



**Open Enrollment 3  
The Commonwealth Fund  
Alliance for Health Reform  
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MARILYN SERAFINI: Okay, we are going to go ahead and get started. Welcome to today's briefing on the third open enrollment period, which is -- I'm sure everybody in the room knows, begins November 1<sup>st</sup>. We are going to be talking today about what to expect -- premiums, deductibles, other costs. Trends in the kinds of insurance products that will be offered, challenges in signing up the remaining uninsured population and a whole lot more. On behalf of our honorary co-chairmen, Senators Ben Cardin and Roy Blunt, I would like to welcome you and thank the Commonwealth Fund for being our partners in this event.

Moderating with me today is Sara Collins to my right and she is Vice President of the Health Care Coverage and Access Program at Commonwealth. I'm going to introduce the rest of our speakers. To my far left is Jon Gabel, Senior Fellow at NORC at the University of Chicago. Cori Uccello is an Actuary at the American Academy of Actuaries. And on the other side of Sara is Carrie Banahan, who comes to us all the way from Kentucky. She is responsible for the implementation and operation of the Kentucky exchange. To my far right, Mila Kofman, who had a little shorter commute. She is the Executive Director of the DC Exchange.

If you are watching us live today on CSPAN II, we welcome you and encourage you to tweet your questions to us. We will try to get them to our speakers to answer today. You can use the hashtag OE3. And you can also -- we will be live tweeting today, so we welcome you of course to live tweet with us. Again, the hashtag is OE3.

So I am going to turn it over now to Sara Collins with the Commonwealth Fund.

SARA COLLINS: Thank you, Marilyn, and on behalf of the Commonwealth Fund, I want to thank the Alliance. I thank the panelists for coming today and also to extend a warm welcome to the audience this afternoon. In looking ahead to the 2016 open enrollment period an estimated 29 million people remain uninsured. HHS estimates that about 10.5 million uninsured people are eligible for coverage through the marketplaces. In addition, about nine million people currently have coverage through the marketplaces and most, if not all, are likely going to want to re-enroll.

To gain some insights into what both current and perspective enrollees might be thinking about as they consider their options this year, I'm going to share some recent findings from the Commonwealth Fund's Affordable Care Act tracking survey, which we fielded at the end of the 2015 open enrollment period in the spring. I'm going to focus in particular on the issue of affordability and I will highlight data about the costs that people faced, by people who are currently enrolled in the plans and how they compare to costs in employer based plans. I will also look at how affordability factored into people's decisions about health plans when they shopped in the marketplaces last year.

In our analysis of the survey data, we found that premium costs for people with marketplace plans are comparable to those with employer plans among low and moderate

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income adults. Few people in marketplace plans said it was easy to afford their premiums, compared to those in employer plans, although differences were narrow among people with low and moderate incomes. With regard to deductibles, people in marketplace plans had higher deductibles on average compared to those in employer plans, but again, differences were narrow among adults with low and moderate incomes. Among marketplace enrollees, premium costs were the most important factor in their choice of a plan. And affordability was the top reason given by adults who shopped in the marketplaces but didn't end up enrolling in a plan. About 60% of adults with health plans that they purchased through the marketplaces, paid about \$125 a month or nothing for single policies. A similar percentage of people enrolled in employer plans reported they had paid that much. The similarity is due to the fact that most marketplace enrollees were eligible for a subsidy and didn't pay the full premium. Likewise, most employers pay part of their employee's premiums. The effect of the subsidies was most pronounced for people earning less than 250% of the poverty level. The people with higher incomes in marketplace plans paid more and more than people in employer plans. This is because the amount of the premium subsidy in marketplace plans phases out at high incomes, which means that people pay increasing amounts of the premium as income rises.

Overall, adults with marketplace plans consider their health insurance to be less affordable than people who have employer coverage, but differences in perceptions of affordability between adults and marketplace and employer plans were wider among high income adults than they were among lower income adults. People in marketplace plans on average reported higher deductibles than those in employer plans. Forty-three percent of adults in marketplace plans had per person deductibles of \$1,000 or more, compared to 34% of adults in employer plans. Differences in deductibles between those in marketplace plans and employer plans were wider among higher income adults than they were among lower income adults. This is likely because people with incomes under 250% of poverty who enroll in silver level plans in the marketplaces are eligible for cost sharing reduction subsidies that lower their deductibles, co-pays, and out of pocket limits.

In the most recent open enrollment period, premium costs on average mattered more to people when they were choosing a plan than either the deductible or whether their doctor was in the plan's network. Consistent with this finding, we found that more than half of marketplace enrollees, who had the option, chose a plan with a limited or narrow network of providers in exchange for a lower premium. Among people who visited the marketplaces, but didn't enroll in a plan, affordability was a key factor in their decision to walk away. Fifty-seven percent of adults, who visited the marketplaces but did not enroll, said that they could not find a plan they could afford. Looking a little more closely at this group of adults who told us they didn't enroll because they couldn't afford a plan, and also excluding people who gained coverage elsewhere, 26% were living in a state that had an expanded Medicaid and had incomes under 100% of poverty, which meant that they weren't eligible for the premium subsidies. More than half of those who couldn't find an affordable plan had incomes in the range that made them eligible for the subsidies. People who shopped in the marketplaces but did not enroll, had greater

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difficulty comparing features of health plans like premiums and out of pocket costs, compared to people who did enroll. Fifty percent said it was difficult to compare the premiums of different plans and 60% of those who didn't enroll had said it was difficult to compare plans by what their potential out-of-pocket costs might be. Receiving personal assistance appears to make a difference in whether people enroll. When we control for demographic differences, we found that 78% of adults who said they had received some kind of assistance, ended up enrolling in a marketplace plan or Medicaid. In contrast, only 56% of those who did not receive assistance, enrolled.

Just to recap the major findings of the analysis, the Affordable Care Act's subsidies have been effective in making premiums for marketplace plans similar to those in employer plans. The people in marketplace plans have high deductibles. Cost was the most important factor when people were considering health plans and it's the primary reason why many adults didn't enroll. The findings suggest that many people who shop for insurance, may not have the information they needed to help them buy coverage and many had difficulty comparing basic features of plans. Personal assistance does appear to help people enroll, but the lack of the Medicaid expansion in 20 states is clearly an insurmountable barrier for the poorest residents in those states. I will stop there and look forward to your questions.

MARILYN SERAFINI: Great. So if you are in the room with us, you have the results of these tracking surveys that Sara is discussing in your folder on the left side. If you are not in the room with us, you can still access these materials on our website -- [www.allhealth.org](http://www.allhealth.org) and I will turn it over now to Jon and let me just point out, for those of you standing, there are seats on the other side of the room.

JON GABEL: Thank you, Marilyn. I also would like to thank Sara and the Commonwealth Fund for making this work possible. I also would like to thank Ed Howard for his many years of service, bringing the work of the research community to the policy community.

This is a history of employer based health insurance since 1988. I show it to provide context for the historic record. Now, you may be asking right now, why are you showing employer based insurance? Why not individual insurance? And the answer is simple; because we are incapable of showing that record for individual insurance. But I want to emphasize three points. Number one; there is a history of volatility. Take 1989, premiums increased 18% that year. Secondly, premiums almost always outpace increases in worker's wages and the overall consumer price index. So now let's turn to results for exchanges. This is early information. Very early information. It is limited to five Northeastern states; most of them are very small states. It is also, why these five states? Because these are the states which have posted all the information so far on their websites. And when I say "all that information", I'm talking to cost sharing information in addition to premiums. So, currently, on these five states, we note that the average increase is 4.9% and the median is 2.1%. Now, I would also add that McKinsey says that

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the number of carriers who are coming into the marketplace in this current year will be up and it looks like it's up at least 10% for last year and that may have a dampening effect on premium increases. If we look at the benchmark plan - and the benchmark plan is so important because it is the basis for what the federal government will pay and also the basis for what enrollees will pay. We see the average increase is 6.7% and we see that the median is 5.8%. Kaiser Family Foundation recently posted increase in benchmark plans for 14 states and their numbers are lower. Their average is 4.4% for the benchmark plans.

So what is happening to cost sharing? We know from employer based health insurance, that deductibles are today about seven times as great as they were in the early 2000's. This increase in deductibles has held down premium increases. On the exchanges, we are not seeing much change. We are seeing on average a drop of about 5.9% and the median is 3.3%. Another important point of cost sharing is the out of pocket max, and here we are seeing the max increase 5.8%, but it's almost entirely due to Maryland. The median increase is 2.3%. So, let me summarize what these early returns are. How typical are these five states of the rest of the nation? It's really very difficult to say. What we do know is there are great differences from state to state. Last year, ten states had double digit increases and according to our data, the overall increase was zero percent. So the average -- this is what I dare say, based on early returns. Number one, average premium increases will be higher than last year. Benchmark plans show greater increases than the average increase for silver plan. The averages are going up, but it is not a catastrophe as some have reported. Instead, what we are seeing is something more in line with employer based health insurance, where the historic average is around 7%. Where we had been at 4% for about the last four years. Lastly, cost sharing remains stable. Thank you.

MARILYN SERAFINI: Thank you, Jon. We will move now to Cori Uccello with the American Academy of Actuaries.

CORI UCCELLO: Thanks Jon and thank you to the Alliance and Commonwealth Fund for inviting me to participate today.

So, Jon provided an overview of general premium trends and now I will give you some information on the drivers that may be underlying these trends. But before I get to that, just a quick reminder of the components of premiums. Claims make up the largest share of premiums and they reflect not only who has coverage, but also what their medical spending is. Other premium components include administrative costs and profit and of course laws and regulations can affect each of these components.

So I won't get into this slide in detail, but I just wanted to highlight some of the elements in the premium development process. So one thing that insurers have to do is to determine their plan designs and performs actuarial value testing to make sure their plans fall into one of those metal tiers. Another thing they have to do is examine their prior claims and enrollment experience, make necessary adjustments and then project that information forward to 2016. I will talk a bit about what those adjustments are in a

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minute. Insurers also have to negotiate with the providers to get their provider payment rates.

So I will talk about three major drivers of 2016 premium changes. The first of these is medical trend, which is the underlying growth in healthcare spending. Now, although medical spending has been relatively slow recently, compared to historical trends, prescription drug spending has been increasing fairly rapidly due to the introduction of specialty drugs. On average, 2016 premiums reflect a medical trend of about 6 to 8% and a prescription drug trend of about 10 to 12%. The second major driver of premium changes for 2016 is the scheduled reduction in the reinsurance program. So the reinsurance program subsidizes plans for their high cost enrollees. And it does so by off-setting some of those high cost claims. By off-setting claims, the reinsurance program then lowers premiums. But the reduction in the reinsurance program means that there will be a lower offset to claims and that lower off-set will in turn produce some upward pressure on premiums. And on average, the reduction in the reinsurance program could increase 2016 premiums by about 3 to 5%. Here is more detail on the reinsurance program parameters and how they are changing over time. The third major driver of premium changes, is how the expectations regarding the 2016 risk pool profile differ from those that underlie 2015 premiums. So as a reminder, when insurers put together their 2014 premiums, they didn't have a lot of information to go on in terms of who would enroll in coverage and what their health spending would be. In 2015, for that plan year, insurers had a little more information to go on. They just had the first few months of enrollment in 2014. Now, looking forward to 2016, insurers have a lot more information on their own experience for 2014 in terms of who enrolled in coverage and what their health spending is. They also have a few months worth of data from 2015. And as they have more information, they are able to change their assumptions regarding 2016 accordingly. And these changes in assumptions can either lead to higher or lower premiums.

So I noted earlier the need to adjust prior experience data when projecting that forward to 2016. So, in 2014, enrollees who were more likely to enroll early in January for coverage were those who would be more likely to have high healthcare needs and have high healthcare spending. Whereas those individuals who are healthy may have been more likely to delay coverage to later on in the open enrollment period. So that is one thing that needs to be adjusted for. Another adjustment might need to be made to reflect pent up demand. People who are newly insured in 2014, those who were uninsured in 2013, who then gained coverage in 2014, might experience a temporary spike in their spending based on pent up demand. They put off obtaining services until they got coverage. Now, some of that will be temporary, it's not expected to kind of be at that high level permanently. So not accounting for these two things, in terms of enrollment timing in 2014 and the pent-up demand -- if those aren't accounted for, this could result in an overestimate of 2016 claims.

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Insurers might also need to adjust the risk profile expectations if they think that the increase in the individual mandate penalty will lead more people to obtain coverage, especially among the healthy folks. An influx of people who have lower healthcare needs could actually put some more downward pressure on premiums.

So Jon's slides showed how premium changes can vary across states. One of the reasons for this is the transition policy, which allowed individuals to hold on to their non-ACA compliant coverage. Sometimes this is referred to as "grandmothered" plans. Many, but not all states adopted that transition policy. So, in states who did have the transition role policy, people who kept their old plans might have been those who were more healthy, because they might have gotten lower premiums and they didn't necessarily care about pre-existing condition exclusions or things like that. So they may have kept their old coverage, whereas people who had high healthcare needs, had a lot of pre-existing conditions and maybe previously had been rated higher because of some health conditions, they would be more likely to switch into the new ACA compliant coverage. So states that adopted that transition role might be seeing higher premium increases than plans in states that did not.

Finally, I just want to point out that we hear a lot of information that is coming out just in the past couple weeks, regarding premium changes. But I want to caution you that this is really just looking at averages either in the state as a whole or for particular insurers. But what a particular consumer faces in terms of his or her own premium change is likely going to differ from that average. The premium change that a consumer faces will reflect that consumer's particular plan. That consumer aged a year, so right away that is going to result in an increase in premium. Consumers can also have changes in their premium subsidy eligibility and they may have other changes as well. So those are things to keep in mind when comparing a consumer's individual premium change as opposed to the change in the market as a whole. So, thank you.

MARILYN SARFINI: Thank you, Cori. We will turn now to Carrie Banahan with the Kentucky Exchange.

CARRIE BANAHAN: Thank you for inviting me here today to talk about Kentucky's health benefit exchange Connect. As a state based exchange, Kentucky was able to develop an integrated eligibility system with online, real time determinations of eligibility for Medicaid and qualified health plans. This is why we were able to enroll over a half a million people into coverage for the first time. This resulted in a decrease of the uninsured from 14.3% to 8.5% based on some recent U.S. Census data. This was the largest decrease in the nation. Based on a Gallup Poll on the first half of 2015 for individuals under age 65, we decreased the rate of uninsured from 20.4% to 9% and that was the second largest decrease in the nation.

Prior to the Affordable Care Act, Kentucky basically had two insurance companies in the individual market. When we launched Connect in 2013, we had three insurers that

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offered products on our exchange. Due to our success in 2015, we had two additional insurers -- Care Source and Well Care and we are very excited to say for 2016, we are going to have eight insurance companies offering products. We have added Aetna, United Healthcare of Kentucky, and Baptist Health, which was formally known as Blue Grass Family Health. Without the Affordable Care Act, Kentuckians would not have these additional choices. And also I wanted to note that outside of the exchange in our regular commercial market, there is about two or three additional insurers that are going to offer products.

In Kentucky, we plan to have a passive renewal process. Individuals can remain enrolled in their current health plan and they don't have to do anything at all. October 1<sup>st</sup>, we issued a notice advising individuals that open enrollment was coming up; that we were going to have more insurers and more health plans on the exchange. Around October 21<sup>st</sup>, we planned to mail out our open enrollment packet. It will include the individual's premium amount for 2016, if they keep their coverage as well as their APTC amount. However, we are encouraging everyone to check out all of their options, because of the new insurers and the new plans that will be available. As part of the passive renewal process, we will be accessing the federal data service hub to verify income. If we are unable to verify income, we will issue an RFI, requesting documentation of their income. And as a new feature of our system that we implemented in 2015, if they don't provide proof of their income within the 90 day period, we will utilize what is on file with the IRS.

For 2016, we are implementing several system enhancements that will improve the consumer's shopping experience and assist the consumer in selecting the best qualified health plan options that meet their needs. During open enrollment II, we identified thousands of individuals who had purchased a gold or platinum plan and they were actually eligible for cost sharing reductions if they would have selected a silver plan. As a result, we sent out a letter to these individuals in December, notifying them of the availability of cost sharing reductions if they selected a silver plan. Since that time, we have developed system functionality in plan browsing as well as our regular shopping, where the silver plans will be displayed first, if you are eligible for cost sharing reductions. We also have special messaging strongly encouraging individuals to select a silver plan on our screens if they are eligible. At the request of the agent community and our in person assistors, we will be launching a tablet application in the individual market as well as for Medicaid enrollees and shop. The tablet application allows the user to enroll from start to finish. It also utilizes an intuitive and conversational process. Many Kentuckians are overwhelmed with the number of qualified health plan options to choose from and often times do not select the plan that best meets their needs. We have seen individuals buy platinum and a gold plans who hardly ever go to the doctor and we have seen people purchase a bronze plan who are heavy utilizers. As a result, for open enrollment III, we have developed a cost shopping tool to assist individuals in selecting a plan that best meets their needs. With this new cost shopping tool, individuals will enter their medical condition -- for instance, diabetes, asthma, COPD. They will also be asked

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to write their health status from poor to average to good. They will also include any health care providers that they are seeing -- their physicians, maybe the hospital that they go to. Frequency of physician visits will also be collected. And they will also enter any type of prescription drug medication that they are taking. We also ask them if there is a future medical need such as a hip replacement or a knee replacement. They would enter that information in the system as well. And based on all the information that is entered, the system will display the best value option for the applicant.

In 2014, we had a Connect retail store at the Fayette Mall, located in Lexington, Kentucky. It was highly successful. We had over 7,000 visitors. We took almost 6,000 applications. Local agents, in person assistors and state staff helped with the store. We will also be having a second store for this open enrollment in Louisville, Kentucky. For open enrollments 2016, we will be conducting statewide outreach and education and advertising through various channels-TV, radio, cable, billboards, print media, and social media. But we will also be targeting certain populations with tailored messages. In rural counties there are 18 that probably have a higher uninsured rate than we would like, so we are working with the University of Kentucky rural extension offices, hosting enrollment events with local agents and in person assistors. We are also running newspaper and radio advertising in those counties. We have targeted 32 counties in Kentucky with low dental health. We will be distributing 10,000 toothbrushes to dental clinics and schools in those areas and we are going to increase our efforts in marketing dental plans that are offered through Connect in those counties through increased advertising. Individuals on transitional and grandfather plans, who could obtain their coverage through Connect and receive a discount, are being targeted as well. We sent out mailers to households, we are running TV ads and commercials advising of discounts through Connect. That is the only place you can receive a subsidy is on the exchange. And we also have early renewal fact sheets available, instructing people how they can enroll through special enrollment. We are targeting the justice involved population; we are working with our statewide health re-entry coalition, comprised of correction personnel, federal, state and county. Advocates and connectors are also on this project as well. And we have actually produced a two to three minute video by former inmates, educating individuals about the importance of healthcare coverage once you are released from prison. And on how you can actually obtain that coverage by enrolling through Connect. We have allocated resources to the prisons and the jails for education and enrollment. And it's important for the justice involved population to continue a course of treatment or medications once they are released. These efforts will help ensure that they enroll in coverage as soon as possible and continue their treatment.

MARILYN SERAFINI: So we are going to turn the microphone over to Mila Kofman with the DC Exchange and I want to remind you that if you are following us on Twitter, that the Twitter handle is hashtag OE3. We welcome your questions that way or comments as well. After Mila finishes her presentation, we are going to turn to Q&A, so start getting your questions ready. You will be able to ask your questions both at -- we have two microphones set up in the room -- or you also have a green card in your packet

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on which you can write down questions and our staff will be circulating around the room and we will pick them up and bring them to us. Of course, again, if you are not in the room with us and you are following on CSPAN2, you can tweet your question at hashtag OE3. Mila?

MILA KOFMAN: Thank you so much. First of all, thank you to Dr. Collins and the Commonwealth Fund to continuing to do research and invest your research dollars into work that actually informs people on the ground. Very much appreciate your ongoing effort. Not only informs but influences our approach on the ground. I would like to thank Ed Howard for his many years of leadership. He, I'm sure, mentored many people in this room including myself, fresh out of law school, so his leadership and his contributions we will miss and maybe he will reconsider retirement.

So the Affordable Care Act is working in the District of Columbia, just like it's working in Kentucky and in most states. According to the census, our uninsured rate dropped by 20% and in the District of Columbia, as many of you know, we had a very low uninsured rate for many years. Through the years we have invested a whole lot in coverage expansion and expansion to medical care efforts. So my whole team was very proud when the census report came out, that it really did matter that we were on the ground finding the hard to reach population. We are not done yet and we won't stop yet until every single person, child, individual who lives in the District or works in the District has access to affordable, quality health coverage. Since October 1, 2013, when we opened for business, over 166,000 people have come through us, on the individual marketplace side; over 24,000 have come through us. On the Medicaid side, over 120,000 people were found eligible for Medicaid. We have no wrong door policy, which means you complete one application online and instantly you will get your Medicaid eligibility or eligibility for APTC. And on the small group's side, called CHOP, we have had over 21,000 people come through us, which includes certain members of Congress and designated staff. So, folks here from the Hill, who are my customers, thank you very much for being my customer.

On the individual side, we have a very healthy risk mix. You often hear that if you only insure older people with lots of claims, premiums will be very high. We tried very hard to make sure that people who are insured through us are young and older and everyone in-between. Our biggest by--age category insured pool is 26 to 34 year olds. It's 41% of our individual enrollment. We also have pretty diverse population choosing diverse levels of coverage. Although bronze is 29%, as you can see -- gold is 23% and 18% of our enrollees are in platinum plans and that is all on the private individual side. Small group side, that is not including Congress. The largest, most popular level of coverage for us is platinum, 48% of small groups are in platinum coverage, and 32% are in gold. We offer full employer and employee choice. That means the small business can choose a choice of carriers and a choice of products for his or her employees. In fact, about two thirds of our small businesses offer choice to their employees. Out of the 840 employers that we looked at, two thirds offer a choice of carriers by choosing metal-level and letting the

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employees choose which carrier they want to be enrolled in. Or, offering all products from the same carrier and that means employees can choose all levels from that carrier, from bronze to platinum.

Our role is to advocate for all of our customers and we advocate for the lowest possible premium rates. We have outside actuaries who review rate filings and provide actuarial analysis to the insurance regulators, arguing for the lowest possible premium rates through DC Health Link. We also advocate for our customers by empowering our customers to have access to all commercially available products from all carriers doing business in the District of Columbia. As we go into this open enrollment period, we are deploying many new tools for our customers that we didn't have before. We are thrilled that we are able to launch an all plan doctor directory. The English version is up on our website and Spanish version is available in beta on our website. We found that there has been a whole lot of bait and switch when it comes to doctors and relying on directories available from each carrier. They are not always up to date and when a customer makes a decision about the health plan based on his or her physician participating and then later to find out the physician is no longer participating, it may be too late to switch plans because open enrollment is done. So the all plan doctor directory is designed to help our customers have access to better information. We also, a couple of weeks ago, launched DC Health Link Plan Match and that is powered by the Washington Consumer Checkbook. It is very similar to what Carrie described for Kentucky. Our customer or potential customer -- you don't have to have an account with us -- can just go on DCHealthlink.com, put in your age, put in how many family members you want to cover. Put in your basic health status if you think you are in good health or excellent health or poor health. Any anticipated medical needs in the following year and any doctors that you are seeing. And the tool will give you all health plans ranked in order. It will give you your total out of pocket anticipated costs including the premium, the co-insurance deductibles and co-pays and it will give you that for an average year as well as a bad year. So we believe that kind of consumer empowerment tool will help our customers make better decisions. Next year, we are going to have 136 different group health plans and 26 different individual plans. And so when you have that many options, we know, and literature shows, that it's just overwhelming. And we heard that from our customers currently. We heard it from our broker partners, our navigators, and our assistors. So we are really excited about that new tool. Next year will be launching something similar for SHOP.

For 2016, we will also have new standardized plans. That means standardized benefits as well as out-of-pocket expenses. That will help our customers make more informed decisions, compare apples to apples. In our first year of operation, we had semi-standard products, meaning the benefits had to be the same in the essential health benefits benchmark. No substitutions, but co-pays and other out of pocket cost varied. Although that was helpful to our customers, it wasn't the complete tools that some needed to make good decisions. We, like Kentucky, experienced the same thing. Some folks chose platinum when they had very few opportunities to get medical care. They didn't need it,

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they were healthy. Others chose bronze and ended up paying more out of pocket than they should have, had they made a better decision.

Our products are very diverse. Everything from high deductible health plans that a comparable to zero deductible nationwide networks as well as regional networks from all major carriers. Our success is in large part due to our partners. We have strong relationships with the broker community. With assistors, navigators, other government agencies, elected officials, the faith-based community has been significant in our efforts and we find that when we have Sunday enrollment events, our numbers always go up in terms of number of completed applications and plan selection. We have strong partnership with all of the largest chambers in the District of Columbia and the National Association of Health Underwriters does our training for brokers and that has helped significantly with our broker community.

So we learned many lessons from the first two open enrollments. Last year, what was successful for us was having storefronts with regular hours. So a person anywhere in the city could just go to a storefront and know that someone will be there. Either a broker or a navigator or an assistor. So we are gonna continue doing that. We have one touch enrollment events where we bring together other government agencies like Medicaid brokers, navigators and assistors to help people enroll. One touch means, you don't let the person leave until they are fully taken care. If they need identity proofing, we are right there to do that. If they need health plan selections, brokers are right there to do that. So it's just one touch, you get everything done in one place. We also did many creative things like 24-hour enrollment events where for 24 hours we were somewhere in the city, mostly in clubs and bars and diners, Ben's Chili Bowl, doing enrollment events. And that helped us with some of the younger population we were trying to reach. On Super Bowl Sunday, if you ordered pizza from some of the restaurants we partnered with, you got a flyer about DC Health Link, reminding you to enroll. And that actually generated a bunch of enrollments. We saw an influx in our data when we looked to see if that worked.

We targeted specific populations who we know have a higher rate of uninsurance, so we did special events at Selma opening, we had Boys to Men barbershop days. On Valentines Day we stuff little DC Health Link -- if you love someone, make sure they have health insurance cards. They said better things than that, but you get the gist of it. And of course during all the college bowls and other events, we were out there doing enrollment and education. For this open enrollment we have even a bigger challenge. We think we got most of the uninsured and we are just looking for folks who are just hiding from us. We haven't found you. So our effort is going to focus on Each One Link One, so, because you care, be the link. Reach family, reach a friend, reach a neighbor. So it's going to be very much localized, more localized. We are also expanding our social networking community through social media and digital campaign efforts. We learned a whole lot that certain populations use certain types of communication, so for instance, the Greater Washington Hispanic Chamber is going to be doing a bunch of texting for us. Texting is a major way that the Latino community communicates. Not email, not

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Facebook, but texting. So we are going to be utilizing and expanding our social and digital campaign. And just one ad, Huan Cry, it's a local business. They make customized dress shirts for men only, maybe they will expand to women, but they are in our ad and they say, we are saving money and providing great coverage through DC Health Link. We have many local businesses -- cupcakes and several breweries. So if you are a beer drinker, you are probably getting it from one of our customers. Also, the other major population we have served are people who had job lock in the past, were afraid to leave their job without access to affordable, stable coverage, so many people in our ads are folks who are entrepreneurs who couldn't leave their jobs before, now have that freedom to pursue their dreams because they have stable coverage through us. With that, I will conclude. Thank you so much for the extra time.

MARILYN SERAFINI: Great, thank you, Mila. So we will now open up to take your questions and again, we have two microphones here and here. You can submit a question on a green card and you may tweet a question to hashtag OE3. And we already have a question here at the microphone. If you could please introduce yourself.

AUDIENCE MEMBER: [inaudible] Cori and Jon, do you have any idea to what degree the use of mental health and substance use services may have an impact on premiums? And Carrie and Mila, do you have any idea to what degree choice -- enrollee's choice of plans are influenced by the mental health services the plans are providing and is someone in each of your states monitoring mental health care?

JON GABEL: Well, I'm sorry; I don't have any data on that. I know in the trade literature, there have been a number of articles about the increased use of mental health services, but I can't give you any numbers and I can't cite any studies that I can recall that gave us numbers.

MARILYN SERAFINI: Anybody else?

CARRIE BANAHAN: We don't have any numbers, but I will tell you that we have a behavior health sub committee under our advisory board that meets and we have had conversations regarding mental health parity and to our knowledge -- and we have also engaged the Department of Insurance in those discussions, we are not really having any issues with mental health parity in Kentucky. But we do have a meeting scheduled on November 9<sup>th</sup> and we are bringing together all of the issuers and either their medical directors or their staff that are familiar with behavioral health as well as the Medicaid managed care organizations to have a fully discussion on mental health parity.

MILA KOFMAN: Thank you for your question. So, in January of 2013, one of our working groups was looking at mental health and substance abuse issues and early on, we decided that we weren't gonna allow day limits. So that is from the first day that was part of the requirement in the District. We, like Kentucky, are monitoring everything and one of our high priorities areas are our folks who have mental health, substance abuse needs.

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Often times and this is back to our state insurance regulator days, I can tell you that that particular segment of the population doesn't always call you when they need help. So it is extra important, if the local societies are hearing of issues, even though it's anecdotal, it will help us tremendously to monitor if there is a problem. So I encourage you to get in touch with us.

MARILYN SERAFINI: Okay, let's go to this microphone and then we will swing to this side.

AUDIENCE MEMBER: Thank you, John Gray, National Center for Policy Analysis. I'm just wondering about how enrollment in the exchange evolves over the years. It looks like in the first year there was a drop off -- high water mark at the end of open enrollment and then you lose a lot of people. It looks like the same thing is happening in 2015. Is that persistent and what explains that?

SARA COLLINS: I will take a stab at it and then maybe Carrie and Mila will want to jump in. So, people do move in and out of the marketplaces. People have always moved in and out of the individual insurance market. So people who may sign up in March or April or in this case, in January, may actually find another source of coverage halfway through the year and leave. What we don't know is the number of people who are leaving because of the plan itself, so I think that is a question, but this market has really been characterized by a lot of fluctuation historically.

CARRIE BANAHAN: You know, we have had some movement. We had a slight decrease based on some recent numbers issued by CMS, but that is pretty typically and you know, we try to track that as best we can.

MILA KOFMAN: Yeah, for us as well and actually in D.C., after open enrollment, we have high volume of people coming in through special enrollment periods, so after open enrollments are done, every month we have between 500 and 1,000 people coming in, which is significant for us. I can tell you anecdotally, people who end up losing their coverage, not because they have a job or move away, but because they missed paying their premium, they lost their source of income or their circumstance changed -- that is -- I'm seeing about 10 to 15 people a month and the reason I see them is because I review all of the SEP denials before the person is denied access to coverage. And so that is a growing concern for me, even though it's 10 or 15 a month, it tells me that affordability is still an issue and we may have to look at policy interventions to catch people when they have a bad period. We shouldn't force them to wait six or eight months to get back in through open enrollment.

AUDIENCE MEMBER: Rebecca Adams with CQ Roll Call. This is a question I hope a few of you can address. We recently learned that CMS has a 2.5 billion dollar shortfall in risk corridor payments and I'm wondering if you can look ahead and talk about how this might affect premiums going forward.

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CORI UCCELLO: So I don't think that it directly -- the request for risk corridor payments going out, exceeds dramatically the money coming in from the risk corridor program. Which suggests that premiums were understated. But the fact now that CMS have said that they are only going to be paying a portion of those requests should in itself have an effect on 2016 premiums. Because the information that insurers had to set their 2016 premiums, was kind of the same that they had when submitting their risk corridor requests. So that shouldn't have an effect on premiums. Where I think you will see more of an effect and a concern is on the solvency side, especially for those small and newer plans who expected to be getting some risk corridor payments and now they are receiving only a portion of those, that may be more of a concern that we need to look at more. The CMS statement -- that one page statement that they put out, just really had the top line information about how much was requested, how much they expect to receive. But I'm hoping in the future they will provide a little bit more information that we can understand a little better what is driving some of these numbers. Is the transition policy that I talked about -- is that driving some of this? So being able to examine those numbers by whether the plan was in a state that had the transition policy would be very helpful in better understanding these numbers. Remember in 2014, that transition policy occurred after 2014, premiums were already finalized. So I would expect in some states for that to be a significant driver of some of these risk corridor requests.

MARILYN SERAFINI: Cori, could you just take a half a step back and just explain what a risk corridor is and what the issue is? I know you got into some of that, but just take a half step back, very briefly.

CORI UCCELLO: I will take a full step back. So the ACA has three risk sharing provisions in it. There is risk adjustment, which shifts money between plans based on the relative risk profile of the plan. So, plans that enrolled high cost people were gonna be getting money from those plans that enrolled more healthy people. There is the reinsurance program, which I spoke about, which provides some subsidies to plans for their high cost enrollees. Then there are risk corridors. And the risk corridor provision was to -- in a sense acknowledging that in 2014 -- and this is a temporary program, like the reinsurance program, just is scheduled to run from 2014 to 2016, in the early years of this new program there was a lot of uncertainty, as I said, regarding who was going to enroll in coverage and what their health spending would be. So the government was going to mitigate some of that pricing risk by sharing some of the cost and some of the gains; if insurer's premiums were either too high or too low. So if premiums came out in the end to be too low relative to the claims that the plan experienced, the government would pay that plan to share in those losses. To offset some of those losses. If, on the other hand, the plan's premiums were actually high relative to what was actually experienced, the plan then would pay the government a share of those gains.

SARA COLLINS: I just wanted to also jump in and put the claims and context with the other claims in the reinsurance program and the risk adjustment program. So the claims

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are about 2.9 billion for the risk corridor program this year and they actually can be -- continued to be paid out in out years -- so 2016 and 2017 as the payments come into that program. But on the reinsurance side, nearly 8 billion dollars were paid out this year in claims for people that -- for companies that needed them. There were fewer claims that came in that were expected, so actually the dollars that came out were larger than they originally were going to be. Then also the risk adjustment transfers amounted to about 4.6 billion dollars. So the risk corridor program, though really important for some smaller insurers, was actually a smaller part of those risk adjustment programs.

We had a question on insurance consolidations and what in fact we might expect those to have -- or those proposed consolidations on premiums.

JON GABEL: Well, my research on both SHOPs and the individual exchanges indicates that as the number of the insurers in the state increases, you see a decline in premiums. Modest -- maybe 2% per carrier, but still, if there is lots of carriers, that can be pretty significant. So, I think its good news that we are going to see on the individual marketplaces, more carriers participating. Overall, the individual insurance market has always been a heavily concentrated market. When I say "always", I say, since about 2000. Last time I looked at it, in a typical state, the largest carrier had 55% of the market. So this is pre-ACA. So I would say, I don't look at consolidation based on my research. I don't look at it as something that will lower premiums. I think it's much more likely to raise premiums.

CORI UCCELLO: Just stepping back, we call that the largest component of premiums is claims. So that anything that helps lower claims can help put downward pressure on premiums. But there is still some uncertainty about the impact of mergers and that will depend in part on the particular market regarding both the level of insurer competition that exists in that market right now and also the relative balance of negotiating power between the insurers and providers and whether insurers can get increased power when they are negotiating their provider payment rates and also the enhanced ability to implement some alternative payment and delivery system reform. So I think there is some potential there, but I think it really is going to vary by market.

MILA KOFMAN: I would just quickly add -- in some states, before the ACA, the largest carrier was essentially a monopoly with 90% or more of the market. And since the ACA, certainly in many places, we have seen market share shrink, which is good, if you believe that smaller market share increases opportunities for other carriers to come in and compete effectively. That has happened since the ACA. I agree, it really depends on where you are and some cases where you still have a market that is 90% monopoly; it is really hard to enter that market because of the investment it takes, by the insurers. So in some cases, it could be very helpful to get new players in through consolidation; in other states it's not going to be helpful.



SARA COLLINS: I also want to remind people of Carrie Banahan's really striking slide of what is happening in Kentucky, just the small number of plans and then that just --

CARRIE BANAHAN: Right, I mean, prior to the ACA, we basically had two insurers, but the dominant insurer had 80% of the individual market, so post ACA, we have new carriers coming in the market, prices are more competitive. So it's been a tremendous benefit to Kentuckians.

MARILYN SERAFINI: Okay, let's take a question at the microphone.

AUDIENCE MEMBER: So, Kyle Redfield from the Congressional Budget Office. So this is primarily for Carrie, but as you noted, there is a pretty rapid expansion of the number of insurers available, so I was just wondering if you have any sense of what was driving that interest and then if there was any impact on premiums as a result. Separately, but related, for Mila, I'm not an actuary, but is the pool size in DC any issue for insurers? Does that drive their interest at all?

CARRIE BANAHAN: So, I think the reason that we have more carriers entering the Kentucky market is the success of Connect. So we are extremely excited about that and you know, those coming in, some of them are offering very, very competitive prices as well. So, you know --

MILA KOFMAN: We are not actuaries either. But we speak the talk.

CARRIE BANAHAN: I have one more thing to add too. One thing to note too, that I guess some of the carriers that have come into the market have offered Medicare Managed Care plans. So you know, they see this as positioning themselves for those people maybe who were terminated from Medicaid due to increased income -- that, you know, they will stay with Anthem or they will stay with Humana or they will stay with Aetna. So, I think probably the Medicaid Managed Care organization is just trying to position themselves with the insurer as well.

MILA KOFMAN: So you had a two part question for me. The first one on price competition. After we were created, there was legislation passed in DC to make us the sole distribution channel. That means everything is sold through us. So when you get that kind of private market environment where their full transparencies on one website, all of our customers see prices and coverage options. That created real price competition in the first year. One carrier re-filed their proposed rates, twice lowering them once they saw what their competitors filed. Another carrier re-filed once, lowering their rates and a third carrier re-filed, lowering their proposed rates and added new products. So actually, that kind of price transparency has created price competition in DC. In terms of being a small state and those of us who live in DC, we would like to be officially a state -- I will just make plug. It is a small market and if you are not in the market, it's a huge investment for the carrier to come in. We try to take policy steps to make it as easy as possible, but when

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you have only 15 to 20,000 covered lives in the individual market, you are not going to have lots of carriers competing for the 5,000 they may get. On the group side, we have four major carriers and I say four, it's really -- they are legally organized in a way where United has two or three different companies. Aetna has several. So all of the carriers on the group side have various legal entities they do business with. It's a larger market and so there is more incentive for carriers to come in for a piece of that market.

JON GABEL: Let me just add that according to McKinsey, of the new entrance in 2016, they are largely provider based plans and Medicaid Managed Care plans.

AUDIENCE MEMBER: Hi, Bernadette Fernandez with Congressional Research Service. My question is about data that Sara presented, but I would like to hear from the entire panel, if applicable. The question I had is about exhibit two, where you found lower to middle income exchange enrollees essentially experiencing comparable premiums to employer coverage. I wonder how much of that has informed your exhibit six, where number of enrollees chose narrow network plans. To the extent that -- I mean, those are not exactly comparable populations, but to the extent that the kind of network feeds into the decision making process. I would be curious to hear, maybe from the exchanges, if you know from your enrollees how much that played into their decision and then why that might look a little more comparable to employer.

SARA COLLINS: Just a brief perspective on that. We really think that that equalization and that income range is pretty much driven by the subsidies, so that people are just getting really large subsidies in that income range to make - it makes what they are paying for premiums pretty comparable to what people are paying in employer based plans, which are also heavily subsidized. But I think the question about the decisions people are making about their premiums relative to deductibles and putting so much emphasis on the price of their plan, choosing more limited networks, is a good one and maybe you want to -- Mila and Carrie want to mention.

CARRIE BANAHAN: I mean, in Kentucky, price is the primary factor in selecting a plan. At the expense of selecting narrower networks, we have a couple of our insurers that have very restricted networks and we have seen an increase in enrollment in those plans.

MARILYN SERAFINI: Are we seeing an increase in the offerings of those kinds of plans? What other kinds of new products might we see going into the next cycle? We heard more about more sharing of risk and provider sponsored plans coming up. What are we seeing in those kinds of trends?

MILA KOFMAN: So, to answer the first question, premiums are the biggest drivers for decision making for our customers. On the networks, until recently, we really didn't have narrow -- what you would call narrow networks. Most of the networks that we offered were nationwide or pretty regional, which covered Virginia, Maryland, parts of

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Pennsylvania, West Virginia, parts of Delaware. DC consumers are used to the broader networks. We do have a few new products on the group side for 2016, which have more restricted networks and it remains to be seen whether customers make their decisions based on those networks. I do think that the new decision support tool that I talked about earlier, powered by consumer checkbook, will help consumers make better decisions not just looking at the premium, but looking at the out-of-pocket liability the consumer may have.

JON GABEL: I would just add, last year employer based health insurance and exchanges are going in the opposite directions with regard to plan type. Employer based insurance, high deductible health plans are on the rise. HMOs and Point of Service are on the decline. In the exchanges, the HMOs and EPOs, exclusive provider organizations, seem to be on the rise and they tend to have lower premiums than other plans.

MARILYN SERAFINI: Okay and related to this question of affordability being a huge factor in enrollment decisions, we have a question about the introduction of health plan quality ratings in 2017 and what effect those quality ratings may have on consumer's enrollment decisions.

CARRIE BANAHAN: That is just another tool, I think, that consumers will have in making informed decisions about which plan to select. So, we have already had -- well we have stars on our shopping tools, but they are blank. Once we do receive the information from I guess, the federal government, on populating those stars, I think that will be very helpful to consumers.

JON GABEL: I just would add, I'm working on a project for CMS where we are working on how to present the information and as I have learned of the history of consumer information and the use of it, it does not make you upbeat. Historically consumers have not used the information. I mean, we know more, we know you have to keep it very simple, you have to have stars for example and you can't provide too much information.

SARA COLLINS: So another question: With new carriers coming into markets and adding plans, what is being done to encourage people to re-shop for better deals? And I will just add a data point onto that. I was just looking at Kaiser's analysis of the premium changes in ten states for 2016 and all but one of those plans -- those are silver level benchmark plans and all but one will be the same plan next year. So if people are receiving premium tax credits, the plan that they are in will no longer be the lowest cost silver plan. So what do we expect consumers to do this year when they are confronted with that choice too?

CARRIE BANAHAN: So in Kentucky, as part of our renewal process, we send out the enrollment packets and we highly encourage our enrollees to shop and check out all of their options because of the new insurers and new plans. We did the same thing last year.

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We also have TV ads statewide, radio ads encouraging people to purchase their coverage through our exchange; because it's the only place in town you can receive discounts or APTC.

MILA KOFMAN: So, last year we did what is called "passively renew people", meaning you are just automatically renewed unless you shop and select something else. About -- over 95% of our individual marketplace enrollees stayed with what they had in year one. The ones who made a choice to shop, the reasons or the outcomes varied. Sometimes they changed metal levels, sometimes they changed carrier. Sometimes they stayed with the same carrier, same metal level, but just a different plan. And there was no pattern to what was driving those. We were pretty agnostic about encouraging or not, shopping. We sent lots of information last year, essentially saying, if you are happy with what you have, you don't have to do anything. If you want to shop for a better deal or something different, please come online and shop. So what we found, I think is pretty typical of most large employers, very few people who work for large employers that have open seasons, actually make a switch. This year we are going to be more aggressive about encouraging people to shop for better deals, even though our rates are stable and the increases aren't as huge as you have in other areas. In fact, there are some decreases, as Jon noted earlier. It depends on what plan you are in. You might be facing a steeper increase and you will get a lot more value out of shopping around. We have improved our website based on feedback from our customers to make it easier to shop around. Even if you don't want to use the consumer checkbook tool, we have new search features to make it a lot easier and quicker to shop.

JON GABEL: Just research. According to Peter Cunningham, about 10% of large employers switch. On the exchanges, JD Power says 22% switch. I think the numbers are higher from HHS, I think they might be as high as 30% or so. I mean, this is a modest to low income population and they watch their dollars a lot more, so I would expect to see more switching.

MARILYN SERAFINI: There is a question, Carrie, about your decision support tool. This person asks, if you can't ask medical questions, how does the tool determine the best plan based on co-morbidities?

CARRIE BANAHAN: So this is just a screening tool. Basically it's just to capture data, to help the consumer select the best plan. It's not required. When you are in shopping or you are browsing for plans, we ask the question, would you like to check out your options and find a value based plan? If they say, no, I'm fine, I want to continue shopping -- it's not a requirement that they use this tool. And all of the information that we capture on their health condition or their health, it's immediately, I guess, terminated once they exit the program. We don't save any information at all.

MILA KOFMAN: And the economists in the room will know this better than I do, but there is well documented literature that people are pretty good at self-identifying their

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medical needs just by answering one question. And that is, are you in good health, fair health, poor health, excellent health. And there is a huge probability on getting your medical expenses, the severity of them, in the next year, correct. So the tool that we use, that is the principle question and it relies on that literature and that experience of people being able to self-identify their needs. It is certainly an estimator, it's not designed to predict in any way, but it's much better than what we have now, where people are just looking at deductibles and are not considering all the other out-of-pocket expenses, where if they just bought gold, they might be better off financially than buying bronze, depending on their needs.

SARA COLLINS: I just want to ask a follow-up question to that on the deductible. We see a lot of confusion on our surveys about what people understand is included in their deductible and what is excluded. For example, preventative care costs don't count toward your deductible; you get preventive care screenings for free. But we are seeing in our surveys that a lot of people aren't getting preventive care tests who have high deductible plans. So the lack of understanding about what is excluded from a deductible. A lot of plans also exclude certain out patient visits. What should consumers be thinking about when they look at a plan with a high deductible or any deductible? What should they be asking themselves in terms of the services that they might have to pay for/

CARRIE BANAHAN: So, in Kentucky, depending upon this plan you select, in some situations you might have two deductibles. You will have a medical deductible and a pharmacy deductible and that has been confusing for some of our consumers, but as one of our shopping tools, you know, if you view all the information out there, it is evident that there are two deductibles. Another confusion factor, I guess, is the pediatric dental. Oftentimes the insurers will include that just in one deductible.

AUDIENCE MEMBER: Hi, I'm Russ [name] with LNM Policy Research. I had a question about your consumer interface. Carrie and Mila -- Carrie, I heard you say that your default setting for your display of plans is going to be -- you will show silver plans first? I know that you have these decision tools, you could also potentially set a default setting for out-of-pocket liability and other things and there is some research showing that that does help people make decisions that end up saving costs. Are you considering changing your default settings and how did you go about that process? What research backed up your decision?

CARRIE BANAHAN: So there were several ways in Kentucky that consumers can filter on plans. It's only if you are eligible for cost sharing reductions. If your income is below 250% of the federal poverty level, we will display the silver plans first. But there is also some other filters where if you just want to look at bronze plans, you can filter on bronze plans. If you want to filter on the amount of your deductible, all the plans with, let's say, a 2,000 deductible would displayed. If you want to filter on premium amount, you can do that. So there is other functionality that they can filter on.

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MILA KOFMAN: So we have a variety of search tools as well. The DC Health Link Plan Match, the Checkbook tool, is just one and they do filter by your lowest predicted out-of-pocket liability, which includes everything. Not just premiums. On the regular search engine, we are deploying new search tools, so in the first two years, we had very similar tools to Kentucky. You can filter by HMO, deductible, a carrier, a metal level. Now you will be able to do more sophisticated searches and you will be able to see a summary of features comparing the plans. So you can look at the prescription drug benefit or how hospitalization is covered. It used to be that you had to open up a PDF file to do that kind of plan comparison. Since this is our first year for 2016 offerings, standardized products, meaning same deductibles, co-insurance, co-pays, and same benefits. Those will appear first in our standard search engine. We want to encourage our customers to really compare apples to apples and it remains to be seen whether that produces better outcomes for our customers in terms of what they select. We will know next year.

MARILYN SARAFINI: So we have a question from Twitter about the CBO's 2016 ACA enrollment projections at 22 million and the question is: How realistic is that and what is the better national goal?

SARA COLLINS: I will just jump in with some data based on our surveys, so these are just projections of people who remain uninsured. Out of about 25 million uninsured adults -- so these are 19 to 64 year olds, about 6.5 million or about 26% are under 100% of poverty and living in Medicaid non-expansion states. So that is a group that will likely remain uninsured this year. We are showing about 10 million people who are eligible for marketplace plans, so they have incomes in the range that make them eligible for the marketplaces -- it's similar to the number that HHS is expecting, who are eligible for marketplace enrollment. About 5.5 million are eligible for Medicaid in expansion states. So that is sort of how the breakdown goes. These do not adjust for immigration status. One major barrier that we are seeing in our surveys is that a lot of people who are eligible aren't aware of it. So clearly the outreach efforts that Carrie and Mila are talking about will really be addressed towards that. Then also this issue of people attempting to enroll and then going away, but maybe both of you want to jump in on that?

MILA KOFMAN: Yeah, for us from day one, we have defined our success by the number of uninsured people we can get coverage for. Whether it's public insurance like Medicaid or private full pay or with premium reductions. It is -- as I mentioned earlier, the District of Columbia has always had a very low uninsured rate, so for us, it's been using creative partnerships, creative outreach, to reach the uninsured. We think in the first couple of years we have done a really good job and we are going to become even more -- what they call hyper local, which is almost door to door type of initiative to find folks who remain uninsured. For us, we have -- and this is anecdotal -- I don't have data to share with you -- but one of the populations we are still missing are folks who get APTC eligibility, but still don't enroll in a health plan because it's still too expensive. They just can't afford it. We know that from the first open enrollment, when we actually contacted

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every single person who qualified for APTC, but didn't make a health plan selection and we asked and a significant portion said they still couldn't afford it. So for us to really reach all of the uninsured who want to be insured, we may need policy interventions either local or federal at some point in time, to make private coverage even more affordable.

**CARRIE BANAHAN:** As part of our passive renewal process, we have thousands of people that for whatever reason, they checked out Connect in November of last year and they were eligible for some type of subsidy, but they never enrolled. So what we are going to do is send those individuals a letter saying, open enrollments coming again, November 1<sup>st</sup>. You are eligible for a subsidy based on the information that was previously reported. Please come to Connect and check out your options. We are also, through TV ads and radio commercials, trying to target those folks that are eligible for a subsidy and don't realize it. One of our TV commercials says, family of four, up to \$95,000 a year, qualifies for some type of subsidy. So we are doing what we can. But like DC, we have made significant progress in reducing the number of uninsured in Kentucky in the past two years.

**MARILYN SERAFINI:** We have time for one more question and we will take it -- we had a couple questions from Twitter that have to do with prescription drugs. First, are qualified health plans increasing out-of-pocket costs for prescription drugs? If yes, is that a problem? And this is a separate question: Why are prescription drugs not considered prevention to be eligible for zero cost sharing?

**CORI UCCELLO:** So in terms of the preventive care that has to be covered prior to the deductible, I think that is in the law how that is defined. So I think that is the reason there. I can't remember if it's IOM or what, but the preventive services are listed. They are defined. So in terms of prescription drug cautionary requirements, out-of-pocket spending for drugs, as you recall, in my presentation, I noted that prescription drug spending is increasing a lot faster than medical spending. So I think insurers are going to be looking at ways to better manage those costs. And they have a couple of different ways they can do that. One is to change the cost sharing requirements for particular prescription drug tiers and they can also change where on the tiers particular drugs go. And they can also -- and changing the formularies. So they have different ways to do that. I can't make any specific comments on what plans are actually doing, but I think those are the things to look at, to better understand what is going on.

**JON GAMBEL:** What I can say is that in 2015, employer based insurance and marketplace insurance were very different when it came to applying the deductible to prescription drug benefits. Employer based insurance, less than 10% apply. Market place insurance, I think the majority of plans, maybe as much as 70%, you had to meet a deductible for some of the tiers at least, before you receive prescription drug benefits.

MILA KOFMAN: Post ACA, all of you know, there is a requirement you can't discriminate in benefits and we jointly, with sister agencies including the insurance regulators and folks from the Health Department, looked at the tiering on the formulary and with the help of outside researchers, there was a pattern that evolved that certain HIV drugs were classified in the highest out-of-pocket tiers and based on that, we thought it was discriminatory benefit design. In that case, the carrier saw the problem and voluntarily fixed it, moving certain HIV drugs to lower cost tiers so there wouldn't be that kind of discrimination against people who need HIV medication. There are opportunities to look at how formularies are structured for discrimination patterns, but whoever mentioned that there would have to be a law change to change how things are considered -- whether or not they are considered preventive. That would require a law change.

MARILYN SERAFINI: Thank you. We have run out of time. If you would kindly take one moment to fill out the blue evaluation form in your packet, we would be grateful. Also, we had a question earlier about consolidation and I wanted to mention that we will be back to you, the Alliance and the Commonwealth together to bring you another briefing on the subject of consolidation on November 20<sup>th</sup>, so please watch your inboxes for that. And please join me in thanking our panel for a very interesting conversation today.

[Applause]