ALLIANCE FOR HEALTH REFORM

Rates of Change: Putting 2015 Insurance Premiums into Context
The Commonwealth Fund
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ED HOWARD: Alright, let's try to get started, we are just at noon. Those of you who are still looking for seats, look for a staff member to help guide you toward the ones that are still open.

And good afternoon. My name is Ed Howard; I'm with the Alliance for Health Reform. And I want to welcome you on behalf of Senator Blunt, Senator Rockefeller, our Board of Directors, to this program on health insurance rates, including the market forces and regulatory structures that affect them. Every few days it seems we read about insurance rates for 2015 being proposed in one state or another, so even though it seems that we just got through the open enrollment period a few weeks ago, insurers are already filing their proposed rates, mostly with the state insurance departments for the coming year. Now, what we are going to try to do today with the help of a group of panelists with deep experience and big analytical fire power is to help explain what those numbers mean, what factors affect them and what importance we should place on them. One fact that I would like you to keep in mind while you are listening, is that most of the rate numbers you will be hearing, refer to policies sold in what is called the individual market and in the year 2012, about 19 million people were covered in that market out of the 267 non-elderly Americans who had coverage from all sources. So as interesting and useful as this discussion will surely be, remember that it applies to about 7% of Americans with coverage.

We are pleased to have as our partner in today's program, the Commonwealth Fund, a century old philanthropy established to promote the common wheel, common wealth or common good. And we are doubly pleased to have as the co-moderator, Rachel Nuzum, Commonwealth's Vice President for Federal and State Health Policy. Somebody with a lot of policy experience herself including stints on the staff of a couple of US Senators. Rachel is going to start us off with a bit of context on this complex topic of health insurance rates for 2015 and how they are shaped. Rachel?

RACHEL NUZUM: Great, thanks so much, Ed and welcome to everyone. We are thrilled that this is how you are choosing to spend your Friday afternoon with us. So thank you for joining us. I will wait for the slides to come up. But as Ed said, this topic is a really critical topic of the moment. The briefing today really represents an important part of the work that the Commonwealth Fund is doing to really track and measure how the Affordable Care Act is being implemented. We know that a vast majority, about 85% of folks who are enrolling in health plans through the marketplaces this year will be eligible for a premium subsidy, so therefore we know that the cost of the premiums represent will be important to consumers and to the federal government alike. So understanding what goes into the rate setting process is critical. It's one of the things that we wanted to do today, was to kind of help everyone understand what are the factors that are going into the numbers that you are going to be seeing throughout the summer and the fall. And I think it's important to keep in mind that there has never before been a systematic effort to collect and analyze this data on premiums nationwide, looking at the individual insurance market – and we will talk about why and some of the policies that

are new, that are enabling us to do this. And we really think that in order to understand the impact of the changes the ACA has made to the private insurance landscape, we really have to start by orienting ourselves to the baseline. What we are measuring our progress against. And so part of what you will hear today is some of the work supported by the fund that Dr. Gruber will discuss to really provide a benchmark to compare future trends and to help determine if the laws achieving one of it's major goals, providing comprehensive health insurance to nearly all Americans who are buying coverage and at an affordable price.

So just to recap, I think most of us understand what some of the shortcomings were in the individual market prior to the ACA, but again, just to kind of level set, prior to the ACA, the rates in the individual market were unstable and highly variable. There is also an immense amount of variation across the country in terms of how states regulated plans on the individual market, which you can see in this slide. For example, not every state conducted rate review. Some collected rates for informational purposes only, even in states with prior approval processes, many of the states had a deeming period, which meant that the rates that the insurers were proposing went into effect unless the state took action in a given time. Public access to rate review data was limited. Only 13 states had access to public internet access to rate filings or summary statistics on rates. And there is much variation on how states made the rate review information public at all. So what that really means is that prior to the ACA, we were very limited in our ability to look across plans, to look across states and look across the country to make conclusions about both the adequacy of coverage as well as the affordability of coverage in the individual market.

So I think as we also know, regulation of health insurance and the health insurance market has historically fallen to the states. The Affordable Care Act did provide new rules for the federal government to contribute to this process. A major way that the Affordable Care Act inserted the federal government into the regulation, was providing grant funds to states to assist them in this new authority and responsibility to review rates. And by requiring that plans and insurers justify certain rates. So for example, you see some of the highlights here and kind of milestones that plans had to meet in the Affordable Care Act. In 2010, about 250 million dollars was made available to states to use over five years to assist them in the rate review process. Currently 43 of the 45 decided that as part of those new resources, they would focus on making that information publicly available. Available on the internet in a consumer friendly format.

Also in 2010, the medical loss ratio provisions went into affect, which determined that insurers needed to spend 80 or 85% on premiums; of the premiums on medical claims and quality improvements. And so that resulted in about a billion dollars in rebates being paid out in 2011. So we are starting to see some actual outcomes from these early provisions in the Affordable Care Act.

So what this comes down to is the Affordable Care Act really aims to bring down premiums by increased transparency regarding premium increases and the minimum medical loss ratios. I think its important to keep in mind it does not include a formal approval process at the federal level for proposed rate increases. Instead, Health and Human Services is tasked with working with states to develop a process for annual review of rates. They do not have the authority to deny proposed rate increases. The theory behind this is that by opening this process up to transparency will really help enable consumer choice and spur on competition in the market. So due to the changes made in the ACA, consumers now do have more complete access to systematic information about the benefits covered by their plans and the prices of those plans regardless of the state that they live in. And, importantly, especially for this group, researchers and policy makers have the ability to make informed decisions based on standardized data, to be able to look across time and talk about and think about what has been happening in that space.

So why are focusing on this now? What does this mean? As you know, as you may have noticed, every week it feels like a few more states are coming out with proposed rates for 2015. The rate filings range from one insurers proposed decrease of 6.8% in Washington, to basically flat premiums in Maine and larger double digit increases in states like Indiana and Maryland. It is really important to keep in mind that states typically report the average premium rates and insurers requesting a cost all over the plans. And we will talk more about this. So keep in mind, these are also the proposed rates that the final premium rate changes could increase or decrease before they are final. And the main reason that we really wanted to focus on this today is that the majority of states will be releasing rates this summer, leading up into the fall and the federally facilitated marketplace states will also be releasing their 2015 rates in the fall as well. And we will talk more about the regulation process as well.

So as Ed mentioned, we have an esteemed panel of experts today to really help us get under the hood of how rates are set and what it means for 2015. Our first panelist, John Gruber of MIT, will discuss the findings from his latest report, which set an important historical context through the premium rates that will continue to be released this summer and into the fall. Cori Uccello of the American Academy of Actuaries will describe the various factors that go into the rate setting process with the major drivers of the cost increases in 2015 are likely to be. David Cusano on my right, of Georgetown University's Center on Health Insurance Reforms, will provide more details about state's regulatory processes as well a variation across the country. Finally, Liz Hall, the Vice President of Federal Affairs of WellPoint and no stranger to Capitol Hill, will provide an on the ground perspective of the nationwide insurer and some insight into how 2014 has gone so far and what they expect for 2015. You can find full biographies in your packet along with contact information for these and for other experts. And with that, I will turn to Dr. Gruber. Thank you.

ED HOWARD: John, if I may, can I do a little housekeeping here? I want to make sure that people know, for example, that if you want to engage in the – or engage the Twittersphere, you can do that. The hashtag is #rates2015 – you will see it on the lower right of the slide that is on the screen now. We've got a new feature, if you want to use a device for which you need WiFi access, we actually have arranged for WiFi access for you. There are instructions on each of your tables. The username and password either is on those instructions or I will get them and get them to you. They are on there, there we go.

Okay, there will be a video recording of this briefing in a few days on our website, Allhealth.org and a transcript a couple of days after that. Call your attention to two pieces of paper in your packets – one is blue and one is green. The green one is a question card that you can use to ask a question when we get to that part of the program. The blue one, very important; an evaluation that we would like you to fill out so that we can improve these programs as we go along. And if you are watching on C-SPAN, you can find all these background materials that we have distributed to the people in the room online at that same website – allhealth.org. And you can follow along, including with the slides that Dr. Gruber and the other speakers will just be using.

Jon? Thanks for the -

JON GRUBER: Thank you. Thanks Ed, thanks to the Alliance for having me and I want to thank the Commonwealth Fund for sponsoring the work I will talk about today. I think the title of this session says it all. It says context. When we think about things in life, we think about them have context. So if it's 85 degrees today, is that hot or not? That depends on the historical pattern of weather in DC and what we expect to happen. If the Redskins win 12 games this year – that is pretty good given how bad they were last year. If I was a Patriots fan, 12 games is sort of what you expect. Everything is about context and we are used to that. Yet somehow when we come to policy, we forget our human basic instincts. $500 billion dollar deficit, that's terrible! We don't mention that that's actually historically okay as a GDP; it's about where we have been in many years, etcetera. And I think health insurance rates are no exception. That people, when they hear health insurance rates, evaluate them in some abstract fashion relative to zero as if zero is at all relevant. Okay, zero is not relevant. When we talk about health insurance rates and what we are going to see, we should compare them to what scientists would call the counter factual. What would have happened otherwise. And that is really the goal of my report is to talk about what that counter factual should look like. And to do so, I'm going to rely actually on data collected by someone else. I'm going to rely on data that was collected by John Gable and his colleagues at the National Opinion Research Center under contract at HHS from 2010 to 2013. This is important data because it is really the first systematic data ever collected on rates in the individual market. There is some survey data out there, AHIP for example does – has put out reports with some averages. But there has never really been a comprehensive evaluation of what the filed rates – rate increase requests have been across states and over time. This is really the first effort to do

that. What they did is they had a sample that grew over time. It started with about 21 states and grew over time. And they reported overall national data as well as state specific data. All the state specific data was only reported for states where they had at least 50% of the individual market enrollment. So what they did is they went on the web, they went to all the regular websites, collected all the information they could on the five largest insurers in the state – which in some states was all the insurers, in other states was not. They then took a sample of the remaining smaller insurers and then they developed a set of weights based on market share to get a weighted representation of what the rates were in that state. So they have the universe of the five largest insurers, a sample of the smaller insurers and then they give you sort of a weighted average. Now, this is not perfect data – I want to be very clear on that. This data is for an incomplete sample of states and for an incomplete sample of insurers. But it is the best data out there and the most comprehensive data collected to date. And importantly, it's the data that is best available for the period we care about, which is the period before 2011. So actually, that should say it was collected starting in 2008 and not 2010. And the reason that matters is because the ACA, although the exciting aspects of the ACA really kicked in in January, there were very important aspects of the ACA, which mattered starting in 2011. In particular, beginning in 2011, there was federal rate review of all insurance rates that were more – proposed insurance rate increases of more than 10%. As well as minimum loss ratio regulations, which really shook up the individual market. So really, if you want to think about what is pre-Obamacare, individual market, you really have to focus on pre-2011. Because really the individual market of 2011 on, reflects the effects of Obamacare itself. So this data is really the best data we have to look at that pre-Obamacare market. So I will focus on the 2008 to 2010 period. Just a summary of what we find. From 2008 to 2010 there was high and variable premium growth in the individual insurance market. Overall, premium growth average more than 10% a year in the pre-ACA period. And growth rates were highly variable. With some states, premiums rose as little as 3%, others, they went up by as much as 21%. Within states, there was even more variability across insurers. There was huge variability in rates. And so the bottom line is that premium rates pre-ACA were both rapidly rising and very variable and I will come to sort of what that means at the end. But why don't we start by sort of looking through the data.

So exhibit three shows this highly technical graph – that's a joke – shows the average rate of premium increase on individual market across time. And what you see is, in these three pre-ACA years, rate increases vary between 9.9% a year and 11.7% a year. Basically rates were increasing 10 plus percent a year. This was sort of the state of the world in the individual market before the ACA. This was a market with consistent double digit premium increases. Let me be clear what that means. This is for the same product over time. Now, if you look at what people actually paid, if you look at data on what people paid for individual insurance, they didn't quite go up this much because people were buying less and less generous policies to compensate for these premium increases. So if you look at what people actually paid, it might have gone up less and their deductible went up. But if you look for the same policy at what was charged, the

premium increases were double digit in these pre-ACA years. And that is the first, you know, consistent finding here. Now, as I mentioned, these data are not perfect. They have some limitations, the coverage is not complete. So what the next table does is says, well, let's play with the data a little bit. Let's cut the data different ways to see how robust this conclusion is. So the first column is what we just showed you. The second column says, what if I only consider states where the data included more than 60% of the individual insurance market? The third column says, what if I only included states where the data included more than 80% of the individual insurance market? And the final column says, what if I only included states which had more than 60% of their market in every single year? So this is trying to restrict the data ask – do the results suffer from the incomplete data coverage? And the answer is no. You get the same bottom line. Numbers bounce a little bit, but it's the same bottom line result no matter how you cut this data; which is sort of low double digit rate increases in the pre-ACA period. That is our baseline. That is our baseline temperature. That is our baseline number of wins. That is what we should be thinking about when we see this data that is coming out – starting to come out, is going to be coming out over time our rate increases. Basically single digit rate increases means that they have gone up less than what we had before. Low double digit is comparable and high double digit will be more than they were going up before. And that is the context in which we want to put these rate increases. That is the first point I want to make.

The second I want to make is about variability. Now, this is gonna be pretty hard for you guys to see so you might have to look in the packet. This shows the state rate of increase for states which had a large enough sample where they collected at least 50% of the market. This shows a state rate of increase. The only important point takeaway from this table – I don't expect you to memorize it, there won't be a quiz afterwards. The main point to takeaway is these numbers are all over the map. So you look in 2008, Iowa had 2.8% increase and Illinois had a 14.4% increase. In 2010, you had Kentucky with a 5.5% rate increase and Nebraska with a 21.8% increase. The point is, these numbers are all highly variable. And what that means is, we cannot draw conclusions about the overall impact of Obamacare on this market from any one state's numbers. Okay, these states are going to be very variable in the numbers that are coming out and we cannot overreact to any one state's numbers. Even further, is to go to the next table, where I show a graph of the percentiles of the change by actually – by companies by state. So what I do is I take all the data. Every observation is sort of one insurance company in one state. And I graph the distribution of the changes. So what this says is, for example, if you look at 50%, okay, and focus for a minute on the blue line, that says that the 50% percentile of premium increase was 10.8%. That is the typical firm – increase their premiums by 10.8%, which is consistent with the earlier tables. But actually for 1% of firms, premiums actually fell by 9.5% and for 1% of firms or more at the upper end, premiums rose by more than 28%. So there is a lot of – this is just showing you how variable premium changes were across firms. That is the blue line. Now the blue line is weighed. The red line is unweighted. The red line is what the newspapers are reporting today. Okay? The red line is saying, let's just look at this data, ignore if it's a big insurer or a small insurer and just ask what is happening in premium increases? Well, there you see they are even

more variable. You had some firms that were reporting 50% or more premium increases. Now it turns out that typically they are very small firms, which is why that red line goes up so much higher than the blue line, but the important point here is the steepness of these lines. That there was a lot of variability in the reported rates over time. This says you could not learn anything – anything from any one premium preset was released. Certainly not if you don't weight it and even if you do. You can't learn a whole lot. And with the previous table saying it's hard to learn a whole lot from any given state either. That really, it takes a large sample of states to get a picture of what is happening overall nationally.

So really, what I want to do in my zero seconds left, is just – what I really want you to take away from this is really two conclusions. The first conclusion is, in some sense – let me start with the second point I made, which is we cannot draw conclusion about what is happening to rates in this market from any one newspaper story or one state. We have to wait and see the broad picture. Really, to be honest, we are gonna have to wait till we get the federal rates, given how many states from the federal exchange; even when all the state exchanges are out. It's gonna be hard to really know what is happening till we get a final set of rates for the federal exchanges. That is conclusion one. Conclusion two is when we do get those rates, the right context to come back to the title of this session – the right context in which to interpret them is the double digit increases we saw before Obamacare was passed. Thank you.

CORI UCCELLO: Thanks Jon. I too will be providing some context. My role this afternoon will be to provide a very brief overview of some of the premium components and then talk about some of the major drivers of changes for 2015 premiums. So in terms of premium components, the major factors here are – who is insured and what are their health costs? So in terms of who is covered, what do they look like in terms of their demographics and their health status? And then from that, what is their health spending? Other premium components include administrative cost, taxes and profits and laws and regulations can affect any or all of these three different components.

So I will be talking about three major drivers of 2011 premium changes. And the first of these is changes in expectations regarding the risk pool profile. So when insurers were developing their 2014 rates, they had to make a lot of assumptions regarding who was going to purchase coverage and what their health spending would be. There was a lot of uncertainty about those assumptions and now we are moving into 2015 and there are still a lot of – there is still a lot of uncertainty regarding that. Liz is going to talk about this in a little more detail, but in terms of what we know about the 2014 enrollee population, we do have some information regarding enrollee demographics, but the information on their health spending, their health status, is still fairly limited. So there is still uncertainty – especially for the people who are newly insured. So there is still some uncertainty moving forward, but insurers – changes in those assumptions from 2014 to 2015 could be affecting premiums and we also have to keep in mind that insurers also need to make assumptions not only, well is the enrollee population sicker or healthier than we expected

in terms of kind of retrospect of what is happening in 2014, but also looking forward to 2015, are we going to get an increase in enrollment because of the increase in the individual mandate penalty?

Another couple of things that we need to think about when we are looking at the risk pool profile is the single risk pool requirement. And that means, when developing premiums, insurers have to incorporate enrollment and claims not only inside the exchange, but also outside the exchange. A lot of the data that we are seeing coming out regarding enrollment and the characteristics of enrollees, really focuses on in exchange enrollment. And so we need to kind of just think about that that's not the whole story.

Another issue is the transitional policy for non-ACA compliant plans. Recall that policy was implemented late last year and allows states to allow insurers to renew non-ACA compliant plans. Insurers had already finalized their premiums when that policy was implemented, so they couldn't incorporate the changes to the risk profile that would result from that policy. What could happen here is under the transition policy, people who were lower cost might end up staying with – keeping their non-ACA compliant coverage. Whereas higher cost people could move to new coverage and making the risk pool a little less healthy or high cost than maybe insurers expected. Well, insurers, like I said, couldn't incorporate that into their 2014 premiums, but for the most part, insurers are going to know ahead of time what – if that policy – if states chose to continue that policy in 2015 and beyond, so they will be able to incorporate that into their 2015 rates. So you may see higher premium increases in states that allow that transition role as opposed to states that did not. And that is just one reason why you may see state to state variations in premium changes. Other reasons could be reflecting different success of enrollment outreach efforts and those kinds of things.

The second major driver is the reduction in reinsurance program funds. So for 2014 there is ten billion dollars that will be used to reimburse high cost claims in the individual market. That amount will decline to six billion in 2015. What happens here is that reinsurance program offsets claims. And by doing that, which can lower premiums. So a reduction in the reinsurance payments will result in a lower offset to claims, which will then in turn put upward pressure on 2015 premiums.

I have an example here, I'm not going to go into detail about it now, but I'm happy to during the Q&A if anyone has questions.

And the final driver is medical trend. As Jon talked about premiums, medical spending goes up every year, reflecting an increase in medical inflation, the cost of medical services, increases in utilization, so that is something that happens every year. And the big question for 2015 is, will the recent slow down in medical trends continue? So insurers have to make assumptions about that when they are developing their premiums.

So those are the major drivers. There were several other – or minor drivers of changes including changes in provider networks, broad networks versus narrow networks can have an impact on premiums. Changes in provider payments – those kinds of things. I won't list all of these off, but again I would be happy to talk about them in more detail during the Q&A. So thank you.

ED HOWARD: Thanks Cori. Pass the baton to David.

DAVID CUSANO: Thanks Ed and I want to thank the Alliance for Health Reform and the Commonwealth Fund for the opportunity to be here. Today I will just - wait for my slides to come up – thanks. Today I will be discussing the follow topics. The rate review landscape prior to the Affordable Care Act or ACA. The new rate review requirements under the ACA. The rate review landscape post ACA and the interplay between departments of insurance and the state and federal marketplaces.

So both pre and post ACA state rate filing requirements generally fall into one of two categories. File in use or prior approval. In a prior approval state, issuers must submit rate filings to the Department of Insurance for prior approval before they can charge those rates in the market. In a file in use state, issuers must submit rate filings to the Department of Insurance, but they can begin charging those rates in the market without approval from the Department of Insurance.

So based on research conducted by the Kaiser Family Foundation in 2010, in the individual market, approximately 30 states and the District of Columbia required prior approval of rates. Seventeen states required rates to be filed but not approved and three states had no rate filing requirement. The rigor of rate review also varied on a state by state basis. For example, a state with authority to disapprove rates or approve rates may appear to have more leverage as compared to a file in use state. But if we look at Idaho, which is a file in use state, they were able to use their general authority to engage insurers in informal discussions about rate filings, which in some cases actually resulted in reductions in the filed rates. So even absent prior approval authority, they were still able to engage carriers and put some downward pressure on the rates that were offered in the market. It is also important to point out that the rate review process prior to the ACA included minimal transparency and consumer input. So for example, rates generally were not published. The information included in rate filings was often considered to be trade secret and competitive information from the carrier's perspective. And there was also no mechanism for consumers to review rate submissions and provide input.

So the Affordable Care Act sets forth national rate review standards in an effort to create consistency and transparency in the rate review process. So under the federal program, HHS will review all rate increases unless it has determined that a state has an effective rate review program, in which case, the state is responsible for reviewing the rates. As of April 16th, 2014, 45 states and the District of Columbia have effective rate review programs. Its important to note that the federal law does not authorize HHS to approve or

disapprove rates, so to ensure consistency with this federal limitation, HHS considers file in use states to be effective, even though they do not have prior approval authority. But with that said, based on research conducted by the Kaiser Family Foundation in 2012, in the individual market, four of the 17 file in use states and one state with no filing requirement still passed legislation to obtain prior approval authority. It's also important to point out that under the federal rate review program; HHS provides a pool of 250 million dollars in grant funding to states to improve their rate review programs.

So what is an effective rate review program? To be an effective review state, the state must receive sufficient information to review the rate increase. It must consider at least 15 rating factors identified by regulation when reviewing the increase. It must make a determination of the reasonableness of the rate increase. It must make the rate filing information available to the public, which creates transparency and it must provide a mechanism for receiving public comments on proposed rate increases, which allows the public to have input. And it also must report the results of its rate reviews to HHS.

So what has the impact of the federal rate review program been on the rate review process? Well, 43 states and the District of Columbia received federal grants to improve the rate review programs. And New Mexico provides a nice snapshot of how the rate review process is continuing to improve as New Mexico's initiatives are similar to those in other states that have received grant funding. So New Mexico has received approximately 7.2 million dollars in total grant funding from HHS. That allowed them to pass legislation to allow improved transparency. So New Mexico posted their rate filings online and the state now conducts public hearings on rate submissions. The state also plans to use its Cycle 3 grant funding to pursue more in-depth analysis of co-insurance, co-pays and deductibles and also analyze and publish pricing data in coordination with premium and rate filing information.

ED HOWARD: David, could I just ask you to clarify the difference between the rate information and the pricing information?

DAVID CUSANO: Right, so that is a great question. So the rate information is the information that the carrier files to justify the underlying – to justify the ultimate premium that is charged in the market. So if you pay, you know, just making up numbers, if you pay $500 a month in premium, which is what the issuer charges you. The rate filing is all of the data that supports how they get to that price.

So in terms of the interplay between the Departments of Insurance and the state and federal marketplaces, the Departments of Insurance are solely responsible for viewing and improving rates; except for those five states that HHS has determined do not have an effective rate review program, in which case HHS is reviewing rates in that state. So when you go online to the federal or state marketplaces, the premiums you see for the qualified health plans offered, reflect the underlying rates approved by the Departments of Insurance. So while the exchanges or the marketplaces do not have direct input and do

not have review or approval authority over the marketplace rates, the marketplace do create premium transparency across insurers, which drives pricing competition among them and hopefully puts downward pressure on premiums for consumers. Thank you.

ED HOWARD: Turn to Liz.

ELIZABETH HALL: I just want to thank everyone for letting me be here and join you as part of the panel and the discussion, to have some insurer perspective on what is going on, how we set our rates, how the market has been working over the transition. And let me start by really talking about who WellPoint is. We are a large national insurer. We serve customers in every single state. We do business in many of our states, particularly in individual and small ground markets and you will see on this map the states in which we do business as a Blue Cross or Blue Shield plan. We generally are known as Anthem Blue Cross or Anthem Blue Cross and Blue Shield. We also do business in New York as Empire Blue Cross and in the state of Georgia as Blue Cross Blue Shield of Georgia. It is through those subsidiaries that we are participating in the exchanges. We also are the nations largest Medicaid managed care company, particularly through our Amerigroups Subsidiary and the map also shows those folks. However, anything in the health insurance sphere, we participate in. We are also a third party administrator for many large self-insured employers. We offer Medicare coverage, Medicare advantage, Medicare part D, Medicare SOP. So we have a lot of experience across a number of markets, but we are the largest individual and small group market insurers, so we have a lot of experience in this space. And when you think about the ACA, this is just simply an overlay of the states in which we are doing business in the Medicaid market as well as in the individual and small group markets and an overlay with the ACA impacts. So states that are doing Medicaid expansion, states that are doing duals demonstrations. So where we are participating in right now, we are actually actively participating in two of the duals demonstrations in Virginia and California. We are also working with the states of Texas and New York, who are putting together their duals demos. We are also, in six states that are expanding Medicaid and then we are participating in 14 exchanges. Those 14 exchanges line up with our 14 Blue Cross/Blue Shield plans. It's a little bit messy a slide, but if you spend a little time studying it, it's pretty straight forward. We are in six state based exchanges. We are in California, Colorado, New York, Kentucky, Connecticut and Nevada. Those represent very varied and different experiences. We are also in nine federally facilitated marketplaces or partnership arrangements with the federally facilitated marketplace, which is Maine, New Hampshire, Georgia, Missouri, Ohio, Wisconsin, Indiana and Virginia. That is a long way of saying that we've got a lot of experience with a lot of different regulatory schemes. We have a lot of experience with a lot of different rules in terms of what is required under the essential health benefits. Varied and different demographics of the population. So I think I was asked to participate because we have got a great breadth of experience. And one of the things that I think is very clear from the other presenters is that context is very, very important. And so one point I would like to make is as we look at 2015 rates, we cannot forget where we were in 2014. And going into the 2014 market, we were looking at, for the most part, a very

different regulatory structure than most individual market insurers had experience previously. In most of our states we were allowed to rate based on health status, based on age, based on gender. And we used those mechanisms and those tools to try to price our products to encourage people to come into our plans. We were also looking at our risk profile and looking at how we maintain affordability and balance affordability with risk. Coming into 2014, that had changed very significantly. The market rules had changed. We could not rate or price our products based on health status, gender – there is a limit of three to one in the age bands. And so it's a very, very different environment in which you are pricing your products. That was just one major factor.

Second major factor is new requirements in what you had to cover. The essential health benefits and some of the other requirements. A third factor that I will mention is that we did not know who the uninsured were and how the uninsured act. We had a good sense, but we did not know that. So when WellPoint or our Anthem company – Anthem and Blue Cross companies, started pricing our products, we started with doing our research. And so we looked at one, our broad individual market experience. Who was already in the insurance market? And we drilled down particularly in the three states in which we did business that had experience in a guarantee issue community rated setting. So we are in New York, we are in Maine – both of those states were guarantee issue community rated. We also are in Kentucky, which had had that in place, repealed it, and obviously now under the ACA has it back in place. So we looked at all of that experience. The third thing that we did and I believe it's the biggest project, although our competitors have not really talked about what they have done. We went out and we did a simulated experience with about 60,000 uninsured Americans. And it was a web based experience. We walked them through a number of questions, asking them what would motivate them to purchase insurance? What was important to them? Looking at network, looking at formulary and try to better understand how they were going to purchase and how they were going to behave in an insured marketplace, particularly one where they have a subsidy and that was another factor that we did not have with the exception of Massachusetts, which we did not do business in. But we did not have subsidies in the marketplace either. So trying to understand how they make decisions, particularly when they have subsidies to purchase coverage. We took all of that and we factored it into our 2014 rates and one of the things that we found as we did our research is that we thought that the individual market under these market rules, with subsidies was going to behave much more like a traditional small group market would look. And so we actually started our rate process based on our small group rates in the past and tried to look at those and modify from there. But really, what you end up with for 2014 is a guess. It's an educated guess. We tried to make it as well educated as we could, but it is a guess. And then you fast forward to today as we are looking at and filing our 2015 rates, and you have to ask yourself, what additional information do you have? Cori did a great job of talking about – you know, you have information about medical trend; you also now have some demographic data. We know who our in our plans. Who selected our plans? What their ages are, what their genders are, what their geography is, where they live in each individual state. But that really is the most concrete additional information that we have. And she also mentioned

we have got some medical claims data and some pharmacy data and I want to caution everybody that it's difficult to draw broad conclusions based on that data and I want to tell you why. Medical claims data generally has up to a three month run out period. That means that it can actually take up to three months from the date that you are provided a services by a provider before your insurer gets the claim. Often it doesn't take that long, but it can take up to that long. So if you think about the open enrollment period and how far we are after the end of the open enrollment period, many people actually did not start having effective coverage if they applied up through the April 15th deadline until May 1st. So we don't have a lot of medical claims data and the medical claims data that we have today is going to tend to be heavy on those who utilized services right away. Those who had a pent up demand, those who needed services or those who really worked hard to get enrolled as of January 1st.

We do have more up to date pharmacy data. Pharmacy data has a little bit more real time. Again, it's hard to draw broad conclusions about how our entire enrollment population is going to behave through the end of the year, because it is early data. So we are analyzing that, we use it a little bit, but we won't really fully use that claims experience data until we price for 2016. So another point that I would like to make is, this really is a transition. And so to one of Jonathan's points, looking at context, think about this not as a one year or even a two year process. You really have to think about this as potentially a three or even a four year process until we get full claims data, full experience that we can factor into our pricing.

So, long story short, it's very difficult to draw broad conclusions about pricing for 2015 based on 2014 pricing. Every company had different information. Every company was making their best educated guess. Similarly for 2015 they have tried to enhance that, but it still is very much an estimate. You also can't generalize, as we have said, the averages over what an individual's experience will be. So at risk of now contradicting myself; one resource that I want to point you all to as you look at materials that are coming out about rates is some work that McKenzie is doing. It is on their website, which is on this slide and it is available to anyone in the public. They have actually – I just went on today, this is a summary from a couple of days ago, but they have actually added two additional states. As states make information available, they are putting it up on their website. What I think you can see from this slide is that there is a great deal of variety in the experience across the board. So again, don't draw individual conclusions about an individual person or an individual state from this slide, but I think it does point out a few interesting things. One, you have got additional players coming into the marketplace, so up here on the top corner, they talk about carrier participation and there are 55 carriers coming back into the markets from a total of 56 across all of those 10 states. And there are an additional 18 who are coming into the market. So again, while we starting out from the beginning, because we wanted to go where our customers were and make sure that we were serving our customers and try to limit disruption as the largest individual market insurer, there are additional folks who didn't get into the market right away who are going to be coming into the market and that will impact competition and that will impact pricing and rates.

Similarly there are additional products, so we all learned who bought our products, did they like our products? Are we introducing new ones? Different ones? So there is a change on the number of products that are going to be available. When you look at the premiums and again, this is across all ten states, don't draw broad conclusions based on the data, its upside and downside. So you see that when you look at individual bronze plans, silver plans, both the lowest and the second lowest, there are both changes downward in rates and changes upward in rates. People made educated guesses; they are now adjusting based on additional information and they will have to do it again next year. And then the most interesting aspect of this slide that I will point out to you all before I pass it back from questions is really that the premium alone in a market that is 80%-85% subsidized is not enough to look at. You also have to – if you are trying to understand the impact on individual consumers, you also have to look at how that pricing impacts the subsidy, which is a totally different element to this entire marketplace that didn't exist before. And so it's very, very interesting on this slide, it shows that about 78% of consumers – and this is 175% of the federal poverty level, male, 40 years old, non-smoker. So again, depends on your background and your age and your income whether or not you will see an upward or a downward trend. But for this population they are saying that about 78% of people will see their subsidized rate go up and about 22% will see it go down. Interestingly enough, when you look at individual states, you can see states that look like they have a big decrease in rate that still have an increase in the premium that the subsidized individual will pay. Similarly you have states where you actually see increases in premiums overall, but you see a reduction in the premium that a subsidized individual may pay. So don't draw broad conclusions, we are still learning about this population, we are still growing, it's still changing, it's still evolving. But it's been really interesting and fun and we are really glad and proud to be supporting our individual market customers.

ED HOWARD: Great, thank you Liz. Can I just ask – to the extent that you have a sense of this – when typically in the various states that WellPoint operates in, did you have to file or are you going to have to file the 2015 rates?

ELIZABETH HALL: So, thus far in all of our 14 states, we have had to file. In one case, we file first with the exchange before we file with the insurance regulator. So in that case, we have filed with the exchange, but not yet with the insurance regulator. That is the State of California where there is an active negotiation that takes place with the exchange before the rates go to the regulator. But in all of us states thus far we have filed, not all of them have made them public yet. And the other thing I would point out is the other piece for folks to keep in mind when it comes to rates, is that we often have to provide a certain amount of notice to our existing customers about the impact on their individual rate and that varies state by state based on state requirements. In the state of New York we actually have to send a letter when we file our rates as to what that filed rate request is. But in most states, once they are approved, we have to provide somewhere between 60 and 90 days notice on the individual rates.

ED HOWARD: Hence very few data on which to base those filings. Thank you. I've gotten us going. I didn't mean to usurp your prerogatives. But we are now at a point where you are able to join this conversation. We have microphones that you can use to ask your question orally in which case I would ask that you keep it brief, identify yourself and your intuitional affiliation if you have one. And as I mentioned, there is a green card in each of your packets that you can use to write a question, hold it up and it will be brought forward. Rachel, do you have any questions you want to get to before we go to the audience?

RACHEL NUZUM: Sure. I've got one, thanks Ed, to get us started. And thanks to the panelist for laying the foundation for a really great discussion. Several of you talked about variation among states, both in the rates that are being released, pre-ACA and as well as in 2014, but also on how states regulate and how they operate their private insurance market. But there is also quite a bit of variation within states. In fact, there has been some reports out this summer that suggests that maybe variation within states may even be increasing. So I was just wondering if you could each take a few minutes and kind of explain what you think is going on there, what contributes to that – to the variation within states and what questions should folks such as staffers or other folks in the press be asking themselves when they see one published rate for a state, to really have a better sense of what that represents.

CORI UCCELLO: I will start things off. I think one thing to kind of keep in mind when we are looking at how rates may change for a particular insurer or in a state and how things vary within the state. Where were they in 2014 and then where are they in 2015? Because you might see some convergence in rates. I know I have seen some where there is actually divergence in some states with some new players coming in. That can affect some of the comparisons of rates. But maybe if some insurers were really expecting a very unhealthy population in 2014 and now they are seeing some things like, well maybe we overstated that and we are going to come down a little. And visa versa. So every insurer started off at a different place and it shouldn't be surprising then that their rate changes are different because they were starting off at different places.

ELIZABETH HALL: I will also add that a lot of healthcare is still very, very local. As a Blue Cross/Blue Shield plan, we serve everyone within the entirety of our service area. So most of the states in which we do business, we are actually in the exchange in every single geographic rating area. I think amongst all the insurers, many of them are in the same number of states, but not in the same number of geographic rating areas. And what that brings is different behavior and different dynamics. So in an urban area, and I know Georgia as a state of ours that has gotten some attention in an urban area like an Atlanta metro area, you have got a lot of different providers, a lot of different providers competing. You have a lot of choice and a lot of variation. It's a very competitive marketplace for providers as well as for plans. In other parts of the state, we may be the only insurer and there may be only one hospital or one hospital network, one provider

network. And so a lot of the variation for us at least within the states, has to do with the provider networks, has to do with the formularies, has to do really with the underlying cost of care, which gets automatically reflected in the rates and we cannot lose sight of that, that ultimately our rates are based on the cost of care and the care utilized within the pool. So that is one of the places where we see a lot of variation.

DAVID CUSANO: Yeah and I would just add to that too – Liz's point that from a rating perspective; carriers have the flexibility to include a geographic rating factor. So you may be, as Liz said, across the entire state. But you will have a different rating factor depending on the pricing in that particular area. So you end up with variability across the state because carriers can price based on geography.

JON GRUBER: If I could just add three quick things. The first point is – a point that is important to emphasis is, you know, we have to look at aggregates instead of anecdotes here. This just points out, there is always going to be some folks that are going up a lot, some folks that are going down a lot. We can't draw broad conclusions about the effects of the law from any one filing. The second point is just to emphasize, so important what Liz said, this is a three year process really. That is how long it took us to sort of get to – our program fully up and running in Massachusetts. That is what CBO projects as the phase in period for this law. So not to make too much of year one results. We are right now about halfway through one year of a really three year process. And the third point to make is, the rates are not finalized yet. There will still be the rate review of the kind that has been discussed here. So I think these are just – and different companies made different views about to what extent this is an opening bid and to what extent this is really where they want to end up and that could drive some of this variation as well.

ED HOWARD: If a non-expert can jump into this, I want to call attention to something that Rachel mentioned in her opening remarks, which is that this is the first time that we have had the kind of transparency and therefore, the availability of the data and that that may in fact have an impact on the ultimate rates as Jonathan alluded to just now. So lets go to the microphones, as they say on TV.

AUDIENCE MEMBER: I am Dr. Caroline Poplin; I'm a primary care physician. My question is for Jonathan for before 2014 and for the lady from WellPoint, after 2015. It has to do with benefits. So for Jon, what did you do about the fact that the benefit packages were totally different? You know, you could have a very thin plan that had a low premium and you could have the whole nine yards executive program that would have a higher premium. How much the ACA mandates the ten required benefits or whatever – how much variation is there in benefits going forward? I mean, we know about the bronze and the silver and that has to do with the degree of coverage, the premium. But it terms of actual benefits, how many variety is there still?

JON GRUBER: Let me see, for the before period, that is a great point. There is a huge amount of variation. That is why the rates I'm giving you here are rates of increase for a

given product. So these are sort of – what is the rate of increase averaged across all products, but for a given product. And it's just a mix of all of them. So it's really just a representation across all the different kinds of products that were offered in this market beforehand. What was the average rate of increase holding the product characteristics constant? So that is sort of what we are trying to get at. Liz?

ELIZABETH HALL: And to answer your question about after 2014, the variability and benefits I think you are correct. There is a much lower variability in benefits where you see more variability is again, amongst the middle levels in co-insurance and deductibles as well as in provider networks, in the formularies. And what you are going to see, I think, from insurers is that we are competing more on customer service, we are competing more on value added things that we can do. Our ability to help keep you healthy, help try to get you engaged in your healthcare in a more active manner. But the variability based on benefits is greatly, greatly reduced.

AUDIENCE MEMBER: Do you still offer gym memberships? Is that an added value?

ELIZABETH HALL: I have to go look at what we offer in our individual market plans. I know that we continue to offer gym memberships in some of our Medicare Advantage plans. Again, sort of looking at those value add, how do we keep people engaged and how do we try to keep people healthy.

ED HOWARD: Yes, go ahead.

AUDIENCE MEMBER: Bernadette Fernandez with Congressional Research Service. My question is about provider networks. From where we sit at CRS, we see a lot of reports and it may be more anecdotal that some of the premiums that we saw for 2014 were artificially low and that is not my phrase, so please do not attribute that to CRS. But artificially low because of narrower networks and we are a little puzzled because we are not sure if this is truly what is going on in the marketplace or if it's just a bunch of health reporters found people who are new to insurance, so they had no concept of what a network was. So if anybody could provide some insight as to this issue, whether or not it is – for the lack of a better word – real. That would be helpful. And then a specific question to Elizabeth, also related to provider networks. In the March letter to issuers that CMS sent out, they mentioned that they were going to scrutinize network adequacy to a greater extent for 2015 than 2014. I don't believe any additional information has come out from CMS, unless there is somebody here who would like to speak on that. Anybody? No? No takers.

ED HOWARD: Before you go, I do want to put in a commercial – we are actually going to be holding a briefing July 21st – is that right? We doing a program on July 11th in which we look at some results from a survey that the Commonwealth Fund had put together about the experience and exchanges and what has been going on there. And then

later in the month we will be doing an explicitly focused program on narrower networks. So stay tuned.

ELIZABETH HALL: Bravo. So as the one who represents those who is putting together the networks, I will try – but please I invite my fellow panelists to add on. I think that a lot of the focus around provider networks is that for many people, value networks are something new. Particularly from a Blue Cross/Blue Shield plan where you are used to a very, very broad network. What I would say in terms of pricing is – we would never go in pricing artificially anything. We feel very strongly that we have to price based on all of the information that we have. We have to price appropriately, we have to price accurately and we as a policy and as a company do not go after quote, unquote "marketshare" at a loss purposefully, which then ultimately impacts the consumer in a negative manner, because you have to increase prices later. So that is not something that we do and I would say that our pricing is scrutinized very heavily through the regulatory process, including having our networks scrutinized by our regulators. So I can't speak to us pricing artificially low, we aren't doing that. You are correct that we have not gotten additional guidance on scrutinizing our networks, but we are very conscious of the scrutiny that is on our networks and generally even in our smaller network products, we are still covering around 80% of the hospitals in our states and at least around 70% of the primary care providers in our states. So even though the network is in some cases smaller than it has traditionally been for us as a company, it still is a rather broad network and we go above and beyond the network adequacy standards in most of our states. Most of our states have them. To make sure that we are also ensuring that we have got adequate specialists, obgyns, oncologists, etcetera for very key conditions.

AUDIENCE MEMBER: Thank you. Lynn Quincy from Consumer's Union, the Policy and Advocacy arm of Consumer Reports. My question is for the whole panel. We talked about providing context, but I think even more than year over year increases in rates, don't we want to know if the rate that has been requested reflects the robust efforts of regulators, insurers and providers to keep costs low for consumers? The Institute of Medicine would claim that 30% of healthcare spending is waste, even if they are off by 50% that suggests that rates are 15% too high. So – and I think in terms of figuring that out, that thing that we really want to know – that there is a driver that Cori didn't mention, which is rate review. Rate review, contrary to the promise of the Affordable Care Act is actually not very transparent. In most states, except with a few exceptions, the public cannot see the detailed justification for the rate increase. In the few states where that happens, such as Oregon, they have, despite the entire justification being public, they have robust competition and they extreme scrutiny that those rates are given suggest that they are trying to keep them low by every means possible. So I would like for the panel to comment on the value of greater publicity of the entire rate filing, in terms of being able to keep rates low and get to that thing that we really want to know, which is, are we actually keeping it as low as possible? Thank you.

CORI UCCELLO: I think in terms – no, I didn't specifically mention rate review, but I think part of this is going on to the greater transparency of – if not the complete rate filing, which as David said, there are some proprietary things in there that I think is appropriate to not divulge all of those details. But there is greater transparency in the rates that that itself, I think the goal is for that – having that more information does put more pressure on the insurers to better manage care, maybe provide networks that have those high value providers in them. That can keep the pressure on to keep spending low. So I think that part of the idea behind the competition and the transparency is to try to get at this to some extent.

DAVID CUSANO: If I could jump in, I would just add to that too. I think the rate review process is much more transparent and so as a lot of folks have mentioned, the panel, that there is going to be data out there to use. But I think we have to be realistic is that rate review from a pricing perspective doesn't necessarily give carriers the leverage to drive down price with providers. So a lot of the tool that you are seeing carriers use particularly narrow networks is one way to try to get at price. But there is no ability for a Department of Insurance to actually regulate what a provider charges a carrier. And I think what you are seeing and particularly maybe Jon can speak to this and Jon can speak to this in Massachusetts. They are trying to actually address pricing as issues and tie reimbursement and healthcare spend to the increase in the consumer price index. So there is a lot of discussion around how do we manage cost generally? I think the rate review process is a good way to get the data out there, but I think the next step is to really look at it more globally and engage all the stakeholders.

AUDIENCE MEMBER: I have a question. I am Rebecca Adams with CQ Roll Call. I have a question for Elizabeth, but also if anybody else wants to jump in as well, that would be great. So I wanted to ask what your average rate increase is among your companies, if you could share that with us. And if you could tell us a little bit about the impact of the Three R's program. Separately, I also wanted to ask about your levels of enrollment. Are they about the same as they were at the end of open enrollment? Are you retaining all your members and are you getting a lot of people through special enrollment periods?

ED HOWARD: Rebecca, what was the name of the program in the second part of your question?

AUDIENCE MEMBER: The Three R's – the reinsurance, risk adjustment -

ELIZABETH HALL: So I will try to do my best. We are not actively, again, it's somewhat proprietary, we are not actively talking about our rates unless they are released publicly. What I will say is some are up, some are down, some are up more than others. So I am happy to talk offline about any of the specific states where it is public and any of the particular increases or decreases that you might be interested in. With regard to the Three R's – that is the three risk mitigation tools that are in the ACA, the reinsurance,

risk adjustment and risk corridors. What I would say in terms of impact on pricing and how it's reflected in our products, reinsurance very clearly you can see it in our filings. It is something that I think all insurers factor into the pricing. Reinsurance is designed to help transition the individual market from that underwritten market to a community rated market. So for many individuals, just simply the elimination of health status rating could result in a very significant premium increase. And so the reinsurance program is really designed as a transition payment of sorts to the plans to help mitigate some of those increases, help the market transition. So that is very clearly included in our rate filings and I am pretty sure included in all insurers' rate filings. At this point in time we don't have enough information on reinsurance – risk adjustment – they are the three R's and I often use the wrong one at the wrong time. The risk adjustment program, we don't have enough information, there isn't enough public information to know how we did compared to our competitors. The risk adjustment program is really intended to spread risk amongst carriers. So if one carrier receives all of the very high risk individuals, there would be a distributive payment that is made from the plan – from plans that receive lower risk individuals. And then there is the risk corridor program and again, both risk corridors and risk adjustment – we will not know what our payment are, we will not have enough information, we will not actually receive any payments until probably summer of next year. We won't actually go through the full reconciliation process until late in the spring of 2015 and then payouts would come once that process is completed. And again, it's very difficult to know under the risk corridor program exactly where we sit. Again, when we have said this very publicly, we did not price for the risk corridors, we did not risk our products purposefully to make or lose money through the risk corridor program. I think that we said in our last earnings call – which there will be another one upcoming – I think we said in our last earnings call that we have booked a very, very small payable, but at this point in time, we did not price for it, we won't know where we come out until next year at the earliest. And then I think the last question on that was our levels of enrollment and again, I'm happy to talk to you offline about overall levels of enrollment. We did just revise upward to say that we believe we will have about 750,000 enrollees through the exchanges by the end of the year. We continue to see through the special enrollment process a small number just like we would outside of an employer's open enrollment period for people who either have lost coverage or had another type of life change. So we do see a small, steady level of enrollment since. I think we covered them all.

CORI UCCELLO: I just want to highlight something that Liz said, because I think it often gets lost. Because the risk adjustment program is shifting funds between insurers, insurers when they are doing their estimates of what their costs are going to be for their enrollees, they actually also have to be figuring out well, what is the market going to look like as a whole? What is enrollment not only for my plan, but for the market as a whole? What is that going to look like? And that is really even exacerbating some of the uncertainty that insurers are having when they are calculating the rates because they have to think about not only their particular experience, but the experience in the market as a whole.

ED HOWARD: And Cori, you mentioned in your remarks that when the risk pools are being constructed, it includes both the exchange plans and the non-exchange plans and we actually had someone ask about what changes that might have contributed to in that off exchange ACA compliant market. Is there a difference and does it affect that calculation?

CORI UCCELLO: Okay, just to clarify, when I'm talking about the single risk pool and having to combine experience on and off the exchange, I'm talking specifically about the ACA compliant plans. So when developing the rate for the ACA compliant plans on and off the exchange, you are – it's those ACA compliant plans. The non-compliant plans in those states that allow the transition rule, they are treated separately, but what can happen is, because now consumers will have a choice in certain states by renewing their non-ACA compliant coverage or purchasing compliant coverage, they can decide what makes most sense for them and it's more likely that someone who is a high cost person could benefit more by moving to a compliant plan whereas the low cost people could stay with their old plan. And so that could just mean the risk pool of the compliant plans, whether they be in or outside the exchange, could be a little worse than maybe what was expected.

ELIZABETH HALL: And Ed, if I can just add on as well. Anything that we base estimates on today can change dramatically before we get to the end of the year because again, remember we have that very limited medical and pharmacy data as is. So as we get more experience, what we see today could change drastically. So it's difficult and if you do follow some of the Wall Street analysis, it's difficult to draw long term conclusions based on what we are estimating today for various purposes. Just want to put that disclaimer on it.

AUDIENCE MEMBER: Good afternoon, my name is Carol Sardita, I'm an independent healthcare business communications consultant and I have two quick questions and I think they are both for Elizabeth, but please feel free to chime in if anyone – you are really getting the questions, Elizabeth. My first one and you talk about the considerations of pricing kind of evolving. I'm wondering to what extent you can comment on the role of specialty pharmaceuticals in possibly driving up premiums and we go forward.

ELIZABETH HALL: No, it's an excellent question and there is no doubt that the cost of – the high price of many specialty pharmaceuticals is a major driver. We have said that it's going to have a hundred million dollar or more impact on us this year and it's only going to continue to go up, particularly as there are several drugs in the pipeline, I think we have used this, of all the example in the past, it is a – it is in many ways a cure for hepatitis C, which is a fantastic thing. At the same time, it comes at a very, very high price point for a very – potentially very, very large population where the science and the medicine has really evolved faster than clinical experience has evolved. And so it's difficult in this environment to know exactly what the cost impact is going to be, but not have to estimate that it could be very, very significant. So yes, it's definitely been a

driver. It's definitely something that we factored into our rates and at this point we don't see a mitigating factor for that right now.

AUDIENCE MEMBER: Okay, thank you. And my second question is – to what extent you can comment on whether some of the dynamics we are seeing in the individual market may be carrying over to the traditional group insurance market. I know they are separate lines of business, but I think some of this up and down and uncertainty has to be having some ripple effects over pricing and coverage on the commercial side. And if that is something you can comment on, I would appreciate hearing your thoughts.

ELIZABETH HALL: I think that is a really, really good question and probably something that we are going to have to watch over the next few years. I think as we went into the exchange marketplace and into a world where again, individuals subsidized, you know, I think one of the big questions that was around during the ACA debate as well as since then is, how will employers respond? Will they increase their offer of coverage? Will they pull back on their offer of coverage? I think it's a little bit early to draw conclusions but I think it's something that we are watching closely. Right now I can't say that it's factoring into our prices, but I can go back and talk to our team. But it's definitely something we are watching.

AUDIENCE MEMBER: Thank you very much.

ED HOWARD: Rachel has some green cards; I've got some green cards. Do you want to trade questions on a green card? I should say that we have less than 15 minutes left. So let me just ask you to keep those blue evaluation forms at hand so you can fill them out as we finish the program. And also, take advantage of the opportunity to ask the questions at the microphones.

RACHEL NUZUM: So I am going to move to a question for Dr. Gruber. Most of us have been talking about transparency, the importance of it in the market. Although there is a question that – although there is a push for increased transparency, there is also a large amount of regulatory barriers for entry for smaller innovative new firms. And so how do you see that balance between regulatory barriers to entry and then transparent pricing requirements and what do we think at the end of the day, the impact could potentially have on prices going forward?

JON GRUBER: Yeah, I guess I view them as two separate issues. They are both important issues. I mean, the transparency issues obviously critical. I think that the Affordable Care Act can promote the entry of small insurers. I mean, I know there is a regulatory barriers that exist, but we are setting up an environment where before there was really no way for them to effectively compete because people couldn't shop. You can't have competition in a market where there is no shopping. We have set up a market with the shopping, we saw it in Massachusetts. After a couple years we had a major new entry into our market for the first time in about 20 years and it significantly brought rates

down. I think a lot of the innovation is going to happen over our networks. I think that is where a lot of these – you know, if you are a new insurer, you just come in and offer the same thing WellPoint is offering. You are going to get beat by WellPoint. I mean, basically they are the big person in town. I think you are going to have to figure out a way to innovate and a lot of the innovation is gonna happen around our networks, I think that is gonna speak to – you know, Ed said there will be other live briefings on this – this is going to speak to how policy makers react to the stores we are going to start hearing about now in our networks. Remember, this is not the first time in our lifetime that healthcare costs have grown slowly. Actually, from 1990 to 2000, did you know that healthcare cost did not increase the share of our GDP? Over that entire decade. And that is because healthcare costs fell dramatically in the mid 1990s because of HMOs. And then what happened? There was a giant backlash because people didn't like their networks being restricted. And the HMO movement fell apart. The question is, are we going to have that backlash against narrow networks this time or will policy makers let narrow networks flourish? And I think that is going to be a lot of the determinant of whether small entrants can come in and compete. I think that is a lot of the way the competition can happen.

DAVID CUSANO: Yeah, I just want to add one point to that too. In terms of new entrants, I think what you may also see is that generally speaking, for a lot of the larger carriers, they have independent contractual relationships with their provider networks and so over time you may see providers saying, hey, this carrier is doing a narrow network. Me as a provider, I can do that myself and so you may actually start seeing – and you are seeing some movement now where provider organizations are actually entering the market as an insurer because then they can manage sort of both sides. They can manage the pricing, but they also manage the delivery of care. So that creates integration and some efficiency. So over time you may see more provider organizations potentially move to the carrier side.

ELIZABETH HALL: I will just make follow-up comment which is less about what you might see coming into the market, but as a cautionary point on just looking at network alone. A lot of the work that we are engaged in as a plan right now is truly delivery system reform and the network size is just one minor aspect of that. Looking at the way that the contracts are setting up, looking at the quality indicators, looking at the measurements, the motivators. We, I think, have the biggest patient centered primary care initiative in the country going on right now. We are really trying to both pay providers to support – primary care providers to support them. To both stay in the primary care field, but also to be able to expand their reach, expand their hours, put together care plans for our members, for their patients. So there is a lot beyond just network or how many providers you have in your network and a lot more that goes to how meaningful is that relationship with the provider. Are they doing the right things for the patient at the right times? Is it a medical home for the member and for the patient? So there is a lot of focus on – and I hope you will talk about this in the next panel or the next briefing, there is a lot

of focus on the size and the number but again, it's also the real value and the quality that you are getting out of the relationship.

ED HOWARD: Actually, we will go back to you if we can, Jon. At least the initial question is triggered by something that you said. That is that people have traditionally switched plans in the individual market to avoid premium increases. How do you anticipate this translating now in the 2015 exchange market where people are going to see their premiums changing, especially in relation to the benchmark plans that their subsidies are tied to?

JON GRUBER: Well, first of all, I think a lot of the – what happened before is not necessarily people switching plans, but the plans themselves becoming less generous plans as compared to the new ones arising. But certainly I think what is gonna happen to plan switching is a really important question. CMS just issued their regulations about auto reenrollment; people being reenrolled in the same plan if they don't actively choose a new plan. I think traditionally we have seen very low plan switching in both the group – especially in the group context. The individual market, the data is less clear. I think that is it is really critically important that we promote important decision support tools as much as possible. Decision support techniques for individuals so that they can every year reevaluate this. People hate choosing their insurance [unintelligible], they hate filing taxes, but in fact it's a really, really important decision and a couple hours can make a big difference in terms of peoples' financial well being and I think we ought to be setting up tools that while they allow people to – if they really don't want to pay attention to just continue rolling forward, but really promote as much as possible people's choices and actively shopping, because this is going to be a really special – the first few years will be a really dynamic market, lots of new entrance, lots of new ways to look at things. New networks, new delivery mechanisms and I think it's very important that we promote the ability of individuals to switch, given the right information and make active choices.

CORI UCCELLO: I'm just going to add this – I know this is what Jon meant, but he didn't say it out loud, so I will. The importance of looking beyond just the premium amount and looking at the cost sharing. So having these decision support tools that combine the premium plus maybe expected out of pocket cost sharing, that is really what is important here.

JON GRUBER: What she said. I think actually – I just want to emphasize that in my own research we have looked at Medicare Part D, which was sort of where we first started doing these kinds of exchanges and we found that only 12% of seniors when you factor in both the premiums and the out of pocket costs – only 12% of seniors shows the lowest cost plan and the typical senior left about 30% of the dollars on the table, mostly because they just pay attention to premiums and not to out of pocket costs. So I think that is a really important factor.

ED HOWARD: And aren't the very high rates of reenrollment in their old plans among the -

JON GRUBER: Very high. Once people make a mistake, they stick with the mistake, so I think it's both a matter of promoting that initial choice, considering all the factors and also having people reevaluate, especially as their life circumstance changes.

ED HOWARD: Rachel, do you have any others you would like to throw in?

RACHEL NUZUM: We have one more at the microphone.

AUDIENCE MEMBER: Hi, John Green with the National Association of Health Underwriters. Of course I represent agents and brokers who I think are a great decision support tool to help people navigate through that difficult system. It is an important decision and it's more than just picking on prices, as you said. There is risk tolerance and your health status and agents and brokers do know what the networks look like. Some people choose a more narrower network for a lower price on purpose. It isn't necessarily a terrible thing that they would choose a more narrow network in exchange for a lower premium. But I hate it coming – the thought of the decision on health insurance coming down to a tool. It sounds like you press a button. I think this is something that should be evaluated each year to see if it's the right fit and with all these new plans coming in, it would be malpractice not to look at other plans.

JON GRUBER: I agree that it is very important that people shop carefully. I do think that sure in a perfect world everyone had their hand held and the carefully walk through the choices. Some people don't have the time or the financial resources necessarily to do that. And I think that computer based tools can help them a lot and at least avoiding very poor decisions. It might be hard once you are in a narrow subset to choose the best among those, but I think there are a lot of people – potentially making quite poor decisions. People who are getting premium tax credits who are choosing gold plans when the silver plan just dominates – things like that that a tool could really help avoid those problems.

ED HOWARD: I have a question here that I guess would initially at least go to Liz Hall. The questioner writes that insurers no longer have the administrative cost of underwriting, additionally with the marketplace in place, advertising costs presumably could be lowered. How much do these changes affect the rates that insurers are calculating?

ELIZABETH HALL: I think what I would say is that for years now we have put a real focus on reducing our overall administrative costs and year over year the trend amongst the industry as a whole is downward on all of those things. So how you parse that pie may have changed a little bit, so you may be spending a little bit less on, for example, underwriting, but that doesn't mean that you aren't spending those administrative dollars. You haven't shifted those administrative dollars to a very, very important part of your

operations in the ACA world. Let me just give you a very, very concrete example that we have talked about publicly. In the first two days of January, we had almost a million calls total. Just for our exchange products. Just for our exchange customers. And the average length that those calls took in talking to people about their benefits, about their coverage, helping them get to the end place where they need to go because of less familiarity, less experience with the individual insurance marketplace, took a lot longer. So yes, we might maybe be spending a little bit less on some of those underwriting dollars, but we have probably shifted those dollars to working with our customers and helping them navigate the system just – we talk about choosing plans and having tools to help people choose plans, we are really focused on helping our customers use their plans. Making sure that they understand that. I think the other thing I would say on marketing dollars is, don't assume that we have reduced those. We have a lot of people to reach. We have a lot of people who may not be native English speakers. We have a lot of people who may not have traditional – may not be watching traditional television or receiving traditional mail as an advertising tool. So we have had to get very creative in how we reach potential customers. So overall, we are very, very focused on reducing our administrative costs, but even more than that, trying to make sure that we are spending them wisely.

DAVID CUSANO: And I would just add to that that the medical loss ratio requirements in terms of having a certain amount of premium dollars collected, go to medical spend, that excludes a lot of the administrative costs that Liz was just talking about. So in terms of the correlation between admin and premium, it's really not there because that has been kind of stripped out through the medical loss ratio requirements and the requirement to pay rebates.

RACHEL NUZUM: So I think we've got time for just one or two more questions. Why don't we go to the microphone.

AUDIENCE MEMBER: Hi, my name is Hilary Nesti, I'm an intern at the National Association of Community Health Centers and Elizabeth, you mentioned delivery reform and I was wondering if there has been any data collected around payment reform, for example bundled payments? And if that has had any effect in the states that are working on payment reform on the insurance premiums as of it? Or if it's not – I know it's new, so I'm not sure if it's been collected or not.

ELIZABETH HALL: I am not aware of anything that is done in the correlation back to the underlying premium and I'm not sure that we are actually going to see a reflection in the underlying premium yet, because again, I don't think that healthcare cost growth has really gone down. But that is the ultimate goal. So I don't know that it will reduce the premium, but whether the rate of increase will be as significant I think is something that should be reflective of the overall cost of care and if we are successful we can bring down the overall cost of care and improve outcomes. There is a ton of data on improved outcomes. A little bit on reduced cost growth. I'm just not sure if we have linked it back to any premium.

JON GRUBER: Yeah, I think you know, whenever we talk about cost control, I mean, the two words that come to mind is to be humble and to be patient. To be humble about how little we know and to be patient about how long it's going to take to learn it. This is a long process; we are really moving up that learning curve, we are running hundreds of experiments now. The ACA promoted them, we are going to evaluate them, but it's going to take time. Unfortunately humble and patient, I would imagine are not two words you all use to describe your bosses – so that is just something that is important to take away from this today – while we all want to know the answer tomorrow when it comes to healthcare cost, growth and things of that nature, it's going to be some time till we figure it out.

ED HOWARD: That sounds like a pretty good place to stop. Reminding ourselves that we should all be patient and humble. We will be patient until the next time we take up an exchange related topic, which will be July 11th. We ask you to be patient enough to fill out the evaluation forms while you listen to me ask you to hear my thank you of the Commonwealth Fund for its support and active participation in the shaping of this program. And ask you to join me in thanking the panel for handling a really complicated topic in a really good way.

[applause]

And there were some updates and slight changes to some of the slides – we will have the updated versions on our website at allhealth.org, if not by the end of the day, first thing on Monday. Thank you.