ALLIANCE FOR HEALTH REFORM

Health Insurance Marketplaces in 2014: Behind the Numbers
The Commonwealth Fund
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ED HOWARD: My name is Ed Howard, I am with the Alliance for Health Reform. I want to welcome you on behalf of Senator Blunt, Senator Rockefeller, our Board of Directors, to this program today on how the health insurance marketplaces or exchanges have worked during the open enrollment period that has just ended and what we may have learned from that experience, that could be useful in the next open enrollment period, which I understand is not that far away. We want to explore what went well, what went not so well, how people faired using the marketplace and getting the care that their insurance is supposed to offer them access to. And whether there are areas of concern that need to be addressed before that next open enrollment process starts all over again in less than three months. You are going to hear some of the national results collected by the Department of Health and Human Services, results from a major new survey of those who used or tried to use the marketplaces. And you are gonna hear some on-the-ground observations from people running or trying to work with two of the state marketplaces. One run by the state itself, the other a federally facilitative one. And we are very pleased to have as our partner in today's program, the Commonwealth Fund, which is a philanthropy with a New York base and a strong Washington office that has been pursuing the common wheel or common wealth for about a century. So we are doubly pleased to have as co-moderator, Sara Collins to my immediate left. The Commonwealth Fund's Vice President for Healthcare Coverage and Access. She is also the author of a very impressive issue brief that is in your packets with findings from a Commonwealth sponsored survey of some early results from the recent open enrollment period and in addition to moderating with, Sara has some important information to share with us a little later from that survey.

So, can we do a little housekeeping before we turn the panel loose to illuminate this subject? First of all, let me just point out – I think it's on the – maybe not on that slide – yes it is. If you are in a Twitter mode, you can note that #ACAMarketplace is available and by the way, if you have a device that can make use of that and feel the need to tweet, you can tweet not only in the Twitter verse in general, but you can submit a question and the staff will try to pick it up, put it on a card and bring it forward. Technology sort of breaks down at that level. In your packets, there is a lot of important information, including a lot more biographical information about our speakers that we will be able to tell you about verbally. There is a lot of background material and a list of additional background material that you can pursue if that is your want. And I would say that if you do it electronically by going to our website at Allhealth.org, you can click on those links and it will be a lot easier. There is a video that will be available and you can tell your colleagues who weren't smart enough to be quick to register for this briefing, that they can watch the video probably Monday afternoon if not first thing Tuesday morning. There will be a transcript available a couple of days later, for your use. And two pieces of paper that I like to call attention to in advance, from your packets. The blue evaluation form that we would like you to fill out at the end and before that, when we get to the Q&A section, there is a green card that you can write a question on and have it asked by one of us or you can use a microphone to ask your own question verbally.

So, I want to get to the program. We had just a terrific panel lined up today. They are going to give some brief presentations – then we will save the bulk of the time to respond to your questions. And we are going to start with Dr. Arnold Epstein. He is the Deputy Assistant Secretary for Planning and Evaluation at HHS, that is a post that he has had for only a few months, but he has been one of the leading health policy analysts in the country for a long time. Most immediately, he chaired the Department of Health Policy and management at Harvard School of Public Health and I'm really pleased and proud to welcome him back. Arnie? Thanks for being with us.

ARNOLD EPSTEIN: Thank you. I'm prone to try – this room is long enough and thin enough that folks at the back can't possibly see the people sitting down. Does this project pretty well? Yeah? Great. So if you take a look at that slide, that is the title of the presentation, but there is already a big mistake on it. It has my name on it and in fact, a lot of what I'm going to present today is due to the really hard work of some terrific staffers who have been following this issue and working with it and helping me to do it. Beth Hadley and Audrey McDowell here today, among others, but it's really been a team effort. So let me correct that. I'm just a talking head today. And I want to introduce what we know about the marketplace – let me just see if I can figure out how to make this work. I feel like a pitiful helpless giant. One of the essential goals of the ACA was to create a functioning marketplace. We haven't really had one in healthcare. A place where consumers could come and compare apples to apples and oranges to oranges and get really clear information about price and eventually, increasingly, about performance. And the ACA has started to put that in place and has done quite a job. In terms of choice, let me draw your attention, I hope you folks in the back can see it. You have your own handouts to the row that reads *average*, which says that each of the 501 waiting areas, by the average one, had five different issuers, 47 different health plans. So there was certainly a lot of choice. Many of you may have seen curves like this, which is the path of enrollment. Very little, less than 5% in the first eight weeks and then in the last four weeks, including the special enrollment period, almost half. So a lot of us who have the experience of not starting our homework until the night before it was due? It is an American cultural trait.

Here is what we know on top line numbers about marketplace selection - 85% of those who entered the marketplace and got a plan, got financial assistance and I will show you shortly just how important that financial assistance was. 28% were the youngsters who wanted to make sure they got in – ages 18 to 34. Slightly more females – 85% of the choosers chose either a bronze, 60% actuarial value, where a silver plan, 70% actuarial value. If you look at what they choose within metal type, again, bronze, silver, gold and platinum, 42% - nearly 43%, selected the lowest premium plan. Another 21% took the second lowest premium plan. So it seemed clear to us that premium was a big deal and people were really selecting on that. Let me give you some information about just how expensive those premiums were. Amongst people who choose silver plan, that was again, almost the majority. The percent who selected plans with tax credits was 94%. Their average premium before tax credits was $345, their average after the average tax credit a

month was $276 and they paid on average themselves, out of the $345, $69 or only 20%. So within silver plans, tax credits were really important and the subsidies really matter. Here is what choice looked like. Nearly half the people who bought into plans, had a plan that cost less for premium than $50 a month and about 70% had less than $100 a month. So there were substantial aid for individuals who were indigent to get help with their insurance.

It looks like, if you look at what I'm going to call competition, but it's really a proxy variable. It's number of issuers in the rating area. If you look at that, there is about a three to four percent drop with adding each issuer, going on this slide from 243 to 212 and that drop with increasing numbers of issuers and increasing competition may be important. We think we learned a few things in our long experience with the open enrollment period. The first is that [unintelligible] matter. Nearly half of all consumers waited until the end to select a plan. And it shows the importance of an action forcing event and the implications are, for the next open enroll period, which is going to be shorter, we are not particularly worried about that being compressed. Its already been compressed and we think we will do fine with that. Next lesson learned is that the initial open enrollment period, very likely sowed the seeds for future success. Since July of 2013, awareness doubled through the marketplace and for healthcare.gov and among those who are aware, visits to healthcare.gov tripled and we expect that the kind of outreach and education that we have done already for this year's open enrollment period, is going to pay us dividends next year and the years ahead. Finally, premium prices are likely to be key. They are just very important. We have anecdotal information that more issuers are entering the market and we are hopeful that that will seed lower benchmark plans for individuals who choose those benchmark plans. It means lower payments and for the government it means more sustainability.

Let me close by saying a word of what we can expect going forward. The early evidence for 2015 suggests that lots of issuers are entering the market and again, we are hopeful – don't have proof of it, but looking at the past epidemiology, that that will drive down the price of premiums for benchmark plans. We intend to focus on key demographic groups. We hope to simplify the consumer experience. There is a new proposed rule for auto enrollment, modeled in part on the FEHBP. And we hope to engage partners and interest groups to go after select populations where participation has not been as high as it could be and can be. We think we are on the road to producing a market that is going to work effectively for Americans and providing millions of people with healthcare that they will find changes and enriches their lives. Why don't I stop there?

[applause]

ED HOWARD: Now, if I can reclaim the clicker and move it this way. We are going to hear now from Sara Collins, as advertised, to tell us about the Commonwealth Fund survey, looking at basically how people fared in their marketplace experience. Sara?

SARA COLLINS: Thank you, thank you, Ed. On behalf of the Commonwealth Fund, I want to thank the Alliance and also the panelists for joining us today and to extend a warm welcome to the audience this afternoon. I'm going to present some highlights, as Ed said, from the Commonwealth Fund's Affordable Care Act tracking survey and a report that we released yesterday. This will help us understand what the new enrollment numbers that Arnie highlighted mean for the nation's uninsured rate and people's access to healthcare. I would like to recognize my co-authors on the report, Petra Rasmussen and Michelle Dody. The survey interviewed a nationally representative sample of 19 – 64 year olds including a sample of those who were potentially eligible for the law's new coverage options. The survey firm SSRS, conducted the telephone survey of 4400 adults between April and June of this year. The results are compared to a similar survey that SSRS conducted of 6000 adults from July to September of last year. The survey found that the Affordable Care Act's coverage provisions are helping to reduce the number of Americans who are uninsured and improving access to healthcare. Adults who have historically been most at risk of lacking health insurance; young adults, Latinos and those with low and moderate incomes are making the greatest gains in coverage. States that have decided not to expand eligibility for Medicaid are leaving large shares of low income adults without health insurance. A majority of adults with new coverage hold positive views of their new insurance. A majority of adults are using their new health plans to get healthcare, a majority said that they would not have afforded this or accessed this care prior to getting their new insurance. The survey finds that the uninsured rate among 19-64 year olds across the country fell from 20% to 15% between July – September 2013 and April – June 2014 or an estimated 9.5 million fewer uninsured working age adults. Two other surveys that were released yesterday showed similar declines. Young adults ages 19-34 experienced the largest decline of all adult age groups. The uninsured rate in this age group fell from 28% to 18% or 5.7 million fewer uninsured young adults. This means that young adults comprise 60% of the decline in the overall number of uninsured adults. In addition to young adults, people with low and moderate incomes and Latinos, experienced significant declines in uninsured rates. The uninsured rate fell from 35% to 24% among adults with incomes under 138% of poverty. The share of Latinos who lacked health insurance fell from 36% to 23%. In the 25 states and the District of Columbia that had expanded eligibility for Medicaid by April 1st, the uninsured rate among adults with incomes under the poverty level, declined from 28% to 17%. In states that had not expanded their Medicaid programs by April, the uninsured rate among poor adults was statistically unchanged at 36%. The majority of adults who enrolled in coverage in the first open enrollment period were uninsured prior to gaining health insurance. 59% of adults who selected a private plan through the marketplace and 66% of those who enrolled in Medicaid were uninsured. The survey asked adults who had selected a private plan through the marketplaces or had newly enrolled in Medicaid about their views of their new health insurance. Large majorities of adults with new coverage, regardless of their prior insurance status, their age or their political affiliation are optimistic that their new health insurance will improve their ability to get the care that they need. Equal shares of people who had health insurance prior to getting their new plan and those who are uninsured, expressed optimism about their new insurance. More

than half of adults with new coverage considered themselves to be better off now than they were before they got their new insurance. About 27% said that their plan has had no affect and 9% said they were worse off now. A majority of people who had been uninsured prior to getting their new insurance and those who had been insured said they were better off now. The difference between those two groups is not statistically significant. Large shares of people who newly enrolled in Medicaid said they are better off now compared to those who selected a private plan. The survey asked adults with new coverage about their experience using their new plans. 60% of adults with new coverage said that they had used their new plans to go to a doctor or to a hospital or to pay for prescription drugs. Of those, 62% said they would not have been able to access or afford this care prior to getting their new insurance. People who enrolled in new coverage, appeared to find plans that included at least some of the doctors that they wanted to go to. 54% of adults with new coverage said that their plan included all or some of the doctors that they wanted, but 39% didn't know which doctors were in their network. About 20% of adults with new coverage told us they had tried to find a new primary care physician or a general doctor. Of those, 75% said they found it very or somewhat easy to find a new doctor. Two thirds of adults who said they found a new primary care doctor were able to get an appointment within two weeks. However, wait times were longer for some adults. 26% waited longer than two weeks.

Just to wrap up, the survey findings provide early evidence that the law's new coverage options are helping the most at risk Americans gain health insurance. New coverage is helping people gain new access to the healthcare system, both among those previous uninsured and those who were insured. But the results point to remaining vulnerabilities, state reluctance to expand the Medicaid programs is leaving a third of the poorest adults uninsured in those states. Awareness of the marketplaces and financial assistance is lowest among people who would benefit the most. Some people with new coverage are experiencing long wait times for doctor appointments. I will stop there and turn this back over to Ed – thank you.

ED HOWARD: Great, thanks very much, Sara. Terrific results. Those are the data, now lets fill in a little bit of the detail. You are gonna hear now from two people who are dealing first hand with the marketplace experience. And first, Linda Sheppard, who is the special council and Director of Health Policy and Analysis at Kansas Insurance Department. She has been directly involved with the department's implementation of health reform laws insurance provision. You may know, Kansas marketplace is one of the majority of state market places where the federal government is operating it and so we will get one perspective from that state's view and another from a state operated exchange. So Linda, thank you so much for being with us and we are looking forward to hearing what you have to say.

LINDA SHEPPARD: Alright, thank you Ed and good afternoon everyone. So the marketplace experience in Kansas, as Ed said, we are an FFM state and the first couple slides I have here for you and I hope this switch – great, are really just some base setting

for us. This is some statistics that are based on the 2012 census data for our state and so you can see there are about 359,000 Kansans who were uninsured at that time. It's about 12.5% of the state's population, 56,000 children and almost 61% of those folks are between the ages of 19 and 44 and 66% of them have family incomes above the FPL. And then one of the statistics that always is a great concern to me is the fact that three out of four of the uninsured are employed and so I think a lot of people certainly assume that folks who are employed get coverage, but in fact, that is definitely not the case. When we switch now to our insured market, so these are folks who actually do have insurance in our state, most of them, over half of them, are covered by their employer's sponsored insurance plan. Almost 30% of them have public insurance, so Medicare or Medicaid and over half of the children who do have insurance in our state are covered under their parents' employer sponsored plan. And then about 35% of those children have public insurance. The number of uninsured adults ages 19-25 has declined in our state since 2009 from 26.8% down to 22.3% and that statistic is not a surprise to me at all when I think about the reaction that we got right after the law was enacted in 2010 and families in our state, like states all across the country, found out that their young adult children either could stay on their plan much longer than they thought or in fact, who may have aged off and now were very interested in finding out whether they were going to get an opportunity to put those children back on their plans. So we had quite a bit of consumer activity coming into our department at that time, asking about how that was going to work for them. Also, a small percentage of the population at that time, about 6%, had individual or their own insurance and of course we expect at this point that that number would have changed significantly after the enrollment in the marketplace. For our federally facilitated exchange – I just realized I didn't click the thing – for our exchange we technically had four companies and the reason I make that distinction is we have two Blue Cross plans that operate in our state. Our primary plan operates in 103 of our counties and two of the counties that border – are along the border between us and Missouri, there is a Blue Cross company that sells just in those two counties, but they also sell on the Missouri side as well. So we had both of those companies offering plans and then Coventry Aetna was offering both a PPO plan and also an HMO plan in our state and they do that under two separate corporate entities. We had a total of 72 health plans on the marketplace for 2014 and also 12 stand alone demo plans and then only the Blues companies were offering a shop in our state at that time, although as we all know, that really – that shop function wasn't really applicable, but they were qualified as the shop plan for the State of Kansas. Real quickly, I just want to mention this, because as I pointed out, we had 72 plans last year and – but we have over 250 plans for the 2015 plan year. So the companies are clearly trying to expand the products that they are offering and looking at price points and trying to figure out where things work best for consumers in our state. So we will have a significantly higher number of plans for the 2015 market.

The one thing I will say about this and I know Ed said to talk about our experience, but the difficulty of getting the marketplace up and running and then even after the website went live, did create a lot of confusion, a lot of frustration, in our state, certain on the part of us as the insurance regulator, but also our insurance companies and our consumers and

the agents and brokers and navigators that were working in our state to try to help people do what we were gonna do. And so it um – as a result of all that difficulty, it really provided us with – I will call it an opportunity, but an opportunity and a necessarily that we work very, very closely with the insurance companies in our state to make sure that we were all on the same page in terms of the information that was coming from HHS about the plans and how things were being approved and what was going to be shown on the website and that that information was accurate and it really required a lot of coordination. And then after enrollment started, obviously a lot of consumers continued to be very confused and there was some delay in the data and people were thinking they were enrolled, but they didn't have their ID cards or they hadn't been contacted by the insurance company and so that – we got a lot of activity down in our consumer assistance division because people wanted – they were concerned, they didn't know what was happening, what was supposed to be happening. We did have three navigator grants awarded in our state. The largest of those grantees trained and certified over 160 navigators. We did not have any navigator legislation in Kansas, that was something that was not going to be possible for us. And but what ended up happening was this largest grantee organization approached the insurance department and asked if we could be a partner with them in this consortium of organizations they put together to become the navigator grantee. And we went back to HHS and asked if that was an appropriate role for the department and they indicated that it was. And frankly, I will tell you, it actually worked out way better than if we had just been the regulator. We were given a lot of opportunity to work directly with the navigators in a way that we probably wouldn't have if we had just been the regulator. Probably the biggest thing and I know you probably cannot see this at all, but I wanted to put this up. Insureks.org, this was the website that we created. It actually went live right after Labor Day of last year, because we were looking for a way to try to get as much information out to consumers as we could. So I know you hopefully all have it in your packet and I would encourage you to go to the website if you have any other interest or questions. What I will tell you is we tried to – leading up to open enrollment and even after open enrollment started, we tried to put as much information on here as we could. We started out with some general information about the marketplace and I'm looking at the menu along the left side. We did put a tax credit calculator up there pretty early on. When it appeared that there was going to be some problem with consumers being able to see the rates and plans on the marketplace, we added all of that to this website and we also provided a way for consumers to search to find in person assistance in their cities or their counties where they could go to get specific help. And we had a lot of other information on there as well.

This was great and it worked really, really well for our state, but it created some confusion because when we kept adding more content to the website, a lot of consumers thought they could go here and enroll, but we had to tell them no, you can't do that. But we tried to provide as much information as we could. Flipping to our enrollment numbers, we had a little over 57000 Kansans who enrolled in the marketplace during the open enrollment period and I listed the April 15th because we definitely knew there were some folks in our state who were still trying to complete their enrollment period officially

ended. Just like the national data, a little over half are female. 38% are age 34 and younger and I did point out that that's 4% higher than the national data, which is good for us, I mean we were glad to see that and that is certainly a sign that we were happy to see. 19% chose the bronze plan, 60 silver, 16 the gold plan and again, this is another little quirk that came for us. Our enrollment in gold plan is 7% higher than the national average. Again, we view this as a good thing because we think that there were consumers out there either who already knew or through working with an assister, understood that they needed a little bit richer coverage for their particular situation and they chose to go up and purchase the gold plan instead. So we feel that that's a good thing and a very small percentage going into the platinum and the catastrophic. 79% went with the financial assistance, which is a little bit lower than the national. The Kansas legislature has taken no action on Medicaid expansion in our state and actually there was a law passed that prohibited our governor from doing anything on his own. So he would have to have the full support of the legislature to do that. We have about 315,000 Kansans with incomes below the 138 FPL who could be eligible if the expansion were to occur. That being said, we had over 28,000 folks who did go ahead and go on to Medicaid or CHIP which is a 7% increase over our enrollment for – prior to the ACA. So there were folks that definitely went on there probably looking for regular enrollment in a plan and found out that they were eligible for Medicaid or CHIP and went that way. Thank you.

ED HOWARD: Great, thanks very much, Linda. Actually, if you want to pass it, I will wait. I'm sorry, we have a large panel. We are going to turn now to Richard Onizuka who runs the Washington State benefit exchange or marketplace and as that implies, Washington State runs its own marketplace. Dr. Onizuka has been helping shape Washington's healthcare policy for nine years before he took that position as the assistant director of the state healthcare authority and it probably helps that he's a licensed psychologist to be able to do that. Dr. Onizuka, thank you for joining us.

RICHARD ONIZUKA: Thank you Ed, and I appreciate the support of the Alliance and the Commonwealth Fund to participate in this. I'm very excited to be here to talk about the other Washington and the experiences that we have had with our exchange out in the other Washington. A couple of background about us in terms of the state based exchange and can people in the back hear me? Okay, good. So we are a public/private partnership like most of the other state based exchanges. All of the state based exchanges though and their public/private partnerships look a little bit different so if you have seen one state, you have seen one state, basically. We have an 11 member bipartisan board, we have got – our legislation was all bipartisan legislation, so that is a really interesting piece for us in Washington State. We are the entry point for both QHP and Medicaid, so we do the new MAGI Medicaid folks as well as the renewals in Medicaid, so it drove a whole lot of volume for us and I will talk about that when I talk about some of the numbers in another slide. The other thing that is really different about us is, the state based exchanges, we are aggregating premiums, which means that when we report enrollment numbers, those are people that actually have paid on the QHP side. So on the enrollment numbers, those are people that have actually paid, we are collecting the premiums, so we know we has paid

and who hasn't paid and those types of things. It's created some of the challenges for us, as I will talk about in terms of the back end activity that we have engaged in. [unintelligible] is our system integrator, Faniel is our call center operator, we have outsourced our call center and so I will talk a little bit about what we have done with our call center that is driven mostly by the volume that we have had since we went live. We have, like all the state based exchanges now, working on a sustainability plan for 2015 and we will go to our legislature this year, we have just started to socialize that with our board and with our stakeholders, so we are just in that process of doing that back home. So just on a high level, we think we have had some success around QHP enrollment and Medicaid enrollment. We have also had some success and we had challenges just like everybody else had challenges with stabilizing our system and how we opened up. So we started open enrollment on October 1st and we went live at 5:00 am and we were operating very effectively until about 8:30 when we crashed and we were actually down for most of the day. The first day, which was a Tuesday and all of these days are imbedded in all our exchange's minds. Tuesday we went live, we have some difficulty. Wednesday we went down overnight, we fixed a lot of things. Wednesday was a little bit better, but Thursday we really began to show some improvement and it's been pretty good since that that period of time. But the challenge was always trying to balance the need for – this was a new IT system, which needs time to stabilize, but then we are also trying to fix it at the same time and improve at the same time. So trying to get a real balance between stabilization and improvements is a real challenge for us. We, like a lot of states, will talk about – have a really strong consumer assistance network. Just the amount of energy and activity in the community organizations, the agent and brokers, the certified application counselors. Most of those are hospital folks. And then the tribal assisters. So a really strong community involvement and engagement to help us with enrollment. And the other thing that people forget is we were also creating this ourselves as a new organization at the same time and so we do talk a lot about the metaphor of flying the plane, just as we are trying to build it. Any maybe living in the house as you are trying to build it is probably the better metaphor. But it was a real challenge. But one of the things that we count as a real success is that we have had clean financial audits the last two years. And so that is a really good accomplishment, I think. But we have had some challenges. Volume is, I think, threw all of us for a loop. And we spent a lot of time during the open enrollment period trying to adjust to that volume. We call them complex applications and so we have had lots of situations and I will talk about, especially on the Medicaid side. People renewing their Medicaid who already had data in the eligibility server system and now we are adding data, new potentially in the health plan finder, which is our exchange system. And a lot of times it was designed to throw edits if the data didn't match to be able to make sure that that information was consistent. We have had challenges around the back end transferring payment information and our shop exchange, which I will talk about too.

So a little bit about our metrics. So since October 1st, about 1.2 million have enrolled in healthcare coverage. So again, because we aggregate premiums, we are able to say what those numbers are. QHP new enrollment. So we are now shifting from reporting new

enrollments to we are going to start reporting current enrollments, because this is the individual market and we all know that the individual market, people go in and out, people get jobs, a lot of things change in the individual market. So our enrollment will start to fluctuate now in the individual market. But the people that have paid once, we are now 170,000 in terms of QHP enrollments that have paid at least one premium. We are now going to start tracking what the attrition rate is going to be. We have been able to track to the new Medicaid – the new MAGI Medicaid folks at over 300,000. That number is now up to over 340,000. And then we are also able to track the people that were previously eligible but not enrolled in Medicaid, at about 171,000. That number probably surprised us. We are also doing the Medicaid renewal, so we have over a half a million people in renewing their Medicaid, about 80,000 a month are renewing their Medicaid each month with the health plan finder. So just to put that in perspective, the MAGI Medicaid enrollment exceeded the target that the state set for January of 2018. January 2018, their target was 250,000 and so we are well over that January 2018 target. So we have seen a really good interest in the insurance market, especially on the Medicaid side.

Call Centers. So Arnie talked about the fact that a lot of people waited till the last minute. So our call center – we opened our call center, thinking we would get about 1500 calls a day or so – 1500 to 2000 calls a day. We opened up in October – actually we started in September, but on October 1st, we started getting about 10,000 calls a day. So obviously we weren't able to handle that, so our staffing rose from about 140 from the time that we started, to over 500 in February. We are now, in July, at about 320 customer service reps still and we are still getting right now about 5000 calls a day. We were averaging about 8,000 – 10,000 calls a day. On March 31st, starting at about 10:00 am, we were getting 10,000 calls an hour. We got 90,000 calls on March 31st. And obviously we weren't able to handle that kind of volume. We got 5% of our total enrollment on March 31st. So people didn't just wait to the last month, they waited to the last minute. They literally waited to the last minute. We had 6000 concurrent users on the system at 11:00 pm. On December 23rd, which was our other deadline, the most we had at any one time was about 7500. We had about 8000 to 10,000 people on the system at one time. We had 6000 people still on at 11:00 pm and our last application was started at 11:59:58. Needless to say, we gave that person a special enrollment to get them through.

A couple highlights. We are a little bit higher on the people that aren't receiving tax credits, so about 24% of our QHP enrollments are over 400% of federal poverty level. 18-34, we are about 25%, but we had a spike in March to – and our March number was about 29% to bring the overall number to about 25%. And again, if you include the Medicaid folks, we get up to about 35%, which is a pretty good number. Speaking of survey data, we have done brand awareness surveys before and after open enrollment. And 57% in April, we were [unintelligible] in Health Plan Finder. We had about 43% of our enrollments assisted by either in person assisters or agents and brokers. The in person assisters did about 90% Medicaid and the agents and brokers did about 60% QHP. The QHP number or actually the Medicaid number for agents and brokers surprised us a little bit, until we found out that a lot of them were dealing with mixed families. So families

where kids qualified for Medicaid and the adults qualified for QHPs. We put the last bullet in there, the second to last bullet in there, talking about the value that we brought to the exchange, particularly as we go to the legislature this next year and start talking about our budget. But we wanted to have that slide in terms of the amount of tax credits we are bringing in – up to 130 million dollars in tax credits and 20 million dollars in cost sharing reductions. That is all benefits to the state. The other question and this was really helpful in the Commonwealth surveys, is a lot of attention has been made about how many of the people that have been enrolled are from the ranks of the uninsured. And so our insurance commissioner's office has done some surveys recently that are individual market is increased by about 30% when you consider the inside and outside market. And we've reduced our uninsured, we think, by about 370,000 people, which is about a third of our uninsured rate. The other thing, and it looks like the last slide got dropped off – this is a really interesting statistic in the sense that Harborview, which is our safety net hospital in Seattle, last year their uninsured rate was about 12%, this year its running about 2%. And that is a huge drop in the rate of uninsured, which has had a huge impact.

I will go through this really quickly. A lot of things worked well for us. I think managing scope and governance was a real critical piece of this. Having good vendor partnerships and a good relationship with your vendor and being transparent about it. All of our QA reports, all of our independent verification and validation reports were presented to our board, which is all public meetings. And so there is a lot of transparency around our activity. Even the things that we weren't doing well and the things that we are having challenges around. The things that were difficult was trying to project what was going to happen. And so we really didn't know what was gonna happen. We didn't know what we didn't know in a lot of things. So we've done a lot of things around work-arounds in trying to adapt to things. We knew a lot of this was going to be new. Anything that we have done that has been new, we found new challenges on. So this next open enrollment, we are going to do renewals and QHPs for the first time. And so we expect to find different things around renewals and QHPs. What we found is everything that we started with that was new in terms of enrollment, activity, invoices, all those things we have challenges on as we have gone forward.

I will try to wrap this up. Again, we are talking about 2015. We will have four additional carriers, we hope. We have had four additional carriers apply to be in our market. We more than double the qualified health plan options. We had 38 this year. We've had proposals for over 100 QHPs for next year. We even had one of our existing carriers come in with a rate decrease, which is also really good. We think that is what the exchanges are supposed to do in terms of driving competition. And then we are also preparing for financial sustainability in 2015, that is going to be a huge challenge for us as we work with our legislatures in the next year. So with that, there are some stories that are there around individual people that have enrolled. Thank you.

ED HOWARD: Terrific, thanks very much, Richard.

[applause]

Our final speaker is Professor Tim Jost from the Washington and Lee University School of Law. Tim has literally written the book on health law. That is to say he is the author of a widely used law school text on the subject. He is a prolific and insightful blogger – those of you who follow the Health Affairs blog know that. And we are most grateful to him, not only for sharing his expertise, but for doing it by taking a pause in a family vacation to join us this afternoon. Tim, welcome back and thanks for being with us.

TIM JOST: Thank you. Well, I will start with a story. A couple months ago, my wife and I visited some friends who raise horses and sheep in Western Virginia, in the mountains. When we got there, they were working very hard because they had two mares that had fouled over night. They bare on their bodies the burdens of many years of hard, physical labor. They have been uninsured for as long as I have known them. Like many family farmers and small business people across the United States, they have not enjoyed the benefits of employer sponsored health insurance, which cover most Americans. They were eagerly looking forward to 2014 when they could get Affordable Care Act coverage and start taking care of some persistent and long standing physical problems. They were very disappointed to learn that given the income and expenses of their farm, their income was below the poverty line. Since Virginia has failed to expand Medicaid, our friends are ineligible for assistance under the Affordable Care Act. I think the experience of the last year, a message reinforced by the Commonwealth Fund report we are reviewing today, has taught us several things. First, most Americans really want to have health insurance. Like our friends. Surveys show overwhelmingly that the uninsured are not insured because they can't afford coverage, do no know coverage is available or are in states like Virginia that have blocked Medicaid expansion. Very few simply don't want insurance. Second, they ACA has in fact made health insurance affordable for many Americans, as we heard this morning from Arnie, the ASPE report found that ACA tax credits reduced premiums for enrollees by 76%, allowing 69% to purchase health insurance coverage for under $100 a month. More importantly, ACA coverage is making care itself affordable as the Commonwealth study shows. Third, surveys have shown repeatedly that the ACA is reducing the number of uninsured, exactly what it is supposed to do. The Commonwealth study shows again, however, that the number of uninsured is dropping much faster in states that have expanded Medicaid than in those that have refused to do so. Fourth, the newly insured under the ACA are in fact finding doctors and other providers who will treat them and many have found plans that include all the doctors they want. In many states, consumers are choosing less expensive narrower network plans, but they are still finding care. This is not to say that everything is perfect as the ACA's persistent critics are quick to remind us. In fact, serious challenges continue to lie before us. First, all states need to expand Medicaid. Some may find ways to do this that are better suited to their political culture and HHS has demonstrated a willingness to work with the states to accomplish this. But leaving out the poorest of the poor, including many hard working people like my friends, is immoral and makes no sense economically. Second, we need to dramatically ramp up enrollment moving forward. This year 8 million Americans chose

plans through the health insurance exchange, perhaps 6 to 7 million of those are currently covered. Millions more are covered by Medicaid. But the CBO estimate for 2015 is 13 million enrolled in the exchanges and 22 million for 2016, plus 12 million for 2015, enrolled in Medicaid. We need to retain existing enrollees and find at least as many again next year and then again the year after that. The administration has proposed an ambitious agenda for more or less automatic redetermination of eligibility and enrollment for 2015. Hoping to hang on to those who are currently enrolled. That agenda is heavily dependent on technology that works, however, and if we have technology failures like those that occurred in 2013, it will be a disaster of the first order. Consumer assisters also need to make sure that enrollees are aware of the options available to them. Most enrolled last year as we saw in the least or second least expensive plan. But those plans may well not be the least or second least expensive for 2015, and many enrollees may need to change their plans to maximize their subsidy. Continued aggressive outreach is also essential. Many Americans who are eligible for tax credit assistance still don't know it and still assume that coverage and care is unaffordable. They need to get the message of the Commonwealth survey and as of the [unintelligible] report. Those covered can in fact access affordable care and health insurance is in fact affordable. Outreach is especially essential to non-English speaking communities. Third, continued attention to insurance markets is essential. New plans are joining the exchanges almost everywhere as we have heard today and this should bring premiums down. State insurance departments must still review premiums however, to ensure that they are not excessive and some insurers have requested some pretty large premium increases for next year. Regulators also need to take a much closer look at network adequacy, an issue that the NEAC has on the front burner at this point. Narrow networks can reduce premiums and still provide adequate care as the Commonwealth study shows. But too narrow networks can keep enrollees from getting the care they need. Also, insurers need to be encouraged to come up with products that are more attractive to consumers such as policies that cover routine care outside of the deductible and regulators need to ensure that insurers do not try to avoid high cost enrollees as for example by imposing excessive cost sharing on specialty drugs. I'm hoping that my governor will find a way in Virginia to expand Medicaid or even a very ambitious hope that the state legislature will find a way to do it and that my friends will finally get the care that they need and deserve. The Commonwealth study demonstrates that many Americans have already gotten that care and are pretty happy with it. But we have a long way to go before every American who wants access to healthcare, can get it and we need to press on. Thank you.

[applause]

ED HOWARD: Thank you, Tim. We are now in the part of the program where you get to take an active part. You have a triple threat opportunity here. You can write a question on a green card and hold it up, you can go to one of the microphones in which case I would ask you to keep your question brief and identify yourself, or if you can manage to get a signal in this room, which I can't seem to do, you can tweet us a question at ACAmarketplace. Let me start off with a question that we received in advance. It has to

do with one of the pieces that appears in your materials and I guess Dr. Epstein could take the first crack at this because it's referring to the HHS inspector general report that there were a bunch, I guess the proper characterization is "millions" of inconsistencies between the information submitted by people applying for coverage and subsidies through the marketplaces. And he recommended that HHS publish a plan and a timetable for resolving those inconsistencies and I wonder if you have any update for us about the HHS plan to get a plan.

ARNOLD EPSTEIN: I don't.

ED HOWARD: Okay, that is that.

TIM JOST: Could I respond to that? There has been a lot of discussion of this and there in fact were a lot of inconsistencies that were not resolved, many that are still not resolved. A lot of that had to do with the technology. A lot of it has to do with the fact, however that the verification plan, I think largely because Congress was so concerned about verification and so concerned about security, has been really ambitious. That HHS has been trying to – and the states have been trying to very carefully verify every bit of information that they have been getting. This is in, I think, stark contrast to the way most tax issues are handled in this country. This is of course applications for tax credits. Largely we are on the honor system in this country with respect to taxes. And I believe that if we tried to verify every business expense that was claimed in this country in the same way that they are trying to verify income, we wouldn't have billions of inconsistencies. So I think this is a serious problem, but I think it's one that in part can be addressed by technology, but in part is an inevitable part of a system that is trying to provide income based tax credits to people whose income is highly variable and very difficult to predict and can – you know, you've got a waitress getting tips or a landscapers who works on days when the sun shines and not on days when it rains. And you ask them, what is your income going to be next year? So I think these are problems that are inherent to the system and would probably be inherent to any system that is based on trying to accurately measure the income of low income people and moderate income people.

ED HOWARD: Very good, thank you. Sara, you have a question?

SARA COLLINS: So we are between open enrollment periods and I'm just – and we know that people can come in on special enrollment periods right now. And so I think there is some curiosity about whether we are seeing that in – how many people we are seeing coming in right now and with the federally facilitated exchanges and also in Washington State? So I'm curious to know what all three of you are seeing in terms of people enrolling during special enrollment periods now that we are between the open enrollment periods for 2014 and 2015.

RICHARD ONIZUKA: I would be glad to talk for the national perspective. I don't have numbers for you, but we are seeing some activity around that. That is why we are going to be reporting current enrollment, because we are going to see some attrition and we are going to see some ads around special enrollment. So I don't have a sense of how it's going to net yet, because we are still starting to see that. We just issued a couple press releases recently around the COBRA special enrollment period. For married couples, same sex married couples in Washington State, we just issued a press release to encourage them to come in for health insurance, so that is a qualifying event also. And we are going to be also doing that with college campuses because what we found, interestingly in some of our college campuses is that they are going to stop providing health insurance for a couple reasons – one is because a lot of kids can stay on their parent's plan and then they can also qualify for possibly Medicaid or tax credits in the exchange. So I don't have numbers, but we are seeing a lot of that kind of activity right now.

LINDA SHEPPARD: In Kansas, obviously as an FFM state, we don't have any direct information about the number of folks in our state who may be enrolling during – under the special enrollment period rules. But the website page that I showed you, if you would look at that right now and that was just a screen shot of the current home page right now, we were getting a lot of questions, again, coming into our consumer assistance division, from folks who wanted to understand, you know, can I still get in even though open enrollment is closed. And under what circumstances? So we have posted a lot of information that is on the front page right now, to make sure that consumers know what their different options are and what types of qualifying events may make that possible for them to go in during this special enrollment period. Again, just based on what we are hearing through our consumer assistance representatives, we do believe there are folks that continue to be interested in this and are taking advantage of it if they fit into any of those categories.

ARNOLD EPSTEIN: Let me start by recommending a paper to you that was written by Sara and David Blumenthal, published two weeks ago in the New England Journal, which talks about the changes in the insurance market and one of the major points they make is that most of the attention has been on the marketplace, but in fact, the changes that are keyed by the ACA are much broader than that and include not only the Medicaid expansion but the changes in non-QHP health plans. Changes that have affected youngsters between – up to age 26 who can stay on their parent's plan and so forth. And you really need that complete picture of what is going. And part of that is the SEP enrollment, where the focus has been on – we talked about earlier today, the last open enrollment and we are anticipating the next open enrollment, but the SEP enrollment keeps on going on and on. We don't have a number for that, but our impression is, just what you say, a lot of people for those categories and we are still accruing them and getting insurance.

ED HOWARD: We have a bunch of questions on cards and we will try to get to as many of them as we can. I want to try to pursue something that our two state folks have brought up separately. One of Richard's slides has a wonderful cartoon describing what looks like Promontory Point gone bad. Where the two groups building the railroad tracks toward each other don't quite meet. And I go back to what Linda talked about in describing the need for the extraordinary cooperation and communication between the Kansas Insurance Department and the carriers and I wondered if you could talk a little about the communication and cooperation between the insurance department and the exchange.

LINDA SHEPPARD: Okay, yeah, I would be happy to talk about that. Because that also presented us with a really um, big challenge, but also a really great opportunity because we found the HHS folks to be very open to talking with us as an FFM state about the problems that we were seeing. I have told people that even though I live in Kansas and although I have had a chance to visit Washington a bunch of times over the last few years, I made what I consider to be a lot of really good friends here because these were folks that we were talking to daily, sometimes multiple times a day, trying to work through some of the issues, trying to get clarification for our insurance companies, trying to get clarification of what we were supposed to be doing as we were doing plan management and then as things started to get going with the open enrollment, trying to coordinate all of the problems that we were seeing. And it just took a lot of communication, a lot of willingness to listen, ask a lot of questions, try to get the answers as best we could and that communication was going on day and night and weekends and it was really kind of an exhilarating experience because there was so much activity that was going on. But it – I mean, in the end it actually worked out better because it certainly did help us understand what was happening at HHS, folks were very good about providing us with information about what was going wrong and what they were trying to do to solve that and then we were trying to work all of that with our insurance companies as well in making sure that they understood what we had been told about how things were moving forward. So it was a challenge, but there was a good coordination.

SARA COLLINS: I have a question for both Kansas and Washington – do you have any data that speaks to the number of enrollments from rural communities in comparison to urban and suburban?

RICHARD ONIZUKA: So we issued – and I just pulled it out of my bag, we have an enrollment report that we issued for the open enrollment period and we have enrollment by county in that enrollment report. So we do have data. I don't have it broken out off the top of my head in terms of rural versus urban. And then you sort of determine what is rural in terms of enrollment. But I have – this report will have QHP and Medicaid enrollment by county and we have also reported it to legislature also.

LINDA SHEPPARD: Sara, in Kansas – this actually is something we are working on right now. Again, because we are not able to get that kind of data from the marketplace, the federal marketplace. We are in the process right now of putting together what we

refer to as a data call, but its basically a survey to our QHP carriers asking them a series of questions to try to get much more down to this detail. So we have been waiting on that because we wanted to give them an opportunity to make sure they felt very comfortable about who their enrollees were and that they thought they had good data within their systems and so that survey will be going out later this month and hopefully we will have a lot more details, that type of data that Sara was asking about it and much more about who these new enrollees are and what their situation is.

RICHARD ONIZUKA: Just to add to that – I think our insurance commissioner's office also did take the data that we had and did break it out by rural versus urban counties. That is also available.

ED HOWARD: Great. We have a couple related questions here, one person asks, are there any examples of interventional strategies for enrollment that work particularly well? And asks for speculation about why that might have been the case. More generally, are there any clear practices that are leading to more successful exchanges? Federal or state run. I would assume, the questioner writes, outreach and awareness plays a huge role. Any other factors that are influencing success?

ARNOLD EPSTEIN: So Ed, we have learned a lot about that from our experience. It's clear that – and you should have gotten this from my presentation – that money matters, premiums matter, that people are choosing the plans that are – have the lowest premiums and when they don't choose a plan but they are eligible, they say affordability was a concern. While they say that, at the same time, the amount of subsidies by percentage is extraordinarily high and for many people, they can get plans at a very affordable rate. And so part of our strategy is communication about that and making sure that it's accurate and as you know, communication is not as easy as saying it once. It's saying it again and again. I think we are also trying to tier that with an understanding of where there are pockets of people who are eligible but have not yet participated. And to go to those markets regionally and [unintelligible] communication patterns at those markets and at those groups of people. And we think that was likely to be effective. It's mostly a matter of spreading the word about what people really care about and should care about.

RICHARD ONIZUKA: I will be able to say, from Washington State's perspective, the community engagement was what was really, really critical and what we found in different parts of the community is, for example, libraries were very effective an outreach tool. Churches were a very effective outreach tool. Especially in reaching to ethnic communities, limited English speaking communities. Just getting into the community organizations and using community workers. People want to have a fact to face contact a lot of times and to be able to get enrolled and understand what their health insurance options are. So those are the things that were really effective. We are doing both an analysis of what worked and what didn't work, to be able to help guide us for the next round of open enrollment too, in terms of how do we target different efforts. Because I think the second round is going to be a little bit different than the first round, because the

first round we got sort of the people that were really interested in this and wanting to get that. I think the second round is going to be a little bit harder.

ED HOWARD: Sara, the Commonwealth Fund survey showed a substantial increase in the level of awareness of the key components of this enterprise. I wonder if that makes it more likely to be easier to build on the fact that 60% of the people know what you are talking about instead of 30, when you go back on the second enrollment period. Does that make sense?

RICHARD ONIZUKA: I believe so. And what we found is we had really good reach in our TV ads. Our TV ads were effective and it drove a lot of brand awareness and we had similar information just like Sara got, around just sort of the amount of people that were aware of it going on. And yeah, like you said, the awareness is what helps them get the different levels of information.

TIM JOST: One issue that I haven't seen any data on, but I would suspect is an important issue is something I mentioned very briefly and that is, even if you are paying $50 or $100 a month, if you are buying a $5000 deductible policy, your chances of ever using it are very, very small and I think people understand that and it may be affordable, but it may not be good value. And a Family's USA put out a report about a month ago on insurance plans that are out there that companies have come up that offer at least some primary care services, some generic drugs outside of the deductible or find other ways to make those available. And it seems to me that that is something – there is a potential there for adverse selection, but I think trying to look not just at affordability of the premiums, but affordability of care, I think is a very important thing. I guess I was a little bit surprised in the Commonwealth study to find that so many people not only thought their insurance was affordable, but also that care was affordable.

SARA COLLINS: I will follow up on that and we also had a question from the audience about this, whether or not we are – this is really for our need, but whether we are tracking affordability on that dimension. Whether we are looking at people's ability to access healthcare, given their cost sharing. So just – are we tracking how much of a barrier deductibles and cost sharing are in these policies. One thing I will say and I will let Arnie speak, but in our – in the Commonwealth Fund survey, when we ask people if they – who used their policy to go to the doctor, whether they had been able to get this care before, about 62% said no. And what is interesting, it was much higher among people who had been uninsured, so about 75% of people who had been uninsured before said they wouldn't have been able to get this care before. But 44% of people, who had insurance before, also said that. So I think that is also an indication of how poor many people's policies were, how high some of the deductibles people were facing in the old market, compared to what they are seeing now.

ARNOLD EPSTEIN: For some of these, yeah, $5000 deductible is a really good deal compared to what they had before. If you look at the statistics, the most popular policy

was silver and my hunch is, that probably reflects the cost share and reductions that people got and for people whose income is roughly 200 or less percent of the poverty line, they are really very substantial and make a huge difference. I learned that, like most policy experts, learned by going online with my daughter to help her choose a policy and saw the different cascading for her predicted income. It also made Tim's point for me because when she had to predict her expected income, she had no idea. It changes each month, so both of those, we will see. We are going to try and track going out, not only premiums, but their total cost and learn more about that. But at this point we don't have those data.

ED HOWARD: If I can turn back to the Commonwealth survey, one of the things that struck me, Sara as you were going through those illuminating slides was, when you broke out the decrease in the uninsured rate among different ethnic groups, Hispanics of course declined substantially. Among African Americans, the decline was almost zero. Do you have any speculation about why that might have happened?

SARA COLLINS: We were very surprised to see this, given the declines among Latinos and so we went back in, my colleague Petra Rasmussen who is here today, went back in and we looked at this a little more closely and what we find is that about 62%, at least in our survey, of African Americans, lived in states that aren't expanding their Medicaid programs. The other important statistic that Petra found was that about 32% of African Americans in our survey had incomes under 100% of poverty or 138% of poverty. So that gives you an indication of some barriers that people are facing to getting covered in those states. So we think that that has a lot to do with it. The other thing is, this is a relatively small – we had 4,000 people in our survey, but it is a relatively small sample, so there is that issue as well.

ED HOWARD: I don't know what the African American populations are for Washington and Kansas, but is there any experience that you have come across that might have bearing on that?

LINDA SHEPPARD: Yeah, I wouldn't have any.

RICHARD ONIZUKA: This new data is really hard for us to track because it's a voluntary question. And then it gets into all of the other mistrust of government to be able to tie answering that question with an enrollment process. Or an eligibility process. So it gets to be really, really challenging around that. We get most of our information anecdotally from the community organizations and again, it's getting that touch out in the communities that is really effective.

ED HOWARD: Question from a Congressional staff member. Of those who are new system participants – 60% using healthcare services, are any of the studies tracking the possibility of over utilization among those folks? Not among these researchers, apparently. There is a grant opportunity somewhere.

LINDA SHEPPARD: Let me make one comment about that, because I think it's going to be interesting to see how this plays out. We are going to be doing this survey of our companies and asking them a number of questions about this new population that they are looking at, but just in some really informal conversations with some of our carriers, we are hearing about medical loss ratios that are over 200%. In some cases, way over 200% and it's gonna be interesting to sort of see – and this is clearly in this new QHP population that they have taken in and we have always known or expected that there was going to be this pent up demand that these folks who are getting insurance perhaps for the first time now, have put off care for a long period of time and once they got this care, began to use that in ways that – trying to make up for all of the time that they hadn't had any care. So I think the companies are certainly expecting that that loss ratio will start to taper off once folks get some of the services that they haven't had for a very long time. But that is something obviously as an insurance regulator, we are going to be very concerned about and watching that closely because obviously if that were a pattern that were to continue, we would have to start having concerns about solvency issues and which then ultimately goes into rate setting. So it is something that we are looking at, but certainly I expect when we do the data call, that the companies are going to be reporting to us these – at least for these first few months, these very large loss ratios that they are experiencing right now.

SARA COLLINS: So while we are on the subject, someone asked about – in our survey, if we differentiated between the kinds of doctor appoints that people were looking to make – well visits, physicals or sick visits – and we just ask people who wanted to see new primary care physicians. So how long it took them to find a new primary care physician, so these were not sick people, people who don't need urgent care, but people who are looking for a new primary care physician. And I also wanted to just provide some context for what we found in the survey. We did find – the majority of the people found new primary care physicians relatively easily and about two thirds got an appointment – were able to get an appointment within two weeks. There was a tale of people who did have to wait a long period of time and we look back at surveys that we have done a couple years ago where we asked a very similar question of people's experience, getting primary care physicians just in the general population. And we found very, very similar wait times. So what we are seeing in our survey for people who have new coverage, is very similar, we think, to what people are experiencing in the broader population.

ED HOWARD: There is a question here, a couple of folks have talked about narrow networks and this questioner wants to know how serious a problem it is that excessively narrow networks or disparate cost sharing for that matter, for specialty drugs, are being used to screen out individuals with greater health needs. Anecdotal data driven?

ARNOLD EPSTEIN: The emergence of narrow networks has been obviously one of the phenomenon that has caught people's attention. It's clear that you can manipulate

networks much like you can manipulate premiums, but use differences in products that are meaningful to people. Where the government – I think, will be paying close attention to that as will people in the industry, to understand how networks influence utilization, how they influence selection, how they influence quality of care. And I expect that to be happening, but we don't have all the data that we need at this point.

RICHARD ONIZUKA: I will probably say something similar. Narrow networks have gotten a lot of attention in Washington State. Our insurance commissioner has issued a separate set of rules around narrow networks for 2015 planned filings. He has also given the carriers a lot of flexibility in terms of working with the approval process to try to define those a little bit more. I think its balance between trying to hold down costs, but also trying to give consumers choice and I think it's a delicate – I think it's trying to find where that balance is going to be a key piece of it. But I think it's something that is going to evolve over the next year or two in terms of what carriers are going to do and what providers are going to do around their networks.

LINDA SHEPPARD: Yeah, you know, in Kansas for the 2014 plan year, our companies that sold QHPs did not utilize much in the way of these narrow networks. We really didn't see that happening for that first open enrollment period and obviously we were glad that that didn't happen. The one company that did sell an HMO product last year, obviously they have a different sort of a situation and that is always a component of an HMO plan. As I mentioned earlier, we have got over 250 plans that have been submitted for approval for the 2015 plan year and I do believe that we are going to start to see a little bit of that because as I said earlier, I think the companies are trying to find different price points that will appeal to different consumers depending upon their financial situation and using those narrow networks, that is one way that you can control that cost. That being said, you know, you also have to be concerned about doing a very good job informing and educating the consumers who may be looking at those products to make sure that they understand what they are getting and that in fact, the doctor or the hospital that they want is included in that. But that is something we are going to be looking closely at and it's a little bit frustrating because we are a state that currently does not have any law on what constitutes an adequate network. And so it's gonna be something that we are looking at. Certainly looking at any guidance we get from HHS about what we should be concerned about, but we do not really have any set standards in Kansas law at this time.

ARNOLD EPSTEIN: So I think you really just bring to the floor and underscore the point that I make, that this is a really important phenomenon that we are learning about it. It's a wider phenomenon than one might appreciate. It affects things like, do they have the right amount of primary care doctors? Do they have good access to tertiary and quaternary oncology services? What about behavioral health? Do they have that? And of course teaching hospitals in quaternary care. The people who have studied this, one of the few things that is out already on this, is work done by McKinsey and Company, they put out an issue brief where they looked at networks defined by use of hospitals within 50

miles of the center of the plan. And the narrow network had only a small subset of hospitals and progressively on out and interestingly, they were able to plot the epidemiology of that and ask the question, is there any evidence that patient satisfaction was lower as measured by the CAP survey or quality was lowered as measured by Medicare Compare or a bunch of other industries and they didn't find much at that point. But I am not saying that to say that there is nothing there – don't hear that. I think it's interesting, I think we are just getting to start and all different parties are going to be involved.

TIM JOST: One thing to keep in mind, in so far as we are talking about narrow networks as a risk selection strategy is the premium stabilization programs. Because specifically the risk adjustment program is going to move money from plans that have low risk populations to plans that have high risk populations and there is some evidence that particularly when that is added to the reinsurance program, that plans that embrace a high risk population are going to be overcompensated rather than under compensated. And so one strategy that a few insurers are taking, is to go after a high risk population and then try to manage their care very carefully so that they get good care. But the utilization is kept in check. But companies that are simply trying to avoid high risk populations are going to get dinged when the risk adjustment, be it bills, show up.

ED HOWARD: By the way, I should have mentioned this earlier, but some of you may not have noticed the location of the microphones that you could use to ask your question verbally. They are way up front. So you can start now and by the time we ask another question to get an answer, you might, from the back of the room, be able to get to the microphone in the front. But they are there and you can use them. And I wanted to follow up on the mention several times of the striking increase in the number of plans that both Linda and Richard have noted in their states and the questioner actually wants to know whether in the marketplaces in 2015, what do you do about the evidence that consumers struggle to make decisions, when presented with too many options? And asks for your opinion about how consumers are going to fare when they are confronted with 215 choices?

LINDA SHEPPARD: That is absolutely a great question and I think the two ways that we would see that attempt to be addressed in our state was falling back very strongly on the in person assisters. And you know, health insurance agents are very trained and very capable of sitting down with somebody and looking at the options and doing a really good job of explaining to that person and trying to understand what their personal or family situation is and giving them some good guidance. But the navigators – that is – that is something that they do not have probably as intensive training as we would like for them to have in that area and I think that that is one of the things, as I mentioned to you earlier, you know, we were a member of the consortium that operated the largest navigator program in our state last year and we are going to join them on the grant for this subsequent year as well. And I think that is one of the things that we will be talking with them about, is to what extent if any are any of the new requirements from the federal

training, for the navigators, going to start to address that and give the navigators some more insight to that. In the alternative, what could we as the insurance department or the insurance companies do in working directly with the navigators to provide them with a little bit better understanding about how to sit down and talk with somebody and determine what the situation is and maybe you know, encourage them to look for certain things when they are looking at the plan. So I think there is a way for it to be addressed, but one thing I will say about the navigator situation is, you know, when we were talking to the navigators about the amount of time that they were having to spend with each person that they sat down and talked to, it was significant. I mean, hour or an hour and a half in some cases that they were spending with these individuals to try to help them understand that and I think that is a concern when you have a limited number of navigators and agents and brokers who are working with these folks. So that is a certainly a concern that we have and will be looking at a lot of different options there.

RICHARD ONIZUKA: Linda, that is a really good question. Our Board is starting to raise that kind of a question in terms of how would we help consumers make choices in the marketplace with more than twice as many plans, options that we have. We are going to use some of the search features of our website and the other thing that we are also focusing on is we spent the first year really just getting people enrolled and just getting them into the marketplace. We are now realizing that we need to do a lot more in terms of education around want you have and we all talked about the challenge – you know, the difference between choosing a plan with a low premium versus a plan with a lower deductible. Or out of pocket max. And maybe with the higher premium. And so how do you use that? How do you then also – how can you use your benefits more effectively in terms of – taking care of the primary care benefits, the preventative benefits and those types of things. So there is a lot more in terms of health literacy that we are going to be engaging with, with our consumers over the next year or so. And we have engaged the carriers on that and we have engaged a vendor around that to help us do that.

ED HOWARD: Richard, that does raise the question, particularly for people who are in the system now and have had coverage as a result of this first year. Arnie made reference to the reenrollment mechanism that is being put in place to try to make it easy to hang on to the coverage you have, but there is also a lot of turmoil in the markets, whether it's a series of new plans, new entry coming in that are gonna change premiums, shifting coverage of different drugs or providers – how do you balance the need to give people the information they need to make a new choice given the reluctance of people to do anything different from what they have been doing, with the need to keep them in the system. How do you try to do that?

RICHARD ONIZUKA: So I think we are going to do something similar to what most states – I'm not sure actually how it's going to work on the federal side. We are going to do an early look at trying to do a reauthorization for folks. We asked permission for enrollees this year to use their data to try to get a head start on that and again, we actually had one carrier in our marketplace come in with a rate decrease. And so if that gets

approved, that could change the second lowest cost silver plan, which then changes the whole structure of what people can get. So it may be that people could get a cheaper plan, which will be more effort on their part to do that. But what we will try to do is make it as easy as possible that if your income doesn't change and your plan is still available, you don't have to do anything. You may want to because you may have different options because of the change in the market place, but you really don't have to if you don't want to. But it's going to be a lot of effort. That is why our notices are going to go out in October, a month ahead of open enrollment, and so we are starting already to plan to bulk up our call center in October in anticipation of all the questions that that is going to generate.

TIM JOST: The question that was just asked about simplifying the process – there are some states that have standardized the products. In all states, there is a meaningful difference requirement that insurers are not simply supposed to file two plans that are almost identical, but slightly different. My impression is that that has not been terribly strongly enforced. But some states have standardized the products and some states have talked about – well, California in particular, about being an active participant in the market and trying to negotiate better products for people. I think one place where we can really have a lot of room for improve though is in plan finder tools. And California was, I believe, the only state in the first year that allowed people to shop for plans and see what their cost sharing would be as well as – or to have a tool that will allow people to calculate the effects of cost sharing, as well as the premiums to come up with a total cost kind of figure. And there is a lot of creativity going on there, I think probably many people in this room are familiar with Consumer Check Book, if you are a federal employee, but they have come up with a tool that the exchanges could use and that is one place where I really hope we see some improvement, where people get much more sophisticated tools to allow them to shop for plans, looking at something other than just the premium and the deductible, for example.

ED HOWARD: We have a questioner.

AUDIENCE MEMBER: Bob Griss with the Institute of Social Medicine and Community Health. With the kind of information that has been presented so far, is there any basis for comparing the benefits and costs of the kind of fragmented system that you are describing with what a standardized benefit package would have looked like if every state had provided one plan the way the ACA was originally intended to do? In other words, we are talking descriptively about what the marketplace does in response to the kind of new policies that have been introduced, but I'm not hearing a comparison with what we could have expected, had a standardized benefit package been required across states with less choice -with no choice in fact, but just the option of the standard benefit that we thought we were gonna get with ACA. To me, that is a relevant comparison if we are trying to evaluate the success of this experiment.

TIM JOST: Well, we actually have in many respects a standard benefit package because every insurer must cover the ten essential health benefits, each state defines those a little differently, usually in terms of the most widely purchased Blue Cross plan or some other plan in the small group market. I think the huge variation between the plans is not, however, in the benefits, but rather in the cost sharing and in the networks. And there was the hope that we would standardize cost sharing into four levels that would be roughly comparable, but its turned out, I think, to be very complicated to comparing one plan to another and then of course the networks was a variable that was always there, but I think people didn't really realize was going to make as huge a difference as it does. But I mean, there is certainly an argument for trying to simplify it. On the other hand, there is an argument for – as long as we are going to have a free market system for creativity and innovation, which is what the insurers at least think they are doing.

ED HOWARD: Alright. Yes?

AUDIENCE MEMBER: I'm Rebecca Adams with CQ Roll Call and I wanted to build on a comment that Richard made. How likely is it that your exchange may not be financially sustainable in 2015 that you might actually need some federal support? If anybody else wants to jump in that as well. More broadly for Linda and Richard, are you looking for – what do you need from CMS the most before November 15th? What are you hoping they might provide in terms of additional policy information or anything else, that would ensure a successful sign up period?

RICHARD ONIZUKA: I was only able to get parts of the question.

AUDIENCE MEMBER: You had talked earlier about the challenge of making sure you are financially sustainable for 2015 – is it likely that you might not be and can you talk about what you need to do to ensure that you would not need federal support?

RICHARD ONIZUKA: Okay, so in 2015 we are supposed to be self-sustaining and it's up to our state legislatures to fund the state based exchanges. We have a funding mechanism. We have appropriation level that was determined a year and a half ago, before we even opened our doors. So the legislature – we didn't have good data as to what it was going to cost, it was this whole thing of projecting cost a year and a half in the future. So they appropriated a funding level of 40 million dollars, projecting forward. We are going to go into this legislative session and have discussions about that. What we have presented to our board is what we think we need to function relatively reasonably on. And it's higher than 40 million dollars. So the discussion is going to be, what do we raise that cap to and what is an appropriate level of funding? I expect that the legislature will have lots of robust discussions about that and we will come up with some solution that is reasonable, I just don't know what that is going to be. Whether its some place – high far higher than that is it going to be? It is going to be 40? It is going to be 45? It is going to be 50? Higher than that? It's hard to tell. What we gave to our Board and actually all of our materials are online, is our whole budget scenario. You can fund this

level, what we think are sort of our fixed costs are. So for example our operation and maintenance contract with [unintelligible] specifies a certain level of dollars. For us in 2015 it's 7.2 million dollars. But you have variation in terms of how you staff our call center. So you can staff it anywhere from the original contract at 80 CSRs, which we think will project about an hour and a half wait time, to 450. It also comes with a varying level of expenses. So it's just a matter of how much the Board and the legislature will choose to fund. I think the second part of your question was CMS and so what can CMS do to help us? A couple things on the state based side is, CMS and their last set of rules put a couple of things back onto the states around the calculation of the individual mandate and the employer mandate. That is something that we hadn't anticipated in terms of our sustainability budgets. So that is also something that we are going to have to fit in the mold. I think that the best thing that I would say from CMS is, we need – anything that is still remaining in terms of guidelines, we need those as soon as possible and that has been our mantra from the very beginning, is we need guidelines as soon as final. We need rules as soon as they possibly can. They still haven't defined an open enrollment period for 2015 and so we would like to have an open enrollment period defined for 2015, so that we know what that is going to be and we can plan for that. We would like it to be within the calendar year, so we would like the open enrollment period that begins in plan year 2016, to conclude before the end of 2015. Open enrollment periods that extend into the calendar year of the planned year are a difficult transition. So the fact that this next open enrollment period that starts in November and goes into February, that is always a challenge to be able to implement. So we would like to end it December 15th to be able to start January 1st. That allows us to have a couple weeks to make sure that we can get cards out to people and those types of things. So some of those things would be really helpful.

ED HOWARD: We are going to take a couple more card questions, we have time for, and I would ask you since we just have a few minutes to listen and digest that, while you fill out an evaluation form that you will find in your kits. Sara?

SARA COLLINS: There is a question to Richard – does Washington State have any data on how much money you are saving on uncompensated care due to the Medicaid expansion?

RICHARD ONIZUKA: We don't have anything that we can count on at this point, but I did mention the Harborview information in terms of their rate of uninsurance going from 12% to 2%. So they project a 20 million dollar impact of that through this next year. That is just one safety net hospital. So we don't have any other data at this point, but that is a critical question. It is a question that our legislatures are asking also in terms of the impact. It's also something that will help us as we talk about our budget, to demonstrate the value of the exchange too. So it's all part of what we are going to try to see if we can collect as much as possible.

ED HOWARD: I want to try to squeeze in this question because it is a tweet. It is addressed to Sara Collins. How many new ACA market place – private entrance, will also participate in Medicaid? The questioner says it's 4 in 10. Anything like that in your survey?

SARA COLLINS: So we asked people who visited the market places whether they selected a private plan or they enrolled in Medicaid. And of that group, the enrollment, selecting private plan and enrolling in Medicaid was split relatively evenly. But there were very big differences by age. So we had much larger – there was – let me backtrack on that a little bit. There was actually more private enrollment, less Medicaid enrollment across that whole enrollment group who visited the market places. What was different was the age – enrollment by age. So the enrollment of young adults was split evenly. So about the same share of young adults enrolled in private plans as enrolled in Medicaid. Much larger shares of older adults – 50 – 64 year olds enrolled in selected private plans. And you see that when you look at the – at least in our survey, the total enrollment in Medicaid and the total enrollment in private plans, young adults dominated enrollment of adults in the Medicaid programs. So about 42% of those who went through the market place and selected a Medicaid plan were young adults. It's flipped on the private enrollment, much higher representation of older adults. So it really does show you a lot about the income distribution of young adults – as we think of them as young invincibles, but actually the majority of them are in very low income households. So the Medicaid [inaudible], Richard mentioned this too, that they are seeing in Washington State, has been really important for insuring that age group.

ED HOWARD: Well, I think we have exhausted our time if not our expertise. Let me just take a minute to do a commercial here. We have talked a lot about navigators, we talked a lot about narrow networks, both of those will be subjects of Alliance briefings in the upcoming weeks. I believe the 21st is the narrow networks briefing. The first week of August we will be talking about navigators and other assisters. We do have a briefing on Monday for kids and if you are registered for that, take note that it starts at noon, not at 12:15. Commercial is over, thank you. And speaking of thank you, let me thank the Commonwealth fund both for expertise they contributed in it's publications and the publication's authors and ask you to help me thank our wonderful panel for bringing a wide range of experience to this talk.

[applause]

And thank you for sticking around on a Friday afternoon.