Health Insurance Marketplaces: The First 8 Weeks
Alliance for Health Reform
The Commonwealth Fund
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ED HOWARD: Good afternoon, my name is Ed Howard, I am with the Alliance for Health Reform and on behalf of Senator Blunt, Senator Rockefeller, our board of directors, want to welcome you to this program to take a look at the initial almost eight weeks of experience since the marketplaces or exchanges opened for business on October 1st and the major pieces of implementation of the Affordable Care Act began taking shape. We want to recognize our partners in this enterprise, the Commonwealth Fund, which is almost or maybe just over 100 years old. A New York and Washington based philanthropy devoted to pursuing the common wheel or common good and you will be hearing from Sarah Collins from Commonwealth in just a moment.

This program is important because we want to both give you as much information as we can and to put every piece of data you have seen, into a little perspective, particularly from a perspective from the folks that are actually dealing with this situation. There is an awful lot of interest in the number of people who are registered in the exchanges, the number of folks who can't get through on a website, the number of people who are signing up for Medicaid through these portals, and I would like to announce that we have completed a 50 state survey this morning and we have the latest numbers for you from each of the states. I would like to announce that. But I ain't gonna do that. In fact, I think we all want to emphasize that we are at the very beginning of a process and whether you adore or abhor the Affordable Care Act, what you need to do is to listen to the very insightful comments from our panelists today about what is actually going on in various parts of the country and put that together with the policy context that goes along with this very complicated and far reaching piece of legislation.

As I said, we have Sara Collins, who is Vice President at the Commonwealth Fund, both as a co-moderator and someone who actually knows an awful lot about this topic and whom we have not only asked to go moderate, but help us frame the issues in a way that will enhance your ability to digest the rest of the program. Sara, thank you for being with us today.

SARA COLLINS: Thank you, Ed and thank you to the Alliance and the Palace and also this great audience for coming together today to talk about these timely issues on the marketplaces. Surely the hallmark of this law, the Affordable Care Act, is a degree that was just being implemented at the state level and this means that the local politics and state decision making will influence outcomes across the country both in states and nationally. This is in particular playing out over the last couple of months and the large variation we have seen in website functionality and the ease with which people are able to get into the marketplaces, go to them, visit and actually enroll. In terms of the marketplace, marketplaces themselves, about 16 states in the District of Columbia are running their own marketplaces and it's great to have Mila Kofman here today to talk about the DC marketplace. Idaho and New Mexico opted to use the federal website this year for enrollment. This means that residents in about 36 states are using healthcare.gov to enroll in health plans. State participation in the Medicaid expansion is also going to have a significant impact on enrollment. So far 26 states in the District of Columbia are

expanding their programs. About 24 states are undecided or not going to expand. The congressional budget office is estimating that by 2018, about 25 million people will enroll in the marketplace plans. They are expecting about seven million to people enroll in 2014. In Medicaid, CBO is projecting about nine million people to enroll next year and about 12 million by 2018.

So the central question on everyone's mind is, will consumers enroll in these plans now that they are available? Who will enroll? Will the young and healthy enroll in numbers that are equivalent to the representation in the overall population? This is clearly going to be critical to well functioning marketplaces, premium stabilization over time. To learn what people are experiencing during these first initial weeks of enrollment, the Commonwealth Fund in October interviewed a nationally representative sample of over 600 adults who are potentially eligible for marketplace options or Medicaid. People who are either uninsured or were purchasing coverage in the individual insurance market. We found that about 60% of those adults were aware of the marketplaces in October, this was up from about a third of that group in a similar survey that we conducted in the summer, in the summertime. 17% of these adults reported visiting the market places in October. The age and the health distribution of those who went to the marketplaces generally reflected the age and health distribution of that potentially eligible population. About one in five were ages 19 to 29 and nearly three quarters reported being in good health. Only one in five, however, said that they had actually enrolled in a health plan. We asked people who didn't enroll in the plans, why they hadn't in October. 48% in the survey said they didn't enroll because they weren't certain they could afford a plan. And about 46% said that they were still trying to decide which plan they wanted. 37% of those who didn't enroll, cited technical difficulties on the websites as the primary reason. A majority of survey respondents appeared determined to come back to gain health insurance coverage over the next few months. About 58% of those who hadn't gone to the marketplace or had gone and hadn't enrolled in a plan, said they were very or somewhat likely to visit by the end of the enrollment period, to enroll in a plan or at least find out about whether they were eligible for financial assistance. Young adults in our survey were as likely as older adults to say that they were going to go to the marketplaces by the end of the period. The survey found widespread support for expanding Medicaid in their states, nearly three quarters of respondents said that they were strongly or somewhat in favor of making Medicaid available to more residents in their states.

Despite the difficulties involved in the rollout of healthcare.gov and some of the other state marketplaces, the latest November enrollment figures from 14 states that are running their marketplaces, show that enrollment has climbed to around 200,000 people nationwide and I think that is a pretty – an estimate that probably has a lot of variation around it. But this is up from about 106,000 who had selected a plan or had enrolled in a plan by November 2nd, reported by HHS earlier this month. This latest figure doesn't account for the many new enrollees that probably gained covered through the federal marketplaces this month and we will find out what those numbers look like in the next few weeks. Many states are also reporting significant enrollment in the Medicaid

program. Among those states who are running their marketplaces and are reporting Medicaid enrollment, about 344,000 people have enrolled in the program. It's really too early to assess the age and health distribution of the marketplace enrollees, but there is evidence that young adults are enrolling in the plans. Reuters reported this week that Connecticut, Kentucky, Washington and Maryland, 20% of those enrolled so far are ages 19-34 and we heard yesterday in California, that about the same percentage of young adults had enrolled in plans in that state in October.

The poor performance of healthcare.gov has been a huge a largely unforeseen challenge, but these numbers do show that people are determined to gain coverage despite the obstacles that they are currently dealing with. As the websites are repaired, we should continue to see growing enrollment across the country. I will turn this back to Ed.

ED HOWARD: Thanks very much, Sara. A couple of housekeeping items. There is going to be a video recording of this briefing available probably Monday on our website, allhealth.org. There will be a transcript available shortly after that. You will also find all of the speaker's slides and other background material that those of you in the room have in your kits, on the website, accessible through the website. That is important also for those of you who many be watching on C-SPAN and have computer access, you can go to allhealth.org and follow along with the slides and do the background that is embodied in the materials that the folks in person attendance have at their disposal.

At the appropriate time, you are going to be able to ask questions of the panel, either by filling out the green question card in your kits, or by coming to one of the microphones that you can see in the audience. At the end of the briefing, we would appreciate you pulling up a blue evaluation form and giving us some feedback that will allow us to improve these briefings for you in the future.

Well, let's get to the discussion. We have just a terrific lineup for you today with national and state and community level perspectives that I think will help you understand what a lot of the noise that you hear is really about. We are going to start with Matt Salo. Matt is the Executive Director of the National Association of Medicaid Directors. He has as his members all of the state and territorial Medicaid directors and many of you may know him from his work for many years at the National Governor's Association, working on health reform agendas from the Governor's perspective. Today, we have asked him to tell us about enrollment is going in Medicaid in the various states since, as Sara pointed out, enrollment in Medicaid is outstripping actual enrollment in the exchange plans themselves. So Matt, what is happening?

MATT SALO: Great. Thanks a lot Ed, and thanks to the Alliance and Commonwealth for hosting this and thanks to everybody here. It's really exciting to see a large group of people coming together to hear about what is happening in Medicaid and the marketplaces. So before I get into sort of talking about some of the Medicaid and marketplace dynamics, I think it is important to take a real quick second just to give a

little bit of brief context on Medicaid, what exactly is this program? We have thrown around numbers, Sara talked about numbers. Well, we are expecting seven million here, nine million there; I think it's important to put a lot of that in context of what Medicaid is. Because Medicaid is, suffice to say, the largest and most important program you probably don't know anything about. We had 72 million Americans walk through the doors at some point in time last year in Medicaid and/or CHIP. 72 million. It is the largest health insurance program in the country. We also spent 430 billion dollars last year. And what does it look like? The face of Medicaid is often kind of a TANF population – pregnant women, kids, low income working families, but all of the dollars in Medicaid are in seniors, people with disabilities, long term care. And I think it's – and the other important thing to note is that again, as Ed pointed out, whether you adore or abhor the ACA, literally one half of the trillion dollars that the ACA spends over a ten year window, according to CBO, half of that is in Medicaid. So it is going to get bigger. So I just wanted to put that out there and put some context.

So one of the things that we have been doing as an Association is trying to monitor how the state experience has been going with respect to getting ready for October 1, getting ready for January 1. And we started back in August a series of monthly snapshots, looking at a representative sample of states as to what their experience has been. And then come October 1, we shifted that to weekly, which is a lot of work for our members, at the time they are really busy, but it is really important because we felt that this experience needed to be shared with folks to get a sense of what is going on. And all of this information – the monthly, the weekly and everything moving forward, is available right now, on our website. Medicaiddirectors.org. Go there now, go there later, take a look at it. Sign up for our newsletter, you can get the stuff pushed out at you, it's great. And then just a couple days ago, we released sort of a snapshot with broad state perspectives on how things have been going for the past couple of months. Really talking about the states and some of this stuff doesn't sound very sexy, but it's really important. It's designing the systems that make this work. It's how Medicaid interfaces with the marketplace. It's the enrollment efforts that states are undertaking and at the end of the day, its how do we do this in a way that really benefits the consumer? Because their experience really matters here and if they are not happy, they are not calling President Obama if they are not happy with the consumer experience, they are calling us. So it is incumbent upon us as states to figure out how to make this work as best as we can for them.

And I think here is a point that can't be stressed enough. Standing up systems, like I said, not very sexy, but this really, really hard work. And states come at this from very different perspectives. We have a lot of states that run eligibility systems that were built in the 1980s and this is a terrific opportunity for many of them to modernize what they have been doing. And unfortunately put to retirement some of those old fogies who are still doing [cobault] in some basement somewhere and this is all they do because no one else runs these systems. But states are coming at this from a lot of different perspectives. And here is a point that is also really important; regardless of whether a state made the

decision to expand Medicaid or not to do a state exchange or a federal exchange, every single state has had to enormous work in totally overhauling a lot of their systems and ensuring this connectivity with the federal data hub and with the exchange. This is building eligibility systems; this is reworking your application procedures and all the business processes that live underneath that. Again, this is figuring out how do you communicate that information seamlessly with the hub and then thinking about again, once you get people in, how do you make sure you have the delivery infrastructure in place to make sure they get the high quality care that they need? Again, this is a lot of work and anybody who goes around saying, oh well, it's just a website, how hard can it be? Obviously has no idea what they are talking about. This is some of the most complicated stuff that has ever been done and just purely from the federal side where you are talking about creating a system that's got real time seamless interaction between HHS, Department of Labor, IRS, Treasury, Homeland Security – and then that is just on the Federal Data hub, then connecting that seamlessly to 56 state Medicaid agencies. This is not starting up Amazon.com, this is Manhattan Project. This is moon shot type stuff.

And again, the state experience with procuring and developing and building IT systems, is not a real pretty one. And we hear from our states that the basic rule is the number of times that a system you procured comes in on time, on budget and to spec, is well, basically never. It doesn't happen. So we have been saying for months, this is going to take time. Roll out is going to be bumpy. Now, roll out has been bumpy, but these things do get fixed. And we – obviously the challenges that healthcare.gov are out there, states have had their challenges with trying to build their own state systems, and I think its important to keep in mind again, that we work in a real world here and these things do take time.

So what, with that, do the numbers tell us? A couple of things, I think as Sara pointed out, it's a little too early to be drawing broad conclusions. We are less than eight weeks in. we have data from just a relatively small number of states. But I think what we can see from the numbers is that the Medicaid enrollment is higher than people thought. The Medicaid enrollment is higher than the exchange enrollment and I think there is a lot of reasons for that. The states that have a state exchange, the states that are doing the Medicaid expansion, there is a pretty tight Venn diagram of those states and there is a pretty strong correlation with those states and efforts to do really aggressive and targeted outreach. Going out looking at snap beneficiary roles. Looking at people who are getting other types of state or local benefits. You do that cross walk, you know who these people are. You know where they live; you know what their income is. You know they are okay getting government benefits. So when you reach out to them and say, hey, we have got something we think you might interested in, Medicaid, it's not a surprise they come back in pretty large numbers and say yes, we are interested. Will those numbers be sustained? Will this sort of four to one, or whoever it is, numbers – no. No, I think what we will see is the Medicaid enrollment that we have seen spiking, will go down and then exchange numbers will go up. But in all, I think what we are seeing is that the numbers according

to the states we talked to, which is pretty much everybody, it's largely consistent, largely in line with what their projections were at the onset.

And so what states really are doing though is – it's a constant quality improvement process. As they are building systems and as they are interfacing, they are testing and they are fixing and they are patching and sometimes they have to go back and resort to mitigation strategy. Sometimes they have to go back and do things with paper, God forbid. But paper enrollments. This happens, its okay, and it's a mitigation strategy to get us through until when we get fixed. But the things we are going to be watching for are, who comes in? Who comes in the door? Are they newly eligible? Were they this group of the eligible but not enrolled? Sometimes called "woodwork", sometimes called "welcome mat". That makes a huge difference in terms of – federal government pays for 100% of one of that group, the expansion group. They don't pay anything additional to the other, that matters. The other issue is, what is the case mix? Who is coming in? Are they young? Are they healthy? Or are they older? Are they sicker? Do they have co-occurring substance abuse and mental health disorders? This matters.

I'm out of time so I'm going to roll through the last slide or two. I think the success story that I think a lot of states see is, if you can treat the roll out of their exchanges with Medicaid like a soft opening of a restaurant, build some functionality in early and then build upon that. That is where we have seen the most success and the fewest glitches. That is not always possible, but that is certainly something we have taken away.

So then finally, October 1 is important, January 1 is going to be even more important for us, because that is when coverage actually starts and we have to make sure that the system is ready for them. And then finally, closing, on some level, coverage is the easy part. Once you get them in the door that is the easy part. With 72 million plus people, 400 billion plus dollars a year, all of the sick, the frail, the disabled, the chronic conditions, we have got to do more than just get them covered. We have got to actually improve their healthcare and bend the cost curve. And Dr. David Blumenthal of Commonwealth does a terrific job of explaining this. This is what our states are doing, that I think is the really exciting news and I'm going to pitch these guys in doing another session on this. Reforming the delivery system and reforming the way we pay for care in this country. We have got to move away from paying for volume and treating healthcare just like a bunch of economic widgets and towards paying for value and that is the key and that is what Medicaid is focused on these days.

So I will stop there and look forward to questions at the end, thank you.

ED HOWARD: That's great, thanks very much Dan, a great start to this discussion. And now we are going to turn to Dan Schuyler who is the director of exchange technology at Leavitt Partners and the former director of Technology for Utah's Health Insurance Exchange, which has been in business as long as anybody's. Dan and his colleagues at Leavitt have been helping a number of states prepare for ACA implementation, especially

the exchanges and we have asked him to talk about – we have heard there are a few challenges in the area of technology and we have asked them to talk a little about those challenges and the other challenges that states are facing, in your experience. Thank you for being with us.

DAN SCHUYLER: Thank you Ed, thank you Sara, I appreciate being here. So today I'm going to give you an overview of health reform in Utah, talk a little bit about healthcare.gov, talk about what the state based marketplaces are doing and then just sort of try to give some guidance to some remaining uncertainties. But Matt said it the best and I think it's fair to point out that health exchanges are the most complex – one of the most complex IT projects every initiated by states or the federal government. The reason for that is, all of the points of integration that exchanges need to make, they need to connect with Medicaid, they need to connect with the Federal Data Services hub, they need to connect with carriers across the country. So with that, I will go ahead and give you a little bit of background on what we did in Utah.

So in 2007 and 2008, Utah passed enabling language to build the Utah Health Exchange, which is now known as Avenue H. The impetus for the exchange was to provide a tool that employers could use to help mitigate the rising costs of healthcare in Utah. And one of the ways they did that was by establishing a fine contribution marketplace, which would allow employers to provide their employees with a set dollar amount every month that they could use to go into the exchange and purchase any health plan that was available on the exchange. It provided predictability, more options and lower administrative costs to the employer and for the employee it provided more choice, transparency and portability. So if they moved from one job to another, they could take their plan with them. It's been very successful, as many of you know, Utah has defaulted to the federally facilitated marketplace for the individual exchange, but they have been given a waiver to run Avenue H as the shop exchange in Utah.

So with healthcare.gov, what happened? Why did we see such a miserable launch on October 1st? Well, there is two things that really speak to the causation of the failure, if you will. One of them was the lack of time to build and test and one of the reasons there was a lack of time was HHS, CMS, sort of delayed the necessary regulations and guidance to provide the business rules or processes, if you will, for how an exchange should function. For how the subsidies should function, for how the integration should work. All of the nuances with respect to how an exchange should function. It was sort of like trying to build a plane while it's flying in the air or a race car while it's going around the track. They were sort of trying to develop these rules and regulation and guidance while also planning the development and build of the exchange. The administration delayed internal progress and there was no end to end testing. They tested the components individually, but they weren't able to, because of the time, do an end to end test and that led to the issues that we saw on October 1st. Additionally as CMS and HHS had admitted that they decided to take on the role and responsibility of managing this project internally. The administration was advised early on that they should leverage

expertise in the private sector to manage this project. Again, one of the largest IT projects ever initiated by the federal government and they chose to bring that in house and do that in on their own. Again, we see what happened on October 1st with that lack of knowledge and expertise to really guide a project of this size. There was also a lack of communication between the sub contractors and the general contractors. Again, this was part of the overall project management of an IT project. The sub contractors would express concern about a certain component or a certain issue and that would never filter up to those in charge who could make the necessary adjustments to the project plan or the necessary adjustments to resolve those issues.

So if you look at the states and what happened in retrospect with healthcare.gov, what did the states do differently and why are we seeing much more success with the state based marketplaces? So I mentioned – I sort of touched on this. The states leverage is existing technologies. They went out and hired best practices. They hired system integrators and project managers to oversee their implementation. They were proactive and innovative. Instead of waiting for the guidance to come out, they started their project planning early on and started to build and design their exchange without the necessary guidance from HHS. Now, that did require them to make changes as the guidance came out, but because they started early, they were able to achieve a level of success that we saw on October 1st. they descoped when necessary, so they looked at what the core fundamentals of an exchange were, to start on boarding people and sort of, if you will, removed all the bells and whistles and just focused on developing the core fundamentals of an exchange. And they set expectations low; I think they were very proactive in the media and with consumers, letting them know that this is going to be a bumpy start on October 1st. It is not going – we are not going to have all the bells and whistles. We are going to deploy the core functions that will allow people to enroll and begin the eligibility process. And so all in all they took a completely different design philosophy, versus the federal government when it came to building the state based marketplaces. And in retrospect, or in hindsight, it might have been appropriate for the administration to have collaborated with the states in some respect on building an exchange. I think we might have seen a different outcome on October 1st with healthcare.gov.

But again, with healthcare.gov, they now have some project management in place, they have an IT contractor overseeing the repairs to the platform were seeing progress on a day to day basis and improvements to the healthcare.gov platform. Not sure where we will be on November 30th, the administration said that on November 30th, that 80% of individuals will be able to complete the enrollment process and 20% probably will not because of core design issues that still needed to be addressed as well as the complexities of specific eligibility scenarios that Matt spoke about. You are going to have individuals that will have sporadic residency or citizenship or have never filed an income tax return. And those will sort add to the complexity of determining eligibility for premium subsidy. So it will be a while before the system can accurately and enroll people on a consist basis, but we just have to see where the platform is on October 1st.

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So some minor – I just want to end with some Federal Health Reform uncertainties. Enrollment plan B, we heard the administration sort of emphasize direct enrollment with carriers and web based entities. There has been a lot of confusion in the media as exactly how that works with respect to what the carriers can and cannot do. But I think the administration is making a proactive decision to encourage consumers to use direct enrollment. The concern is that direct enrollment through carriers and web based entities is not fully completed. They are still working on the technologies on their end to ensure that that enrollment path works. Premiums that cancellation fix, the administration announced last week, there is a lot of concern as to how that is going to work. And what will happen to premiums? Will this destabilize the risk pools going forward? I think there is a lot of uncertainty as to what that will do to premiums in 2014.

State based exchanges – which states that are utilizing the federally facilitated marketplace or healthcare.gov, will transition to a state based marketplace over the next two years. I think in some respects the rocky rollout of healthcare.gov will probably be a catalyst for some states including the partnership states, to quickly transition and in other states that have been adamantly opposed to the Affordable Care Act, this may re-entrench them in that position to not build a state based exchange. But we anticipate that many of the partnership states will transition over the next two years to a state based marketplace and some, not all, of the federally facilitated marketplaces or states that are utilizing the federally facilitated marketplace will transition.

Last, but not least, funding the federal deficit. What will the funding look like for ongoing development of exchanges? States have until December of 2014 to apply for a grant to build an exchange. The question is, will that funding still be there at the end of next year? Thank you.

ED HOWARD: That's great, thank you Dan. Even if you did end with questions instead of answers. We will get to you later with the answer part. Mila Kofman is next. Mila is the winner of the award for the shortest distance traveled by a local official to get to one of our briefings. That is to say, she is the director of the DC Health Benefit Exchange Authority. In previous lives, she has been among other things, the Superintendent of Insurance in Maine and an office in the National Association of Insurance Commissioners. And today, we have asked her to discuss your experience in DC at the marketplace, which is one of the handful being fully run by local jurisdictions. Mila, thank you so much for taking a cab and coming on over.

MILA KOFMAN: Thank you very much and Ed, you had me there, I thought you were going to say we had the shortest amount of time to October 1st. As you know, the city didn't sign its contract with its systems integrator until January of this year, so we were the last to the picnic and one of the first out of the gate, I'm proud to say. So thank you so much for having me here and I just want to say how important your – this particular session is and how critical the research that Dr. Collins has done on the first eight weeks experience, it certainly is informative for everyone, but especially people on the ground

who can then take the research and utilize it to be more strategic in our own outreach and enrollment strategies, so I thank you very much for your commitment to helping not only policy makers, but folks who are on the ground implementing the reforms. So thank you.

In the District, it really did take a village and I just want to acknowledge some of my staff members who are here, my deputy Debbie Curtis and Alison Nelson. When I came on board in January as the Executive Director of DC Health Benefit Exchange Authority, I was the first employee, so I got to build my team and I just stole the best people I could find from everywhere – the private sector, talked people out of retirement, from the Federal Government, from the Hill, from everywhere. So I was very fortunate to have a great team to help us get to the finish line. And we of course had great consultants and I see some of them here, like David Holmes and I think I saw Shelly, who were all with us helping us succeed. One of the things that we did, just like you heard from Dan, is that early on we realized we couldn't do everything, so we had to prioritize and we prioritized for functionality and we took many things, all of the bells and whistles, off of the table. So we focused on the core functionality. We wanted to make sure on October 1st that we were open for business and we were. And we wanted to make sure that everyone, all consumers and small businesses, could come to us and do everything from start to finish and they were able to do that on October 1st. So consumers were able to open up accounts, they were able to shop, they were able to select a plan and they were able to say, hey, invoice me button. And employers were able to come in and set up their accounts as well.

So this is just our landing page. I wanted to make sure that you are aware that we are DChealthlink.com and we are not the federal site. We are a local site and we are fully functional.

We had great participation by the insurance industry from the start. In fact, we have all the major insurers offering coverage to individuals and small businesses. On the individual side, we have Aetna, we have CareFirst Blue Cross Blue Shield and we have Kaiser Permanente. On the small group side, we have those three plus United Healthcare. So we are very pleased with the fact that all of the carriers are in fact participating through DC Healthlink. There are significant choices available to consumers, both individual and small business consumers at all levels of coverage from bronze to platinum.

We also offer full employer and employee choice in our shop. That means that when a small business comes to us, the small business can choose to offer the workers all of the insurance products that are available at a particular level. So if a small business offers gold level coverage, that means the workers can choose – and each one can choose a different plan, so anything in the gold level and there are 112 different products. So any of the insurers, they can choose from any of the HMOs or PPOs or point of service. And the products do vary. You can get a no deductible plan or you can get an HSA high deductible plan and everything in between. So full employer choice or if the employer

wants a particular insurance company, but wants to offer different levels of coverage, that employer can choose that option as well. So full choice.

I wanted to include a slide on prices, since that has been in the news quite a lot. Our premiums are very good, very competitive and – I know you can't see the slide, but hopefully the one in your packet you can actually see. If you are a 27 year old here in the district on the individual site, you can get a bronze level policy for $124 a month. If you are 55 and you live here in the district, you can get a bronze level policy for $295 a month. So very competitive. The same is true on the small group side. Very competitive prices. I want to note that when we posted our prices and adopted legislation, that requires full transparency in pricing, we saw real price competition. Proposed rates were filed, we made those rates public. One insurance company came back and lowered their rates twice; their proposed rates. Another company came back in and lowered their rates once and a third insurer came back in, lowered their rates and added additional products. So we here in the District saw real price competition work through price transparency. And of course competition greatly benefits individual consumers as well as small business consumers.

We have had a lot of activity in the District. Lots of shopping, many accounts being opened up. Lots of people taking their plan and requesting the invoice to pay. I'm not encouraging anyone to pay early because they have until December 15th to pay, so I want to make sure that anyone who actually lives here in the District, watching this, knows that they have until December 15th to pay. None the less, some have paid and Dr. Collins asked me to share some early statistics with you. This is – I had my staff look at the first 120 people who fully enrolled themselves, paid. Selected the plan and paid. So the largest category of enrollment in the first 120 that we saw is age 31-40. The second highest is age 20-30, the third highest category of the first 120 enrollments is 51-60. So Ed, I'm making news here for you today. The other interesting observation is that most of those folks who already paid and are fully enrolled, selected platinum level coverage, which actually surprised me. I thought it would be more evenly split in terms of selections. But the early birds have selected platinum level. The other interesting fact I would like to share with you is that we had several enrollments age 65 and over, so I'm not sure why that is, it's unclear to me whether folks are dropping Medicare coverage to enroll or if in fact they are not eligible for Medicare and that is why they are enrolling. So that is something to pay attention to as well in terms of who enrolls in the state based exchanges.

And that is just some contact information if you are looking for more information about the District's marketplace. You can go to DChealthlink.com or contact our call center.

I do want to note, in terms of – I will just make a quick comment about one of the earlier comments made about HHS and the federal implementation. I was in state government when the legislation Affordable Care Act was being debated and states had a clear choice. There was a House version which had one nationwide exchange and there was a

Senate version which had each state setting up their own. And every one of us, me included, in state government, lobbied heavily for state based opportunities. We argued states can do it better and we have done it better and we should do it. So part of the issue has been that so many states who lobbied heavily to have the opportunity to set up their exchanges decided not to do that. And so I think we have to keep that in mind when we set expectations about achievements and opportunity for success when you have the federal government having to set up a marketplace – a very complicated online portal, in so many jurisdictions. Thank you.

ED HOWARD: Thank you very much, Mila. By the way, your last slide reminded me that if you are Tweeting about this topic and this event, there is a hashtag on the title slide, #acamarketplace. Did I do that right?

MATT SALO: You sound very Twitter savvy, Ed.

ED HOWARD: Right. Our final speaker is Katy Caldwell, she is the Executive Director of Legacy Community Health Services and they are a federally qualified health center in Houston that has been working very actively to help its patients with both ACA and Medicaid enrollment and she is here to share some of their experiences. "They" being both their patients and Legacy itself, with us. We are very happy to have that happen. Katy?

KATY CALDWELL: Thank you Ed and Sara. So I'm going to start with just a brief introduction of who Legacy is, how we are navigating the system and how our patients are navigating the system, what the interest level that we have seen, what our successes and opportunities have been and what are our next steps.

Legacy is a federally qualified health center. We are in Southeast Texas in both Harris County and Jefferson County, which is Houston and Beaumont. We have eleven clinics and clinical locations in seven school based clinics. Our clinics are located in historically gay neighborhood, Hispanic neighborhoods and African-American neighborhoods. We are a certified application counselor organization. We have 28 certified application counselors and we see – this year we will see approximately 60,000 individual patients through 200,000 visits.

Also, I would be remiss if I didn't say, Texas, as all of you I'm sure in this room knows, is not a Medicaid expansion state. We chose not to expand Medicaid, so therefore only children, the elderly and the disabled are still eligible for Medicaid. We are also on the federal run exchange; we did not opt to do a state exchange. We also have one of the highest uninsured rates in the country.

So our marketplace and how people are accessing it. They are coming into our clinic, making an appointment or walking in, and they meet first with a certified application counselor who starts the process by getting them to walk through the consents. This

causes a lot of anxiety for some people and – because they have heard a lot of the bad publicity, they have heard about identity theft, there have also been several groups in Houston that have been out – that are fraudulent groups out collecting information from people and basically stealing their identity and there has been a lot of publicity around it. So we have to kind of get over some of that anxiety. Then we have to determine the client's knowledge and this has been interesting, we knew that people didn't really understand insurance, but we have had to do a lot of education around just even the terminology in insurance. The majority of the people coming in have never had insurance. A lot of them have low literacy to begin with and low health literacy. So this group, especially the people who are really uneducated on insurance, hit information overload at this point. Many times they leave, they take information and make another appointment to come back. Some of them stay and continue on, in which case if they have all their information with them, we go through their household information, what subsides they might be eligible for, the different ways that you can apply. We confirm all of their documentation and then decide which means of applying is the best for them. Either the online application or the paper application. One thing that has surprised all of us has been also – about a third of the people that have come in, have never used a computer. Another third have a computer, but have no internet access. And then the other third basically have a computer and have internet access. So some of our folks are taking time now too, to help people get email addresses and also connect them with the resources in our community where they can get low cost internet access and low cost computer. Then we assist them in getting on and getting an application in the marketplace. And then work with them to determine what is the best plan for them. The other part, about half now were doing in paper application and this was largely because of language issues. We are a very diverse community and the online is only available in two languages and we try to do everything in the languages of origin of our clients because they understand things better. And there is eleven languages on paper, but only two online. So – and it takes longer to do it on paper, because of the length of time of submission.

The next part, if they haven't had information overload again, which most have by this time, or if they have to submit by paper, we ask them to come back after their – with their eligibility. So then it's determining which plan is the best and making the application. This again, becomes very complicated especially for any of our clients who have chronic illnesses such as HIV, diabetes, congestive heart failure, asthma – because they have to look not only at often times the lowest cost plan on premium, is not the best plan for them. And it's not easy on the federal exchange to go through and compare medication formularies, to compare with doctors, what hospitals are on different plans – and so you have to take all those things into account and explain what all of those things mean to people. Eventually though, they get through the application process and will choose a plan.

So who are we seeing and who is asking? Just at our location, we have had about 3,000 inquiries that we have been tracking since October 1st. We have seen about 1300

individual people, most of them the average number of visits has been three visits with our CAC's. We have completed 89 applications and have had 18 people go all the way through to enrollment. The majority of the people coming in are existing patients, so they have a high level of trust with us and they are the ones that are really getting through the process much quicker than the ones who are coming to us from various outreach events, from finding us on the internet. We are also seeing a very strong mix of age and race across every age that we have been seeing and we have seen quite a few people coming in who are 65 and over, just wondering what this is all about. Then we end up helping them a lot of times choosing the appropriate Medicare Part D plan for them. So we are helping on that side also. And we were surprised how many young families are coming in and we were really pleased to see that and most of the young families that are coming in, their children are already on Medicaid and they are coming in for care for either themselves or other family members.

So our success and challenges. So what is working? The system is improving. The awareness level is increasing and good publicity, bad publicity; it's made people aware that this is out there. That the marketplace is open. So it's brought more people in. Most people are surprised when they come in at how affordable it is. I think there is a preconceived notion by especially people who have sought some of the high risk pools or people with chronic illness in the past, have been unable to really afford it, but as with the DC exchange, there are various prices and people are really surprised that it is affordable. We are doing a lot of referrals for tax advice in our community. We have a couple of organizations that do free and low cost tax services, filing services, for people of low income. So we are doing a lot of that. And we are collaborating a lot with other enrollment groups and with other non-profit organizations.

So, what are the barriers or opportunities? Trust. Trust is a huge issue. Again, the majority of people that come in, do have a lot of skepticism in the system. A lot because of the publicity that there has been. Online access and literacy has been also an issue and learning insurance terms. Understanding what a co-pay is, what co-insurance is, what – and just what a premium is. Fear of the INU, Homeland Security, is very large in our community and lots of people are fearful that while they may be a citizen and eligible, they have people in their household or their families who are not citizens and they are fearing – fear from INS is very real. Also fear from other law enforcement, that this information will be available to other law enforcement agencies. Setting up email accounts – lots of people don't have email accounts. That was a big surprise for all of our staff. Also the other issue is inability to really compare easily the different plans on the healthcare.gov system.

What are our next steps? We are doing a series of town hall meetings to encourage both our patients and people in our neighborhood to get educated and doing large education sessions. We are setting up in our lobbies of our computer's online access for our patients so that they can come in and so some exploration on their own or get comfortable with the computer. We are doing actually some more computer literacy classes and assistance

with that. We are continuing to all of our outreach and engage potential enrollees and then we are starting in January, going to be doing a lot of health literacy for our patients and for other members in the community, because once again, just because you have insurance doesn't mean you know how to use it. What our goal is, at our health center, is to make sure that – so they get insurance, well that doesn't mean they just go to the emergency room when they get sick, like they have been doing and they are in the habit of doing. They learn that they have a healthcare home and how to use the insurance at that healthcare home. So thank you.

ED HOWARD: Well, we are into the part of the program where we give you a chance to check out the questions that might have been raised by the presentations you just heard. I would also encourage the panelists, if they have heard something they disagree with or want clarification about from one of their colleagues on the panel, they should speak up at any point that they would like to. And of course Sara is in a position to ask very informed questions. If you do go to the microphone, I would ask that you identify yourself and try to keep your question as brief as you can so that we can get through as many of the questions as we can. And you have the honor of the first question.

BERNADETTE FERNANDEZ: Thank you. Bernadette Fernandez with Congressional Resource Service. I have a couple of researcher questions. The first one to Mila. Your initial enrollment data about folks who were coming in, gravitating surprisingly to a platinum, just a question about what do you attribute that to? Are these folks uninsured with pent up demand? Are they kind of tied with the over 65 that maybe just are looking for more generous coverage? That is my question to you. Then to the broader group, kind of looking forward, beyond broad and moment data and premiums, is there any plan to put additional information out there such as enrollment by demographic categories as well as addition plan features like cost sharing requirements?

MILA KOFMAN: Thank you. So, I wish I knew, is the short answer. And I should caveat all of the initial numbers I gave you by saying, I don't think it's a prediction of anything. It's just looking at the first 120 – period. I think it's interesting that pretty much every age category is represented, including the younger population. Of course in enrollment you want to make sure that you are targeting everyone and that you have a healthy risk mix and I do not know anything about the insured status of enrollees. We actually unfortunately did not build that data element into our application, so we are not collecting it. We do plan to do a survey in 2014 of all of the enrollees to ask them whether they were previously insured and what kind of coverage they had and we do have plans to closely examine our data, probably early to mid next year, once all of the dust settles and we have good data to look at. We will be making all of our information, the demographics and enrollment statistics, all public once we have good data to share.

ED HOWARD: Have others on the panel experienced the same sort of platinum coated enrollment phenomenon that Mila was describing?

KATY CALDWELL: No. Many of ours have been silver. So that is what we are seeing. But we only have 18 so far, so – not a representative sample by any means.

SARA COLLINS: Also, on the data availability, I think that is a really excellent question and we really – everyone who is looking at this carefully wants to know who is enrolling. The [unintelligible] Fund will redo our survey that we did in October, in December, just to get another snapshot of what is happening in the marketplaces. Hopefully we will have a little more sample so we can have a little bit better idea, at least in a very broad way, of who is coming in. Then go in at the end of the open enrollment period again with a little bit larger sample. In terms of the national data that will be available, National Health Interview Survey data I think will be the first national look at least at a broad individual market level perspective, available starting in September; we will know what the first quarter coverage looked like in this year. So I think the state reports of – Mila's report just now, so important, so interesting and then California – other states that are reporting just demographic distributions, are going to be really important to understanding what is happening.

ED HOWARD: Alright?

LARISSA WASCOB: I'm Larissa Wascob, I'm a legal intern at HHS. I have a question that is mostly directed for Katy Caldwell. How is your health center responding when you encounter people who fall below 133% of the poverty level and also, do you help people realize if they are eligible for subsidies?

KATY CALDWELL: On the subsidy question, yes, we do help people determine what their subsidies are. That is the easy one. The hard one is telling people that they are too poor to get a subsidy and it is difficult and we have had people coming in now looking at that, that have fallen into the category, where if we had expanded Medicaid, they would be eligible. So we are talking to them about just what we normally do, which is, here are your options if you come here for care. We do everything on a sliding scale, we will help you in any way we can, but it's still – we are using our grant funds and other funding that we have to help care for them. What our goal is then with them is to educate them and like we do with all of our patients, try to keep people out of the emergency room and keep them in routine care.

SARA COLLINS: Just to put a data point on that too, the size of that coverage gap population, Kaiser's numbers is right at about a million people in Texas, so it's a considerable number of people.

DR. POPLET: Hi, I'm Dr. Carolyn Poplet, I'm question is for Mila. Are you concerned that with over 100 plans to choose from, people will be overwhelmed by the choice or they all just choose based on price? It was a problem for part D, it's still a problem for part D, people are reluctant to go back in and make another choice and I think Kaiser has shown that they don't make the best choices for them.

MILA KOFMAN: Thank you for the opportunity to clarify. So on the individual side, we have 34 products, 31 are metal levels and three are catastrophic. So on the individual side, there are a fewer options, fewer choices. On the small group side, on the shop side, 267 different products, we know from experience that small businesses themselves are like choices. If a $15 co-pay is right for one small business, another small business wants the $20 co-pay. So we know that from the Massachusetts connector experience in the small group market and we know that based on the commercial side of the market. So we – and I have a private board that made many of these decisions with a lot of input from policy stakeholder work groups. So we decided early on that we wanted – that we did not want to limit product. We wanted carriers to be as innovative as they wanted to be. Now, the one early decision that we made, which was unanimously recommended by all stakeholders, including consumer groups, providers and carriers, was that we would not allow benefit substitutions to the essential health benefits package. And so the product could have additional benefits like acupuncture as an example, is not one of the core benefits. So the variation in products is really additional benefits on top of the essential health benefits benchmark and the variation in your out of pocket liability, so the co-pays, co-insurance, etcetera.

AUDIENCE MEMBER: Thank you, my name is [inaudible name]. I'm with Voice of Vietnamese Americans. I also work in coalition with many Asian-Americans organizations. So my question has to do with the language barrier. Have you seen that problem at all since we have that only on paper, you said 11 languages on paper and only two languages online for the applications. Does that pose any problems? In Virginia, we have a high percentage of Asian-Americans in Virginia and it's rising, but Virginia happens to not choose the [unintelligible] so I don't know if you have any numbers from the healthcare.gov from the federal side of how many of us Asian-Americans coming and do you have any problems with that? Is there anything that you think the community should step up and work with you? Because as I understand, you only have two mitigators in Virginia and we have a tremendous amount of Asian-Americans, small businesses and many of us are not in the habit of having insurance.

KATY CALDWELL: I can talk from Texas. It is a problem. We have the largest Vietnamese community in the country in Houston and we are pushing to get the third language to be Vietnamese for us. But it is a problem and we are just glad that there are at least 11 languages and we run across people that it is not - that we don't have appropriate language in those documents. So it is an issue. Because it is much easier for people to understand in their language of origin. So we are working with everyone to try to get better access. But the answer is yes, it is a big barrier.

MILA KOFMAN: So in the District, our biggest immigrant population is Spanish speaking and the next largest is Amharic, which is Ethiopian community. And then we have also an Asian population. For Asian and Pacific Islanders we have partnered with our mayor's office and our partners are essentially doing very on the ground work. We

found with working with different – culturally different groups, that having a working online portal is not relevant and many people, maybe immigrant people, small business owners and individuals really like the one on one interaction with the trusted voice. So we actually have focused a lot of resources into the on the group people in the community who can work one on one with the small businesses and individuals, with all of our diverse populations.

ED HOWARD: What kind of relationship do you have with the insurance brokers in the District?

MILA KOFMAN: So, we – from my perspective, excellent. We actually had the brokers involved very early and we built a broker portal, so there is a consumer portal and there is a separate broker portal that is designed to help make it easier for brokers to place business, to shop it. We have very good feedback from brokers and in fact we are doing some enhancements to our portal based on some feedback from not only consumers, but brokers using the portal. The other point I just want to add, we also partnered in a formal way, with the National Association of Health Underwriters and they did all of our broker training, which also helped a lot. We also have partnerships with all of the business – most of the business associations like the DC Chamber of Commerce, the Hispanic Chamber in DC and that has helped a whole lot in terms of not only educating people about the Affordable Care Act and all of the opportunities, but also as being trusted messengers and now those business partnerships, they are helping us with enrollment as well.

DAVID HELMS: David Helms, LMI, but more to this discussion, I led the Robert Wood Johnson Foundation's healthcare for the insured program where we tested voluntary subsidized products for the working uninsured and I am interested, Mila and those of you who have had a chance to look at the plans. The Washington Post, of course, discovered that maybe some of these plans will have to have narrower networks than may exist in the rest of the market. And I would report that there are no easy ways to make health insurance affordable and we tested a lot of these from purchasing cooperatives to subsidies to narrower networks and from those early projects reported in Health Affairs in mending the flaws in the small group market, note that the uninsured were not unwilling to use narrower networks. They wanted the range of care from hospital to ambulatory and so forth. But I just wondered if you are hearing any or seeing any evidence that looks like this will be the next shoe people want to draw here, is that not everybody is going to get the same choice of health providers that maybe they had before.

MILA KOFMAN: Well, I can tell you that in the District, the products that are being offered are very much, in terms of their provider networks, are very much the same as currently in the commercial space. And so about half of the products offer nationwide networks and the other half, very robust, local and regional provider networks. I don't think there is a single product that was filed to be sold through DC Healthlink that has what we would consider a narrow network.

MATT SALO: I might add, I would say that from a macro perspective, narrow network – it connotes different things. It doesn't necessarily mean bad quality, there are a lot of providers out there, I don't know that we want to be contracting with. And I think it is an inexorable move in the insurance industry in this country towards narrower networks. Selective contracting. Now, obviously, ideally, you want to do that so you have the high quality low cost providers within that. But lets not try to pretend like that is necessarily a bad thing.

ED HOWARD: And I would refer to the briefing we did last week on reference pricing for a number of private sectors entities that are moving in that direction on a very large scale. I believe you were next.

MONICA PEREZ-NELSON: I'm Monica Perez-Nelson from Gia's office of General Council and one of my practice areas is health IT and I had a question for Dan and Mila about the bells and whistles you referred to in the CMS federal system and you pointed out that one of the things that led to the successful design and implementation of DC and some of the other state systems where you scope down the requirements and you cut out the bells and whistles and in comparing that to the federal system, that has to interact with the hub and the carriers and make that – and make the decision for the applicant. What are some things that you can scope out? What are the bells and whistles?

MILA KOFMAN: So just for the record, I did not say we scoped out anything, we actually right shifted, so we still intend to do everything that we had planned, we just couldn't do it for October 1st. So it's just been right shifted to 2014 and perhaps future years. Its things like the provider network. Ideally we would have a button a consumer could click on and have access to the carrier's network right there. We couldn't build in the provider network feature into the portal and so what happens now is a consumer has to click several times and actually from our site, clicks into the carrier's site and goes straight into the provider network that the carrier maintains in their website. So that is the – an example of a bell and whistle that we just could not do for October 1st launch. We planned to do and we will do, it is just going to be some time in 2014.

DAN BROWN: Hi, my name is Dan Brown; I'm with the American Occupational Therapy Association. Katy made an important point that the lowest cost option is not always the best option for consumers. She also mentioned that it's difficult to access information about provider networks and drug formularies. We have also found that it's difficult to access information about covered services unlike NBC. In most states, substitution and benefits is allowed even if the consumer is aware of the central benefit benchmark plan and knows what is covered by that plan. There could be variation in the marketplace. I am wondering with all the IT problems and enrollment challenges, if DC or other state run exchanges are actually looking at the consumer experience, making sure that all the information that ideally would be available for consumers to make informed choices, is available, and a related issue that is accurate, we have found some information

that is available on the marketplace interface that is not the same as the summary of benefits and coverage for the plan. So I'm wondering if any state run marketplaces are looking at the availability of that information and the accuracy of that information. Thank you.

MILA KOFMAN: Yes, yes, yes and yes. So we found early on that it was difficult to find the formulary and so we worked with the carriers to make that more prominent and easier to find. But again, that formulary is not going to be in our portal until next year, so a consumer still has to do a few clicks to the formulary. The consumer experience – so let me just say, the most important part of all of this is the consumer experience, because if a consumer has a bad experience, then it's harder to convince the consumer to sign up, get coverage. So we are very interested in consumer feedback. And any feedback we get, whether it's constructively phrased or not, we take seriously. And we have a long list of improvements and add-ons we plan to make to improve the consumer experience. We do updates to our system on a regular basis to add in enhanced features to help with the consumer experience. In terms of the contradictions and the information with the summary of benefits and coverage and then what the plans actually cover, just like we build a portal for brokers, early on, we build a portal for carriers. And so this summer, carriers had to load all of the rates and the plans and we did a significant back and forth testing with the carriers. So the carriers would come into their portal to check everything out, to make sure that the summary of benefits and coverage actually matches the plan that was approved for sale and there are no discrepancies. And that is how we were able to address some of the discrepancies that the plans and us identified early on. So hopefully a consumer shopping in DC does not find any discrepancy and if they do, I want that call personally so we can address that. But I just want to end by saying, the consumer experience and improving the user experience is critical to me.

LEON COLLINS: Leon Collins, Office of Personnel Management, the Federal Employees Health Benefit Program. I have two questions actually. The first one is for Mr. Salo. On the Medicare expansion, with the large volume of soldiers coming home, how are we buffering for that large population to transition to there, even though their state may or may not be offering it because the jobs may or may not be there. Income obviously is going to lower. How are we setting buffers for that? And then the other question is for the states. Excessive healthcare and now that we have that, what are the states proposing to build up the clinical provider side so that we can provide services for those people that are one low income that is being added to the mix there.

MATT SALO: Okay, so that is a great question on returning soldiers, returning veterans. I confess, I'm not sure. This is not traditionally a job that Medicaid takes on to try to look at. I think the core of the issue that you are getting at is, employment opportunities for returning veterans and I think it is a really, really important issue and I know that a lot of states pay a lot of attention on that. That is not something that we focus on, so I can't address that. But to the extent that there are issues there that we will take a look at that and we can get back to you.

ED HOWARD: Matt, you actually have one other aspect of the gentleman's second question about the adequacy of the provider networks in one of the other question cards that we have up here. Someone was wondering weather there is any state that has decided to hang on to the primary care increment in Medicaid that was included for a limited time at federal expense in the ACA.

MATT SALO: So I guess the question there is, because one of the things the ACA did was that it increased Medicaid's payment rates to primary care doctors, to the Medicare level. Which is great. But it did so for two years and then sunsetted it. And in fact, it was intended to improve access, although the first year that it went into effect is actually 2013, before the expansion started and it ends at the end of 2014, which I think is a terribly cynical way to go about doing public policy. I think the framers of the law just sort of assumed that a future Congress would come in and extend it and we would have a Medicaid doc fix just like we had kind of so much success with the Medicare doc fix forever now. I think it's way too premature to say what are we going to do when that goes away, because I think this is very much in Congress's court to figure out do they want that to just go away and then what is that going to do to access? I think that is a question for Congress and not for us. We are not going to try to answer that at this point.

REBECCA ADAMS: Hi, I'm Rebecca Adams with CQ. So I have a question for Matt and a question for Mila if I can. I wanted to ask Matt, in your snapshot you had said that you think Medicaid data may be changing. So I wanted to get a better sense of that. Are you seeing different people enroll now than you saw previously? Given that the enrollment data has not been – it's been delayed because of the account transfer problems, are you concerned about how solid the HHS data that we have seen might be? You also had expressed some concerns that some people who enrolled were – or people who applied were actually already enrolled in Medicaid. So how solid is the HHS data and for Mila, I'm wondering something people here might be curious about is, do you envision any way at all for people who have been assigned to go to healthlink, to be able to go back to FAHB if they want to?

MATT SALO: So to the first question, in terms of the data, and you are right, the ability to actually do account transfers is not yet fully functional. It will come, I'm not sure when. I don't know that that is a catastrophe. I don't know that that is a crisis. And the issue that I think you are getting at around some of the data, which we call sort of the batch files that are coming across, sort of say, it's really more of a sense from HHS of, here is who we think will be coming to you. And here is some information about them so that states can kind of better prepare some of their workloads and do we need a staff at the call center? And yeah, so we have seen some challenges there. There is a lot of challenges with everybody's data at the onset, so I'm not terribly concerned about any of that. It will get cleaned up. It's not going to be a huge problem, I don't think.

MILA KOFMAN: Yeah, I would just refer you to OPM. As you know, the Affordable Care Act has a provision that says that certain designated Congressional staff and members can get or have to get their coverage through the exchanges and the final rule OPM issue, designated DC healthlink shop as the source for qualified coverage that is eligible for the employer contribution. So I welcome all Congressional staff and all members and look forward to serving each and every one.

STACY COLLINS: Hello, I'm Stacy Collins, I'm with the National Association of Social Workers. My first question is both on a micro and macro level for Katy and Matt. Are either of you, either at your agency level or at the association level, collecting any data about the turn away rate in the non-expansion states? Katy, you mentioned there are about 3,000 inquiries at your clinic in the last two months – if there is any data as to how many of those were people below the poverty line who could not get coverage because you are in a non-expansion state?

KATY CALDWELL: We are collecting that. I don't know the number off the top of my head, but we are collecting it and we are seeing quite a few and we know that we are going to be seeing a lot more. We have – we are historically HIV provider and we have about 4,000 HIV patients who are on Ryan White and we know just by our data that about 1500 of those patients will not qualify – would qualify for Medicaid expansion, but not the other. But we are tracking it. The short answer is yes, we are tracking it.

MATT SALO: And the short answer is no, we are not tracking it. The work that we do, we represent the Medicaid directors, we have a third of our staff here today. We try to prioritize on providing information to the members to help them better implement so that the snapshots we have been doing have really been to help level set, to help states figure out, are you struggling with this issue or that issue? Are you the only one or is everyone struggling with it? So we don't have the capacity to dig down and really, really be a data warehouse for everything like that, unfortunately.

SARA COLLINS: Someone else had a question related to that. Wanted to know states that are using alternatives to the traditional or the Medicaid expansion under the law, using premium assistance, whether those states might see differences in enrollment as a result of that. A different approach.

MATT SALO: Well, I don't know that we would see much in terms of differences in enrollment. I mean, because at this point we are really only talking about Arkansas at this point. When the ACA had the Medicaid expansion and then the Robert Supreme Court declared it unconstitutional, it turned the Medicaid expansion into a state option. And as your slides have pointed out, about half of the states said yes, and about half have said no, in large part because largely the only choice they have had was, yes or no. And then we had Arkansas come along in a very, very interesting scenario, where you have a Democratic Governor and a very conservative Republican legislature and Governor Beebe went to Secretary Sebelius and said, I need to do the expansion, I can't get it

through if it's just Medicaid, let's figure out a third way. And together, they worked out a plan to essentially expand Medicaid, but to take the vast majority of those individuals and essentially enroll them via the exchanges, via the marketplace, through premium support. And at this point, Arkansas is really the only state that has been approved to do that. And I think what they are going to see is – you are going to see the – by definition the sicker, the frailer, the more disabled individuals as part of the expansion, will be in Medicaid. The younger, the healthier, the better health risks for the pool, will end up in the exchange and quite by intension, according to their calculations of their proposal, that in of itself is going to sustain and save the exchange market by having that boles, if you will, of younger, healthier lives in that pool. So I think you are going to see a lot of folks in there.

AUDIENCE MEMBER: I guess this is actually sort of the same question that I was going to address to you, Mr. Salo – I just wanted to know if you will be seeing more states who have opted out of the Medicare expansion who will be using the model. I think Wisconsin now is using that same model. I think I heard that they are going to disenroll people off of Medicare and put them on exchanges and then – to make way for new enrollees and I guess I just wanted to hear whether or not there are some downsides or upsides to using that kind of model and do you think other states are going to do the same?

MATT SALO: So in terms of Medicaid, I would say the Wisconsin issue is different. Wisconsin – it's funny, the Wisconsin folks say, why do we keep getting labeled as a non-expansion state? We expanded a decade ago and they already cover all of these people. So it's – the Wisconsin situation is very, very different. But I think it's a very, very salient question to talk about. What does Arkansas mean for the other 24 – 23 states or so that are currently either leaning no or – already at no. I think – I mean, I know for sure that the vast majority of states who are currently in the "no" category are – I would call it, they are in the no, but looking for a way to get to yes. What they do is they look at the options that they have. The options that they have are, expand the program as is or nothing. And they keep coming back and saying, there has got to be more on this menu. There has got to be another option. Arkansas has got one. Is there another option for us? And I think really at the end of the day, it's all about whether or not those individual states – because they are all going to ask for slightly different things, you know, Pennsylvania and Michigan and Iowa, they are all asking for slightly different things. It is really going to come down to, is the administration going to be willing to work with them to come up with a fourth option, a fifth option, a way to get to yes. And I think the Arkansas model with sort of the conservative flavor, the private sector approach and as a way of strengthening the exchange market could potentially be a big win-win for everybody if the cards still align.

SARA COLLINS: This also raises a question that Dan brought up earlier too about the states that may, on their exchanges, also on the marketplaces who are doing plan management, there are about 14 states that are actually doing a little bit more than some

of the other states, whether we will see a shift in that responsibility too. Taking on more – the states taking on the marketplace operations. Maybe you want to talk to that?

DAN SCHUYLER: So CMS is allowing states to transition from a partnership model or a fully federally facilitated marketplace to a state based exchange over the next two years. States were anticipating filing a blueprint on November 18th – the states that were interested in doing that transition and we'll have to see how many states actually filed a transition blueprint. But they have until the end of 2014 to make that decision. So again, we think there is a lot of impetus for many, if not all of the partnership states to transition over the next two years and some of the FFM states, but we will just have to keep an eye on those states and see which ones do.

ED HOWARD: As we go into our last ten minutes or so, I would like to ask you to pull out the blue evaluation forms and fill them out as we get these last few minutes and I would like to ask you to ask your question.

NATALIE VILLACORTA: Hi, I'm Natalie Villacorta with POLITICO, I've got two questions. The first one is just about the enrollment data that has been released thus far in terms of young people, so maybe Sara and Mila, you guys can answer this. Is that data on target thus far? Does it represent a lot of work that has to be done or is it a good sign? Secondly, is that – how is that data informing strategy specifically for reaching out to that group? Mila, earlier you were talking about how data is helpful to adjust outreach strategies, so what is the data telling you thus far in terms of what is working or what needs to be done and are there going to be specific things to sort of try to lure in those procrastinators that have been talked about?

SARA COLLINS: Just in terms of the data that is coming in, I think just this week we saw that in states that are running their marketplaces that were reporting it, significant shares of young adults, about 20% of those who enrolled were ages that 19-35. In terms of what CBO is projecting, of the seven million people expected to come into the marketplaces next year, about two and a half million or so are expected to be people between the ages of 19 and 35, so about 38% of that total. In our survey data, in October, we did see about 21% of those people who visited the marketplaces and these are people who were uninsured and eligible to come in, were 19-29 years olds. About 32% were 19-34 year olds. We also found that a high percentage of young adults and there are really no difference, across the age groups, in terms of people who said they were going to come back to the marketplaces or go to the marketplaces by the end of the open enrollment period. And just in terms of the Massachusetts experience, young adult may have waited somewhat longer, but the pre – the uninsured rates among young adults was 21% in the year prior to the passage of the law in Massachusetts. That rate dropped to 8% in the year after. So I think it does – the survey research that we have done, the experience in Massachusetts has suggested that young adults are likely gonna come into the marketplaces in numbers that are going to help do what we are hoping they will do. Not only helping them, but also stabilizing the market and premiums over time.

MILA KOFMAN: So we use all sorts of information sources to, on a weekly basis, hit the restart button. I have a meeting with my senior folks every week, looking back at what we know about enrollment, what we know about folks who are on the ground. So if we know that holding an event in the evening results in five people showing up versus lunch, you get 50 people to show up, that is where our resources go. So we look at everything that has happened. Not only the data that we are seeing, but also what we are hearing from our DC Healthlink assisters, what we are hearing from brokers, in community groups or on the ground and every week we slightly shift our strategy and I can tell you, week one we had a lot of events planned; educational events and what I would call "show and tell", the communications people have a fancier term for it. But essentially how to use our web portal, the range of prices, products, and we found that consumers were coming in ready to enroll. So the following week we made sure we had assisters and brokers at those events to help people actually enroll. So we learn a lot about the needs and demands every week and we retool to make sure that we are right there and available to help people wherever they are in their decision making process.

NATALIE VILLACORTA: So are there any specific strategies to reach out to young people? Specific outreach programs or things that are yet to be unveiled?

MILA KOFMAN: So some of our DC Healthlink assisters include young invincibles and groups who worked with University populations. They are doing very creative things. One of our DC Healthlink assisters is going to bars to provide information. So they are very creative and the one thing that we are not doing is kind of door to door or going into people's homes. We essentially said, for a number of reasons, we are not going to allow assisters to do that. But they can be as creative as possible and we ask for daily and weekly updates and we share that among the assisters, what has worked, what hasn't worked as well and how to retool.

NATALIE VILLACORTA: Can I ask just one last thing? We learned a few minutes ago that the deadline to sign up for coverage for January 1st has actually been moved back a week to December 23rd and I just was wondering if that has an affect on what any of you guys are doing or will have any kind of ripple effect in general?

MILA KOFMAN: No, we are pushing for December 15th to enroll and fully pay for coverage to be effective January 1st.

ED HOWARD: We have time for just a couple more questions and one, Dan is directly specifically to you. Your mention of the direct enrollment option that is direct by plans, the questioner wonders whether that raises technology issues in the first place and what potential will this option have for increasing enrollment?

DAN SCHUYLER: That is a great question. I don't think HHS ever intended for Healthcare.gov to be the single channel for enrollment and I don't think they ever

anticipated that they would be the single channel for enrollment in 30 plus states. So there is a provision in the law that allows carriers and web brokers like EHealth and Get Insured and others, to direct enroll consumers directly from their platform into the exchange. When I say direct enroll, enroll in a plan that the carrier is offering or a plan that the web broker is offering. There has been a lot of confusion in the media about this since the President sort of announced direct enrollment, it's been obscure and there hasn't been a lot of information about it. So literally how it works is HHS is providing the technologies to the federally facilitated marketplace states and these technologies are called API's and it allows the carriers and the web brokers to plug into the FFM and to direct enroll. There has been some confusion and misrepresentation in the media saying that well, you can't do that because the only way to get a premium subsidy is directly through healthcare.gov. Well, you can get a premium subsidy through direct enrollment and the technologies allow that. So somebody would go to a carrier's website or a web broker's website, they would pick a plan and then you would be securely transferred to the federally facilitated marketplace or a state based exchange to calculate your premium subsidy. You would then be taken back to the carrier's website or the web broker's website to complete your enroll in the plan that you have chosen. Now as of today, only carriers that are working directly with the federally facilitated marketplace or healthcare.gov, can do direct enrollment. And while those technologies have finally been completed, they were supposed to go online October 1st, but there were a lot of issues, just like there were with healthcare.gov on October 1st. A lot of the carriers and web brokers are still trying to complete the final integration to make that work. Now, I'm not aware of any state based exchanges and Mila, correct me if I'm wrong, that are facilitating direct enrollment this year. But I know that there are some that intend to do that next year. So to answer the question, I think it was the intention of HHS to provide multiple channels for consumers to enroll with state based exchanges, healthcare.gov and through direct enrollment. It's a little late in the game to speculate on how well direct enrollment is going to work, considering the technology wasn't completed until just a couple of days ago and again many of the direct enrollees are still working on integration issues.

ED HOWARD: Any final observations by any of our panelists? Sara?

SARA COLLINS: I just wanted to add just one more thing too, for people who have been concerned about consumers and this process of direct enrollment. Health plans actually have to let people know that there are other options available to them on the marketplace sites and also about the other range of products – other qualified health plans that the insurer might offer. But clearly this is a way that enrollment might increase over the next few weeks as we get towards the end of it. Now that December 23rd date -

DAN SCHUYLER: Yes, that is correct. They need to inform the consumers that there are other options on the state exchange and that they can opt out of direct enrollment any time they want and go directly to the state exchange or the federally facilitated marketplace if they so desire.

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MILA KOFMAN: I would just like to make a plug for tomorrow, we have a city wide enrollment event at MLK Library and we are going to have Zumba and health screenings and bring your whole family and I encourage all of you to come out.

ED HOWARD: Well, what an appropriate to come to a conclusion of this discussion. We may come back to this topic some time in the near future, in case there might be a few remaining issues we haven't quite tied up in neat bundles yet. But at this point I think we have learned an awful lot, at least I have. And reminding you, as we finish up, to hand in those blue evaluation forms after you have filled them out, if you would. I want to thank our colleagues at the Commonwealth Fund for their health in planning and obviously making a big direct contribution to the success of this briefing. Thank you for some of the best card and microphone questions that we have had in a long time and ask you to join me in thanking the panel for a really enlightening session. And happy Thanksgiving and Hanukkah.