“Rate Shock”- Or Not?

Alliance for Health Reform
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ED HOWARD, J.D.: Good afternoon, good morning in some time zones, I guess. My name is Ed Howard. I'm with the Alliance for Health Reform, and I want to welcome you to this webinar on health insurance rates that are going to be available in the insurance exchanges, when they open just seven weeks from today, on October 1st. People and small businesses will be able to enroll in one plan or another. There'll be an exchange in every state, and that's one of the major features of the Patient Protection and Affordable Care Act, the health reform law that we're going to call the ACA for today.

Predictions are that about seven million more people are going to get coverage through these exchanges, or market places, in 2014, and that would increase the number getting individual coverage, that is covered not through their employers, by about 50 percent. I think it's worth setting a piece of context here; that is, most Americans who now have coverage will probably not be dealing with the exchanges. If you get your coverage through your employer, and it's a substantial enterprise, you'll continue to get your coverage through your job, perhaps with some changes in what's covered, perhaps with some changes in what you have to pay, but you won't touch the exchanges. Though there'll be an exchange in every state, and there are some federal rules that apply to all

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of them, they'll look different from one state to another—and we'll find out exactly how in just a few moments—partly because the ACA gives states discretion in a lot of the aspects of exchanges, including whether they want to run one themselves, or let the federal government do it. Simply put, about a third of the states are going to operate their own exchanges. A handful will handle some of the major responsibilities, like insurance market rule enforcement, and about half, or a little more, are going to have exchanges largely or wholly run by the federal government.

Now, there's been a lot of attention paid to how these exchanges are going to work. If you're interested, the Alliance For Health Reform conducted a briefing on exchanges, specifically just last week, and you can look at the broadcast tape of that event on our website allhealth.org, and one of the most hotly discussed aspects of that issue was how much will these policies cost. Hence, our closer look today at the rates expected in the exchanges. Are they going to cause rate shock among buyers, are different people going to be affected differently, are high rates going to keep people away from exchanges altogether? How much do we know now about rates that are going to be chargedcome January 1st, which is when the coverage actually begins? That's the heart of today's discussion.

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Joining us in sponsoring today's webinar is the Robert Wood Johnson Foundation, which has been working to improve the health and healthcare of Americans for more than 40 years now. We're grateful for that support.

Here's how we're going to proceed; if you can hear me, you're already on the webinar homepage. You'll be able to see the PowerPoint slides of our panelists on your screen when they're discussing them, and you can ask a question yourself by simply typing it in to the box on the right hand side of the screen. You can follow the Twitter conversation at #rateshock. This webinar is going to be archived on our website, allhealth.org, in a day or two, and we'll proceed from there.

We're grateful not just for the Robert Wood Johnson Foundation support for this webinar, but also for the terrific panelists we've lined up to discuss this issue and respond to your questions. You'll find more biographical information about them right there on the homepage for the webinar. There's also a link labeled webinar materials to a bunch of relevant background material.

Let me now just briefly introduce all of our panelists. To my immediate left, Linda Blumberg is one of the country's most respected health economists, and for more than 20 years, she's been analyzing private health insurance and a whole host of other policy issues at the Urban Institute. Uwe Reinhardt,

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on my immediate right, is a Professor of Economics at Princeton. He's served on most of the important advisory policy bodies convened nationally. He writes regularly and quite entertainingly for the *New York Times* blog, Ecomonix. On my far left, and it gives me pleasure to say it, that way—

TOM P. MILLER, J.D.: That's the first time.

ED HOWARD, J.D.: —Tom Miller, also a health economist, in fact former Chief Economist for Congress' Joint Economic Committee. He's with the American Enterprise Institute, where he heads their Beyond Repeal and Replace project. I assume that refers to the Affordable Care Act, Tom.

TOM P. MILLER, J.D.: That'll do.

ED HOWARD, J.D.: Uwe, let's start with you, if we can. The ACA required a number of changes in insurance markets. We know that insurance companies, once the ACA is fully implemented, won't be able to take a person's health condition into consideration, in setting the premium. We're moving towards some kind of a common rate structure, one you economists, I think, call modified community rating. I wonder if you could explain to us what's behind that rationale, and how it works.

UWE E. REINHARDT, PH.D.: The idea of an insurance pool that people can join, without having their premium reflect their health status, is actually not so novel in America. All

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employment-based insurance actually uses that principle. Every congressman benefits from this principle, every senator does. It's only the small market niche, which is for individually purchased insurance, and for small groups, that is actually at play here; that's the first thing that has to be noted. Now traditionally in that market, particularly for individuals, insurers did indeed medically underwrite, which means they asked a long questionnaire and might even send you to a doctor to get more information, and then base their premium to you, as an individual, on your own health status. The effect of that was that for sick people, premiums were sky-high, and many were just refused insurance, outright. I just looked at a study done by Milliman for Indiana, 24-percent of people aged 55 and over were refused insurance because of their health status. What this bill does, it levels—

ED HOWARD, J.D.: Do you want to use your slides?

UWE E. REINHARDT, PH.D.: Oh, yes, in fact, let me actually go directly to what I'm talking about. On the vertical axis, in this graph—I'm a professor, I've got to use these tools—on the vertical axis, I have a little equation; one plus L times X i. That X is the expected, actuarially expected cost of individual, i, in the coming year. Then L is a loading factor for administration, for marketing, and for profits, which, for small insurers selling in that market, can be huge.

For example, in that market, of the total premium that you pay, at currently somewhere between 35 and 45 percent, just go for marketing, profits, and administration. That should be much lower on the exchanges.

Now, in this traditional market, the premiums you would have, as shown by this white line on the horizontal axis, I have people, a rate from very healthy on the left, to very sick on the right. As you can see, at some point, where the line is dashed, you wouldn't even be sold insurance, because the premium would be just too high.

What this bill does, is essentially draw a line through this curve, and say, for the same amount of money that gets paid out, healthier people will now pay a higher premium, but sicker people and those who were refused, will pay a much lower premium. That is why it's not fair to talk about premium shock all the time; that refers to the younger people, who would not have to chip in more to help pay for the healthcare of the sicker people. The sicker people and those who were denied insurance, they will experience premium joy. For them, this will be a whole novel experience that they can actually get insurance at an affordable premium. It's premium shock for the healthy young, and premium joy for the sicker and older people. That needs to be understood.

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Now, if you do this kind of arrangement, you have to be sure that young people actually enroll in the sick pool, because if they did not, then the pool of people who are actually insured will be relatively sicker, and their average cost, on which this so-called community rate of premium is based, will be higher too, so you might get the red line. The reason why the Obama administration is recruiting young people to join the pools is precisely to prevent that line from shifting from the green, toward the red line.

It, in my view, has been reported very poorly in the press, because all you ever read is premium shock. Have you ever run across the word premium joy, that so many people are actually better off? If anyone just talks about premium shock, you already know they're biased or, which is likely, they don't understand this graph, which is why I drew it. They would like to be honest, but they don't really understand actuarial principles.

Now, when you do community rating, that is, give everyone the same premium within a risk pool, and within a certain age band, then you need a three-legged stool. First of all, you have to tell insurers, you must accept everyone, and sell them a policy at that rate, the green line. Secondly, you have to mandate people to be insured, because otherwise, people will say when I'm healthy, I'm not going to insure, and then

when I am sick, I can go to the insurer, they have to sell me a policy, not pegged on my health status, but pegged on the average community rate. That is officially—that's supporting freeloading, and I don't think the idea that supporting freeloading, as a national policy, is a good idea, so I support the mandate, as, incidentally, so have many, many people.

Both Republican and Democratic economists and Republican and Democratic congressman have supported the mandate. What we now have is not actuarial; it's just the partisan politics. Then, finally, you must also give subsidies to the lower income people, who cannot even afford the community-rated premium, and that is, of course, in the bill; there will be federal subsidies to help low-income people.

That's another little wrinkle that you really have to be careful about. The premium that is quoted to an insured individual is not the premium they will actually pay. You have to look: what is that premium; minus what subsidies do they get from the government? You have to look at the net premium, and if you look at that, the premium shock for many people will be, actually, rather mild, or might also be premium joy, because after subsidy, the premium you pay might actually be lower than the premium you paid before for the same benefit package.

I think that's pretty much what I wanted to tell you, but just to understand what is the actuarial mechanism at place

here, and why do some people benefit, and others will get hurt, or might get hurt. How this will come out is a purely empirical question; you cannot answer it now. You can demagogue, you can spin your wheel either way, but we actually really want now, until this is run in for a couple of years—but we do have a good clue now, where things stand and I think the next speaker will address some of that.

ED HOWARD, J.D.: Indeed, thank very much, Uwe. We do turn to Linda Blumberg. Linda, help us understand what we actually know, and don't know, I guess, about what insurance rates people are going to be facing in these new exchanges, and why that might be the case in a particular instance.

LINDA J. BLUMBERG, PH.D.: Okay, sure. Can I borrow that?

ED HOWARD, J.D.: Oh, yes, sorry.

LINDA J. BLUMBERG, PH.D.: Thank you. In recent months, what we have seen from news reports has been a real mix of information and concerns and different tones. For a long stretch, we were hearing from insurers and others, who were very worried about premiums that would be charged under the Affordable Care Act's new non-group marketplaces, or exchanges, as some would call them, would be that they'd be very high relative to currently available prices. This is the rate shock that Uwe was just referring to.

More recently, however, we began hearing more positive stories, as some states were releasing the actual premium bids that were submitted by insurers, and that turned out to be lower than expected. These reports remain mixed, with statements out of some states of enormous increases, relative to the pre-reform premiums. With all the back and forth, it can be very hard to identify what's actually going on, and to figure out what we need to know, and the questions we need to ask, to be intelligent consumers of pretty complex information, in the midst of a very highly charged political environment.

We should start out by getting a clear understanding of how the marketplace premiums are going to vary within each state, and then move on to how and why they'll vary across states, and across geographic areas. Premiums in almost all states are going to vary with age, although in New York and Vermont are exceptions, and New Jersey and Massachusetts will have less variation across age than other states will.

Smoking status will also be a factor, although seven states won't let the premiums differ for smokers, versus non-smokers, and three states are going to allow less variation in that premium factor, that what the federal government allows. Family size is also going to be reflected in premiums, as will sub-state geographic areas; Rhode Island, for one, is a state that has one big rating area for the whole state.

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Premiums will also vary by the tier of coverage that people buy, with different tiers named for precious metals; bronze, silver, gold, platinum, and having different average levels of cost sharing, to go along with them. Premiums within a tier of coverage, within one of those precious metal tiers, will also vary across plans, due to differences in cost sharing, that are placed on different services. There'll be benefit differences in those states that allow some substitution of benefits within particular categories. There'll be different plans, with different administrative costs, that are going to be reflected in the premiums. They'll also have different provider networks, with some focusing on less expensive providers than other plans, and then having lower premiums as a consequence.

Now, premiums are also going to vary across geographic locations. This is due to differences in medical spending and medical practice patterns across the country, and just states' different choices of essential health benefit benchmark plans. Very importantly, the level of competitions in both insurer and provider markets differ significantly across the country, and these differences have long preceded the implementation of the Affordable Care Act, and much of it is going to persist after the full implementation of the law, as well.

This is because entry into insurance markets is difficult. A new entrant must be able to negotiate favorable rates with hospitals and doctors, in order to compete effectively. If a market is dominated by one or two large insurers, providers can't justify giving a new market entrant low payment rates as a deal. The situation is very difficult to change in these markets that are already heavily dominated by one or two large insurers, even under the Affordable Care Act.

In some areas though, we're already seeing entry into the private market by formally Medicaid only managed care plans; so public plans operating only in the Medicaid market before now. That appears to be making a real difference in some areas. These are plans that are used to serving a low-income population and have previously been able to negotiate lower payment rates with a group of hospitals and physicians.

Co-ops are entering some markets as well, and some of those may do better than others, but their impact on competition is pretty unclear. We don't expect that the multi-state plans that are being developed by the Federal Employees Health Benefit Plan is going to be a major factor. If there's a dominant hospital system in the area, one must-have hospital system, it can make it hard for even a dominant insurer to negotiate good rates, which limits the ability of the insurer

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to hold down premiums. In areas that are not plagued by a dominant insurer or hospital system, there's evidence that the Affordable Care Act may well be catalyzing additional competition in these markets, beyond what they have had before.

Here, in this chart, we have premiums that are age-adjusted; it's an average over the expected distribution of age of enrollees in the non-group marketplace. These are monthly premiums for the lowest cost silver plans in 10 states, plus the District of Columbia. We see that these are clustering in the neighborhood of about 300 dollars a month, some higher, some lower. There are obviously higher premium bids than these in the exchanges, but this demonstrates that reasonable premium levels are being seen in the states where we have information so far. Bronze level premiums are going to tend to be lower than these, and gold and platinum premiums higher, due to the different out-of-pocket requirements that those plans carry.

Some general observations so far: premium rates are coming in generally lower than many expected, but there are some outliers for sure. Some insurers are even modifying their rates after seeing where their competitors have landed, so that they aren't too high, relative to the competition. We can also expect competition to increase over time. In the first year, bids are fairly competitive so far, but uncertainty remains among insurers on the best pricing strategies. In years two

and three and beyond, insurers will have a better understanding of the health characteristics of exchange enrollees, the ability of tools, such as reinsurance and risk adjustment, to adjust for any adverse selection that might occur, and they'll have more information on the choices being made by consumers, and their preferred tradeoffs.

It is definitely worth placing these premium bids in perspective. The estimated average employer single premium in 2014 is 6,190 dollars a year, or 516 dollars per month, which is my calculation based on the most recent Kaiser Family Foundation employer survey. This is compared to the bids that we are seeing in the 300 dollar per month range, in the non-group market place. In addition, it is comforting to know that the expected health status of enrollees in the new market places is similar to that of the employer-covered population, which was a finding of a recent analysis that John Holahan and I did. This is true with respect to self-reported health status, an array of chronic conditions, smoking status, and obesity rates. There's just not that much difference between who we expect to enroll in the exchanges and the employer market.

Plus, as Uwe already suggested, large majorities of exchange enrollees are going to have incomes that qualify them for tax credits, limiting their premium payments to a fixed

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percentage of their incomes. It's very important to recognize that some comparisons that are being reported in the media comparing them to pre-reform premiums are very misleading, due to focusing only on young healthy male premiums under the current system, those with the lowest premiums today, or comparing comprehensive reform premiums to very thin pre-Affordable Care Act non-group premiums, and products that have limited benefits and very high levels of out-of-pocket responsibilities. When we hear claims that sound extreme, it's important to ask questions about the details around how the comparison is being made.

ED HOWARD, J.D.: Right, thank you very much Linda. You will pass the clicker to Tom, and let him reboot it on his own slides. Tom Miller, you've been looking at all of these rate predictions and the projections and, as Linda mentioned, we've seen headlines about 30 and 40-percent increases in the individual market. We've seen headlines in New York that the rates are going to be half as much as they have been. What do we really know now about what the rates are going to be, and when are we going to really know what they are?

TOM P. MILLER, J.D.: Well, the short answer to—I am trying to get to my title slide: Rate Shock, or not—is yes, both. First off, I have to say I am a conscientious objector of—when we get to this title slide on the use of Orwellian term

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market places for exchanges without real markets. I use the old term, which we used to know in the pre-Obama redefinition, the phrase exchanges. Let's see, here we are, okay, powering up the Affordable Care Act's exchange grid.

I'll give you a little bit of a wiring schematic on this, as to the questions to whether or not the grid is going to have the current flow, like a conductor, in which charges are free move from place to place—we can call that a market—or perhaps an insulator, where are charges are fixed in one place and can't move. We call those subsidies, regulations, and mandates. The question is what kind of railroad are the conductors running? Well, we have some brownouts, or blackouts. A lot of this, of course, depends upon who's doing the viewing. You may think of the description of exchange effects, depending on who's narrating the story. The Rashomon effect, the 1950 Japanese film, in which it turned out you have four different individuals describing a crime incident in four mutually contradictory ways; a problem arises in the process of discovering the truth. A different way of thinking this in the political context is a bit of a political Rorschach test, in which we see different worlds in this slide depiction. It was one I used before, to indicate whether you're seeing incentives or compulsion, depending upon how you want view the inkblot; is

this a fair and less costly mechanism, or a more expensive and bureaucratic one?

Let's talk about how we got here, to what originally set the expectations in the context of what we thought was going to happen in 2014. It probably goes back to the 2009 CBO projections, artificial in their own ways, but came to the conclusion, when the law was being considered by Congress, that the individual market, after all was said and done, would see an increase above what otherwise would have happened to individuals premiums, about 10 to 13-percent. A lot of assumptions embedded in that, that there would be offsetting the expense of the greater amounts of coverage, in terms of benefits provided. There would be lower administrative costs, perhaps some heroic assumptions on that part, a healthier population mix; all that also embedded with full scale Medicaid expansion, pre-Supreme Court decision, individual mandate of greater strength, it appears to be the case, and less adverse selection.

Now, that was somewhat challenged, not very successfully, by various private actuaries for hire. PricewaterhouseCoopers got hammered a little bit for saying that individual market premiums would go up more significantly, based upon a limited set of assumptions. It was the Oliver Wyman study. These were somewhat sponsored by the insurance

industry, so there were some questions as to exactly how well they would hold up in their own artificial assumptions.

Later on, we've had some other actuarial studies. The American Academy of Actuaries has tended to suggest that the per-member per-month cost in the individual market may go up; one figure was 32-percent, but these are a lot of artificial assumptions, fairly complexly embedded. You can spin them around however you want to and get somewhat different numbers along the way, and it depends which cohort you are looking at. If you go to younger people, you get higher increases, say, below age 30, or even 30 to 39.

House Energy and Commerce did a survey of about 17 of the largest health insurers. Again, you can go and get them all over the lot, but basically, the takeaway point with a lot of embedded assumptions are individual markets could go up as much as 96-percent for newer business, whereas people who were keeping their insurance in the individual market would see rate increases of about 73-percent. Again, you can challenge all the assumptions embedded in this, but basically, is the argument that increased benefits, higher actuarial value. Assumptions of a less healthy population, rather than a more healthy population, going into the exchanges and effective rating restrictions, all is what drove those costs higher.

A lot of this is not just differences of opinion, but sometimes-partisan polarization. You can choose your state, you choose your sources, you can choose your assumptions, and you can get the results you want, just like watching cable news, or talk shows.

What are some early state returns around the horn? Linda mentioned the ASPE study; these were the early reporting states in the exchanges, most blue ones, I might add. A little bit of the eager beavers interested in having a better reporting number. There's also a smaller set of states for the smaller group market, and basically, they were saying their premiums will be about 18-percent lower, but they were using a very artificial CBO-extrapolated baseline, where you first take the average premiums for 2016, roll them back, and then compare them to the lowest silver plan premium. It's not really a fair comparison, but it makes you look better and everybody gooses this a little bit, to make it look like it's somewhat of a better result, depending upon the source of it.

Avalere Health did a little bit more of a balanced survey from 9 states, using the lowest cost silver, second lowest silver plan. They found that the rates were below the old CBO estimates, but were still higher than the current individual market.

Let's take a look at some individual states on this front, the blues, and the reds. California was an early reporter; big press release, terrific, we're giving as low as 29-percent in the individual market; artificial baseline comparison. Everybody plays games like this. What California did was they compared the individual rates to what the rates were in the small group employer market. I'd like to be able to make those comparisons as well, but it's not the same thing as apples to apples. Avik Roy, at Manhattan, did a pretty good job of taking that apart. When you actually look at a balance and say the five lowest premiums and the private market outside of the exchanges, you get very different figures, and it shows substantial increases in individual market premiums, compared to what was before. More interesting is a subsidy cutoff point where you get into about maybe 160 to 180-percent of federal poverty, or even with subsidies, you still pay more if you are a younger male, a non-smoker, below age 30, and below age 40, in some cases.

We also did a *New York Times*, spreading the news in New York. If the ACA can make it anywhere, it will make there, saying how great it was that the premiums were going to come down in New York. Of course, that's an interesting bias sample. We had a very tiny individual market post community rating. It's not hard to improve New York, as they did, by

assuming that the mandate would hold up, and you bring more people into a pretty dysfunctional individual market.

Maryland just had some success report. In this, they did a lot of rates suppression, rate squeezing, with more active rate review, and rolling back some things; some insurers dropped out, but that's a much more regulated market, and so they've got some numbers that look good. Vermont is pretty much a wash, because there're only two insurers anyway, so it's pretty much same old-same old story, regarding what they wanted to do politically. Washington state, if you actually massage the numbers, it turns out their rates were going up.

Now we've got some other states where they're not playing ball with the exchange, but they still look at the rates as state regulators. These are the soon to drop federally facilitated exchanges, barter places, whatever you want to call them. They're not the formal rates, but the insurance commissions have begun to say here's what we are looking at, and we're passing through. Ohio, which probably Uwe will say is a biased description of this, came up with oh, they brought it down from old , and now they're at 41-percent higher. Indiana, 72-percent higher—these are individual market, basically, depending on what cohorts you want. Florida, 30 to 40-percent higher in the individual market. Georgia, more interestingly, in terms of spikes as much as

three times as large, and I think they did a fair job on that front, from what I have seen, in terms of the original description list. The Georgian [inaudible 00:31:28] asking for actually a 30 day delay, saying we really can't approve these rates, although they're justified; I'll take it back to the shop.

What we are doing is we are waiting to see what the real rates are, but the early indications are depends upon what your assumptions are. Some of those assumptions take up distribution. Does the mandate really have an effect? Who actually goes in to the exchanges, are they healthy or not healthy, and there are difference of opinions on this. The Medicaid expansion, whether that's going to be full, partial, or where we are going to be on that front, makes the differences to the bottom part of the tail you might cut off. Pre and post subsidies depends upon whether you're counting all-in costs, or just what the sticker price is to people; regardless of who pays, there is a crossover point though, at which even those subsidies, if you go further up in the federal poverty level, aren't that generous to the folks when you get above 200-percent, 250-percent of federal poverty; it does not make enough of a difference. Either these are differences to whether, just because this stuff is offered, who is going to

buy it; the distribution on the ground could be very different in what's assumed beforehand.

Let's take a look at some other variable variables. Oh, it looks like I am blowing through my time here. Pre ACA, Linda indicated this basically; the more regulation you had in the state, the more likelihood you have a chance to not go any higher and could drop lower. More competition opens up different possibilities to change it. Insurer dropout's another factor. The effect of low bids on subsides, we saw in Oregon, indicate that what look like who might be generous subsidies, they mean a lot less, if the two low bids turn out to be much lower than everybody else. You're making the worst and best political cases in the messaging, and you may be setting expectations either too high or too low. The snapshots and the future factors, is a statically dynamic first year, is one thing. Second and third are very different, and the strategies of the insurers and whether they want to add the winners curse, or believe that by getting market share, which later will have loyalty in expanding business later on; low ball, or selectively engage. We're shuffling subsidies.

One thing we forget about, all these subsidies are, their other costs. Every time you route dollars through the tax system, you end up having dead weight losses and effects on

economic growth. That's another that's the political version of administrative cost.

Finally, are we benefiting from the recent cost slowdown, will that continue and how much does that change some of these projections? Thank you.

ED HOWARD, J.D.: Great, thanks very much Tom. In fact, let's start this discussion where Tom left off. Let me remind you that we now have a period of time when you're able to ask a question. If you type it into that box on the right hand side of your screen and hit send, we will get to as many of those questions as we possibly can in the time we have, and we have enough time to take advantage of the fact that we have some very knowledgeable panelists who can respond to those questions.

Tom was looking at some of the rate variations in specific states. Not everybody is going to pay the same thing. Some are going to pay more than they do now; some are going to pay less than they do now. What do you actually think the most important factors are that are going to affect these differences in rates? We've talked about some of them. Is there one or another we ought to be keeping a particular eye on, or does it vary from state to state? Linda, do you want to start off?

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LINDA J. BLUMBERG, PH.D.: Sure. Well, there are a number of factors that are important, such as age and the health status of the people that have already been in the insurance market, as others have said. One of the important things to remember is that is the non-group market in the vast majority of states in the US has been the most dysfunctional insurance market that we've had. What is very characteristic of policies in the vast majorities of these states is that it's not only the rating that is different, based on the individual's characteristics—what their age is, what their health status, what their past health claims experience has been—but that the product the product that they're buying varies too.

Some individuals are buying very personally, as packages that have many benefits, such as maternity and mental health, and prescription drugs, and other general types of benefits that have been just excluded from that market, in general. Others are only offered policies that exclude parts of their bodies or body systems because of the past health experiences that they've had. What somebody has today in the non-group market can be very non-comparable to what is being offered in these comprehensive complete packages that contain all essential health benefits under the Affordable Care Act. While people had—it is not just the premium that people should

be thinking about. They should be thinking about the out-of-pocket costs as well. If they had, for example, deductibles of 10,000 dollars that excluded everything having to do with their past health claims, they may have had very large out-of-pocket requirements, even when they used medical care and had insurance, whereas that would be reduced, but somewhat of a higher premium, under the Affordable Care Act.

There's lots of variation out there in the products that people have, the cost sharing, the benefits covered, and the premiums that they're charged, and so it's a very complicated milieu to do those comparisons.

ED HOWARD, J.D.: Uwe, do you want to supplement that list, or is there one of those you want to endorse?

UWE E. REINHARDT, PH.D.: If you had to make points, you would say, obviously, the composition of the risk pool, for which this community rated, this common premium is calculated, if most young people don't join it, then you will have a sicker risk pool, and that'll drive up the community rated premium. Linda mentioned these aged-weighted premiums, and I wonder why did they age-weight them, because it doesn't tell you very much. You would really want to know, if you want to do these comparisons, how much for a given age group, do the premiums vary before and after, because you could have a high premium in

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the state, simply because there are a lot of old people there, if you age-weight. I don't think I would have done that.

The other thing we often overlook, health care is cheaper in some parts of the country than in others. I think New York is very expensive. Boston, I think, is very expensive health care. If you go to Iowa, or some other places—North Dakota is probably a lot cheaper—so that, obviously drives premiums as well, and then, all the other factors Linda enumerated; they're in there. It's an extraordinary complicated mixture of factors that drive the ultimate number, which is that premium. That is why everyone is wrestling with it and why economist are on the one hand, on the other, because it really does, as Tom pointed out, depend a lot on what assumptions you make to make these predictions. The beauty is, a year from now, we will know what it was, although economists will probably manage to disagree about that one too—

TOM P. MILLER, J.D.: We'll find a few things to argue about.

UWE E. REINHARDT, PH.D.: —but that's just— we still have trouble understanding the Great Depression of the 30s. I think we will know a lot more once this is running, run in. What we're seeing now, at least, isn't alarming to me, the studies that I have seen, but again, it doesn't have every state in it, and we'll just have to see how it comes out.

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ED HOWARD, J.D.: Tom, I don't want to cut you off, do you want to add something?

TOM P. MILLER, J.D.: Well, I think this is a postscript; I think the conclusion I would make is we're still lost, but we not even making good time.

ED HOWARD, J.D.: Which may, or may not, be a bad thing, right?

TOM P. MILLER, J.D.: Right.

ED HOWARD, J.D.: One thing that hasn't, I think, been emphasized that I want to make sure that people understand and, for that matter, I want to make sure I understand it, all of the data we've been seeing so far on premiums has to do with premiums in states where the states are running their own exchange, is that correct?

TOM P. MILLER, J.D.: Well, there've been some, really, glimpses, which aren't official, because the feds, when they finally say what they are going to do in your exchanges, may end up not approving some rates. It's not the final word, but from some of the states in federally facilitated exchanges, they've indicated, at least the ones who are sounding off, are saying the rates look higher to them.

UWE E. REINHARDT, PH.D.: I think the ASPE study had four state and 12 federal exchanges, didn't it, or three?

LINDA J. BLUMBERG, PH.D.: Yes, they had Ohio in there, Virginia in there. New Mexico is a partnership split, because they're running the shop exchange. The rest of them, I think, were state-based exchanges. Most of what we're seeing is that there are differences in state law about when the departments of insurance have to reveal the premiums that have been submitted for approval. Some states say you have to release these right away, and others states can hold them in reserve; that's why we are seeing different ones come out at different times.

UWE E. REINHARDT, PH.D.: The answer is this should have been active exchanges and passive. An active exchange actually gets premium bids from the insurer and then makes judgments on the, and renegotiates those rates with the insurers. Maryland, for example, did that. A passive exchange will just be like the healthinsurance.com, a broker that just lists whatever rates they were given, but they themselves, the exchange, won't actively negotiate the rates. That ultimately drives some differences in the premiums you ultimately see, because I remember Maryland actually, for some bidders, reduced the rates in the end.

TOM P. MILLER, J.D.: They also lost a couple of bidders.

UWE E. REINHARDT, PH.D.: They lost to some, yes.

TOM P. MILLER, J.D.: One of the effects—we saw in California with other types of insurance, you can suppress rates for a year or two, but if you look at the long line equilibrium, they end up having to restore them later on, based upon the economics. You can do that for a period of time, and that is something—we need to look at this over several years, rather than what the first squeeze might be, where you say you're either in or out, and you're going to take this rate. Insurers with some strategies will say we can take the loss for a year, because we think if we can get loyal customers, then in the later years, they won't move, and we can move it back up.

ED HOWARD, J.D.: Which brings me to the first question submitted by one of our viewers, which is, what is a fair length of time to give this part of Obamacare, before judging it a success or a failure? Is there a projected equilibrium point, if not, a projected rate?

LINDA J. BLUMBERG, PH.D.: I don't know that there's a magic number. I think that we're talking about two or three years, here. I don't expect that the equilibrium is going to take that long to reach, but I don't think it's fair to look at the first year, and judge it wholly based on the first year, because there's information that has to be dispersed, people have to understand how to enroll, all of the IT systems have to get their bugs worked out, et cetera, and the outreach systems

have to be in place. I think the first year is going to be, potentially, a little bit rocky, and a lot of variables and things should improve as that year as goes on.

UWE E. REINHARDT, PH.D.: I think it might take even five. Look at when we changed just a rate, we switched from fee for service or usual customer in hospital reimbursement, under Ronald Reagan, to DRGs, and that was a four-year phasing of that. We did a similar thing for physicians; four years, so I don't think you can fairly judge what really happens until four or five years out, because there's learning by doing. People learn how to deal with this. People also will learn how to get in the system, and then the regulators will react. I think this is a living thing in progress. I don't think—even Medicare; there were fixes and changes along. Medicare has never been totally not changed. You have to wait, certainly, until the soccer game is over to see who won. In this one, I say that game will take at least four years.

TOM P. MILLER, J.D.: I think among the more active partisans, the conclusions will be in about a day after the exchanges open. There'll be a rousing success out of the Obama White House, and the tea parties will be saying this is an unmitigated disaster, hell has arrived upon us, let's scrap it entirely. A lot of built in conclusions are already there, as

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well as some of the folks who are analyzing this and saying look what it shows.

UWE E. REINHARDT, PH.D.: When you say analyze, these people work in a data-free environment basically.

TOM P. MILLER, J.D.: You choose the data you like.

UWE E. REINHARDT, PH.D.: Oh, yes.

TOM P. MILLER, J.D.: They then look underneath and look at the assumptions. If you really burrow through assumptions, you can find out what real people think should happen, as opposed to the one that necessarily is arriving.

ED HOWARD, J.D.: One of the questions about data-free environments that arose for me is who is it who really sets these rates? Is it the companies themselves, is it at the state insurance commissioners; who has the final say, is it the exchanges?

LINDA J. BLUMBERG, PH.D.: No, the insurers set the premium rates. Now, as Uwe suggested, some states like Maryland can come in and they look at the data underlying the rationale for different premiums and they say listen, these assumptions that you're making are not assumptions that we will accept and so, if you're going to participate, you're going to have to participate using this assumption instead, and that's bringing the premium down. Then, insurers can decide whether or not they're willing to accept that or not, so they have the

final say, at the end of the day, and they are submitting the premiums, initially, based on their expectations of who's going to come into the pool, and then they'll have to adjust those in subsequent years, based on what they learn as they go along.

TOM P. MILLER, J.D.: We've seen that the actuaries, in many cases in this unchartered environment, are guessing and they're guessing all over the lot. You can see the variation of different plans in the same market, all over the lot, because we are doing things in unchartered territory, and the eye of the beholder says it's reasonable or not reasonable.

ED HOWARD, J.D.: I can't remember which of you mentioned that it's not just premiums that people have to worry about, with respect to expenses, it's deductibles, it's copayments, it's services that you might need that aren't covered, or vice versa. How should consumers try to compare health plans on those criteria?

UWE E. REINHARDT, PH.D.: One thing you left out—it's also the network and insurers entering into deals with hospital and doctors and pharma companies and have a network. What you're buying is actually access to that network, and if you care about who your doctor is, who your hospital, you do want to care about who's in the network and not. That's where I would start to say what are my options when I'm sick, for having a choice. Then, obviously, you do have to look—I would

next ask, if worse came to worse, what would be my maximum hit, out-of-pocket, that I would have to take; that's the second thing you would want to see, rather than deductible coinsurance, et cetera. Tell me my maximum hit, just in case I get hit by a bus. Now, this is unlikely to happen, but don't let anyone ever feed you actuary averages. If so many people who jump off a building, three survive, that doesn't mean anything to you, really. You really want to know at the extreme what would happen to me.

TOM P. MILLER, J.D.: Well, based on *The New York Times* today, we don't even know what the maximum is, because the administration has delayed that for a year.

ED HOWARD, J.D.: Do you want to say a few more words about that, how important is that?

TOM P. MILLER, J.D.: This is because of different deductibles and out of pockets, and about pharmaceutical as well as regular medical spending. There was a little embedded, I think tucked away, saying, because it's difficult to get computer systems to match, what was supposed to be the maximum sealing on out-of-pocket costs, starting at 2014, is delayed at least a year, like the employer mandate has been delayed, like a lot of other things have been delayed.

UWE E. REINHARDT, PH.D.: Yes, but we should just expect delays. You have that in business; you build a new

plant, you think it's always done on time? There's always delays. Think of weapon system, are they ever—

TOM P. MILLER, J.D.: This is resembling a weapons system.

UWE E. REINHARDT, PH.D.: Yes, well, is stuff ever delivered on time? Things happen, things are complicated, and a slippage of year, to me, is nothing when you did this. Normandy Invasion probably slipped too, a few days or a month; these things happen but, as you say, Tom, somebody there will then declare failure or not, over something that's really rather trivial.

ED HOWARD, J.D.: I've got a question from one of our listeners or viewers. An important aspect of insurance rates is insurance coverage. The ACA allows health exchanges to interpret the meaning of essential benefits, as Linda mentioned. What do you know about state variation in essential benefits, and how might this account for lower rates in some states?

LINDA J. BLUMBERG, PH.D.: Well, I think it will matter. A lot of the states, what they've chosen, most of them have chosen the most enrolled small group plan as their benchmark for essential health benefits. The benefits, as long as everything, all the categories in the law are covered in the most enrolled small group plan, then that is the benchmark for

designing benefits for the insurers. The fact that some plans of that, in the small group market, where more narrow than they were in other states, that could lead to some variation. We don’t think that’s going to be a huge amount of variation, but it is going to make some differences. In addition, some states are allowing insurers, even around those benchmark benefits, to make some substitutions within categories of service, and that is going to change the premiums for some plans, relative to others, if they are able to finagle enough to dissuade those enrollees with high costs from coming into their plan, because they increase cost sharing on a particular service that’s associated with people with a lot of medical needs.

I think those are things that we need to look out for. I don’t think the overall differences in the essential health benefits benchmarks are going to make an enormous difference, but they will make some.

TOM P. MILLER, J.D.: There was a little slippage on what was supposed to be a requirement, that if the state’s mandated additional benefits beyond a certain cutoff point, they would have to pay for it on their own dime, and that was fuzzed away, so that doesn’t apply. We’ve also got the other category, which is not the exchanges; the minimum essential benefits, we’re finding out there’s a loophole by which employers can offer very skinny benefit plans and, in effect,

dodge the requirements of the mandate, which may have other ripple effects, in terms of who's enrolled and who isn't enrolled, and whether they go to the exchanges where there's a penalty.

ED HOWARD, J.D.: We've talked almost exclusively about individual markets. There's another exchange that is going to be operating, come October 1st, and that's the so-called shop exchange, the small business exchange in each state. Is there as much controversy about what's going on on that end, or that much visibility? I haven't heard a whole lot about what the small business exchanges are going to look like, and what they're going to be charging, and what their anticipated enrollment is.

UWE E. REINHARDT, PH.D.: Are they going to be ready October 1st? I thought that was—

TOM P. MILLER, J.D.: It depends on the states. The feds say they'll have it, but a lot of the states have been rolling it back; Connecticut is one example.

UWE E. REINHARDT, PH.D.: If they can, I think.

TOM P. MILLER, J.D.: Well, you can roll anything back under this law.

LINDA J. BLUMBERG, PH.D.: Well, what's interesting is that the federal government decided that the employee choice, the component of the law that is going to allow workers whose

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employers participate in the small business exchange to make choices around an assortment of plans. They are delaying that in all the exchanges run by the federal government. The states that are running their own also have the opportunity to delay for a year, if they want. However, all the ones that we've spoken to are moving forward with it, because they see that choice as the way to attract more small employers to participating in the shop. It's one of the value-addeds of it. I think we're going to see some very interesting kinds of dynamics in some states, whereas as I think the fact that there's a delay in choice for workers in the federally run exchanges, until 2015, is going to make them somewhat less of a draw in those states.

TOM P. MILLER, J.D.: You've got two other facts. It seems like there's less demand for the shop exchanges. Unless you've got very attractive subsidies—we even saw in Massachusetts, an unsubsidized exchange, or connector, for the small business market doesn't draw many people. There aren't that many efficiencies in it. We've also got the one-year delay in the employer mandate, so the folks who are on the fence and haven't offered can be on the fence for another year. It doesn't seem like this the driving area, as much as the individual market exchanges.

UWE E. REINHARDT, PH.D.: That is what my impression was, that it's not set in stone, certainly by October, those exchanges, that they could be postponed and I think some will, probably more than a few.

ED HOWARD, J.D.: Okay. We have talked a lot about potential winners and losers, of young people versus old people, healthy people versus sick people. Has anybody been able to quantify the number of folks who fit in to each of these modules? Are we overwhelmingly going to see higher rates for certain age groups, or disability levels, or is this 12 people in northern Idaho?

LINDA J. BLUMBERG, PH.D.: Well, I think that it's very, very complicated. We haven't made a calculation of numbers of winners and losers, precisely because of how complicated the non-group market is today, and how bad the data is on those policies. In order to really understand who's truly willing and who's truly losing, you need to be thinking about not just the premiums that they're facing, but the out-of-pocket cost, and that goes back to the variation in the benefits and the coverage that people have in that market place. We do know that when you look at the young adults in the non-group market, that many of them, the vast majority of them, are either going to be eligible for financial subsidies in the exchanges, to lower the premium cost to them, or they're

going to eligible for the Medicaid program in the states that expand coverage. There're also many of them, another chunk of them are already eligible to stay on their parents' plans, because they live in household with parents who have employer-based coverage, and they are under age 26.

There's a lot of pieces here that need to be taken into account, and truthfully, the data isn't great for giving you a perfect count, but we do think that most people—there's going to be more people that are better off under the law, than are worse off, once you take all the pieces into account.

TOM P. MILLER, J.D.: Yes, the good thing is the way the economy is going, there'll be many more of those low-income young people.

ED HOWARD, J.D.: Good news, bad news.

TOM P. MILLER, J.D.: You'll hand out subsidies, build your market.

ED HOWARD, J.D.: To what extent—several mentions, so far, of the fact that what's the required benefit package, the essential benefit package, is richer than the typical coverage in the individual market. Is that a 20-percent factor; is it a 50-percent factor? I remember seeing a study that showed one of the major benefits that's not usually covered is maternity benefits, in the individual market. Presumably, that's something that's going to cost a little bit of money to cover.

If you're a young woman, as opposed to a young man, maybe you'll find it a little cheaper. Is that enriched set of benefits going to really have an impact on the premiums that are being formulated?

UWE E. REINHARDT, PH.D.: I remember seeing a study on that, and it didn't seem—it makes some difference, but I don't think it was overwhelming, actually. The actuarial mix of whether young people join or not drive it more, but obviously it depends very much on the policies. I was looking at healthcare.com, and then you could see, say for Ohio, where somebody gets a policy for 50 bucks a month, and you ask yourself, what could that be. They must have a giant deductible and all kinds of limits, and there, certainly, maternity wouldn't be in it. There're probably limits on drug spending, and specialty drugs may not be covered. God knows what's in those policies. Some of them are actually better described as unsurance, than insurance, because when you actually get sick, you think you're covered and you are not. *The Wall Street Journal* had some interesting story—I remember Barbara Martinez at MD Anderson, and also Steve Brill, where people thought they insurance, and when you actually look, there were upper limits on all kinds of stuff. That is what makes everything so complicated, winners, and losers. You say now you have a better policy. When you think you'll never get

sick, you might say well, now I am worse off, because I didn't want to have a better policy. Wait until you get sick, then you thank God that you had a better policy. It's very hard to know how to calculate those benefits. A lot of people are myopic about life. If you ask them at a point in time, you might get the wrong answers.

TOM P. MILLER, J.D.: In terms of the premium cost, if you look at more of the actuarial studies, that's been a big factor in what they say. It's not just the way you describe the benefits, it's really the increase in the actuarial value, from before and after, that drives a lot of that increase in the premium costs.

LINDA J. BLUMBERG, PH.D.: Don't forget, when you take a benefit that now, for a young woman goes and gets health insurance coverage, and in the non-group market, there are very few policies that actually cover maternity care as all. If she was going to get that care, and even the care associated with what she's buying is a higher cost for women who are of childbearing age, whether or not there is maternity covered in there. You take those costs and you then spread them over the entire population of people who are insured, and you bring in more people to be insured, then the marginal costs that every person has to pay for an extra benefit is much smaller than what you see today.

If someone goes in and wants to buy a plan with prescription drug coverage in the non-group market, they're labeled as somebody, by the insurers, who they must expect to use a lot of medical care, so we're going to rate them up. When we have those cost concentrated among somebody who's potentially a current user, it's a very high cost add on. When you spread them over the entire population of insured, then the marginal cost for each person is much lower.

UWE E. REINHARDT, PH.D.: I think this maternity- because I'm a European and somewhat brain damaged in that regard—but somebody called that Obama's war on men, forcing coverage of maternity care, and I have to say, as an ex-European, I had trouble even comprehending what they were talking about. I think, personally, women who have children, particularly at an age where you worry about Social Security, should be applauded and thanked, rather than punished, but that's an old-fashioned, as I say, vaguely brain-damaged view, that I brought over from Europe. I personally was astounded that maternity care wasn't covered.

LINDA J. BLUMBERG, PH.D.: Well, I've also noticed, in my personal experience, that men do have some involvement in the production of children as well, so—

UWE E. REINHARDT, PH.D.: I've read that.

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LINDA J. BLUMBERG, PH.D.: —they might want to have some responsibility for the payment.

UWE E. REINHARDT, PH.D.: Just brief—it goes by minute, you know.

ED HOWARD, J.D.: Speaking of brain damage, your moderator has managed to wipe out the connection that brings him the questions that are coming electronically, and I wonder if I could ask one of my colleagues to try to restore it while we go forward.

Meanwhile, I wanted to ask our panelists what their estimate is of the impact of something that was just mentioned in passing, and that is we have a Supreme Court decision that limits the ability of the federal government to impose Medicaid expansion on the states, some states refusing to do it; some states are not. To what extent will the impact on the exchange reflect the fact that there are reluctant states, both in expanding and in extolling the virtues of the Affordable Care Act?

LINDA J. BLUMBERG, PH.D.: Well, I think there's going to be some significant differences, in terms of the impact on coverage across states. When you've got a very active state that is invested in their exchange and having it running, or even in a partnership where they are running a piece of the exchange, or taking on some responsibilities, then there's a

very different investment of the state in following through and making sure people enroll and participate. We have a very uneven distribution of funds under the law. For states that are running their own exchanges or taking responsibility for consumer outreach and enrollment, they've a lot more funds for bringing people in, and providing assistance, and educating them about the law, than in states that are not taking that role. There is discontinuity in the states that are not expanding their Medicaid programs, while a little slice of those folks will end up being eligible for the exchanges, and we're going to have this very strange, really perverse situation, where somebody who is poor is going to come to the exchange, potentially looking for help, and they're going to be told that they're too low income, they're too badly off in order to get help; we're only helping people who are higher income.

That is a situation that's going to lead to more uncompensated care remaining in those states, which is a burden on hospital systems. It's also going to be leading to more confusion about who's going to be able to participate or not. I think that that's going to play out in coverage effects, and it may also play out in terms of just making sure that all the people who know that they are eligible for assistance, really know what's there and how to access it.

UWE E. REINHARDT, PH.D.: In terms of economics, it is surprising thought—there's a lot of money on the table, sent to the feds, if they do the Medicaid expansion. Right now, for the first few years, it's 100-percent financed by the feds, but then 90-percent financed. My hunch is that eventually, there will be local pressure from people, particularly the counties who are now picking up the tab for the uninsured, to bring this money to the state, because they say look, we're sending money to Washington, but we're not getting this money back. Ohio, I think Governor Kasich actually wanted to—

TOM P. MILLER, J.D.: He wanted to do it and state legislature won't let him.

UWE E. REINHARDT, PH.D.: Won't let him, yes.

TOM P. MILLER, J.D.: Which is what happens, a lot of these Republican governors leaning one way, and the state house going the other way.

UWE E. REINHARDT, PH.D.: Because you're basically saying good-bye to a lot of money, so I find—my betting would be five years from now, some of these governors who now resist it will cave, and take the money.

LINDA J. BLUMBERG, PH.D.: I think that's right.

TOM P. MILLER, J.D.: It's bit more of a Rubik's cube, because even in terms of—I'm going out on a limb here against my friends—if you look at the Republican governors who have

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opposed the Medicaid expansion, you get a creeping desire, maybe these exchanges aren't that bad, because we can basically use federal money, rather than the state portion of the money, in order to pick up, at least that tier, from 100 to 138-percent. We don't know what the longer term dynamics on that aspect would be, but this Medicaid swing makes a big difference, because part of what is being assumed as the cross-subsidy by younger, poor, and healthier people paying, if you have the Medicaid coverage taking that out of the exchange market, you've got a thinner tier for those people who are then, in fact, going to be paying higher rates as younger and healthier, in order to subsidize everyone else.

It works in several different directions. I'm just throwing a wild card into it, because I have some involvement in it. An Oklahoma lawsuit just got passed standing, so that's still moving, which would impair the potential of the federal exchanges and the federal tax subsidies, subject to what happens later on this year, in a motion for summary judgment.

ED HOWARD, J.D.: Could the lack of enthusiasm on the part of the state governments for the exchanges limit enrollment in them to the extent that we see a death spiral in some of these places?

LINDA J. BLUMBERG, PH.D.: I don't think you're going to see a death spiral, because the subsidies help to counteract

that, and so, even when you see, potentially, in the first year, higher average premiums in those states that aren't being aggressive with their outreach and enrollment efforts, the subsidies offset those higher premiums to a significant degree. I think that it's a longer-term issue though, in terms of the cost for the federal government, of those subsidies, and the fact that you want to push forward with getting people insured, and reducing on compensated care, and providing affordable access.

I think it's important to keep in mind too, as I think Uwe was alluding to, is that even in the long term, when the states have to pay up to 10-percent of the cost for the Medicaid expansion, this is an excellent financial deal for the states, and they put very little money in and get a huge amount of money back from the federal government. It is not a fiscally responsible step to take, to not do the Medicaid expansion for your state, although I do believe that, over time, those decisions will change. It's just unfortunate that it's such a politically charged, as opposed to economic rational decision-making.

TOM P. MILLER, J.D.: It's amazing that people who live in states don't pay federal taxes; that's always a one-way deal, that this money just comes from the federal government, and they haven't actually paid for it as federal taxpayers.

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Leaving that aside, we've got a skewed sample, in terms of what will be the outreach in aggressiveness of pushing these exchanges, because in the state-based exchanges you've got a lot of funding, a lot of grants in order to do all this type of stuff. In the federal facilitated exchanges, they're running on fumes, in terms of being able to do this. They've rated every other pod within HHS in order they would transfer funds over, but they really don't have the power on the ground to get the people lined up on this. You can get a much slower take up in a lot of the federally run states than you will in the more enthusiastic and aggressive state-administered ones.

LINDA J. BLUMBERG, PH.D.: Don't forget when you're talking about states putting money in, versus the federal government, the very states that are deciding not to expand the Medicaid programs are the ones that win the most, because those are the lower income states, the states where federal funds go to. The ones that are participating are the ones that are paying in much more in federal taxes, so don't distort that.

The other thing we have going for us, in terms of enrollment in those states, is that the hospitals are very interested in having people enrolled, because it helps them reduce their own compensated care load. It benefits them a lot, and I expect the hospitals to be very active participants in enrolling and outreach. We also are seeing private sector

entities, such as the drug stores and the Walmarts, et cetera, that are gearing up to do more active outreach and enrollment, et cetera, and those are very present types of businesses in these low income neighborhoods, and that will attract young people in, to some extent. There's going to be offsetting dynamics here; it's not going to lead to a death spiral, but it is a very different dynamic.

TOM P. MILLER, J.D.: A medical version of the iron triangle strikes again.

ED HOWARD, J.D.: Let's change focus a little bit. A questioner wants to know, for anybody on the panel, what impact do you think the creation of exchange for the uninsured will have on the costs of plans offered by employers; that is, will workers who pay extra coverage through employers face a higher bill one the ACA is implemented, because of the availability of the exchange coverage?

UWE E. REINHARDT, PH.D.: I'm not sure how that would actually work. All of us have haven't learned what is covered.

TOM P. MILLER, J.D.: There is speculation.

UWE E. REINHARDT, PH.D.: It's not something I'd lose sleep over; it's unlikely, I would say, unlikely to happen.

TOM P. MILLER, J.D.: You have the marginal effects, in terms of restructuring in order—if you're a particularly heavily low-range-based company, you might then face different

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incentives than one that is more weighted towards upper wage people. On the margins, you may offer a less attractive plan, so people will migrate to the exchange, and you'd be willing to pay the penalty, compared to insuring those folks. These are speculative things on the margin; we haven't seen that happen, beyond the part time hours, has been the main place it's shown up, thus far.

ED HOWARD, J.D.: I wanted just to mention a message. It's not really a question. It's from Cori Uccello actually, at the American Academy of Actuaries, who wanted all of our viewers to know that it was not the American Academy of Actuaries that released the study finding the 32-percent increase; it was the Society of Actuaries.

TOM P. MILLER, J.D.: Excuse me, oh. You can't tell those actuaries apart, without a [interposing]. You see one, you've seen them all, right, those dynamic personalities. My apology.

ED HOWARD, J.D.: How likely is it that most healthy people, regardless of age, are going to initially choose a lower cost plan, say a bronze plan, with the thought that if they do develop and illness, they'll be able to switch to a silver or gold plan, with better coverage, during the next open season enrollment?

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LINDA J. BLUMBERG, PH.D.: Well, it's a risk that people are taking, right, in terms of what their costs are in a particular year. There may be some movement from one tier to the next, but just because you have high costs in one year doesn't mean you're going to have a high cost in the next year. In fact, we see lot of back and forth, depending upon particular years, for individuals. I think there will be some of that going on. I don't think it's going to be a huge issue, because there's uncertainty from year to year about what your costs are going to end up being.

UWE E. REINHARDT, PH.D.: It would affect someone who developed a chronic illness, who was healthy, and then all of a sudden developed some chronic illness they never thought they'd have diabetes type two or something and all of a sudden, realized that they should be in a higher plan. The number of people like that among young would be quite small, I think.

TOM P. MILLER, J.D.: Well, if you're recruiting from a pool of people who have been occasional or never visitors to the insurance market, then they'd be maybe more prone to economize and go on the low side, and therefore, even though the premiums are set for the silver plan, they're not going to pay for everything. If you buy a bronze plan, you may come closer to covering most of your costs, at least for the time

being, if you're younger and thus far haven't had any major illnesses.

ED HOWARD, J.D.: One more question about those young people: What are the expectations for young people signing up for health insurance who are deciding to take the penalty; that is, what consequences if they don't signs up in large numbers, what consequences personally for the young people who don't sign up, and decide to have to pay, or become liable for the tax penalty?

UWE E. REINHARDT, PH.D.: Well, I think it is within our culture, it seems, that we like to offer people the chance to get in the system, in many ways. I think Paul Starr, my colleague from Princeton, had a proposal saying that if you don't join the exchange now, for the next five years you can't, no matter how sick you get, you just can't join it.

I said you are a softy, I would have made that 20 years. Say, you have a choice; you join or you don't, right. If you want to stay outside, it's a free country, but don't come back later when you're sick. It's not when the going gets tough you run to the government; that you don't do. I wish that had been put in, or would be legislated. Now, the chance of that happening would be quite low, but it should be something that should appeal to Republicans, because that'll allow you to opt out.

TOM P. MILLER, J.D.: Well, Paul did it in the extreme. I propose, basically, you extend the portability to the individual market, so you get a one-time shot, when you go over and say, you want to be a member of the club, you have to stay continuously insured. If you don't, you can stay in the spot market. He stacked that by basically saying you are a leper for five years, which isn't really, what's necessary.

ED HOWARD, J.D.: What has happened in Massachusetts? Young people in Massachusetts basically face the same choice; that is, they had to pay a penalty. It was pretty much a nominal penalty, as I recall, where lured by insurance, what did they do?

LINDA J. BLUMBERG, PH.D.: It's very high rates of participation; they are joining. I think it's a myth that all these young people don't want to have health insurance. I think many of them do, most of them do. They do recognize that there's value here. They want to get something that's affordable, and a little push can go a long way. I think that we see in Massachusetts, there's basically been a cultural shift. There's an expectation now, that people in Massachusetts have health insurance coverage. I think that's made a significant difference there, and I think that that can make a significant difference under the Affordable Care Act. Now, their penalties were small, to begin with, in

Massachusetts, and they increased them now, but at the maximum now is half of the cost of the lowest cost plan available for that individual, as a penalty. In fact, they've had very high rates of participation across the board.

ED HOWARD, J.D.: We seem to have a predominance of questions concerning younger folks.

TOM P. MILLER, J.D.: They're the folks who are paying for all this.

ED HOWARD, J.D.: How likely is it that younger consumers will be assisted by subsidies, and therefore, if it's a high proportion, won't younger consumers benefit from subsidies and cushion some of the sticker shock? We talked a little about this, but is that a substantial factor, or is that margin?

UWE E. REINHARDT, PH.D.: I think it would be a substantial, because a lot of younger people are also at the lower range of their lifetime income stream. I think it would be quite substantial, and given they have the subsidy, as Linda said; I think a lot of young people, when you talk to them actually do want to be insured. It's just in that market that has existed so far, it was just forbidding to get insurance, or they sold you products that really aren't insurance; sort of a car with three wheels. I think there'll be a substantial number of young people who will get subsidies, who will join

the pool, and probably, as Tom says, use the bronze plan, initially, and that, we should understand, will happen.

LINDA J. BLUMBERG, PH.D.: Those folks, the younger adults, are also eligible for purchasing catastrophic plans. They can't use the subsidies to do that. Those are lower cost, plan options for them, as well. We estimated, of young adults in the 21 to 27 year-old range, that we estimate to enroll in the exchange, over 90-percent of them have incomes below 400-percent of the poverty level, so that they be eligible by income for financial assistance.

TOM P. MILLER, J.D.: But, only a smaller share, though, were getting substantial subsidies. You get in to the 300, 400-percent range; they're not getting much of a subsidy, after all is said, and done.

LINDA J. BLUMBERG, PH.D.: Yes, but you're well over— 80-percent of them have incomes below 300-percent of poverty, where the larger subsidies are available, so it' still very substantial.

TOM P. MILLER, J.D.: There's a built-in contradiction in this type of description though, because we start up by saying the way we're going to make this work is we're going to get all these deadbeat young kids to pay higher premiums, it's good for them. They're going to be able to pay for all the sick and the unhealthy, and that's going to give you this

surplus to do the cross-subsidy. Then we go ahead and say, oh, you're all going to be subsidized anyway, so don't have to pay anything more. Basically, it's the taxpayers, if this all works out, who are taking it in the shorts, and have to pay for it. The costs don't go away. You can move them from rock to another, and think that someone else is coming out ahead, but when you add them all up, it's a more expensive system, which is going to cost some more money and people are going to have to pay for it. Maybe that, directly, there will be one step removed, and they will still be paying for it, even though they thought they were being subsidized.

UWE E. REINHARDT, PH.D.: Well, I wouldn't call that a contradiction. I'd call that clever, because it isn't necessarily clear to me that it's fair that these young people who happen to join that insurance pool would have to subsidize older people. I think it's actually very good that we're saying, but we're not asking you to do that all on your own. We, the general taxpayer, are going to contribute quite substantially, and this is just one vehicle to get general tax money to subsidize low-income people who should have insurance. I think, in fact, there, I would give the designers a good grace—

TOM P. MILLER, J.D.: We've already given them more Medicare, Social Security, and student loan debt. Do we have to add more to it?

UWE E. REINHARDT, PH.D.: A lot of them are pretty hard hit, believe me.

ED HOWARD, J.D.: Let me move away from young people, specifically, to one question that looks to me, from a lawyer's point of view, like it might be a good economist question. This person asserts that he believes the main determinant of consumer behavior in the exchange is going to be price, maybe even more so than today, and that that would tend to push costs down; competition. Do our economists on the panel agree?

UWE E. REINHARDT, PH.D.: Well, an insurance company has, really, two cost components. One is cost they themselves incur in their operations, and the other one is basically, what they have to pay for healthcare. What they have to pay for healthcare, it's not clear to me, that having more insurers in a given market will lower the price of healthcare, because you have a given hospital now has a lot more insurers, each of them weak visiting that hospital. I would expect, for that price is to actually to go up, if anywhere. Where you could have some saving is in the individual market, the fraction of the premium that went for marketing, administration, and profit, was certainly north of 30-percent, but I know the Council of

Affordable Health Insurance, which represents them, was claiming up to 45-percent should be allowed. Forty-five-percent; it's almost half the premium.

Now, you would think that a good exchange, if it's well run, should lower that cut, that haircut from 45-percent, to what is it, 80-percent, which is what, under the law, is all that can—or 20-percent is all they can take. In other words, they're supposed to pay out 80-percent of the premium in the form of benefits, and can blow only 20-percent. That's a cost saving, in my view, that should—in your—to the insured. I'm not sure that having more insurers in a given market would lower the cost of hospital care, physician care. I think you have to use other instruments to get that done.

LINDA J. BLUMBERG, PH.D.: The other thing I would add is that when you learn about what's perfect competition, and competition in school, being taught economics, some of this, the cornerstones they tell you was that the product has be identical, and the information has to be perfect. One of the things that we know about the non-group marketplace is that the products are not even comparable, person by person, in the same plan, because they can vary the benefits and the cost sharing, et cetera, based on your own individual characteristic, and the information has been terrible. It's been very difficult to get pricing information, and to get information on the description

of the benefits before you buy the plan. What the new exchanges are going to do, that can promote greater competition among insurers that are out there, is it's making the products more comparable, so people will know that they are not all perfectly identical, but they're much more looking at apples to apples, when they're comparing. They've got these much more easily accessible information.

No more is the insurer going to be able to say we're not going to give you the plan document and the description of what's in this plan that you're buying until you actually enroll. I even had someone that I was helping the other day buy insurance where the insurer, a large one, not a small one, told her that they would not tell her the final price of what she was buying until she paid what she had been paying the year before, gave them her credit card. Once she was enrolled and had paid, they would tell her what the price was. That kind of stuff is not allowed under the Affordable Care Act, and you've got much more information to be comparing apples to apples, and people can compare on price better, and on the networks, and on the benefits, and then make the decisions about the tradeoffs they want. I do think, in some cases, that's going to promote greater competition than what we've seen.

TOM P. MILLER, J.D.: We've seen some improvements in the transparency situation with healthcare.gov, what GAO's

doing now, which is good to get the prices more widely available to people. The point of going beyond that, though, is where you begin to censor what that competition can really do, once you know what the prices are, where you say you can only operate within these certain bounds; only these products, we're going to set a higher floor, you can't go beyond, if you want to buy something less. We don't have perfect competition almost anywhere; that's a mythical construct. We can have better competition, and it's certainly true that, in this environment, people are going to be even more sensitive to price, because it's going to be much more evident and available to them.

I would just like to take one distinction though, with what Uwe said. I've read some of your older pieces as well on this. These expense ratios, medical loss ratios, if you actually looked at the work in the field, among what the real costs were, even in the individual market they weren't that high, in the small group market. Look at some of Doug Sherlock's work. They're older studies, which overstated what the amount of the expense ratios was. That's why the MOR didn't have that big an effect, even though it does some harm on the side. It was somewhat of a sideshow for window dressing.

ED HOWARD, J.D.: A slightly different tack in this next question; actually, it goes back to something that Linda mentioned in her presentation. What's happening with the multi-state plans? Are the large national plans signing contracts with the Office of Personnel Management? I might ask you, for the benefit of a lot of us, to just say a few words about the multi-state plans and what they are, before you predict what's going to happen with them.

LINDA J. BLUMBERG, PH.D.: Sure, the multi-state plans are required, under the Affordable Care Act, that the Federal Employees Health Benefits Plan, the agency that is in charge of providing health insurance benefits to fellow employees, would create plans that would be available, eventually in all states, starting out in at least 30, and that these plans would then be competing in all the exchange markets. The difficulty here has both finding plans that have the reach, or joining with partners to have that kind of reach across so many states. Then also, on top of that, is finding plans that are willing and interested to do that and that might also have different premiums, or different packages than what's already been provided in those states.

We don't know a lot about what those plans are going to look like yet, we haven't heard a lot of the details yet, but if you think about a situation like the Blue Cross-Blue Shield

plans, which are licensed separately in every state, they could join together to create a multi-state plan under the law, but those plans are then already in those states, and they're already providing coverage to many people in those states. What's the incentive for them to be able to negotiate either lower rates with providers, or create other efficiencies, because they would be competing with themselves if they did that? It's a very complicated to see how that multi-state plan is really going to play a role.

Maybe, over time, there will be other insurers that will connect with each other, state by state, but it's the same issue of if you don't have a network in a state already, you can't really come in and negotiate good rates, because you've got no market share start with, and compete effectively. It's an uphill battle for even those federally organized multi-state plans to play a big role, in terms of changing the dynamics in the insurance markets.

TOM P. MILLER, J.D.: The conspiracy theory on the right was that the multi-state plans were stocking courses for a public option. Now, they have been very slow to get off the ground; I think they are now talking about maybe 31 states, maximum; few details provided thus far, and it doesn't seem like, as a pure stand alone, as Linda was describing, they have a lot of role in the marketplace.

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UWE E. REINHARDT, PH.D.: I thought the co-ops were the stocking [interposing].

TOM P. MILLER, J.D.: No, co-ops are another story.

UWE E. REINHARDT, PH.D.: This whole thing of—this is actually, you see more on the political right, this yearning for being able to sell insurance across state lines. Newt Gingrich, I remember, has written about it too. I always wonder what is it they actually try to achieve.

TOM P. MILLER, J.D.: Regulatory competition.

UWE E. REINHARDT, PH.D.: Huh?

TOM P. MILLER, J.D.: Regulatory competition.

UWE E. REINHARDT, PH.D.: Regulatory competition, yes. If I, as a New Yorker, want to buy health insurance, to get healthcare in New York, through an insurer in Iowa—what I'm really saying is I want to have New York healthcare, but with Iowa regulations.

TOM P. MILLER, J.D.: Yes, right.

UWE E. REINHARDT, PH.D.: Okay, then I understand it, because most people suggest this will be cheaper.

TOM P. MILLER, J.D.: You're reshuffling the deck of cards, and trying to squeeze out the regulatory wedge of higher cost.

UWE E. REINHARDT, PH.D.: Right, okay.

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ED HOWARD, J.D.: We're running out of time, unfortunately. I do want to, first of all, prepare our panelists, if you have the 30 seconds valedictory address, you can prepare it at this moment. I do want to take this time to thank our colleagues at the Robert Wood Johnson Foundation, for allowing us to put this program together. I want to thank all of you who have been quite rich in your sharing of your questions and observations with us over the internet. Of course, I want to thank the panel, but not before I extract from them one last bon mot or here's what to watch for in the coming weeks; seven weeks from today, train wrecks, on time arrivals, a base for a three-year or a four-year observation. What should we be looking for? Who of you want to start?

UWE E. REINHARDT, PH.D.: Yes, well recently I read that quite a few Americans are willing to give up their citizenship, and I always wonder, is that over income taxes or the premium shock? I think the message, I hope, that came from this, if you want to give up your citizenship, that's okay, but not over premium shock. Wait until that happens. My own feeling is it will be less shocking than many people think, but that's speculation, as much as anyone else's, with my own set of assumptions. Don't leave the country over that. We will get through this and I think, five years from now, we'll be happy we did it.

ED HOWARD, J.D.: Tom, do you expect to be shocked or awed?

TOM P. MILLER, J.D.: Both, as usual. I think the stuff that's going to matter is whether the software works. You put a virus in the wrong place and you've got a big meltdown. Who enrolls in these exchanges and what the mix is, and the argument—in this country, we can tolerate a lot of bad government, and we'll continue to, so I think it will exist for a long period of time, in one form or another. The payment, the costs are going up. Just because the payments are reshuffled, doesn't mean they've been reduced. Now, if some other things happen, that might be good, but the exchanges by themselves aren't really reducing any costs. Uwe talked about premium joy. I think more of Almond Joy; sometimes you feel like a nut, sometimes you don't.

ED HOWARD, J.D.: Alright, Linda, you get the last word.

LINDA J. BLUMBERG, PH.D.: Well, I'm not expecting a disaster, and I think that some people are going to experience somewhat of rate increases, but think it's really important, and other people, a lot of people, I think, are going to get savings, either because their premiums are going down in general, or because of the financial assistance available through Medicaid and through the exchanges. Most people, as

you alluded to originally, who have big employer health insurance, are really not going to feel very much of a change here at all. I do think it's time for us to change the conversation a bit, away from what is the difference between what I'm paying now and what I'm going to pay an hour from now, and focus much more on what we want the system to look like.

When we look at ourselves, in terms of our health care spending, we all vary, in terms of what we spend on medical care, over the course of our lives. Even if some of us pay a little bit more now than we would have otherwise, that means that later we're going to make sure that we have adequate accessible affordable health insurance coverage, when our costs would have been much higher. I think, looking at the big picture, and thinking about a system in a rational way, that we would want it to be, if we were designing it from the ground up, is really the perspective that we want to be judging from.

ED HOWARD, J.D.: Terrific. Well, from the standpoint of the Alliance for Health Reform, what I'm looking forward to is future panels that are even half way as enlightening as the one we had today. Thank you so much for sharing your time and your expertise with us, and thank you for listening and watching. We'll be following this issue as it goes forward. Thanks very much.

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