The ACA: Experiences in Health Care Coverage and Access
The Commonwealth Fund
Alliance for Health Reform
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ED HOWARD: Good morning. My name is Ed Howard. I'm with the Alliance for Health Reform and I want to welcome you on this first day of the new fiscal year in many states, and the first day of one of our panelist's official retirement. On behalf of Senator Blunt, Senator Cardin, the Board of Directors of the Alliance, I welcome you to today's program on Access to Healthcare and the Coverage to Facilitate that Access in the wake of, I guess you'd call it, the near death experience of the Affordable Care Act that took place just down the street in the Supreme Court.

You know, there was obviously heavy speculation about the impact of a decision that would've gone in favor of the plaintiffs in that case and what it might have on insurance coverage, but now we know that even with the finding that preserves one of the basic mechanisms of the ACA, there's still a lot of concerns about coverage and access to care, enough interest that you showed up on a recess week morning at an unusual time. In fact, we had, I was telling my co-moderator, that we had to cut off registration about four hours after we sent out the announcement because the response was so robust and that's obviously why we have our program here, today.

Here's a sobering thought. Open enrollment, the third period of open enrollment, begins in just four months and, especially in light of the uncertainty surrounding exchanges and subsidies in recent months, how well prepared are states and the federal government for that third season and what had been the trends in these last two years in coverage? And what can we expect in the upcoming season? Are consumers getting the right information they need to make choices? And, are people, even with coverage, getting the care they need as a result of that coverage.

So, we have a lot of unanswered questions and we're going to get to a lot of them. We may not solve all of them, but with your help in the discussion we're going to address them with some care.

We're very pleased to have, as a partner in today's program, The Commonwealth Fund, an almost century old philanthropy, established to promote the common wealth, or the common good, and doubly pleased, on my behalf, to have, as a co-moderator, Sara Collins, Vice President for the Healthcare Coverage and Access Program at The Fund, and a prominent health economist in her own right, and you'll hear from her in just a moment.

Couple of housekeeping items. If you're in a Twitter mode you can see the #ACAcoverage on the screen behind me. If you want to tweet we would encourage that. There are credentials that you can see on the screen and on the sheet on your table in front of you. So, feel free to do that. That will get you into the Wi-Fi. There's lots of important information in your packets. All of that information is also available electronically at the Alliance website, allhealth.org, where tomorrow, probably you'll be able to get a video recording of this briefing. A couple of days after that, probably next week, there will be a transcript that you can refer to.

At the appropriate time, you're going to be able to ask questions of our panel. There are microphones that you can use to ask the question in your own voice or, if you want to do a real zinger, you can pull out the green card and write your question and we'll have it brought forward at the appropriate time. If you happen to be watching on CSPAN you can feel free to use the hash tag to tweet a question at the appropriate time, and we'll try to get those forward as well.

And, one final note, there's a blue evaluation form in your packets that we'd very much appreciate you filling out so that we can make these programs more responsive to you and better suited to your needs.

So, let's get to the program, let's start with my distinguished co-moderator, Sara Collins.

SARA COLLINS: Thank you. Thank you, Ed, and on behalf of The Commonwealth Fund, I'd like to thank the Alliance and the panelists for coming today, and also extend a warm welcome to the audience this morning.

I'm going to present some highlights from The Commonwealth Fund's Affordable Care Act Tracking Survey that we released in a brief about two weeks ago. The survey interviewed a nationally representative sample of forty-eight hundred 19- to 64-year-old adults from March through May of the spring, including a sample of people with Marketplace or Medicaid coverage, or who were uninsured. We compared the results to two similar surveys that we conducted before and after last year's open enrollment period.

These recent data from CMS show that, by the spring of 2015—so just recently—more than 22 million people had gained coverage either through Marketplace plans or Medicaid. A majority of Marketplace enrollees have subsidies that help them reduce their premiums and also offset their cost sharing requirements.

In The Commonwealth Fund's Affordable Care Act Tracking Survey, we looked at the effect of this new enrollment on uninsured rates and access to healthcare. By March through May of 2015, about 13% of working-age adults were uninsured. This is down from 20% just prior to the first open enrollment period in 2013. These survey estimates from our survey are in the range of those reported by other recent surveys. The law has been particularly targeted at helping low and moderate income families gain health insurance and there have been significant coverage gains in these income groups since 2013. But we do see, in this survey, a leveling off in gains among the lowest income adults in 2015.

We find that the law is helping previously uninsured people gain coverage. More than half of adults enrolled in Marketplace plans and 66% of those enrolled in Medicaid were uninsured prior to getting their new coverage. We're also seeing that, for many adults, this new coverage has ended long periods of time in their life without health insurance. Among adults who had been uninsured prior to gaining their insurance, 80% in

Marketplace plans and 64% of those in Medicaid had gone without insurance for a year or longer.

The survey indicates that coverage through the Marketplaces and Medicaid is improving people's ability to get healthcare. Sixty-eight percent of people currently enrolled in either source of coverage had used their plans to visit a doctor or a hospital or to fill a prescription. Of those who got care, 62% said they would not have been able to get this care prior to getting their new insurance. While people who were uninsured previously were more likely to say they wouldn't have been able to afford or access this care, nearly half of those who had insurance when they enrolled also said they wouldn't have been able to get this care before.

There has been some concern that people with new coverage would have difficulty finding doctors or might not be able to get appointments without a long wait. We are not seeing, as of yet, at least in these survey data, problems like these. About 21% of Medicaid or Marketplace enrollees had looked for a new primary care doctor with their coverage. Seventy-seven percent of those who had looked said it was very or somewhat easy to find a new doctor.

We also questioned respondents who found a doctor how long it took them to get a first time appointment. Forty-six percent got an appointment within one week; 14% got an appointment within one to two weeks. These wait times for primary care physicians, and also for appointments with specialists in a similar set of questions we asked, are nearly the same as what we found last year during the first year of open enrollment. And they're also comparable to wait times among U.S. adults in other surveys that we've conducted.

In terms of satisfaction with their health plans, more than 8 of 10 adults said they were somewhat or very satisfied with their insurance. This was true regardless of people's age, insurance type, income level, or political affiliation.

Based on this survey, there are an estimated 25 million adults who remained uninsured as of March through May 2015. Compared with the overall adult population, those who are uninsured are disproportionately younger, poorer, and more likely to be of Latino ethnicity. One factor behind these high rates of uninsurance in these groups is a decision, by 22 states so far, not to extend eligibility for Medicaid. Thirty-eight percent of adults with incomes under 100% of poverty are uninsured in states that haven't expanded their programs. This is more than twice the rate of those living states that have expanded.

But the Medicaid expansion is not the only reason why many adults remain uninsured. Many uninsured adults in the survey were unaware of the Marketplaces, of the financial assistance available to them for health plans, or the Medicaid expansion. We also asked adults, who told us they knew about the Marketplaces, why they hadn't visited a Marketplace. Among those currently uninsured, 60% said they hadn't visited because they didn't think they'd be able to afford health insurance; 39% said they didn't think they'd be eligible; 37% were too busy; and 28% said they didn't think they needed it.

Looking forward, with the King vs. Burwell decision resolved, what are the key challenges ahead for coverage and access in the United States? Clearly, based on our survey findings and other research, a major challenge for policy makers going forward will be covering the remaining uninsured, in particular, where we see some of the 22 states that have yet to expand Medicaid move forward. And what do we know so far from states about the best strategies for reaching those who are eligible but not enrolled? Peter Lee is here with us today from Covered California and will probably provide insights on what's working best in his state.

Another challenge will be the affordability of premiums and health care going forward. There was considerable variation in premium growth rates across the states in 2015 in the Marketplaces. What do we know so far about what's driving this variation across states and, in particular, do state policy decisions make a difference? Brian Webb, with us today, may be able to provide some insights across the 50 states from where he sits. And, on the out-of-pocket side, will we see higher deductibles every year going forward, or are we going to instead see innovation and benefit design that will shift the focus away from deductible growth? Many state-based Marketplaces are struggling financially as their federal grant funding runs out. Kevin Lucia and Peter Lee and the panelists will provide some insights on how states, with their own Marketplaces, are approaching this problem. Legal challenges to the law remain, including a case focused on the cost sharing reduction subsidies that Tim Jost will tell us more about today and we're likely to continue to see federal and state legislative efforts to change some of the provisions of the law.

And finally, states may be able to address many of these challenges with so-called 1332 Innovation Waivers that will begin in 2017 and will allow states to try out new ways to formulate their own vision of healthcare reform. And I'll stop there and turn this over to Ed. Thank you.

ED HOWARD: That's terrific, Sara, both the survey data and your summary of some of the big questions that remain. And now we're going to hear from the panel whom Sara has just described. Not only are they very distinguished, they are very nimble because when we first approached them, which we had to do because they're all very busy, we didn't know which way the King v. Burwell decision was going to come down, so they were prepared to address either eventuality. And we needed to only refocus them on the original conversation when we started preparing them for the post decision discussion.

And you've already gotten a preview from Sara, but let me just give them equally inadequate introductions and then we'll not interrupt the flow of the conversations. We're going to start with Tim Jost, who's an emeritus professor of Law at Washington and Lee University as of today, and writer of a widely used health law textbook. He also is a consumer representative at the National Association of Insurance Commissioners, so he will bring a number of perspectives to this conversation.

Next to him is Brian Webb, who is manager of healthcare policy and legislation at the NAIC. He's worked on the Hill, he's worked in a governor's DFC office, and for both provider and insurance groups.

On my immediate right, Kevin Lucia, research fellow and project director at the Center for Health Insurance Reforms at Georgetown's Health Policy Institute. He also served in a state oversight capacity within CMS for the Affordable Care Act and, next to him, and our final panelist, is Peter Lee who, as Sara noted, runs one of those Affordable Care Act Marketplaces established by the state, as the phrase goes, state in question being California. He, too, has held ACA-related positions within CMS, as well as running a business coalition on health and a noted consumer group on the west coast.

Gentlemen, thank you all for being here, and let's start with Tim Jost to get the conversation going. Tim, thanks for being with us.

TIM JOST: Thank you, Ed. The Supreme Court's decision in King v. Burwell is, by now, old news, but I would like to begin with a few observations concerning it. First, as you all know, the decision was not close. It was 6 to 3, the opinion was written by the Chief Justice and he was joined by Justice Kennedy, who had joined the dissent in the NFIB case.

There was, however, in the King v. Burwell case, an outraged dissent. Justice Scalia's dissent was the same length, 21 pages is the majority opinion. It is eloquent and well reasoned. It focuses on the phrase at issue in the case, "exchange established by the state," which I had already mentioned, arguing that it could not possibly mean or include exchanges established by the federal government. Scalia argued forcefully that his reading of the phrase was consistent with other provisions of the ACA and could support one conceivable purpose of the law to encourage states to establish their own exchanges. Scalia's opinion could've been the opinion for the majority had it been able to convince Justice Kennedy and the Chief Justice, but the Chief Justice looked beyond the narrow reading of the phrase "exchange established by the state" to discern what, in fact, Congress was trying to accomplish through the exchanges. He considered the context of the phrase, its structure, its purpose, and how the wording was used in other provisions of the Act. In particular, he examined the provisions of the ACA regarding the creation of the federally facilitated exchanges which are to take the place of and perform the functions of the state-operated exchanges. Chief Justice Roberts nowhere referred to the brief filed by the Democratic members of Congress in which they clearly stated their intent that the federally facilitated exchanges would grant tax credits. But he clearly grasped what Congress was trying to do and how reading the statue as Justice Scalia would have, would have defeated that purpose. The Chief Justice concluded his opinion by saying, and I quote: "A fair reading of legislation demands a fair understanding of the legislative plan. Congress passed the Affordable Care Act to improve health insurance markets not to destroy them. If at all possible, we must interpret the act in a way consistent with the former and that avoids the latter. Section 36B can be fairly read consistent what with what we see as Congress's plan, and that's the reading we adopt."

From the standpoint of legal analysts, perhaps the most interesting aspect of the decision is that the Chief Justice did not rely on what is known as Chevron deference. It is commonplace in administrative law that when the meaning of the law is unclear the courts defer to the administrative agencies charged by Congress with interpreting the law, and that's the approach that the Fourth Circuit took in this case. Chief Justice Roberts rejected this approach, effectively saying that the question of the authority of federal exchanges to grant tax credits was too important in the issue to leave to the IRS and, thus, decided the issue for himself. What this means for the law generally is being debated by legal scholars, but at least it means that the Chief Justice intended to nail this issue down and not leave it to be reopened by later administrations.

So, where does this leave us? First, there's a lot of ACA lawsuits still pending. Several of these cases are in their death throes, such as two cases challenging the ACA under the origination clause of the Constitution, claiming that the ACA was a revenue build that did not originate in the House. This claim has been rejected by the panels in the Fifth and the D.C. Circuit, but those cases are now pending for rehearing on banc in the Circuits. A string of other cases have been rejected by the federal courts, mainly on jurisdictional grounds, with the courts recognizing that the plaintiffs are simply trying to raise political grievances and have not, themselves, been injured in any way by the law. There are cases that do show some promise of going further but that don't fundamentally threaten the ACA like the hundred or so cases challenging the contraceptive mandates. The Administration has now won a string of decisions in the circuit courts upholding its most recent accommodation of religious organizations, but the Supreme Court, on Monday, entered an injunction limiting the enforcement of the rule pending the court deciding whether to grant cert in one of those cases, so we may be hearing more about that.

One case, as Sara mentioned, that is worth watching is House v. Burwell. In this case, the House of Representatives has sued, challenging the Administration's delay of the employer mandate and its provision of cost sharing reduction payments without an explicit appropriation. The delay issue is essentially moot, but the cost sharing reduction payment issue remains important. As Sara noted, nearly 60% of exchange enrollees get cost sharing reduction payments and those are what make actual healthcare, as opposed to just health insurance, affordable.

The CSR's are technically paid to insurers who must, in turn, legally reduce cost sharing so a decision against the Administration would not necessarily end the cost sharing reduction payments, but it would put the insurers in an untenable position of having to provide them without compensation and cause massive premium increases across the individual market.

The government has moved to dismiss, based on precedential holdings, that members of Congress can't sue and the Executive interprets the law differently than they do. Congress has many ways of enforcing its understandings of the law when it disagrees with the Executives without getting the courts involved, but Judge Collyer, who's hearing the case, has shown some interest in getting to the merits and has asked for a supplement briefing and the Arizona redistricting case, which was decided by the court on Friday or

Monday, has some language that is on standing of legislatures which is going to be cited by both sides in support of its position.

Another consequence of the King decision is that the states can now decide whether they prefer to have a federal exchange without having to worry about the loss of tax credits. Pennsylvania has already broken off its tentative efforts to establish a state exchange and it's likely that several states, including Hawaii or Vermont, may opt for a federal exchange as well. Others, like Oregon, Nevada, and New Mexico, which are using the healthcare.gov platform, may also go further in moving toward a federal exchange. When the law was adopted in 2010, many states considered setting up exchanges to retain control over their insurance markets, but the Administration has consistently interpreted the law so as to interfere minimally—and Brian may disagree with me on this—with state insurance oversight, so except for states that have a particular vision of how the exchange should be run, like California, there is, perhaps, little reason for states and, in particular, small states to struggle with exchange financing and operation if the federal exchange can run the exchange for them.

The battle of the ACA is far from over. This is just one small battle, and the war goes on. Appropriation bills that would defund the ACA are moving through the House. Bills that would limit funding are moving through the Senate, and a reconciliation bill will likely follow late this month or next. The ACA faces major challenges over the coming months. Yesterday, the Administration released information on the Premium Stabilization programs, the Risk Adjustment and Reinsurance program. I have a post-up that went up at Health Affairs a few minutes ago on that. Exchanges face major challenges in increasing enrollment, as Sara mentioned, particularly as premiums seem likely to increase more dramatically in 2016 and 2017 as the Reinsurance and Risk Corridor programs expire, healthcare costs go up, and the risk pools do not seem as healthy as we'd hoped for. But the next really big challenge to health reform is likely to be the 2016 election, and I hope that this gives us a little time to consolidate gains we have made before we are thrown, once again, into a life and death crisis. Thank you.

ED HOWARD: Alright. Brian, tell us more about this life and death crisis.

BRIAN WEBB: That's quite an ending there. So.

TIM JOST: We've had a lot of them.

BRIAN WEBB: That's right. Well thank you. Again, I'm Brian Webb with the NAIC, and just to kind of do a little bit of a poll here, how many of you have the foggiest idea who your insurance commissioner is? I'm not going to quiz you, so make me feel good. Just get your arms up. They're a good person to know. Your insurance commissioners are the ones that really do know what's going on in your states, what is going on in your Marketplaces, and they are the primary regulator responsible for making sure consumers are protected and the markets work. And that's really what they're doing right now.

As we look towards 2016, there are some deadlines coming up and your departments of insurance in each of the states are working feverishly to make sure that the plans are going to be sold in 2016, meet all the requirements, will be solvent, will protect the rights and abilities of the consumer, and that they will have healthy Marketplaces.

Some of the deadlines that we're looking at, obviously, first couple have passed. All rates, both inside and outside the Exchanges had to be filed by May 15th, and they were. So they were submitted then started the process of reviewing those. But first, they had to be posted. Any rates that were 10% and above had to be posted at the same time, again, that's inside and outside the Exchange, any of those 10% above had to be posted at the same time. That was kind of a new provision, but we did that and they were posted June 1st. Some of the state-based Exchanges came a little later—June 19th, I think. Some are still awaiting them to come out but, for the most part, they're out there. Again, just a note there. Those are just the 10% and above. There are a handful of states that made all rate requests, including for new plans, and decreases, and those below 10% available, but what's out there right now is primarily just a 10% and above.

Also, as was mentioned, the Reinsurance and Risk Adjustment data came out yesterday. This is important. This kind of gives us an idea of how much money they're going to collect under Reinsurance and then who's going to get that money in the individual market. It tells us in the Risk Adjustment program who's going to get money and who's going to pay money. And this is important because this is for 2014 and really, rates for 2015 and 2016 have been submitted with just assumptions, projections, guesses as to how these programs are actually going to work. In fact, there are states that are going to allow companies, now that they have the 2014 data, to make adjustments to their 2016 rate submission based on the new data. Maybe they have a little more information about how much those are going to affect them, so there is still going to be some interplay here. As we go forward they will be fully reviewed, and we'll get into that in a minute, but all of them have to be finalized, and QHP's must be submitted by August 25th. That's kind of the next big date when things have to be finalized. So, all the states are trying to make sure all the rates, all the forms, are approved before that date so companies can get those in.

Now, final rates posted. Again, they have to be at the same time. All final rates have to be at the same time, so you may see some rates, after that August 25th date, start being posted by the states. As long as they're uniform, they can really post them at any time before open enrollment. Now, the agreements won't be signed with the QHP's until September 21st or 25th, so some may wait until then, but then the feds, if the states haven't posted them, the feds definitely will post them before open enrollment—it sounds like maybe a day or two beforehand. So if your bosses are kind of curious when are rates, when will we know, what are they going to look like, in some cases, we may not know the final until the day before or a couple days before open enrollment, but some states will start posting before then. And, of course, open enrollment starts November 1st.

So, what's going on in the states right now? Well, they're looking at the rates. As you've seen in some press releases, you've seen, you know, they're going up, some are

requesting higher, everybody's nervous about what it's going to look like, kind of projecting what the average rate's going to be. Well, all those are currently under review. None of them are final. What they're looking for is first, of course, are they compliant with the law? There's rating rules in place: age – can't be more than 3 to 1; can't rate based on health factors, those kinds of things. So, of course, the states are going to make sure that they're compliant with the rules. And, of course, the other thing that we're looking for is, are they actuarially sound? They have to be signed by an actuary who basically puts their reputation and their career on the line by saying yes, this complies with the actuarial guidance, actuarial methods, and we think that this is an honest, good rate request. Then they're going to look to see if they're reasonable. Obviously, there's a lot of assumptions and there can be differences of opinion on assumptions, but are they reasonable? Are they reasonable, again, for things like Risk Adjustment and Reinsurance? Are they reasonable for morbidity? Are they reasonable for projected claims? Are they reasonable for projected costs? Are they reasonable? And they'll go back and forth with the companies over that.

But, let me circle the next one. This is the big one. It comes down are they sufficient? Insurance commissioners want to make sure that if somebody buys a plan – it may be a really low cost plan, it may be, you know, too good to be true, and that's the problem. If it's too good to be true then this plan's going to go insolvent and there's really going to be nothing to cover anybody. So they want to make sure that all of these plans, their rates, are sufficient to cover their projected claims. So that is something they also go through. And then, of course, that they're nondiscriminatory. They're set up in a way that you're not trying to get a certain segment of the marketplace in the way you design the various rates.

And that brings us to the forms. The forms, think of those as the contract. What are you going to cover? And they're reviewing those as well. And they go through them with a fine tooth comb, going through every provision, every disclosure, every part of it to make sure, first of all, of course, that it's compliant. Does it include the essential benefits if it needs to? Does it include all the preventive services? Does it cover it without a cost sharing, like it's supposed to? They also look at network adequacy. They want to make sure that they have sufficient networks to provide the services that they are going to cover. Also want to make sure that they provide information to consumers that's accurate about those networks and about formularies, etcetera.

And then, there are a lot of disclosures. Consumers need to know. Summary of benefits and coverage is one kind of disclosure that's out there and we're working on that to make sure that's informative, but there's other disclosures, too, about what exclusions may – what isn't covered by this particular plan. You need to make sure those are clear and accurate so people can make good decisions. So that's what it comes down to. Can regular Joe on the street go on the Exchange, get the information, look at the contracts, and make a good decision?

And then, of course, they need to make sure the benefits are nondiscriminatory, and this has become an issue that we're looking closely at. There was a lot of issues down in

Florida with the way the formularies were designed where basically all the HIV drugs were in the highest tier. That appeared to be discriminatory. Are there other kinds of ways in the way you set the cost sharing, the way you set up the benefits, any kind of limits to where they're discriminatory? We're looking at that, as well, and getting better at that every year.

There's other issues, too. Just as we move forward, as we work, first of all, with the federal government. There are some concerns about state and federal coordination. I think everybody would agree that if you have too many regulators all asking the same question but slightly differently, that's not really good for anybody. It's just going to increase costs, there's going to be confusion, and we've had a little bit of that, as you can imagine. But we're going to keep trying to get better at that to make sure that we're all kind of working and coordinating when it comes to market conduct reviews, when it comes to plan reviews, form reviews, etcetera.

Network adequacy continues to be an issue. Again, want to make sure, up front, that consumers have full, clear, accurate information about who is in the network before they make their decision, and then, also, that they have a network that they can go to for their various needs during the year. The NAIC is currently in the process of updating our network adequacy model. That's an open process. Anybody can participate. In fact, if anybody wants to take Tim's place, he's more than willing to give up his slot. We're going to four hours a week. On this network adequacy, going through there, we hope to be done by the end of the year and have a good standard model for the way we ensure network adequacy.

Definition of small group is changing. January 1st—don't know if you're aware of this—but the ACA requires that they go to employers with 1 to 100 employees. Currently, it's 1 to 50 employees. That means, if you're an employer out there with 51 to 100 employees, your benefits are going to change because now you have to have essential health benefits. Your rating rules will change because you have to be in the small group rating changes. You have to go under that single risk pool. A lot of changes. Now, there's been transition offered by the Administration to allow those to continue through, really, October 2017, but there's a couple bills, too, out there that we recommend. NAIC has endorsed changing the ACA to go back to 1 to 50—I just want to point that out. Essential health benefits, we are currently in the process of changing the essential health benefits for 2017 and beyond. We will have, this fall, that will all be put out in a proposed regulation, people will be commenting on that and posted by the end of the year. State innovation waivers have already been mentioned. States need to start looking at that, not just wholesale, we're going to change the entire ACA and not do it, but what ways can states maybe change certain provisions. That's what they're going to be looking at. And then, of course, the big one, and we never have enough time for it, is cost. What are we going to do about cost? And that's something everybody's going to start taking a look at as we move forward.

And that's what I have.

ED HOWARD: That's a lot. Thanks very much, Brian. We turn now to Kevin Lucia from Georgetown.

KEVIN LUCIA: Thank you. So, yes, I'm at Georgetown University, and we're very fortunate to have funding from The Commonwealth Fund to run a program where we're allowed to watch how each state, at a high level, is implementing the Affordable Care Act, both the broader market reforms and also how they're setting up their exchanges, and all the decisions, the legal policy decisions that are on that.

So, today I would like just to share some kind of high level thoughts on the financial sustainability of SBM's going forward post King. Also, some of the transitions and my thoughts a little bit on what we can expect on that front. Also, just some consumer challenges that we've been starting to focus on—network adequacy, for sure, over the last couple of years, but also balance billing and continuity of care. And then, just to wrap up at the end, a pitch for more data that's available coming out of issuers to help policy makers make their decisions.

So, post King. Over the last week we keep getting the same call: What is the incentive now for a state to maintain their status as an SBM, or to transition to an SBM? You know, for some, like Hawaii, as it was mentioned, it looks inevitable. They're going to move on to the federal platform. But for others, like Vermont, it really comes down to a question of control and vision. So, Vermont is a state-based Marketplace. They had a larger vision about where they wanted to bring their entire healthcare delivery system going forward, but they've been having some serious IT problems. So, do they move to the federal IT system, or do they continue to try to build out their SBM and improve their IT system? And I think it'll come down to do they want to be able to maintain their vision of control, their integration with their Medicaid program, which you really can't get just by using the federal platform. You have a better chance of reaching that level of integration if you're developing your own system. And so some states, like Vermont, may maintain their SBM status and continue to try to build out their own system. Arkansas is another state. They're marching forward to build a state-based Marketplace and they need a local solution to kind of realize their vision on their Medicaid, and how they integrate with their Medicaid program. So, I think we'll see differences, depending on the state and kind of what direction they want to go as far as fulfilling their vision at the local level.

On financial sustainability, the questions are also very, very challenging. We're seeing significant variation between states from 10 million in Idaho to 30 million in D.C. to 80 million plus in Maryland to maintain their state-based Marketplace. Many states have basically adopted an assessment that's linked up to enrollment and premiums, and so, if the enrollment goes down their budgets go down, can they maintain their financial situation going forward? So, I think now that King is done what we'll probably see is many states starting to look internally about how they can affect their cost drivers, which seem to be on the call center front and the IT maintenance fronts, but also looking at other states that have successfully been able to maintain their financial status like

California. What's happening there? What can we learn from there? How are they dealing with these cost drivers?

So, no doubt about it, back to the narrow network issue, we are in an era of selective networks. So, for consumers, what has this meant? Up until, you know, certainly the first year and continuing to the second year, inaccurate and out of date physician directories. Plan labels, like HMOs, PPOs, EPOs—they don't really tell you a lot about how robust the network is, and a very common complaint was consumers really didn't realize that their physician was not in the network until after they purchased the plan and it was difficult to get this information from the issuer. I list a couple of the other common complaints that we heard in the media.

So, Georgetown, last year, went out and published a report to figure out what were the actual network adequacy standards on the books at the state level, and we found just about half of the states had what we call quantitative standards. And that's like the maximum travel time and distance to get to a doctor, 23 states had that. Provider to enrollee ratios, 10 states had that. Maximum wait time, 11 states had that in place. And some of these standards didn't necessarily apply to all QHP's that were offered in the Marketplace. Some of them only applied to HMOs. So, we're interested in watching how states move forward on this front, if they will adopt new protections, where the NAIC lands on their model law. And what we did find out, going forward through 2014, was very few states actually moved forward on creating new standards. Arkansas and Washington, they had new quantitative standards that went into effect in 2015, California DOI filed emergency regs that implemented new network adequacy and it's kind of got them up onto par with the other plans that have been offered in the state. We saw a number of states, five states: California, Connecticut, Nevada, New York, and Washington that beefed up their oversight so they were empowering regulators to look at their networks and to engage the insurers on this front. And then we saw five or six states that addressed provider directories, for example, New York mandated that provider directories had to be up to date within 15 days of changes.

Policy questions going forward on the network side, it's a complicated space, the network adequacy space. There isn't a lot of data out there that clearly points to what works for which state and which region. Also, for better or worse, networks affect price, and so there's a balancing act between price and access and choice that, I think, regulators have to kind of get their head around.

And then, finally, transparency of provider directories—it's really difficult. Everybody seems to want and think that it's kind of a no-brainer to have up to date directories, but if you talk to regulators and issuers and providers it's very, very difficult, logically, to keep these provider directories up to date. Some states have been innovative. D.C., for example, is working with a third party contractor to kind of collect all the information from the issuers and the providers and then put it up into a seamless box that is available for their consumers. And other states are following suit.

Balance billing. So, 10 years ago, Georgetown reported out on how states were regulating around balance billing and we're mostly interested in how people are being protected in the ER setting, so when you go to the ER, you go to a par hospital, and you're tested by a non par provider and that provider doesn't have a contract with your insurer so they can basically bill you what they want or above what they're paid. And the same thing was happening in network hospitals. A woman goes to the hospital to have a baby and the anesthesiologist has a network and she gets a $2800 bill. So, we studied this 10 years ago and I think the hope was that the ACA would take care of it, but it didn't. Cost sharing includes – the cost sharing limits includes those finds related to co-pays, deductibles, and co-insurance, but they don't include balance billing. So, this is an issue now. There's no federal protection, and state protections vary. Only about a quarter of the states have some protection against balance billing, and sometimes it varies depending on the setting. There's been a lot of recent activity around this issue—New York, Connecticut, New Jersey had a very comprehensive bill that failed. But I think this is an issue, as we start to go into more selective networks, we're going to see possibly an increase in balance billing and it'll be interesting to see how states try to deal with it.

Continuity of care. And this is disruptions of ongoing care during active treatment when either a participating provider is terminated from the current plan, or when a provider is not participating in a new plan. And so, we're asking people to go back to shop on the Marketplace and we want to make sure that those people who are undergoing care, for whatever they might be going undergoing care for—post maternal care, mental health issues—that there's some kind of continuity of care to allow them to transition into that new plan. And certainly, if we're going to allow flexibility on networks then we need to make sure, at the state level, that states are protected when a provider is dropped so that provider can continue to treat that person that's covered under a QHP, at least temporarily.

The federal government, the feds, are on this, I think, and in the 2016 guidance they're encouraging issuers to have transitional policies. State protections vary significantly. I would tell you that DC Health Link, the DC Marketplace, did put in a policy that basically requires 90 days of continuity of care for people who are switching between plans. And I think that's an important step forward for that state and other states may follow.

And then, finally, I'd like to finish up on just transparency data or make a pitch for this. So, there's a provision in the Affordable Care Act, 2715A, that basically allows the collection of a significant amount of information that really, I think the vision was to help the behavior of issuers and the experience of consumers to inform policy makers. That provision has not been implemented. There's some work going on at the NAIC to figure out what data should be collected to inform implementation of 2715A but it's not with us yet. And so, hopefully this information and this provision will kind of see the light of day in the next year. But you can understand that if you have the right data, when you're making decision about balance billing, when you're making decisions about network adequacy, when you're making decisions about changes to continuity of care provisions, it would be good to know exactly how many people are experiencing those issues and

how issuers are setting up their plans or paying claims to influence how people experience those specific situations.

ED HOWARD: Great. Turn now to the guy who's really working one of these state-based exchanges, Peter Lee. Peter, thanks.

PETER LEE: Thank you very much, and thank you to the Alliance and Commonwealth for having me here, and thank all of you for joining us. One of the things I say often in California is that we try to do evidence-based policy making. We wish the same of all of you. So that's what, I'll try to give you some of the stories on what's happening in California.

I was a little daunted to recognize that open enrollment starts in four months, so I actually need to leave in five minutes to get back to California. [Laughter.]

I would note that I have additional slides that I'm not going to go through but I'll refer to some of those as I give my remarks.

I want to start by noting that we, in California, very much believe that we are not just about giving people insurance cards. We believe in the triple aim: trying to encourage better healthcare to be delivered, encouraging better health, and lowering costs. That drives what we do. It drives a lot of the elements of the Affordable Care Act. For all exchanges, there's four elements that I think go into their success: how they are a purchaser—we are a very active purchaser, I'll talk about that in a moment; doing effective outreach—getting people in the door; making sure we have affordable products; and, finally, making sure people are actually getting the care they should.

Now, when I say being an active purchaser, to my mind there's four key elements there, and there's only a half dozen states that are active purchasers in different ranges of the spectrum. It means, first, selecting plans. We turn plans away. We don't take any plan that wants to play. They need to show they've got good networks, good prices, offer something meaningful. Second, we negotiate price very actively. We're in the middle of doing that right now. Third, we standardize benefit designs. Beyond essential health benefits and actuarial tiers we have standard designs. And fourth, we have contractual provisions that push our plans to change the delivery system. We recognize that, in the end, healthcare is delivered by doctors, by nurses, by hospitals and we think it's our role to be an agent in partnership with CMS, with our Medicaid agency, with private purchasers in changing how care is delivered. So that's a role of being an active purchaser that different Exchanges take different philosophies in.

Now, before talking about California, there has been so much talk post King about what's going to happen to state-based Exchanges. I wanted to frame for you from an Exchange that lives this, some of the main core functions that may be easy to do nationally or regionally and others that are local. To me, there are four key functions that an Exchange does. There needs to be more IT. The website for enrollment. Healthcare.gov has a very good functioning enrollment site, so does California, so does Colorado, so does

Connecticut, so does Kentucky. That is really not largely location specific except for interface with your Medicaid program. That's a big except. Second, customer service. People answering your phones. In California we have state employees of the state of California answering our phones for our California workers and for our California enrollees. Every other state and the federal government contracts with a private vendor to do that service. It's a big service. It's about a third of any Exchange's budget. Third, marketing and advertising, outreach and enrollment. That is never national. That's a local effort. It's local insurance agents, it's local faith-based groups, it's local advertising in a market. It's a local effort. And, finally, purchasing. Selecting plans, negotiating contracting, even if you're a light touch, knowing the plans in Arkansas is different than knowing the plans in California. That's a local, location-specific effort. So I'd warn you of say, oh, all these state-based Exchanges are going to become federal. Certain things don't go federal. Healthcare is local. Marketing is local. Outreach is local. And that's one of the things to remember.

And I'd also note, Kevin did a very good outline of some of the budget issues. About a third of our budget, which is about 330 million dollars in this fiscal year, which started today, is one-third each in IT, customer service, and marketing. So you think about where this money is spent—it's a lot of money, but you will need to do outreach forever.

So now let's bring you to California. Now this is sort of hard to read, but I just want to note, one of the things the President said after King v. Burwell is, "this is no longer about Obamacare, no longer the Affordable Care Act, this is now healthcare in America." Well, this is very true in California. So, in California we saw the number of uninsured decrease about in half. We saw the Medicaid program, which is MediCal in California, grow by about 3 million. That's the orange bar. We saw the individual market expand dramatically from 1.5 million to about 2.2 million. Of that, 1.3 million are covered in Covered California. We saw the employer market decrease a little bit, and that's what I need you to look at more. I'd note, in our uninsured, and I think I'd note Sara's note about the number of Latinos who are uninsured, more than half of our uninsured are not eligible for subsidies because they're undocumented. So we will have challenges across this nation of addressing all the populations across the country who are uninsured if we aren't addressing undocumented. So, eligible for coverage are about 1.3 million left. So we've done a pretty good job. We're changing healthcare for many folks.

Covered California is big. We're obviously a big state. We have 1.3 million insured today. We are the second largest purchaser of healthcare for those under 65 after the Medicaid program in the state of California. That means when we talk health plans listen. It means we have the budget to do outreach. You can see that we have 6.5 billion dollars in premium—we're a very going proposition.

A couple things that I'd call out here, though is since we opened our doors 1.8 million people have had coverage, some for two months, some for six months, meaning 500,000 that are not covered today have used our services. That's exactly what we thought was going to happen from day 1. The individual market is a market which has what's called churn. People are there, some of them temporarily because they're in between jobs.

Others are there while their income is adjusting, oh, income drops, they're in the Medicaid program. That 500,000 is part of what any Exchange is doing, in many ways, being the glue that holds the employer-based system together with support from the public sector.

The other thing I'd note is we have plan assessments to support our operations. We were collecting them from January 1, 2014. We, today, have over 200 million dollars in the bank. Unrestricted, we can use as we please. Our state law says we cannot now, nor ever, use state tax funds. We knew that from day 1, we developed our budget to be totally financially independent. We have about 100 million dollars of federal establishment funds we're still spending as completing the establishment process. After that we're on our own and we're on our own running just fine. We can dial up or down our plan assessments and, I'll tell you, the plans want us to dial them down but we are the cheapest date in town. In terms of getting enrollment in the individual market it used to be very expensive.

So, enrollment. How did we do? We did a good job. So, on the right hand side of this chart is the ethnic mix of those eligible for subsidies. Thirty-eight percent Latino, 34% white, 21% Asian-Pacific Islander. Second open enrollment period, what did we enroll? Thirty-seven percent Latino, 18% Asian, 5% African American, 34% white. We enrolled people that reflect the diversity of those eligible for subsidies. How did we do it? It was hard work. We did it with radio, with TV, on the ground work, insurance agents in every part of the state working together to get the word out and the word is largely out there. For those that didn't sign up, the Commonwealth data, is spot on. It's people that still don't believe healthcare is affordable. It's something we'll be working on continuously.

Let me talk briefly about being an active purchaser. We're a big state with 19 rating regions. Virtually any one of those regions is the size of many states around the nation. Those rating regions have anywhere from 3 to 6 health plans in them. In 2014, we turned plans away that wanted to be in our Marketplace. In 2015 we turned plans away. We'll see if we turn plans away for 2016. Last year, our average rate increase was 4.2%. It wasn't bouncing up and down for a lot of folks because we look very closely at what the plans bring forward. I'm very optimistic for next year because we do have a good risk mix, and that's exactly what the re-insurance pools were supposed to do—give the, in essence, seed funding to have low rates early on to get a good risk pool in to have affordable costs on a go-forward basis. Our rates will be announced at the end of July, so stay tuned for that announcement.

Next issue to being an active purchaser is standard benefit design. And this is really important. There's a lot of talk about do consumers have access to care because these plans—and these are not just Exchange plans, but plans for employers—have big deductibles. Well, in blue—and look at this in more detail later—are the sorts of coverage not subject to a deductible. If you are in any silver, gold, or platinum plan no care you receive on an outpatient basis is subject to a deductible except specialty drugs in a few limited cases. The only thing subject to a deductible is when you go to the hospital. And we designed this. They're standard. Every plan in Covered California has the exact same

benefit design. And, by law in California, the exact same designs have to be offered off Exchange even by plans that are not in Covered California. Now those plans can offer other products off Exchange, but they must offer this exact product so consumers can compare apples to apples, plans they're shopping for off Exchange. This is a huge benefit to consumers.

What's it mean for affordability? It means that many consumers are paying very little to get very affordable coverage. We have 120,000 people that are paying less than $10 a month in bronze plans. Seventy percent of those that have subsidies are picking a silver plan. Many of those, in that cost sharing subsidy you heard about earlier, where, in California, at the highest cost sharing subsidy and outpatient visit is $3.00. A bus ride. That's not a barrier to care and there's no deductible. I would encourage you to look in the background slide. This is not the story across the nation. If you look, and we did some looking at Colorado and Miami, instead of having 7 products, like we have in LA, in Denver they have 35 different silver products. In Miami, 35. And some of those products that are the cheapest premiums mean you don't get any care unless you've satisfied a $3,000 deductible. That's not good for consumers. Standardized design is something active purchasers do. I think it's the right thing for consumers.

Let me quickly note about getting access to care. We have some very early indicators that are very, very positive in California. There is a lot of discussion about narrow networks. I'd note that virtually all of our plans, to some extent, have a not-all-in network. I think that's good for consumers if you give consumers the tools to understand who's in. Well, in California, 91% of our enrollees said they could find healthcare from a usual source of care close to them, identical to the number of people that said that in the employer insured market—91%. Identical rate. So, 9% cannot find local care. The same for people with employer-based care. And often, issues that are raised as Exchange issues, you need to pause and say, is this an Exchange issue, or is this a health insurance in America issue, like balance billing and other issues? These are not issues that are specific to Exchanges.

In terms of getting care, I really appreciated The Commonwealth's recent study that 86% of those newly covered were satisfied with their care. I think that's the case and some people aren't but 86% is a pretty good number. I'd ask you to compare that to employer-based coverage individuals. My bet is it's very similar. We're seeing people in California getting access to care. Those in Medicaid, MediCal in California, Covered California, or private insurer, 60%, as of October, had gotten preventive services. Over 70% had seen care. Those rates are identical across the board.

Last, I want to note on delivery reform. We have, in our contract with our plans, what's called Attachment 7, that lays out a whole range of requirements of the plans to tell us what they're doing, to making sure people get care that's appropriate based on their culture, their language, etcetera. We also, in California, back to Kevin's point on transparency, have a requirement that every plan give a third party vendor every piece of their claims data which is held totally confidentially to be analyzed to see which plans are doing a better job to serve diabetics. Is it different by age, by ethnicity, by income? We're going to be analyzing that data in the years to come. It's something the federal

government should do. It's something every state Exchange should do to understand is the right care being delivered at the right time. But we're also raising the bar in the near term to say what can we do with CMS as Medicare, with our Medicaid agency, with private purchasers to make sure consumers are getting the right care in the delivery system, because in the end that's what matters—making sure people truly do get the right care at the right time.

So, thank you very much. I look forward to your questions.

ED HOWARD: Terrific. Thanks very much, Peter. Let me just remind you that you now have the opportunity to ask questions of our panel, either to a specific panelist or in general. There are microphones that you can use to ask your question. There is a green card that you can fill out and have someone bring forward. You can tweet a question to #ACAcoverage and I would also invite my co-moderator to jump in with questions as she has, at this point, and I don't know if you want to start us off, Sara, but you have the opportunity if you would like.

SARA COLLINS: One question I'd like to ask Peter. We know that people don't understand their insurance policies very well, just from our surveys, and in particular people don't really understand their deductibles very well. And so, California has been very innovative in terms of excluding outpatient primary care from their deductible and do you know, Peter, how well people understand that exclusion?

PETER LEE: It's a really great question. So, the Kaiser Family survey results that I noted asked people do they understand their benefits. Seventy-five percent said yes. I'm not sure if I believe that, quite honestly. The good news, though, is in our last open enrollment year, 70% of the people that enrolled enrolled with help from an individual. Someone in our service center, 43% with an insurance agent, others with navigators. Those people were all trained to describe what the benefits are. The benefits of choosing a cost sharing subsidy plan. So you'll note, 70% of our people eligible for subsidies picked silver. That's pretty good. That a quarter picked bronze, for many of them, they literally had healthcare coverage for free because they took their advanced premium tax credit, applied it to that bronze plan. But they did that because they had informed interaction with a trained counselor to help them make an informed choice. That said, I think one of the challenges we all have is to improve health insurance literacy. But, early indications are pretty good.

TIM JOST: Sara, if I could respond to that briefly. One of the other initiatives the NAIC is working on right now is revising the Summary of Benefits and Coverage and the Affordable Care Act provided that every has to have a Summary of Benefits and Coverage that is made available to consumers to decide which plan is the best for them and also to better understand their plan. And the agencies had proposed to revise that last year and then, at the request of the NAIC, they turned that over to the NAIC, the job of revising it. And that's another group at the NAIC that's meeting three hours a week to revise the SBC. But one of the major focuses of that effort so far has been to provide

much better information to consumers about the deductible and how it works and what is covered by it.

ED HOWARD: Good point. Yes, and I would ask those of you who are asking questions from the microphones to identify yourselves, and if you have an institutional affiliation, mention that as well.

DR. CAROLINE POPLIN: I'm Dr. Caroline Poplin. I'm a primary care physician. I have a narrow question and a broad one. The narrow question is to the lady from Commonwealth. When you do your surveys, how satisfied people are with their insurance, do you ever break it down by people who are sick versus people who are healthy? Very often the healthy people are satisfied with their insurance because they've never had to use it.

The broad question is, you've described a very complicated system—many plans, many regulators, many regulations—has anyone every calculated the cost of the whole bundle, the government part, the time people spend choosing their plans, the regulations—how all these transaction costs compared to, say, Medicare where, except for Medicare Advantage, but even Medicare Advantage, everyone has to get the same benefits? The Medicare Advantage can add on a little bit, but there are no risk corridors, it's just much simpler. And I wonder, we've looked at, you know, cost of this and cost of that, but if anyone has ever looked at the entire package of costs that we pay to have various plans and consumers picking every year.

SARA COLLINS: I'll start off with your first question. I think that's a really important question and we do look at health status in our survey. We look at how people rate their health. We ask people how they rate their health and we also ask people if they have a chronic health problem and then look how they answer questions. And what we find is that people who have health problems know their plans really well, so they're much more likely to have used their plans and we've asked, for example, whether or not people feel like they're better off now with their new insurance coverage. People who have health problems are somewhat more likely to say that they're better off now than they were before. And I think that's partly because they're just more likely to have used their plans.

I think the other important thing to keep in mind, too, we ask people who had insurance before getting their new policy whether they could've gotten that coverage that their new health insurance before, of people who had used their plans, whether they could've gotten the care that they're getting. And what we see is about nearly half of people who had insurance before getting their new plans said they wouldn't have been access that care before. So I think what you see in a lot of these data are people who had insurance and had really crummy plans before, maybe had their diabetes care excluded from their benefit package, and so seeing themselves with somewhat better access to care than they had before.

TIM JOST: With respect to the second question, there is, as you would expect, a huge literature on that question and it breaks down pretty much along ideological lines. I mean,

I think it's pretty hard to argue with the fact that most countries in the world spend a great deal less on healthcare than we do. They operate it through programs that are either government run or very closely supervised by the government and they have healthcare that is every bit as good as ours, sometimes better. On the other hand, you can certainly find literature that shows that public programs impose very high costs of various sorts and this isn't just a perpetual argument, but I think the issue here is really more political than economic. We are not going to get a national single payer system in my lifetime, so, there we are.

DR. CAROLINE POPLIN: We do have Medicare.

TIM JOST: Do I have Medicare?

DR. CAROLINE POPLIN: We have Medicare.

TIM JOST: We have Medicare. Yeah. And there was a debate in 2010 to extend that to everybody and I don't think it ever – it never got to a vote. It just wasn't close. But, there we are.

It's the people in this building. [Laughter.]

ED HOWARD: Yes. I believe you were next.

JARED : Jared Grossman with the Mercatus Center at George Mason University. My question is for all the panelists but I specifically want to hear from Mr. Lee for his state perspective, also.

ED HOWARD: Do you want to get a little closer to the microphone.

JARED: So, my question is regarding the waivers for 2017. What can we expect with those waivers, what changes are states likely to make, and then, is there a difference or will there be a difference if it's a federal Exchange versus a state Exchange.

ED HOWARD: And I would ask whether it's Peter or one of our other guest experts to just say a couple of words about what the nature of these waivers, for those of us who aren't necessarily students of Section what was it? 3518B?

PETER LEE: Briefly, this is actually just in the beginnings of being explored by all the states, so every other week I'm on calls with every state Exchange executive director, talking with the federal Exchanges as well, and the range of the latitude that these waivers provide is pretty broad, but it's not limitless. I mean, there's guard rails, and states are looking at anything from narrow opportunities to do things like fixing the family glitch, which is a provision that actually excludes subsidies from families where one of the spouses has employer-based coverage and the rest of the family doesn't, to much more broad programs to try to have better integration between Medicaid and the Exchange program. So it's really, there's a really wide spectrum being looked at. And we

are just barely starting down the path of looking at that right now. We're really focused, right now, mostly on open enrollment 3. 0:9:47

KEVIN LUCIA: I'd just like to add, you know, The Commonwealth came out with an issue brief about two months ago in 1332 waivers and it's a great introduction and kind of talks about the guard rails on these decisions. And I would agree with Peter. There's probably going to be a range; some states really going for everything and other states making small tweaks to issues that are bothering them and what they're seeing coming out of their enrollment.

I would say, because we track this stuff, we have seen about 10 states that have either set up task forces or, at least, acknowledged publically some of the things that they're considering in public debate through their Exchange board meetings. So, there's definitely activity taking place at the state level. I think that they're waiting for the feds to give more guidance. We don't have the official regs, we have kind of a process reg but we don't have anything further than that. And so we'll know more in the next couple of months I would say.

TIM JOST: I'd say, in response to that, that the 1332 waiver process is probably going to be the factor that is most influenced by the next presidential election. We're going to get some regs, substantive regs, before the election. There's a lot of talk about 1332 waivers, but if you read the section, there's not a lot of wiggle room in there. Basically you have to be able to provide at least as good coverage to at least as many people without causing a greater budget deficit for the federal government. It's pretty hard to imagine a program, for example, that's based on health savings account or something that would ever meet the requirements of 1332. I mean, single payer system maybe, but nobody's going there. And so, one can imagine that if we elected a president who was hostile to the Affordable Care Act that they would exercise a great deal of discretion in trying to allow states to do all kinds of things under the 1332 process, but I would expect that if we elect a president who is supportive that it's going to be construed as its written as a fairly narrow opportunity to improve on things but not to abandon the Affordable Care Act and go in a completely different direction.

BRIAN WEBB: We're a little more optimistic. [Laughs.] We believe there is some latitude there. We've seen it, even in this Administration, who I would say is very supportive of Medicaid and supportive of the ACA under 1115 waivers, they've been very broad in working with the states and I think this Administration, next Administration, whoever, will want to work with the states. If you could come up with something that makes it better for consumers, more competitive or better markets, states can come up with positive changes that will move things forward. And that may be easier to do than even doing major changes here at the federal level.

ED HOWARD: Okay. Yes, sir.

FANG CHAO: My name is Fang Chau, and I'm an intern at Health and Human Services. I have a question that's specifically addressed to Mr. Lee, but also to the panel in general,

which is Mr. Lee, you mentioned at the beginning a little bit about specialty drugs and that's an issue that I've been working on in the office and I was wondering, I know that California recently was trying to reform their policy regarding specialty drugs and especially with the new wave of cholesterol medicines that have the potential to impact millions of people. What ideas do you think could be implemented at the state and national level in order to regulate the cost of these drugs and their impact on the healthcare system?

PETER LEE: Great question. So, I know that in California we have standard benefit designs. Every plan offers the same benefit designs. We don't make many changes each year but, for 2016, we made a couple of changes. One is we, instead of having two silver plans, an HMO and a PPO, we merged that into one because we think that choice is great but too much choice is not healthy for consumers. But, in terms of specialty drugs, with drugs like Solvaldi and others, that are costing as much as $25,000 a month, what we are seeing is consumers needing to meet their entire deductible, excluding them from actually getting care. So we actually have established a cap on monthly out of pocket for any specialty drugs across all of our tiers and across all the plans. These are standardized. They'll be in place as of 1/1/16. This means the entire individual market in California will have caps on specialty drugs.

We did this really concerned. One, we didn't want to have consumers caught in the middle, but we are very concerned about the pricing, especially drugs. We are very worried that some of the pharmaceutical companies are making profits hand over fist that when you compare that to the MLR and the restrictions on profits being made by health plans, which I'm looking at the profits and they're coming in to bid to Covered California, profits are between 1% and 3%. I've seen some of the pharmaceutical companies having profits of 100%. Profits. Profits. That is something that, I think, we look at as we can by setting our benefit design but beyond my pay grade is some of the other issues that are going to be addressed because this is one of the major cost drivers of future healthcare costs in the nation.

FANG CHAO: Thank you.

SARA COLLINS: If I could just follow up on that too. I think this is such a fascinating example, too, of where an innovation occurred in Covered California and I just wonder what the potential is of it spreading into employer-based policies in the state.

PETER LEE: That's actually a great question. This is one of the issues where a number of employer-based benefit designs already had caps. Some did. And we actually looked at what was in place in large employers, in small employers in the market, and there were a number of employer-based benefit designs that did just this—had caps in place. And so, what we did was, and generally, Exchanges have, in terms of actuarial value, plans that are less rich than the average large employer plan. That's what the 70% actuarial value is not what the large employers—actuarial has more like 80%-90%. But we need to look at making sure people get access to care, and so that's why doing things like we've done on our deductibles, things like specialty drugs, to make sure that even though it's a lower

actuarial value than the average large employer plan, it doesn't serve as a barrier for you getting the access to needed care.

FANG CHAO: Thank you.

ED HOWARD: And we are down to the last 10 to 15 minutes of question time and if you do have to leave and, as you are listening to that last segment, I would appreciate your pulling out that blue form and filling out the evaluation for us.

Yes, I believe you were next, sir.

JACOB BRADSHAW: My name is Jacob Bradshaw. I'm here for the National Alliance on Mental Illness and I have questions about two concerns we've been having. The first is regards to transparency for the Medicare and Medicaid networks because we get a surprising number of calls from people who have called their state Medicare/Medicaid office and have informed us that they've been told that there is no directory available and that they told them to call my nonprofit organization for a list of treatment referrals. And then, the other concern that we have is in relation to the Institutions for Mental Disease Exception with Medicaid, and how future plans for the ACA might help to alleviate that.

ED HOWARD: Go ahead, Tim.

TIM JOST: No, I was just – I don't deal with Medicaid. I don't think that any of us do in our work. We work with private insurance. I realize these are serious issues but—

PETER LEE: Let me take it just briefly. We work very, very closely with MediCal, our state Medicaid program, and in California, which is the case around the country in a lot of places, Medicaid programs are increasingly contracted with Managed Care Organizations, and have clear requirements in California that provider directories and provider information be made available. The issue of Medicare is clearly a federal issue and, again, in Medicare Risk plans I think CMS regulates the availability of provider directories there. I have no clue on your second track question, though.

ED HOWARD: You have stumped the band. And we would invite, let's crowd source this. If anyone would like to respond to the gentleman's question more fully and would address their communication to info@allhealth.org, we'll try to post that on our website.

Yes, sir.

RICK CURTIS: Rick Curtis, Institute for Health Policy Solutions. This is primarily for Peter, but Kevin, I'm sure you'll want to chime in.

ED HOWARD: Rick, that microphone doesn't seem to be working very well, so sort of swallow it if you would.

RICK CURTIS: Can you hear me now? Peter, I think probably everybody in the audience read the press accounts in the initial year in California where there was such dramatic change in the cross competitiveness of the nongroup market, largely because of the Exchange. And there were real problems, and you know better than anybody in the country, with the directories and there were problems with access. Obviously, your consumer experience survey data strongly suggests you've largely resolved those problems. It seems to me it might be interesting to folks to understand how you went about working with folks to get as far as you've gotten and where you think you need to get, and Kevin, you may have some national perspectives on exactly those issues.

PETER LEE: Thank you very much, Rick. You know, Covered California's mission statement is that we're about enabling consumers to make the right choice of health plan and provider, to pick something – the individual, the institution that's right for them. So when we opened our doors in 2014 we actually had a combined provider directory that took all the directories of all the health plans and put it in one place so you could say, Dr. Ramirez, which health plan does she contract with? We took it down because the underlying data was so bad, and it was particularly bad from two of our largest health plans that had gone through major changes in the networks. Our regulator—and in California there's two regulators, but 95% of the individual market is regulated by the Department of Managed Healthcare—did audits of those two plans and found their directories wanting significantly. We found the directories wanting and we worked directly with those plans to say what are you going to do now to reach out to every doctor that they thought they had contracted. They did that. We also did it jointly. So we did joint letters from Covered California and the health plans. We also, in California, did joint mailings with our medical societies. So last year we did mailings from Covered California and the California Medical Association, the Association of Family Physicians, jointly signed by myself and the presidents of those associations saying it's your job to make sure you know which network you're in. It's your job to be part of the solution. I want to be clear that, you know, we heard earlier, provider directories have been pretty bad for a long time. When it really makes a difference, though, and this relates to continuity of care, is when people are changing plans. People that went into new plans that had a new network didn't have problems. It was where people are previously in these plans and were changing, they had concerns.

Now, I'm optimistic the directories are going to be a lot better, but they're still—this is going to be a work in progress. I mean, we're still doing audits and reviews of our plans, but this is a core element of consumer choice to make sure that if they're picking a plan because of a doctor that information's accurate. And the other thing we did, if the information was inaccurate, we let them change plans after open enrollment. I mean, that's the sort of thing that an Exchange can do as an active consumer advocate, more than just being a purchaser, to make sure that the system works for consumers. So, those are some of the things that we did. Thank you, Rick.

ED HOWARD: Kevin, before you respond, and this will give you more to respond to, we have a question that came in on one of the cards asking about whether there is anything, and I would ask Peter, if there is anything in your reforms, either to the

directory or otherwise, that would give consumers information about the quality—and they ask about the price, but maybe your rules preclude that problem—of the providers who are listed in the directory?

PETER LEE: That's a great question. First, California is one of the states that has had network adequacy regulations for quite a while. The Department of Managed Healthcare has really been one of the national leaders of having adequacy standards. But I think the question is a great one. It's not just adequacy. If you don't have an existing relationship with a doctor he's a good doctor. Well, there are not in regulation standards but I'd turn your attention to Attachment 7 of our contract, and if you pull down the website, the full thing, you can link to that attachment. We actually ask every one of our health plans what are they doing to give tools to consumers to make treatment choices, to make doctor choices, to make hospital choices, that is informed by what it's going to cost them out of pocket and informed by the quality of that provider. Now, this is, right now, an evolving area, but it's one of the things we're pushing every one of our health plans on. Because that choice is one that you make once you're in a plan, and that choice is one that needs to be informed by your benefit design, your out of pocket, etcetera. So, the way we're dealing with that in California is, again, active purchasing. It's our expectation that our health plans help people make the right doctor and treatment choice that's well informed in terms of quality and cost.

ED HOWARD: Kevin.

KEVIN LUCIA: Just as a quick follow up. I don't know of any state-based Marketplace that didn't struggle with the provider directories. And it's not just provider directories, it's also formularies, too, and that's another important piece for folks that are undergoing care, how to make sure that the plan that they're going into and understanding their responsibilities and what drugs are covered. So, you know, Maryland, D.C., they, too, moved ahead with integrated provider directory systems that I think have been successful so far and other states have followed suit.

On the formulary side, last year we did kind of a sampling of state-based Marketplaces that was very – it was still very difficult during open enrollment to find the links for the formularies and actually pull up the formularies in many of the state-based Marketplaces.

ED HOWARD: Peter.

PETER LEE: Let me follow very briefly on that, but I think that's absolutely right. When we look at consumers choosing plans, about 30% care about finding a doctor. About 10% or 15% care about drugs, and these are chronically ill individuals that say I'm on a drug, I want to maintain it. Now, the vast majority don't, but for those that do, they care a lot about it, so at Covered California, people can link to each plan's formulary. We look forward to having a consolidated formulary directory and it's not going to be in 2016. One of the things I've learned is IT is not as fast as nimble as we would've all thought. But we are looking at building a system such that someone can say, here's the drug I'm in, which plans have that at a preferred tier, what would it cost me? So they can

see that as well as they're seeing what their doctors are, and that's the sort of consumer responsive Marketplaces I think a lot of the Exchanges are looking at, as well as the federal government.

TIM JOST: I should also add that the guidance now requires that information on formularies and networks be provided by issuers in machine-readable form, and I think we're going to see a lot of innovation here in the private sector where companies merge some of that information with information on quality that might be available elsewhere. So I think it's not just the government that's going to be providing solutions here, but the private sector as well.

ED HOWARD: Okay. I think our time would dictate that you are about to ask the last question.

CAROLYN IODICE: My name is Carolyn Iodice, I work for Representative Justin Amash. My question is about trends in changes to premiums. This year, like last year, we saw some large jumps from major insurers of sometimes more than 10, sometimes more than 20%. My question is, when, if ever, can we expect premiums to level off and not see these year over year jumps of that size?

PETER LEE: One crack at that. We haven't seen anything yet about final rates for this year, so the rates that have been posted are those over 10% and not yet subject to having been reviewed by state regulators. In the majority of states, the state regulators and the gentleman from NAIC could speak to this better, have the authority to actually reject rates and order them to be lower. So the interim preliminary numbers anyone should either take to the bank or take to doomsday scenario. That's number 1. Number 2, again, California, last year had an average rate increase of 4.2%. I think we're going to have—stay tuned, end of July our rates are going to be public and then subject to a 60-day review by our regulators. But what we're seeing, when we see these jumps, it is plans doing bad pricing. And I think this is an issue of either regulators missing the boat the prior year, or Exchanges not doing active enough purchasing. You won't see that in California. And to have price jumps of 25% means that a plan underpriced dramatically the prior year. And it's not about the risk pool, it's about plans blowing it.

And so I want to be clear that across the nation the enrollment was strong. Good enrollment with a good risk mix across the entire nation. So look at, I think it's very dangerous to say, oh, here's some examples of 15%-20%, clearly it's a bad risk pool. It's not. It's bad underwriting and bad plans screwing up. Look at the overall national averages for rates, look at the overall rates that we're seeing, and I think what we're seeing, in terms of the 3 R's, working reinsurance, which you saw the report that came out a few days ago. A lot of money went to health plans, that was why their rates were so low in 2014. 2015. They're calculating what they're going to get paid for reinsurance.

Then, in 2016, when we sit down and negotiate with the plans we look at their assumed trend, we look at everything, and when we kick their tires we didn't have one plan, in 2015, that had big spikes and stay tuned for later. But it's so easy to grab a few numbers

as if those are really meaningful. They're not. Look at overall averages, and that's what the whole risk pool story tells. The issue for consumers, though, if you are in that plan with a big rate jump it's meaningful to you, but then it's a matter of making sure that plan or that Exchange gives consumers information they've got cheaper options to make that tradeoff. Many Exchanges last year did what's called passive enrollment which says if you don't do anything we're going to keep you in the plan you were in. Well, that makes sense if you're in a state that actually rates didn't bounce around very much. But if you're in a state where last year you were the lowest silver and next year your plan is 20% higher, is the 5th highest silver, you could save a lot of money by changing.

And so, I think the issue that I think about variation in rate increases isn't about an indicator of the risk pool, it's an indicator of Exchanges needing to give consumers information to make a better choice in the next open enrollment period.

BRIAN WEBB: And I would just say, some of it is bad choices or bad assumptions. Some of it's we're still in a transition period. You have transition plans, we have grandfather plans, we have changes in the Risk Corridor program, in the middle of it, we still have the reinsurance amounts going down, about to be phased out. We just now got risk adjustment numbers, just now got reinsurance numbers. So the carriers out there are doing their best trying to figure out what's ahead and figure out what all the factors are, but we're still out there and that's why one of the reasons we are seeing some spikes in some. I would always caution on percentages. Percentages, as my statistician teacher always told me, are lies. You have to look at them very carefully as to—it's a percentage, but a percentage of what? And what we're looking at now is trying to figure out where that dollar amount is—not the percentage increase or decrease, but what actually a premium is going to be charged versus everybody else in the market, and where is everybody coming to? And I think we'll see some settling down now that we're getting closer to where everybody's in the pool, all the rules are set. We still have kind of this small group change coming, we think. Maybe. Maybe not. Everybody's still trying to feel their way so we are seeing some of them, but we do feel like it will settle down in the future.

TIM JOST: And we always have to remember that even before the Affordable Care Act we had large jumps in premiums and premiums all over the place. So this isn't new. But I really agree with Brian that we're going through a transition phase here and probably three, four years out we'll know a little better where we are unless, of course, we decide to do something completely different all over again.

SARA COLLINS: And I would just follow up on something that Peter said, too, about consumers making choices in changing plans, there was a remarkable number of people change plans last year, so about 30% of people actually did change plans which is a lot higher than you see in employer-based plans, the Medicare program, too. So, people really are exercising their choice prerogative on plans.

ED HOWARD: Okay. Thank you all for an active participation in this and for showing up in the middle of a week like this.

I want to thank The Commonwealth Fund, especially Sara and her colleagues for helping to shape and make good this particular program. Also thank you for filling out that blue evaluation form that you're scribbling on right now. And I want to ask you to help me thank the panel for addressing most of the questions anyway.

[Applause]

And my apologies to those of you who took the time to write questions on cards that we couldn't get to in the time that we had. I don't think we are done with this project yet and the subject may be showing up in your briefing schedule soon. Thank you.