ 120,600.00	1000	$ 2,756.25	$ 6,996.48	NO	5.80%

ASSUMPTIONS

1) MAGI equals gross income. In other words, there have been no adjustments to gross income and no non-taxable interest, non-taxable Social Security, or foreign income.

2) Individuals are filing as single (not Head of Household)

3) Average monthly bronze plan cost is placed at $257/month for individual

SAMPLE MANDATE CALCULATIONS

FAMILY, JOINT TAX FILERS (2 Parents both age 30 + 2 kids)

Modified Adjusted Gross Income	% Federal Poverty Level	Annual Individual Mandate Penalty	Annual Lowest Bronze Premium (w/APTC)	Exempt from Federal Individual Mandate	Premium Cost as a % of Income
$ 24,600.00	100	$ 2,085.00	$ 9,552.96	YES	38.83%
$ 36,900.00	150	$ 2,085.00	$ 9,552.96	YES	25.89%
$ 49,200.00	200	$ 2,085.00	$ 9,552.96	YES	19.42%
$ 61,500.00	250	$ 2,085.00	$ 8,435.40	YES	13.72%
$ 73,800.00	300	$ 2,085.00	$ 9,552.96	YES	12.94%
$ 86,100.00	350	$ 2,085.00	$ 6,564.60	NO	7.62%
$ 98,400.00	400	$ 2,085.00	$ 7,740.48	NO	7.87%
$ 123,000.00	500	$ 2,557.50	$ 9,552.96	NO	7.77%
$ 147,600.00	600	$ 3,172.50	$ 9,552.96	NO	6.47%
$ 172,200.00	700	$ 3,787.50	$ 9,552.96	NO	5.55%
$ 196,800.00	800	$ 4,402.50	$ 9,552.96	NO	4.85%
$ 221,400.00	900	$ 5,017.50	$ 9,552.96	NO	4.31%
$ 246,000.00	1000	$ 5,632.50	$ 9,552.96	NO	3.88%

FAMILY, JOINT TAX FILERS (2 Parents both age 40 + 2 kids)

Modified Adjusted Gross Income	% Federal Poverty Level	Annual Individual Mandate Penalty	Annual Lowest Bronze Premium (w/APTC)	Exempt from Federal Individual Mandate	Premium Cost as a % of Income
$ 24,600.00	100	$ 2,085.00	$ 10,859.76	YES	44.15%
$ 36,900.00	150	$ 2,085.00	$ 10,859.76	YES	29.43%
$ 49,200.00	200	$ 2,085.00	$ 10,859.76	YES	22.07%
$ 61,500.00	250	$ 2,085.00	$ 8,207.52	YES	13.35%
$ 73,800.00	300	$ 2,085.00	$ 10,281.24	YES	13.93%
$ 86,100.00	350	$ 2,085.00	$ 6,336.72	NO	7.36%
$ 98,400.00	400	$ 2,085.00	$ 7,512.60	NO	7.63%
$ 123,000.00	500	$ 2,557.50	$ 10,859.76	YES	8.83%
$ 147,600.00	600	$ 3,172.50	$ 10,859.76	NO	7.36%
$ 172,200.00	700	$ 3,787.50	$ 10,859.76	NO	6.31%
$ 196,800.00	800	$ 4,402.50	$ 10,859.76	NO	5.52%
$ 221,400.00	900	$ 5,017.50	$ 10,859.76	NO	4.91%
$ 246,000.00	1000	$ 5,632.50	$ 10,859.76	NO	4.41%

SAMPLE MANDATE CALCULATIONS

FAMILY, JOINT TAX FILERS (2 Parents both age 50, + 2 kids)

Modified Adjusted Gross Income	% Federal Poverty Level	Annual Individual Mandate Penalty	Annual Lowest Bronze Premium (w/APTC)	Exempt from Federal Individual Mandate	Premium Cost as a % of Income
$ 24,600.00	100	$ 2,085.00	$ 13,899.60	YES	56.50%
$ 36,900.00	150	$ 2,085.00	$ 13,899.60	YES	37.67%
$ 49,200.00	200	$ 2,085.00	$ 13,899.60	YES	28.25%
$ 61,500.00	250	$ 2,085.00	$ 7,677.12	YES	12.48%
$ 73,800.00	300	$ 2,085.00	$ 9,750.96	YES	13.21%
$ 86,100.00	350	$ 2,085.00	$ 5,806.32	NO	6.74%
$ 98,400.00	400	$ 2,085.00	$ 6,982.20	NO	7.10%
$ 123,000.00	500	$ 2,557.50	$ 13,899.60	YES	11.30%
$ 147,600.00	600	$ 3,172.50	$ 13,899.60	YES	9.42%
$ 172,200.00	700	$ 3,787.50	$ 13,899.60	YES	8.07%
$ 196,800.00	800	$ 4,402.50	$ 13,899.60	NO	7.06%
$ 221,400.00	900	$ 5,017.50	$ 13,899.60	NO	6.28%
$ 246,000.00	1000	$ 5,632.50	$ 13,899.60	NO	5.65%

FAMILY, JOINT TAX FILERS (2 Parents both age 60, + 2 kids)

Modified Adjusted Gross Income	% Federal Poverty Level	Annual Individual Mandate Penalty	Annual Lowest Bronze Premium (w/APTC)	Exempt from Federal Individual Mandate	Premium Cost as a % of Income
$ 24,600.00	100	$ 2,085.00	$ 18,352.80	YES	74.60%
$ 36,900.00	150	$ 2,085.00	$ 18,352.80	YES	49.74%
$ 49,200.00	200	$ 2,085.00	$ 18,352.80	YES	37.30%
$ 61,500.00	250	$ 2,085.00	$ 6,900.36	YES	11.22%
$ 73,800.00	300	$ 2,085.00	$ 8,974.08	YES	12.16%
$ 86,100.00	350	$ 2,085.00	$ 5,029.56	NO	5.84%
$ 98,400.00	400	$ 2,085.00	$ 6,205.44	NO	6.31%
$ 123,000.00	500	$ 2,557.50	$ 18,352.80	YES	14.92%
$ 147,600.00	600	$ 3,172.50	$ 18,352.80	YES	12.43%
$ 172,200.00	700	$ 3,787.50	$ 18,352.80	YES	10.66%
$ 196,800.00	800	$ 4,402.50	$ 18,352.80	YES	9.33%
$ 221,400.00	900	$ 5,017.50	$ 18,352.80	YES	8.29%
$ 246,000.00	1000	$ 5,632.50	$ 18,352.80	NO	7.46%

ASSUMPTIONS

1) MAGI equals gross income. In other words, there have been no adjustments to gross income and no non-taxable interest, non-taxable Social Security, or foreign income.

2) Average monthly bronze plan cost is placed at $257/month for individual, $1,285/month for families.

SAMPLE MANDATE CALCULATIONS

COUPLE, JOINT TAX FILERS (both age 30)

Modified Adjusted Gross Income	% Federal Poverty Level	Annual Individual Mandate Penalty	Annual Lowest Bronze Premium (w/APTC)	Exempt from Federal Individual Mandate	Premium Cost as a % of Income
$ 16,240.00	100	$ 1,390.00	$ 5,193.12	YES	31.98%
$ 24,360.00	150	$ 1,390.00	$ 5,193.12	YES	21.32%
$ 32,480.00	200	$ 1,390.00	$ 5,193.12	YES	15.99%
$ 40,600.00	250	$ 1,390.00	$ 2,382.60	NO	5.87%
$ 48,720.00	300	$ 1,390.00	$ 3,751.68	NO	7.70%
$ 56,840.00	350	$ 1,390.00	$ 4,527.96	NO	7.97%
$ 64,960.00	400	$ 1,390.00	$ 5,193.12	NO	7.99%
$ 81,200.00	500	$ 1,512.50	$ 5,193.12	NO	6.40%
$ 97,440.00	600	$ 1,918.50	$ 5,193.12	NO	5.33%
$ 113,680.00	700	$ 2,324.50	$ 5,193.12	NO	4.57%
$ 129,920.00	800	$ 2,730.50	$ 5,193.12	NO	4.00%
$ 146,160.00	900	$ 3,136.50	$ 5,193.12	NO	3.55%
$ 162,400.00	1000	$ 3,542.50	$ 5,193.12	NO	3.20%

COUPLE, JOINT TAX FILERS (both age 40)

Modified Adjusted Gross Income	% Federal Poverty Level	Annual Individual Mandate Penalty	Annual Lowest Bronze Premium (w/APTC)	Exempt from Federal Individual Mandate	Premium Cost as a % of Income
$ 16,240.00	100	$ 1,390.00	$ 6,499.92	YES	40.02%
$ 24,360.00	150	$ 1,390.00	$ 6,499.92	YES	26.68%
$ 32,480.00	200	$ 1,390.00	$ 6,499.92	YES	20.01%
$ 40,600.00	250	$ 1,390.00	$ 2,154.72	NO	5.31%
$ 48,720.00	300	$ 1,390.00	$ 3,523.80	NO	7.23%
$ 56,840.00	350	$ 1,390.00	$ 4,300.08	NO	7.57%
$ 64,960.00	400	$ 1,390.00	$ 5,076.36	NO	7.81%
$ 81,200.00	500	$ 1,512.50	$ 6,499.92	NO	8.00%
$ 97,440.00	600	$ 1,918.50	$ 6,499.92	NO	6.67%
$ 113,680.00	700	$ 2,324.50	$ 6,499.92	NO	5.72%
$ 129,920.00	800	$ 2,730.50	$ 6,499.92	NO	5.00%
$ 146,160.00	900	$ 3,136.50	$ 6,499.92	NO	4.45%
$ 162,400.00	1000	$ 3,542.50	$ 6,499.92	NO	4.00%

SAMPLE MANDATE CALCULATIONS

COUPLE, JOINT TAX FILERS (both age 50)

Modified Adjusted Gross Income	% Federal Poverty Level	Annual Individual Mandate Penalty	Annual Lowest Bronze Premium (w/APTC)	Exempt from Federal Individual Mandate	Premium Cost as a % of Income
$ 16,240.00	100	$ 1,390.00	$ 9,539.76	YES	58.74%
$ 24,360.00	150	$ 1,390.00	$ 9,539.76	YES	39.16%
$ 32,480.00	200	$ 1,390.00	$ 9,539.76	YES	29.37%
$ 40,600.00	250	$ 1,390.00	$ 1,624.44	NO	4.00%
$ 48,720.00	300	$ 1,390.00	$ 2,993.40	NO	6.14%
$ 56,840.00	350	$ 1,390.00	$ 3,769.68	NO	6.63%
$ 64,960.00	400	$ 1,390.00	$ 4,545.96	NO	7.00%
$ 81,200.00	500	$ 1,512.50	$ 9,539.76	YES	11.75%
$ 97,440.00	600	$ 1,918.50	$ 9,539.76	YES	9.79%
$ 113,680.00	700	$ 2,324.50	$ 9,539.76	YES	8.39%
$ 129,920.00	800	$ 2,730.50	$ 9,539.76	NO	7.34%
$ 146,160.00	900	$ 3,136.50	$ 9,539.76	NO	6.53%
$ 162,400.00	1000	$ 3,542.50	$ 9,539.76	NO	5.87%

COUPLE, JOINT TAX FILERS (both age 60)

Modified Adjusted Gross Income	% Federal Poverty Level	Annual Individual Mandate Penalty	Annual Lowest Bronze Premium (w/APTC)	Exempt from Federal Individual Mandate	Premium Cost as a % of Income
$ 16,240.00	100	$ 1,390.00	$ 13,992.96	YES	86.16%
$ 24,360.00	150	$ 1,390.00	$ 13,992.96	YES	57.44%
$ 32,480.00	200	$ 1,390.00	$ 13,992.96	YES	43.08%
$ 40,600.00	250	$ 1,390.00	$ 847.56	NO	2.09%
$ 48,720.00	300	$ 1,390.00	$ 2,216.64	NO	4.55%
$ 56,840.00	350	$ 1,390.00	$ 2,992.92	NO	5.27%
$ 64,960.00	400	$ 1,390.00	$ 3,769.20	NO	5.80%
$ 81,200.00	500	$ 1,512.50	$ 13,992.96	YES	17.23%
$ 97,440.00	600	$ 1,918.50	$ 13,992.96	YES	14.36%
$ 113,680.00	700	$ 2,324.50	$ 13,992.96	YES	12.31%
$ 129,920.00	800	$ 2,730.50	$ 13,992.96	YES	10.77%
$ 146,160.00	900	$ 3,136.50	$ 13,992.96	YES	9.57%
$ 162,400.00	1000	$ 3,542.50	$ 13,992.96	YES	8.62%

ASSUMPTIONS

1) MAGI equals gross income. In other words, there have been no adjustments to gross income and no non-taxable interest, non-taxable Social Security, or foreign income.

2) Average monthly bronze plan cost is placed at $257/month for individual, $1,285/month for families.

Appendix M

2010-2011, 2015 Uncompensated Care Summary

The State Health Planning and Development Agency (SHPDA)
District of Columbia Department of Health

Table 1. Summary of uncompensated care data as reported by District of Columbia hospitals to SHPDA for 2010

		Provided To All Persons		
Hospital	Uncomp. Care Obligation	Charity Care	Bad Debt	Total
CNMC				
G.W	$4,991,832	$2,426,796	$5,338,364	$7,765,160
GT	$12,538,320	$4,477,998	$8,513,136	$12,991,134
HOWARD	$4,456,887	$29,664,367	$11,139,798	$40,804,165
HSC	$360,891	$314,028	$10,784	$324,812
NRH	$1,568,442	$73,414	$1,229,531	$1,302,945
PROV	$1,963,033	$16,914,103	$3,587,065	$20,501,168
PIW	$442,725	$21,582,125	$249,659	$21,831,784
CAP HILL**	$632,170	$689	$1,280	$1,969
HADLEY**	$487,481	$120,817	$224,375	$345,192
SIB	$4,722,422	$2,892,664	$3,274,723	$6,167,387
UMC	$1,008,701	$31,033,416	$45,348,292	$76,381,708
WHC	$17,451,444	$23,522,619	$38,752,561	$62,275,180
Total	**$50,624,348**	**$133,023,036**	**$117,669,568**	**$250,692,604**

*Uncompensated care is the combination of charity care and bad debt. Charity care is defined as medical care which is provided to persons who do not have the ability to pay for care. Bad Debt is defined as medical care which is provided to persons who had the apparent ability to pay for that care, but who fail to pay.
**Hospital did not meet its obligation (Obligation amount is less than the Sub Total Provided to All Persons).

Table 2. Summary of uncompensated care data as reported by District of Columbia hospitals to SHPDA for 2011

	Uncomp.	Provided To All Persons		
Hospital	Uncomp. Care Obligation	Charity Care	Bad Debt	Total
CNMC	partial report	partial report	partial report	partial report
GW	$5,269,553	$4,164,021	$4,539,029	$8,703,050
GT	$12,522,069	$4,713,663	$10,880,234	$15,593,897
HOWARD	$3,940,021	$15,844,046	$11,119,716	$26,963,762
HSC	$118,040	$19,816	$3,820	$23,636
NRC	$1,543,273	$1,667	$1,251,542	$1,253,209
PROV	$2,093,045	$2,706,227	$2,881,217	$5,587,444
PIW	$357,993	$386,000	$419,422	$805,422
CAP HILL	$602,915	$185,132	$343,816	$528,948
HADLEY	$7,227	$0	$72,707	$72,707
SIBLEY	$2,526,134	$1,675,609	$3,371,839	$5,047,448
UMC	$1,522,555	$13,281,343	$16,767,450	$30,048,793
WHC	$17,863,911	$7,864,390	$30,191,308	$38,055,698
Total	**$48,366,736**	**$50,841,914**	**$81,842,100**	**$132,684,014**

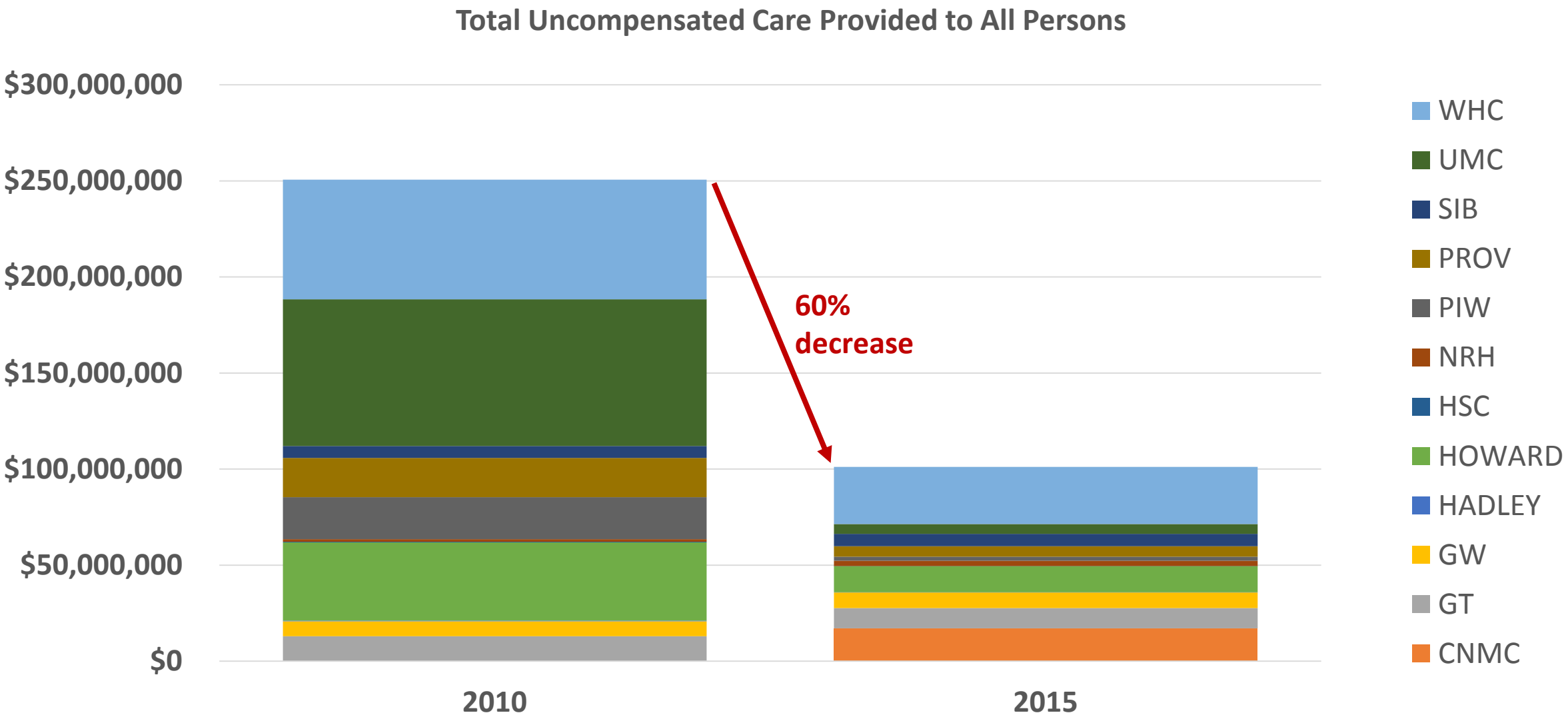
*Uncompensated care is the combination of charity care and bad debt. Charity care is defined as medical care which is provided to persons who do not have the ability to pay for care. Bad Debt is defined as medical care which is provided to persons who had the apparent ability to pay for that care, but who fail to pay.
**Hospital did not meet its obligation (Obligation amount is less than the Sub Total Provided to All Persons).

Table 3. Summary of uncompensated care data as reported by District of Columbia hospitals to SHPDA for 2015

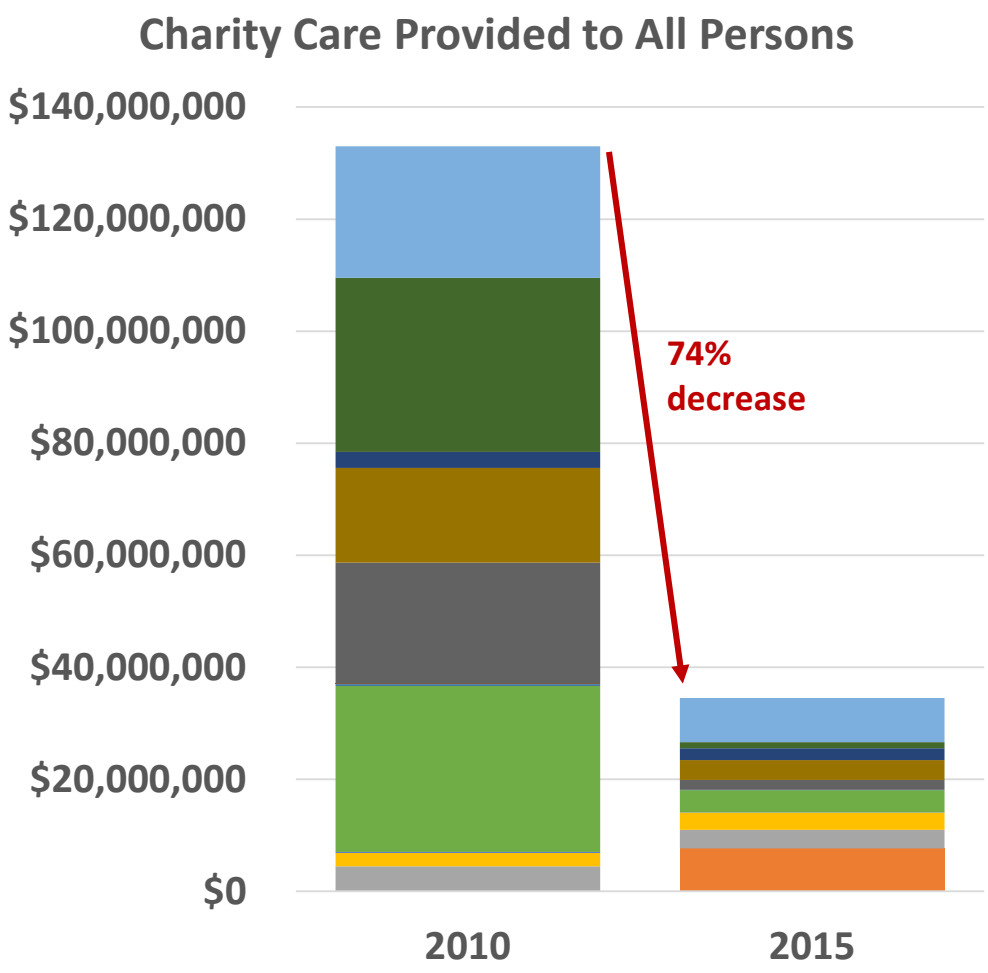
		Provided to All Persons		
Hospital	**Uncomp. Care Obligation**	**Charity Care**	**Bad Debt**	**Sub Total**
WHC	$16,923,718	$7,876,418	$21,865,046	$29,741,464
CNMC	$13,836,838	$7,651,143	$9,444,838	$17,095,981
HOWARD	$4,441,845	$3,977,543	$9,619,521	$13,597,064
GT**	$13,550,187	$3,322,790	$7,298,232	$10,621,022
GW	$7,701,131	$3,080,915	$5,041,967	$8,122,882
SIB	$6,263,040	$2,143,917	$4,302,397	$6,446,314
PROV	$1,718,768	$3,507,976	$1,864,820	$5,372,796
UMC	$1,316,522	$1,069,320	$4,103,789	$5,173,109
NRH	$2,085,376	$0	$2,806,590	$2,806,590
PIW	$761,294	$1,764,831	$314,337	$2,079,168
HADLEY	$2,658	$69,781	$0	$69,781
HSC	$495,896	$51,606	$0	$51,606
Capital Hill	No report			
Total	**$69,097,273**	**$34,516,240**	**$66,661,537**	**$101,177,776**

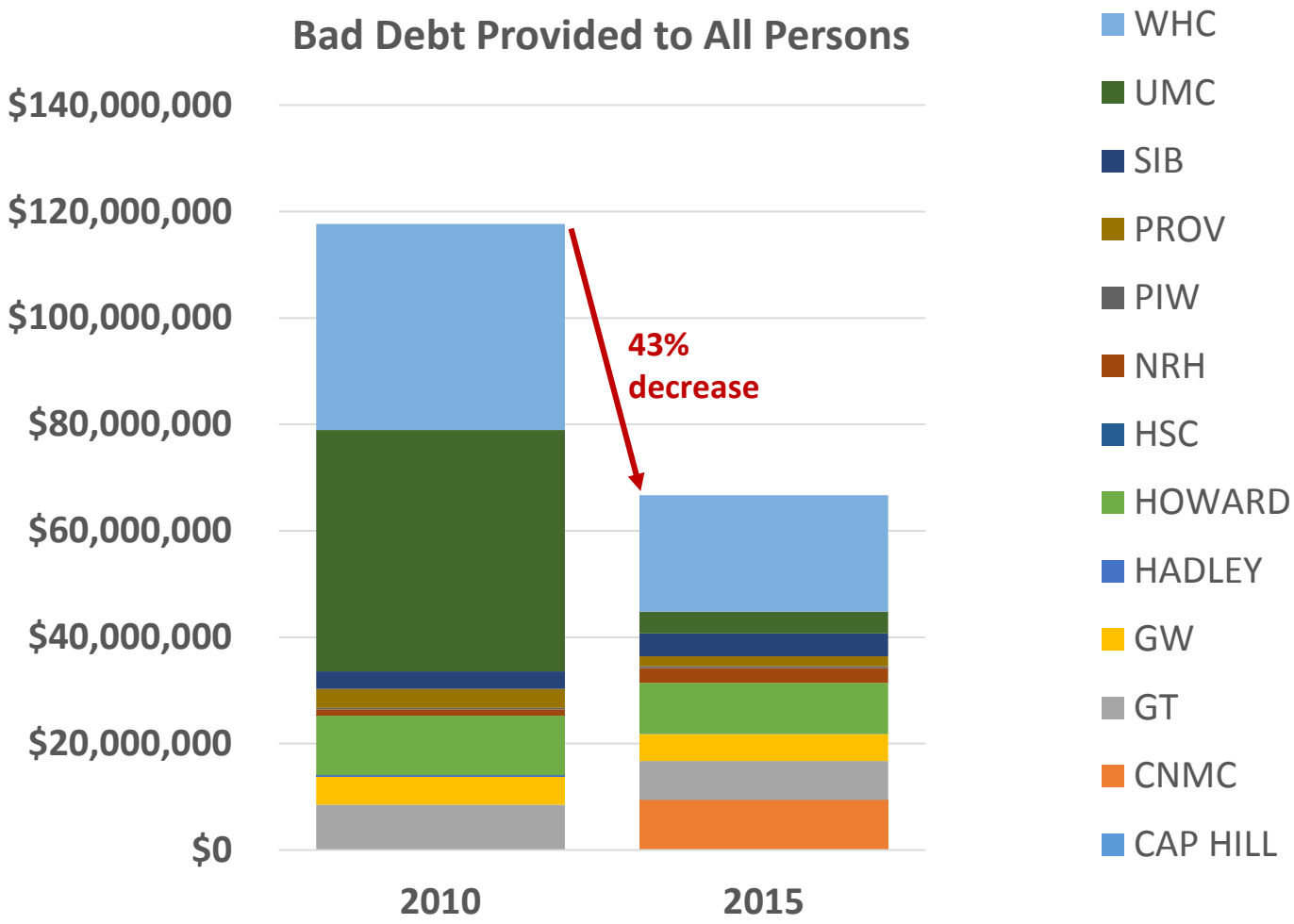
*Uncompensated care is the combination of charity care and bad debt. Charity care is defined as medical care which is provided to persons who do not have the ability to pay for care. Bad Debt is defined as medical care which is provided to persons who had the apparent ability to pay for that care, but who fail to pay.
**Hospital did not meet its obligation (Obligation amount is less than the Sub Total Provided to All Persons).

The amount of total uncompensated care provided by District of Columbia hospitals decreased by 60% between 2010 and 2015



The amount of charity care provided by District of Columbia hospitals decreased by 74% between 2010 and 2015; the amount spent on bad debt decreased by 43%





Appendix N

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

February 6, 2018

Impact of the Repeal of the Individual Mandate

Dear Mila:

In this letter, we provide an estimate regarding the impact to the District of Columbia's (the District's) individual ACA market as a result of the repeal of the individual mandate penalty. Please note that the estimates that follow are not based on robust actuarial micro-simulation modeling specific to the District. However, the unique characteristics of the District's market has been taken into consideration, including but not limited to its Medicaid eligibility requirements and distribution of its individual market membership by age and income. Therefore, in our opinion the estimates we have developed do provide the District with a reasonable starting point for discussions related to the potential impact on rates in the individual ACA market.

Results

Overall, we are estimating that the repeal of the individual mandate penalty is expected to result in a decrease in the District's 2019 individual ACA market enrollment equal to approximately -15.1%, or about 2,500 covered lives. Further, we are estimating that it will result in an increase in average claim costs in the individual ACA market equal to approximately +7.2% (on a per member per month basis, excluding the portion which can be rated for through the ACA age curve). This estimate does not include any increase in costs resulting from loss of coverage in the employer market or on the Medicaid side.

A description of the methodology which was utilized to develop these estimates is provided in the following section of this letter.

Methodology

In conducting our analysis, we began with a dataset provided by the District of Columbia Health Benefit Exchange Authority (DCHBX), which includes the following detail for each member who was active in the ACA individual market in January 2018: Policy ID, Member ID, Date of Birth, Gender, Federal Poverty Level (FPL), APTC Indicator, Issuer Name. To assess the impact of the repeal of the individual mandate penalty, we first organized the DC individual market data by the age (e.g., 0-20, 21-30) and FPL (e.g., 250-300, 300-400) of the policy subscriber. For the purpose of this analysis, because the District does not collect FPL information for enrollees who do not receive APTCs, it was assumed that any of those individuals are in the 400+ FPL segment. The distribution of January 2018 members in the District's individual market by subscriber age band and FPL are summarized in Tables 1 and 2 below:

Table 1 – Age Distribution

Age Band	Distribution
0-20	2%
21-30	24%
31-40	30%
41-50	21%
51-60	17%
61+	7%

Table 2 – FPL Distribution

FPL	Distribution
< 200	1%
200-300	3%
300-400	1%
400+	95%

Next, we applied projected changes in membership. We note that the District's individual ACA market distribution of membership by age band and FPL is significantly different than nationwide ACA membership. Specifically, when compared to nationwide membership, a very low percentage of the District's membership receives advance premium tax credits. Additionally, the District's membership generally skews younger than nationwide membership. Recognizing that age and FPL are expected to be key drivers of how individuals will react to the repeal of the individual mandate penalty, we note that it was important that the District specific distributions be taken into account. We applied membership adjustments to each of the member segments (i.e., age band and FPL) based on micro-simulation modeling which we had previously performed, but which was performed on a nationwide basis, making the assumption that individuals in the District would behave similarly to individuals of the same age and FPL nationally, with regard to the individual mandate. In total, and all else equal, we are estimating that enrollment in the District's individual ACA market is expected to decrease by approximately -15.1%, or about 2,500 covered lives. Tables 3 and 4 below provide the distribution of covered lives that we are projecting will drop coverage, by subscriber age band and FPL:

Table 3 – Distribution[1] of Coverage Losses by Age

Age Band	Distribution
0-20	2%
21-30	31%
31-40	31%
41-50	19%
51-60	13%
61+	5%

[1] Distribution does not sum to 100% due to rounding

Table 4 – Distribution of Coverage Losses* by FPL

FPL	Distribution
< 200	0%
200-300	4%
300-400	1%
400+	95%

*For the individual ACA market only; estimates do not include potential coverage losses in the employer or Medicaid markets

Based on the projected changes in District membership from the prior step, we again utilized past nationwide modeling results to calculate how the claim costs of the District's individual ACA market would be expected to change for each age band and FPL. Using this approach, we have estimated that average claim costs in the individual ACA market are expected to increase by approximately +7.2% (on a per member per month basis, excluding the portion of the change in claim costs that can be rated for through the ACA age curve).

Alternative Scenarios and Estimates

There is a significant amount of uncertainty associated with projecting future ACA membership, including as it relates to the impact of the repeal of the individual mandate. In addition to the analysis we have completed, there are two additional data points we wanted to discuss.

First, the Congressional Budget Office (CBO) produced analysis[2] in November 2017 in which it estimated that the nationwide effect of repealing the individual mandate would decrease non-group enrollment by approximately 18% in 2019, 22% in 2020, and 28% in 2021+, and would lead to an increase in average premiums equal to about 10%. However, on January 10, 2018, the CBO indicated in a presentation[3] that it has "undertaken considerable work to revise and update their methods of estimating" the effect of the mandate's repeal and that "preliminary results of analysis using revised methods indicates the estimated effects on health insurance coverage will be smaller than the numbers reported" earlier. It is not clear yet how significantly the CBO's revisions will impact its prior estimates.

Second, the Kaiser Family Foundation (KFF) summarized results from one of its health tracking polls[4] in October 2017 and, in that tracking poll, one of the questions asked was as follows: "If the government stopped enforcing the fine for people who don't have health insurance, would you continue to buy your own insurance, or would you choose to go without coverage?" In response to this question, approximately 92% of all non-group enrollees between the ages 18-64 indicated they would continue to buy coverage, with 7% of non-group enrollees indicating they would go without coverage, and the other 1% replying that they don't know what they would do. When narrowed to Marketplace enrollees, approximately 90% of all non-group enrollees between the ages 18-64 indicated they would continue to buy coverage, with 8% of non-group enrollees indicating they would go without coverage, and 2% replying that they don't know what they would do. There is a stated margin of sampling error around these responses of

[2] https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf

[3] https://www.cbo.gov/system/files/115th-congress-2017-2018/presentation/53448-presentation.pdf

[4] https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-october-2017-experiences-of-the-non-group-marketplace-enrollees/

approximately +-7%. Additionally, the survey was conducted on a nationwide basis so it is not clear how these responses may differ for District residents. However, to the extent the responses provided accurately reflect the actions non-group enrollees in the District will take in 2019 the effect of the individual mandate being repealed on both membership and premium rates would be lower than those which we are currently estimating.

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

- Estimates rely on information provided by DCHBX. If the information used is inaccurate or has been misinterpreted incorrectly, the underlying findings and conclusions may need to be revised.
- The estimates are not based on robust microsimulation modeling and therefore may not fully recognize all interactions specific to the District's individual market that might exist.
- Values are based on estimates of future events; therefore, actual results will vary
- Actual results are expected to vary on a carrier specific basis
- Estimates are based on the isolated impact of the repeal of the individual mandate penalty and do not consider the impact of other changes in legislation or regulation at either the District or Federal level

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

Thank you.

Sincerely,

Ryan Schultz, FSA, MAAA

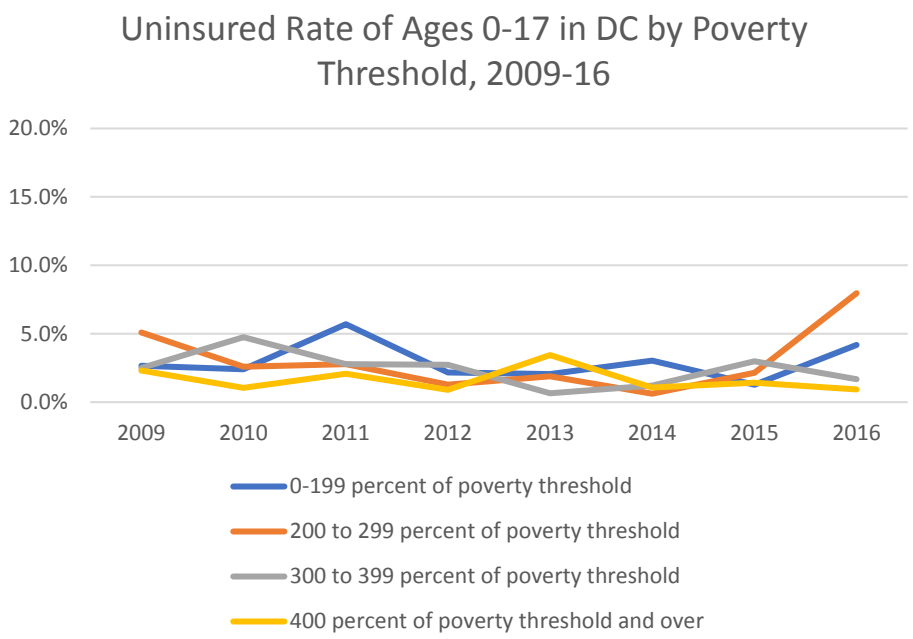
Copy: MaryBeth Senkewicz, DCHBX
Purvee Kempf, DCHBX
Debra Curtis, DCHBX
Tammy Tomczyk, Oliver Wyman

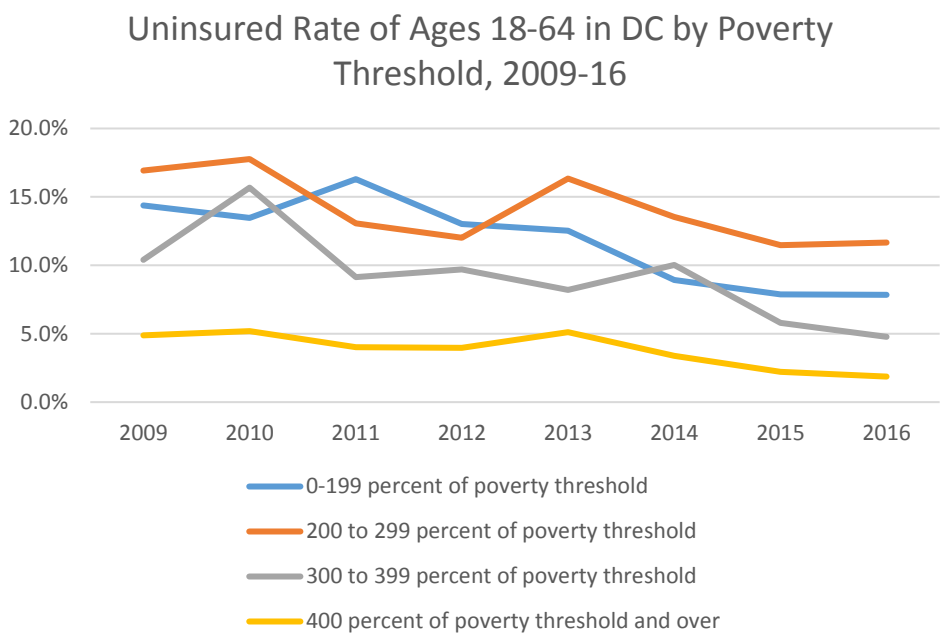
Appendix O

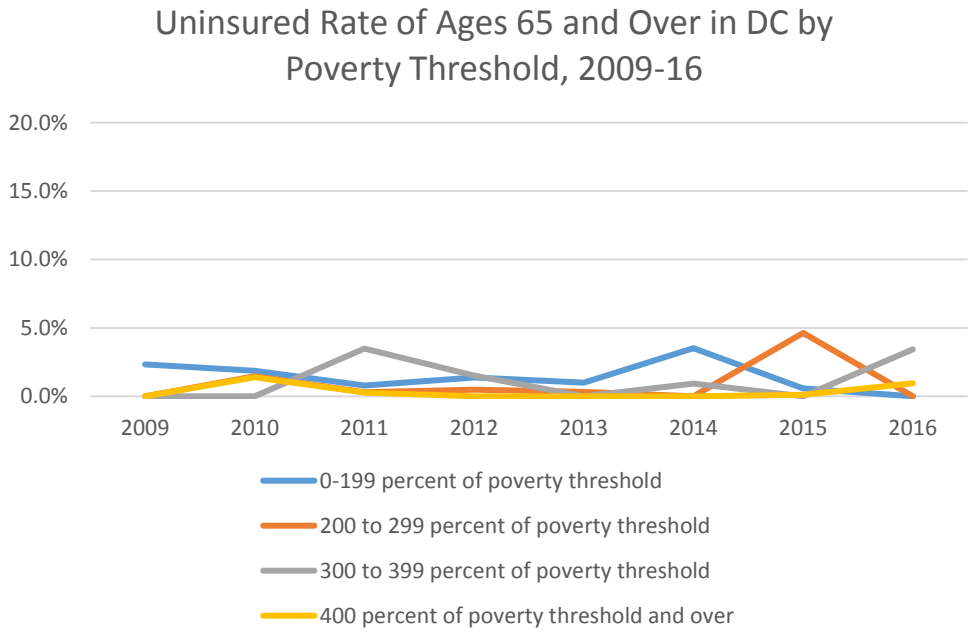
Uninsured Rates in the District of Columbia by Age and Poverty Threshold, 2009-2016

Poverty Level in the Past 12 Months by Age	Percent Uninsured by Year							
	2009	2010	2011	2012	2013	2014	2015	2016
0-199% of poverty threshold								
Under 18 years	2.7%	2.4%	5.7%	2.2%	2.0%	3.0%	1.3%	4.2%
18 to 64 years	14.4%	13.5%	16.3%	13.0%	12.5%	8.9%	7.9%	7.8%
65 years and older	2.3%	1.9%	0.8%	1.4%	1.0%	3.5%	0.6%	0.0%
200 to 299% of poverty threshold								
Under 18 years	5.1%	2.6%	2.8%	1.3%	1.9%	0.6%	2.1%	8.0%
18 to 64 years	16.9%	17.8%	13.1%	12.0%	16.3%	13.5%	11.5%	11.7%
65 years and older	0.0%	1.5%	0.3%	0.5%	0.3%	0.0%	4.6%	0.0%
300 to 399% of poverty threshold								
Under 18 years	2.5%	4.7%	2.8%	2.7%	0.6%	1.2%	3.0%	1.7%
18 to 64 years	10.4%	15.7%	9.1%	9.7%	8.2%	10.0%	5.8%	4.8%
65 years and older	0.0%	0.0%	3.5%	1.5%	0.0%	0.9%	0.0%	3.4%
400% of poverty threshold and over								
Under 18 years	2.3%	1.1%	2.1%	0.9%	3.4%	1.1%	1.4%	0.9%
18 to 64 years	4.9%	5.2%	4.0%	4.0%	5.1%	3.4%	2.2%	1.9%
65 years and older	0.0%	1.4%	0.3%	0.0%	0.0%	0.0%	0.1%	1.0%

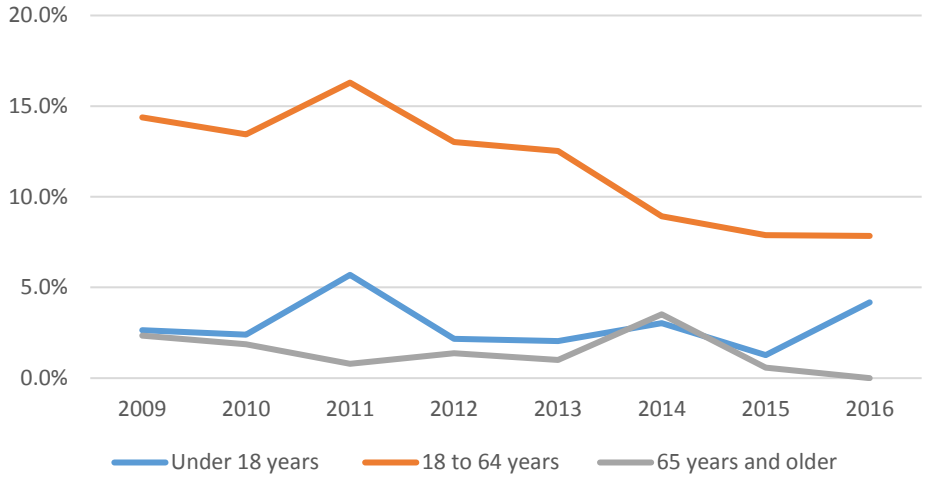
Source: "HEALTH INSURANCE COVERAGE STATUS AND TYPE BY RATIO OF INCOME TO POVERTY LEVEL IN THE PAST 12 MONTHS BY AGE," American Community Survey 1-Year Estimates, United States Census Bureau, 2009-2016


Uninsured Rate of Ages 0-17 in DC by Poverty Threshold, 2009-16
20.0%
15.0%
10.0%
5.0%
0.0%
2009
2010
2011
2012
2013
2014
2015
2016
0-199 percent of poverty threshold
200 to 299 percent of poverty threshold
300 to 399 percent of poverty threshold
400 percent of poverty threshold and over

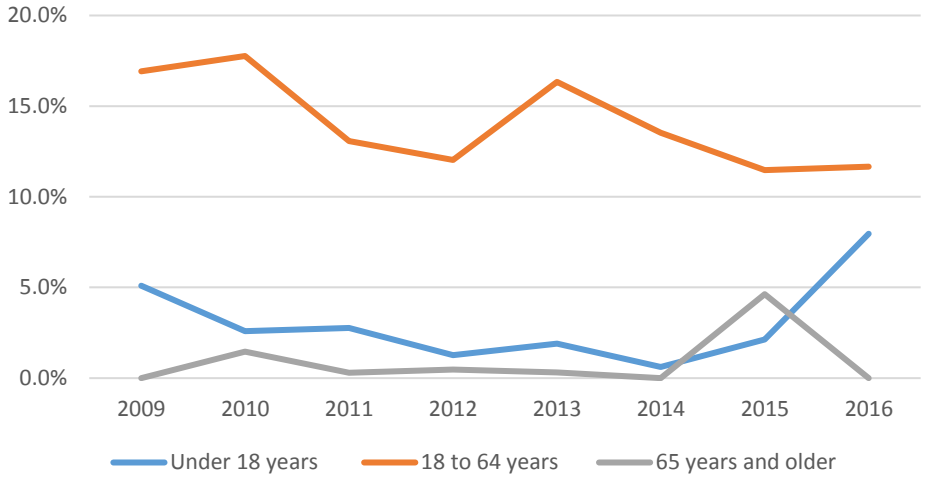

Uninsured Rate of Ages 18-64 in DC by Poverty Threshold, 2009-16
20.0%
15.0%
10.0%
5.0%
0.0%
2009
2010
2011
2012
2013
2014
2015
2016
0-199 percent of poverty threshold
200 to 299 percent of poverty threshold
300 to 399 percent of poverty threshold
400 percent of poverty threshold and over


Uninsured Rate of Ages 65 and Over in DC by Poverty Threshold, 2009-16
20.0%
15.0%
10.0%
5.0%
0.0%
2009
2010
2011
2012
2013
2014
2015
2016
0-199 percent of poverty threshold
200 to 299 percent of poverty threshold
300 to 399 percent of poverty threshold
400 percent of poverty threshold and over

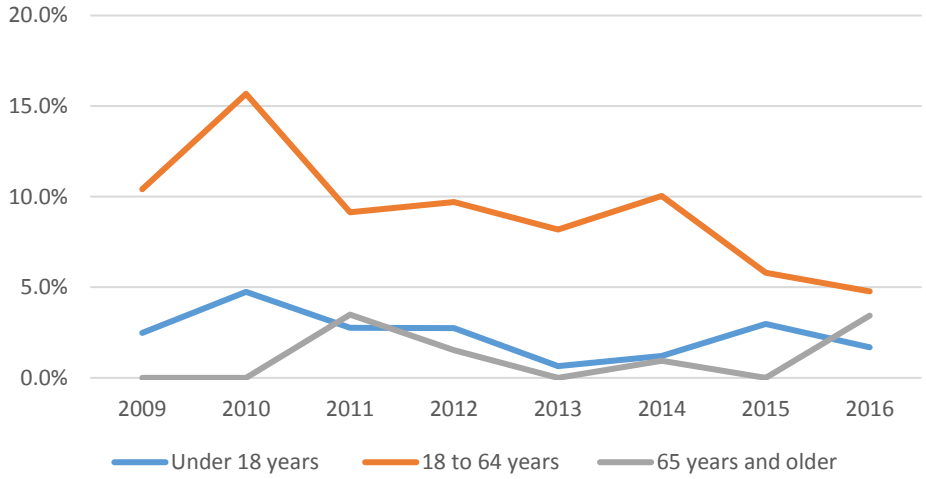
Uninsured Rate of DC Residents 0-199% of Poverty Threshold by Age, 2009-16



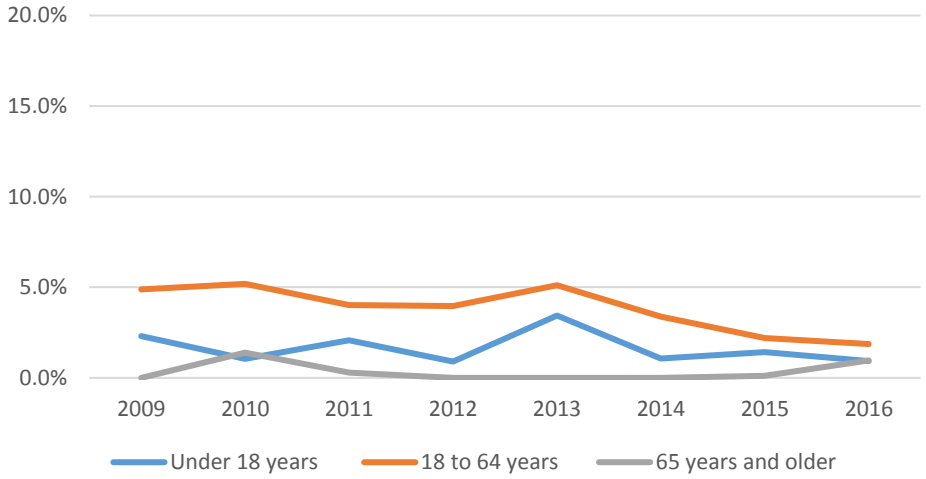
Uninsured Rate of DC Residents 200-299% of Poverty Threshold by Age, 2009-16



Uninsured Rate of DC Residents 300-399% of Poverty Threshold by Age, 2009-16



Uninsured Rate of DC Residents 400% of Poverty Threshold and Above by Age, 2009-16



Appendix P

STATE-BASED INDIVIDUAL MANDATE
FRAMING QUESITONS 1-2
DISCUSSION DOCUMENT
FEBRUARY 7, 2018

Data Considered:

- US Census Data on the uninsured in DC by age and income level
- IRS District specific data from 2015 on how many returns paid the individual mandate penalty by income level
- Enrollment in Medicaid and the DC Alliance Program
- Enrollment in Individual and Small Group coverage
- Congressional Budget Office nationwide analysis of repeal of the individual mandate
- National Academy of Actuaries Letter related to the repeal of the individual mandate
- Sample Mandate Calculations by Income level and family size for penalties mimicking the last federal penalty
- MA evidence
- Uncompensated care costs before and after the ACA
- Actuarial analysis of the effects in DC of the federal repeal of the individual mandate

Framing Question 1.

What is the Evidence of the Effects of the ACA's Individual Mandate and of Its Repeal?

See attached review by Leighton Ku, Professor and Director of the Center for Health Policy George Washington University and Chair of the HBX ACA Working Group

Is there support for a District individual mandate?

PROS of implementing a local mandate	CONS of implementing a local mandate
Protects the ACA: DC has effectively implemented the ACA where the federal government has abandoned their responsibility and left a void. The ACA relies on a three legged stool: insurance market consumer protections, an individual mandate, and tax credits to support affordable coverage. While the primary effects of the ACA on insurance coverage were caused by changes in Medicaid eligibility and the creation and subsidies for health insurance exchanges, about 30% of insurance expansions were likely attributable to other causes, including social perceptions of the insurance mandate (Harvard and MIT based on 2014 data)	**Penalty is unnecessary:** District uninsured rate was relatively low (92%) before the ACA, a penalty is unnecessary. 6.7% in 2013 to 3.9% in 2015; Medicaid participation rose, while private insurance coverage did not change (American Community Survey).

Maintaining the status quo: A DC mandate can protect insurance coverage and keep insurance premiums down without increasing taxpayers' costs. 96% of DC residents have coverage and if they maintain that coverage, a District individual mandate does not impact them. DC taxpayers that go without coverage will pay about the same amount as they would pay under federal policies for 2018. Public is roughly evenly divided in opinions about keeping or ending the individual mandate: 30% favored keeping it, 40% favored ending it and 30% was not sure. Support for retaining the mandate was higher among African Americans, those with higher income, those with more education and Democrats (Urban Institute, September 2017) Massachusetts implemented a state individual mandate prior to passage of the ACA. It was introduced in 2007 without controversy and they receive minimal public comments when they adjust policy features of the mandate.	**Health insurance may not be affordable**: Cannot require everyone to be covered if health insurance is not affordable and federal premium tax credits are not enough to make coverage affordable.
Retains coverage gains: Helps maintain gains in DC insurance coverage that have improved since 2013.While DC already had high coverage numbers prior to the ACA, the number of uninsured has been almost cut in half since the law has been implemented. DC now has less than 4% uninsured down from approximately 7% pre ACA. Without a mandate, CBO estimates estimated 4 million nationwide would lose coverage in 2019, rising quickly to 12 million by 2021 and to 13 million by 2025. Analysis conducted by HBX outside actuaries estimates that approximately 15% of our individual market would drop coverage without a mandate.	**Politically based opposition:** General opposition to new penalties/taxes or the ACA by some District residents. Republican controlled Congress could intervene on Congressional review.
Keep premiums down: Prevents premium increases by maintaining incentive for the healthy to remain or get covered. Without a mandate, the cost of nongroup insurance premiums, CBO estimates that premiums would rise on average 10% nationwide because those retaining coverage would tend to be less healthy and older, while those dropping coverage would be younger and healthier (CBO)	**Confusion:** Confusion among taxpayers that individual mandate exists in DC, when repealed at the federal level.

Analysis conducted by HBX outside actuaries estimates that repeal of the federal mandate will result in an increase in average claims costs in DC's individual ACA market of a 7.2% increase.	
Mitigates an increase in uncompensated care costs: Uncompensated care costs effect providers and cause healthcare costs to rise for everyone. Some providers will continue to provide care to those that are uninsured and unable to pay, cost shifting that uncompensated care to the privately insured. The amount of total uncompensated care provided by District of Columbia hospitals decreased by 60% between 2010 and 2015.	**Regressive Tax:** Penalizing low income individuals and families is regressive. 5,370 DC returns for individuals and households making under $50,000 included the payment of a penalty in 2015. This was 75% of the total number of DC returns that included a penalty. (IRS 2015 data)
Keeps any reinsurance money focused: Reinsurance to stabilize premiums in DC will be more expensive if premiums are higher due to the federal repeal of the individual mandate. Retaining an individual mandate would mitigate increased reinsurance costs due to premium effects from a repeal.	

Framing Question 2. If so, should DC's mandate conform to the federal mandate or should DC create its own unique mandate?

YES - Local mandate should conform to federal mandate	NO - DC should develop its own local mandate
Ease of implementation with federal law, regulations, and guidance already in place.	A complete locally devised mandate gives DC full control over all aspects of the mandate.
Taxpayers and tax preparers already understand it.	DC can work with state neighbors such as MD to pass something comparable for regional consistency.
Some flexibility to customize rules in accord with local needs and preferences.	Feds could retract all federal regulations and guidance.

Appendix Q

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?

Appendix R

What is the Evidence of the Effects of the ACA's Individual Mandate and of Its Repeal?

Leighton Ku, PhD, MPH

Revised Feb. 12, 2018

The Tax Cut and Jobs Act of 2017, enacted in late 2017, terminated the Affordable Care Act's Individual responsibility requirement (hereafter, individual mandate) by reducing the tax penalty to $0, effective January 1, 2019. As the District of Columbia (and other states) considers the possibility of creating a state-level mandate, an important question is what is known about the effect of the mandate, its repeal and its replacement?

- The Congressional Budget Office (CBO) estimated repealing the individual mandate would lead 4 million Americans to lose coverage in 2019, rising quickly to 12 million by 2021 and to 13 million by 2025. This includes losses in nongroup coverage, including exchanges, Medicaid and employer-sponsored coverage.[1]

Effects of Repealing the Individual Mandate on Health Insurance Coverage

Millions of People Under Age 65, by Calendar Year

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Change in Coverage Under the Policy										
Medicaid	0	-1	-2	-4	-4	-4	-4	-5	-5	-5
Nongroup coverage, including exchanges	0	-3	-4	-5	-5	-5	-5	-5	-5	-5
Employment-based coverage	0	*	-1	-2	-2	-3	-3	-3	-2	-2
Uninsured	0	4	7	12	12	12	12	13	13	13

Source: CBO, November 2017

- CBO also concluded that the cost of nongroup insurance premiums would rise by 10% because those retaining coverage would tend to be less healthy and older, while those dropping coverage would be younger and healthier. Thus, average insurance premiums for those remaining insured would rise because the risk pool becomes less healthy overall.
- The American Academy of Actuaries[2] agreed that insurance premiums would rise, but went on to note that this would weaken insurer solvency, could cause more insurers to withdraw from the market and that strong actions would be needed to counteract these adverse effects.
- Prior, independent research by the RAND Corporation reached similar conclusions.[3]
- Research by economists from Harvard and MIT, based on early data from 2014, found that, while the primary effects of the ACA on insurance coverage were caused by changes in Medicaid eligibility and the creation and subsidies for health insurance exchanges, about 30% of insurance expansions were likely attributable to other causes, including social perceptions of the insurance mandate.[4] Although there were exemptions from the tax penalties for those with low incomes or hardships, it is not clear how well the public understood these policy details. They

also note that effects were likely to rise in later years, as tax penalties rose substantially after the first year.

- A national poll done in September 2017 found that the public was roughly evenly divided in opinions about keeping or ending the individual mandate: 30% favored keeping it, 40% favored ending it and 30% was not sure. Support for retaining the mandate was higher among African Americans, those with higher income, those with more education and Democrats.[5] Given the profile of DC residents, this suggests greater support for the mandate in the District.

Findings from Massachusetts

Much of the evidence about the effects of an individual mandate relies on findings from Massachusetts, which instituted its mandate in 2006, as part of its state health reform. Research indicates that:

- The mandate resulted in overall increases in insurance coverage and in lower insurance premiums.[6]
- The mandate was associated with increases in employer coverage. In addition, there were health care savings as preventable hospital admissions declined and length of stay fell, although there were no overall increases in hospital costs.[7]
- Although there were no major changes in Medicaid eligibility in Massachusetts, there was nonetheless a substantial increase in Medicaid enrollment.[8]
- Overall, Massachusetts' health reform helped reduce economic problems, including reduced past due debt, improved credit scores and reduced personal bankruptcies.[9]

In discussions with the ACA Working Group by officials from the Massachusetts Connector indicated that there is no evidence that the state's individual mandate has any significant adverse effects on the state's economy or employment.[10]

The experience of Massachusetts is particularly relevant to the District, since both pre-reform Massachusetts, as well as the pre-reform District, had relatively strong insurance coverage levels (compared to other states) before reform and already had relatively generous Medicaid coverage and strong employer sponsored coverage.

Changes in Insurance Coverage in the District

At the request of the DC Health Benefit Exchange Authority, actuaries from the Oliver Wyman consulting firm provided estimates of the effects of the repeal of the mandate for the District of Columbia, drawing on its microsimulation model and data about the composition of DC Health Link beneficiaries.[11] The firm found *the repeal of the mandate would result in a decrease in the District's 2019 individual ACA enrollment of about 15.1%, or about 2,500 covered lives.* It also estimated that *repeal would lead to an increase in average claim costs in the individual ACA market equal to 7.2% per member per month*. Insurance carriers would have to increase premium rates to cover those costs, although insurance representatives in the working group orally mentioned that their internal estimates of the impact could be higher. Oliver Wyman did not include estimates about the employer

market or Medicaid because they lacked comparable data about the composition of those beneficiaries, but orally agreed that the repeal would have negative effects in those markets too.

Other data show how conditions in the District have improved since ACA implementation in 2014, suggesting the harm that could occur if the mandate is terminated:

- Analyses of Census data show that the overall percent of uninsured residents fell from 6.7% in 2013 before ACA implementation and creation of DC Health Link to 4.0% in 2016; Medicaid participation rose, while private insurance coverage did not change.[12]

- Data from the State Health Planning and Development Agency of the District of Columbia Department of Health indicate that the level of hospital uncompensated care expenses (including charity care and bad debt) fell by 60% between 2010 and 2015, falling from $250.7 million in 2010 to $101.2 million in 2015.[13] Reductions in uncompensated care expenses strengthen health care providers' finances and strengthen their ability to provide quality care to all patients.

- There was lower growth in health insurance premiums for employer-sponsored insurance in the District than for the overall U.S. Data from the Medical Expenditure Panel Survey (Agency for Healthcare Research and Quality) indicate that the average premium for a single person rose 9.5% between 2013 and 2016 for the nation, but only 8.1% in DC, while the average premium for family coverage rose 11.0% for the nation, but 9.2% in DC. Changes in the District market may have helped stabilize private insurance premiums, compared to overall national changes.

An economic analysis conducted in July 2017 of the Senate's "skinny" repeal bill, which mostly proposed to repeal the ACA's individual and employer mandates, estimated that the losses in federal funding caused by that bill would reduce overall employment in the District by 714 jobs in 2020 and 1,191 in 2026 (and overall losses of 67,000 jobs nationwide in 2020 and 131,000 by 2026).[14] These losses were driven by reductions in Medicaid and premium tax credit revenue in the District. While that bill differs somewhat from the change enacted in the tax law, it demonstrates the harmful negative economic impact of repealing the mandate on the District.

Taken together, these data suggest that loss of the individual mandate poses significant risks to the District, its residents, the insurance market and health care providers. Creating a District replacement for the discontinued federal mandate could help prevent those losses. If a District replacement is comparable to the federal mandate, this could be accomplished without creating serious new burdens for District residents.

[1] Congressional Budget Office. Repealing the Individual Health Insurance Mandate: An Updated Estimate. Nov. 2017.
[2] Shari Westerfield, Vice President of American Academy of Actuaries. Letter to Kevin McCarthy, Richard Neal, Orrin Hatch and Ron Wyden, Dec. 12, 2017.
[3] C. Eibner and E. Saltzman. How Does the ACA Individual Mandate Affect Enrollment and Premiums in the Individual Insurance Market? RAND. Nov. 2015.
[4] M.Frean, J.Gruber, B. Sommers. Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act. National Bureau of Economic Research. Working Paper. April 2016.
[5] J. Holahan, M. Karpman, S. Zuckerman. What Explains Attitudes toward the Individual Mandate? Urban Institute. Nov. 21, 2017.
[6] M. Hackman, J. Kolstad, A, Kowalski. Adverse Selection and an Individual Mandate: When Theory Meets Practice. Amer. Econ. Rev. 2015, 105(3): 1030–1066
[7] J. Kolstad and A. Kowalski. The Impact of Health Care Reform on Hospital and Preventive Care: Evidence from Massachusetts. J. Public Econ. 2012 December 1; 96(11-12): 909–929.
[8] J. Sonier, M. Boudreaux, L. Blewett. Medicaid 'Welcome-Mat' Effect of Affordable Care Act Implementation Could Be Substantial. Health Affairs. 2013; 32(7): 1319–1325
[9] M. Bazumder and S. Miller. The Effects of the Massachusetts Health Reform on Household Financial Distress. Am Econ J: Economic Policy 2016, 8(3): 284–313
[10] Audrey Morse Gasteier. Chief of Policy and Strategy, Massachusetts Connector, Jan. 23, 2018.
[11] R. Schultz, Oliver Wyman. Letter to Mila Kofman on Impact of the Repeal of the Individual Mandate. Feb. 6, 2018.
[12] Data from the Census Bureau's American Community Survey, including tabulations from the DC Fiscal Policy Institute provided by Jodi Kwarciany.
[13] State Health Planning and Development Agency, District of Columbia Department of Health. 20010-11, 2015 Uncompensated Care Summary. Data provided to ACA Working Group, Feb. 2018.
14 L. Ku, E. Brantley and E. Steinmetz. Senate "Skinny Repeal" Option Would Create Job Losses in Most States. George Washington Univ. July 27, 2017.

Appendix S

FEDERAL INDIVIDUAL RESPONSIBILITY REQUIREMENT
COMPARED TO
ACA WORKING GROUP RECOMMENDATION
BEING CONSIDERED ON FEBRUARY 14, 2018

The federal individual responsibility provision requires individuals and families to maintain qualifying health coverage or pay a penalty on their federal taxes, unless they qualify for an exemption. Pursuant to the Tax Cuts and Jobs Act of 2017, the federal government repealed the federal individual responsibility payment effective January 1, 2019. On February 14, 2018, the DC Health Benefit Exchange Authority Affordable Care Act Working Group is considering a recommendation for a District individual responsibility requirement.

The table below reflects the ACA Working Group discussions and proposed recommendation.

Gray

ACA Working Group opted for the federal structure and had minimal discussion regarding these provisions.

Blue

ACA Working Group had significant discussion about how the District should address these provisions.

COVERAGE: What coverage meets the individual responsibility requirement?

	Federal	ACA Working Group Proposed Recommendation
Federal Programs (Medicare, Medicaid, FEHBP, VA, DOD, etc.)	✓	**Same**
QHP (individual and small group plans – includes ACA essential health benefits and market reform rules)	✓	**Same**
Large Group Plans	✓	**Same**
High Deductible Health Plans that meet federal rules	✓	**Same**
Student Health Plans	✓	**Same**

Peace Corps, VISTA, AmeriCorps, Corporation for National and Community Service (NCCC)	✓	**Same**
Health Care Sharing Ministries	✓	**Same**
Tribal or Indian Health Service Plans	✓	**Same**
Association Health Plans (AHP)	✓	There is a pending federal regulation to loosen the rules regarding AHPs that could undermine the District's private health insurance market. Exclude from the definition of qualifying coverage future AHPs that may be permitted under these looser rules. AHPs that meet the requirements in place under federal law as of December 15, 2017 will meet a District individual responsibility coverage requirement.
Limited/Short Term Duration Plans	Does not meet the individual responsibility coverage requirement	**Same**
ACA Grandfathered Plans	✓	**Same**
DC's Immigrant Children's Program	Undetermined	Meets the individual responsibility coverage requirement

EXEMPTIONS FROM PENALTY – Who is exempt, or can apply to be exempted, from the individual responsibility payment?

	Federal	ACA Working Group Recommendation
Individuals/families below the federal tax filing threshold	Exempt	**Same**
Incarcerated individuals	Exempt	**Same**
Those not lawfully present	Exempt	**Same**
Citizens living abroad and certain noncitizens	Exempt if: • Lived abroad at least 330 continuous days • U.S. Territory Residents • Certain resident aliens living in US	**Same**
Religious Conscience exemptions	Exempt	**Same**
Native Americans	Exempt	**Same**
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.	**Same**
During residency in another state	N/A	**Exempt**
DC Healthcare Alliance	Does not meet the individual responsibility coverage requirement	Exempting the enrollees from the individual responsibility payment
Short term periods without health coverage	Exempt if uninsured less than three consecutive months (i.e. 2 months and 29 days would be fine)	Exempt if uninsured for three consecutive months or less

Affordability Exemption	Exempt if the cost of coverage (either ESI or the lowest-cost bronze plan, net of APTC) would be more than 8.05% (the percentage is indexed annually). Apply for the exemption through an ACA Marketplace based on projected income or on the tax return.	**Same** Substituting a District average bronze plan as the cap.
Individuals/families below a specific FPL threshold	No such exemption.	Exempting low-income individuals and families, such as those under 200% of the federal poverty level or at Medicaid or other public program eligibility levels Does not require the tax filer to request or apply for exemption.

OUTREACH AND EDUCATION:

	Federal	**ACA Working Group Recommendation**
Outreach and Education	IRS is permitted to send ACA marketplace information to those that are uninsured.	The District will use the tax filing process as an opportunity to conduct outreach and education regarding health coverage options for those that are uninsured.

INDIVIDUAL RESPONSIBILITY PAYMENT CALCULATION:

	Federal	ACA Working Group Recommendation
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.	**Same** Substituting a District average bronze plan as the cap.
Calculation	Monthly penalty calculation based on 1/12 of annual amounts.	**Same**
Deductions in Penalty	N/A	If the federal government reinstates a federal individual responsibility payment, District residents will not be subject to double penalties. District penalty will be lessened by amount paid to Federal government.