Boomers Come of Age: Covering Early Retirees and Other 50-64 Year-Olds
Alliance for Health Reform
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ED HOWARD: Good afternoon. My name is Ed Howard. I'm with the Alliance for Health Reform. Thank you for coming. I want to welcome you on behalf of Senator Rockefeller and our Board of Directors to this program to take a closer look at the ways that the patient protection and Affordable Care Act – we'll call it the ACA for this purpose this afternoon – the way that the ACA affects Americans age 50 to 64. I could fall into that age group, but it's too late [laughter].

In general, the older you get the less chance there is that you'll be uninsured in this country. But if you do lose your coverage, you're a lot more likely to have trouble replacing it because you'll probably have a chronic condition or two to make it expensive or maybe even impossible to get coverage on your own and the increase in the share of folks in that age group who lost coverage during 2009 as recorded in the Census Bureau's latest report, was higher than for any other group.

Of course some of the general changes in the insurance rules, an end to preexisting condition, bans for example subsidies for lower income people, are going to be helpful to some older adults as well. Some provisions are even more targeted to them, most notably the federal reinsurance of early

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retiree benefits. Now our program today is going to spotlight some of those latter provisions.

We're pleased to have as a partner in today's program AARP, which is to quote their website, "a nonprofit, nonpartisan membership organization that helps people 50 and over improve the quality of their lives". You'll be hearing from AARP's John Rother in a few minutes. John, is that an accurate characterization of the mission?

JOHN ROTHER: Correct.

ED HOWARD: We have a couple of logistical items if you don't mind before we get to our program. Important information in your packets including the PowerPoint slides of our speakers and biographical information, more generous and more lengthy that I'm going to have a chance to give them.

Lots of other background info is available on our website, AllHealth.org including the PowerPoint presentations. There'll be a webcast available sometime tomorrow and a podcast at kff.org which is a service of the Kaiser Family Foundation and in a few days you'll be able to see a transcript of this briefing on our website at AllHealth.org.

Just a reminder, those of you who are regulars probably have heard me say this once or twice before, but there are blue evaluation forms that we'd love to have you fill out before you leave and green question cards that you can use to get a

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response from our panel when we get to the Q&A part of the program. We are missing Joe Antos on this roster but we know he is in the area and we hope he's going to join us soon and we'll go forward with that in mind.

So, first up in our program today is Sara Collins. She is the vice president for affordable health insurance at The Commonwealth Fund. That's good to have somebody in charge of affordable health insurance [laughter]. She's also head of their national insurance program. She's the lead author of a new paper that's directly on point for our briefing today. It's in your packets.

It lays out the impact that the Affordable Care Act is expected to have on the older adults who are our focus today. Sara, thanks for coming down and we'll look forward to hearing from you. There you go.

SARA COLLINS: Thank you, Ed. And thank you very much the Alliance for Health Reform and also AARP for inviting me to join you on this panel today. There are about 57 million men and women who are between the ages of 50 and 64 in the United States. In 2009, 8.6 million of them were uninsured. This was an increase of more than a million over 2008 and three million more than were uninsured in 2000.

In addition, there are nearly 10 million older adults who have health insurance who have such high out of pocket

costs that they are effectively underinsured. Losses in coverage have been driven by record high unemployment in this age group and also long periods of duration without jobs so that even people who had COBRA benefits maybe a few months ago are now nearing the end of those benefits.

Losing employer benefits can be really devastating to people in this age group. As Ed mentioned, many of them have chronic health conditions. An estimated 35 million older adults have at least one chronic health problem such as diabetes or heart disease. Both high rates of chronic health problems and actually the mere fact of being older and being at risk for those conditions makes it really difficult for people in this age group to buy health insurance on the individual insurance market where people are underwritten on the basis of their health and their age in most states.

We found in The Commonwealth Fund Biannual Health Insurance Survey, that of those older adults who tried to buy a plan in the individual insurance market over a three year period, 61-percent said it was difficult or impossible to find an affordable plan and nearly two in five were turned down, charged a higher price or had a preexisting condition excluded from their coverage.

Poor coverage is linked to both poor access and also financial problems. About three quarters of uninsured older

adults in our Commonwealth Fund Survey reported that they had skipped or delayed care or not filled a prescription because of cost. About 70-percent reported carrying medical debt or other problems paying medical bills.

These financial barriers to getting needed care have long run financial implications, both for people in this age but also for the health system in general. Research by Michael McWilliams and colleagues at Harvard University found that among adults with chronic conditions, previously uninsured adults who enrolled Medicare at age 65 had significantly higher total costs, more doctor visits, hospitalizations than did previously insured adults and that different actually persisted through age 72.

The Affordable Care Act will substantially improve the health insurance coverage in this age group. Most older adults who are uninsured and underinsured will gain access to comprehensive health insurance beginning in 2014, but the early provisions, many of which went into effect this year, will provide important transitional relief for many people in this age group.

Some of those include, and Ed mentioned a few of them, pre-existing condition insurance plans. These are now enrolling people in 50 states and the District of Columbia who have health problems and have been uninsured for six months.

And we're going to hear a lot more about those this afternoon from Richard Popper. Insurers and employers are banned from rescinding coverage and placing lifetime limits on benefits and they must phase out annual limits over the next three years.

Employers and insurance carriers are required to cover recommended preventive services without cost sharing, including colorectal cancer screening, mammograms. The Early Retiree Reinsurance Program is also in full swing and we're also going to hear a lot more about that this afternoon.

And finally, the Affordable Care Act establishes a national voluntary program for long term care insurance. The law will have its biggest effect starting in 2014, an expansion of Medicaid up to everyone earning up to 133-percent of poverty. This is about $29,000 for a family of four. New state insurance exchanges with premium and cost sharing tax credits premiums will be capped from 2 to 9.5-percent of income for people earning up to 400-percent of poverty which is about $88,000 for a family of four.

Insurers selling plans in the exchanges and the individual and the small group markets must offer a federally determined essential benefit package that's similar to those in employer plans. There will be four different levels of benefits, bronze, silver, gold and platinum, but they'll vary only by cost sharing. Insurance carriers will be restricted

from denying coverage or charging higher premiums on the basis of health or age.

These limits are particularly important to this age group. By 2014, all US citizens will have access to affordable health insurance, much of which will be subsidized. The expansion of Medicaid and the premium tax credits for private insurance will have the largest effect on reducing the number of uninsured. About 38-percent of currently uninsured older adults, or about 3.3 million, will become eligible for Medicaid in 2014.

More than 40-percent of those uninsured, or 3.5 million, will become eligible for the premium tax credits through the insurance exchanges. About 17-percent, or 1.4 million, have higher incomes, but they could also buy coverage through the exchange or the individual insurance market. They're no longer rated on the basis of their health and restrictions on how much their premiums can vary based on their age.

About 14-percent of older adults who are uninsured nationally, the rate is higher than that in about 16 states with the highest rates in Texas, Florida and New Mexico. Take Texas, for example, about 23-percent of older adults are uninsured. Adults without children are not eligible for Medicaid currently in Texas and this is the case in the

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majority of states. Parents are eligible in Texas only if they earn 27-percent of poverty, which is about $6,000 annually for a family of four.

So Texas adults in this age group stand to make considerable gains in coverage starting in 2014. To give you a sense of where things are headed in states as this law is implemented over the next few years, the uninsured rate among older adults in Massachusetts which has implemented a law really similar to the Affordable Care Act is the lowest rate in the country at 4.1-percent. So I think I'll stop there and I'll look forward to your questions. Thank you.

ED HOWARD: Terrific. Thank you, Sara. Next, we do turn to Richard Popper, who is the director of insurance programs for the Office of Consumer Information and Insurance Oversight, OCIIO, which I understand may or may not have that name into the future indefinitely, which is within the Department of Health and Human Services.

That means that he has responsibility for many of the programs Sara described, the Early Retiree Reinsurance Program, the temporary network of state level high risk pools federally funded through the ACA to be most notable.

Before coming to HHS, Mr. Popper ran the Maryland high risk pool known as the Maryland Health Insurance Plan which in fact is one of the country's largest high risk pools that

preexisted before the ACA. Richard, thank you very much for being part of this discussion and we look forward to it.

RICHARD POPPER: Okay. Thank you, Ed and thanks – am I on air? Okay. Thank you, Ed, and thanks for inviting us to participate today to give you at least an update from HHS on where some of the implementation efforts are with the Affordable Care Act provisions that Sara just described.

My part of what is known at least for the next week or so as OCIIO, which was created in the Office of the Secretary but soon will be moving under CMS, OCIIO has a broad range of activities that we're supposed to implement, not the smallest of which is the health insurance exchanges which we'll be talking about a lot for the next three years as well as additional oversight and consumer assistance provided through the Affordable Care Act.

My part of OCIIO that I work with is focused on insurance programs that are being established under the Affordable Care Act and you see the cover page of the presentation has the word immediate and two of the three programs I was responsible for bringing up are the immediate ones, the ones that took effect a couple of months after the President signed the Affordable Care Act in March. Luckily both of those are areas that this group is interested and this panel is talking about today.

So the Affordable Care Act includes a number of advantages and assistance to individuals and Americans over age 50. It closes the Medicare Part D donut hole over time, provided last year an immediate benefit for a portion of the donut hole costs incurred by lots and lots of Medicare Part D enrollees. It also provided immediate coverage for preventive services in Medicare and a prohibition on annual and lifetime limits and preexisting condition exclusions starting in 2014 in the commercial marketplace for those under age 65 who weren't on Medicare.

The two programs we're going to focus on today are providing today immediate assistance to individuals, employers and unions as well as state and local governments. They are the Early Retiree Reinsurance Program, which began taking applications about two months after the President the Affordable Care Act and the Pre-Existing Condition Insurance Plan that began accepting applications just over three months after the Affordable Care Act was signed into law.

First one, let's talk about the Early Retiree Reinsurance Program. This is basically a reinsurance program for employers who are providing, as well as states and local governments and unions and religious organizations, that are providing employment based coverage to early retirees and their dependents. These are the folks ages 55 to 64, some of whom

are counting the days until Medicare begins at age 64 and it's to address the fact that over the past two decades, while some of you may have heard about the shift of defined benefit to defined contribution plans in the pension world, what's also been taking place has been a gradual but steady erosion in health coverage offered to early retirees in the employer based marketplace.

Because of greater competitiveness and greater demands, there has been an erosion in the number of people who are offered retirement health insurance coverage if they retire before age 65 and this program was designed to temporarily buttress or reverse that trend, or at least address that trend until the broader aspects of the Affordable Care Act were implemented starting in three years. So the Early Retiree Reinsurance Program provides reinsurance subsidies to employers who provide health coverage to their early retirees from now until 2014 to address and try to at least stop or slow down this trend of employers dropping the coverage.

To be eligible to be a company to receive this, and again this is only provided to employers, state and local governments, unions, religious organizations and other entities that provide retirement coverage to their employees, you have to have a employment based health benefit plan for the early retirees, spouses and surviving spouses and dependents and

these have to be maintained directly, either on a self funded basis where the employer is assuming all the risk or through an insurance based relationship where the employer buys coverage through an insurance plan.

We're not directly subsidizing individuals, we're subsidizing the sponsors that run these plans, the employers that run these plans, and they pass it on to their employees. The subsidy only goes for early retirees. This is folks who are ages 50 and older, who are not eligible for coverage under Medicare and they're not active employees of the employer or the sponsored health plan and they have to be enrolled in that health plan at the time and they can't be eligible for Medicare as I said earlier, whether they're eligible for Medicare as a disabled individual or because they're age 65 and over.

What the program does, is it provides a federal subsidy for the catastrophic costs that these employment based plans incur. So if the employer has a retiree who over the course of the plan benefit year, 12 months, begins to have costs that exceed $15,000 a year, and that's a combination of the employer's health plan costs as well as the insured's out of pocket costs, then at that point the federal government will, once the employer informs us and provides us the detail, the federal government will cover 80-percent of the costs over

$15,000 a year until the total costs reach $90,000 a year and then the federal subsidy ceases.

So again, it's designed to offset the more catastrophic costs that these employers are incurring for their high cost individuals in order to help keep the plan going for all of the retirees in the plan. And these reimbursements are received by the federal government on a quarterly basis as the employer submits to us the cost detail and, starting in a couple of months, the claims detail that justifies the expenditure and shows what the expenditure was and then the federal government transfers the funding directly to the employer.

When the employer or plan sponsor receives the funding, it can only use the funding in limited ways. It can use the funding to reduce its own plan sponsor's costs towards providing the health coverage. So if it's seeing costs increase year to year, as many plans have seen costs increase, it can use those federal subsidies to reduce the growth in the cost that it's incurring or it can reduce the cost of the retiree.

So it can take the cost and reduce the premium that the retiree may have to pay or the deductibles or increased deductibles that the retiree has to pay or the coinsurance or copays that the retiree has to pay or it can use the funding to do both, offset its own employer sponsored costs that the

entity, the sponsor, incurs as well as the individual's cost. So it can use one or the other or both.

There was one limitation that is specific in the statute, is that the retiree plan sponsor cannot use the money as general revenues. So it can't use it to pay for its other activities related to the entity. You know, it can't use it as general revenue or revenue for its other business operations. The money has to be used for the employment costs – the health insurance employment costs of the plan.

We have had, since we began taking applications in June, we've received applications from more than 5,000 health plan entities. Actually it's over 5,500 at this point. And these include Fortune 500 companies, name brands that you'd recognize from commercials or products that you by, as well as state and local governments including cities, towns and villages. We have a number of applications from villages as well as special districts that you have – that you see in the government structure. Nonprofit organizations, educational institutions and religious organizations all have submitted applications that have been approved for their organization.

More information about the program is at our website which is www.ERRP.gov. The other program I want to talk to you about today is not for large health plans, but designed for individuals. This is the Pre-Existing Condition Insurance Plan

and this is designed for people who want to buy health insurance coverage, have the means to buy health insurance coverage, but no one will sell it to them because they have some kind of preexisting condition and this is for people who are too young to be on Medicare, don't have employer based coverage and they have assets or resources to make them ineligible for Medicaid coverage.

And these are the folks basically that were locked out of the insurance marketplace, the willing buyers who no one was willing to sell health coverage to. And this is again, just like ERRP, designed as a bridge program to provide immediate coverage to fix those sectors of the health insurance marketplace that needed immediate help as soon as possible as a bridge until the broader reforms of the Affordable Care Act take effect in 2014.

In order to qualify for PCIP, you have to be a US citizen, you have to have been uninsured for six months or more and have to have a preexisting condition that prevents you from getting health insurance coverage. It provides very comprehensive health insurance benefits, basically covers all types of services and in most of the states, it provides health coverage identical to what federal employees like me get and in some cases even more generous coverage than federal employees get. So it's a very robust benefit package that's available,

covering prescription drugs, home health, inpatient, outpatient, behavioral services, what have you.

It also has a lot of important features for consumers such as first dollar coverage for preventive services, no lifetime maximums. Benefits are available immediately when coverage begins so there's no six month, three month, 12 month preexisting condition exclusionary period where you're paying premiums, but you're not being able to access benefits because of a temporary exclusion period.

So once coverage begins, the day after coverage begins, if everything goes through the authorization process, you can get an organ transplant, you can begin chemotherapy, there's no kind of waiting period where you're paying premiums and not getting the benefits that you need. And it offers benefits to any – at any qualified provider, whether it's in the program's network or out of network.

This gives you a flavor of the premiums and the benefit structures available. Now the premiums are designed to be the same as what's available to healthy people in the individual insurance market who can pass medical underwriting. So there's no premium surcharge based – because the person has a preexisting condition. So the same person who's considered obese like me pays the same premium as someone who has – is undergoing chemotherapy or what have you. You're laughing. I

am considered in some insurance companies to be obese and would be denied health insurance coverage so that isn't meant to be a joke.

So it's the same premium regardless of your condition and it's the same premium that is available to healthy individuals who can run marathons, things I can't do. So – and you see the premium varies on income – I mean, not on income. The premium varies by age because that's the way the individual market works in most states. Younger people pay a lower premium than people ages 40 and over, people like me.

It has a deductible that varies by plan option. We have a number of plans that have no deductible, but on average they have about $1,000 deductible, $250 drug deductible and there's an out of pocket limit that limits your total cost you for copays and coinsurance of just under $6,000 a year, $5,950. There's more information available at www.PCIP.gov. You can just select your state and it'll take you to where and how to enroll.

It is – it varies based on your state because there 27 states that agree to administer the program directly and the federal government pays for it and there's 23 states plus the District of Columbia where the federal government runs it directly because the state said it was not interested or unable to implement the program quickly according to our timeframes.

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We also have a toll free number and the call center's open more than most business hours.

I will just turn to this page right here. If you do a lot of community based work and you have an event that you invite a lot of uninsured people or health care providers to or stakeholders, disease groups in your local area, please contact me at Richard.Popper@HHS.gov because we're doing a lot of community based outreach to get the word out about this program because it is a new product. There's nothing like it really out there right now that has benefits so affordable and premiums so affordable.

So please write down my email address and if you have an event coming up, whether it's in a church basement or at a statewide provider, conference, we'll be happy to be there to educate people about the program like we are today. Thank you very much.

ED HOWARD: Thank you very much, Richard. Let me just ask you one clarifying question about that premium chart that you had up. The last column is labeled State Plans, are those the high risk pools that were already in existence at the state level?

RICHARD POPPER: Of the 27 states, 20 of them are the existing state high risk pools that were available prior to the Affordable Care Act. But they are – PCIP, the program they're

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running is different from your grandfather's state high risk pool because the premiums are lower, average of 50-percent – or I'm sorry, about 33-percent lower than what the state risk pools are charging and there's no preexisting waiting period so you get coverage right away. So don't confuse it with the old state risk pools.

The other seven states are they created their own nonprofit health plans directly to implement this quickly, states like New York and Ohio and Illinois where they either didn't have a risk pool or they wanted to implement this a different way.

ED HOWARD: Okay. Very good. Finally, we turn to John Rother who needs the clicker [laughter]. John's the executive – as I mentioned, he is with AARP. In fact, he is the executive vice president of Policy Strategy and International Affairs, quite a portfolio for AARP. That makes him responsible for all of the state and federal policy initiatives and for AARP's overall strategic direction.

Some of you may know he served a long stint on the Hill working for Senators Jacob Javitz and John Hines before he went to AARP and I'm pleased to note he is also now a member of the Alliance Board of Directors. So, John whatever you want me to say, to ask you a question about, I'm happy to do.

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JOHN ROTHER: Okay. Good afternoon everyone and thank you, Ed, thank the Alliance for sponsoring not only this event, but a whole series of events that help people better understand what's going on in healthcare. And I think I'm going to start by stepping back a little bit and trying to paint a little bit of a larger picture of this largest generation in American history, the Boomers.

They're now age 47 to 65 so you can think of that as going from Barack Obama to Bill Clinton, that's your range and what's happened to them in the last couple of years has been terrific economic reversal and for many, loss of job and of course loss of health insurance. And I think you have to understand that fact to really appreciate what is going on and I'm going to walk through that as we go forward.

So most Boomers of course are employed and they will not be directly impacted by what we're talking about here because what we're talking about here is mostly applicable to the individual market where we have several million Boomers but not the majority. But for those people who are not covered by employer based health plans, of course you have a problem with denials based on preexisting condition, 20 to 30-percent are refused coverage due to preexisting condition in this age range.

Again the prevalence of chronic conditions increases with age. High risk pools are the option that's been available so far, but only 200,000 are covered by them so that's pretty tiny and of course those risk pool rates are set at a pretty high rate, 150 to 200-percent of the standard premium. So of course as you get older under – in today's market, you're age rated, it means your premiums go up. Oftentimes, you're charged four or five times as much in your 60s as you were when you were younger.

There's no other part of the American healthcare system that varies rates by age. And then of course you've got premium variation based on health status as well. Deductibles in the individual market today are approximately $2,500, so people then are paying a high premium and getting no benefit whatsoever until they pass $2,500 in total expenditures. A third of the plans have deductibles above $3,000.

So we're really moving under today's system toward back end kind of almost catastrophic type coverage for most middle class families. As a result, two thirds of those in the individual market in this age range spend more than 10-percent of their income on premiums plus out of pockets costs. And 10-percent is usually the figure that we use to say what's affordable.

Now people can afford 10-percent of their incomes for healthcare, but above that we're getting into clearly unaffordable range. Now on top of that, we have a declining individual – I mean, sorry, declining employer based market and again, in this age range, we've gone from 50-percent coverage just in 2008 down to 45-percent as of last month. And maybe that can come back with an economic rebound, but many of those who have lost coverage, have lost them now permanently.

If we take a look at what's happening, the underlying fact here is unemployment. So let's take a look at unemployment. The unemployment rate since December, 2007 has more than doubled. It's gone from 3.1-percent to 7.3-percent, but the fact of the matter is for people who are in this age range, the older part of the workforce, they have been unemployed for a very long time. The numbers – the percent of unemployed who have been out of work for more than one year has gone from 12.2-percent to 42.4-percent.

So not just unemployed, but unemployed for a very long time and the average in weeks unemployed before finding another job has gone from 21 weeks to 45 weeks. So this is an age segment that is in crisis in many dimensions, but certainly healthcare is one of the major ones. Of course, mostly we're talking about – we think about full time workers, but of course part time workers are also less likely to have employer

coverage from the start. This is a population that because they typically have worked and saved a little bit, they're not going to be eligible for Medicaid and COBRA which is what's available to many of them when they become unemployed is unaffordable for quite a few because of course they're paying the full freight of the premium and at a time when they have no income.

So where does that lead us? In terms of what people have reported to us, one in five say that they're having difficulties paying their healthcare bills. One in 10 said they've used up their savings or they're getting collection calls or difficulty with paying other bills because of healthcare costs. Four of 10 report that they have delayed or skipped care and one in four report that they're very worried about healthcare overall.

So this is a population that really is focused on health insecurity and they probably are one of the groups that has the most to gain from the full implementation of the Affordable Care Act. Let me just review briefly, because we've covered it already, what the Affordable Care Act would do. First of all there are improvements in access and cost because of no coverage denials, lower age rating limits and tax credits to small employers.

As Richard talked about, there's the immediate availability of state high risk pools. I'm not going to go through that and there's also better coverage in terms of rules for insurers starting this – last year and again, this year we've had some improvements in terms of medical loss ratios and then we're going to go on in 2014 to caps on out of pockets costs and the implementation of subsidies so we get to true affordability.

But these are big changes. Richard also talked about the Early Retiree Program that is a bridge until 2014 and so let me just focus on the next slide if I could. What's happening at the state level? In terms of activity now, we have to set up exchanges, we have to synchronize eligibility between Medicaid and the state exchanges, we need to put in place the mechanisms to do rate increase reviews, we need to plan for Medicaid expansions because there'll no longer be categorical eligibility and of course many states are already operating the pre-existing condition insurance plans.

So that's a lot of activity that's benefiting the Boomer generation today and will benefit them tomorrow. That's a lot of activity at the state level as well. And let me just close with a final hope. This is that the legislation can be a beginning at least on bending the cost curve which would be of tremendous importance, not only to the country, to our deficit

situation, but even more so to the family budgets that are bearing the brunt of healthcare costs today and businesses.

If we can keep healthcare costs growing only at that lower curve, which is GDP growth, that's a tremendous economic benefit probably larger than almost anything else we could devise that would support economic growth and support health security. So that's what the hope is for the affordable care and I look forward to questions.

ED HOWARD: Very good. Terrific. Thank you, John. Finally we're going to hear from Joe Antos. He's the Wilson Taylor scholar in healthcare and retirement policy at the American Enterprise Institute. He is a member of the CBO Panel of Health Advisors, former CBO assistant director for health and human service – resources and we've asked Joe to look at the issues that you have just been hearing about through the lens of what I might call thoughtful skepticism.

So Joe, thank you for joining our panel and take it away.

JOSEPH ANTOS: Thanks, Ed. Well in looking at John's slides, this survey – and looking at the three of us, I'm excluding the rest of the panel – this is the surveys that you were quoting were surveys of the worried young. Wouldn't you agree, John?

JOHN ROTHER: Worried young?

JOSEPH ANTOS: Well yes, they're younger than us [laughter]. And I hope they're younger than Ed, but they're younger than me. Anyway, so I did want to make one comment on John's estimate of the number of people with employer coverage. I looked – I was startled at these numbers and I looked at the Census Bureau and the Census Bureau Annual Report gives a slightly different picture.

For people between the ages of 45 and 54, the Census Bureau claims that indeed employment based coverage has slid over the years, that's just universally true I think for all ages. But in 2009, the number was 67.3–percent and then for 55 to 64, it was 65.7-percent. So, I really do think this was a – some of these slides were from the worried, but not necessarily informed, young.

Not that young. Most of you people are much younger than they are, but people have impressions about what they're situation is and the impressions do matter a lot. It isn't just the objective facts, it's how you feel about it, so that's a useful thing. Anyway, I'm going to turn now to the questions about the Pre-Existing Condition Insurance Plan and the Early Retiree Reinsurance – is it Plan? I guess it is.

RICHARD POPPER: Program.

JOSEPH ANTOS: Program. And the first question that comes to my mind is why is it $5 billion anyway? Why $5

billion for each one? That's a disturbingly round number and regrettably in this modern era of politics and budgets, $5 billion is a small number. So awfully round and awfully small. So that's one of the questions.

Another question that I'm going to try to raise and probably not answer - has to do with how these things are supposed to work really and in particular, the Early Retiree Reinsurance Program. I think there are a lot of questions, in my mind at least, about how you actually make this happen. And then another question, I think Richard more or less said something – mentioned something to the effect that the – one or more of these programs is transitional and I guess the question is, transition to what and what do you really expect from 2014 on?

I think those are questions that deserve some consideration. I don't think we're going to know the answers to a lot of these questions, because it's fairly early in the game. So let me start with the high risk pools and point out something which I didn't have to study the slides, so I'm – if I'm repeating myself – repeating something Richard may have said, excuse me.

So we know that as of November, which I think might be the latest figure, that the – can I call it PCIP? The Primary – I mean the Pre-Existing Condition Insurance Plan, fewer

syllables. The PCIP program had enrolled by November something like 8,000 people whereas the 30 existing high risk pools in I guess the latest figure – I'm not sure I understand my own thing here. But I get a number that indicates that there's something like 196,000 people in those pools.

And you can chalk part of it up, part of the difference in performance, to the fact that if course this hasn't been a full year, it takes a while to get anything going and if the PCIP is available in states that didn't already do something like this, of course it takes longer in spite of the fact that of course the folks up here set deadlines, reality and congressional deadlines. Sometimes they're not always in sync.

So it's understandable that the PCIP program would not have gotten to a completely roaring start right away, but maybe there's another reason. And I think it has to do with a combination of the $5 billion in the rules that in fact do limit eligibility to PCIP. Let's talk about the $5 billion. The 30 high risk pools that have existed in the past have spent a total of $124 million for the fiscal years 2008 and 2009.

I guess that was [interposing] – yes, yes. Add them up. Two years in a row over the 30 programs and these are your CMS grants. So it's $124 million over two years for less than the full country. That suggests to me – I may be wrong about this – but maybe the PCIP is underfunded by a lot and it's easy

to understand why that would be the case. But I think the underfunding is an issue.

Now, how do you get around that underfunding? Well, as I say, there are some restrictions to become eligible for the PCIP. You have to have a condition that disqualifies you from health insurance. So it's – it could be a pretty serious condition, not necessarily Richard's serious condition, but other serious conditions. And you have to actually be turned, except in the states where there's universal access or universal – I got the wrong words – but Massachusetts obviously, you can't really figure it out that way.

So there's a little bit of extra complication about how you figure out who in certain states like New York and Massachusetts could actually be eligible for the PCIP. But the fact is that in order to get into the PCIP, you have to a condition that disqualifies you from coverage and you have to have been turned down and you have to have been without insurance for six months.

Well, that'll certainly keep your enrollment down. So it's not just the rollout which is very difficult, but it's the fact that when all is said and done, if you're seriously – you have a serious condition, not – again, not Richard's alleged condition, but if you have a serious condition, you're not

going to make it six months without some kind of help, some kind of coverage.

And so I think that's a serious problem, by why is it there? Well, since nobody really sized what $5 billion will buy, there's a suspicion that some people have raised, people who strongly support this provision that maybe the problem is that they were trying to stay within the $5 billion and it of course raises a question that if you go into this as a state, then are you on the hook later on when the money runs out?

And a number of states, I think mostly states chaired by – governed by Republicans, but nonetheless, I think it's an honest green eye state budget office point of view. What are we going to do when the money runs out and we still have these people? Do you want to be the governor who is known as the guy or gal who threw out – threw a bunch of actually deserving people off a program that got started by Capitol Hill. So nobody really wants to do that, it's a problem. So that's an issue.

Let me turn now to the Early Retiree Reinsurance Program and raise some questions about exactly how that's supposed to work as well. That one seems a little more benign. I don't – and that's another $5 billion program, so it's another one of these arbitrary well let's put a plug in and let's get some publicity. It's good publicity, but nobody –

this is one where you really don't know what – how much you're in for if you were to fully fund the various provisions that are associated with this Early Retiree Reinsurance Program.

We need a – I can't say ERRP. That sounds rude at lunch. So – sorry. So again, it's pretty arbitrary in that regard. The questions that come to mind have to do with just how do you know whether an individual has gotten up to the point where their employer is eligible for a payment under this program? This has to do with do we – does the federal government accept all bills for all services?

Does the federal government say well certain categories of services, things that may not be for example in the Medicare set of standard benefits? Maybe it excludes some of those because some employer plans of course are a bit more generous in terms of the breadth of services. I'm not talking about how much they pay for coverage, I'm talking about different categories of services that may be covered that may not be covered by some standard which I haven't seen anything written about yet.

So do you accept all of the bills? Do you accept some of the bills? And then do you accept the payments that were made? I think that's the big question. I think the specific services probably not a big issue, but do you say okay, well since the XYZ corporation didn't hire a very good private

insurer and paid through the nose, then should the taxpayer also now be on the hook because they didn't make a good deal with their health insurer and the various healthcare providers that service their members.

I don't know the answer to that question, but if the answer were to be that there has to be some review of the bills, then we're talking about some pretty substantial delays and some very substantial opportunities for employment among accountants and actuaries and they're already over employed by our health Reform Law. So we're going to have a problem and I strongly suspect that there are going to be some issues about confidentiality and personal privacy that will be at stake that in don't think can be at stake, but I think they will – it will be.

So now this is an attempt to marry a federal grant program to an existing complicated, certainly non-uniform bunch of private insurance plans where there's never been a relationship like this and I know likely we're going to go on ahead and do it. Now, I can see why employers, unions and other kinds of plans sign up for this because it looks like money, but they may change their mind and they probably have the right to back out if it turns out there are very serious problems that would cause them difficulties with their own workforce because, let's face it, the retirees don't matter

that much, it's the people coming up that they care about, they're still working and they don't want to have trouble with their labor relations.

So I think that's a real issue. I probably have a lot of other great notes here somewhere, but I can't find them so I'll stop now.

ED HOWARD: Well you can shuffle through them and get to them while we get into the question and answer period. It occurs to me, I don't know, Richard there are a number of sort of factual issues that Joe raised that you may have answers to or you know that there aren't any answers to. If you'd like to try to respond, we'd be happy to give you the chance now.

RICHARD POPPER: Okay. I'll just go over them as I wrote them down, but if I missed any, Joe, please let me know if I should – if I forgot something. Regarding the $5 billion for both programs, unfortunately when the Affordable Care Act was enacted, I was in the employment of the state of Maryland working in Annapolis and not here in D.C. so I wasn't in the room when those numbers were agreed to by Congress, so I can't really relate to that.

I can say that the existing state high risk pools spend in total roughly $2 billion a year. So when you take a look what the existing state high risk pools that cover 200,000 individuals cover, their costs are roughly $2 billion a year.

Now, about half of that is premium, half of that is subsidies because high risk pools are in business to have to be subsidized, that's why they're high risk pools. They don't make a profit or have a loss ratio between 100-percent like for profit health plans do.

So given that, you have $5 billion to provide coverage under this new program for about three and a half years. So it is a – it's not out of the ballpark in terms of thinking if the new Preexisting Condition Insurance grew to a comparable level as the existing state risk pools. It does give you some degree of scale to be able to have the same level of operation in terms of covering the same number of claims.

Sticking with Pre-Existing Condition Insurance Plan, the enrollment numbers that we reported at the beginning of November for our first three months of operation was 8,000 subscribers. Now, the program opened in just over three months. We had to focus all – and actually most of the program we had to implement in two months because when the bill first passed in March, we had to ask all the states and give them 30 days to decide whether they wanted to implement this at the state level or have us do it so that we had to sort of wait for their responses.

So we really had to get this all up and running within just over two months. And because of that, we were focused a

lot on implementation and making sure the phones would be answered, the claims would be paid, the premiums would be processed and not being able to do a whole lot of outreach and education about the program because it was still cooking.

But with it being open in most states starting in July and in all states by the end of September, we have now begun to focus doing a lot of education and outreach to get the word out about this program. Now PCIP is not for everyone. It's not for all the 50 million uninsured in the United States. It's designed for people who have preexisting conditions and have the income and resources able to buy health insurance coverage.

So this is no substitute for the Medicaid expansion that's in the Affordable Care Act. It's no substitute for the health insurance exchanges, but it is designed to fill the most pressing and needed gap in the health insurance marketplace, the gap for people who want to buy health insurance, have the means to buy it, but companies say no, we're not going to cover you because of your preexisting conditions and that affects a lot of early retirees, it affects a lot of people who are unemployed, a lot of people who are self employed and a lot of people who work for employers that don't have to access – with an employer that doesn't offer group coverage.

The eligibility does vary by state because we had to get this up and running quickly. In most states it is a denial

by an insurance company that gets you into the Pre-Existing Condition Insurance Plan if you've been uninsured for six months. But in just about half of the states, you can also get in if you have a qualifying health condition. You just have to prove and provide a letter from your doctor that you've been treated or diagnosed with diabetes, with cancer, with Wilms' tumor, with AIDS or HIV, or with hemophilia.

Just having a letter from your doctor that says you have one of those conditions and the number of conditions varies by state, some states it's about 30 conditions and in other states it's as high as 70. Just having a letter from your doctor indicates that you're eligible for the Pre-Existing Condition Insurance Plan. And just the comment about states being wary of implementing this, the statute – the Affordable Care Act gives the Secretary the authority to limit enrollment in the plan in case it's going to spend more than the $5 billion and also our contracts with all 27 states, both red and blue that agreed to contract with us to implement the Pre-Existing Condition Insurance Plan, has triggers built into it to make sure that both parties become aware when certain cost thresholds – as the money is budgeted year to year, if expenditures exceeds 75-percent of projections, actions take effect to review benefits as well as to review enrollment to

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make sure that states are not put on the hook for having to spend one penny on this program.

So that is built in, not only to the statute, but into our contracts and we've developed these contracts directly, jointly with states as varied as Arkansas and Oklahoma, as well as Maine and Maryland and California. So they were all agreeable to these provisions that we developed jointly together. In terms of the Early Retiree Reinsurance Program, Joe talked about what we pay for in ERRP. On our website, www.ERRP.gov, is guidance that we issued in September saying that ERRP will pay for covered benefits basically using the Medicare covered benefit standard.

So if Medicare covers it, ERRP covers it. If Medicare doesn't cover it, ERRP will not cover it. It's basically using the Medicare benefit standard. So there's no coverage in ERRP – we won't be reimbursing for gym equipment or spa treatment or massage therapy or things like that that you might have in more robust employer based plans, but we'll also be providing the same Medicare benefit that's useful and very popular among tens of millions of retirees in the United States.

In terms of reviewing the claims that do come in, plan sponsors have to commit in agreeing to participate in the program to provide us prima fascia evidence of what their costs were as well as what the employee's costs were for us to do

reviews of the costs. And the plan sponsors are also required to submit to us de-identified claims data that reconciles the amount of money that they're requesting for us to review and audit and we also have authority to do field based audits and company based audits as well to ascertain and reconcile the amount of dollars that the employer is claiming along with the costs that are incurred.

And I should add, that is a more robust review process than was put in place in the Medicare Modernization Act for the retiree drug subsidy program that was created under the Bush Administration where there was no requirement for claims data to be submitted in order for costs to be reimbursed by the employer. So it is a more robust and more thorough review process. So that's it. I'm not sure if I missed anything in responding, Joe.

ED HOWARD: Go ahead, Joe.

JOSEPH ANTOS: Prices?

RICHARD POPPER: Prices? The prices are based on what the employer negotiated. We – now with the availability of ERRP, employers could go in and try to renegotiate their prices, but this is reinsurance, we're reinsuring the plan, we're not taking over the plan because there was concern that this was designed to try to improve the current system, but not entirely remake the current system as a temporary program.

ED HOWARD: Okay. Let me remind you that you have green cards that you can fill out and there are microphones there – and is there another one somewhere over here – that you can use to ask questions. If you do use the microphones, please be as brief as you can, identify yourself and direct it if you have a particular panelist you want to answer. Go right ahead.

JOHN REICHARD: John Reichard with CQ Healthbeat. I wondered what percentage of applications that have been accepted by the Early Retiree Program were filed by companies versus state or local governments versus unions.

RICHARD POPPER: Don't have that data available in my head. I know we're planning on releasing it in the coming weeks, but it is fairly proportional among the groups with the exception of religious organizations. I think religious organizations is our smallest percentage. But when you look at state and local governments versus employers versus unions, it is basically proportional. A little more than a third for one entity and a little less than a third for two of the other entities, but it's fairly – it's roughly even in terms of being proportional.

ED HOWARD: Yes, sir.

JOHN GREENE: John Greene with the National Association of Health Underwriters. So Medicaid has come up a lot in this

discussion and some of you may have read that Arizona is going to look for an HHS waiver. I'm not asking you to comment on whether you think they'll get the waiver, but surely there are many, many other states behind Arizona given the budget situation in lots of states.

So this is kind of a reality check of what the states can do versus what maybe the law says and I was asking if maybe you guys could comment on the state side of this in terms of for their responsibility for the costs.

ED HOWARD: And let me just try to clarify and then you can tell me if I've got this right, that what the waiver would ask be waived are the maintenance of effort requirements that a state has to meet in order to comply with the ACA.

JOHN GREENE: That's my understanding, yes.

ED HOWARD: Okay. Eligibility and benefit standards in effect have to stay in effect, in effect [laughter]. Any speculation or any comments from any of our panelists?

SARA COLLINS: I was –

ED HOWARD: Go ahead Sara.

JOSEPH ANTOS: The recovery's just right around the corner.

SARA COLLINS: I'll just comment on the expansion provisions and how the amount of federal spending as a share of overall spending for the expansion, but it's really 95-percent

federally financed between 2014 and 2019. So there's a major influx of federal expenditures into states for the Medicaid expansion itself up to 133-percent of poverty.

So most states would see a very small increase in their spending for the Medicaid expansion relative to the large decrease in the number of uninsured in states, so across the states, about a 44-percent decline in the uninsured as a result of the expansion with only about a 1.2-percent increase in federal – in state spending across the country.

JERRY GEISEL: I'm Jerry Geisel of Business Insurance Magazine. These questions are for Mr. Popper. To date, how much money has been distributed to employers and other organizations for the Early Retiree Reinsurance Program? What's the most you've paid to any single entity? And do you have any projections on when the $5 billion will be exhausted?

RICHARD POPPER: To respond to your question, John, we are planning on releasing that information next month with the President's budget, so at this point it is not available. What I can tell you, is we have received and paid requests from – funding requests that have met our program requirements from hundreds of employment based plans, as well as unions and nonprofits and state and local governments. But there'll be more information available with the President's budget to answer those questions.

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MARJAN ASI: Marjan Asi, Press TV. This is a general open question to the panel. The House voted last week to overturn the Patient Protection and Affordable Care Act so there is opposition to that and by extension this program, the Early Retiree Reinsurance Program.

Can you expand on a couple of those arguments and your response to them?

RICHARD POPPER: I guess the question is to me. The [laughter] –

ED HOWARD: Not a celebrity roast.

RICHARD POPPER: No, no [laughter]. I guess the response is what's the substitute? I mean, if the bill is repealed, what's your solution for people with preexisting conditions who are locked out of the insurance market who want to buy health insurance but no company will sell it to them. What's your response to employers who are having to choose between the health of their early retirees, people who've worked for them for years or decades and who counted and made long term plans that they'd have something to tide them over until Medicare begins and are now having to face the decision of dropping that or increasing the cost or dropping coverage to their current employees.

I mean, what is the alternative, what's the solution to that? It's easy to be against something. It's far more

challenging as we know from the long lengthy public debates that went on about the implementation of the – and the adoption of the Affordable Care Act to come up with something to address these varied problems that are resulting in more and more people becoming uninsured.

ED HOWARD: Joe, you had a comment?

JOSEPH ANTOS: Yes. Well, this is with respect to the Early Retiree Program, if we were talking about real money instead of $5 billion, this would have more of an impact. But it does make me wonder, why is it that this is a good expenditure of money? This is going towards people who have had insurance, continue to have insurance and it's not going towards people who don't have insurance.

Now, again $5 billion regrettably, that's a drop in the bucket, it really doesn't matter. But from a policy standpoint, this is one of the provisions that doesn't strike me as in line with let's help people who need the help. It's great, employers and other plans, union plans and so on, happy to take the money, who wouldn't, but does it really contribute something fundamental to the operation of the healthcare system.

I assume it's transitional in the sense that it disappears in two years and if that's the case, I think that's probably a good thing.

RICHARD POPPER: Joe, I wonder do you distinguish that kind of program, which I guess is intended to induce private employers or other employers to keep doing what they were doing, from the situation with the Part D drug benefit where there was a subsidy to employers to – who offered drug coverage to continue to offer drug coverage?

JOSEPH ANTOS: Well, there's one gigantic difference, of course, and that is that Medicare never had a drug benefit, not that it wasn't tried. But Medicare didn't have a drug benefit. I mean, was this – was that a payoff to employers? Was this a payoff to employers? Sure it is. I'm not a politician, I'm not bashful to say that. Was this much of a payoff? No, but it meant something. Was the other one a bigger payoff? Yes, it was. Okay.

JOHN ROTHER: No, I think we should be careful about words. It's not a payoff to say that people who have been insured and who are worried about losing that insurance, should have peace of mind about making it to Medicare and it's not a payoff to say that people who have had drug coverage through their employer should continue to enjoy that when their employer may otherwise drop coverage.

So I don't think it's right to call them payoffs. I think it is true that these are provisions designed to stabilize the employer based system which, over time, is – it's

questionable whether it will continue or not. But at least for the next few years, they're trying to keep damage from happening to people who don't control whether or not they have insurance. Their employer does.

JOSEPH ANTOS: No, I accept that, John, but I guess the question is then, why isn't it more money if this is a important priority, which I think it could be, but that implies that it's not as important a priority as other things. And also, why is it – is this something that's going to go beyond the next two years? If it isn't, then it really doesn't provide any incentive whatsoever to any employer to hold on past 2014, at least if that's an issue.

And it's also not even clear if you're that close to dropping it in the next two years or three years – I get confused about arithmetic, I'm only an economist – then is that the program that's going to keep you on? Because after all, you had to pour more money into it for people who are no longer working for you. Now I would agree, if you were to say this, John, that this is really part of the compensation package that people signed up for when they started to work.

But, things change, so pension plans went from defined benefit to defined contribution plans just like that in the '90s and we're still alive and people still work. So I guess

I just don't see what the real logic is of that particular program.

RICHARD POPPER: One more time, John, then we'll go – if you –

JOHN ROTHER: I think you have to look at these as transitions to prevent further damage before and until we get to 2014. At 2014, you may not need these kind of programs to continue on, but certainly I think there's a legitimate interest in preventing people from getting hurt between now and then.

RICHARD POPPER: Or having to navigate the individual insurance marketplace where they'd have to be – they'd have to go to where you have the things that John talked about of very high deductibles, not as robust coverage, preexisting condition insurance waiting periods and the fact that you could be denied or have an exclusionary rider applied to the condition that is the reason you need health insurance coverage.

ED HOWARD: Richard, can I just follow up on one other aspect that you mentioned of the Reinsurance Program? Something like 6,500 applications, 5,000 approved. Are those 1,500 not approved disapproved or are they being processed? And if they are disapproved, how come?

RICHARD POPPER: Some have been disapproved because they were duplicates because there was such an interest in the

program, a company would fax in and mail in and email in an application because they wanted to get in three different ways. So some of the deals with that, other situations deal with the fact that the employer has put something in the application that indicated they wanted to use the money in a way that was not acceptable according to program guidelines, that they were proposing to use the money and it's being used for general revenue and not to benefit the retirees who were covered under the health insurance plan or the current enrollees in the employer's plan for its existing workers.

So it was not using the plan according to those standards. There also have been some where the – we require the plans to have some kind of cost reduction program – and this actually gets to Joe's earlier point – that they have to have a disease management program and/or case management program to try to keep costs down and if the employer didn't relay that they had such a disease management or cost containment program, or else it wasn't detailed enough, we've told the employer it has to go back and revise the application and provide more detail.

So these aren't rejections, these are more needing clarifications. Some may lead to rejections because the employer doesn't provide enough information to prove their

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eligibility, but at this point, no employer or no retiree plan has been rejected yet.

ED HOWARD: If we can stay with that program and probably with that responder, someone has asked what happens when the claims of an individual cost more than $90,000? The Reinsurance is operated between $15,000 and $90,000. Does the percentage of the reimbursement decrease or is there no reimbursement at all?

RICHARD POPPER: No, at that point on, $90,000 and above, it is the plan sponsor's responsibility to pay those costs above that. And I think it addresses Joe's other question and concern about the fact that the Early Retiree Reinsurance Program doesn't focus on how much the plan pays the provider. At the end of the day, the plan sponsor – in Early Retiree Reinsurance Program, the employer or the group plan of the union still has to focus on containing their own costs, whether it's before the Early Retiree Program kicks in at $15,000 per member cost or over $90,000 when the program ceases.

ED HOWARD: Very good. Thank you. This is a slightly different angle on this discussion, a person asks, as the Boomers age, we will see the increased incidents of Americans living with multiple chronic conditions. Fair enough. How

should care delivery models for this population change and how should the associated workforce issues be addressed?

JOSEPH ANTOS: Well, this is the standard advice that I think every health policy expert gives which is we need better coordination of care. We need to get the patients more involved with their own care. We need to help them understand what their choices are, their personal choices in terms of behavior. We need to get them to understand better their choices in terms of what the medical system could do for or to them. They're all – it's the standard advice.

I think this question brings up the point that the population is aging, we're holding up our end of it up here and so that means that this issue is not ever going to get better. If you look at the Medicare Trustees' Report, you can see that there may be some slight reductions in the rate of growth of the spending line in Medicare.

The fact is that it always rises and that is to a large extent a consequence of the fact that we are an aging society and the good news is of course that we're aging that way partly because of the success of healthcare. People aren't dying off as early as they used to.

ED HOWARD: This question is directed to you, Sara. You had mentioned that Medicare pays eventually when people

turn 65 with these pent up demands that weren't covered. Would you say some more about that phenomenon of them going without insurance, having cost implications for Medicare?

SARA COLLINS: Well this is one reason why the Early Retiree Reinsurance Program is so important, one of the reasons. We know that there is – has been an erosion in early retiree reinsurance. We know that more people are losing their jobs or having in this age group long periods of spells without coverage and as Richard said, it's really difficult to get coverage on the individual insurance market when you're over age 50.

You're rated on your age, you're rated on your health and so these are ways of ensuring that people have coverage when the major provisions go into effect in 2014 where people in this age group will not be underwritten anymore on the basis of their age and will be able to get the healthcare that they need, rather than 75-percent telling us when they're uninsured, they're not getting the needed care because of cost.

Now this has significant cost implications for the Medicare program and research, as I mentioned in my opening comments, Harvard researchers has found that costs for people who were previously uninsured in their 50s and 60s are substantially higher once they enter the Medicare program than people who are insured for all that time. So it's a cost that

hasn't been estimated by the Congressional Budget Office, but it is an offsetting cost in this program. It may offset completely the $5 billion that we're spending on the Reinsurance Program to make sure those people have – this age group has coverage until they retire.

ED HOWARD: Okay. Richard, we have – I know this is a shock – several questions directed toward you [laughter]. It's a fairly factual question. How sick, if you know it, are the people who are in the PCIPs? I have seen some news reports that said that even though states had only a couple of hundred people, they had already run through their allocation of funds, so it may only be $8,000, but that might be a very sick sub-population.

RICHARD POPPER: Yes, just some clarifications on that, Ed. There was a couple of states, New Hampshire being one, where they exhausted their 2010 allocation, not their entire allocation, for the Pre-Existing Condition Insurance Plan. So New Hampshire has tens of millions of dollars for the Pre-Existing Condition Insurance Plan in that state and they only ran through their first year's worth of money which is about $1 million.

So it wasn't that they used their entire multiyear allocation. And the challenge we had is that we had to do a projection for a state based on about five months of actual

claims experience, so sometimes actuaries or bureaucrats like me get it wrong. But it wasn't any situation where any of the states had to close enrollment or deal with that, it was just a short term temporary projection that didn't come to pass. But the remaining states over 20 – over 44 of them our projections have been good and the funding is available.

Some examples we've had, the first person enrolled was a woman who had a brain aneurism that was actually diagnosed, she's from New Hampshire, right when the Affordable Care Act was enacted and she was the first person to enroll in the plan, completely coincidentally with coverage starting July 1st. We've had low birth weight infants, one born in Texas, that we've covered. We have a number of – probably over a hundred individuals who have cancer and have used the plan to begin getting chemotherapy and other radiation treatments and we know that the program has – the plan has been out there and it is extending lives and it is saving lives that otherwise wouldn't have had coverage and could be in a lot worse situation than they were in.

So those are the types of things that we're seeing. Anecdotally, we've just begun the process of collecting some of the initial claims data for us to analyze it more closely and after we have a decent enough time period, we'll be providing some better organizations and presentations of the examples and

types of conditions that people have in the program and are benefiting from the coverage under the plan.

ED HOWARD: And the allocations that we were talking about, are subject to review as you go along? I mean, isn't there a mechanism in the Act for a reallocation once they are interposing?

RICHARD POPPER: Yes, the Secretary has the authority to do that reallocation process if it is necessary.

ED HOWARD: Okay. Here's someone who has paid a great deal of attention to your presentation because there is a reference here to the footnote on Slide 11 [laughter]. According to that footnote, the high risk pool cost sharing depends on in network use of services. How is that network built? What are the requirements under the ACA? What kind of choices to consumers have? Is that knowable information?

RICHARD POPPER: The network available in the PCIP varies by state. So if you're in the 2e states plus the District of Columba, this includes states like Florida, Texas, Minnesota, Virginia where the state said no thanks, we have no interest in administering the Pre-Existing Condition Insurance Plan here at the local level. You can do it federal government. The benefit and network is set up through a mechanism that we use through the collaboration between HHS and the Office of Personnel Management where we use one of OPMs

FEHB, Federal Employee Health Benefit plans that contracts with OPM to administer the plan in those 23 states.

So if the provider is in the – is an entity called Government Employees Health Association, GEHA, which currently covers about a million federal employees, if the provider is in the GEHA network, then it's considered in network. If the provider is not in the GEHA network, the plan still covers it, but on a non-par, non-network basis. So the member may have to pay some – little bit higher coinsurance or copays to go out of network, but the benefit you have – it's in the Affordable Care Act for the Pre-Existing Condition Insurance Plan is that there is a statutory limit on member out of pocket costs, $5,950. So that's the most an individual will pay in copays, coinsurance and deductibles which can be higher if you go out of network.

So that's how it was devised in 23 states plus D.C. In the other 27 states, it uses the health plan that the state designated. In 20 of those 27 states it's the existing state high risk pool provider network which is robust because these high risk pools have been in business, some of them for 35 years and they serve high risk patients so they have very good provider networks that includes some of the centers of excellence like the Cleveland Clinic as well as very good provider networks locally within that state.

But it is not a one size fits all approach, it is – in the 27 states that contracted with us, those states came up with provider networks to meet the needs of their citizens through either the high risk pools or direct nonprofit health plans that the state encouraged us to contract directly with through the State Department of Insurance and again these were nonprofit health insurance plans and that was required by the state – by the federal law as well.

ED HOWARD: At the risk of – pass that down to Richard because he has already exhausted that –

RICHARD POPPER: You guys have to tell me if I'm frothing at the mouth, I really need to know [laughter].

ED HOWARD: Since I'm about to direct one more question to you, the question writes about the PCIP program and the six month requirement, that participants be uninsured for six months at least. Is there any relief, say a waiver, for early retirees who have insurance coverage but are locked into very expensive plans due to preexisting conditions? And in any case, are there states that have exemptions from that requirement? And if so, how did they get them?

RICHARD POPPER: The statute is very clear that an individual can't be eligible for the federal high risk pool, the Pre-Existing Condition Insurance Plan, as we've called it, if they've had creditable coverage in the past six months. And

creditable coverage is a longstanding definition and a very broad definition of existing health insurance coverage, whether it's Medicare, Medicaid, employer based coverage and a number of other individual market coverage, what have you.

So if an individual has had creditable coverage which includes all the things I just mentioned in the past six months, they are ineligible for the Pre-Existing Condition Insurance Plan until six months has lapsed. That's nothing – the Secretary has no waiver authority for that under the statute, so that can't be waived.

But the issue of individuals having inadequate coverage that they feel like that they're locked into and they have no choice to move from that coverage, that's why we need the longer term aspects of the Affordable Care Act because in 2014 there will be exchanges where people can move to new plans and there'll be no preexisting waiting period, there'll be no more discriminatory premium pricing and there'll be income subsidies for individuals who have limited income.

So then there will be much greater portability so people aren't locked into employer plans that don't meet their needs or individual plans that don't meet their needs. They can move and shop in an exchange where there's multiple options available to them that are subsidized if they have limited

income and get the coverage that they need if their existing coverage isn't working for them. That's the long term goal.

It's a shame that the Pre-Existing Condition Insurance Plan can't address that need now, but hold on, 2014 is coming where those problems will be addressed.

ED HOWARD: Okay. And the end of our time is coming as well. I want to give our panelists a chance to offer – we've worn Richard out. If our other panelists would like to offer some final comments and actually Richard, if you would like to offer some final comments, we'd love to hear them too, but let us give our folks a chance to get a word in before we go. John?

JOHN ROTHER: Well it's interesting, I think we've probably talked to death the early retiree and high risk pools, but the one feature of the Act that did go into effect this year that we haven't talked about much is the requirement to individual plans to meet a medical loss ratio which really does put pressure to lower rates in the industry and could be a benefit to most people, not just to those in the individual market because there's requirements for group insurance as well.

So I think that that's an important step that we've already taken. The idea is that people should see some early benefits before the promised land of 2014 finally arrives.

ED HOWARD: Sara, do you want to –

SARA COLLINS: I just want to also look ahead to 2014 and how important the expansion of Medicaid and the premium subsidies to the exchange are for this age group. I think Joe mentioned some skepticism about whether employer based coverage is actually declining and we know the Census numbers are from 2009. We know that the number of weeks unemployed in this age group has only gone up over the last year, that it's really difficult for them to find jobs and then even finding a job with health benefits that they're forced to do part time.

So these provisions are just so important for this age group. The transitional provisions will help them – some people get through to that 2014 period, but we really will see a transformed landscape starting in 2014 where people if they lose a spouse, lose their job, they're no longer going to be without health insurance coverage.

ED HOWARD: Thank you. And before I give Joe Antos the final word, I'd remind that we'd love to have those blue evaluation forms filled out so that we can tailor these briefings even more closely to your needs and preferences. Joe?

JOSEPH ANTOS: Okay. Thanks, Ed. I think the broader perspective for me is not just are there good things we could do, but are there good things that we can sustain? And by we,

I don't mean people in Washington. I mean the country. So we're talking about massive expenditures, we're talking about massive commitments and we're talking about massive promises.

The promises are great, being able to fulfill commitments are unfortunately proving to be quite another thing and I think we're going to see that – again looking at 2014 and beyond, I think we're going to see that the mismatch between spending and revenues and efficiency improvements, we're going to have difficulties with that and so I would just urge all of us to keep an open mind about these things. And of course we can all be grateful that we will be permanently employed.

ED HOWARD: Wow, what a terrible thought [laughter]. I know it's too late for early retirement, but I have something in mind. Let me thank you folks for contributing to a very lively discussion and I want to thank AARP for its participation in indeed its shaping of part of the agenda of this session. And I want to ask you to join me in thanking our panel, particularly Richard Popper who sat in the hot seat and didn't get scorched even once. Thanks very much [applause].

[END RECORDING]

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