# Affordable Care Act 101: What You Need to Know

## Alliance for Health Reform

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**ED HOWARD:** If we can ask you to take your seats, we'll try to get started fairly close to on time. Good afternoon, everybody. My name's Ed Howard. I'm with the Alliance for Health Reform. I want to welcome you to this program on the basics of the Patient Protection and Affordable Care Act herein and after referred to, as they say up here on the hill, as the ACA, and I extend that welcome on behalf o Senator Rockefeller, Senator Blunt, our board of directors. We're very pleased to have us with us.

Now, you'd expect more than three years after the enactment of the law we'd be pretty familiar with the ACA whether the familiarity breeds contempt or commendation in your mind, but this law has a lot of moving parts, some of which because many of the provisions have been phased in over time are just beginning to move. So it's no surprise that most Americans, even a few LAs in occasional backwater office maybe don't know some of the important aspects of this law, and regardless of whether you love it or loathe it, your boss' constituents are going to have questions about it, and there will be activity, major activity, in your state and district because of the ACA. In fact, there has already been a lot of activity, and we'll hear a little bit about that later. So

we're very pleased to be presenting this primmer on the health reform law with our colleagues at the Kaiser Family Foundation.

Now, if you've done any work on the ACA, you've probably used the analysis that has been generated by the foundation. If you check your kits, you'll see a lot of KFF logos on documents, and that's because they do an incredibly good job digesting this complex law, tracking it, and translating its sometimes opaque provisions into actual English, and, in fact, one of the things we didn't do in the course of this program but I would commend to you is to begin to learn about this law by watching the nine-minute video on the KFF.org website narrated by Cokie Roberts. It's the best cartoon you'll see all week.

Now, this primmer is one of a series that we're pleased to cooperate with the foundation on. We've already done Medicare and Medicaid versions, and we're planning to do one later in the year on the subject of health care costs in general, and I want to thank the foundation, Drew Altman and of course Diane Rowland and her colleagues for their active involvement in this important work, which is a nice enough segway for me to call on Diane Rowland, who is Kaiser Family Foundation's executive vice president and a co-moderator of today's discussion. Diane?

**DIANE ROWLAND:** Thank you, Ed, and welcome to the ACA 101. Ed said we usually do a series, and for many years one of the series has been the uninsured as a 101, so I'm pleased that today, instead of talking about the uninsured as a 101 we're talking about a law that's been enacted to try and provide health care coverage to many of the uninsured.

I think that some of the other briefings we've done in the 101 series it's been hard to put Medicare into an eight-minute slide presentation. It's been hard to do that with Medicaid, but I think as you'll see today it's even harder to do that with the Affordable Care Act because it has so many parts and so many ways in which it is going to influence our health care system. So I think this should be a very good learning experience, and we'll see how all of our different panelists in their perspectives can help shed enough light for you to know what questions to ask and how to answer some of them in the future. So thank you for coming today, and let's get on to understanding the ACA a little better. Thank you.

**ED HOWARD:** Okay, thank you. I'm going to ask you the usually boilerplate. You know there are question cards you can use once we get to the Q and A. There are blue evaluation forms that we'd love you to fill out, but we have a lot to cover, and we have a lot expertise on the panel, so let's get started. We're going to have, as our first speaker, Jennifer

Tolbert. We've asked Jennifer to start us off with an overview of the reform law. She's director of the state health reform activities at the Kaiser Family Foundation, which means she's keeping track of how states are implementing the ACA among other things, and before the foundation Jennifer served as a senior advisor to the assistant secretary for the planning evaluation within HSS and with the National Association of Public Hospitals. So we're very pleased to have you, I think, on your very first panel with us.

**JENNIFER TOLBERT:** Yes. Great, well, thanks, Ed. I appreciate. Can you hand me that?

**ED HOWARD:** I'm sorry, yes.

**JENNIFER TOLBERT:** All right, well, as Ed said trying to describe and provide an overview of the ACA in five minutes or less is nearly impossible, so I'm going to focus on a few key issues, and I'm going to try to run through this really quickly because I know Mike Hash has to leave early, and I'm sure you all will have a lot of questions for him, but one of the main goals of the ACA is to expand coverage to those who lack coverage today and also to improve the quality of health insurance coverage for those who actually do have health insurance today, and it does this by building on the base of employer-sponsored insurance and then filling in the gaps that currently exist in our system. The ACA will expand Medicaid

coverage to low-income adults by establishing a uniform eligibility threshold across all states that will go into effect on January 1, 2014. In addition the ACA creates new health insurance marketplaces where individuals in small businesses will be able to go and shop for and enroll in private coverage. In addition subsidies, premium subsidies, will be available for consumers to make that coverage more affordable.

Now, all of this is made to work through health insurance market reforms that will prohibit insurers from denying people coverage or charging them more simply because they are sick, and finally there are new requirements on individuals to purchase coverage and on employers to offer affordable coverage to their employees.

So when we look at the uninsured, the nearly 48 million that are uninsured, the ACA will provide more affordable coverage options, and when we look at this population by income, we find that about 51-percent have incomes low enough that will qualify them for new expanded coverage through the Medicaid program. An additional 39-percent will be eligible for subsidies in the new health insurance marketplaces.

So with respect to the Medicaid expansion, as I said, the ACA fills in the current gaps in the program today, and it establishes a uniform eligibility threshold across all states

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of 138-percent of the federal poverty level. That translates to about $15,900 for an individual or about $32,500 for a family of four. Today the Medicaid program does a fairly good job of covering low-income children and pregnant women, and so what the expansion will do is extend that coverage to other low-income adults. The federal government will pick up a hundred percent of the cost of the new eligible population for the first three years of the expansion and will phase down to cover 90-percent of those costs by 2020.

So the Supreme Court ruling on the constitutionality of the Affordable Care Act issued last summer upheld the law, including the Medicaid expansion. However, it did limit the ability of the Department of Health and Human Services to enforce the Medicaid expansion. As a result it left the decision whether or not to expand the program up to the states. Currently 27 governors have indicated that they support the Medicaid expansion while another 20 have indicated that they oppose the expansion. This issue is currently being debated in state legislatures across all of the states, and I think it's going to be a few more months before we know whether or not states are going to move forward with the Medicaid expansion.

At the same time new health insurance marketplaces are being created across all states, and these are online marketplaces where individuals and small employers will be able

to go to apply for coverage to shop for qualified health plans using standardized information to select plan that are available to them and to actually enroll in coverage, and as I mentioned before premium subsidies will be available for individuals, lower income individuals, without access to other coverage who have incomes between 100 and 400-percent of the federal poverty level, and 400-percent of the poverty level is about $94,000 for a family of four, and these new online marketplaces through the streamlined application processes that will be available will screen people for eligibility for Medicaid, the children's health insurance program, as well as the premium tax credits.

So states have the option of running their own state-based marketplaces partnering with the federal government to run a marketplace, but if they choose neither of those options, the federal government will run a marketplace in that state. So to date 16 states in the District of Columbia have indicated they will be moving forward with running their own state-based marketplaces. Another seven states will be operating a partnership marketplace, and that means 26 states will be defaulting to a federally facilitated marketplace, but beyond the coverage provisions in the ACA it includes also a number of provisions that are designed to improve access to care as well as quality of care. So recognizing that there will be millions

of new people coming on to coverage beginning in 2014 the ACA seeks to bolster access to primary care by increasing Medicare and Medicaid payments for primary care and by enhancing funding for community health centers. It also coordinated primary care especially for high-need populations through the establishment of health homes, and it makes significant investments in workforce development to train and educate new primary care physicians and includes incentives to encourage those physicians to practice in underserved and rural areas.

In addition the ACA creates the innovation center within the Centers for Medicare and Medicaid services to test new innovative delivery system models designed to improve quality and to constrain cost growth. I'm not going to go into those models because Karen is going to cover that in her presentation.

So the ACA is paid for through a combination of federal savings, mainly through the Medicare and Medicaid programs as well as new revenues. Some of the savings provisions that are included include reductions in payments to Medicare advantage plans as well as limits on increases on provider payments to hospitals as well as other providers in Medicare and reductions in uncompensated care payments. The ACA also creates the independent payment advisory board, which is charged with

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developing recommendations for constraining per capita Medicare spending, if that spending exceeds targeted growth rates.

In terms of new revenues, the ACA imposes new taxes on health insurers, drug manufacturers, medical devices, and indoor tanning services. It also increases the Medicare tax for high earners, and in 2018 new tax on high-cost health plans will go into effect. So as we look to 2014 and the implementation of the coverage expansions much has been accomplished, but much work remains to be done, and with that I will turn it over to Mike and let him talk about that.

**ED HOWARD:** That seems fair. The aforementioned Mike is Michael Hash, who is the head of the HHS office of health reform to give us a sense of administrative activity related to the ACA, and as Jen alluded to, Mike has a late-breaking white house appointment that is going to require him to leave before this session is over, so we'll have a chance to ask a couple of questions after he's finished. Mike, thanks very much for being with us.

**MICHAEL HASH:** Thanks, Ed. It's a pleasure to be here and join this distinguished panel and to have the opportunity to talk to all of you about our work at the Department of Health and Human Services bringing the promise of the Affordable Care Act into reality. Now, if I'm doing this

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right, which I guess I'm not, of course I have it upside down. Hope that's not a harbinger of what's about to be said.

The first slide here really just gives you a little sense of where I'm going in the brief time we have together and what topics I want to address. Let me start out by saying clearly our goal in the implementation of the Affordable Care Act is to make sure that all Americans have access to high quality, affordable health insurance coverage. We've been hard at work since the enactment of the law back in March of 2010, and our work is certainly not alone. We are engaged actively with federal partners across the administration, which I'll talk about in a minute, and also with many private sector organizations who are anxious and willing to help with the implementation of the law.

It's always, I think, important when we start to talk about the Affordable Care Act and implementation that we remind ourselves of the many accomplishments that have already been put in place as a result of the law and are giving American consumers protections and rewards that they previously were unable to access. Just to tick off some of the more important what we used to call early deliverables in the Affordable Care Act include offering the opportunity for young adults to stay on their parents' policies as some 3.1 million Americans who were previously uninsured up to the age of 26 have now become

insured as a result of this provision. We have provided, because of the law, discounts for seniors who are in the Medicare drug benefit coverage gap, which is giving them discounts on their drugs and, as you can see from the slide, nearly six million dollars in savings averaging out to about $700 per beneficiary.

We have a large number of Medicare beneficiaries, 34 million, who are now enjoying access to recommended preventive services without deductible and cost sharing, out of pocket costs, and obviously we've also extended that access to preventive coverage to existing policies so that we have a very large number, 71 million Americans for the first time in their health insurance policies today having coverage for recommended preventive services without cost sharing, and then in terms of an early market reform in the insurance marketplace was the elimination of the annual lifetime dollar limits that some health insurance policies previously imposed.

Pardon me. No conversation about accomplishments would be complete without saying a word about the contributions of the Affordable Care Act to reducing the growth in health care costs in the country. I think many of you know, who follow this story, that we have had the slowest sustained national increases in national health care spending in 50 years. We're at or right at or around the growth on a per capita basis of

the gross domestic product, sort of an unheard of slow down in those national health care expenditures. Some of you may be aware that one of the early provisions that is in place is something we call the 80/20 rule, more technically known as the medical loss ratio rule, which essentially has one purpose, which is to say every health insurance premium dollar needs to— 80-percent of every health insurance premium dollar needs to be applied to the payment for services that are covered by the policy.

That's really been a very important consumer protection and a source of great value for the premium dollars that consumers are paying, and as a result for issuers who are unable to meet that standard of the 80/20 rule, they were required to return cash rebates to the policyholders and individuals, and for the first time in history actually individuals, instead of paying a premium completely, actually got a check from insurance companies that totaled 2.1 billion dollars, and I think you also know that we've been enhancing with money provided by the Affordable Care Act, the capacity of states, and the departments of insurance to engage in a very robust insurance premium review and assessment, and as a result of that we set a threshold that any issue that we're proposing rates above ten-percent would be submitting their filings for review. In just a couple of years the filings over double

digit level went from 75-percent of all filings down to 14-percent so far in 2013, and then lastly but not unimportantly we've done a record job in terms of the assault on Medicare and Medicaid fraud and abuse. We've returned record amounts of dollars to the treasury and to the trust fund, and we are continuing to put into place new tools for fighting fraud and abuse that the Affordable Care Act put into place, many of which are now, I guess, in many ways what credit card companies now do in terms of prospectively preventing the erroneous use of credit cards, and we're trying to do that with respect to claims for Medicare services.

Pardon me. Turning for a moment for the rest of really my time I want to bring you up to date on where we are on the implementation of the new marketplaces. These are essentially the markets that were focused on by the Affordable Care Act because they were the dysfunctional markets for consumers and small businesses, that is to say the individual market and the small group market.

We have pretty much completed the policy work that was necessary to establish he new marketplaces around the country, the market rules, the benefit rules, and so fort. I apologize. I'm recovering a cold, but in any event the policy's largely in place now, and that's why most of our focus is, in fact, on operational implementation. You see a list of things here in

terms of federal systems that we have been building or have completed building. They're all part of the infrastructure that's necessary to not only operate the marketplaces but to also give consumers a streamlined efficient process for applying for financial assistance for coverage and for helping them to select, shop and enroll in health coverage, and of course part and parcel of that is the development of a streamlined application that collects all the information that will be necessary to make a determination about whether an individual is eligible for financial assistance in the form of tax credits or whether they, in fact, are eligible for the Medicaid program. That consumer application is going through the final stages of public review and comment and will be available in a few short weeks for everyone to see.

We're also, of course, keeping close eye on the progress of states. As Jennifer noted in her remarks, 17 states including the District of Columbia are operating their own exchanges and are following a set of milestones and are making progress, and we're working with them every day.

The next slide really just gives you a little timeline of where we're going. This month the most important activity this month has been the opening of the opportunity for insurance companies to file their plans that they intend to offer on the individual and small group marketplaces. That

process is completing at the end of this month, and it's being done electronically by the issuers. We're also getting ready in June to launch a revised version of our healthcare.gov website, which will be the platform that consumers will use to access application and enrollment opportunities and also a call center which will be available in all the federally operated marketplaces, a 1-800 type call center number, and then in July and August we are also going to be training both navigators, who are individuals that will be supported by grants from exchanges to help consumers understand the value of insurance and to help them through the enrollment process, and then we will also be doing similar training for other in-person assisters who will be available around the country to help people on the ground in person, and then, of course, in October, on October the 1st, we'll be open for the initial open enrollment period, which will last for six months from the first of October to the 31st of March, and for people who begin enrolling in October their coverage will become effective in January.

Pardon me. The next slide really is just kind of a process slide for how we're going to evaluate the submissions by issuers. Essentially without going through this slide in detail I'll just tell you if you're familiar with the process that CMS uses for the evaluation of Medicare advantage plans

this is really an analogous process, and we can talk about it later.

The next slide really describes for you the process that consumers will experience as they seek to be determined eligible for either financial assistance or the Medicaid program, and this is really just a schematic to show you that at the end of the process there will be a determination in real time of what it is the individual is eligible for, the extent to which they have a tax credit, and how much that tax credit will be if they're in that category, or they will be enrolled in the Medicaid program.

Now, the next three slides are really quite important because they have to do with plans that we're putting into place to launch really a very aggressive broad based education and outreach program. As all of the people, I'm sure, in this room know that in order to make sure that people can avail themselves of the opportunities in the Affordable Care Act they need to know how to do it, what it's about, what's the value of health insurance and similar kinds of questions, and what this slide summarizes really is how we're disaggregating the audience because the one take away about how we're approaching getting information and understanding out is this is not a homogeneous audience, and for us it segments into a number of very key demographic groups, and they need to be dealt with and

communicated with in ways that resonate with them that meet them where they are and that help them understand in many cases the value of health insurance because for many of them they've ever had an association with health insurance and don't really know much about it.

The next slide really just shows you the ways in which we are targeting the uninsured group. I think these kind of speak for themselves. Clearly a very significant cohort in the population that's being targeted here are what we call the healthy and young. Nearly half of the uninsured in the age group from 18 to 35 and again, and again we're thinking about ways in which we can reach those individuals, how we can take advantage of social media and other opportunities to communicate with them and also how we can find objective trusted sources that will likely add to the validation of the importance of health insurance coverage.

The next slide really is just a timeline of all of this talking about how in the springtime that we're in now we're doing consumer—I mean, stakeholder engagement and outreach, doing training, preparing to launch further educational materials and so forth. Then come the summer we'll be doing that website and call center and training people to assist people in the marketplace, and then of course in October

beginning the process of intake for determination and enrollment and coverage.

The summary here is just to say we are on track to make sure that every American, regardless of where they reside, will have access to these reformed individual and small group marketplaces, will continue to be working with our partners at the state level, not only those states that are actually operating their own fully state-based marketplace but other states that are in partnership with us and, in fact, including departments of insurance around the country who are using their regulatory and analytic tools to help us review and oversee the operation of this small group and individual market. We'll continue to complete our infrastructure bill to make sure that all of the capability that's necessary to provide a seamless experience for consumers is in place. We are obviously going to be working hard on our outreach strategy across the federal government but also with private sector partners as well, and we will be ready and operational on October the 1, 2013. Thank you very much.

**ED HOWARD:** All right. Thank you very much, Mike, and I know you're pressed for time. So we'll have probably time for just one or two questions from the audience. While you're coming—okay. Yes? Please identify yourself, and keep your question as brief as you can.

**TONY HAUSNER:** Okay, Tony Hausner with CMS. When do you expect—formally with CMS rather. Mike, when do you expect the navigators to be in place to inform people about the options that they have?

**MICHAEL HASH:** The solicitation for applications for grants for navigators went out about ten days ago. The deadline for grant applications is June 7. We expect to make those awards in the mid to late summer and begin immediately training the individual organizations and their workers, who were awarded the grants.

**TONY HAUSNER:** Okay, let me ask one other question. Thank you for that. I know a number of employers, large companies who have cut down the hours of their employees so that they wouldn't have to provide them health insurance anymore. I'd be interested in your comments on that.

**MICHAEL HASH:** I think the one thing we are confident about is that when we looked at the experience that happened in Massachusetts, which is the only really natural experiment of having a similar policy in place, actually the number of employers offering coverage, particularly smaller employers, actually increased, and so today in Massachusetts there are actually more people with employer-sponsored coverage than there were before the Massachusetts law was enacted and implemented, and so we believe that having health benefits is a

critical component of all businesses, small or large in their abilities to recruit the best and brightest workforce, and lastly we think the real advantage for smaller employers is that they've been paying 18 to 20-percent more for the same kind of coverage that their larger employers have been able to negotiate more favorable rates for. We think with the shop marketplace it will be opening around the country. For the first time the pooling of large numbers of small businesses will give them the kind of leverage and the kind of competition that's going on in that marketplace that they have not enjoyed in the past, which will make high quality coverage not only available but affordable to small business and their workers.

**TONY HAUSNER:** Thank you.

**FEMALE SPEAKER:** Before you leave could you talk a little bit about whether there are any special plans being put in place for the consumer outreach in states that elect not to proceed with the Medicaid expansion and where the federal government will in many of those states be operating the exchange?

**TONY HAUSNER:** Well, obviously that will be factor in training the folks that are going to be working in those kinds of situations, but I would say across the board our outreach and education effort will be targeted to, again, as I said, make sure we're reaching those audiences that are vitally

affected by the law and given the opportunity to get coverage. So even if there's a state in which the coverage is not as complete as we would like it to be, we're still going to be making a very strong effort in that state. Obviously there will be certain information about the consequences of the failure of the state to elect to expand Medicaid that folks doing outreach and education need to explain what the consequences of that failure are for individuals, but we're expecting to apply a consistent set of training program material and information for those people either as navigators or other people. Obviously we're going to depend a lot on agents and brokers. Janet's going to talk a lot about that. They're clearly in a position particularly to help small businesses, but they also help people navigate in the individual market as well. There are lots of other organizations that want to provide in-person assistance, and we're prepared to train and certify those people.

**ED HOWARD:** Great. Thanks, Mike. You need to get to a microphone if you're going to ask it. Right back that way. Yes, you do.

**JONATHAN BLOCK:** Hi, my name is Jonathan Block with Modern Health Care. As I'm sure Michael knows there was a report that came out today from the Commonwealth Fund about the number of uninsureds leveling off in the last two years, but

there was also some information in there as far as affordability of health plans going forward. Given that earlier this week, the largest health insurer, Maryland, came out and was requesting a 25-percent rate hike. Even with all of the subsidies that are going to be available are you at all concerned that come 2014 that a lot of people may not find it affordable, especially given that there is theories that a lot of young people may not enroll and take the penalty instead?

**MICHAEL HASH:** No, I'm not concerned for many of the reasons that I spoke to earlier, the competition in the marketplace, the 80/20 rule, the rate review. The important thing to remember about rate information you may see now that a state may make public is that these are filed rates. They've not gone through any review process. The officials in the state of Maryland made it quite clear that they will be carefully reviewing and analyzing the justification for the filed rates and that they are not the rates that will be in place in 2014, but I think we're quite confident that when you take all of the factors into account that the Affordable Care Act puts into place to stabilize premiums, to increase competition, to make sure that there are opportunities to reduce risk for insurers in the individual marketplace in particular, that all of those factors taken together are going to have a mitigating effect and make—ensure that health

insurance options for individuals and small businesses will be affordable.

Thanks very much. I appreciate again, Ed, the chance to be here.

**ED HOWARD:** Thank you, Mike, and we'll sort of revert to the regular order, I guess, is the way you would put it here. Note, by the way, on the title slide, those of you who are into the Twitter universe, that hash tag aca101 is the key to communicating about this program.

Mike mentioned Janet Trautwein, and lo and behold she's next. She's CEO of the National Association of Health Underwriters, NAHU. Her members help employers of every size understand and administer health insurance and other benefit programs for their workers, and Janet understands how employers are affected by the ACA as well as anyone in the country, and we've asked her today to lay out the basics of that impact for us. Janet?

**JANET TRAUTWEIN:** Well, thank you, Ed. Well, I'm very happy to be invited to speak here again at the alliance. I do want to talk a little bit about a lot of things relative to the employer responsibility. We could talk a whole hour on this topic, which is how long I normally talk on this. So it's kind of a challenge to put it into this microcosm of what we can talk about in a few minutes. So I thought what I would do is

just start off by sort of reminding everybody why it's important to think about what the employer's responsibility is, and I think perhaps Jennifer, who started off, noted if you missed that on her slide that 56-percent of people who are covered today are covered by employer-sponsored plans. It's imperative that that continue, and so we want to make sure that people do not become unduly alarmed about things, that they understand what their responsibilities are, whether it's a small employer or a large employer. I'm going to talk about a small subset of responsibilities today, but there are many more, in addition, reporting and disclosure requirements and new benefit offering requirements that are different, so some people are very nervous about whether they'll be able to do the right thing, where they'll be fined for doing the wrong thing, and whether they'll be able to pay for it, and they are worried that all of these things that are additions to what they do today sound to them like it's going to cost more, and so whether it ends up costing more or not, the point is that we have some unrest here that we need to make sure we're communicating, and we're doing a lot of that, but I'm only going to talk about a few things here, and I'm going to focus primarily on larger employers.

Now, first of all I want to start off talking to you and saying that what small employers do, many of them provide

coverage to their employees, but many small employers are actually large employers under this law. So it's entirely possible for an employer to be considered small under one part of the law and large under a different part of the law, and that's one of the things that they get confused about, frankly, and it has to do if they're sort of borderline in size, maybe between 50 and a hundred, for example, but I'm going to focus in on just a few of those things, and let's assume for a moment that we're talking just about what the large employer requirements are, so that's employers with 50 or more full-time employees.

So as you can see on this slide here there are two basic requirements from employers in this category that have to do with what we call the employer mandate or the employer responsibility requirements. The first prong of that is what we call prong A, and that is that the employer is required to offer, to their full-time employees, minimum essential coverage, and if that term sounds familiar to you, that same language is included in the individual responsibility requirements. Minimum essential is what all of us are required to have in order to not face any sort of taxation under the individual responsibility provision. So it sort of matches up there with the idea that the large employer would be a vehicle

for helping individuals meet their individual responsibility requirement.

So all of these responsibility areas are very much intertwined with each other, and then the second prong of that, what I call prong B, is that the coverage that they offer—and I'll talk about what the penalties are if you don't do this in a moment, but the second prong is that if they offer coverage, it needs to be affordable, and there's a very specific definition of what it means to be affordable and that the coverage will meet minimum value requirements, and if it doesn't do either one or both of those two things, there's a separate fine associated with that. So, one, not offering coverage at all, two, not offering adequate coverage, either adequate in terms of cost or adequate in terms of the value associated with it.

So this is kind of a busy slide, but I think it's very important because remember when I started talking about that it's very important that you know if you're a small or a large employer, and so this kind of walks you through, and I think this is a very useful slide. I go back myself and refer to it frequently. So it basically hinges on whether or not you are more than 50 full-time employees or less than 50, and it's not as simple as you would think. You would think that, well, yeah, the employer really knows how many full-time employees

they have, but the law says that you don't necessarily count them the way that you might think that you would, and, in fact, you may not even define them the way that you do. For example, many employers do not use a 30-hour a week standard to define who their full-time employees are. If you looked at the majority of employers across the country, the vast majority use a 40-hour a week standard, and so this going down to 30 hours a week is different for them, and for many of them this is a category of employees that were full-time, and so they may have to change all of their systems in order to track this, and they—and some of them then may be variable hour workers, which I'll get into in a moment. That complicates it even more.

So my point is it's not as simple as you think, and then we have the issue of controlled groups where you have one kind of parent organizational entity that may own multiple businesses. They can even be very diverse businesses with separate federal employee identification numbers, but for purposes of the law they are put together to determine whether or not this group is or is not a large group. So, for example, one of the groups in the controlled entity may have five employees, and if you asked that employer whether they are a small or a large group, what would they tell you? That they're small, right, and they maybe have a completely separate business structure from another business owned by that same

employer that is 50 employees or 30 or 20. So some employers are confused by this, and if you hear confusion, I know those of you who are hill staff, you will get these questions. You've probably already gotten them. This has got to do you've got to find out whether or not there is a controlled group going on and who owns them, and that governs actually who has to be offered coverage and what it needs to look like and so forth.

So getting to who has to be offered coverage, I mentioned full-time employees, 30 hours or more per week. There is—when we talk about this requirement to offer coverage, it's not just to the employees. The law requires that coverage be offered to dependents as well, and a recent regulation has defined dependence as being dependent children to age 26, which is atypical from what most policies do today. Most policies offer coverage to the whole family or to children only or to spouse only. Some don't offer dependent coverage at all, but that's not all that common. So this is kind of a caveat in the laws. I think it was in there for a particular reason to allow a little bit more flexibility in terms of people going to the exchange, and I'll expand on that in just a moment, even though I'm going to have to talk really fast now.

So one other thing I want to point out that is relatively new is we did get some regulatory guidance on what

it means to offer it to all full-time employees. It actually means that you offer it to 95-percent of those full-time employees or at least 95-percent, and the other five-percent could have been inadvertently not offered coverage or not inadvertently, and then there is a separate provision about how you deal with the other five-percent should they actually qualify for a subsidy through the exchange.

So a key thing is that you count these employees correctly, and I don't tend to walk through this slide, but I thought it might be useful to some of you afterwards to figure out what's the formula? How do you figure out how to count your employees? So I just put it in here because I thought some of you might have some use for that later.

I will point out one thing. I bet you will get a lot of calls about seasonal employees. There is a provision in the law that in general says that if the only reason you are over 50 and your count of how many full-time employees is because of these seasonal workers that work for you only part of the year, then you would not be considered a large employer, and, again, why does it matter? Well, it has to do with if you don't offer coverage as specified as I've just described, you're subject to penalties, and that's why that's important, and then I would be remiss if I didn't throw something out that is very important and that many, many employers are not so neatly packaged that

we have our full-time people. We have our part-time people. We even know who our seasonal people are. Many employers have variable hour workers, and when they hire them, they have no idea if they'll turn out, over the course of, say, a 12-month period, to be full or part time. They are retail clerks. They work in restaurants. They work in home health care. They're subject to scheduling, that kind of category, and it could be really any kind of business that has this kind of worker.

So fortunately we have some regulatory relief relative to this category that allows them to be monitored over a period of time to determine over that period of time did they turn out to be a full-time employee or not, and if they were full-time, the deal is with employers who take advantage of this is that if you measure them over this period of time instead of immediately offering them coverage, then for an associated stability period of the same length of time, you're required to offer them coverage during that period if they turned out to be full-time, even if during the second period they go—move into part-time status, and then real quickly I wanted to talk about what the penalties are for not offering this. We can go through these last slides fairly quickly.

First of all, there's the penalty for not offering coverage at all, which is—or not offering minimum essential. It's $2,000 per full-time employee if even one of those full-

time employees goes to the exchange, qualifies for a premium tax credit and purchases coverage there. There is an allowance that an employer could deduct the first 30 of those full-time so they would basically have $60,000 of that penalty, which would be waived.

Then there's the question of whether or not the coverage is of adequate value, and that triggers the penalty B that I mentioned earlier, and that's a $3,000 penalty, and basically in that case the employer's offering coverage, but it doesn't meet the minimum value that's required by the law, and in that case it's also triggered by an employee going to the exchange qualifying for a premium tax credit for this reason and getting—and signing up for coverage. They do actually have to sign up for the coverage in order for the penalty to be triggered. In this case it's $3,000 for each employee like that that I just described, and then there is the not affordable. This is the most complicated one.

I'm sorry that I'm going to go ahead and explain this real quickly. So the not affordable is one of the most controversial provisions. The not affordable says that if you offer coverage, even if it meets the minimum value but it's not affordable for a certain of your employees, it could also trigger that penalty B penalty, and so here's how affordability is defined. Affordability under the law, and I will tell you

before I continue on there are some safe harbors we have now, but under the law affordability says that the coverage is no more than the employee's responsibility for the premium no more than 9.5-percent of their family income for the self only premium for the lowest cost plan that that employer offers as long assuming that plan meets the minimum value requirements. It doesn't say anything about what the cost is for dependents, and whatever dependents are eligible under that coverage offer, whether it's just children or spouse and children, they are eligible for an employer-sponsored plan, but it all hinges on the definition of what it is for the employee. So that's been kind of controversial, and it's been reinforced on regulation via regulation.

The second thing I want to mention is that, of course, employers have no way of knowing what family income is, and they can't ask, and they really don't want to for many issues related to liability and other things, and so there have been some safe harbors that were created, which have been extremely helpful that allow employers to say, well, we know what we pay this person. We pay them hourly, or we know their W-2 wages or something associated with that, and because we know that, that's—those were the safe harbors that were associated with that. So it would 9.5-percent of there are three or four different safe harbors that the employer can select because

these are things that they do know. The employee is still protected because if, in fact, their family income is lower than their W-2 wages, which it can be by the way, if they have—especially if they have a lot of dependents, then they can still retain the opportunity to go to the exchange and qualify for a tax credit there, but the employer wouldn't be penalized because the employer had done what they were supposed to do, and so the big controversy here and then I'll stop—the big controversy is relative to what about the affordability for dependents because anyone who is—person that is eligible in any way, shape or form for employer-sponsored coverage is not eligible for a premium tax credit through the exchange, and so that's what's generated a lot of the discussion about, well, why should the affordability for the dependents be based on the employee, but that's what the law says, and it's been upheld on a regulatory basis.

So thank you for giving me a few more minutes, and I'll stop.

**ED HOWARD:** I learned a lot during that presentation, Janet. Thank you very much. We're going to turn next to Sabrina Corlette. Sabrina directs research on insurance reforms and related topics at the Center for Health Insurance Reforms at Georgetown's Health Policy Institute. She's served stints on the hill, practiced health law at a major D.C. firm,

and she's here today to help us understand the state-based insurance exchanges that are being set up under the ACA. Sabrina?

**SABRINA CORLETTE:** Thank you, Ed. Thank you, Kaiser Family Foundation for sponsoring this briefing. It's great. I've learned a lot, too. So I thought it would be—it might be useful for me to just take a moment to step back and first talk about the framework on which the ACA's insurance reforms are built, and that's a framework of cooperative federalism, and essentially states are and continue to be the primary regulators of health insurance for consumers in the individual and group market with one exception, which is self funded or self insured plans, which are primarily regulated by the federal law under ERISA, but congress adopted this cooperative approach in 1996 under HIPAA, the Health Insurance Portability and Accountability Act. Essentially just what it means is that the federal law sets a minimum floor of standard, but the states are really primarily responsible for enforcing the law and also may enact requirements or rules that are more protective than the federal law, and the ACA builds on that HIPAA framework, and so the federal government really only steps in if the state is unwilling or unable to enforce that law or, in the case of exchanges, unwilling to establish their own exchange.

So and Jen has already touched on some of these, but the insurance market reforms in the ACA have been implemented and are being implemented in phases. So there was a suite of reforms that were implemented in 2010. Sometimes these are collectively referred to as the patient's bill of rights, but it's a suite of consumer protections that include the provision requiring plans to allow young adults to stay on their parent's plan up to age 26, provide preventive care at no cost sharing, prohibit the practice of insurance company rescissions, and as Mike mentioned eliminates lifetime dollar amounts on coverage.

So those reforms went into effect in 2010, and the heavy lifting really starts in 2014 with some pretty sweeping reforms to really improve the adequacy of coverage and the access that people have to insurance coverage, particularly in the individual market where people are buying coverage on their own. So I'm going to take a minute and talk about some of these reforms, and I think it's important to some extent to talk a little bit about what the insurance market looks like today and how it's going to change under the ACA.

One of the key provisions of the ACA is the guaranteed issue in renewal provision, and it's important because today, particularly if you're in the individual market and you're trying to get a health plan, most health care insurance companies will require you to submit a health care

questionnaire, which you'll be asked to answer a whole bunch of questions about your health status and your health history. If there's anything in your questionnaire that the insurance company doesn't like because they think it presents a little bit of a risk to them to cover you, they can deny you that policy. They can refuse to issue you that policy. The ACA prohibits that practice, and so starting in 2014 they will have to issue you a policy—a policy to any applicant.

The other thing that insurance companies can do today is they can look at your health factors. They can also look at your gender and your age and your lifestyle, where you work, the industry you're in, where you live, and they may impose a surcharge on your premium based on any of those factors in most states. The ACA implements what's called modified community rating or sometimes referred to as adjusted community rating, and the idea here is that no matter what your health status is or your gender they cannot charge you a higher rate because of that. They do allow—the law does allow insurance companies to charge more based on your age at a three to one ratio. So an older person, 64-year old would be charged about three times what a younger person would be charged.

Another important provision is the prohibition on what are called pre-existing condition exclusions. A fairly common practice in the insurance market today is the health plan might

say we will issue a policy, but we see from your questionnaire that you have asthma, so we will not cover anything related to an upper respiratory condition under this policy. You know, if you get—if you break your foot, we'll cover that, but we're not going to cover anything related to your asthma. Those kinds of exclusionary riders on policies will no longer be permitted under the ACA.

Many of you may have already heard about the provision of the ACA requiring coverage of a minimum set of essential health benefits, and this is largely—it's a minimum standard in the law. It sets out ten categories of benefits that must be covered, and this is partly because a lot of coverage, particularly in the individual market, is what some people called Swiss cheese coverage. A lot of major categories of coverage that anyone had covered in a large employer plan would take for granted, such as prescription drugs or mental health or maternity coverage are frequently not covered in this market. So the law sets a basic minimum standard there. The law also sets an out-of-pocket maximum and essentially says insurers are required to limit the amount of out-of-pocket payments that a consumer must make, and these are things like deductibles and co-payments, things that you would pay at the point of care, and that's set at the limit of the—what was established under federal law for high deductible health plans,

which today is about $6,000 for an individual and about $12,000 for a family.

So it's not a small amount of money, but in many cases it's better than what people are getting in the marketplace today, and then the law also organizes coverage into four precious metal tiers, bronze, silver, gold, and platinum, and those are increasing levels of generosity, and those are pegged to an actuarial value standard, and actuarial value just means it's a term that describes on average the percentage of cost that insurance company pays.

So issues to watch going forward on the ACA's insurance market reforms include compliance. Who is the cop on the beat? In most states it will continue to be the state department of insurance or the state regulator, but in some states some states are refusing to enforce these reforms, and it will be the federal government who will be the cop on the beat, and so how that works and what that means for consumers will be something to watch.

Affordability is another issue we're likely to hear a lot about in the coming months and years, and I think it's important not just to look at the affordability of premiums, that upfront payment that people are asked to pay, but the overall affordability of the package, what are you paying out in co-payments and deductibles, and how are the premium tax

credits and cost sharing credits available under the law helping to make coverage more affordable, and of course it's not just about the insurance card that you get, but it's about what you can do with the insurance card, and so access to care issues are going to be important, and then adequacy. Where are the—where are we seeing the gaps, whether it's in people who can't or are unable to access this market because they're undocumented or are there other issues with the overall scope of the coverage or the cost sharing they have. So adequacy is another issue I think folks are going to want to watch.

I'm actually going to skip over a couple of these exchange slides simply because I think Jen and Mike did a really terrific job providing an overview of exchanges and what they are, and I apologize because Jen and Mike are both using the new nomenclature, which is much more consumer friendly and orientated, which is marketplace, but I'm slow to change, and under the law they are exchanges. So exchange, marketplace, one in the same thing, but I think that we can probably cover any questions you have on exchanges in—during the Q and A, so I'll just skip a couple of slides here, but I do want to just talk about a few issues that I think will be important to watch as open enrollment starts October 1 and as people actually get enrolled in coverage in January.

First of all, as Jen mentioned, there are a number of states that are going to be running their own exchange, and I think they've been conditionally approved to do so, but I think it will be important to watch how many of them are able to meet all of the targets and deadlines that are there for them to try to get operational by October 1. It's not clear that all of them will be up and ready, although I certainly hope that they will be.

Coordination between the federal government and the states, whether it's a federally facilitated exchange or a state-based exchange or a partnership exchange or some other formulation, will be critical to watch both in terms of how insurance companies are being regulated and monitored but also around eligibility and enrollment decisions and how people are accessing appropriate coverage, and I was very reassured by Mike's comments about readiness by the federal government, but certainly they have a lot to do in a very little amount of time, and the last thing I would just say is also noted not all states will be expanding Medicaid under the law, and how that will impact people, particularly lower income people in terms of making sure they get into the right coverage program, will be something that it will be important to keep an eye on.

So with that I'm going to close, but I'm looking forward to lots of questions.

**ED HOWARD:** Terrific. Thank you so much, Sabrina. Our last speaker is the very patient Karen Milgate. Karen is a health policy consultant who until recently served as the deputy director of CMS' Center for Strategic Planning, a job that she held in both democratic and republican administrations, I might point out, and today Karen's going to walk us through some of the ACA provisions aimed at improving how health care is delivered. Many of those provisions, of course, are aimed at effecting delivery systems serving the Medicare and Medicaid populations, but some are broader, and we're very pleased to have you with us to explain them.

**KAREN MILGATE:** Thank you, Ed. Yes, so now for something completely different. In addition to expanding access to insurance coverage the—those that pass the ACA also were concerned about expanding coverage to a system that many felt were inefficient in the sense of costing more than it needed to cost and having outcomes of quality that were less than were achievable in the American health care system. So one of the biggest levers that congress has, as you all know, is the federal Medicare program. Clearly there's some things that they can do also with the Medicaid program, but because that's a joint federal/state program can direct that program a little bit less than the Medicare program.

So what I'm going to talk about here are primarily the reforms that were put in place by the ACA Medicare program, but I want to just say that many of these same concepts were also embedded, to the extent the legislation could, in the Medicaid program, and many of the states have actually taken some of these very same concepts and experimented on their own. Probably the greatest experimentation, frankly, going on in the country on some of these different payment and delivery system reforms are actually happening at the state level in the Medicaid program. However, they are being, you know, also being experimented in the private sector. In my work as a consultant I've talked to numerous different plans and other provider systems who were all experimenting with some of these very same concepts. So the ACA, I think, spurred on many of those efforts that were already occurring and gave a lot more impotice to them because the Medicare program is such a larger payer that to the extent these incentives are actually put in place in the Medicare program they will support and drive many of the other changes in the private sector as well as to some extent in the Medicaid program, although there is certainly a back and forth relationship that occurs there.

So what did they look like? The goal essentially was shifting from paying for volume to paying for value. So in the Medicare program there's essentially two large programs within

the program. One is the fee for service program. One is the Medicare advantage managed care side of it, and just for those of you who aren't familiar with those terms I'll try to explain them quickly. The fee for service program is a traditional program where Medicare itself is really the risk taker. Beneficiaries can go to any physician, any hospital. Pretty much there's free choice of provider, and then the rules around how much they get paid are paid by congress and CMS, and they get paid for their services.

The managed care program is where there's a capitated amount. It's more akin to what we typically experience in some ways as at least federal employees, but others, where there's a capitated amount paid to a health plan, and then the health plan pays the providers. So in the fee for service program there's really incentives there just to do more stuff. You know, providers, the mores things they do, the more they get paid. There has been not that much paid to, okay, well what do we actually get out of those dollars.

So over time there's been more and more concern that the Medicare program because that's the manner in which it pays has actually driven some of the inefficiencies in the health care system, and is there a way that the Medicare program can also help the country dig out of that hole by putting in place some incentives that would really look at value a little bit

more than just the volume of services that are delivered for providers?

So when this, sort of, concept from the ACA came over to the agency, CMS, Don Berwick was not right away at the helm, but he soon became the acting administrator, and he's been very big on this concept of the triple aim of the goals being lower cost growth, better health, and better health care, and essentially when you look at the delivery system reform pieces of the ACA, I think that kind of sums it up. So the agency started using those terminologies actually as kind of the guiding force for implementation of the ACA. So really what it did was put in place incentives at really every level of the health system that Medicare could reach. So there were incentives put at the individual provider level, and this is what I'm talking about on this slide whereas it put in place value base payment programs for hospitals and physicians and directed the HHS to come up with plans for the other settings of care that Medicare pays, and essentially what that means is some small percentage of the payment that would go to providers would be based on their performance on quality and efficiency metrics.

So that means you got to trust the metrics. You got to develop the metrics. You got to collect the information, et cetera, but that was the concept. So there were a set of

metrics that are already developed for hospitals and physicians. There's a timeframe for those going in place, and that plan is actually going to be carried out potentially in SNFs home health, skilled nursing facilities, home health agencies, and ambulatory surgery centers, and then there was also discussion of actually creating—developing and creating measures and collecting measures on the other settings of care and Medicare.

There were a couple of very specific goals that the ACA talked about also, which was reducing readmissions and reducing hospital-acquired conditions. So there were also penalties put in place for hospitals that measured higher than what would have been expected, would have been normal for that hospital on readmissions, and the same thing for hospital acquired conditions, which are infections that occur within the hospital with some evidence to show that it could have been prevented with higher-quality care.

So in addition to actually saying, well, for every provider we pay directly we're going to target part of their payment based on performances, there was also a concern that a lot of the issue wasn't really specifically what an individual provider did but what happened across providers in the FFR system, FFR service system. So, you know, when a hospital discharged a patient, they had little incentive to care really

where that patient landed or how they did, you know, after that hospitalization because they really didn't get paid for that. So how can you actually put incentives in a program that pays individual providers individually for them to coordinate across the various settings of care, and you can imagine with the Medicare population that's a really important question given that those folks do tend to use multiple settings of care, particularly if they have a hospital stay. So there was also a variety of different programs put in place to try to both create incentives right away with programs that were implemented, but also the monies that Jennifer Tolbert talked about for the Center for Medicare and Medicaid Innovation. That was also a huge piece, and I'm going to talk in a little bit of detail on which—what these do so you understand a little bit about the concepts of what are we trying to get at here? What are you actually trying to change in terms of the incentives?

So the Medicare Shared Savings Program, you'll hear it referred to as the ACO program because that's the entity. That's what they call the entity that has to apply for the shared savings program, is essentially a collection of providers who are still paid individually. So there's a fee for service payment going for Medicare services they deliver, but they've said collectively we're willing to be held

accountable for the overall dollars and the quality of care that this patient experiences. So at the end of a certain period of time, there's a calculation that's done that says does this group of people cost more or less than they otherwise would have if they hadn't been in this ACO? If it costs less and their quality scores are at a certain level, then Medicare program will share whatever that difference is with that provider entity.

So people get a misconception sometimes that sometimes it's just—this is just like managed care, but these providers are still getting paid individually fee for service. So it's kind of interesting concept from a policy perspective because it sets up this tension of, you know, individual providers still kind of wanting to get—do more because they get paid more if they do more, but they're also part of this larger organization that, in fact, if there's really good care management, meaning you might reduce readmissions or keep someone out of the hospital, or maybe they don't end up having to go into, you know, as intensive situation, you share savings for the whole entity. So that's a concept that is in some ways being tested, but it's a real program right now in the Medicare program.

The Center for Medicare and Medicaid Innovation is also looking at that concept. They started out a little bit earlier

with some of the more evolved health systems, and that's what pioneer ICOs are. Bundled payment is a concept that bundles payment around a hospitalization, either the post-acute care or the hospitalization and physician care, again, with the concept that if you can put everybody in the same bundle of payment, that somehow they will coordinate more with each other because it will matter more to the whole that they actually deliver good quality and efficient care. So that's the bundled payment.

Comprehensive primary care initiative is more of a paying individual primary care physicians a little bit more to actually do some care management with beneficiaries. I won't go through the other two. The other emphasis in the ACA that I think is actually really important and could have a huge impact on both Medicare and Medicaid is the focus on the dual eligible population. The dual eligible population is a group of beneficiaries who are eligible both for Medicare and Medicaid. They tend to be fairly vulnerable population in terms of poor or sick or both. They're also a very costly population for both Medicare and Medicaid.

For Medicare they represent 16-percent of the people but 27-percent of the cost, and for Medicaid 15-percent of the people and 39-percent of the cost at the state level. So some of these folks are in nursing homes, and so the ACA established

an office that is devoted just to looking at dual eligibles so that there can be better coordination across those two programs because there really has not been very good coordination across the programs both for insurance purposes but also for delivery purposes, and there's a significant number of efforts under way in particular to try to figure out ways to put the Medicare and Medicaid dollars together and then have someone manage those together so there's not this constant handoff between different coverage for nursing facilities versus hospitals and, you know, no one having incentive to really do the care management all together.

In addition to this feast for service program and the need to try to do better coordination there, there was also some incentives put in place for the Medicare advantage program, which is about 25-percent of the beneficiaries. At this point in the Medicare program they created a five-star rating system, and there are bonuses that are given to plans up to five-percent of payment by 2014, which I'll tell you from my work in the private sector plans are definitely paying attention to this, and so, again, this just puts in place a system of incentives that rewards plans for higher quality performance.

In addition to Medicare there were some other infrastructure supports as I call them, which, in fact,

Jennifer talked about a few of them, which I don't have time to go into detail here, but there were definitely more than I just talked about was done in the ACA beyond Medicare. There's a lot of work at CMS and how to actually create more ability for the health care system and CMS itself to use and share its data. Of course the HIT provisions in HITECH are an infrastructure support, which wasn't in the ACA but would clearly help support that, and then some of the other provisions Jennifer talked about also help support the infrastructure.

So I'll stop there, and we'll look for questions.

**ED HOWARD:** Terrific. Thank you so much, Jennifer, and we do have time for as many questions as we can squeeze in. We would ask you to try to keep your questions brief, identify yourself. You can write your question on a green card and hold it up. Someone will bring it forward. Try to keep your questions factual, at least as factual as you can in the context of relatively high profile piece of legislation, and Diane and I will chime in as we are able to. Let me start us off asking. I'm not sure. We have so many good people to respond. Who's the best person? So self select. It may be useful to try to go through. Several people have talked about the different thresholds, the percentages of poverty that divide the ability to get a subsidy and the exchange or that

Medicaid eligibility will be extended to. Can somebody explain relatively simply what happens in a state, how the process Mike was talking about of sorting people out into the different buckets of eligibility would work based on their income, and presumably that is a different answer in a state that is expanding Medicaid from one where it isn't.

**FEMALE SPEAKER:** Okay, I'll take that one. So the law calls for an expansion of the Medicaid program across all states up to 138-percent of the federal poverty level, and then what it does is sort of build on top of that the new health insurance marketplaces. Now, the subsidies in those marketplaces, actually to be able to qualify for the subsidies you have to have income between 100-percent and 400-percent of poverty, but there is another criteria, which means you can't have access to other coverage. So in a state that expands Medicaid, that means those individuals with incomes between 100 and 138-percent of poverty would be enrolling in Medicaid and not eligible for subsidies in the health insurance marketplaces, and then the subsidies for the marketplace would begin at 138 up to 400-percent of poverty, but obviously in a state that doesn't expand Medicaid, the subsidies will start for folks at incomes beginning at a hundred-percent of poverty, but what that does is it leaves people who are not currently

eligible for Medicaid in that state without access to affordable coverage.

Most states set their eligibility thresholds well below the poverty level, and, in fact, until the passage of the ACA states were prohibited from covering adults without dependent children or what we refer to as childless adults unless they obtained a waiver from CMS for—waiver of the federal rules. So in many states you have no coverage for those childless adults below the poverty level, and for parents in many states that coverage is set below even 50-percent of the poverty level.

**ED HOWARD:** Okay, that's very helpful. Diane?

**DIANE ROWLAND:** We have a question directed to Janet, which raises the issue of brokers not being able to be part of the navigator program since they get paid by health insurers and what has that done to the market that brokers have been in?

**JANET TRAUTWEIN:** Well, I would just say that there are going to be a number of different types of assisters that are helping individuals, small businesses and so forth. There will be individual assisters, you know, the individual IPA, I believe it's called, program. There will be navigators. All of those types of assisters programs are actually somewhat limited in duration, at least currently they are, and the one group that does not require a grant or any new money are brokers and agents who are already there today, and so we know

that brokers are going to continue to operate where they have not been excluded from dealing with consumers at any level in the exchanges and not in any state and not in the federally facilitated exchange either, and so it's just different. Navigators are not the same. They are just different than brokers, and I think, you know, there are—is a role for a lot of different types of assisters to be helping people and that in some cases they'll probably work together particularly when there are language issues and things like that that where it would be helpful.

So I—it's not really an adversarial thing that brokers don't really want to be navigators. They are brokers, and navigators can be navigators.

**DIANE ROWLAND:** And, Karen, the question here is about the incentives and the readmissions and the hospital acquired conditions so that those would be ways to also penalize, the question is, hospitals that actually take care of a high percentage of vulnerable patients. How does—how do those incentive program potentially disadvantage some of the hospitals with large numbers of vulnerable patients?

**KAREN MILGATE:** Well, so clearly that's one of the issues that CMS has had to wrestle with. The readmission rate, and I'm not the person at CMS that implemented this, so I'm going to try to answer it as a high level and accurate level as

I can, but the comparisons are relative to what you would expect at that hospital would have as a readmission rate. So it's not there's one set rate that everyone's compared to. So there is what you will call a risk adjustment that says, well, this is what we would expect given the population of the hospital the rate would be, and then there's a comparison to that actual rate. Are there still concerns that that's not good enough? Yes, there are still those concerns, but that is the calculation that's done is to try to calculate what would be that individual hospital's rate, and that's really the same answer I would give on the hospital acquired condition side. There is an attempt to try to risk adjust both of those targets so that you aren't penalizing hospitals that have a higher than average proportion of sicker patients.

**DIANE ROWLAND:** Okay, and this question is really getting to the preventive services pieces of the legislation since we recognize that most health care dollars are spent on care and only a small amount is spent on preventing disease. What does the ACA do to focus on preventing people from getting sick in the first place?

**FEMALE SPEAKER:** Well, I can talk about it from the insurance side and maybe, Jen, if you want to talk about the prevention fund? So one of the very first reforms that the ACA authorized and put into effect was a requirement that plans

provide first dollar coverage for preventive services that have received an A or B recommendation from the U.S. Preventive Services Task Force, which is an independent body that looks at evidence around things like cancer screenings and, you know, diabetes, preventive exams and things like that, and if something gets an A or B recommendation, then the health plan has to cover it without any cost sharing, meaning that when the consumer goes to get that service, they don't have to pay a co-payment or pay towards a deductible. So the idea is to improve access to those kinds of preventive services.

**JENNIFER TOLBERT:** So in addition to that there's also a strong emphasis throughout the law on community-based prevention activities, and so the law does establish a prevention and public health fund that was designed to fund sort of these population based activities that will focus on addressing the risk factors for chronic disease and actually trying to prevent people from developing disease in the first place, so some of them they focus on asthma prevention, diabetes prevention, obesity, tobacco cessation, and so a number of programs across the country at the community level have been funded through this prevention fund.

Unfortunately because of the limited federal dollars to implement the health reform law overall some of the funding or the funds from that prevention and public health fund have been

diverted to support other important causes such as some of the workforce development initiatives, but there still is money in that fund, and it is funded on an annual basis, again, to support more population-based activities.

**DIANE ROWLAND:** And Janet?

**JANET TRAUTWEIN:** And just real quickly to add one thing there are also provisions in the law relative to employer-sponsored coverage, and so there's an increased allowance for employers to offer wellness programs with greater incentives, and the reason why this is important is because obviously you can get to many more people at the same time, and of course all of those market reform provisions relative to what plans need to include also apply to employer-sponsored plans as well. So the employers play a very, very gig role in this prevention aspect.

**DIANE ROWLAND:** And, Sabrina, this question is for you. Do you think the six months is enough time for the federal government using agents, et cetera, to educate the public in the health insurance marketplaces in the 33 states that are going to be a federally run exchange or a partner exchange?

**SABRINA CORLETTE:** Yes. I think that it will be an all hands on deck kind of environment. As Janet mentioned there will be a huge need to rely on agents, brokers, community-based organizations, providers, insurance companies and others, all

of whom I think have strong incentives, whether it's from because you're part of a non-profit mission oriented organization or because you have a business incentive to try to get as many people covered and into the system as possible. So I think the federal government and I think Mike indicated that they are on track or where they need to be, but I think they're also going to have a lot of partners in this effort between now and the end of open enrollment.

**DIANE ROWLAND:** This is a request to clarify the medical loss ratio requirement's effect on insurance agent commissions.

**FEMALE SPEAKER:** Okay, well, I didn't know we were going to get into that one today. The—so first of all people should understand how someone obtains an insurance agent. They're not assigned by an insurance company. Individual consumers actually select who they would like to deal with, and the avenue today that commissions are received, because of various state laws, primarily comes from an insurer. Nonetheless, if the consumer does not want to deal with that particular broker anymore, they are the ones that decide not to do that, not the insurance company. So there's been a big controversy as to whether or not those are actually a part of an insurer's administrative cost. We contend that they are not, and so this is what the impact on MLR has been that they

have been considered an administrative cost of insurance companies even though the insurance companies aren't the ones that hires the person, and so when the squeeze came associated with MLR, the result of that is that agent compensation was in many cases cut in half within about ten days, and so it has been—it had been a pretty traumatic situation, but we still have people hanging in there and wanting to continue to help consumers as they have in the past, but it has been a financial difficulty, yes, significant.

**DIANE ROWLAND:** This question is with regard to where do we stand with multi-state plans and possible vendors, Sabrina?

**SABRINA CORLETTE:** Well, I can't speak for how many insurance companies have applied to be part of the multi-state plan. I think we'll know more at the end of the month the final sate of the application process. At office of personal management those applications are due April 29. So hopefully we'll know soon which issuers are going to participate, but, you know, it is a phased in program so that I think that will start in about 30 odd states to begin with and then ramp up over four years.

**ED HOWARD:** Sabrina, could you sort of—could you tell us exactly what the national plans are, the multi-state plans?

**SABRINA CORLETTE:** Sure. So one provision of the Affordable Care Act is to create what's called the multi-state plan program, and it's a provision of the law that I think first put forward by Senator Olympia Snowe of Maine during finance committee deliberations, and I think some of her thinking was to try to make sure that there is more competition, particularly in state insurance markets that are highly concentrated. What's interesting about how the multi-state program has evolved over time is that I think a number of progressive lawmakers came into think of the multi-state program as potentially an alternative to the public plan option, which was debated and ended up not being included in the ACA, and part of the reason why is because this would be a program run by the officer of personnel management, which also operates the federal employees health benefits plan program, and it has an incredibly strong record of providing really good high-quality coverage to federal employees, and so the idea was if you could get some plans that would have the seal of approval of this agency that you sort of had a government seal of approval that these would be plans that people might gravitate to, and the idea was that they should be in every state. One would be a non-profit, and one would be a—one had to be a non-profit, and they have to have two plans in each state, and so OPM has begun to implement that program in taking

applications from insurance companies to become a multi-state, and if you would get—if you qualify as a multi-state, you are deemed eligible to participate in the exchanges. So the idea is to give these folks a leg up and have potentially a new player in the exchanges.

**DIANE ROWLAND:** Okay, this is kind of two questions rolled into one. First, there's a request for clarification of what—who is an individual under the act. These are persons under age 65, but the question is can someone over 65 with Medicare buy Medigap insurance in the exchange, and the answer is no, it is not a provision. So that when we are talking about the ACA we're mainly talking about individuals without Medicare coverage under age 65, and the second point though is to explain who is exempt or what the exemptions are under the ACA, who has received them and is there a rationale?

So I assume it's exemptions from the individual responsibility?

**FEMALE SPEAKER:** I assume that's the—individual mandate, yeah. Okay, so as I mentioned very briefly in my overview, the ACA imposes a new requirement on individuals to purchase coverage. Now, there are a number of exceptions to that requirement. So, for example, undocumented immigrants, people who are incarcerated, those with religious exemptions are all not subject to the penalties if they do not have

coverage. In addition people with income below, I think the recent reg below a hundred-percent of poverty. The law says below the tax filing threshold, which is very close to the poverty level, but there is a little bit of a gap, but I think because of issues related to decisions about whether states will expand Medicaid in the shared—individual responsibility rule HHS proposed that the people with incomes below a hundred-percent of poverty be exempt. In addition there is an affordability test. So if an individual cannot find coverage that costs them less than eight-percent of their income, they are also exempt from the penalties.

**DIANE ROWLAND:** Okay, please address or touch on what are grandfathered plans and what are Cadillac health plans.

**FEMALE SPEAKER:** Well, I can talk about the grandfathered plans. Janet, do you want to talk about the Cadillacs?

**JANET TRAUTWEIN:** Sure.

**FEMALE SPEAKER:** Okay. So grandfathered health plans are those that have been in existence since before the law was passed, March 23, 2010, and they are actually exempted from a number of the insurance reforms under the law including the essential health benefits requirements, the out-of-pocket maximums, et cetera. However, in the implementation of this provision I think it's important to note that you're not just

grandfathered forever. If the plan makes significant changes to benefits or cost sharing, then they lose their grandfathered status and will be subject to all the requirements just as new plans are.

**JANET TRAUTWEIN:** So relative to the Cadillac plans, this is a tax. It's actually the Cadillac tax that goes into effect in 2018, and it's an excise tax that's 40-percent, and it's on amounts in excess of a certain dollar amount, and I don't remember. It's 10,000 something, and 27,000 something for family coverage if that's close enough for us to talk about it. So what's interesting about this, the reason why theoretically that was in there other than to generate funds was to encourage—to discourage the very rich plans that are provided to upper echelon of highly paid executives that—and to encourage a little bit more fairness among an employee population. That was one of the reasons, but the way—what some people may ask you about, those of you who get questions from your constituents, is why were these amounts selected, and one of the things that has caused some of us some concern is whether or not by the time we get to 2018 this will really be Cadillac plans because the indexing factor is pretty narrow in the way that it's applied, and I've seen some estimates that many not Cadillac benefit types of plans could be swept into this tax at that point. So we're all wondering if maybe there

might be some modifications to that before we get to 2018, but that's a question you might get from your constituents.

**ED HOWARD:** Janet, there's no geographical adjustment in that sealing, is there?

**JANET TRAUTWEIN:** There's a minor adjustment. I don't work on this one everyday, but it's still—and it's not—by the way it's not just straight health insurance premiums. There are a few other things that are added into what the total is, and so there is some concern about what the dollar—that the dollar amounts are kind of—some people think that they're arbitrary, and those are the questions that, you know, our staffers are likely to get. When people are asking about that, they may be concerned about, gee, 40-percent over this amount, that's a lot of money, and so that's why you would get probably a question like that, and no one has really worked too hard on that particular provision yet because we're really busy with all these other ones that happen sooner.

**DIANE ROWLAND:** Okay, and, Janet, while you're up, why is the employer penalty greater for offering some insurance that doesn't meet standards than it is for not offering insurance at all?

**JANET TRAUTWEIN:** That's a pretty good question. So I can't assume to state the intent of the people that wrote the bill even though Sabrina and I were just talking about being

in a lot of meetings before it actually came into being. However, the idea—one of the ideas behind this is that if an employer is offering coverage, we want them to keep doing that. Employer-sponsored coverage is extremely valuable, but a very related part of that is that an employer can offer coverage every single day to a lot of employees, but it has to be something that they can take up, that they can actually pay for, and particularly employers with a large lower-wage workforce, no matter how great the benefits look, some of them just may not be able to afford their share, and that's why there is some value, and that's why we have a different definition of what your minimum benefit is on the first prong and the second to say, look, if we can get more people in and covered somewhere, and we're not talking about completely skinny plans. There are some basic requirements on either side, but if we can get them covered in some way, shape, or form, then that's better than them not having any coverage. It's better for numerous reasons.

So I believe that that's why they styled it like that, and not that I can know for sure, but I'm pretty sure that that was the thought process to really have a strong incentive for employers to keep doing what they do today.

**DIANE ROWLAND:** Okay, this question relates to probably more the future of outreach and enrollment, but what efforts

have been made, and I'm going to add or could be made, to integrate the Affordable Care Act with social service programs like TANF, SNAP that low income individuals may also be eligible for? For example, in Maryland, the recipients, their list has been very valuable in identifying individuals who would be eligible under the Medicaid expansion.

**FEMALE SPEAKER:** Well, there actually as states are—particularly states that are creating these new state-based marketplaces one of the things that they are doing as they move forward is building brand new integrated eligibility and enrollment systems because the requirements of the ACA are that sates integrate the eligibility determination process for Medicaid and the Children's Health Insurance Program with the premium tax credits. They're all under the—they're all called insurance affordability programs, and so what a number of states are doing, including Maryland and others, are integrating those eligibility systems with other social service programs, so bringing in TANF and SNAP and other programs so that when someone goes to the web portal on the exchange and fills out that application, they are screened not only for eligibility for Medicaid or CHP or the premium tax credits but also for some of these other social service programs, and so I think, you know, again, this is happening in states that are building their own marketplaces.

Some states, where the federal government is running the marketplace, there is still a requirement that those states upgrade their Medicaid eligibility systems, and so, again, some states that may not even be doing their—running their own exchanges or marketplaces, they are working to upgrade and automate their Medicaid eligibility systems, which will also in some states include pulling in eligibility determinations for these other social service programs.

**DIANE ROWLAND:** We have a question here about the impact of states not expanding their Medicaid program on national health care costs. I don't think we know very much about what that might do or expect that would do to national health care costs, but obviously it will have a big impact on whether the federal government's cost for covering the new eligible population at a hundred-percent are. So I don't think it will change the overall health care spending, but it will certainly the change the cost of federal government will be to support those expansions and obviously leave many more people uninsured than are expected to covered under the act. So that's—I answered that one.

**ED HOWARD:** And very well.

**DIANE ROWLAND:** So for all the panelists, we have two questions that we'll let you answer, and then we'll close the session down as you will. The first is that if we agree that

the Affordable Care Act has some non-ideal and non-optimal provisions, what are the major issues or what is the major issue you believe the ACA will run into down the road either in the long-term or the short-term? As part of that, do you all share Mr. Hash's confidence in the affordability of the health insurance plans to be offered in the ACA marketplace? So you can as panelists answer any part of these two questions.

**ED HOWARD:** Or not.

**DIANE ROWLAND:** Or not.

**ED HOWARD:** Apparently.

**FEMALE SPEAKER:** No, well, I think all of us would hope that—I mean, every single person on here has worked relative to uninsured issues for a long time. So all of us want more people to be insured, and all of us know that a key component of that is being able to pay for it. You want the coverage to be great, but it also has to be something people can buy, or they are just priced out of coverage. So it's very, very hard to balance those two things. You know, I do think that there are some of the provisions that aren't going to make coverage more affordable. So I have to be honest and say that. I would rather not say that, but there are some provisions that really need some modification, I believe, and I'm hoping they don't have unintended consequences so that people do face those price decisions and they make the ones we don't want them to.

So, you know, I think the modified community rating is going to be tough in some states. I wish we had more time to move into that, you know, so that it wouldn't—you know, if you're in Massachusetts or New York, it's not such a big change for you, but if you're in Texas or you're in Louisiana or you're in Georgia and some of those, that's a real big change for them. I wish we could ease into it a little bit more because what I've seen over the 30 years that I've been in the health insurance industry is that any abrupt market changes are extremely unsettling for consumers, whatever they are, abrupt, and that it's—if you can have kind of an easy move into things, usually you have less anxiety and less knee jerk reaction type of thing. So that's my answer.

**FEMALE SPEAKER:** So I will also speak a moment to the affordability issues. I do think it is a real concern that we have. We do know that for particularly low income individuals even though the subsidies are in the marketplaces are structured to really lower the cost for those lower-income individuals in that marketplace, still some of the required premium contributions may be difficult for these individuals and families to afford.

I will, however, make a plug for a program that was built into the law, but for which regulations haven't yet been written, but this is the basic health program, and what this

is, is this allows states to develop a program, state-subsidized program, for individuals with incomes between 138 and 200-percent of poverty who would otherwise go into the exchanges—marketplaces and pay subsidies for coverage, and so this program allows states to provide coverage that may be more affordable to those individuals, especially if they kind of build on the base of their Medicaid program and extend some of the same plans and providers that are available through Medicaid. Unfortunately as I said those regulations haven't been drafted yet, though, we have heard from CMS that they will be drafted by the end of the year so that states can implement this program beginning in 2015.

So I do think at least for that population below 200-perent of poverty this will offer an opportunity to provide them with a coverage that may be more affordable than what they would pay in the marketplace.

**ED HOWARD:** Janet?

**JANET TRAUTWEIN:** So I'm going to answer that from the perspective that I was asked to present here. Clearly if the ACA is capable of creating a more competitive marketplace in the insurance market, that, you know, would help, but underlying insurance is the real thing that we're trying to get at, which is getting care delivered to people. Insurance is really just a way to get to that, and we do have a health

delivery system that could use some improvement, so I think that the answer to, you know, what issues we really run into from my perspective is are the shifting incentives powerful enough to really create some real lasting change in the delivery system that is a real change for the delivery system? I mean, you're used to, as providers, focusing on an individual patient, what do they need right now? It's not so much thinking about it from an overall care management perspective of that person or of even thinking, which I would just throw this—these words out on the table from a population management perspective how do you really create a health system that supports the health of the people rather than just delivering care so that the provider then gets paid, and that's a really big shift, and there were a lot of incentives in the ACA to start along that path. There was a lot of programs in the ACA that have been talked about here to support that shift, and I would say I'm not sure where we are in the continuum of knowing how successful those will be, but to me a lot of the success of the insurance reforms and the affordability frankly rest on the success of the delivery system reforms. So that, I guess, would be my answer to it.

**ED HOWARD:** Sabrina?

**SABRINA CORLETTE:** So I do think that the affordability is probably one of the things that keeps me up at night most of

the time, but—and I was particularly struck recently the organization Enroll America did some national surveys, and if you look at what consumers think is an affordable premium and what, even on a subsidized basis, they're likely have to pay, there is a pretty stark disconnect, and so there's going to need to be a lot of education about what insurance really costs and what it's worth and what its value is.

I would also just say that I think we should think about the Affordable Care Act as a beginning and not an end. I'm working on a project with a colleague at the Health Policy Institute looking at lessons learned from Medicaid Part D, and one thing that keeps coming back at us over and over again is that when Medicaid Part D was launched, there were a lot of issues, a lot of challenges, a lot of problems, but we tinkered at it. You know, each year we worked at it to make it better, and so I think that's how we should approach implementation of the Affordable Care Act and know that it's not going to be perfect on day one, but there will be lots of opportunities to make it better.

**DIANE ROWLAND:** We'll have lots of opportunities to come back here and talk about how we're making it better.

**ED HOWARD:** Here, here. Thank you for being part of a very lively discussion. I don't know when we've had so many good questions on these green cards. It's been really very

helpful. Remind you to please help us make these programs even better by filling out the evaluation form that's in your packets, and there is a flip side to it, which you're probably not used to, that we'd like you to fill out. It's just another couple questions.

There will be a webcast available of this briefing next week, along with a podcast through the good offices of our friends at the Kaiser Family Foundation on their website at kff.org, a transcript a few days later on our website at allhealth.org, and in addition to thanking Kaiser I'd like to thank our panel and ask you to help me in doing that. [Applause].

Thank you all. It was terrific.

[END RECORDING]

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