Health Insurance Exchanges: See How They Run
Alliance for Health Reform and The Commonwealth Fund
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ED HOWARD, J.D.: I want to welcome you. My name is Ed Howard, at the Alliance for Health Reform, and welcome you on behalf of Senator Rockefeller, Senator Collins, our board of directors to this briefing to examine a proposal to put together a health insurance exchange or some people call it a connector as part of health reform plans that are being discussed.

I want to, first of all, congratulate you for exercising good judgment that you'd rather be listening to a number of experts and panelists talking about the connector than at some silly White House meeting about the stakeholders [laughter] who are going to contribute $2 trillion to the health reform effort. But one aspect of this debate that so far has been pretty close to developing a consensus is that the current individual insurance market isn't all that functional.

It doesn't work for anybody with a health problem. It doesn't work for people of certain age and it doesn't even work as well as it should for the insurance company. It is, simply put, pretty poorly organized, and an exchange is seen as a tool to better organize that individual market or perhaps, a small group market, even more.

Now, unlike the discussion we had a couple of weeks ago about a public plan option, exchanges are not like unicorns. They do exist in nature [laughter] and we're going

to hear a fair amount this afternoon about the Massachusetts Connector Authority and also some about the Federal Employees Health Benefits Plan, both of which have aspects of an exchange in their nature. And today we're going to look closely at what it takes to make an exchange work and what work we want the exchange to perform in the first place.

Our partner and our co-sponsor in this briefing is the Commonwealth Fund, which has commissioned and done some very good analysis on the topic of an exchange and they are represented this afternoon by Cathy Schoen.

Cathy is the Senior Vice President at the Commonwealth Fund. She's a member of the Fund's executive management team. She's a research director of the Fund's Commission on a High-Performance Health System and she's a veteran, obviously, of a number of Alliance programs. We're very happy to have you. Cathy, would you get us started please?

CATHY SHOEN: I'd be glad to, Ed. You have a set of slides for all of us in your packets. My role is to set the stage for the panelists and we are, today, focused on the potential of a national insurance exchange which would also operate at the state or regional level.

And I want to just lay a context because all of the remarks of the panelists will be in the context of assuming a broader range of reforms and market reforms. These include

reforms that would build off the current public and private insurance system.

We're not talking about a total replacement, but building off of it, changing the way insurance market rules now operate so that when plans are sold, they would no longer discriminate based on health or age. You'd pay the same premium. Everyone would be able to have renewal as well as guaranteed issue. So, we would really change the nature of competition.

Everyone would participate with premiums available to make coverage affordable and/or an expansion of the Medicaid program for very low income, so there would be affordability and there would be shared financing to support this expansion. There would also be a new insurance standard, a floor across the country. We're talking about national market rules as well as a national insurance exchange.

The interest in an insurance exchange is because of its potential to fundamentally change the way our insurance markets currently work. Exchanges have the potential to provide better access to high-value insurance, better choice with portability and continuity. They have the potential – and I'm going to stress potential because that's the focus of the panels today – to improve on our insurance market efficiency.

We operate with a very high overhead currently, with high rates of churning, marketing, underwriting. We know we can bring those down and re-focus the competition on adding value, better access, better outcomes and cost. So, this notion of a new basis for insurance market competition through exchanges, where the exchanges are really making markets work in the public interest, is one of the core interests in having an exchange.

If you look at the current market in the United States, when we talk about choice, you'll find because of mergers and acquisitions, the commercial insurance market is highly concentrated. There are only three states in the country right now where the top two plans have less than a 50-percent market share.

There are about 21 states where they have a 70-percent market share. So, part of the issues is how to hold plans accountable for delivering value and focusing them in the direction we want them (to go)in a more monopolized insurance market.

When we look across the way, risk is now segmented in very small pools. It's extremely expensive to sell on a one-by-one basis, to check everyone's health status. People change plans a lot. As much as 25 to 30 or more percent of your premium in the small group and individual market goes for something other than healthcare, goes for overhead.

The panelists are going to focus on two cores issues: the exchange function and oversight, to what extent is the exchange holding plans accountable for value, is it achieving transparency, more informed choice, creating a foundation for payment and other system reforms and the issue of who participates in the exchange. Is it individuals, small groups, large groups? Is there still a market outside the exchange or is it a replacement? And this raises a whole range of issues on risks.

We're starting with Linda Blumberg, who will be followed by Rick Curtis and then Nancy Turnbull. You have their biographies, so I'm not going to take to each of them and they will discuss each of these sets of issues in more detail.

ED HOWARD, J.D.: Thanks, Cathy. Let me just say as we're moving to the panelists, that Cathy noted all of the slides are in your packets. You can follow along. By tomorrow, you'll be able to watch a webcast of this briefing on Kaisernetwork.org. In a few days, there'll be a transcript that you can take a look at, both there and on our website.

All of the materials in your packets are available on allhealth.org, our website, and let me just point out, there are microphones that you can use to ask questions at the end of the presentations and green question cards in your packets

that you can jot down a question to bring it forward. So, without further delay, Linda Blumberg. Thank you, Linda.

LINDA BLUMBERG: Thank you and thank you, Cathy, to both of you for including me on the panel today. I'm happy to be here.

Now the rationale for having an exchange, as already alluded to, is that insurance markets are just not very well organized today. There are significant barriers to obtaining coverage and these are largely the result of having a voluntary health insurance market.

In order to prevent individuals from just purchasing coverage when they think they're going to have a significant healthcare need, insurers impose pre-existing condition exclusions. They deny coverage outright to some. They permanently exclude certain types of benefits and they rate up premiums based on health statuses of individuals and groups.

Insurers also have a lot of flexibility in their marketing practices and the design of their products, and these are strategies that they also use to try to attract enrollees who are lower cost. The market rules and consumer protections that we have vary a great deal across states and we will find also that often the products that are being sold in insurance markets can be very confusing.

In most cases, in fact, insurance plan documents can't even be obtained until an individual enrolls in health insurance coverage. So, people often get surprises when they actually enroll and they find out the details of the coverage that they have, and in some cases, even once they have the coverage documentation, it can be very hard to follow and to understand what's in those documents. So, exchanges can be designed to provide the structure and oversight to insurance markets, which they lack today.

Now, I'm going to briefly mention what I see as the central goals of healthcare reform, all of which I believe exchanges can play a role in achieving. I'm going to focus my detailed remarks on the three that are highlighted in blue, which it may be hard to tell which ones are highlighted in blue, [laughter] but they're the second, third and fourth ones I'm going to focus my remarks on.

But, competition in insurance markets today focuses on getting the lowest-risk enrollees and hence, the strategies to separate the high-cost from the low that I mentioned a moment ago, and (there are) resulting access barriers for people with high medical needs, and reform should spread costs broadly across the population for those that are highest need. Slowing the rate of growth in healthcare costs is a goal that's very understandable, doesn't need a lot of explanation.

Affordability, which is the third one on the list, we have to keep in mind that, as of 2007, the most recent data that we have, two-thirds of the uninsured population are under 200-percent of the federal poverty level. These are individuals that we can't expect to consistently finance their healthcare without some kind of financial assistance, so affordability is going to be a very central issue in reform in order to expand coverage significantly.

Next is facilitating enrollment in insurance coverage. We want to make it easy for people to enroll in insurance without having to jump through a lot of hoops. And finally, we want to promote transparency and accountability in insurance coverage. We want to foster competition based on efficiency and we want to be able to verify compliance of insurers with market rules and make sure that they're observing risk-spreading regulation, that they're paying their claims promptly, and we'll need to collect the data that's going to be sufficient to verify that plans are being held accountable.

So, I'm going to start with the cost-containment goal. An environment that is more conducive to real competition than the one that we have now has the potential to slow the growth in healthcare spending. And two factors determine the cost of coverage for a given level of benefits

and ideally, we'd like to find some savings from both of those components.

The first are the underlying costs of providing care. How many services of each type we use, and how much we pay per unit of service, and high provider payments, and the absence of strong incentives to manage care effectively in current markets may reflect the lack of competition, both in provider and insurance markets that we experience today.

The second component of costs are the administrative costs of insurance and these are the costs that are not related to the payment of the – they're not the dollars that are going to actual purchase of benefits for individuals who are enrolled, so they're the non-benefit costs.

So, what can the exchange's role be in addressing costs of care? An exchange can be a given authority to negotiate with plans over price. They can also exclude plans based on price as well, and these are important roles for an exchange to be able to play to deal with costs. Having an exchange only offer standardized benefit packages would promote price comparisons by consumers.

It's very tough to make smart decisions about what kind of plan is going to be the best one for you when the options vary so much that it's hard to take the information in and figure out exactly what you're choosing between and what the best deal is. An exchange can limit the types of

plan offered to simplify these kinds of comparisons and make it easier for individuals and groups to make cost-efficient decisions. If individuals and groups are making cost-efficient decisions, it puts pressure on the insurers to be more cost-efficient.

All employers buying coverage for their workers within the exchange could be required to make fixed contributions toward their workers' coverage. In this way, workers who pick something that's higher-cost would have to pay the difference between what their employer pays and what the costs are, and this gives incentives to individuals to choose lower-cost plans, also putting pressure downward on costs.

Offering a public plan option within the exchange could also spark competition among private plans, which is largely absent today, as Cathy was showing us, leading to more cost efficiency overall. And greater transparency means giving consumers an array of organized, easily understood information about plans so that they can understand the trade-offs of their different options. And without this kind of information, which is really terribly lacking in most places today, there's really no competition. An exchange is a prime locale for producing this type of information and for disseminating it to purchasers.

So, exchanges can also play some role in addressing administrative costs, depending upon the group size or whether somebody's and individual purchasing on their own, administrative costs for insurance range from about 7-percent to 30-percent of premiums today. While exchanges have some potential to achieve efficiencies in this regard, administrative costs of selling to individuals are always going to be higher than when you're selling to large groups and so, there are limits to how much savings can be achieved here.

But, exchanges can reduce marketing expenses, which go into administrative costs, by centralizing much of those roles. It can reducing churning across plans each year if individuals are allowed to stay in their plans when they change jobs and that there's the lack of underwriting is also going to lead to some reduction in churning. By requiring detailed reporting and disclosure of administrative costs and operations, plans can be prompted to reduce these costs for competitive reasons. Once this information is out there, people can compare on that.

And if a public plan option is allowed to operate within the exchange, this would introduce a lower administrative cost option for consumers and this could put additional pressure on the private plans to hold down their administrative costs as well to maintain their market share.

Moving past cost containment to affordability and subsidy delivery – as I mentioned, most of the uninsured are low-income, so affordability is going to be key to expanding coverage. We know that the cost of delivery subsidies in a non-organized market can be very large, though a healthcare tax credit – the credit that goes to some displaced workers to help them purchase coverage, which can be used with any private insurer in the marketplace. We have found that the administrative costs of processing those subsidies and paying them out are huge.

Over a third of the program's total costs are going to the administration of those subsidies and it would be much more efficient to centralize all the processes involved in that and have the subsidies available only for those enrolling in exchange plans. So, it would be a very big cost savings relative to doing the subsidies in the unorganized market. And additionally, having exchanges require participating plans to cover the same benefits, but with different levels of cost-sharing, can also help us a lot in terms of administering subsidies.

What we can do is subsidize individuals who are lower income to plans that have little or no cost sharing and then, as people's incomes go up, introduce a little bit more and more out of pocket costs and in this way, we can avoid going through the cumbersome and administratively costly process of

administering out-of-pocket subsidies separately, where individuals have to track all of their payments and submit receipts, etcetera, in order to verify what it is that they're doing. We can do it all through benefit package standardization through the exchange and that would be another savings.

And the final role I'm going to talk about is the exchange's role in the facilitation in enrollment. If we make it easy for people to comply with requirements to enroll in coverage, then the vast majority of people are going to do so and enforcement of any individual mandate that we might put in place is going to have to be concentrated only in a small percentage of the population. In order to achieve that goal, we've got to make enrollment barrier-free and we've got to make the coverage affordable.

Now, exchanges can help tremendously on this count by providing a central location for reliable information on insurance options and all the processes related to coverage, kind of a one-stop shopping kind of idea. An exchange would have well-trained staff available to assist people with choosing plans, determining eligibility for subsidies, making the payments to plans.

It could also track enrollment and disenrollment to minimize gaps in coverage for individuals when they have employment changes or when they have changes in family

structure. We know that maintaining coverage is a battle, not just at getting people in, but keeping them in and a centralized location that's working with plans and can track enrollment and disenrollment can help us a lot in that regard, in keeping voluntary coverage rates very high.

So, just to conclude, there are many different problems that we have in our insurance marketplace today and that we need to address under reform. The exchange idea is one that is needed in order to coordinate all the tasks involved in these different types of reforms, guide markets to compete in cost-efficient ways and monitor compliance with consumer protections.

If we don't have an exchange, it's possible to put all of these types of reforms in place, but what it would require some new government agencies, and lots of new roles for existing agencies. It would feel much more like a patchwork with different responsibilities and roles in different places and the efficiency that would be lost as a consequence of spreading these responsibilities out into various places — I think — would be relatively large. So, thank you very much.

ED HOWARD, J.D.: Very good, thank you [applause]. Turn now to Rick Curtis and the Institute for Health Policy Solutions.

RICHARD CURTIS: Hi. Everyone in this room understands that a key role for reform, a key goal is getting accessible, relatively affordable coverage readily available for all. I assume most of you understand that we need to bring everyone into coverage in order to afford -- that so that low-risk, low-cost people that Linda referred to are participating in a pool so that when they get sick, they can afford coverage as well. So, that's a first prerequisite.

The roles, as she said, and the coverage within the exchange would be available on a basis that the people who are sick, when they're sick, aren't stuck with a catch 22, pre-existing condition limits, don't have to pay more. And a goal here is that plans are competing on the basis of quality and price, not on the basis of going out and spending a fortune administratively, finding the lowest-risk people and avoiding the higher-risk people.

The right kind of market rules and the right kind of exchange structure can help a lot in achieving that. But even with all those structures and roles in place, some plans are going to end up with a higher proportion of those costly people and some plans are going to get a lower proportion of those costly people and (have) mostly lower-risk people, whether by happenstance or design.

And basically, behind the scenes you need what's called a risk adjustment mechanism going on so that the plans

that have the more expensive people are compensated for them and the plans that have the lower-risk people help pay appropriately. That can help level the playing field and there are a variety of ways this could be structured. I'm not going to bore you with that.

But, an important systems reform goal that's a little more subtle, but equally important is that right now, if a integrated healthcare system develops a way to care for people with expensive, chronic conditions and (does) it better, their reward is getting more of those kinds of expensive people and they can't compete. So, there's no incentive to do the right thing with that kind of structure.

If you get the risk adjuster right – and there's no perfect instrument now and so we should be phrasing this in terms of handling it well -- it means the plan will be well-compensated for doing the right thing and developing more efficient and effective systems of care for people with expensive conditions will be rewarded rather than penalized in the system.

Again, in order to structure a market to achieve these kinds of goals, and exchange is an efficient way to get there. But as everyone in this room knows, we're not exactly starting with a common ground consensus on exactly what these things should look like. Some people rush to judgment and say as soon as you establish something like that, it's going

to be price down government regulation of everything and people aren't going to have any real choice that makes any difference. Whereas, other people are very concerned with just a market structure that doesn't have anybody in the position to be a Priceline negotiator to represent individuals.

I think there are some people here in the audience which have differing views and we should give them an opportunity to air them.

ED NEUSCHLER: (sings) You say negotiates and I say compares.

ELLIOT WICKS: (sings) I say select the best and you say not fair [laughter]. Negotiates.

ED NEUSCHLER: Compares.

ELLIOT WICKS: Selects.

ED NEUSCHLER: Not fair. Let's call the whole thing off [laughter].

ELLIOT WICKS: Let's call the whole thing off.

ED NEUSCHLER: You like standard plans and I'm like, no way. I like rich benefits and you're like who'll pay? Standard plans.

ELLIOT WICKS: No way.

ED NEUSCHLER: Rich benefits.

ELLIOT WICKS: No pay. Let's call the whole thing off.

ED NEUSCHLER: Let's call the whole thing off. But, if you like connector –

ELLIOT WICKS: And we could conjecture –

ED NEUSCHLER: Bond silver, gold measures –

ELLIOT WICKS: Could be real treasures.

ED NEUSCHLER: Choices compared.

ELLIOT WICKS: Access unimpaired. Let's get the whole thing on.

ED NEUSCHLER: Let's get the whole thing on.

RICHARD CURTIS: Panelists [applause].

ED HOWARD, J.D.: Do you want to introduce the troop [laughter]?

RICHARD CURTIS: The person in the back, for those who don't know, is Elliot Wicks, who actually has been a student of this kind of structure for longer than you could imagine [laughter]. And Ed Neuschler is my colleague, who also is a great expert on these issues and they're both much better –

MALE SPEAKER: [Inaudible] [laughter].

RICHARD CURTIS: And another distinguishing characteristic is they're both much better singers than I am [laughter]. So, if we go back to slide, you'll notice there are shades of gray within these hues and we're going to talk about them for a moment. There are alternative approaches. There's no absolute right or wrong here, but importantly, while various combinations of policies can work, other

combinations can't. And I'm not going to bore you to tears here with arcane trivia, but I just wanted to lay out some of the basics.

Some would argue that if we're going to have an exchange it should allow in any licensed carrier. And basically, they just post like an Expedia mechanism. Whatever the prices are, the carriers set their own prices, but they're going to have to compete against each other and basically, whatever benefit plan they want to offer, can be offered as long as it meets, again, market-wide minimums. And that individuals not only can go there to choose among competing plans, but also can go to the outside market. And in fact, even if they're lower income, they can have basically a subsidy in the form of credit they can apply, either place.

That, in my judgment, could not be made to work because the adverse risk selection problems and incentives to compete on the basis of risk selection that we have in the current market would continue to exist and arguably would be exacerbated.

In the middle of the continuum, there is the notion that all plans have to at least meet some exchange standards -- those are higher than outside market minimum standard. The exchange, at least, is adjusting risk between plans in the market. This is the place that people go to get

subsidized coverage, which is going to make it far more efficient, as Linda mentioned. And carriers must offer plans in each actuarial equivalent benefit tier or benefit tier.

And the idea there is a plan could not go into the market and offer just a plan well-designed as a high-deductible plan to be attractive only to low-risk people. No risk adjuster in the world is going to able to make up for that kind of thing.

And then carriers in the outside market — if there is one still — have to meet new outside minimum credible coverage plan requirements and existing plan enrollees might be grandfathered. It might be the final compromise, has some elements, but a problem with this is if you're only risk adjusting between plans within the exchange and plans on the outside of the exchange can design plans that have lesser benefits and are more attractive to low-risk people and not to higher-risk people, you've still got a systemic adverse selection problem going on. And you can take a step away on these various dimensions and address those by basically, possibly allowing the exchange to pick the plans it thinks best meet its standards.

It selectively contracts to a degree, but it has to offer substantial choice. It can negotiate some on price, as is sort of true in Massachusetts, although the price for the

same plan has to be basically the same inside and outside the exchange and in the outside market.

And there would be standards for benefit tiers rather than just actuarial equivalence, which, as Nancy's going to talk about, can lead to quite a bit of confusion in comparing. So that would mean for the richer benefit tier, you would at least have a level of benefits that is defined and every plan has to include that package of benefits and might be able to also offer additional benefits in addition to that.

Importantly, here the risk adjuster works across the market so that plans inside or outside the exchange are participating in the broader risk pool. That's the kind of thing that could most assuredly kind of work, but may include elements that some wouldn't accept, and people that matter more than me.

There are other important elements that have to fit in, whatever the design is. Of course, an important one is what kind of employer responsibility in terms of minimum contributions for employers, for which size employers.

Exactly what the rating and access rules are – I think there's common ground on this already, that it should be guaranteed issue. There should not be pre-existing conditions. There should not be underwriting based upon individuals' health status.

But, on the other hand, there's not complete agreement on how much rates could vary by how old people are and there's not complete consensus on what happens with people that already have lower-cost benefit plans that pre-exist the market reforms.

The design of a workable construct will involve these and other kinds of measures, and a very important determinate of whether it works is that you've got a coherent package across these measures.

ED HOWARD, J.D.: Very good. Thank you, Rick. Now, we'll turn to Nancy Turnbull, and by the way, we're familiar with the concept of a high performance health system and now we're going to find out about a high-performance panelist. High bar to try to compete with, Nancy. But if you just tell us the facts about Massachusetts, we'll be very happy.

NANCY TURNBULL: Okay, great. Thank you, Ed. I'm very pleased to have been invited today to share some of the experience we've had in Massachusetts over the last three years with our version of an exchange, which we call the Connector. We have found that while the Connector is not a panacea, our reform has played a very important role in helping to expand coverage.

Let me start – just a little bit of background – on the roles that the Connector plays in Massachusetts.

So, our connector plays four important roles. Two are programmatic. It runs a program called The Commonwealth Care Program, which is a program of subsidized health insurance for lower income adults. And in this role, the Connector has an exclusive role. People can only enroll in this program through the Connector.

The second program is called Commonwealth Choice. This is a plan of unsubsidized coverage. This program operates as a market “structurer.” It establishes benefit packages. It selects insurers that can offer the benefit packages. But then insurers can also offer the products outside of the Connector. We sometimes refer to this as the Connector's role as the Travelocity of health insurance in the state.

And also starting last November, the Connector started selling products in the small employer market, although there are very few people so far. Then the Connector is also an important policymaking body for implementing our individual mandate, the requirement that adults buy insurance if it's affordable. Here, it both sets the minimum level of coverage and also determines what's affordable.

And then finally, the Connector's played a really important role in education, outreach and marketing. I'm

going to focus on the first two roles in the rest of my presentation.

We have learned a great deal in the last three years in Massachusetts from the Connector and I want to highlight four points and I'll say more about each of them.

The first point -- the Connector's just one piece of health reform and by itself, it would have had very little impact on expanding coverage. Its success has come, in large part, from the expansion of public programs and from the individual mandate, and the Connector has been important in implementing these programs.

In particular, our coverage expansions come on a very strong base of Medicaid coverage and there are about 800,000 people in Massachusetts, non-Medicare, non-dually eligible who are covered on the Medicaid program. This created a very important foundation of coverage on our state on which the Connector has built.

Second point -- the Connector's also built on a strong foundation of health insurance market reforms. Without these reforms, the Connector would not have had the success it's had in expanding coverage in the private market and certainly, would not have had success in making more affordable coverage available.

The third point – we actually have two connectors, really, in Massachusetts. We have one that's exclusive for

the Commonwealth Care Program. The second, which is non-exclusive for the Commonwealth Choice Program, so we've learned something about what happens, the benefits and weaknesses of an exclusive versus a non-exclusive approach.

And then finally, we have two different approaches we've taken in our two programs. One, in Commonwealth Care, we've had standardized benefits. In Commonwealth Choice, we've had non-standardized benefits. We set what's called an actuarial value standard and we've decided – and actually, we're going to move away from actuarial value in the Commonwealth Choice Program over the next few months, because we've found that it's just too confusing for consumers.

The first point, the importance of public coverage expansions, can be illustrated if you look at where the newly insured people in our state have gotten coverage. This would show you 60 percent of them have gotten subsidized coverage either through Commonwealth Care or through the Medicaid program. So, public program expansions -- very, very important to our success in expanding coverage.

Another third of people have gotten coverage through employer groups and I think we all agree in Massachusetts – regardless of whether we like the individual mandate or not – the individual mandate has been important in all coverage expansions, but particular for the increased uptake of employer coverage.

So only about 9 percent of newly insured people have gotten it through unsubsidized, private coverage and one-half of those people – about 19,000 – through the Connector, through the Commonwealth Choice Program, another 20,000 through private plans available outside the Connector. So, the Connector itself in the privately unsubsidized market accounts for only 4 percent of every newly insured person.

Now, every person who's newly insured is precious and important, but the Connector in and of itself, without the public program expansions and the individual mandate, wouldn't really have had much of an effect on expanding coverage.

The second point -- the Connector stands on the shoulders of 20 years of health insurance market reforms in Massachusetts. It's in the central foundation of our law and we made two series of market reforms between 10 and 20 years ago. And so in the small group market and the individual market, we have long had guaranteed issue and renewability, modified community rating, no rating on health status, on gender. The self-employed for 20 years have been in our small group market.

And very importantly, we 20 years ago, decided that insurers had to put everyone, regardless of what product they bought, into the same rating pool and this has been very essential for broad spreading of risk in Massachusetts.

We know that policies that offer more coverage attract people who need more health care and conversely, policies that have less coverage attract healthier people. We make insurers put them all together and we have for a long time. In our 2006 reform, we went further in insurance market reform, so we merged the individual and the small group markets for broad spreading of risk. This produced anywhere – depending on the carrier – between 25 and 40 percent reductions in premium for individuals.

This was essential to allow affordable coverage to be available to individuals and to increase the scope and reach of the mandate. We have the same rules, the same insurance rules, whether somebody buys inside or outside the Connector, including a requirement that people who buy inside the Connector are pooled -- the same rating pool again at each carrier with people who buy outside.

Another change we made is we allowed carriers to sell what we call young adult plans, YAPs. These are available to people between the ages of 18 and 26. They're designed to make coverage more affordable for the very difficult-to-insure group of young adults. The major thing that they have that other policies don't is they're allowed to have annual benefit caps. But, we've allowed the sale of YAPS within very tight rules, so they're rated in the same rating pool as everyone else and of course, that's exactly what we want for

spreading of risk. We want those young, healthy people to bring their good experience into the pool.

We didn't allow insurers just to come in and sell YAPs because we were very concerned about cherry picking. So, in order to sell a YAP, you already have to be active and have at least 5,000 people in the market and then you can only sell a YAP through the Connector. So, we really wanted to tightly control the sale of these products. So, insurance market reform very important.

I said that we run two exchanges and they have very different roles. Commonwealth Care is exclusive, an active purchaser, it negotiates aggressively. Commonwealth Choice, people can buy the same products inside and outside and we've learned a few things about exclusivity, I would say, through this structure. I think one of the things we've learned is the Connector has much more ability to create value where it's been exclusive. In Commonwealth Care, it's 100 percent of the market. Commonwealth Choice only has 25 percent of the individual market and having more members gives you more leverage.

Commonwealth Care has standardized benefits, much easier for people to compare. Where there's been a market outside the Connectors – there has been for Commonwealth Choice – a lot of gaming going on by insurers. For example, insurers can sell any products that they want to outside of

the Connector and there're dozens and dozens of products other than the Commonwealth Choice.

The last time for someone my age, I had 83 choices of products. It's very confusing and allows the kind of risk selection opportunity that Rick was talking about. Risk adjustment, we're about to do in Commonwealth Care because we're the exclusive market. Hard to do in Commonwealth Choice, where there's a big market outside. And it's also been much harder to innovate where the Connector hasn't been exclusive.

We're doing a lot of good innovation in Commonwealth Care, much harder to do in Commonwealth Choice. And I just wanted to show you a little bit about the power that comes from exclusivity. This just shows you, on your left, of the market share we have -- the four health plans that contract with Commonwealth Care -- and as you can see, we have anywhere between 15 and 35 percent of all of their members. They pay a lot of attention to us.

In the individual market, which is very small, we're kind of membership dust in a way – I guess you would say – [laughter] to the insurers, a very low market share. Even if we are exclusive for the individual market, this is what it would look like if every single person – so very low.

Now, if we were to add the employer market, the small employer market, this is the market share we'd get. As you can see, we start to have serious power.

The final lesson is about benefit standards. Commonwealth Care has standardized benefits. The approach in Commonwealth Choice has been different and it's evolving. So, we give our seal of approval to plans -- the statutory language is good value and high quality. And this includes express encouragement of limited network plans. So, we have four benefit tiers, the Olympic theme -- bronze, silver and gold -- and then the YAP plans.

And we specify an actuarial value for each of these, but we don't specify the benefits themselves. So, plans in each tier have to meet the same actuarial value and all carriers have to offer all four product tiers.

This shows you – it would probably be better if you looked at it if you were me -- and you had last week, gone to the Connector website. If you were me, you're 54 years old, live in the Boston area, these are the bronze plans that would have been available to you. And I think it shows you the limitations at actuarial value and why we're moving away from this.

So, you would have six bronze plans. So, these are all plans which have the same actuarial value. There's a 50 percent variation in premium, anywhere between $314 a month

to $476. You have three different choices of deductibles, anywhere between $250 and $2,000. You have doctor co-payments ranging from $24 to $40. You have three different choices of drug plans. You have three different emergency department co-pays. You have four different configurations of drug benefits. Not surprising, what we hear from our members, it's very confusing.

Focus groups that we've done recently with Commonwealth Choice members say we want choice, we like the benefit tiers, but please standardize the benefits. It's very hard to compare this, particularly with the price variations. So, we're going to be moving. We have a board meeting this week, of the Connector, and we'll be voting next month.

The proposal that we've got out on a re-bidding is to move to standardized benefits. It's too confusing for people. You'll also notice — this also shows us why risk adjustment is important. So, these are all plans, 50 percent variation in premiums.

The major difference is between the plans that were already in the individual market -- particularly Blue Cross, the highest rate – (and) the plans that weren't in the individual market but came in. So, risk adjustment would be very, very helpful here, but it's impossible for us to do, really, because we're only 25 percent of the market.

ED HOWARD, J.D.: Thank you very much and in case you haven't plowed through the biographies yet, Nancy is a member of Connector Authority board that has made some tough decisions so far and is continuing to have to confront a number of tough decisions.

Now, we get to the point where we can have some interchange among our panelists and with you. You can pull out those green cards, write a question and someone will bring it forward and you can use the microphones to ask questions.

I would ask you, by the way, not only to identify yourself and direct a question if that's appropriate, but also to be as brief as you possibly can so that we can get through as many. And let me just – at the risk of offending the very first person who has appeared at the microphone – exercise the prerogative of the chair to ask a question that has come in, in several different forms, in advance. For those of you who don't pay too close attention, you can submit a question in advance when you registered for the briefing.

We've gotten several questions -- and I would direct this to any of the panelists -- that reflect concerns over how low-income people, how vulnerable people would fare in a system with an exchange. Are there design features that would affect that population that we've been talking about,

or is this something that can be handled in just the same way as any other population? Rick, you want to start?

RICHARD CURTIS: Well, I think a first concern about the very poor, if they were – some of them or all of them – were referred to the exchange is that very simply, they have greater health care needs. If you look at any objective measure, their needs are greater and not just economic needs, but health status needs.

Among the uninsured poor, if you just look at the current population survey, over 7 percent of those under 50 percent of poverty report they're in very poor health, and that's compared to the normal working population with employer coverage in the vicinity of 2 percent. If you look at the very poor people on Medicaid now, it's much, much worse than that.

These are people with very substantial health needs and if you put them in the Connector – number one – or exchange, it would have to have a substantially more generous plan than it otherwise would. And number two, if it exclusively had that population, it would drive up the cost.

If there's risk spreading within all the plans in the exchange, it would drive up the costs considerably within the exchange and even if the exchange were the whole individual market and some other people, this population could well

constitute have of the total enrollment in the exchange, which would mean the prices would go way up.

There's good reason why, in general, the determination here and elsewhere is if we're going to finance coverage for people in great need, who are very poor, it should be from broad revenue bases, that we should all share in financing that rather than burden some portion of the population -- in this case, other people in the individual market.

And then the second concern I would have is the very poor have little or no attachment to work. We're including people who are mentally challenged, homeless people who are childless adults who are not now covered.

And these exchanges – if they're part of reform – are going to have a heroic group of tasks before them, just as it did in Massachusetts. And for the exchange to try to do all of those things on its platter, plus meet these very different needs of this very population, I'm afraid it would great imperil chances that reform would be successfully implemented.

There are variations on these policies that might be made to work, but in its purest form, I don't see how.

ED HOWARD, J.D.: Nancy.

NANCY TURNBULL: Yeah, I agree with what Rick has said and that's certainly the approach that we've taken in Massachusetts with the Commonwealth Care Program.

Most people who are on Commonwealth Care are very similar to Medicaid people and the program has been designed deliberately to recognize that -- the needs and the challenges of people who are low- and moderate-income. It has comprehensive benefits. In fact, it has the same benefits as Medicaid, except for long-term care for people under poverty. It has very low cost sharing, very low co-payments, no deductibles, sliding scale premium, where people at less than 150 percent of poverty pay no premium at all.

We provide it through the four managed care plans that contract with our Medicaid program. This was initially a statutory requirement, but we just went out to re-bid the program for the first time and no commercial plans bid on the program. So, they weren't interested in it. It's rated separately, the Commonwealth Care Program, which I think goes to Rick's point.

And people enroll in it through exactly the same eligibility system. We have a common portal through which people come into any public program. So, I think low-income and moderate-income folks, they have different needs and programs really have to be designed around that. Our program builds just so much on the expertise and experience of our

Medicaid program, including a lot of the background administrative functions.

ED HOWARD, J.D.: Cathy has given up her place in line and we'll go to the microphones. Yes, sir, John.

JOHN GREEN: John Green, with the National Association of Health Underwriters. I just wanted to clarify, Ed, that FEHBP is an employer plan. It's a large employer plan. I worry about FEHBP being compared to an exchange as a single entry point, single exit point, as an employer. It's not anything like the exchange concept, really. FEHBP allows for a lot of different plan variations, not standardized plans.

ED HOWARD, J.D.: Can I just stop you long enough to explain – I'm happy to be able to know this – that FEHBP or F-E-H-B-P, we're talking about the Federal Employee Health Benefits Plan, okay. Yes, I'm sorry, John.

JOHN GREEN: Okay, sorry. I get used to the Washington-speak. So, speaking of Washington, up here. We're talking about – in reform – about changing all the rules of the road, guaranteed issue, no health status. It's not the current form that we're talking about, going forward. We're all talking about changing no pre-ex and getting everybody in. So, our administrative costs are going to come down anyway.

Now, talking about the current environment in Massachusetts, their administrative costs, add another 4.3 percent on top of current administrative costs. So, in terms of affordability, a $15,000 family policy in Massachusetts is not very affordable to someone in Michigan or Mississippi.

NANCY TURNBULL: Actually, not very affordable to anyone in Massachusetts, either.

JOHN GREEN: Having said that, the subsidies that we're going to need to help people at the lower income scale afford coverage is going to be substantial and I just worry that building brick and mortar connectors around the country is going to be very expensive to do that, and I don't know where we get the money for that.

So, if you build this thing and we don't have a functioning market outside, if we have different rules inside from outside the pool, there won't be any outside pool to go back to. It'll all take us down another path, which I don't really want to go, to tell you the truth.

ED HOWARD, J.D.: Cathy, and then Linda, and I should point out that you might not know Cathy actually lives in Amherst, Massachusetts.

CATHY SHOEN: I'm going to just make a couple of quick comments, because I think we often get within our own little boxes of thinking very narrowly. So, I'm just going to do a little bit of an international perspective on this.

If we were willing to be bold and think of the exchange as a facilitator, a market-maker and transparent where, as Rick discussed, potentially all the business flows through, you dramatically lower the marketing cost because you're posting on a transparent Internet site. You dramatically eliminate the underwriting costs. Risk pooling becomes possible.

And when we look internationally, there are three countries out there that have competing plans, multi-payer, and their carriers are operating in the 5 percent of premium range and the premium is much lower. So, if I translated it into overhead, it's more like we're at $500, $600 and they're at $150. And we cannot do that without that type of pooling mechanism.

The exchange itself doesn't need very much money. Some of what Massachusetts had done -- they have already done a template. It's an Internet transparent site. It's a way of posting. It's a way of collecting money, potentially. So, those can be shared. The economies of scale on that overhead are tremendous if we took it to scale across the country.

We wouldn't want 50 exchanges inventing it. But, these other countries are operating in addition to the insurers at a very low additional operating cost to make that all work. So, I think if we think broadly we can imagine a

quite different world. It's a question of where we're willing to go.

ED HOWARD, J.D.: Linda.

LINDA BLUMBERG: I'll just add to that that when we think about what we want reform to look at, and the changes that we need under reform to overcome the problems that we have in the current system, we need to remember that there are new roles that need to be played and new roles are going to incur some administrative costs at implementing them. And what we want to do is think about how to implement them through a mechanism that is going to be the most cost-efficient way of doing that.

So, it is going to cost us money to check people's eligibility for subsidies and to get the low-income population enrolled. It is going to cost us some money to do better oversight of insurers and how the markets are working and to collect the data that we need in order to make sure that we're holding insurers accountable. So, what we want to do is say, okay, listen, we've got these roles we need to play. How can we implement them most efficiently?

And those changes are going to — by the way, hopefully — put some pressure on this system to lower costs overall over time. But, we do need to recognize that these are new roles that aren't being played today. No state department of insurance is negotiating rates with insurers.

All these things are new roles. Let's just figure out how to put them in place in a way that's going to be the lowest cost, most efficient way to do it.

ED HOWARD, J.D.: Yes, go ahead, Rick.

RICHARD CURTIS: Nancy could elaborate on this, but one of the reasons it's a 4. — the reason it's 4.3 percent individual market in Commonwealth Choice is because it's such a tiny fraction of the market, right, and their estimates of what would happen with substantial increase in enrollment are that would come down considerably. That's number one and number two, Massachusetts — before this final set of reforms — as Nancy mentioned, already had modified community rating in place.

They had an extraordinarily high cost and after all these reforms are in place, it dramatically reduced the cost of individual health insurance.

ED HOWARD, J.D.: Yes, go right ahead.

WEIWEN NG: Afternoon, Weiwen Ng from the Center on Budget and Policy Priorities. As I understand things, when risk adjustment was first used in Medicare Advantage, it kind of understated the true cost of high-risk beneficiaries. I'm wondering if the panelists could describe (if) the present risk adjustment factors that we now know of are adequate to capture all the differences in health status?

ED HOWARD, J.D.: (to Nancy Turnbull)You got one. You're using one.

NANCY TURNBULL: Actually, we've not put ours in place yet, but we're moving, starting in July, to a system where we'll be looking at prior claims of Commonwealth Care members and be adjusting – along with a lot of other factors – of payments that are made to the four managed care plans that contract with Commonwealth Care. So, I think it's fair to say that the science of risk adjustment has evolved quite a bit over the last 10 years. They're still far from a perfect risk adjuster.

But, I think we have noticed significant variations in the people, and their experience, that are enrolled just across our four plans and so we're quite confident that we're going to have a fairly robust system that at least will make it better. It won't make it perfect and there'll be significant transfers of money from plan to plan as a result of that.

ED HOWARD, J.D.: And we have all these economists who have always been telling me that risk adjusters are in their infancy, but I've been hearing that for 20 years [laughter].

CATHY SHOEN: It's a big topic, but I think Nancy's ending point on what we know how to do is much better than it used to be, and doing something is better than doing nothing

on risk adjustment. We can see the risk variations within plans. You dramatically re-channel the energy and again, we can look within the Medicare program, but you can look at three or four countries that are literally transferring a large amount of money, potentially.

But, what it's meant is the plans actually can compete for diabetics without fear of losing their shirt and they changed the nature of the competition by saying if you get a disproportionate share, you're going to get paid for it. So, doing it changes the dynamics, even if it's imperfect.

RICHARD CURTIS: Well said. The only other thing I would point out is, because it's not perfect and because most of us would think it's not going to be perfect anytime soon, you need these other market structures and rules because a risk adjuster by itself in any willing plan, any benefit plan, selective marketing to individuals with your special plan. You only show this to individuals who are healthy. That level of risk fragmentation in the market cannot be dealt with by a risk adjuster. Go with a structured market. It should be adequate.

ED HOWARD, J.D.: Linda.

LINDA BLUMBERG: Yeah, I was just going to amplify Rick's point that when you've got a lot of variation, in actuarial value of an insurance package or a lot of variation

in the benefit package period, you can't overcome that with risk adjustment. The more uniform are the packages, the closer they are to each other, the more you can do with risk adjustment. Once you get really far apart, then the structure falls apart.

I'd also add that one of the roles of the exchange that's going to be really important in being able to do risk adjustment is that you've got to collect a lot of data on claims and on the characteristics of the enrollees from the plans in order to do that.

And if you agree to participate in the exchange, that's basically an agreement to participate in that. It's a lot easier to do that when you've got plans that the exchange is used to dealing with. They're used to interacting with them over premiums, over other kinds of information to facilitate the process greatly.

ED HOWARD, J.D.: Yes, Enrique.

ENRIQUE MARTINEZ-VIDAL: Hi, Enrique Martinez-Vidal, director of the Robert Wood Johnson Foundation State Coverage Initiative Program. I know most of you have worked at the state level on these exchanges and that's where we have the experience that you've all been talking about today. There's also been a lot of talk about a national exchange in the national discussion that's been going on.

I was wondering if you had opinions about the pros and cons -- how a national exchange would work versus state level exchanges or some combination of the two? Any thoughts?

ED HOWARD, J.D.: And I should say that you're not alone in your wondering. [Laughter] These are all questions that have to do with the relative merits of federal versus state, versus regional, versus opt-ins. Linda?

LINDA BLUMBERG: I will just say that I think that the decision about whether or not to have one big exchange, (or)have multiple exchanges in different areas, is really more of a political decision than it is an operational decision, with certain caveats.

First of all, it’s very important that we not have exchanges competing with each other. You want one exchange for one area because you don’t want to have another opportunity for risk selection where now exchanges are competing in order to get the best risk, so that is number one.

Number two, when we are talking about a federal reform, we are talking about federal equity issues and federal financial issues, okay. You can’t have a huge variation in terms of the benefits that are being provided across different geographic areas if you are trying to make sure that number one, the federal dollars are being used efficiently and

appropriately and that you don't want to have somebody in Mississippi being a lot more soft than somebody in Alabama.

Number two, I think no matter how you do it, you are going to have to respect local prices. You are going to have to allow for local plans to be offered that don't have to (be offered) across the whole country, whether it's one national exchange or many of them. Still, some plans are going to operate in some areas, not in others. We have to allow that and we also have to allow variation in price per geographic location.

So, I think within the fact that you have got to have some real serious federal guidelines within which smaller geographic area exchanges need to operate in order to protect federal dollars and equity in access to coverage across states, that you can kind of set these up either at the national level or lower level but it's got to be within pretty serious guidelines at the federal level.

CATHY SCHOEN: I'll just underscore that most of the discussion when you hear the word national exchange, it's what Linda has just talked about, it's the national framework. We have shared operating rules. There could be some infrastructure that was commonly developed so not everyone has to redevelop it, but there is some level of state operation or regional operation.

Particularly because in addition to the geographic variation, that map I showed you, the country, are the dominant national insurers. There are very high quality integrated plans locally that currently have no access to the small group market, very little access even to the large group market because there are whole replacement products going on with the large commercials so you suddenly get the Harvard Pilgrims, the Fallons, the Group Healths.

If you can have a state-level operation, being on the Choice list again, we don't -- most of us who now have employer- based coverage have one carrier they may offer, triple track, but we no longer have a full range. It has been replaced so we can open up choice in the geographic level by running them locally within the national framework.

RICHARD CURTIS: I agree. I will just put it a different way. I don't think it's a question of whether it's a national one single exchange or state. I'm sure there will be some options for states. And there are shades of grey as to exactly what those options might entail. And in fact, there might be alternatives that states could use where they would have a board but not have to undertake the operations, that the board would make the decisions about which plans are admitted and the states could go beyond that.

And none of us knows exactly how that is going to play out, but I for one would be astonished if it is just one model

nationally, both operationally and in terms of board and governance.

ED HOWARD, J.D.: Here is a related question, actually. Who is going to decide what the benefits are that will be offered, if they are going to be uniform nationally? Are we going to cover breast cancer screening, prostate cancer screening? Are we going to do it in Mississippi and not in Massachusetts? Who is going to decide? Who should decide? Linda's decided that she can decide. [Laughter]

CATHY SCHOEN: Certainly the larger national reform debate is about putting a floor under benefits, a minimum. What is startling to me is when you open up some of these packages, the level of variations are astonishing. Massachusetts found this when they said what should be the minimum. There is going to be a political decision about this.

What has been interesting to us -- and Rachel Nuzum knows of this, at the front table here -- we started looking at the state variations and we are not as variable as we think we are. We say, what is in the federal employees' plan and how many states are well above that? We have got some standards; we just don't have standards in the small group and individual market on what we expect.

So I think there is a way of starting to reach agreement on a minimum but it's definitely a larger political discussion. Our variability gets us into problems and we know

that so what above the minimum, some of what you've heard is how many layers on silver and gold, you know, how standard are we going to be on some comparison rates?

ED HOWARD, J.D.: Nancy you talked about actuarial equivalence and you have sorted the plans into three or four different bundles. Who decides in Massachusetts whether breast cancer screening gets covered or not?

NANCY TURNBULL: Well, our law very explicitly says, for insured plans, that anything that has already (been)mandated (as a) benefit has to continue to be a mandated benefit. But it's essentially the Connector board (who)has decided what the minimum level of coverage is, and the issue that we have struggled with the most is the inability of states to get at employer plans because of ERISA.

So, our individual mandate goes to individuals, but most individuals get their own coverage through employers and yet we have no ability as a state to obligate employers to do anything. So we have grappled mightily with how do we come up with a minimum standard that recognizes the vast differences among employer plans which we can't get to, and how do we come up with minimum standards that apply to individuals when they get their coverage through employers?

So, the biggest one, for example, that we grappled with is: Should we require prescription drug coverage to be included in the minimum benefit package? And as a public health person,

I say of course we should, because drugs are so important to the treatment of so many different conditions.

Well, it turns out even in Massachusetts where we have quite comprehensive coverage, there are a lot of employers that don't offer drug coverage and so we really struggled with that. We have gone and we did decide to include it, but we are going to have -- when that provision of law goes into effect in a couple of months -- many, probably tens of thousands of people who are insured in Massachusetts from employer plans that don't give them drugs, coverage, and there is nowhere in the private market for them to buy it. So at the very least if there is a minimum floor set, it has to apply to all plans.

ED HOWARD, J.D.: A question here about the attitude of insurance companies to the exchange, what arguments -- and if there are those of you who represent insurance companies you can respond to this, you might not want some of these folks speaking for you -- but what arguments do the insurance companies bring against the idea of an exchange? You have lots of private insurance companies participating in the exchange in Massachusetts, Nancy.

NANCY TURNBULL: Yes. We have had several concerns. I didn't do this before I came, but I think in fact that we don't have any private companies participating who aren't obligated to sell through the exchange. Any company that has at least

5,000 people in the small group market has to sell through the exchange.

One concern that we have had expressed, which is there are some insurers who are very happy to sell through the exchange -- and if you look at them, actually most of their individual coverage is being marketed through the Connector. Then there are other companies -- and this is primarily ones who had large market shares beforehand -- who think that they have been disadvantaged through the exchange.

So it tends to be the smaller companies who think the exchange will improve their competitive position who have been excited about it, and our dominant carrier in particular has been less excited.

The one thing that they have expressed concern about, some of them, is that they worry that coming through the exchange that consumers will associate their coverage with the exchange and not with the insurance company through which they get it.

So that if they, for example, have a bad customer service experience through the exchange that is related to the exchange but not to the care, that they will be tared with that. But it’s actually been the brokers who have had more concerns in Massachusetts, I have to say, about the exchange.

RICHARD CURTIS: I can tell you based on the California debate where in that case -- and I think this is unusual, this

is the largest single carrier in the individual market, they have lots of enrollment, heavily underwritten benefit plans designed to be attractive to low-risk people that they make available at very low prices because there are very low-risk people they are covering -- that kind of a plan adamantly opposed all elements of reform in market roles as well as the exchange.

I understand that one exchange has tuned somewhat since then, but that will be a typical reason and it would more typically be a fairly small player in the market whose basis of competition is risk selection, not efficiency or cost effectiveness.

ED HOWARD, J.D.: George?

GEORGE GREENBERG: I was just confused -- I'm George Greenberg and I worked at HHS -- but I was just confused by the last discussion, because I understood the current rules in Massachusetts were if your employer offers health insurance, as long as it's somehow affordable coverage, you have to buy through your employer and you are not eligible for the Connector.

Now, what I just thought I heard you say is that if you include a minimum requirement for drug coverage and your employer plan doesn't include that drug coverage, then you can no longer buy through your employer and then your employer has the choice of either dropping coverage and letting all their

employees buy through the Connector, or somehow the person has to pick up drug coverage through the Connector and not by through their employer.

So it sounds like you are changing the rules dramatically but I am not really sure and I just thought maybe other people didn't follow or maybe I'm just dumb but I thought I should follow up.

NANCY TURNBULL: There are two different things. One, the first is who is eligible to buy Commonwealth Care, the subsidized program. In order to be eligible for that, you cannot have employer coverage available to you and that provision is in the law to prevent crowd-out or people dropping their employer coverage and coming in to the subsidized plan. So anyone who has employer coverage available to them cannot get into the Commonwealth Care program.

What I was talking about are the rules for what constitutes the minimum coverage that somebody has to have in order to meet the individual mandate requirement. And so the issue here is that the minimum coverage will soon include a requirement that you have prescription drug coverage, but you may get your coverage through an employer whose plan does not include prescription drug coverage.

So even though you are insured for purposes of the individual mandate, you don't have sufficient coverage in order to meet the requirements of the individual mandate, you have

what we call non-creditable coverage. So presumably what most of those people will do is they will come and request a waiver under our program and say, even though I have affordable coverage available, but it's not credible. You can't penalize me for the fact that I have coverage that I can't buy, even if I wanted to. So, it is two different things.

GEORGE GREENBERG: How do you feel that dilemma [inaudible] individuals, is it just [inaudible] based?

NANCY TURNBULL: I think it's just going to have to be an exceptions basis. The requirement hasn't gone into effect but we on the Connector board have taken a general policy -- because we are trying to contend and structure something in the system where we don't have full control over all of the pieces -- that we need to have quite a generous waiver and exception policy for people. So certainly as a board member where I'm confronted by saying should we give a waiver to those people, I would say absolutely.

LINDA BLUMBERG: Can I just add a couple of things. First we would anticipate that, given the individual requirement, that plans are going to change over time, that the employers are going to become more and more likely to be including the prescription drug benefits so that the individuals are in compliance with the mandate.

They don't have to worry about applying for waivers because the individual workers can go in and say, listen we

want coverage that is going to satisfy the law's requirement and so we will have to make some trade-offs in other things in order to accomplish that. So, that would be one thing.

The other thing is that being a state, Massachusetts is in a very different position in (relation to) the federal government. The federal government could state in its law that no coverage that is not at least the minimum creditable coverage defined in the legislation can be sold, whether it's in the group market or in the individual market, inside or outside the exchange. So at the federal government there is a lot more power to make sure that what people are buying is in compliance with the law.

ED HOWARD, J.D.: Which would in effect be an amendment to ERISA for that purpose.

NANCY TURNBULL: Yes.

DAVID CONNOLLY: David Connolly with Capital Associates, and I have an ERISA question because Nancy, don't you mean employers who have self insured -- because the employers who are not self insured in Massachusetts can go out and buy a commercial product -- they are subject to all the mandates that your state requires.

NANCY TURNBULL: Yes, ironically enough there is not an insurance mandate to include drug coverage.

DAVID CONNOLLY: Thank you. That clears it up.

ED HOWARD, J.D.: I have a question about something we haven't touched on yet, and that is coordination of benefits. The questioner says, I believe that insurers don't pay nearly all the claims they should legitimately pay because people get so confused, they don't submit the claims. So who is going to do the coordination of benefits under an exchange model?

RICHARD CURTIS: I would just point out that what Nancy described, moving towards more uniform, standardized benefits, that can substantially decrease confusion over this. I can tell you that Dr. Wexler [misspelled?] has a daughter and myself that are supposed to be experts at this stuff. I consider that when I have to get a bill paid that is some category of like out of network or something, it's like the lotto, you know. I have no idea if it's going to be covered or not. It's not a happy circumstance.

ED HOWARD, J.D.: I should say, by the way, we have a number of cards here that we will get asked as time permits and I would ask you to take an opportunity to pull that blue evaluation form out of your packets and jot some things down so that we can improve these briefings as we go along.

I am going to read this one verbatim because I don't understand it in the context that it is being used. The use of Section 125 -- maybe I don't really know what Section 125 does -- may not pose issues in the Massachusetts Connector for

employer purchase of non-group because the non-group complies with HIPAA non-discrimination rules.

What is your judgement about the use of employer contributions from 125 in the connectors that use the tax deduction to purchase individual product that does not community rate or guarantee issue?

RICHARD CURTIS: I actually followed all that. This is something we have spent time –

ED HOWARD, J.D.: Could you sort of explain what it was I just asked you? [Laughter]

RICHARD CURTIS: I can explain what I think it was asking. Massachusetts took advantage of the fact that the federal allowance for exemption from taxation is individual income for employer coverage extends also to the employee contribution when the employer sets up what is called a Section 125 plan.

Some time ago, there was informal guidance from IRS that says well, if it's an individual employee who is buying an individual coverage, so long as the employer's deducting that employee contribution from their payroll that too can be exempt from taxation, this individual income. So Massachusetts said, hey, we can save these people who aren't eligible for employer coverage, but who work for an employer who were required to get coverage, we can save them a fair amount of money by requiring

the employer to make available to them that tax exemption, that 125 plan.

But part of this ruling is that just because this is pretending that the individual plan -- the lawyers called this a necessary fiction -- that because of pretending that the individual contribution is an employer contribution and that is why it has to be deducted from payroll. That is so that they can under the law extend this 125 savings.

This plan has to behave by the same rules which are the HIPAAA rules, which include non-discrimination. You can't charge a sicker person more than a healthier person. So, that is what this question is about and when we think about this. I think it's a damn good thing because if you didn't do that, then the individual underwritten market as we know it now could go out and aggressively take apart small employer coverage.

And even though the coverage is far less efficient because it's got much higher overhead and so forth, for the healthy people in the groups which might include the employer and his key employees, this becomes a lower-cost way of getting coverage, and meanwhile the sicker people are out of luck. I think that is exactly the wrong thing to do and I thank goodness that these lawyers with their convoluted logic came to the conclusion they came to.

NANCY TURNBULL: Can I add one thing? Notwithstanding Rick's very clear answer to that question, you can now

understand why the Section 125 requirements in our law are universally regarded by employers, whenever we survey them, as the most confusing and the ones which they are least likely to comply with.

RICHARD CURTIS: Let me add something, and that is why for federal reform, congress can do better. They don't need to just extend the 125, they can just say for people at different income levels, this is the tax break whether they get it through the exchange, through the employer, and make it simple.

ED HOWARD, J.D.: Nancy, we have a concentration of questions that at least initially are aimed at you. You say that the Commonwealth Care connector, the subsidized model which has exclusivity, is more innovative than the non-exclusive Commonwealth Care. Most of us assume that greater regulation and government control results in less innovation.

In fact, the variety of benefits offered in the less regulated choice, Commonwealth Choice, seems to show lots of innovation. So can you give us some examples of innovation in the Commonwealth Care?

NANCY TURNBULL: I don't regard differences as being necessarily innovation so that may be where I differ. I think within Commonwealth Care -- so there are a lot of benefit differences within the Commonwealth Choice but there is very little innovation -- so Commonwealth Care is moving towards as I said risk adjustment, which will be quite a good innovation.

We are also exploring the possibility of doing more value-based insurance benefit design -- to really try to give incentives to the benefit package for people to engage in healthy behaviors and also to eliminate the cost sharing that does exist for people who have chronic conditions. None of this is going on in our Commonwealth Choice market.

One of the challenges that we have faced in Commonwealth Choice is because insurers are selling lots of different products outside of the market, and this has been a particular challenge in the small employer market where we have a product but very few people enrolling.

As we always need to be careful as we think about innovating, what is the reaction outside of the market going to be, and in particular how might innovative product designs be responded to by insurers outside. So that is why having an exclusive purchasing arrangement for Commonwealth Care just makes it much easier because we don’t have to worry about what the responsive insurers will be.

LINDA BLUMBERG: Just to add to that, I would say we have to remember that the more comparable the plans are, so the more limited the variation is, the more people are going to be looking at price when they are making decisions about what to enroll in, because they don’t have to worry about, well am I getting, is it less because I’m getting less or whatever.

So the more comparability you have in plans, the more it is going to be a competitive purchase market and then the more pressure that puts on the plans to think about well, how can I hold down my costs, how can I manage high cost cases better, how can I do better disease management?

I need to bargain tougher with my providers because I need to hold down costs to make myself look more attractive. There is the cost containment and then the cost reducing strategy, types of innovations, are the ones that are going to come with the more comparability that we have.

ED HOWARD, J.D.: Nancy, one more directed at you. Please explain why you can't risk adjust in Commonwealth Choice because you have such a small part of the market. Why can't you risk adjust for the lives that you do have coverage?

NANCY TURNBULL: Oh, I think we could risk adjust, but I think given that we have less than a quarter of the overall market, what we ideally would want -- and particularly because it's a combined rating pool -- it would be technically possible but I think not as much value to risk adjust just for our population of people.

I think particularly because we have combined the rating pools, if we were able to, which would again I think be technically possible but very, very difficult to do across the entire market. That is where the value of risk adjustment would come, and in particular because we have so many products

that are not Commonwealth Choice products that are sold by insurers outside the exchange.

I think most of us believe that those are the products that are experiencing the most significant positive risk selection and so unless we could bring those products into the risk adjustment scheme, the value of risk adjustment would be really much less than ideal.

CATHY SCHOEN: I think that is the important point, that the reason you want to do it is have all the plans be competing by doing better as if they had the same or equal and if you only have about 20 percent or 10 percent of the lives and the other 80 percent you don't even know what that experience is and you don't have any ability to do it right.

When you get in a system, you have to see systems in action but there are again the Medicare program can do it, the Netherlands knows all 16 million Dutch residents. When they are doing risk adjustment they actually know it and it's just a very different feeling. Did you get a good group of risks, a lower group of risks, is that why your price is higher or lower? The only other piece of the market, it's extremely difficult to get that information.

NANCY TURNBULL: Right, and I think also just because we know that there is such a concentration of high costs in just a small proportion of people, you really do have to find

everyone in order to get the benefit of risk adjustment and the fairness of it.

RICHARD CURTIS: Perhaps this is just an amplification of what Cathy said when she said better than I could have, and that is an example and Nancy could put names on this example. I can't but if you have in the exchange four or five plans and you have got 15 plans participating in the outside market, then 10 of those plans, say nine of the 10 plans that don't participate in the exchange are specializing in selective marketing and benefit plans to attract low risks. They are not in the risk adjuster, so you have got the good guys sharing risks and it's not really solving the problem. That is why you need a far more robust population base.

NANCY TURNBULL: I only know 10 of the 15 names, so you will have to tell me the others. [Laughter]

ED HOWARD, J.D.: This question sort of takes us back to where we started the Q&A. Can you elaborate some about the role of Medicaid in an exchange? Is it best to use it to identify eligible people and get them into Medicaid, which has a very different benefit package, than the standard private plan like EPSDT for kids? Is there any real way to have Medicaid-eligible people covered through the exchange with a wrap through Medicaid by premium support? Right now that doesn't seem, the questioner says, to work so well, so what more do you have to say about that?

LINDA BLUMBERG: I think that regardless of keeping, if Medicaid has kept a separate program at all, I want to make sure that there is -- as I mentioned before -- kind of a one-stop shopping in terms of enrollment and health insurance coverage. (An) exchange could play a big role there in terms of people coming in, that it can be determined whether or not they are eligible for Medicaid or whether they are eligible for other subsidies.

But this is going to require some changes and some careful thought about how we measure income, because what we don't want to do is set up the system where we have got one measure of income for the Medicaid population, one measure of income for the other low-income subsidized population, and somebody is going to be caught in between that eligible for anything because of differences in definition so that is going to be really important.

I think down the road there is going to be potential for creating a uniform system where benefits are enhanced for the very low income and that we are able to take care of people in kind of more of a single comprehensive system. I don't think we are there yet and I think that the risks for the very low income, as people discussed earlier, are quite high. And we don't want to start a whole new system from scratch where we have to worry about the very low-income people falling through the cracks for what their needs are.

So I think the way we want to think about this is right now when we start, we need to think about the Medicaid population as separate but use the exchanges and every other process we can come up with to get them enrolled effectively and then over time how do we make -- how do we bring everybody in together while still adding the extra benefits that the high need population requires?

RICHARD CURTIS: Going to the question of supplementing benefits, it sounds like a simple political compromise. That is extraordinarily different and if I was going to point to any one place in America where the interface between public and private is least efficient and most complicated would be this.

A number of state Medicaid programs now coordinate with available employer coverage. It doesn’t happen with a high degree of frequency because it’s so complicated. If that employer coverage has cost sharing that goes beyond Medicaid cost sharing and benefits that go beyond the Medicaid cost sharing, the benefit part can work. The other two parts are a mess and here is why.

Normally the provider networks in the Medicaid plan are different than they are in the mainstream commercial plan, and so you have somebody in the course of treatment in their commercial plan, they run into a benefit limit. They run into some sort of other higher cost sharing level or they are just

getting the course of care there but there is a 20 percent copayment requirement.

Now you turn to the Medicaid program and say supplement those benefits but guess what? The provider is not in the Medicaid program network or not even in the Medicaid fee-for-service plan. This is very typical and the 80 percent that commercial plans pay to the provider is already twice as much as the Medicaid plan normally pays providers for that service. And, let me tell you, it's a nightmare out there when you try to make that work.

There might be ways of simplifying that over time through some uniform benefits and procedures but I agree with Linda, we are not even close to there yet and to add this one on top of everything else we are trying to do I think is not wise.

NANCY TURNBULL: Could I just add one other point which is: I think however we do it, it is very important to deal with the issue of churning for people, so a major problem for people on Medicaid in Massachusetts on our Commonwealth Care program is people come on and off eligibility very quickly.

One of the advantages that we have seen from having the same health plans contracting with the Medicaid program and with the Commonwealth Care program is that people may be covered by a different program but they can stay on the same plans and figuring out how do we ensure consistent coverage for

people, even if they are moving from one payer to another is absolutely essential.

ED HOWARD, J.D.: Okay, let me just try one last question here before we wrap it up. How important is it to standardize benefits and the other elements of health insurance to create an insurance exchange? And at the very least, does standardizing significantly increase the exchange's effectiveness and the utilization as well?

NANCY TURNBULL: Maybe I can start. As I told you, we've obviously decided that standardized benefits are the way to go after three years of experience and very clear feedback from consumers who are covered under the plans. People have told us also very clearly that they want choice of tiers, that they don't think one size fits all and that some people prefer higher cost sharing and some people want lower cost sharing.

That works in our market because, again, we pool broadly across all products, but I think insurance is inherently complicated and what we have heard very clearly from people (is) we want choice of insurer and we want some choice among plans, but people are very comfortable going to standardized products within a tier.

And I think it's just an essential component of trying again to get broad spreading of risk and to insure that insurers will compete on creating value, doing better care management and all those other things and not on product

design. It's much, much easier always to figure out that one- or two-benefit difference that will lead to positive selection than to actively manage care and do the things that we really desperately need to do in order to control costs.

RICHARD CURTIS: I'll just say again, we all agree that we need a much greater degree of standardization and access, but there are shades of grey here and that can be made to work and I won't elaborate on them again but you can allow variation above the floor plan in each tier, so long as all the plans offer that core plan and people can see how much extra it costs. That way you can have head-to-head competition and more consumer choice at the same time.

LINDA BLUMBERG: I'll just say it's absolutely critical. I'm very much in agreement with what this guy said, but it's very critical that these packages, even if you don't decide to go the standardized route -- which I think is much better in terms of risk spreading, as Nancy mentioned -- but it's absolutely critical that all of these packages, even with the actuarial value variations, have pretty strong guidelines about what the benefits are that are included.

There may be some cost sharing differences but you want that core set of benefits that are being covered to stay the same because otherwise you are opening the door to tremendous amounts of risk segmentation and it just undoes all the good that you are trying to do.

ED HOWARD, J.D.: All right. Good last word. I want to thank you for hanging in with a lot of very difficult material and a lot of very difficult issues. Thank you also in advance for filling out that blue evaluation form to give us some feedback on how we can improve on our briefings.

Thanks to the Commonwealth Fund for its support of, and excellent participation in, the program and thank you -- and I ask you to help me do this -- to the panel, for wrestling with and pretty much getting to the ground a very, very difficult topic. [Applause]