ALLIANCE FOR HEALTH REFORM

Health Insurance Marketplaces, Round II: Results and Expectations
The Commonwealth Fund
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ED HOWARD: Hi, my name is Ed Howard, I'm with the Alliance for Health Reform and I want to welcome you on behalf of Senator Blunt, Senator Rockefeller, our Board, to today's program on affordability to consumers among the health plans offered inside and outside the health insurance marketplaces or exchanges. Now, some of you may have heard that tomorrow -- that is, November 15th, begins the second open enrollment season for plans offered through the marketplace. That period runs through February 15th. A far shorter period than the six month open enrollment time that we had last season. We all know that marketplaces had some major problems with aspects of their operations, I'm sure we will hear some about that today as well as hearing about the steps being made to improver that functionality. And we also want to look closely at the affordability part of the Affordable Care Act. There is a new issue brief in your packets that describe how much people had to pay for private insurance last year and the impact that spending had on those doing the buying. Now the rates for 2015 have only recently become available and we will explore what consumers looking to renew their insurance or seeking insurance for the first time, will encounter in these next few weeks.

We are very pleased to have as partners in today's program, the Commonwealth Fund, a century old philanthropy established to promote the common wheel or the common good and we are doubly pleased to have as our co-moderator today, Sara Collins, the Fund's Vice President for Healthcare Coverage and Access. She also happens to be the principle author of that impressive issue brief I mentioned. It's in your packets, that has findings from a new Commonwealth survey on out of pocket costs in the private insurance market. And in addition to moderating with me, Sara has some important information to share with us in just a moment, from that survey.

Before we turn to Sara, let me tend to a little housekeeping. As you can see on the screen, if you are in a Twitter mode, you can use the hashtag OE2, that is now a new ocean liner, or a new fed plan to float the economy, it's is Open Enrollment, second year. In your packets you will find some important information including speaking bios, more extensive than the intros that you will hear from us today. You will also find a one page materials list, the Power Point presentations that our speakers will use and lots more background is available for you on our website, which is Allhealth.org. There will be a video recording of the briefing available probably Monday, followed by a transcript a couple of days later on that same website. Also, you can find the speaker slides, digital copies of the background materials and those of you who are watching on C-Span, you can find all of that information and follow along by going to Allhealth.org. I should say to the audience here that C-Span coverage is not live today, so check the broadcast schedule. We know that it will be on, on Sunday at 4:25 pm so instead of that second NFL game, come look at this fabulous program that we are about to put together. And there will be other airings as well.

One other thing I just wanted to mention, there are a couple pieces of paper in your packets that are of importance for you to keep in mind. There is a green question card that you can use to write a question and have it brought forward when we get to the Q&A and

there is a blue evaluation form that we plead with you to fill out because it helps us try to respond to the ways in which we can improve these briefings and make them even more useful to you.

Now, let's get to the program and let's start by hearing from Sara Collins who not only can offer the greetings from the Commonwealth Fund, but can also share with you the results from the new Commonwealth affordable tracking survey. Sara, good to have you back.

SARA COLLINS: Thank you very much, Ed, and behalf of the Commonwealth Fund, I want to thank the Alliance and thank the panelists for coming today and also to extend a warm welcome to the audience.

I'm going to spend just a few minutes discussing the premiums of the plans that are going to be sold through the marketplaces this year, at least some preliminary information about what we have about them, that is going to come really quickly with open enrollment starting tomorrow, and how they compare with plans that were sold last year through the marketplaces. And I'm also going to look at the deductibles of these plans. There has been a lot of focus on premiums and I think, and less so on the deductibles and cost sharing. And then as Ed mentioned, I'm going to share with you some findings from a couple Commonwealth Fund surveys that asked what consumers think about their premiums, about the affordability of their plans, as well as what their out of pocket cost responsibilities are.

As Ed mentioned, open enrollment begin tomorrow and it goes through February 15th and Meena Seshamani and Tim Jost are going to help us understand the details of that from a couple of different perspectives today. This week consumers were able to go online and visit the website, Healthcare.gov and browse their 2015 health plan options. So I went online and I entered the zip code where I grew up in Memphis and entered a random age, I'm 40, which is not my age. And a random income and hit the button that says, continue to plans. And this is what popped up on my screen. One hundred and six health plans available for enrollment in Memphis. But I experimented in the browsing feature, by plugging in different ages, different incomes and the displayed premiums all adjusted based on the information that I fed the site. So for people with incomes under 400% of poverty who are eligible for the premium tax credits, the amount of the credit is displayed and then it's applied automatically to the plan options. So it's easy for people to see what they are going to pay. But it's really critical that consumers also look at what their cost sharing is going to be over the course of the year on their plans, looking careful at what the deductibles are and the co-pays are and it's also critical that consumers who have incomes under 250% of poverty, which is about $30,000 for an individual, know that they are eligible for cost sharing reductions that lower their deductibles and their co-pays. These reductions are also applied automatically on the screen when someone in that income range is browsing their plans. But in order for those reductions to apply, you actually have to choose a silver plan.

This analysis is by Jon Gable at NORC, which shows average premiums for silver level plans available in marketplaces this year in four states that had final rates available for him to look at and how they compared to last year. It also computes average deductibles. In this analysis, the 2015 premiums declined in two states from 2014 and increased moderately in one state, Nevada, and less moderately in Minnesota. These are patterns that we are seeing across the country. If you look at the last three columns on the slide, there are similar changes in average deductibles. So in Minnesota, where premiums rose somewhere more than other states, if you look at the average deductibles in that state, they actually fell by the same amounts, with an increase of premiums of 14% and a decline in deductibles of 14%. Its also really important when you look at this rates to keep in mind that these are non-subsidized rates. So in Connecticut, for example, if you look at the second row in the slide, a 40 year old man making $18,000 a year would receive a tax credit of about $270, which reduces his premium to about $65 for the plans that are shown on the slide.

So how do we evaluate the affordability of these plans in premiums and their potential out of pocket cost for people? One way is to look at how they compare to what people pay when they are enrolled in plans through an employer. So in the Fund's Affordable Care Act tracking survey that we fielded at the end of the open enrollment period this year, we asked people with both marketplace plans and employer plans, how much they paid in their premiums. So adults with incomes under 200% of poverty, which is again, just under about $30,000, with marketplace plans paid monthly premiums that are comparable to those paid by adults with employer based coverage. So this indicates that the marketplace premium subsidies this year helped equalize the affordability of individually purchased plans and employer plans. This was not the case prior to the Affordable Care Act going into effect when people in this income range were effectively shut out of that market because of the -- of how expensive the plans were. But as you go up the income scale, the tax credits decline and people pay more of their premium for the marketplace plans. This is not the case for employer plans. Most people who have employer based plans pay the same amount regardless of what their income is.

We asked people in the survey with marketplace plans and employer plans, how easy it was or difficult it was to afford their premiums. People with lower incomes, with marketplace plans, reported finding it easy to afford their premiums at similar rates to those who had employer coverage. But people with higher incomes were significantly less likely than those in the same income range with employer based plans, to say it was easy to afford their premiums.

We also asked people about their deductibles. As I mentioned, people with incomes under 250% of poverty who purchase a silver plan are eligible for subsidies that lowered their deductibles and their co-pays. So in the survey, adults with incomes under that income range, with marketplace plans, had deductibles that are comparable to those in employer plans. Adults with higher incomes, if you look at the bottom set of bars, with marketplace plans, faced higher deductibles than people with employer based coverage. A new survey that Ed mentioned that is in your brief, it features findings from a new

survey that we are doing on how affordable healthcare itself is for people. We are calling it the healthcare affordability tracking survey and again, we looked a people with all types of insurance coverage to get a read on what consumers in general are spending out of pocket for their healthcare. We know that in all types of insurance deductibles and co pays are rising and we want to know how these trends are affecting consumers. We asked people with private coverage -- both employer and individually purchased coverage, who had a deductible, how easy it was to afford it. 43% of adults with private insurance said their deductibles were somewhat or very difficult to afford. About three to five adults with low incomes and half of those with moderate incomes said their deductibles were difficult to afford. We also asked people whether their deductibles had affected their medical decisions. So whether they had done anything with respect to their healthcare because of the size of their deductible, such as not going to the doctor when they were sick, not getting preventative care tests because of their deductible. Forty percent of people with deductibles that were high relative their income said they had not gotten needed care because of their deductible. Just to wrap up, the marketplaces in 2015 are shaping up as stable and competitive; the premiums have increased this year moderately or in fact have declined in many states. The premium tax credits and cost sharing reduction subsidies were critical this year in reducing both premiums and deductibles for lower income families. But current trends towards high deductibles and co-pays across all forms of insurance may leave many people with high out of pocket cost burdens. The reforms of the Affordable Care Act are improving affordability and will help reduce underinsurance across the country. But the underlying rate of growth in U.S. healthcare costs, which drives growth in both premiums and deductibles will be a significant factor in consumer healthcare cost burdens over time. We are lucky to have Dan Durham here today, who is going to discuss some efforts under way to address that challenge. Thank you and I will turn this back over to Ed.

ED HOWARD: Great. Thanks very much, Sara. And let me give the merest of introductions to our very distinguished panelists. We are going to turn first to Dr. Meena Seshamani who directs the Office of Health Reform at HHS. She is a head and neck surgeon by profession and now she attends to HHS's reform implementation, including delivery system reform. Then we will hear from Dan Durham who as Sara noted, is from America's Health Insurance Plans or AHIP, he is the Executive Vice President for Policy and Regulatory Affairs. He has held senior positions at the Social Security Administration and at HHS and now he guides AHIP's reform and policy efforts.

And the final speaker with be Professor Tim Jost from the Washington University School of Law. He is the author of highly respected text on health law, so as we say, he literally wrote the book. And he's also a consumer representative to the National Association of Insurance Commissioners and a prolific and insightful blogger and we are glad to have him back.

So let's turn first to Meena Seshamani from the Office of Health Reform. Meena, thanks very much for being with us.

MEENA SESHAMANI: Thank you for having me, it's a pleasure to speak with all of you today. So I thought what I would do is first go over kind of where we are on the eve of the start of Open Enrollment 2015 and then talk a bit about Open Enrollment 2015. So first again, looking at 2014 and then moving to 2015.

So first, just on basic facts about where we are today. So we are actually at 7.1 million Americans are enrolled and have paid their premiums. About 8.7 million additional people have come in through Medicaid and CHPs since October of last year. Importantly, one of the things that we learned through outreach in 2014 was the importance of media enrollment events, having navigators and in person help and that generated calls. So the call center visits to Healthcare.gov, etcetera. So some lessons that we learned in 2014, which we are applying for this current open enrollment period -- first the combination of paid social earned media, grassroots outreach, all of those things together drive enrollment, particularly when you have key dates and messages that are reinforced across all of these channels. And what are some of those key messages? Well, talking about testimonials. People who have successfully come in, been able to get insurance, are happy with their insurance. Deadlines. People respond to deadlines. And also talking about affordability and particularly the availability of premium tax credits. The majority of people who come into the marketplace. Also of importance is follow-up. Making sure that we chase people who do come into the system using digital media and again, focusing on regions, local partners, because that is where people tend to obtain much of their information.

So now just some basics on the Affordable Care Act, where we have come to date. And we tend to look at evidence that the ACA is working across three buckets -- affordability, access and quality. So I will walk briefly through each one. First, the ACA is making healthcare more affordable. Consumers have saved nine billion dollars since 2011, part of this is through the medical loss ratio provision that requires that 80% of premiums be spent on medical claims as opposed to administrative costs. And if not, families get a rebate. The average rebate in 2013 was $80. We have talked a bit about the premium tax credit. In the last open enrollment, nearly 7 in 10 consumers who selected plans, got covered for $100 a month or less and nearly half, it was $50 a month or less. Employer premiums grew just 3% in 2014, tying it with 2010 for the lowest on record for more than a decade. The law is also making coverage affordable to small businesses with tax credits and through changes in the rating, to prevent a small business from having a large premium increase if one of their employees falls ill. Importantly, hospitals will save an estimated 5.7 billion in uncompensated care this year and particularly in states that have expanded Medicaid, but also in other states as well. Again, harkening to the improvement in coverage. In terms of accessibility, the *New England Journal of Medicine* found that there were 10.3 million fewer uninsured Americans since the start of open enrollment which was a decline of 26% and along with accessibility in terms of being able to obtain coverage is the choice that you have and in 2015 there are 25% more issuers selling health insurance plans in the marketplace in 44 states.

So along with choice, another aspect is what kind of coverage is able to be obtained and now 76 million Americans are eligible for preventive services, vaccines, cancer screenings, wellness visits, without cost sharing, including 30 million women and 18 million children. And again, talking about what coverage people are able to get, you know, there are no exclusions for pre-existing condition, no lifetime limits on coverage, which are also significant consumer protections.

Here, this is talking about Medicaid expansion, so as you know, it is a state option, this is a map that provides you all of the states that currently have expanded Medicaid. Now, moving to quality. To cite the Commonwealth Fund, the survey showing that more than three in four newly insured consumers expressed satisfaction with their coverage and there has been significant work towards improving access to quality -- quality care for Americans including reducing harm nationally, such as fewer healthcare associated infections, which leads to not only better health but also reduced cost in terms of treating those complications. One hundred and fifty thousand fewer unnecessary hospital readmissions, movements in the electronic health record sphere with now 75% of eligible professionals and 92% of eligible hospitals involved. And also demonstrations such as accountable care organizations where providers have benchmarks on quality, patient experience and on how they are able to more efficiently use resources. And these have saved $372 million dollars.

So now I will turn to talking about open enrollment in 2015. As you probably all know, it begins November 15th, tomorrow, and ends February 15th. If someone enrolls by December 15th, their coverage will start January 1st. This year, importantly, we will be focusing both on re-enrolling consumers from 2014 as well as enrolling new consumers for 2015. And just to note that in Nevada and Oregon, consumers will have to come back in because they switched.

I think Dr. Jost is going to be talking more about renewals and auto enrollment, so I will go ahead and kind of gloss over these two slides a bit more, but basically they are a series of notices. We are encouraging people to come back and shop. As I mentioned, 25% more issuers means more choices for people to be able to find a plan that fits their budget and their needs. And that is really one of our driving messages for people. And we have a fact sheet with five steps to staying covered, again, to encourage people to come back in, update their application and shop for a plan.

So just a little bit on our resources for open enrollment in 2015. As I mentioned, in person help is critical and building the assister community is very important. There assisters available in every state to help consumers get help when they are applying for and choosing new coverage and these assisters consist of navigators, non-navigator assisters, in which you are just getting funding a different way, certified application counselors and agents and brokers. And for 2015, HHS awarded 60 million dollars in navigator grants to 90 organizations and were actively recruiting certified application counselors. Especially those with bilingual capabilities, we want to make sure that we have good language access and as some of you may have seen, recently Experian

language line went online with access to 200 languages. And we have a sister training available at our website.

Just a little bit on other aspects of our education, it is important not just to have people come in, shop, get a plan that suits their needs, but also to educate and assist in terms of how they can best use that plan and that is what coverage to care is. It's an initiative designed to help people with their new health coverage, because as you can imagine, a lot of these people may not have had health coverage before and are not familiar with terms like co-payments and deductibles and co-insurance and what is a primary care physician. So this initiative helps them to understand their benefits, connect with a primary care physician, understand which preventive services are right for them, there are written resources, videos, and we also have information online.

So very briefly, just some things of what is new in 2015 as some of you may have seen, the window shopping is live. There is a streamlined application. It's simple. Consumers only have to enter information once and it saves the data as the consumer moves through. Now there are fewer screens. Last year there were 76 screens that many consumers had to go through. Now, it could be only 16 and it's more intuitive.

The small business health options program is coming online as well, available to employers with 50 or fewer employees. This offers a choice of plans to help with making informed choices and also a small business tax credit is available worth up to 50% of employers premium contributions.

And so just some parting things: 4/20/15, the renewals and auto enrollments is certainly a large focus for us. Again, the increased choice I think is key. Provider network transparency didn't get a chance to talk about it much here, but when people shop for plans, there will be a link for them to look at the provider directories. The coverage to care I talked about and also with tax season coming up, one of the things that will be coming into effect is the shared responsibility fee. Thank you again.

ED HOWARD: Okay, thanks very much, Meena. We will turn now to Dan Durham from AHIP.

DAN DURHAM: Thank you. Well, good afternoon and thank you Ed and Sara. I look forward to talking about where we are in terms of results and expectations and hope to have a lot of good questions and discussion among the panel members today. I will focus on health plans' top priority -- delivering value to consumers. American families want value for the money that they spend on their premium dollars. They want affordable, quality coverage. And they want choice. Bronze to Platinum, tailored networks, to broader provider networks. Health plans are delivering what consumers want in a very competitive market. They are delivering affordability, value and choices that meet consumer's needs. Health plans are delivering value by negotiating the best price for healthcare services and by collaborating with providers to ensure quality care. However, there are some major challenges in health plan's effort to deliver value to consumers. The

most significant challenges arise when the market for services is not competitive. For example, while the rhetoric behind hospital consolidation is about efficiency, the reality is higher prices for consumers. The FTC has been very clear on this. It has had many studies in peer reviewed journals. Robert Wood Johnson Foundation Study found that consolidation trends increase cost by as much as 20% with no countervailing increase in quality. Another significant challenge, high priced specialty medicines that have no competitors. No leverage for health plans to negotiate a lower price for consumers. The latest to hit the market is [unintelligible] at $1,125 a pill. $95,000 for a 12 week course of treatment for hepatitis C. Reasonable incentives to develop more effective medicines are appropriate, but $95,000? Really? Is that reasonable? With many higher priced specialty medicines in the pipeline, this is clearly not sustainable for consumers that depend on Medicaid, Medicare and private health insurance. In a 2008 Health Affairs article, Joe Newhouse and Richard Frank called this type of pricing, "patent protection on steroids". Their solution? Binding arbitration. What is Pharma's solution? Put price controls on other stakeholders and ignore the price of the drug and their responsibility. In fact, the ACA includes limits on what consumers have to pay out of pocket. Today, 6% of $95,000 is what a consumer enrolled in the silver plan, pays out of pocket for a 12 week course of [unintelligible]. The plan pays 94%. Individuals with incomes of $17,500 or less, pay 1%. The plan pays 99%. Why? Because the average maximum limit on cost sharing for silver plans is $5,730 and its $1,100 for those with incomes of 150% of the poverty level or less. Clearly the reform market limits consumers' out of pocket expenses, but it does not protect them from monopolistic pricing that drives up their premiums. So what is the real problem here? The cost sharing or the price?

Well, despite these significant limitations for the markets that are not competitive, health plans are doing all the can to deliver value to consumers. We all agree that we have to stop paying for volume and start paying for value. And that is exactly what health plans are doing. This consumer driven value oriented market is here to stay. Forty percent of health plan payments are now tied to value and this percentage is continuing to grow. The breadth of innovation is considerable with our health plans. You can see it on this map here. Across the nation, health plans are driving innovation to deliver value to consumers. We are building on this tool, this map, so that policy makers, reporters and consumers can see what is happening in their markets.

So what are the results? This slide provides a few examples about how health plans are delivering value to consumers and we have many, many more. Medical homes. Anthem's patient centered medical home program has resulted in a 15% reduction in medical and pharmaceutical costs and quality of care was maintained or improved. Care First has lower hospital admission rates and significant overall savings. Accountable Care, Aetna's collaborative Accountable Care relationship with Nova Health, which is a physician association in Maine, has improved quality care at lower cost. Forty-five percent fewer hospital admissions and 56% fewer re-admissions. Cigna's programs across two dozen states are seeing lower cost and fewer emergency room visits. And with oncology, United's bundled payment -- their approach saved 33 million dollars without any reduction in quality. And importantly, we are helping patients engage with their care. We

have cost calculators that help them compare the cost of procedures and the quality of those providers that provide those procedures. We have mobile applications that provide important user friendly healthcare information to consumers. These efforts and many more, drive value by providing consumers with the tools and resources they need to make informed decisions. And we are delivering value and choice to consumers through health plans competing on the exchange. The results? High consumer satisfaction. Just look at today's Gallup pole. And clear choice in high value networks, designs that meet the needs of consumers. According to McKenzie, 90% of individuals have access to broad networks and 92% have access to more tailored networks that deliver quality care with significantly lower premiums. Do we want to take that choice away from consumers? Well, they just did in South Dakota, where a physician owned specialty hospital succeeded in passing a ballot initiative on any willing provider. This destroys the value proposition and the FTC has been very clear. AWP laws harm consumers. Health plans are focused on five areas to bring even more value, affordability and stability to consumers. First, ensuring providers have access to the right information to make the right decisions for their patients. We need effectiveness and value data that all stakeholders can use. Second, alignment and integration across the entire system from partnerships with providers, to removing unnecessary barriers to care from high quality providers. Health plans are leading the way and we are building on what works. And then third, transparency. The only way for all of this to work is if we give consumers and providers access to the best information to make informed decisions with their care. So in conclusion, we have come a long way since the pass of the ACA four years ago, but we have a lot of challenges ahead of us. Health plans are doing their part to be leaders and innovators to meet these challenges. From provider partnerships to equipping consumers with critical tools and to innovative deliver models. Health plans are changing the game of healthcare delivery to bring value to consumers. That is the bottom line and that is what we will continue to do. Thank you and I look forward to our discussion.

ED HOWARD: Okay, thanks Dan. Let's -- if I can trouble you for the clicker, it will allow Professor Jost to move his slides along. We will turn to Tim.

TIM JOST: Thank you and thank you for inviting me today. I think you will be able to tell by looking at the slides which of us work for the federal government or major corporations and associations and which of us work out of a little office off our bedroom. Tomorrow, the marketplace will open its doors for 2015. The door will stay open through February 15th. During this three month period, it is hoped that three to five million Americans will sign up for coverage for the first time. It is also hoped that most of the seven million Americans currently covered through the marketplace, will re-enroll for the second year, making a significant further dent in the number of Americans who remain uninsured. And I just say that the numbers that I have in the slides are from the CBO report as you -- I'm sure you noticed the ASPY put out a report this week with somewhat lower numbers. The re-enrollment process will vary somewhat between the federally facilitated exchanges and the various state marketplaces. Those covered through the federally facilitated marketplace should by now have received a redetermination notice from CMS. This notice will be worded somewhat differently depending on the situation

of the enrollee. Those who receive tax credits for 2014 and authorized access to their 2013 tax returns, will, if those tax returns do not disclose an income close to or above the eligibility level, be encouraged to return to the exchange and update their eligibility information. If people do not return and update, they will simply receive the tax credit in 2015 that they received in 2014, which will in turn be based on their 2012 tax returns. Enrollees should also by now have received a second notice from their insurer advising them to re-enroll for 2015. In most instances it will tell them that they will be enrolled in the same plan that they were in for 2014 or a similar plan, if they do not go back to the marketplace and choose a different plan. 2014 enrollees should return to the marketplace for 2015. First they need to make sure that their eligibility information is up to date. Over the course of the year, there may have been changes in their income or household composition and these need to be reported. Moves, qualification of the household member for other health coverage and changes to immigration status or incarceration of household members should also be reported. If further changes are expected in 2015, these should also be disclosed. Although 90% of the information on the online reapplication form will be pre-populated, enrollees need to check every item on the form to make sure everything is up to date. Enrollees who fail to return to the exchange may well receive smaller advance premium tax credits than they are entitled to in 2015 if premiums may have gone up more than income. On the other hand, enrollees who have seen large increases in their income or who have had members of their household move out or age off of coverage may receive more in tax credits that they are entitled to and may have to pay back sizable amounts when they file their taxes in 2015. Enrollees should also return to the exchange to shop for plans rather than simply being auto enrolled in the same plan. The total number of insurers offering plans in the marketplace, as we have already heard, is increasing by a quarter with new entrants in three quarters of the states. As we have already heard, premiums are going up significantly for some plans, but remaining stable or even dropping for others. Advanced premium tax credits are based on the cost of the second lowest cost silver plan, but the plans that may have been the second lost cost or lowest cost plan for 2014, may cost significantly more in 2015, while other plans may cost less.

Of course premium tax credits are not the only consideration that re-enrollees should take into account. Cost sharing is also important, as Sara has said. Those with incomes below 250% of poverty, who qualify for cost sharing reduction payments, must purchase a silver plan, even though it costs more, because bronze plans do not quality for cost sharing reductions. More over, some insurers are offering plans with basic benefits outside the deductible, that offer much more value to those who need little care and consumers should be looking for these. Consumers shouldn't just assume that they need to pay $2,000 - $4,000 before they get anything at all. It is also hoped that information on networks and formularies will be better this time around and consumers should consider carefully whether they do better with a plan with a narrower network that is less expensive or with a more comprehensive network, which is likely to cost more. Of course, an enrollee who wishes to stay with the same plan can do so. Simply entering the plan number that will be included in the re-enrollment number notice from the insurer when they go online to update their eligibility information. It is vitally important that

enrollees return to the marketplace within the first month of open enrollment, by December 15th to update their information and re-enroll, to ensure that they have continuous coverage beginning on January 1st for 2015. But enrollees can change plans any time up to February 15th, when open enrollment closes or even beyond that if they qualify for a special enrollment period. As we have already heard, the enrollment process has been significantly streamlined for most enrollees and should go much more smoothly this time around. But much of the low hanging fruit has already been plucked and new enrollees will be harder to find.

A recent Kaiser Health Poll found that 90% of the uninsured were unaware that the open enrollment was opening again this month and two thirds of them knew little or nothing about the health insurance marketplaces and over half didn't know that they could get financial assistance through the marketplace. Many will face language barriers and we may well face some more hostile political environments following the election where negative messages have dominated the airwaves. It's rare that you have to go out into a market to sell a product with a torrent of advertisements opposing your product. One factor that should not, and this is important, should not deter new enrollees from enrolling or old enrollees from re-enrolling is the Supreme Court's grant of certiorari this week in the King case. If the court invalidates the IRS rule, allowing federal exchanges to grant premium tax credits, its decision will only have perspective application. Individuals enrolling now will not have to pay back credits that they receive before the court reaches its decision and I quote from a recent Supreme Court case, "The Internal Revenue code gives the commissioner discretion to decline to apply decisions of this court retroactively." Most individuals with offers of employer sponsored coverage will not have the option of choosing premium tax credit financed coverage instead. Some low wage employees for whom coverage is not affordable, however, or employees who are offered coverage that does not meet minimum value requirements, such as not covering hospital services -- and we got a clarification on that last week, may be able to choose marketplace coverage instead. Other employees are able to choose among plans through a private exchange. Still others are offered employer coverage but may be eligible for Medicaid or their children may be eligible for CHP. Employees of small employers that sign up for the shop exchange will be able to offer employee choice in 2015 for the first time in many states. And employees must also then carefully consider a coverage that offers them the maximum value.

While progressives often focus on access as a key value in health policy, conservatives and libertarians often focus on choice. The Affordable Care Act not only offers healthcare access to many who previously lacked it, but also offers unprecedented choice. Consumers must be informed and educated, however to fully exercise their choice opportunities and to exercise them wisely. Thank you.

ED HOWARD: Great, thanks very much, Tim. Even those of us who have a pretty good understanding of how insurance works, sometimes get confused with all of the different factors that are involved in all of this. Well, I really appreciate the panelists putting it in words that most of us can understand anyway. And I would ask that you now join the

conversation. Those of you closer to the front are going to find it easier to maneuver your way to one of the microphones that are up front here. There are also, I remind you, the green cards in your packets that you can write a question on and it will go forward. And before we go to that portion, I wonder if we could just go back to something that was mentioned in Meena's presentation at least briefly and then Tim, you talked about it is well, that is the redetermination process. We are talking about figuring out for people who are already enrolled and getting federal tax credit that lowers the cost of their premium, what the next year's cost is gonna be and what the impact that is going to have on their spending. How important is that and what kinds of advice can you offer to those in that situation? You talked a little about second lowest silver plan that might not be the second lowest silver plan. Who cares about that?

TIM JOST: Maybe I can respond briefly and Meena can supplement. The premium tax credit is -- the formula is basically that you look at a person's modified adjusted gross income and then depending on where that lies on a scale between 100% and 400% of poverty, they have to spend a certain percentage of that on their premiums before they get any help through the premium tax credit. The amount they get though, however, is usually not based on the actual premium they pay, but on the premium of the second lowest cost silver plan that would be available to them in their geographic area, given their family size and the ages of their family and whether anybody smokes. Actually smoking is not a factor. And so if you were in the second lowest cost silver plan this year or the lowest cost, you would be getting maximum assistance. If however, you were in the second lowest cost silver plan this year but your premiums went way up, and its no longer the second lowest cost silver plan or someone else has undercut the premiums of the plan you are in and it is now the second lowest cost silver plan. Your share goes up, the share that is covered by the premium tax credits goes down and so it's really important -- now, it may be that people want to stay with their plan and it may be that the difference is not that great. But it is a factor that people should be aware of so that people can maximize the amount of tax credit that they receive. We all like to get big tax subsidies, right? And also minimize the amount of premium they have to pay.

ED HOWARD: Even if you have a plan that you liked and it worked for you financially, last year, you really should be going back to shop to see what is available this year.

TIM JOST: Yes, I mean you may decide to stay with the plan and there are of course other considerations -- cost sharing networks, formularies, service, quality, but at least it's a factor people need to take into account.

ED HOWARD: Yes, go right ahead.

AUDIENCE MEMBER: I'm Dr. Carolyn Poplin, I am a primary care physician, I'm also a Medicare beneficiary. For Dr. Seshamani and Mr. Jost, you have all been talking about choice and this wide choice that consumers have. Now, Part D gave consumers a lot of choice and what studies have shown is that consumers don't know what to do with

the choice, that they are bewildered by more than three or four choices. If you look at the Federal Employees Health Benefit program, which I am also on, there is also a choice there and in fact I think most people stick with what they have because it's just too complicated to deal with all the choices. And have you factored this into the way you are going to roll out the plan or help consumers or in the design of how the market place is, set these choices up for people? In healthcare, choice of provider works very well, choice of plan has not worked very well, at least in those two instances.

TIM JOST: Well, there is a couple of different ways of addressing that. One is to either standardize -- well, to standardize plans and some states have done that. So that it -- and of course the Affordable Care Act went a long way towards standardizing plans by at least coming up with a minimum benefit package and standardizing cost sharing by middle level. You can imagine what it would be like if every insurer could come up with any kind of cost sharing combination and any kind of combination of benefits, we would be looking at tens of thousands of plans. But at least it's standardized to that extent and some states are going further and standardizing. The other approach, however, would be to come up with tools that help consumers shop. And Consumer Checkbook of course has a tool like that for the federal employee's health benefits program. They have developed a tool that would work on exchanges. I have heard of other companies that are looking at that kind of tool. And I think that would be tremendously beneficial to consumers, if you could simply put in -- you know these are the kinds of drugs I'm using, these are the providers I use, these are the kinds of costs I expect to incur over the next year. These are conditions I have. And then it could direct you to three or four plans that would be best for you. So I think this is an area where we need to grow either in further standardization or in further shopping tools. But I agree, right now, 106 plans -- that is an evening's work trying to work through that.

AUDIENCE MEMBER: Even 46 plans.

MEENA SESHAMANI: But I think the point that you made about, there are these metal levels that divide out plans based on how much cost sharing there is, helps with that and being able to -- through the window shopping as Dr. Collins showed, being able to see in a standardized way and put plans up side by side to be able to compare I think is important. And lastly, one thing that wasn't mentioned is, in person assistance, call center, navigators and all of our outreach attempts to help people and all of the information available on the website through local partners and through the pharmacies, through physician's offices, I think all of those together can help with the consumer education as well so that the choices is a reality.

TIM JOST: And also of course, agent and brokers. A lot of them are out there to help and are eager to help.

ED HOWARD: And actually, that triggers a follow up, if I can. There have been stories in the national press the last couple of days describing the outreach effort that the administration is involved in as low key -- I guess, was the characterization. And being

done with fewer resources and I wonder whether you think those are fair characterizations and how are you trying to maximize the impact that you have?

MEENA SESHAMANI: I would say that now that we are -- we have one year of the outreach under our belt, we have learned from it, we are smarter because of it, we can target, we have relationships that were established last year that we can continue to utilize and leverage and build upon. And in my presentation I mentioned that one of the messages that works very well are testimonials. Well, we have seven million testimonials now. I mean, we have lots of people who have obtained coverage. To the Commonwealth Fund report, who are satisfied with their coverage. And these are all additional resources that we have this year that we didn't have last year, that we hope to leverage in conjunction with all of our partners.

AUDIENCE MEMBER: Carl Schmidt with the AIDS Institute. We have a question about transparency in formularies. You talked about the benefits, hopefully this year the transparency in providers and in your letter to issuers for 2015, you said that there would be -- every plan has to have a formulary with tiering, one URL and also on healthcare.gov website. So I have been using your great function this week, the shopping function. And some are really good, some were good last year. Some of the plans. But we are still finding a lot of them just go to the main website to get the formularies and we still can't find them. They still have 2014. And there is a better summary on the health reform, healthcare.gov, for each plan, for more plan information. None of them have -- that I have seen, have the formularies yet. It says, NA. I guess that means "not available". So I guess the question is, is this -- has this practice, this letter to the issuers, are you still going to be mandating that? We hope so, because patients really -- to make a choice, do have to get this information. I was able to ask someone from HHS the same question yesterday and they said, well it's up to the insurance companies as well. So I would also ask you -- they said that they are the ones who provide the information to put it online and you did talk about the need for transparency, so it is really a question for both you. Thank you.

DANIEL DURHAM: Thank you. Appreciate the question and health plans, when they submit their filings to HHS for review, have to fill out incredibly long spreadsheets that include all of the drugs that they have so that CMS can review that, check to make sure there aren't any outliers and ensure that it meets the requirements both in the statute and with regard to the regulations and other requirements that are placed on them through [unintelligible]. So health plans are doing that or they wouldn't get approved. In terms of access to those formularies, they have to provide that, either on their website -- and you mentioned some have very good search tools, or through other means. You know, sending out a paper copy and the like. That is very important to consumers to shop that kind of transparency. I will also add that I had the pleasure of working at HHS on the Part D program, the Medicare prescription drug benefit and I headed up several of the implementation teams and it was a challenge to get things to where they are today. And we have seen in states where they tried to put too many bells and whistles on their platforms, things didn't work. And so just like in the Part D experience, what works very

well today, I think we are going to see continued improvements in terms of what new features [unintelligible] and HHS will bring in over time, just like happened on Part D. So it's a work in progress, and it's only going to get better.

MEENA SESHAMANI: I think I would just echo that transparency is very important and so that is something that we will continue to work on.

ED HOWARD: Dan, your presentation mentioned that AHIP has been making a point of dealing with plans in the area of provider directories and we have been doing some programming on narrow networks in which the question has been raised about directories that are out of date, providers who were in the directory accurately but were stricken from the roles in mid year without the opportunity for the consumer to get out of that. Talk a little if you would about the steps that you have been taking and how much progress you think there has been from last year to this?

DAN DURHAM: Well, there has been a lot of progress there. Our plans are committed to transparency and we are committed to ensure that consumers know what they are buying and can figure out if their physician is in the network for the plan that they are purchasing. That button is right there on healthcare.gov where you can go to the directory, plans work night and day to keep those directories up to date, but there are challenges here. It's a two way street. Providers have to engage in this as well. You know, we have situations where some providers simply stop taking patients, but they don't inform the plan. We can't update the directory unless we get accurate information from the providers. That is critical too. So I think there is a role here for providers to engage to make sure that they are up to date as well so that health plans can label them correctly in terms of who is in the network and who is not in the network.

SARA COLLINS: I also wanted to add to that. So part of what people will be deciding this fall is whether to switch out of their current silver plan, if it's not the second lowest cost plan anymore and a critical piece of that decision is going to be whether the providers are in the network. And so, having that information correct is going to be -- its actually a really important part of the competition aspect of the marketplaces. So it's not -- we don't know yet how that's all going to play out, how many people are really going to switch, but people really need that kind of information to make informed decisions about -- based on price, knowing whether their same network of doctors is going to be available at another plan.

DAN DURHAM: That is a very good point, Sara, and we agree and just last month we put a consumer guide to networks out. You can find it on our website. We put a lot of time and effort in this. We have worked with literacy experts, we worked with consumer groups, it's a very helpful guide and educational tool that consumers can use when they navigate different plans network configurations. And it provides them with the kind of information they need to make sure they are making the right choice. And we will continue to focus on transparency because consumers have to know what plan is best for them. It's the whole part of value and making sure consumers get the care they need.

TIM JOST: I would just add quickly that the National Association of Insurance Commissioners is currently reworking its model act on network adequacy, which includes addressing the question of provider directories and they have been holding two and a half hours of conference calls every week, which I think is unprecedented in my experience. So I think the state regulators who are ultimately responsible for this are very aware that there is an issue here that needs to be addressed.

ED HOWARD: Commercial alert -- the Alliance will be holding webinars, specifically looking at the soon to be -- actually in draft one, already has been released, new model regulation that the NAIC is developing in the area of narrow networks and that is on the 18th, is it? 19th. You will be getting a notification soon. Yes, go right ahead, ma'am.

AUDIENCE MEMBER: Good afternoon, my name is Rhea [name] and I am an attorney trying to break into health policy. My question builds upon several of the questions asked, but is specific to consumer confusion in anticipating their costs as it relates to the tax credits that they have been given. So as Mr. Jost mentioned, the Supreme Court did grant cert on this issue and while you and I and many educated consumers may understand what that means in terms of impact on the decision and when it will take effect, many other individuals may think, that means I don't get a tax credit. In addition to the fact that the data that they had with regard to their taxes may change. And so I was just wondering what the efforts were that have been made to address this specific issue.

TIM JOST: Well, I think there are representatives of the media in this room and I hope they help get this message out, that the effect is going to be perspective rather than retroactive. People should go ahead and enroll. As to what the Supreme Court will do, I'm hoping that obviously, that they conclude that the IRS has properly interpreted the statute and that solves the problem. If they don't, there are very serious problems that face not only millions of Americans who receive premium tax credits now and who would lose those, but really the non-group market in two thirds of the states. We could, because of all of the carry on ramifications of this decision, I think it's not just low income people, it's not even just moderate income people who could lose access to health insurance, it's virtually anybody who purchases health insurance that they don't get through their employer or government program. And I think it's very important that people understand that this is very serious business. There is no easy fix. The administration I believe has improperly interpreted the statute, but if the Supreme Court disagrees, this is going to be a national crisis, which I think Congress will have to fix.

SARA COLLINS: If I could just follow up on that too and just ask Tim to comment on -- there has been a lot of talk about states just -- if the decision were to go in favor of the plaintiffs, that states could just -- that federally operated exchanges could just go ahead and set up their own marketplaces.

TIM JOST: Well, how much time do we have? I mean, in the first place, that is not -- it would take legislation, it would take probably legislation -- some states it may be able to

be done by an executive act, there are a few states in which that has already been done. But states would have to affirmatively embrace setting up their own exchanges for that to happen. Secondly, under current regulations, a state has to give the federal government six and a half months notice before it sets up a state exchange and under current guidance, it has to do it by -- really by the first of May and have it approved by June 15th. So if a state -- if the Supreme Court delivers its decision at the end of June, it would be 2017 before states could get state exchanges online.

AUDIENCE MEMBER: So the first question is, where do those million people go that have left the exchanges and a second question, which is kind of related is, the network adequacy -- how confident should I be that if I sign up for 2015, the network that Aetna or Cigna or Blue gives me now, will be exactly the same all the way through 2015 or will doctors get fired or drop out? Thank you?

TIM JOST: Well, some of them may die.

ED HOWARD: What are you going to do about that, Meena?

TIM JOST: I think the reduction is pretty obvious; that any insurance company is going to have attrition over a year and I think actually a 90% retention rate is pretty good. And also, you have people who get a job, they get employer coverage, you have people who lose a job, they get Medicaid, there is just a huge turnover over the course of a year. And I was frankly surprised we still had 7.1 million in. Of course there are new people coming on too, but I think that is a very good retention rate. And in terms of providers, I mean, that is a problem now with employer plans too that have networks. It's a problem with any network. And you can't be for sure that your doctor is going to be there.

MEENA SESHAMANI: I would just add that the 8.1 million and the 7.1, it's not the same group of people. Insurance is constantly -- it's dynamic. People come in and buy -- people leave, people get married, they get divorced, they have children, they get a job -- there are any number of reasons that it would lead it to a natural turn in the marketplace. So it's not that you had 8.1 million and then a million people left and you ended up 7.1 million, because the composition could be different because of all of these different factors. So that is the one point that I would add.

SARA COLLINS: I just wanted to follow up on that question too, with what we are projecting this year, to understand -- both Tim and Meena mentioned the numbers of people that are expected to enroll this year and what the total number will be and I think ASPY put out an estimate of nine to ten million this year and I wondered if you could just unpack that a little bit and what that is comprised of.

MEENA SESHAMANI: Sure. Since we had experience from this past year, there was some data that could be used to be able to look at, of the addressable markets, so you have people who are currently enrolled and then you have people who would come in as newly enrolled. And for the newly enrolled, we are able to take the experience from this

past year in terms of take up rates of percentage of people with various characteristics that took up coverage, to be able to get a sense of how many people may come in newly enrolled. And from the re-enroll population, there are several estimates that are out there including from the issuer industry and we were able to use that to get a sense of how many of the people currently in the marketplace would stay in the marketplace and basically those two figures together give kind of a bottom up approach to give a sense of what may we be expecting this year using data that was not available when initial CBO estimates were done. The other way to look at it is that you have a market that is growing and there is a ramp up that is associated with the growth of any market and from experience with CHIP and with the Medicaid expansion, you know, if you moved from a ramp up of three years to a ramp up of five years, that leads to a different trajectory and doing each of those approaches kind of leads you to the same place in this nine to nine point nine million range.

AUDIENCE MEMBER: Joyce Friedan, *MedPage Today*. As you all are aware, the open enrollment last year went -- among the state run exchanges, went better in some states than in others. In Connecticut it went really well and in Maryland, not so much. So I wondered if the panelists could talk about particular states that they might be looking at and what would be signs that enrollment is going better than before?

TIM JOST: It's got to be better in Oregon. They have switched to the federal exchange as has Nevada and Maryland has, I understand, picked up the Connecticut website, so I think there are some states where we will clearly see improvement, but there are -- we will have to see.

ED HOWARD: There is a related question on a card that the panelists might want to address and the specifics of the question are -- have to do with the re-enrollment process, but I wondered more broadly what the application and the principle is. And that is, is that re-enrollment process going to look the same in a state operated exchange as it will in the federally facilitated ones? For example, are they going to use auto enrollment? Tim was describing the sequence of how and when one would have to re-enroll in order not to be automatically re-enrolled. Are all of the state exchanges going to do the same thing? Are they required to do the same thing? How many of the federal rules apply to them?

MEENA SESHAMANI: State exchanges can do their re-enrollment differently. Basically in our regulation on this issue, states can provide their information on how they would like to do it and get people to do it that way. So --

ED HOWARD: Okay.

TIM JOST: And some states, as you said earlier, everybody is going to re-enroll?

MEENA SESHAMANI: Correct, Nevada and Oregon.

SARA COLLINS: I have a question from the audience about, what is contributed to what we are seeing in premiums this year? So why is it that premiums have increased moderately, and so many states have actually gone down in states? What do we think is driving that -- those changes? Even if you look at employer based plans, if you even want to take a little bit more broadly, we have also seen a great moderation in premiums in employer based plans. So maybe Dan would like to address that?

DAN DURHAM: Sure, there are a number of underlying influence when it comes to premiums. I talked a lot about it in my presentation and others where there is substantial provider market consolidation and plans are unable to negotiate better rates for their consumers. You tend to see a correlation in those areas where there isn't market competition among hospitals, you have higher premiums. And that situation has to change if we are going to deliver a value to consumers. So that is part of the equation. It goes right into the underlying cost of care, similarly with prescription drugs. I mean, we look at Sovaldi, which came from Harvoni -- plans had to submit their filings and rates back in the spring of 2013 and health plans are competing. They are competing based on value and value comes from low price, high quality. And that is why we have choice in this marketplace, because competition helps consumers. So you do see variation by state. You see variation within the 501 market areas across the country because of these different types of factors that go into a premium rate setting.

SARA COLLINS: I guess I would just follow up too and ask Tim this, how important we think that the risk adjustment and risk -- the three R's -- the reinsurance risk corridors and the risk adjustment provisions in the law have been in keeping premiums moderate this year.

TIM JOST: Oh, I think they have been very important. And quickly, the re-insurance program provides re-insurance for high cost cases for any plan in the individual market. The risk adjustment program moves resources from plans that end up with a low risk population to those with high risk population and then the re-insurance provides kind of a fly wheel so that if one plan gets their premium way off one way, then they may either compensate or be compensated by plans that got their premiums off in the other direction. But I mean I think, Dan said this, that last year health plans were kind of throwing a dart at a wall. They didn't know exactly what the population was going to be that would show up and who they would end up insuring and some big commercials didn't enter the market under those conditions. This year we are having a number of big commercials entering lots of markets and that is increasing competition but at the same time, some plans that set their premiums too low last year are raising those. So there is a tremendous amount of movement in the market and it's again, very important for consumers to go back and shop to make sure that they know where their plan is at.

AUDIENCE MEMBER: Jeff Fershedi here, *Healthcare Lobbyist*, I had a question for you Meena, again on the coverage numbers. Your slide suggested roughly seven and a half million people enrolled through exchanges, roughly eight and a half million newly enrolled through Medicaid and then the later slide suggests only 10 million newly

covered individuals, the *New England Journal* reference. What happened to the six million people? Were they previously insured and headed to the roles of the uninsured or is it described through [unintelligible] -- can you fill in the blanks on the coverage?

MEENA SESHAMANI: Sure, part of it is that that ten million number is not as recent as the other numbers that I provided, but also there are various aspects of the insurance market when you include employer sponsored coverage, etcetera, that could be playing a role, but I think probably its just that there is a difference in timing of the numbers.

AUDIENCE MEMBER: So it would be accurate to say that 16 million people were benefited by the ACA in terms of acquiring coverage? Or maintaining coverage?

MEENA SESHAMANI: I would venture to say that far more than 16 million people benefit from the ACA because there are so many other consumer protection provisions that affect people who already have insurance, get insurance through their job, etcetera, so I think it's kind of -- you know, I would not -- I do not think just the number of people enrolled in the marketplace, that is not the one and only measure of success for the Affordable Care Act. I think it is much broader than that and I think looking at, for instance the drop in uninsured is important just because that takes into consideration that there are many other ways that people are obtaining insurance as well.

SARA COLLINS: And I will just follow up on that too. In the Commonwealth Fund surveys, we ask people with both marketplace plans who newly enrolled and who newly enrolled in Medicaid and about 60% of people with new plans had not had health insurance before they enrolled. So that gives you a sense of the share of the people who were without health insurance before enrolling.

MEENA SESHAMANI: Yeah, I mean that is the other good point is that some of these people had insurance before and now likely have better insurance.

SARA COLLINS: Right, so people shifted from individual -- a substantial share, probably 20% in some of our data, where shifting from employer based plans. So people do and I think that is -- right now we might see, during this open enrollment period, people who are also in their open enrollment period for their employers, may be looking at whether or not they are paying a lot in their employer based plans and decide to check out the marketplaces and see what is on offer in the marketplaces and if they could in fact be eligible for a tax credit if they are paying too much of their income for employer plans. So you might see some shifting and that -- from employer based plans this open enrollment period.

ED HOWARD: We have about ten minutes left and we are going to try to get to as many of the questions on the green cards that we have in front of us, as we can. I don't think we are going to succeed in getting to all of them. So if there is something that you have written down that you absolutely, positively have to have asked, you might want to repair to one of the microphones. In the meantime, let me just turn to one of these

questions. Meena, a lot of commentators and I think Tim mentioned it as well, have suggested that what happened last year was a fairly large enrollment of people who were motivated to get insurance for one reason or another. The famous low hanging fruit. So you might want to describe what, if anything, HHS is doing to reach and convince those middle hanging fruit people that they need to enroll as year two begins.

MEENA SESHAMANI: Sure. Well, with our very active outreach program, I mean, I think that there are still many people out there who are eligible for premium tax credits, who may be in plans and may not realize what opportunities are available. That we can reach. And so it comes back to some of the points I made previously, that we are working very closely with our partners, with local media, radio, TV, digital media, events, and also reaching out across provider groups, churches, I mean, any number of community organizations to really get the message out. And again, I think having had the experience of the first year and having a lot of people who are enrolled, who are happy with their plans, helps to get more people who may have been reluctant or hesitant or doubtful etcetera to see there are people like me who were able to get quality coverage and I think that that is a very strong message as well.

ED HOWARD: I wonder if the message is going to include at any level whether it's with your partners or with some of the work you are doing directly about the sticks as well as the carrots. We were talking to a member of Congress yesterday who pointed out that the penalty -- that is not the proper term -- the Supreme Court called it a tax, whatever the fee is, was going to go not to the $95 but to a maximum of 2% of the person's income if they didn't have insurance coverage. And I wonder if that word is getting out to people as a way of convincing them that they need to look seriously about getting insurance for the first time. Anybody talking about the carrots and the sticks?

TIM JOST: One thing I would say on that is, this year -- and I think Congress intentionally wrote the statute so that this would be an educational process. The first year you get a little tap, the next year it's a much bigger tap, and by the third year, it's a pretty big tap. But people are going to be getting their W2's in January, they are going to go start working on their taxes and they are suddenly going to realize sometime in February or March or April, that not only do they owe $95 or 1% of their income for this year, but they are also going to owe $325 per adult, almost $1,000 per family if it's a large family. And -- or 2% of their income above the filing limit for next year. However, the exchanges close their doors on February 15th. So people will not have a way of avoiding that penalty unless they qualify for a special enrollment period. I think that HHS had the authority to declare a special enrollment period for people who are going to owe the penalty for next year or who owe it for this year and to leave that open a bit longer. And I don't see how that would hurt anybody and I think it would be a way to bring a whole lot more people into coverage.

ED HOWARD: Is there something to consider in your deliberations at the Department? Yes, Carl?

AUDIENCE MEMBER: Carol Polzer, independent consultant. You answered half of my question. So, the IRS is really going to motivate a lot of the low hanging fruit. The way the law is designed and a lady in my church looks to me to be sort of a navigator. Because I know a little bit about health policy. He works for H&R Block and she says she hasn't received any guidance yet about, you know, this penalty or this thing that she is supposed to deal with. And I wondered how the IRS is going to deal with that on two grounds. One is, you already talked about that it might be easy on people, but there is a certain disclosure element of it. Is there going to be a box I'm going to check to declare if my coverage is creditable or whatever the word is? And then how is that enforced? Because certainly I will make a lot of mistakes. There will be a lot of people making mistakes one way or the other this year about -- what do you mean by this coverage? How are they going to enforce that? So what if I put the wrong information in there? On what basis would I be penalized?

TIM JOST: The forms are already online, the instructions for the forms are already online. The 1040 does have a box. You check that box if you have had continuous coverage and if so, you just proceed and if you haven't, you will fill out a form called an 8965, the instructions are there online and I have put up a couple of blog posts at Health Affairs explaining in some detail how it works. I think the people at H&R Block are very aware of this and if she hasn't gotten instructions yet, she will, because they are going to be major players in helping people understand how all of this works. They and Jackson Hewitt and Turbo Tax and other people. But its not easy and the first year its -- a lot is going to have to be taken on trust because we don't have employer reporting in place yet and there is some other issues.

ED HOWARD: How about health plans? Do they have any responsibility to notify their policy holders that yes, the insurance that you had from us qualifies you -- is a qualified health plan and meets the requirement of the statute?

DAN DURHAM: That comes from the exchange, so that is the exchange responsibility.

ED HOWARD: I see. Sara?

SARA COLLINS: I have a question on -- I had mentioned how important the deductibles are on my presentation and how important people put -- that people should pay attention to what the deductibles are like. Will consumers have access to the information that they need about the implications of cost sharing and provisions of plans available on exchanges? So will you be able to tell what your potential out of pocket costs might be over the course of the year, other than just the simple deductible or co pays?

MEENA SESHAMANI: So one of the provisions of the Affordable Care Act made requirements on the summary of benefits and coverage that health plans much provide and in that, they have to provide certain coverage examples that details out what are kind

of the costs you could expect and with the cost sharing in the plan that you are considering, what would your out of pocket costs be?

ED HOWARD: A shout out to the DC exchange, our operations director was pointing out to me this morning, they have a couple of very good examples in their materials of just what you were describing. How much is it going to cost if you have a baby in this period? How much is it going to cost if you are managing type 2 diabetes? That sort of thing. And it is very helpful to the people in our office in trying to decide as they did. We have come to the end of our time and I apologize to those of you who have written some very good questions that we haven't had a chance to get to. But there are a lot of questions in this area and we will try to keep up with this debate as it goes on and try to schedule programming that might be able to answer more questions. In the meantime, as you are putting on your winter coats to go outside also take out the blue evaluation form and fill it out if you will, to give us some feedback. Thanks to Commonwealth and Sara for putting -- helping us put together and being part of a very useful program and I would ask you to join me in thanking the panel for a very enlightened discussion.

[applause]