50 Ways to Implement Health Reform: State Challenges and Federal Assistance
Alliance for Health Reform
August 2, 2010

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ED HOWARD: Good afternoon. My name’s Ed Howard with the Alliance for Health Reform. Welcome to this program that we hope will help you better understand the division of responsibility under the new health reform law between the federal and state governments.

I just want to say that our partners today in sponsoring this briefing are the Robert Wood Johnson Foundation, the nation’s biggest philanthropy devoted exclusively to health and health care. We want to thank Risa Lavizzo-Mourey and David Colby and Minnie Young and their colleagues with their help in not only supporting the briefing and cosponsoring it but helping us think through how it ought to best meet your needs for information.

Now I’m very pleased to not make any substantive remarks at this point at all. I have the honor of introducing the founder and honorary chairman of the Alliance for Health Reform, the chairman of the Senate Finance Committee Health Subcommittee and not incidentally a former governor of West Virginia, so he understands both sides of this issue, the Honorable Jay Rockefeller. Senator [applause].

SEN. JAY ROCKEFELLER: I’m just happy because I look out and I see two or 300 people and it has been ever so ever since 1991 when this was started. A Senator that you may have

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forgotten by the name of Senator Jack Danforth and I started this. It was nonpartisan. We never took a partisan position. That’s not to say our panelists didn’t. They could fight all they wanted. You could question them and fight with them all you wanted but we couldn’t.

It’s been a terrific success as I look at the Healthcare Reform Bill and with all of the training that went on and all the learning that several generations actually of staff members had, I’m trying to decide what my conclusion is but I’ve decided that I’m not going to have a conclusion. I like the bill but I’m going to simply say that any time more people know something about something really important that’s a good thing regardless of what happens.

The bill as itself has incredible undertaking. It was interesting to me, I’m going to speak for a few minutes okay? You forgive me for that. That’s because Jay isn’t here. If you were here, I’d still speak. It was the opposite of the way the Clintons did it.

The Clintons prepared it at the White House, handed it to the Congress and then we were meant to pass it, didn’t work, bad psychology. There was kind of a, kind of an assumption that we would pass it that that was our duty. They had done all the work and therefore we should do all the passing. It didn’t work like that at all. So it failed rather quickly.
Obama took the other approach, which was let it, to do it from the ground up and that actually, in the end, did work but in the working of it, it took so long, got so many people so mad nobody ever understood what was in the bill because it was constantly changing because it was constantly getting amended. So when it did pass, people were furious at it and are furious at it. So on the other hand, we did get a bill and we did pass a bill. So one can draw one’s own conclusions about that.

Anyway it’s understandable to me that people are unsure about the bill and that’s partly because, for example, the 32 million that we insure that do not have insurance that won’t be completed until 2020. Why? Because we didn’t have the money to do more than that. So we did the best we could. Medicare and Medicaid were created 45 years ago last Friday. You don’t have to note that but it’s nice. You all know the basics of the law here in this room.

Before I introduce the panelists, I want to provide a few examples of why I think implementation matters so much. In fact I think implementation is the ball game at this point. It’ll be very, very tricky. First, health reform eliminates, once and for all, pre-existing condition exclusions for children and you know that but this week now has been corrected.
because of open enrollment but as of this, it hadn’t been corrected.

You saw some insurance companies threatening to stop writing new plans for kids and indeed they were doing so because they deemed the new law too stringent. Well HHS had the unenviable job of deciding how to handle that.

Actually they did ultimately clarify it sufficiently so that open enrollment would be possible and insurance companies backed off and HHS had done its job but it was a very good example of how a most important and rather tricky matter comes down not to the law but to the words in the law and therefore the interpretations of those words and the interpretation of those words by various parties who had different agendas.

The medical loss ratio thing is very, very interesting to me and that’s going to be talked about today. It was interesting to me that the public option and I introduced the first bill on that in the Senate, the one with the Medicare benchmark that would’ve saved $50 billion.

The House public option would’ve saved $100 billion but the Senate’s always a little bit behind the House so we did the best we could on that but there was one problem. We couldn’t get the votes in the Senate Finance Committee. We argued very hard. It saved a whole lot of money. We needed to save a whole lot of money to pay for a whole lot of things, which we

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were yet to do but somehow it became the benchmark, are you for or are you against health care?

The talk shows took it over, the Ed Schultz Factor, are you for health care or are you not? If you’re not for the public option then you’re obviously not for health care. The conversation never came back to the fact that in order for something to happen, you have to have the votes for it. When I put up mine in the Senate Finance Committee, I think it got eight votes. That doesn’t do it. It didn’t pass.

So then Chuck Schumer came in with one, which was a lot weaker, which actually only affected about 3 million people but it was seen as public option two. He ran it up the flag pole. It got 10 votes, didn’t work. So rather than sort of bemoan what clearly wasn’t going to work and sort of hold on to the flag as the ship went under water, we switch to medical loss ratio.

We can always go back to public option if we want to. That can be passed if there’s a will for it but medical loss ratio really intrigued me because of the fact that it set out, it took the whole raise for higher premiums and put a discipline on it and it said that, for large group markets and small group markets, large group markets in particular, 85-percent of all premiums no matter how much you raise them, had to be spent on health care. That was good.
If it was a small group market or the individual market, 80-percent. That was a lot higher, for example, than what was going on in my state of West Virginia, a lot higher, high 60s, low 70s was more the routine there.

So we thought that was really good and it passed. People liked that. I was a little surprised that it passed but it did pass. So that was good but then comes this marvelous thing of how you implement it, the head of the NAIC, the National Association of Insurance Commissioners, is from West Virginia and a good friend and it has been fascinating.

We have listened in on, my staff have listened in on a number of conversations that have been taking place because the insurance companies, health insurance companies, always being the health insurance companies are looking for ways to water that down. This is policy not politics. This is policy. They are doing that. The trick is can you take any administrative expenses and somehow move that subtly across the line into health care quality?

So they have been trying to do that. I’m determined that they’re not going to be able to do that. I’ve written numerous letters to Kathleen Sebelius and we have all kinds of plans to discuss that, which we will also do here today but it was highly predictable but it also showed the absolute importance of implementation. Passing of the law is nice.

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Implementing the law is what counts. That’s where the lawyers really get involved and worry about language.

One more final example and that is a delivery system reform. There unquestionably are going to be challenges in implementing new delivery system models but nothing can be more important. Health care providers and states must seize the opportunity in the new reform law for improving care for dual eligibles, which is a tricky subject, which a lot of people don’t know a lot about, to include the quality of Medicaid and CHIP, to implement accountable care organizations in bolstering workforce and public health programs.

States will still have a tremendous role to play in all of this. Some are happy about that. Some are unhappy about that. They are the ones who must set up the exchanges. They are the ones who must regulate the insurance industry. They are the ones who apply for the grants and help their providers implement delivery system reform. They are the ones who must take advantage of the millions of dollars that the federal government may make available to them.

As Susan Dentzer so eloquently noted in Health Affairs in June, just because these are her words, just because the potential for system transformation is now enshrined into law, does not guarantee that it will happen. If it does, it will be because people seize the opportunities and took action despite

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whatever inertia or inevitable complexities of implementation arise to block their path, much more graceful than I would have phrased it but she makes the point.

So it’s going to take a tremendous amount of work to steer our system in the right direction. Implementation is a vast and complex and actually a wonderful war but I believe it’s our moral duty. So that’s the end of me. So let me introduce our very first distinguished panelist.

Jay Angoff, now Jay is not on your schedule because he just sort of signed up at the last moment. Ed wouldn’t let us reprint anything. So he’s very strategically located, the Office of Consumer Information and Insurance Oversight within HHS, the recipient of a lot of these problems. His office is responsible for the easy stuff, high-risk pools, reinsurance programs, rate reviews, medical loss ratio, and insurance exchanges. That’s all he has to worry about.

So Jay just cleared his schedule to be here. He’s going to be here and then he has to leave and I’m going to try to squeeze in two questions just to show him, he didn’t get a free lunch did he? So I have to be careful. Then we’ll have the other panelists and they will all provide their statements and at that point, I also will leave. So Jay, it’s yours.

JAY ANGOFF: Thank you Senator for that kind introduction. It’s a pleasure to be here. It’s a privilege to
be on a panel with all you distinguished gentlemen, in particular Senator it’s a privilege to be here with you. We thank you for your leadership on so many health insurance issues, so many consumer issues, and particularly we thank you for your leadership on the medical loss ratio, which there’s still a lot to be done but we really appreciate everything that you’ve done.

Now I apologize in advance that I’ll not be able to stay here for long. As the Senator pointed out, we’re in the middle of implementing the bill. I got to get right back to work to continue to implement the bill but it’s very fitting that we’re here talking about how the federal government is working with the states to implement the Affordable Care Act.

Our leaders at HHS are committed to working with the states in so many areas. Many of us have backgrounds in the states and are really state-oriented, first and foremost of course, Secretary Sebelius is the former Governor of Kansas. She’s a former Kansas insurance commissioner and she also is a former Kansas state legislator. Many of us also have experience in the private sector working with consumers, employers, insurers, and others to improve the system that we have.

We all know how important it is to collaborate with our colleagues in both the public and private sector to make sure...
that implementation is done right. Now in my brief remarks, I’ll give you a little overview of our office, a new office called the Office of Consumer Information and Insurance Oversight, set up just a few months ago by the Secretary, talk a little bit about exchanges.

We put out a request for comment and an exchange grant proposal just last week, talk a little bit about a new appeals regulation that we just put out consumer assistance grants that we’ll be awarding, late review grants that we’ll soon be rewarding and also briefly highlight some of the milestones, which have already occurred.

Now the Office of Consumer Information and Insurance Oversight, or OCIIO for short, was created by Secretary Sebelius to help her carry out the many insurance-related provisions of the Affordable Care Act for which HHS is responsible.

Our mission is to provide consumers with information about their rights and responsibilities, to implement a set of rules for insurance companies that eliminate discriminatory practices, and hold insurers accountable for high quality care, and to work with states to create the needed infrastructure to carry out key provisions of the act.

We’ve got four main areas of responsibilities. We’ve got the Office of Oversight, the Office of Consumer Support,
the Office of Insurance Programs, and the Office of Health Insurance Exchanges. Now the Office of Oversight is headed by Steve Larson who’s a former Maryland insurance commissioner, also former chairman of the Maryland Public Utilities Commission.

This office has the responsibility of implementing, monitoring compliance with, and enforcing the new rules governing the insurance market, and very importantly the new rules governing medical loss ratios. It’s also responsible for late review at the federal level and for providing rate review grants to states.

Second, our Office of Insurance Programs is headed by Richard Popper who’s the former head of the Maryland High-Risk Pool. This office is responsible for administering the new pre-existing condition insurance plan and also our early retiree re-insurance program.

Third, our Office of Consumer Support, is headed by Karen Politz, one of the leading insurance consumer advocates with more than 20 years’ experience at Georgetown, HHS, and on Capitol Hill, I believe in your office Senator, at one time. The responsibilities of this office include compiling and maintaining data for our new Internet portal, which we launched July 1st and which provides information on insurance options.

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This office will provide assistance to consumers to enable them to obtain maximum benefit from the new health insurance system and to administer the consumer assistance grant program for states.

Finally, our Office of Health Insurance Exchanges is currently ramping up. This office will establish policies and rules governing exchanges and it will establish and implement planning grants to states. It will also provide oversight for the exchanges. We’re also particularly pleased that just two weeks ago, Liz Fowler, formerly Chief Counselor for the Senate Finance Committee joined us as Deputy Director for Policy in our office. Liz has already been a tremendous asset to our team.

So some of our major priorities, let’s first talk about exchanges. Although they won’t be online until January 1, 2014, there’s lots and lots of work to do and it’s important that we all, both at the federal level and state level, start to do it. On July 29th, we announced the availability of grants of up to $1 million per state to help states and the District of Columbia begin work to establish exchanges. This is the first step in a much larger investment, which will help get exchanges up and running in the states by 2014.

We also released a request for comment, calling for public input on the rules that exchanges should follow. We

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welcome input from all stakeholders including consumer advocates, employers, insurers, providers, states, and others. Now although the exchanges, as I said, are not required to be up and running until 2014, we know that states need to begin conducting the necessary market research and planning as soon as possible. The grants we just announced will give states the resources they need to conduct the research and do the preliminary work necessary to develop a plan for 2014 to determine how they’ll operate and govern exchanges in their state.

States can use these funds for a variety of initial planning activities, which include but are not limited to assessing their current information technology systems and determining their future IT needs in connection with their exchange, planning for consumer call centers to answer questions from the residents and developing partnerships with community organizations to gain public input into the exchange planning process.

Grant applications are available now by visiting healthcare.gov. Those applications must be filed by September 1, 2010 and we expect to announce grant awards by the end of the month. Future funding will support development and implementation activities through 2014. Each state has the
option to establish and operate its own exchange or to partner with another state or states to operate a multistate exchange.

If a state decides not to create an exchange for its residents then HHS will help establish one on its behalf. This offers states flexibility while ensuring access to affordable new coverage options available under the Affordable Care Act.

Now last week, as I said, we also published a request for comment inviting the public to share their thoughts as we develop the rules relating to exchanges. We’re encouraging all interested parties to provide input on a variety of specific topics related to exchanges as well as information regarding general exchange standards. We’ll use this input in developing the standards to support the establishment and operation of the exchanges. Comments are due by October 4, 2010. You can read the complete request for comment on www.healthcare.gov.

We also recently released our new appeals regulation, which governs both internal and external appeals. This new rule gives consumers and new health plans in every state the right to appeal decisions including claims, denials, and rescissions made by their health plans. Now it builds on the efforts of the states. Importantly, it gives policy holders the right to appeal through an internal process and also the right to appeal to an outside independent decision maker.
Next year, an estimated 31 million people in new employer plans and 10 million people in new individual plans will benefit from the new appeals rights under this rule. The number of individuals in employer plans will benefit is expected to rise to 78 million by 2013 for a total potential of 88 million Americans who’ll be guaranteed the right to appeal decisions made by their health plan under this new rule.

We also recently announced our new consumer assistance grants program. This is a new opportunity for states to help consumers. It’s a $30 million grant program. The grant money can be used to establish consumer assistance offices or to strengthen existing consumer assistance offices.

The program will enable states to provide direct assistance to their constituents including help in choosing and enrolling in a plan that best meets their needs, filing complaints and appeals, and navigating the private insurance marketplace and eventually the new health care marketplace. It builds on examples of success by states.

Last year, for example, one state’s existing consumer assistance program helped nearly 3,000 residents and recovered over $7 million in benefits on behalf of consumers. In another state, a similar program assisted about 13,000 residents and helped nearly 8,000 of them enroll in coverage.

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We’ll also soon be announcing the awarding of grants to states to aid them in strengthening their rate review procedures. This grant program is funded with up to $250 million over five years and it will be available to help states review proposed health insurance rate increases.

On June 7th, we announced the availability of the first round of funding that is $51 million in grants for fiscal 2010. These grants will help consumers receive value for their insurance dollars by subjecting rates to new public scrutiny. These awards will be announced soon.

I’d also like to mention our new web portal healthcare.gov. We’re proud to say that this new website has received very good reviews both from health policy experts and from some more technical website experts. It was unveiled July 1st as a powerful and innovative new tool for consumers. It has a great look and feel.

It will help consumers take control of their health care and make informed decisions and it’s the first website to provide consumers with both public and private health coverage options tailored specifically to their needs. Pricing data will be available for the first time in the second iteration of the website, which will be available in October.

We also recently established a pre-existing condition insurance plan program that, along with the states, that’s

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another example of partnering with the states. This provides a temporary health insurance option for those with pre-existing conditions until 2014 when the exchange comes online and insurers will no longer be able to decline people based on health status or to use health status as a rating factor. So this pre-existing condition insurance plan program is a good bridge to 2014 when discrimination against people with pre-existing conditions will no longer occur.

We also have our early retiree reinsurance program. This is a program that provides financial assistance to employers including businesses, unions, states, and local governments, and nonprofits who continue to provide their early retirees, that is people between 55 and 64, with quality, affordable health insurance. We began accepting applications in this program on June 29th and we’ve seen tremendous interest in it.

I’d like to say a few words now about our rule prohibiting insurers from denying coverage to kids under 19 due to a pre-existing condition. This rule is effective for planning years beginning on or after September 23rd. Secretary Sebelius has called on insurers to work with her to ensure smooth implementation and we’ve been very pleased with their response.

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We’ve also been pleased with the response of the industry in connection with the issue of dependent coverage. We’ve been able to work cooperatively and productively with the industry in connection with our rule enabling young adults to stay on their parents’ policies until age 26. Insurers step forward to work with us to accelerate the application of this rule at the Secretary’s request. More than 65 insurers began to implement this rule in June well ahead of the statutory implementation date.

Finally, I’d like to briefly talk about two notable achievements that are not within our jurisdiction, that is our jurisdiction at OCIIO, they’re within HHS. They’re very important programs. First is the small business tax credit. These are tax credits to small employers who purchase health insurance for their employees.

In April, the IRS released guidance and began delivering postcards to nearly 4 million small businesses and tax exempt organizations that may qualify to make them aware of the small business tax credit.

Also in closing the Medicare Part D donut hole, the Center for Medicare and Medicaid Services projects that 4 million Medicare beneficiaries will receive a $250 rebate in 2010.
In June, CMS has mailed checks to nearly 400,000 Part D enrollees nationwide who’d fallen through the gap in prescription drug coverage known as the donut hole. The remainder of those checks will be sent on a rolling basis throughout the year.

So that concludes my remarks. I apologize again for having to run off but it has been a privilege to be on this very distinguished panel. I thank everyone on the panel for their work on health insurance-related issues for so many years. It must be very satisfying to see your work finally come to fruition. Finally we especially thank Senator Rockefeller for your leadership. We very, very much appreciate it. Thanks very much.

SEN. JAY ROCKEFELLER:  Thank you Jay but don’t get up because I have two questions I’ve got to ask you. One, I think it’s in the nature of large organizations and particularly those that have regulatory responsibility that along comes a bill. The bill is clear or not so clear but decisions have to be made as to how the bill is interpreted.

Now take the medical loss ratio and there’s a lot of back and forth right now between the NAIC and you folks and how that is going to shake down trying to include administrative expenses or different kinds of things into something called improving the quality of health care.
Now that’s the kind of thing where people at the top like yourself can make a decision but then as it has to be spread out and implemented across the country over the long period of time, I mean not all at once but it covers a whole lot of situations.

It falls lower in the agency for those who are watching over it, NHHS or in states, and sometimes the zeal of those who’ve come in with a new administration is stronger than the zeal of those who’ve been doing this for 20 or 30 years and who walk into their office in Baltimore, in the case of Medicare, every morning and there’s a stack of paper, here a stack of paper, here a stack of paper, here’s a stack of paper here and they just hit their stacks. So the freshness of thinking the zeal of trying to make this work for consumers isn’t as strong. Now that’s a sociological question I guess but I think it’s a very important one.

What is it that will make, once you have made the decisions of how to handle medical loss ratio and other such matters, do you make it stick over time as it works its way down through HHS to people who have been there fore 20 or 30 years who may like the system as it has been and now have to implement something, which they may not be sure about?

JAY ANGOFF: Well all I can say is we all, at HHS, recognize the importance of the issue. The Secretary
recognizes the importance of the issue. Everybody on down
recognizes the importance of the issue. It is an important
issue and it will continue to be an important issue.

SEN. JAY ROCKEFELLER: I’m going to try again
[laughter]. Jay that was Shakespearean [laughter] but it is
human nature. I mean there are a lot of people who would be
skeptical, let’s say, about medical loss ratio. Oh that’s just
a way of making the insurance companies come to heel.

They are, in fact, making some progress. This is my
understanding because we listen to those conversations. Jane
Klein, head of NAIC, is a West Virginian. So there have been
some inroads into the interpretation, softening the
interpretation a little bit. I don’t know if they’ll stand.

I don’t know if they’re temporary but that is a very
human kind of thing to happen because people, I mean you can’t
just say that everybody in the organization, HHS is large,
believes in medical loss ratio because there are probably some
people that don’t believe in medical loss ratio who will have
something to do with implementing the interpretation of the
challenges being made upon it. What is the mechanism by which
Kathleen Sibelius, yourself, and others keeps peering down to
see how it’s going?

JAY ANGOFF: Well just to answer that question by
saying it’s an important issue [laughter] and it’s going to

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continue to be an important issue. Senator, your leadership has been so important and I just hope it continues. The more that you continue to be involved in this issue, the more we’ll appreciate it.

SEN. JAY ROCKEFELLER: Alright, I give up [laughter]. I can guarantee you we’re going to be all over it in the Commerce Committee strangely more so than in the Finance Committee but in any event, I thank you very, very much for coming. I will ponder.

JAY ANGOFF: Thank you very much.

SEN. JAY ROCKEFELLER: Thank you Jay [applause].

ED HOWARD: The Senator has asked me to introduce the rest of our panelists. I might say these folks probably all of them, will be using PowerPoint slides, those of you in the room can see it behind me. If you’re watching on CSPAN, you can go to allhealth.org, which is our website, and actually see the materials including the slides and follow along with those slides if you’d like.

If it’s okay with our panelists and the Senator, I’d like to introduce all three of you at once so we don’t interrupt the flow once you get going. We’ll start with Len Nichols on our far left. Pleased to welcome you back. Len is a health policy analyst and an economist. He directs the Center for Health Policy Research and Ethics at George Mason

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University. If you’re a Hill staffer, you’ve seen him testify more times than he probably wants to remember over the course of the Reform Bill.

On my immediate right is Lorez Meinhold. If you want to know how states are approaching their duties under the new reform law, you just ask them. One of the people most informed about that is Lorez. She is, as of very recently, head of the Colorado office to implement health reform and a policy advisor to Governor Bill Ritter.

Finally, we’ll hear from Brian Webb who’s the manager of health policy and legislation for the National Association of Insurance Commissioners. She works for the lady from West Virginia who Senator Rockefeller was talking about.

He’s been involved both in advising the members and HHS on matters affecting the shape of the regulations like the medical loss ratio that we’ve been talking about. There was a big NAIC meeting last week to discuss a number of these issues. Maybe we’ll get some insight from Brian into the results of that meeting. So Senator, I turn it back to you and Len do you want to start now?

LEN NICHOLS: Just jump in? Sure. Well one of the virtues of having prepared not knowing that Director Angoff would be able to come today is that some of what I’m going to say has already been said. So I’ll just jump right into the

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core of it since I know the Senator’s patience is running thin after that incredible repartee of the question and answer period [laughter] went before. Ed I’ve hit it three times and nothing’s happened. So I’m ready to start saying should I do something else here.

So basically here’s my basic point. There are two types of health reform. Now you may recognize the road diverged in the yellow wood if you can go back to your high school English. One type is federal takeover. One type is federalists as in federalism.

Just in case you’re wondering, a federal takeover is not 2,000 pages long contrary to popular belief. A federal takeover is two lines. You’re all in Medicare, starts in September [laughter]. So what you have here is 2,000 pages of trying to fit a whole bunch of idea about how to reform our health care system without changing too much of it so that people don’t get too nervous. The Senator was absolutely right in his opening remarks. You can’t get 60 votes. It ain’t going to happen. It’s not real.

So we do think about this bill for what it is. It is attaching a bunch of ideas to a very Byzantine and complicated system. That’s what makes it 2,000 pages long. I will also say the federal takeover does not give states any options.

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This bill has, I can’t even count them all, although we will have it counted in another couple of weeks if Lorez will help us. So we’re working on it. So anyway, you get the point.

What is reform really about? My job is not to give you details but to try to take you up to 20,000 feet and think about this stuff. It is really about signaling that business as usual is over. Business as usual is over for a couple of very simple reasons. We can’t afford it. I’m going to say it one more time. We can’t afford business as usual. Therefore it will end one way or another.

Now the objective evidence is our health care system, even though it has pockets of excellence and some incredibly dedicated people, is failing more of us every year. That’s why this Congress, with the Senator’s leadership, finally got it over the finish line. I think he would agree. I think he said in his opening remarks this bill is not perfect. It will never be. It’s created by humans but it is a start toward moving to where we can serve more of us better over time.

So what you want to think about is the core of it. Peel back all the details. It’s really about changing two obsolete business models. One is risk selection, the one we’re going to talk about today, that is moving from a world in which insurers profit by protecting the healthy from the sick.
Now we can get excited about insurers and some of my best friends work for insurance companies. I’ll just say I don’t hold them morally responsible. They follow the rules we set for them but the rules we set for them are wrong. The rules we set for them do not work for all people and they basically encourage them to protect the healthy from the sick. Well the new bill, the new environment, the entire new set of rules, and note it is a set of rules, it is not a takeover.

The new set of rules is about changing the incentive, changing the business model so that you could make money if you encourage and find ways for all of your enrollees including the sick to find value in the health care system. That’s the deal, moving from risk selection to helping us all find value.

The symmetric business model that really matters has got to be changed as well, is the delivery system side, fee-for-service medicine. We know it’s really good, fee-for-services at engendering volume. That’s how you go from 60-percent of GDP to 16-percent of GDP and headed for 20 in God knows whatever. We can’t afford that. So we got to move to a different way, a way of incentivizing providers to deliver value.

Now note the symmetry here. We’re encouraging insurers to help us find and rewarding providers for delivering value. That’s what we mean by alignment of interest. That’s what we
mean by reinforcing business models to take us to the Promised Land, which is a system that serves all of us at lower costs than would otherwise be the case. That’s what reform is about.

So what we’re going to talk about today is what I’ll call the structure of the Patient Protection Affordable Care Act. This is what PowerPoint can do. You can put HHS on one side and you see draft regulations, N regulations themselves, and enforcement and there’s a little arrow that goes to states. States get to comment and implement. Then on the right hand side, which is what really matters frankly, is the private sector. That’s where people, real people, will react to all this but I want to show you what you can also do with PowerPoint.

You can show that the states actually get to comment on a whole bunch of stuff and affect what the HHS does and the private sector, you might have heard this rumor, get to comment too. If you don’t believe me, ask Brian. There’s a heck of a lot of commenting going on. I would submit to you that’s a good thing because you want feedback because you cannot do this alone. You cannot do this alone. No one is that smart. If they were, our lives would be simpler. My beard would still be red and we’d all be home having a good time. So it is complicated. It’s a full, full court press.

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Alright, here are the choices states have. They can choose to comment or not. I notice they should. They can choose to operate a new high-risk pool or not. Now a lot opted not to do this partly because of the haste and partly because of the reality, which I know the Senator worked hard to overcome but the reality was we didn’t have enough money. So we put in $5 billion, which no live human being thinks is enough to cover all the people who could qualify for this in the four years before we implement full blown exchanges and subsidies.

Well some states chose not to implement it because they didn’t want to be left hanging. I understand that impulse. I would’ve made a different choice if I’d been in charge because my basic view is you’re all going to add money later when you need to. I also think it’s probably better to get the states involved in this. So I think we’re going to see more state involvement going forward in the other issues and I certainly hope so.

Note Director Angoff talked about this new annual premium review process. In my view, this is probably the single most important point I’ll make about the whole insurance regulation changes, it’s really about bringing about a culture of transparency. What medical loss ratio regulation is about

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is essentially discovering what’s really under the hood. Am I right?

So what this is about is making what goes on inside insurance companies much more transparent. That’s why actually in year one there’s no regulation. There’s simply reporting requirements, which is really designed so that Brian and all the technical experts can define what we’re talking about here. By the way, we wish him very good luck.

This is complicated stuff. It makes me glad I’m an economist, not an actuary but anyway that’s the point. States can engage in this new annual review. In fact, they’re invited to offer federal money to help. That’s really the key to making this transparency culture universal just as you said Senator, from the top to the bottom throughout the country. That’s how we’re going to make it work.

Second, states can choose to apply for and accept federal money for this ombudsmen program, the consumer assistance window that Director Angoff talked about, technical assistance for exchanges just announced last week and one of my personal favorites and there’s many more.

There’s the medical reimbursement data centers, which is basically an all payer claims database for the purpose of making delivery system transactions transparent so that people can figure out what they’re spending their money on, what it
costs in different places that individuals, real human beings over there in the private sector can start making decisions based on full information as opposed to partial information. There’s money in the bill for states that create these things.

Finally states can choose to cooperate in enforcing the pre-exchange reforms like medical loss ratio. Frankly and Brian may tell us, I don’t know how the federal government can do this without state help because most the expertise lives in the states. The people that we have running the piece of HHS that is doing it all came from the states. The expertise is in the states. So you’re going to want cooperation. You’re going to need cooperation to make it really work, to make it do what the Senator wants and that is to have it fully transparent from top to bottom.

Actions pursuant to the exchange, the good part about the law on this score is that while the exchanges don’t start until 2014, states are required to create them within two years. That’s a signal. If you choose not to create it, the feds will come and do it but you have a choice about whether you want to make the exchange truly live and breathe and reflect state reality or whether you want it to be directed from Washington. Your choice. You can guess which choice I would make by the nature of my accent and the color of my suit but I will tell you it’s a choice you got.

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Now note that states also can choose whether to run it themselves, whether to have a nonprofit run the thing, whether to have the thing be substate or multi-state. We got a lot of choice there. All this regulation has got to be done again. I can’t imagine how it can be done without state cooperation with the feds.

Finally and this may be the single most important power ex-post exchange. States have the authority to decide, or the exchange does once it’s created, who will participate. HHS defines the regs but the states have to decide who’s going to actually satisfy those regs.

I predict it will be a little bit different in Utah than it is in Massachusetts and I also submit that’s probably okay as long as the people of Utah are comfortable with it, the people of Massachusetts are comfortable with it, and the Senate is comfortable with it.

Fundamentally it is about cooperation in a federalism structure where that cooperation will have to have some breathing on the ground with the goals set by the feds but you’re going to have to have cooperation, in my view, between states and the feds to pull it off. Finally the technical performance of risk adjustment, which is pretty important and we’ll leave that until later because that’s pretty technical.
States also must expand Medicaid. They must streamline enrollment and keep HHS informed. States may propose alternative ways to cover people starting in 2017. They could implement across state lines if they want to, interstate compacts. They, of course, have power to change malpractice laws and they can and I hope they do engage on delivery system reforms with HHS and with local employers and local actors.

Here’s some final thoughts. This is probably the single most important thing I’ll say. Successful health reform is a participation sport, and by that I mean federal government, state government, private actors, private citizens. This is not something that can be done from the top. It is not something that can be done alone from the bottom. It’s only going to be done in cooperation. The bill, in my view, is structured to engender participation and a lot of feedback loops and a lot of room for modifications if we all agree to participate.

Finally let me ask the question, what does failure mean? Sometimes when I give talks and have longer, Ed always limits you to eight minutes. It’s a real pain. I always say failure is not an option. We can’t afford to fail. Why can’t we afford to fail? Let’s remember class, we can’t afford business as usual anymore.
So what does it mean to say we can’t afford failure? What it means is we shouldn’t think about failure as oh you messed up? Okay then we quit. No, failure means if it ain’t working, fix it and keep moving. We have got to make this health care system sustainable for all of us. That means making it work in every state in this country. Thank you very much [applause].

BRIAN WEBB: Hi. I’m Brian Webb with the NAIC. I’ve been talked about already. So we’ll see if we can live up to this. I wanted to start by just kind of building on what Len has already said. What this legislation, what this new law does is establish a minimum federal floor.

It basically says here’s the level of protection that we’re going to ensure every citizen in the United States has but then states can go beyond that. They have a lot of options. They can go higher. This is more like the HIPAA model. This isn’t ARISA where it says okay this is ours and this is yours.

This is the HIPAA model where we’re going to set minimum standards and states can choose if they want to meet those minimum federal standards. They can continue to regulate. If they want to go above that, they want to provide more protection, to do things a little differently as long as
those minimum standards are met, that’s what we’re going to have. So it really now is back on the states.

The states have to, first of all as Len’s already mentioned, they have to work with HHS and the rest of the Department of Labor, Department of Treasury, and others at the federal level to make sure that the minimum federal standards are consistent with what they think the federal law says that it’s something they can meet but then it really is up to the states to decide are we going to implement those at the state level and are we going to go beyond that and that’s what we’re working on.

In fact, the law even states in there it gives jobs to the NAIC. It gives jobs to the states. It provides a very specific advisory role for the states working with HHS. I’ve never seen it at this level before in federal legislation. This is quite impressive the way they did it.

One of the things that’s already been mentioned is medical loss ratio where the law actually says that the NAIC, a nonprofit organization representing state officials, they are the ones to come up with the definitions and as well as the methodologies for calculating the medical loss ratio. It hands us over to this entity to do this.

Now the reason that was done is because it was just a recognition that the expertise for determining this and getting

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it right is really at the state level. That’s where the actuaries are plus there was this recognition too that there’s a process at the NAIC. We develop model laws all the time.

That’s why we were created and we do it in a way that includes all stakeholders. Everything’s open. It’s transparent. Everybody can comment. I think a couple of, like Politico calls us quaint. They call us cute and the way we do it because we have two-hour calls and everybody’s on. We have over 200, sometimes 300 people on these calls from all over the country representing all kinds of positions.

Everybody writes us letters. All letters are posted. All drafts are posted. Everybody can comment. That’s why we believe we will end up with a medical loss ratio that will be a good start. We’re not going to end here.

We’re going to have to keep looking at this and making sure that everybody’s protected but the Senator asked a question to Angoff about how do we make sure this works and really it’s built on how it was developed. That is through an open process. We need to make sure after this is implemented that first of all, it’s implemented based on comments from all different viewpoints.

These are compromises. Compromises will have to be reached to get this implemented but even after that that is a transparent process that really anybody can go and find out

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what is going on with their health insurance company. All the regulators are able to review all the materials, all the submissions of where they’re spending they can look at.

They can find the outliers. That’s the way this will be implemented. This is the way we will make sure that companies are held accountable for what they are presenting. So we continue, the NAIC was told on medical loss ratio to complete its work by December 31, 2010.

That’s way too late and we recognize that because it goes into effect January 1, 2011. That’s when companies are going to have start collecting that data and providing information and pay a rebate based on claims beginning January 1st. So we are trying our hardest.

We really hope to be done by the end of summer. Now is that end of the school summer [laughter], Labor Day, or is that the sun summer more like September 22nd, I don’t know but we’re doing our best and an open process does take time but at the end of the day, it will be something that people are comfortable with. They’ll know what’s in it and they really can’t complain because they’ve been part of the process. So we will get it done.

We’re really hoping by end of summer here. Actually we hope to be collecting information beginning of April 1st next year, information on 2010. So we get a nice baseline. We get
good information on what companies are spending their money on, what are they defining as quality improvement activities, where are the outliers, who’s shifting too much over there and who’s not counting enough.

We want to make sure we get this right so that in 2011 when those rebate checks go out in March 2012 for the 2011 year that they’re accurate, that we have good information to base those on but then going forward, we need to make sure that we have the flexibility, which we believe the bill does, allows us the flexibility to continue to review that.

If we find that companies are shifting too much over into quality improvement, we can tighten it up. If we find out that we’re actually eliminating very important quality improvement activities and innovation, we can go in and add those things and make that clear as well to make sure this works because that’s what everybody wants. Everybody wants value that works and does promote quality improvement. That’s what the law says. So that’s what we’re going to do.

So I don’t need to go through the formula and everything. You guys can look at that later but I do want to note that it is the same process that we’re going to be using for other areas too, other issues such as rate review, which was already described as well.

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There is a push in the bill and they’re going to use money to do it, they’re going to basically give grants to the state so they can improve their rate review process to make sure that when somebody has a rate increase that it is reviewed before it goes into effect. There’s ability to comment on it and to make sure it is actually justified before it goes into effect.

So states will be working toward that goal and there will also be kind of a backstop of the federal government, which will be looking at unreasonable rates and determining whether any of those are excessive. The law, again, says the NAIC will work with HHS in order to define some of these terms such as excessive and unreasonable as well as work with us on what the minimum standards for the rate review grants are. We continue to work with them on all of that.

We also have to come up with a uniform fraud reporting form. We had our first meeting, public meeting, on that issue a week-and-a-half-ago I guess, it was that Friday. I was on vacation last week. I have no idea what today is but it was Friday the 23rd. We had our first meeting and a very good meeting. We actually already have a fraud reporting form but most people felt like that wasn’t meeting the needs what was required here. So we’re going to keep working on that.
There’s also consumer information, the NAIC already collects a tremendous amount of information about consumers, protections, about claims denials, about complaints filed by consumers, about rescissions, etc. The problem is we collect it basically on a voluntary basis.

The states send the information to us and they use their own definitions and the company uses their own definitions. What this bill does, again, sets that minimum standards and we’ll set some uniformity. So we are working with HHS to use our systems, which were already in place.

We have the largest database of consumer information in the world but to use that system in order to get more uniform information so that people really can’t compare companies and get information about their company before they make their choices. Also tremendous amount of data collection, risk adjustment and risk corridors have to go in effect 2014.

I got a call a couple weeks ago from HHS saying we got our team together. We’re ready to start working on the risk adjustment risk corridors. I said fantastic. Can you give us about two months because I want to give our medical loss ratio guys a little bit of a break before we start looking at a risk adjustment risk corridors but that is coming up as well.

There’s also some Medigap reforms, Medicare supplement. We have to add some cost sharing to a couple of the plans and

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also some standards from interstate tie back. So these are just the things that NAIC is called on to do.

This doesn’t even include the exchanges, which we are also working very hard on. We had our meeting the 22nd and 23rd here in town, very well attended, again getting information from everybody. We want every stakeholder involved in this process so that we can have a good product.

We are going to be developing model laws, model regulations. We’re going to be working with HHS, what their minimum standards are. We’re going to be working with states and what their options are, providing White Papers. I mean this is going to be an all-out effort and time is short.

Basically I talked to states and they say the two things they do not have are the things they need the most. They are time and money. They don’t have either one of them. They have their own jobs. They have their own things to do. They’re trying to run their own programs and then on top of it, they’re having to be on these calls for four hours a week. So they don’t have the time and they don’t have the money.

Fortunately the law does provide quite a bit of grant money to the states especially some planning grants, which just came out for exchanges, also some implementation grants going forward. So the money is never going to be enough, never ask a state person if they have enough but there is money there.
We’re going to keep working with the states and keep trying to provide them with that level of input to help them look for best practices, get them talking to each other, and continue to work with HHS. Together we can do it.

If any one group says, “No, I’m just going to do this. I’m going to close the doors and I’m going to do this on my own,” it will never work. As long as we have this open, transparent process and open conversations and keep working with each other, we can get this implemented. It will not look the same in every state but each state will then have the information they need to do what’s best for their state to make this work.

ED HOWARD: Thank you Brian. Lorez?

LOREZ MEINHOLD: Okay. I’m always technology-challenged as well. So I was asked to talk a little bit about what does health care reform mean for states. I’m in Colorado. As was said, I was appointed the Director of Health Reform Implementation in April. So, what this has really meant for a lot of states is more caffeine, less sleep and a lot of time on phones, but I’ll go into a little more detail than that.

Governor Ritter has been really committed to health care reform. It was one of his key premises when he came on as Governor three-and-a-half years ago and really has led this through an interdepartmental team. It’s really all the points...
we’ve heard that it’s participation that helps us end up with a better product. Again his real focus is on Coloradans and people.

So we can hear about medical loss ratios and we can hear about grandfathering and the new changes in the law but ultimately what this is about is people and people accessing health care, getting quality health care at the right time so that they can be productive. They can stay in school that they are educated, that they are an effective workforce. So really not losing sight of that is one of the key priorities. I’ll just say it is failing more of us. I’m even saying this from a personal experience.

I was trying to engage in healthy lifestyles, and I played on the Governor’s softball team, and I slid towards first base - that makes it sound somewhat intentional - and tore a part of my rotator cuff. So I have run a consumer advocacy organization to get consumers more engaged in health care. I have worked for a foundation that partners with hospitals.

I’m currently in the Governor’s office. I could not navigate the health care system, was disempowered and it’s not to say that I’m more important than anybody, but I probably have more knowledge of the health care system than most. The fact that I completely got disempowered is a true sign that it is not working and that failure is not acceptable and sort of

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how we implement this will make a huge difference for everybody in our states, in our communities, and our counties.

So we all have a responsibility to make sure that we do this well but the goal that we’re looking for is even though everything has a timeline, 2010, 2011, 2012, really our goal is by 2020 to make sure that our health of our citizens is improved, that Colorado is a healthier state because we implemented health care reform well. If you don’t look at that bigger vision, you’re not going to know how it all fits together.

So in April, the Governor issued an executive order that created an interagency department and again, health care reform requires departments to work together in ways that they’re not used to so really breaking down some of these barriers.

It might be through the exchanges where you have to have your state Medicaid agency working with your division of insurance to make sure that people end up in the right bucket. These are things that departments’ divisions have never done before, so really having the cabinet members there participating and engaging their staff in making sure that it’s successful. It also appointed a director of health reform implementation.
So the best investment that anybody can make is Starbucks near your state capitol because most of them are the senior health policy analysts for the governor or the Medicaid directors. We are drinking a lot more coffee. So again it’s about getting people to work together in ways that they haven’t before. The key components are in implementation planning.

My governor, like many other governors, almost 30 I believe, are not going to be back in office. Our Governor’s not seeking to serve another term. What I’ll tell you is who’s on the campaign trail right now, they’re not talking health care reform. They’re talking jobs and economy.

A lot of them haven’t been thinking about health care reform and not thinking about health care reform in the detail that they need to. So it’s our responsibility as states to leave a blueprint of sorts to say what decisions have we had to make? What grants have we gone after? What are the responsibilities in ‘11, ‘12, ‘13 and beyond?

How do we make this as clear as possible? Not just for the next administration – because we don’t know who that’s going to be or their love for health care reform – but how do we leave it for the next legislature and the community at large so that there is this momentum to implement this well for people? Again this is about making it better for people, stakeholders.
Participation has been the key word for the governor all along. We had a blue ribbon commission on health care reform that represented all sectors, both parties, and we had 24 of the 27 members agree to an implementation plan of health reform, our building blocks as we’ve called it. It looks surprisingly like health care reform.

So we have this participation model built and it’s what we strive to continue, really the transparency as what you’ve heard. We have a health reform website that we put everything up there. We want people to know and engage because we know that no piece of social legislation that we’ve ever created is perfect. We can look at social security and Medicare.

It’s really the process, the rules and regs, and the next couple years that will make this better and make sure that more people get the kind of care that they need, going after the grants and the grant opportunities, workgroups, and then coordinating among departments.

So what are the things that we’ve done? We were one of the states that decided to move forward with a high-risk pool. It was important to us, because we already had a state high-risk pool, that we make this as seamless as possible for consumers. Not everybody’s going to know to wait for that new federal high-risk pool, “I’ve been uninsured for six months or more and I have a pre-existing condition so I must go here.”

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So what we wanted to do is the no wrong door. So we’ve created the new website, getting us covered, and we think that there’ll be about 4,000 Coloradans that will be covered through the amount of money that we receive and this is really, again, the bridge to 2014 but you go on one website, you answer a couple of questions and it directs you to the right place.

It was important for us to leverage our private partnerships in our state to make this as seamless with the other high-risk pool to make sure that it worked the best for Coloradans.

The health care exchanges, again we have to show intent by 2012 but in order to do that, we have to start some conversations now. We have to leave the next administration with some kind of consensus paper understanding of what Coloradans want out of a high-risk pool.

We’ve heard the Utah to Massachusetts, what I’ll tell you is most states out of the exchange are going to probably end up somewhere in between but what are the values? What are the things you want the exchange to address? So what we’ve heard is about access already in the state, affordability, values, stability, efficiency, and equity.

We did our first of 10 meetings. We had 150 people from the broker community, the business community, the consumer community, disability community sort across the state providers.

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saying that this is what we want to see and the convening of stakeholders is a really important and then also talking about how we integrate with other states.

That, I will tell you, is a tough discussion to even start having. We’ve talked to Utah and New Mexico but we don’t even have a vision as a state what we want. So really to start having conversations with other states about what they want and then getting agreement all within three years on an electronic interface that all works scares the be-Jesus out of most states. The technology of some of these requirements is an overwhelming endeavor. 2014 can feel like a long wait away but for some people, it’s just so close.

There are some other things that we did that we’re trying to implement into health care reform. We passed the first affordability act in Colorado in 2009. What we did is assessed a provider fee and what we did, we’re able to pay hospitals more and cover 130,000 people all before 2012. We had said, as a state, we wanted to cover people to 100-percent that that was an important value. We want to make sure that aligns with health care reform and we do this well.

Again it gives us an opportunity to grow our provider workforce, to grow our systems so that in 2014, we’re not flipping a switch and all of a sudden, we have 260,000 people

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eligible and not quite sure how to do this. So this really gives us the phased-in growth.

Again engaging stakeholders is key to what we do through our forums, through our work groups. The governor has created a series of workgroups. One is called the Center for Improving Value in Health Care. That was created to figure out some of these delivery system reforms some of these payment reforms.

So rather than reconvene another group, how do we leverage what currently exists in the community, to build on that and really use real-life experiences to move us forward and then also just looking at the different grant opportunities. Brian touched on this and I’ll touch on this in a second, we’re using existing staff. We’re using existing funding to do this. There are a lot of grant opportunities. We can’t do them all.

So this is really about prioritizing what’s going to move us ahead, really looking at what exists in the community both from an advocacy organization, a funder level to make sure that we’re moving our state forward and go back to those goals of making the state healthier. So looking at rules and regs - and again we talked about the implementation plan.

This is sort of the last thing I wanted to leave everybody with. What are some of the challenges? The dollars
is a piece of it. Brian said states will never say that we have enough money. That is true. I think there are a lot of implementation grants but the administration that it takes, the staff that it takes at a state level, at the same time, we’re recovering from this, but we were in one of the worst economic downturns in seven decades.

We, over the last three fiscal years, have had to cut $3 billion from our state budget. We’ve had to lay off staff. We’ve had to do a lot of the same things.

So we still have all the work we had to do as a state and now we have additional responsibilities. We’re trying to create more hours in the day and how do we do that? The timing, a lot of states chose not to run the high-risk pool because it had to be operational in 90 days.

That is challenging for states to come up and do. Fortunately we have some great partners and we were able to do that but again, the grant opportunities, typically we have to turn around these grants in 30 days. There’s the same as sort of normal federal grant applications.

If you ever have never had the opportunity to do a federal grant, you should go on to grants.gov and check that out. It’s a fun opportunity to share a lot of information. I will say none of the grant guidelines have changed even though sometimes the deadlines are shorter.

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Really, if you want to be the most opportunistic about these grants, you really need to figure out, do a community assessment, figure out what’s going on, and leverage those resources. To do that and write the grant in 30 days, I’ll just say has made it a little more challenging.

Then changing relationships, that’s really important to understand because it’s not only changing relationships within state government and between departments but it’s changing relationships between the federal government and states.

There are differences that are now occurring and figuring out how to align priorities or how priorities might not align. I will say also one of the challenges we’ve even been facing in our state Medicaid program is there have been pressures and investments in making the enrollment processes in our programs better and easier. We are fully committed to that.

At the same time, we have increased investments in fraud and abuse and more audits on states looking at how we’re enrolling. So these are priorities that don’t necessarily align. So we need to really be thinking about how each of these pieces of health care reform moves us towards making states healthier.

Then, moving forward, state flexibility’s important. I mean, you’ve heard that states implement care and communities

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implement care in different ways. When we read stories, it’s about Grand Junction, Colorado. It’s about McCallum, Texas. It’s not about entire states. So realizing that we need to figure out how these communities figure out that care but then what are the core principles across states that help us do that and then really looking for efficiencies.

One of the big things in Medicaid, we’ve now said everybody’s going to be covered to 133-percent. We’re going to use the same income district cards. Do we need to develop 50 different enrollment systems or can we look at one national system to enroll people, now that we have more similarities across states?

Turning pilots into policies, cost containment is the name of the game. A lot of health care reform was about pilots around cost containment because we don’t know what works across populations but there has to be a lot of pressure to turn these pilots into real things that contain costs or bend the cost curve and then patience.

As a nation, as states, as communities we don’t always have the most patience. We know that health care wasn’t broken in a day. We’re not going to fix it overnight. So as we see increases in premiums and things don’t start to bend immediately, how do we have the patience not to fail and
continue down this path? So those are just some of the state thoughts [applause].

ED HOWARD: Thank you. Very good. Now, you folks have been very patient. Now you get a chance to join the conversation. Let me point out that there is a microphone there looks like, at least a microphone stand. Is there another floor mic somewhere in the back on my left? Of course, there are green cards in our packets that you can fill out and hand forward and we will try to get to as many as those as we can.

I will take this opportunity to note that there’s also a blue evaluation form in your packets that we’d appreciate you filling out before you leave so that we can improve these programs for you as we go along.

Let me take the prerogative to just ask a quick question of those of you who have been talking to a number of the states. I note that states have a lot of discretion in a lot of areas but the secretary has a lot of discretion in how the regulations get written about the level of discretion the states can exercise.

I was wondering with particular respect to the exchanges about which we’ve heard a lot of over the last couple of weeks, how aggressive is going to be the management
initially of the discretion given to the states, and then how are the states seeming to react to the level of discretion?

Are there going to be Utah-style farmers’ markets to the extent that they’re permissible or are they going to look more like Massachusetts regulatory-oriented exchanges? Any signs of that yet? Len you want to start or Brian?

LEN NICHOLS: Well I testified at Brian’s meeting but he was there for two days. So he should probably go first.

BRIAN WEBB: I don’t think we have a clear view of exactly which directions things are going to go. I think they’re, right now, still trying to dig out a little bit and figure out what their options are, what the questions are really before they even start making the answers.

But we have heard some interested in being more aggressive and some wanting to be less aggressive when it comes to negotiating things like that or they’re looking at those options. What they’re going to end up with though I don’t know because the reality is no matter what the Department of Insurance or even the current governor thinks they want there is going to be a legislature. There’s going to probably be another governor in a lot of states and we just don’t know what direction they’re going to take.

LEN NICHOLS: I did hear a pretty big sigh of relief that the million dollar possibility was made available last
week because frankly it was a little sooner than some of them thought it would be. They are looking forward to thinking through these issues as Brian said.

What I’ve heard is a lot of states are very interested in exploring it but not many of them have looked at it in detail yet because they’ve had a few thousand other things to do that we’ll do this year.

LOREZ MEINHOLD: I think the grants will create new opportunities for states. States have been coming together, health reform leads with NAIC, National Governors’ Association, Medicaid directors, and there’s going to be conversations this week, both through the state coverage initiatives and meetings with HHS, to talk about what are some of the visions.

I’ll say states are of two minds. One is “tell us what you want us to do so that we don’t go down the wrong path” and then the other half is “let us show you what we think we can do and lead the way”. There’s danger and peril in both ways.

One, nobody wants to be told what to do as a state from the federal level but also you don’t want to go too far down a path that you have expended resources and need to redirect especially in a short timeline. So I think that’s where most states are between those two levels.

ED HOWARD: Okay, we have some folks lined up at the microphone. I’d ask you to identify yourself and keep your

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questions as brief as you possibly can so that we can get to as many of them as we can.

AL MILLIKEN: Al Milliken, AM Media. At this point in time, are there any states you would identify as most prepared and cooperative in the process? Are there any states you would identify as least cooperative and not prepared? Is there a difference in Democratic or Republican-led states?

ED HOWARD: Brian, you can answer that without any problems, can’t you?

BRIAN WEBB: No problem at all. See I’m here for people who aren’t allowed to speak, so I can say stuff because I’m just a simple country health economist from an academic institution but I would observe no state feels prepared. There’s a continuum in various dimensions. I think all of them, regardless of the public rhetoric, are checking out their options [inaudible].

ED HOWARD: So watch this space. We’ll have this briefing six months from now and we may have some more information. Yes?

MARY AGNES CAREY: Hi, I’m Mary Agnes Carey with Kaiser Health News. I wanted to start with Brian Webb on this question but if others want to jump in, I wondered if you could be a little more specific on what HHS needs to do to make sure their medical loss ratio works as intended.
BRIAN WEBB: Well we’re coming up with the definitions and the calculations but the actual how the rebate will be distributed and how the rebate will be basically paid is a big question and has to go kind of on top of this but even after that, after everything’s put into a federal regulation, we’re really going to have to work together. This information from the companies through what we call our blanks, a supplemental blank, which is a financial document, instrument that we use. That information is going to be coming to the NAIC.

It’s then going to be going to HHS and we’re going to have to work together to be reviewing that, making that public to the extent that we can so that people can review that information and stay on top of it basically.

ED HOWARD: Yes sir?

PAUL WILGING: Paul Wilging, Johns Hopkins University, a question for the Senator. Apropos the Shakespearean dialogue with Jay sub two, I can think of one way that one can maintain the intensity of senior leadership in the Department of Health and Human Services on this health reform debate as it goes through implementation and that is to make sure that we simply keep CMS rudderless. Apropos Don Berwick, how would you phrase the prognosis for confirmation at some time in our lifetimes of a new administrator of CMS?
SEN. JAY ROCKEFELLER:  I’d do it tomorrow but that’s a good question. Floor time is a precious commodity and there’s almost none of it left. It’s like spectrum, nobody knows what it is, how it works, but boy is it valuable. So I can’t answer that question.

I mean the whole concept of not confirming the director of CMS, it just doesn’t make any sense. We had a situation recently when the Director of National Intelligence, the new Director of National Intelligence, Clapper, General James Clapper, when I talked with him, he said if they recess appoint me, I won’t take the job. I understand that. He is going to get confirmed. He was unanimously voted out of the intelligence committee, etc.

The question of the person you ask, in my mind, is can we wait for the confirmation floor time. So what I’m trying to do is weigh in my mind, is a recess appointment worth it? It may be simply because we’re going to be here another week. The House is here, gone but they don’t do the confirmation. So it’s a question can we do this in the next four days?

My guess is that we probably can’t unless it was by unanimous consent and in his case that would be very difficult. I think he’s a superb choice and I don’t care about some of the things that he’s said because I’ve had long, long talks with him and I know what he thinks. I think it’s right. So maybe

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it’s that the recess appointment has to happen with confirmation to follow. It’s not a happy answer, maybe realistic.

**JO WEXLER:** Jo Wexler with Managed Health Care Executive Magazine. Brian you mentioned that one of the big upcoming tasks is the rate review issue. As I understand it, states are sort of all over the map on this already. Some states do rate review and others don’t. How big a challenge is this going to be for states and how different is it going to be for different states and what is the NAIC’s main role in it?

**BRIAN WEBB:** A couple of points on that, one is yes states are kind of all over the map. Some just do file and use. Some use and file. The objective of the law is using the grant money, and that’s kind of the difficult part because that’s really their only tool - basically if you want the grant money, you have to meet these minimum standards.

We don’t know what those minimum standards are yet but they basically require you have to have prior approval. Then that will raise the requirements in several states especially if that’s required of the large group, which typically they don’t deal with.

So there’s going to be some raising but there’s that reality that states could just say, “well I don’t want the
grant money.” Even with the $1 million grant money not everybody took it.

So it’s a matter of “that’s really your only tool” because on the other side, the way the secretary gets involved is they’ll define what an unreasonable rate increase is. Then all those have to be filed with the secretary.

The secretary then can review and say they’re excessive and if the secretary’s running the exchange, they can say, “well that one can’t participate,” but if the state’s running the exchange, the secretary can only make a recommendation. So there’s really no hammer there. That’s why people, like Senator Feinstein and others, have been looking at maybe other tools there to try to improve that.

The NAIC’s perspective, we have concerns about the secretary basically saying something’s excessive if it is justified, which could happen because the state’s looking at it from a different perspective as to whether it’s justified given what’s going on in the marketplace and what’s necessary for solvency and things like that. So we’re kind of concerned about that especially when the secretary really can’t do anything about it but, we have this public perception that they’re excessive. So we’re trying at HHS. We’ve been working very closely with them to try to figure out how all of this is going to work.

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Our objective, what we like at the end of the day is yes, the states are reviewing the rates before they go into effect, determining whether they are justified or not and people are getting value for their dollar. That’s our objective. We think the law will move some legislatures to move in that direction but not all.

LOREZ MEINHOLD: I’ll just say Colorado’s one of the states that had some rate review where $1 million can enhance the capacity, but I think ultimately when I was talking about the grant opportunities, you have to look at the opportunity and say, “is $1 million enough to do what is required and not necessarily being sure that there’s additional funding?”

While there is additional funding allocated for future years, you don’t know, as a state, whether you’re going to get it. This is the precarious position that sometimes we’re put into also with the ombudsman, it’s initial one-year grant to provide that capacity but then knowing that we can’t bind future legislatures, knowing that we have to figure out how we’re going to cut our existing budget, can we commit to some of these activities in the future is the struggle every state is looking at when they’re looking at all these different grant opportunities.

ED HOWARD: Yes.
SARAH CLIFF: Hi, I’m Sarah Cliff with Politico. I apologize, we didn’t mean to offend you if we called NAIC cute or quaint.

BRIAN WEBB: We did find it very flattering actually.

SARAH CLIFF: I was wondering if you would talk a little bit about the states that aren’t interested in participating much in reform - kind of the opposite of Colorado - somewhere like Nebraska, for example, where you see the governor’s thing. We don’t want to touch the money that’s going to implicate us in reform, and I was wondering if you could address how you see things moving forward in those types of states where you don’t have someone like Lorez necessarily at the helm.

BRIAN WEBB: From the NAIC’s perspective, we have not had any states, no departments say we will not participate. So that hasn’t been an issue for us. Of course the departments of insurance have this attitude of legislature passed that you implement it.

So I think that’s probably a question only governors or others in the state level could do because at the Department of Insurance, we’ve had no members of any of our committees or subgroups say they’re not going to participate. We’ve had good participation from the states.

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LEN NICHOLS: It is probably worth saying that there was a really nice piece in the New York Times - I see Robert Pear here, I think his colleague wrote it - Thursday about the state of Texas. They talked about how, at the governor level and at some of the politicians’ rhetoric, there’s pretty strong opposition to reform.

It’s fair to say this bill is very complicated. It doesn’t have universal support but also talked about how the departments, not just insurance, but also insurance, but the departments, in particular the Medicaid director was quoted as saying “no one’s ever told me not to find out what my options are.”

Now, I think that’s what’s really going on. I think there’s still a lot to be done to engender broad political support but I think there are an awful lot of folks trying to figure out what would make my state better that’s in this bill. What would I like to change and talk about that and how can I use what opportunities there are to find out what I can do? I think that’s the general order of the day in virtually every state.

ED HOWARD: Let me just take that one step further because it was a card question actually directed toward Len with respect to the phenomenon of states choosing to opt out of some of these early stage duties or opportunities for

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LEN NICHOLS: Well, I do think it’s worth taking a deep breath, and it’s probably good advice for all of us a couple times a day, but the truth is, I mean I don’t know how to say it any more bluntly, a lot of people think, and I’m one of them, that Congress has managed to lose the trust it takes to run a democracy. That’s kind of where we are. That means there’s a lot of concern about things that get passed that are complicated, hard to explain, all that stuff. You know all the stories. They’re all true.

So, I think it’s fair to say that, yes, it looks like some people would like to completely repeal this thing and they’ve stated it publicly, but in the cold light of day, when you start thinking about – let me get this straight. We would have to raise something on the order of, I believe, an estimated two-to-three-percent over baseline spending on Medicaid in exchange for roughly 10 to 20 times that much money coming from the federal government.

Then suddenly the car dealers and the real estate brokers start thinking a little differently about the

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potential. The amount of federal money that would flow into red states is basically another stimulus package.

When you think about the reality that you would be reducing uncompensated care, you’d be enhancing people’s access to care, all that stuff then people are starting to be, I would say, far more sober about it. I would also say we got a long way to go before there’s any political consensus that this is the right approach.

We’re going to debate this way past my retirement age, which is a good thing, but it is a start and it is a thing people will see the tools that are there and as they examine what is really possible for their state then they’re going to be confronted with the options. That’s really the best all us analysts can do is lay out the options. Let the politicians decide and I believe the politicians’ discussion will be different post-election than it is pre.

**ED HOWARD:** [reading question from card] Senator Rockefeller, the questioner writes, emphasizing the importance of delivery system reform to the success of health reform. What role do the panelists see for physician assistants and other non-physician providers like nurse practitioners in implementing the delivery system changes that are under consideration?

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LOREZ MEINHOLD: Sure. I’ll start. I think we need to look at the way we’re delivering care now and look at are we using people’s time efficiently. I would argue probably we’re not using providers’ time efficiently. We’re not using PA’s time or nurse practitioners’.

Not only that, we have care coordinators to add to this and figuring out how we reimburse for that kind of, the stuff that we know that prevents illnesses and keeps people healthier and facilitates the communication at those kind of investments and looking at how we deliver care differently, and what can we do with telehealth? What can we do with health information technology?

Well there was a big piece in the Affordability Act around health information technology, huge investments in the stimulus package that are really meant to be leveraged through health care reform and how do we do this differently?

So it’s looking at our whole provider community, mental health providers, dental health providers, and saying how do we more effectively, efficiently deliver care? So I think there are a lot of new and defined roles for everyone in this system.

ED HOWARD: There’s a question about sort of an intertwined decision between the federal and state governments. Some states, the questioner points out, have mandatory preventive screening requirements for insurance plans that
include, in the case of 37 states, mandatory prostate cancer screening. Federal guidelines don’t require that kind of screening because it’s not rated as an A or B prevention service by the organization that does that rating.

The question literally is: how should states ensure that mandates are enforced when the federal law is less comprehensive than some state mandates? I might add, how do you finance that kind of thing since it would not be, presumably, in the benefits package that was required under the mandate?

SEN. JAY ROCKEFELLER: That’s a Brian question. Well the bill doesn’t prevent those state laws. It doesn’t eliminate or strike them in any way. The fact that they’re not on the preventive list means they could have a cost sharing and also going forward if it’s not in the essential benefits then there would be a cost, a potential cost to the state. We’re still trying to figure out all that’s going to be calculated but it could be a potential cost to the states for any mandated benefits that end up costing down the road.

So those laws are in place. They’re in the state law. Trying to get them out at this point would be very difficult. So they will go forward and those mandates will remain until such time as somebody takes them out. They will be enforced at the state level.
ED HOWARD: Yes Joe?

JOE: Okay, this is for Mr. Webb. I’m still trying to get my hands around this medical loss ratio. You mentioned in your presentation that something like quality you may determine that there’s too much on it and cut it back or there’s too little but I’m not sure how this works.

Are you saying that quality is medical care, and within that 85-percent only a certain amount of it can be spent on quality or are you saying some quality, maybe medical care and some might not? I’m not sure how that works.

BRIAN WEBB: Basically the way it works is in the numerator you have your claims cost plus quality improvement activities. That’s not a category that anybody’s familiar with as something in the law that was created. So our objective in defining these things, which is what’s been on the NAIC, is trying to figure out what activities of an insurance company could qualify as a quality improvement activity.

There are a lot of administrative like utilization review. Some would argue, “Well, some of that is quality improvement.” Others would say, “No not really.” It’s really just cost containment. There are some very good activities like fraud prevention. Some would say, “Hey, that’s quality improvement because people aren’t getting fraudulent care.”
Others would say, “No, really most of the fraud has to do with cost containment instead.”

So, it really comes down to, how we going to define, and if you go online, you can look at our latest draft. We have a document called a supplemental health blank where the companies would have, they have columns and they’ll have to fit into those how much they’re spending for these quality improvement activities.

Then, there are instructions saying these can be included as quality improvement activities. These cannot, or a portion could if it can be qualified that way. It’s really those instructions that we’re talking about in the future.

If we find that those instructions are really too narrow and eliminating what could be very beneficial innovative quality improvement activities and they’re not being captured in those costs then we would want to broaden the instructions to make sure companies can include those in the numerator.

If, by the same token, the companies are basically driving a truck through the definition and putting all of these really cost containment or administrative costs into quality improvement and we see those percentages going higher and higher, we’re going to have to go back and try to tighten that up.
There’s no real process in the law for doing that in the future but we’re working with HHS to make sure we can because what are the odds that we are going to get this right the first time?

ED HOWARD: Yes, Len?

LEN NICHOLS: I was just going to say zero.

ED HOWARD: Okay, zero. We have time for just a question or two more. This one’s directed actually I was going to say it was directed to Lorez, but it’s not really. It picks up something you said, which is that Colorado’s struggling to think through what they have to do and expect to get from the exchange much less worrying about what other states are going to do. The question is, “is there a need to, or a way to, motivate states to form regional exchanges and if they do happen, where are they likely to happen? Do we want to motivate states to form regional exchange or just leave them alone?”

LOREZ MEINHOLD: Well I’ll take a cut and then I’ll switch it to Brian because I can tell you what our thinking is. I mean, insurance is about pooling risk. So, if you look at Colorado, we know we have a limited number of lives and so the idea of being able to have more lives in that pool seems to lend itself to the idea of how do we make this more affordable. So I think that’s why we’re thinking about it. I think there

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is a motivation if affordability is part of your desire in these exchanges.

The challenge is we might have more carriers than another state and sort of how does that work across state lines? The challenge is, in 2014 our insurance laws will look a lot more the same than they do now but they don’t right now. Then, each state has to have the conversation about what their exchange goal is. So I think we’re having these conversations concurrently. The challenge is there are as many questions each time you add another level of complexity.

Right now, in the law it doesn’t say it has to be contiguous states but I think we’re thinking it would need to be sort of like the referral of care where people go to get care that would be maybe your region. I don’t know that there’s a good way to motivate this because I think we’re just still trying to figure it out and what makes sense. Each state is ultimately going to make a decision that most benefits their state and trying to figure out if that is partnering or not with the state.

**BRIAN WEBB:** The real advantage initially for regional is cost, not to the individual necessarily but the administrative cost. You’re not necessarily even pooling risk. That becomes a much more difficult task with different carriers and different pools, but is there a way you can kind of

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piggyback and have one group operating the exchange and get all the administrative costs, get some economies of scale.

I mean one of the examples could be Rhode Island using the exchange in Massachusetts. It’s already up and running. They know how to run it and use them basically as administrative functions in a single place. That could make sense early on. Even that’s hard though. Even that’s hard because you have to have the same goals.

You have to have the same ideas about what the governance should be, same ideas about what the activities of that exchange should be. So it just becomes very difficult these regional upfront.

Down the road, who knows? That’s something that could as states get closer and closer in their regulatory goals and they get closer and closer in their governance goals and maybe in the future we could see more of this.

The same goes for this idea of interstate sales and sales across state lines, very difficult right now, we argue impossible right now given the differences in the rating rules and the differences in the governance and regulation and things like that but down the road we don’t know. We’ll have to look at that.

LEN NICHOLS: I think that’s fair and I would just add that and emphasize the point about down the road, but I would
also say down the road includes the next couple of years because when the guidance comes from HHS as it is starting to and just in the qualifications for getting the grant, I know a lot of states are sort of making noises like, gee wouldn’t it be nice if there was kind of a template laid out and then give us choices off that template?

I think that template will reduce a whole lot of fear and confusion about what they got to do and then what freedoms they have. Then, I think they’ll be in a better position to have a conversation, do I want to merge or do I want to have the same thing early on but I agree with Brian. It would probably be luck if we got it all done by 2014 but down the road it probably makes a whole lot of sense.

ED HOWARD: Well I think we’ve come to the end of our time. We got through most of your questions. I appreciate your active involvement in this. Let me just say that there’ll be a web-cast and a pod-cast available of this briefing probably tomorrow on kff.org thanks to our friends at the Kaiser Family Foundation. There’ll be a transcript on the Alliance website at allhealth.org within a few days, probably Thursday or Friday along with electronic copies that you’ll find in your packets.

I want to thank our friends at the Robert Wood Johnson Foundation once again for getting into this implementation
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series. It isn’t the last one. We’re going to do some other ones along these same lines. Thanks to the Alliance staff for making things run so smoothly on a Monday. I want to thank my founder and honorary chairman for his active participation in this and ask you to help me thank the panel for a really good discussion of some tough issues [applause].

[END RECORDING]