



**Open Enrollment Preview: Checking the Vitals of the  
Marketplaces**

**Ascension**

**Alliance for Health Reform**

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MARILYN SERAFINI: On behalf of our honorary co-chairs, Senator Cardin and Senator Blunt, I would like to welcome you to today's briefing on marketplace stability.

After several years of participating in the ACAs insurance marketplaces, a couple of large carriers made news recently when they decided that they would not participate in some of the markets next year. Some who are staying are planning to raise premiums and all of this has started some important conversation about the stability of the marketplaces moving forward. Today we are going to discuss the dynamics and the potential impact and possibly policy action. I would like to thank Ascension for its support of today's briefing and I want to let you know that if you would like to join the live Twitter conversation, that the hashtag is #insurancemarketplaces. When we get to the Q&A portion of our briefing, you will also be able to give us your questions via Twitter, so you will just need to use that hashtag #insurancemarketplaces. We will pick up your questions and then I can present them to our speakers. We also have a couple of microphones in the audience, you will be able to ask your questions live and you also have a green card in your packets if you would rather ask your question that way, at any time during the briefing, write a question on the green card and when we get to the Q&A portion, our staff will be around to pick up your green cards and they will bring them up to me.

So, two more pieces of housekeeping before we go ahead and get started. The first is that I wanted to let you know that you have in your packets a number of articles and reports and one of the pieces that you have in there is a piece that one of our speakers, Sabrina Corlette wrote with Jack Hoadley, it does not have – it is the one piece that you will see does not have an author written on it. So instead of killing a bunch more trees, we decided not to reprint it, but you do have a materials list with the proper citation on it and you will know that piece that you are wondering who the author is, that is Sabrina and if you are looking for the citation, look on the right side of your packets, you will see the full citation there. The other piece of housekeeping I wanted to mention is that the Alliance for Health Reform is hiring. We are in the market for a health policy associate, so if you are interested or you know someone who may be interested, please come to our website and look at the description and we'd love to hear from you.

So at this time I would like to introduce our speakers. I'm only going to give you very short bios for our speakers because you have full bios in your packets. First, on my far right, we have Sabrina Corlette. She is a Senior Research Fellow and Project Director at the Center on Health Insurance Reforms at Georgetown University's Health Policy Institute and she is also an adjunct professor of law at the Georgetown University Law Center. Next, we have Elizabeth Hall. She is the Vice President of Federal Affairs and Director of the Washington Office for Anthem. To my left, we have Chris Holt, he is the Director of Healthcare Policy at the American Action Forum and to my far left, we have Peter Lee, he has been the first Executive Director for California's Health Benefit Exchange, Covered California. Again, you have their full bios in your packet.

So we are going to start first with Sabrina. Here we go.

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SABRINA CORLETTE: Thank you, Marilyn and thank you to the Alliance for inviting me to be with you all today. So I was asked to kick us off with a little bit of a discussion of the state of the Affordable Care Act Marketplaces and to put it bluntly, the state of the marketplaces is that they are evolving.

I will talk just about a few indicators of where we are going into 2017 with the marketplaces. We are looking at, in general, lower insurer participation than we have had in 2016. Of course, many of you have probably seen the headlines about Aetna, United Healthcare and Humana, which are large national carriers, reducing some of their participation. So for example, Aetna is pulling out of 11 of the 15 marketplaces in which they have been. United down to three from 34, et cetera. We have also lost a number of the co-ops, which were carriers launched under the Affordable Care Act. We are down to six, from an original of 13. Also, significantly, these haven't grabbed the headlines, but we are seeing the departures of some smaller regional carriers, such as Scott and White Healthplan in Texas and others that are really operational in the local level. A recent analysis by the Kaiser Family Foundation found that in 2017, approximately 19% of enrollees would have just one carrier in their marketplace. That is up from 2% this year. So it's a pretty big change. What we are hearing from carriers and we will hear probably more about that from Liz, but reasons for withdrawing, largely that they are losing money on the individual market. They are seeing sicker than expected enrollees, which stems in part from lower than expected enrollment, but I think some of them will also tell you, they are seeing folks who are jumping in through special enrollment periods, or SEPs to get healthcare services and then jumping out again, causing a lot of trouble for the risk pool. Another issue is inadequate compensation from the three R's or the ACA's risk mitigation programs. In particular, Congress frankly pulled a bait and switch with the risk corridor program, leading carriers to price lower in 2014 than they otherwise might have and then only providing 12 cents on the dollar, thanks to a late budget deal.

We are also seeing premium changes. I will say, these numbers are preliminary, not all states have finalized rates. A McKinsey study from a few weeks ago estimated average increases for silver level plans around 11 plus percent, that is the nationwide average. And it's important to put this into context and understand that while that is a pretty big jump, the net premium change for subsidy eligible, relatively modest. Again, these are McKinsey numbers from August 24<sup>th</sup>. I think it's also important to know that these numbers mask some pretty wide variability state to state, carrier to carrier and market to market.

Some carriers are making this work. Market forces are at play and some carriers are making money or believe they are on a strong path to making money in this market. Those that seem to be making it work point to an aggressive marketing strategy in which they have really targeted the lowest of the low income enrollees. Also, narrower provider networks to control their costs and utilization management. The bottom line here is that some carriers are doing well, but others misjudged this market in terms of their pricing and their marketing strategy. It was interesting to note, for example, Aetna has said, while it's lost a lot of money on its traditional network design products, the products in the

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market that it's offering with a narrow network are actually performing well. So that is a trend probably to watch going forward.

Since we are here in the halls of Congress, I thought it would be important to talk a little bit about strategies or policy changes that could help ensure the long term stability of this market and sustainability. First and foremost, I think it's critical to do everything we can to boost enrollment. There have been considerable headwinds that have dampened enrollment. Certainly the polarized political atmosphere has not helped, the Constitutional challenges and the refusal of Congress to adequately fund outreach and enrollment efforts. And also, frankly, we need to better invest and improve the IT systems that get people enrolled. It should not take your average person 90 minutes to get through the process. This is discouraging enrollment among the people we need the most. I think we also need to look at the affordability of the plans on the marketplace. There are just a lot of people out there, particularly above that 250% of the Federal poverty level, for whom these plans are still not affordable. So, making sure it's a better value for them. Ideally, in my view, through increasing the generosity of the premium tax credits and the cautionary reductions, not only will help get more people enrolled, but will keep them enrolled and that in turn will make it a more viable market for carriers. There has been a lot of chatter about returning the public option plan. Certainly Congress debated this back in 2010 and it was defeated, however, in the report that is in your packets, we did note that back in 2003, when a Republican Congress was debating the Medicare Part D bill, they were concerned that there would be some areas of the country that might lack sufficient competition among carriers and so they actually created a fallback public option plan in the Part D program. So, perhaps, looking at the Affordable Care Act and knowing that there are some areas of the country that may be underserved, looking at a fallback public option might be something that could be revisited.

Also, I do think that there is an argument to revisit the three R's. CMS to its credit is looking at some tweaks to the risk adjustment program because I think there is evidence that it's not working perhaps as perfectly as it should. Then I think there is a strong argument to be made to revisiting the reinsurance program and that this is a market that may, for lots of reasons, consistently have a sicker population than the group market. So revisiting the re-insurance program might be something to consider as frankly, it is a permanent program in the Part D program and might be worth making permanent in the ACA.

Last but not least, I do think that Congress should address some rural area challenges that have surfaced in the wake of the ACA. I would say that, challenges in rural areas in terms of access are not unique to the ACA. They have been long standing challenges at their healthcare system and certainly Congress has looked at helping certain rural providers such as critical access hospitals, continue to serve that market and perhaps we need to be thinking about the same thing for health plans to ensure that rural residents get access to the coverage and ultimately the care that they deserve. With that, I'm delighted to turn it over to Liz and look forward to your questions, thank you.

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ELIZABETH HALL: Thank you, Sabrina, and thank you to the Alliance. I have just one slide. Again, I'm Liz Hall and I lead up Federal Affairs for Anthem. For those of you who aren't as familiar with Anthem, we are a Blue Cross/Blue Shield plan in 14 states. We operate under the Blue Cross and Blue Shield license and we are an active participant in the exchanges in all of those states on the map that you see as blue or in the orangish/yellow color. I am going to speak today in terms of both the Anthem experience, but even more than that, sort of the plan experience more broadly and I'm happy to answer any questions that you all have through the course of the discussion. Anthem went into the exchanges because we have 75 years of experience in the individual market and we wanted to make sure that we were providing coverage for our existing members as well as for those who are becoming newly insured. We elected to go into all of the geographic rating areas in the states in which we have the license, with one minor exception where there are a number of provider owned and operated plans. We just didn't feel we could be quite as competitive. So we are offering on both the federally facilitated marketplace. We are offering on state based exchanges, including Covered California and we are having experience with both. So I think we have a great perspective from which to speak.

As Sabrina mentioned, there were some challenges and we are still probably very much in a transition period – a longer transition period than I think the law had laid out and that we all had expected. And if you recall, 2014 didn't start out as successful as we would have liked, with technological issues with the exchanges, and a lot of challenges with people enrolling. As a result, plans did not have a full year of experience for most of their memberships. The first year in which we had a full year of experience, really was 2015 and if you think about the pricing cycle for an insurer, we are looking at about 18-24 months that it takes us to price before we actually go to market. So we were pricing for our 2016 products in March-April and May of 2015. So we didn't have that full year of 2015 experience until we were pretty far into the year and by then, most of our pricing and most of our products were completely set for the exchanges for 2016. So it's challenging to price from just that perspective. Then when you go into it, we have seen a lot of turnover. The individual market is one that historically has had a lot of turnover of the membership for one reason or another. Oftentimes people will change jobs, they may get coverage through an employer, they may qualify for Medicaid, so they tend to come in and out of the exchange market and we didn't see any change. In fact, I think we have seen some acceleration of that post ACA. All of it again, makes it challenging.

I think on top of that, as Sabrina mentioned, the three R's have been challenging for us in particular. We are really focused on the risk adjustment mechanism that is the permanent mechanism in the law. From what we are seeing and part of what makes it challenging, is that we do think that there needs to be some recalibration of the risk adjustment methodology. It was based on an employer model. The individual market experience is different than the employer model. CMS is looking at making some tweaks, particularly on the very high cost individuals. We do think though that you need to look at both the healthy and the moderately unhealthy and how the risk adjustment system is pricing for both of those sets of individuals to recalibrate it and bring it as close to actual costs as

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possible. Right now, we and many plans have mentioned how they are actually paying more into risk adjustment than costs for those who are healthy and we want to retain an incentive to bring the healthy into the marketplace – a very different dynamic than the pre-ACA dynamic in the marketplace.

So if you look at price increases and you try to break it down from some of the major segments of what is leading to premium increases for 2017, and what you will see as you head into the open enrollment period, probably the biggest change or the biggest segment of the increase is really getting to right pricing. We - and insurance commissioners do not let us “catch up” in terms of making up for what we have lost in prior years, but they do want to make sure that we are pricing adequately to cover the expenses of the years as we go forward. So basically we have a baseline adjustment in CBO and Congressional terminology, to make, and that is going to vary insurer by insurer and state by state, but that is ending up to be probably the largest segment of the increases that we are seeing. Then you look at medical trend and pharmacy trend. What is just the unit cost increase year over year for basic medical services? You have to add that on top of your baseline increase. And I think we’ve been talking about it generally from the six – six and a half range to the seven and a half range for that medical trend and that is a component of that increase, being driven a lot by the pharmaceutical costs right now, more so than physician or hospital costs, which we are seeing start to moderate as a lot of the delivery system reform is going into effect.

The next biggest sort of contributor is the reinsurance wear off, so if you are familiar, another of the three R’s – the risk corridor, reinsurance and risk adjustment pieces, this is the last year – 2016 is the last year in which we will receive reinsurance payments of the three year phase out. So there will not be reinsurance for 2017 and that is another six to seven percent contributor.

MARILYN SERAFINI: Liz, can you explain for anybody in the room who may not understand what the reinsurance is? Just get into a little bit of detail about how that has worked? And what the benefits have been.

ELIZABETH HALL: Sure. So the reinsurance program really is designed to help offset some of the costs of very, very high individuals as we transition. No one knew when we were pricing in 2014, who would actually be in the marketplace. We knew who the existing individual market membership was, but we did not have a really good handle of exactly what the uninsured population looked like. What the pent up need of that population would be. Who would be coming in, although we expected that those who were less healthy would be the first to come into the system, because they did have a need so the reinsurance program really was designed to help offset some of that cost as we transition to those higher cost individuals. So it is designed to help pay for some of the costs of those who exceed a certain amount in terms of expenses every year. So that is the reinsurance program and that goes away, it phases out. So that is about a six to seven percent contributor, depending on the state and the circumstances.

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A help to the premium this year was the moratorium on the health insurer tax for 2017. That's about a three to four percent positive, so it's going to reduce the increase by that amount. That does go back into effect in 2018 if Congress does not make a change. And so from a legislative perspective, that would be the number one thing that we would encourage, be considered as extending that moratorium or limiting the health insurer tax.

Then the last thing I would mention that is a part of the premium is the exchange fees. It is just the cost of operating the exchanges, including the Federally facilitated marketplaces included in there. Those are big chunks. Every plan is going to be a little bit different in how the pieces fit together, but help you get an understanding of how you get to 15, 20, 25 percent increases or more, depending on the state and the plan and the circumstance.

I just wanted to mention a couple of things from a regulatory perspective. As we look at it and we think that it's important to one, stay in the marketplace and two, stabilize the marketplace so that the competitors that Sabrina mentioned, whether they are small or large, come back into the marketplace to serve individuals. There is really just a few that I would mention that we think need to be a focus and can be addressed regulatorily by the administration. One I mentioned is the risk adjustment methodology and recalibrating and we are very grateful that the administration has proposed in the notice of benefit payment parameters, using actual data for 2019, we do think that there are some things that can be done for 2018 and we have put those in our recommendations on the American Academy of Actuaries has also suggested those. Special enrollment period verification, also very, very important to plans, as Sabrina mentioned. We are seeing a fair amount of what we believe is buying to use behavior. Folks who qualify for a special enrollment period come into the marketplace, may be with us for three, four or five months while they are receiving services and then will exit the marketplace. That is not good for the stability of the marketplace as a whole and we really do think that we need to look a few things, including narrowing the number of special enrollment periods as well as verifying qualification for special enrollment periods before granting them. Grace periods – so there is an opportunity for folks and I think there is good reason for folks to have an opportunity to – if they fall behind on a payment to catch up. But again, we see some potential gaining of that system and we do see some ways to adjust for that.

And then the last more industry wide concern is some of the third party payment of premiums and what that is doing to the overall membership and makeup of the exchange population and its stability. I will pause there and turn it over to Chris.

MARILYN SERAFINI: Great, so we turn now to Chris Holt of the American Action Forum.

CHRIS HOLT: Thank you, Marilyn and thank you to the Alliance for hosting this and including me. Thank you all for coming. I don't want to rehash everything that was discussed, but I do briefly want to kind of double down on this idea that there is something going on in the exchanges that isn't healthy right now. So, by the end of this

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year, total effectuated enrollment is going to be less than half of what was originally projected for 2016. Now, part of what I think is driving that is the – and we can debate the degree to which this is happening, but premiums are increasing, but more so, deductibles, co-pays, things like this are increasing. You are seeing these no-network plans. High deductible plans and narrow network plans aren't necessarily a bad thing, but when they become the only thing or when they are increasing because insurers don't have a lot of other options for controlling their risk, I think that is a problem. So you are seeing, I think, individuals choosing not to come in and then on top of that, we are having more of the insurers pulling back and then – I was going to mention the Kaiser Foundation Study as well, but consumers are being left with fewer choices. Now, I think as a conservative, there is a temptation here to sort of sit back on our hands and say, well, this is your problem. We were generally against the law. We foresaw a lot of these problems and felt ignored and so I do think there is a sensibility that hey, this is Harry Reed's problem, this is Nancy Pelosi's problem, this is Barack Obama's problem, why should we help? I think there are a few reasons. One thing is that if you are a member, particularly in this audience, if you are a member of Congress and your state exchange is going belly-up and we have already seen this to some degree, there is going to be pressure to act regardless of where you are in the law. And I would just say that our best policy making is not usually done in crisis. So if we can get ahead of that a little bit, I think that's wise. But I also think if you are a conservative, you need a health, private individual market for any of the kinds of large scale reform proposals that have been put out by the House Task Force and I do think there is reason to be worried that if the exchange market deteriorates, it creates problems for the individual market as a whole, especially, I would say, if that collapses such that it causes a public option to become more viable. I do think depending on how it's structured, a public option could be a real threat both to the individual market off exchange and also potentially even to ESI. So I think as conservatives, we are worried about that, but also just frankly, while we do have, I think, some good ideas out there, I think the work done by Jim Capreta and the group of advisors that he brought together at AEI all last year was very good. I think the replacement proposal that we offered in 2017 was very good. The House Task Force, several other legislative leaders have introduced or at least proposed white papers for how we might restructure the healthcare system. I think the point is that a full sort of replace is out of reach right now and I don't foresee that changing in the near future. So I think it is foolish to miss an opportunity when maybe our friends on the left are more open to some of our ideas to take some of those ideas that are in those larger proposals and put them forward as potential solutions.

So with that, I guess I would piggyback a little bit on what Liz said about grace periods and special enrollment periods. I think that is certainly a place to go. I think particularly on the special enrollment periods. This is a market – people who we are trying to target or that we are being targeted with insurance are people who had chosen to be uninsured in a much riskier market. So we have taken away the danger of being rated on your health condition. We have taken away the risk of being denied coverage for a pre-existing condition. So if these are people who are already hesitant to buy insurance before, we have made it less risky and then we have these special enrollment periods, there are

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something like 30 circumstances that can trigger one, that I think make it even more tempting to just wait until you get sick. There is always some risk to not having health insurance, but I think it's less risk now than it has been in the past. That doesn't serve to incentivize people to enter the program.

Then just a personal pet peeve is the age limit on catastrophic health insurance. I don't really understand why a 31-year-old should not be allowed to have a catastrophic health insurance plan, but a 29-year-old, that is fine. That to me seems like just excessive sort of top down, we know what is best for you, kind of approach to regulating. And so I would just allow those catastrophic plans to be sold to anyone. I'm not sure how much of a difference that makes. We have done some modeling on that in the past on whether or not there would be some savings to people who maybe were eligible for subsidies and then chose a catastrophic plan. But I think it's sort of a sensible change. Then, as I'm getting a little low on time, really I think the best opportunity for collaboration would be on age bans and I'm going to assume that everyone here is pretty familiar with the age bans. But very briefly, the ACA limits what you can charge your older enrollees, to three times that of what you charge your younger enrollees. But actuarially, those older enrollees cost closer to five times what the younger enrollees cost. I understand the idea behind age bands is you want to make sure people can't be aggressively priced out of the market if they are unhealthy. And you do want to subsidize some of that a little bit so that those premiums are more affordable. But since we are struggling to bring younger, healthier individuals into the exchange, it seems to me that extending the age band to say, five to one, which would comport more with actuarial soundness anyway, would potentially bring down costs for those younger beneficiaries and thus will remove some of the disincentives to getting into the exchange.

Lastly, I would just mention – I know the House GOP Task Force Better Way Proposal talks about getting rid of the Essential Health Benefit altogether. In general, I just think that the more that we can allow the individual market to provide the kinds of plans that individual consumers want, the better. So I would certainly highlight that as a place where perhaps we could remove some of the regulation and give the insurers more opportunities to target to their consumers. Thank you.

MARILYN SERAFINI: We are going to turn now to Peter Lee of Covered California. After Peter speaks, we are going to turn to the Q&A portion of our program, so please start getting your questions ready. A reminder that you can write questions on the green card, we will have folks pick them up. You can tweet your questions using the hashtag #insurancemarketplaces or you can ask your questions at the microphone. Peter?

PETER LEE: Thank you Marilyn, thank you to the Alliance, and thank you for joining us for lunch. The title of this panel is on vitals for marketplaces going into open enrollment, but I think many of us are seeing this as a time for all of you to be thinking about what would a tune-up look like for the Affordable Care Act at large? And you really can't think about exchanges without thinking about what they are embedded in, which includes total overhaul and a new structuring of the health insurance marketplace,

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guaranteed issue, medical loss ratio, setting caps on what plans can spend outside of healthcare, Medicaid expansion, changes in CMS and its Medicare payments for delivery reform. So I just remind us that we are going into open enrollment four, but you are going into a new Congressional session next year, thinking about how can a tune-up be done of the biggest change of healthcare policy in the last 50 years?

With that, I'm going to give you a view from one state – a very big state – where actually the Affordable Care Act is working pretty well. Not perfectly, but pretty well and I want to tell you why and I think some of the lessons on what that brings to the rest of the nation.

You have all these slides and I'm not going to read through them, I will go through some quickly. I want to note that the mission of Covered California is to create a competitive marketplace at the plan and provider level. That is really important because we talk about right-left issues and we think a lot of our success is we have actually done that. We have had an environment that has competitively worked for consumers and for plans. Plans have competed for lives and done that in a way that they have had to price it right. If they price wrong, they don't get lives, et cetera. By having a vibrant marketplace, it has worked for both. To our mind, there are four key ingredients to marketplaces working and I'm going to take about each. One is having a competitive marketplace. California is different than a lot of other states, but remember, California has rural areas without a lot of competition. California has urban areas, California has more ethnic language diversity than any place in the country, probably the world. So, competitive marketplace issues, there are lessons from California. Affordable products are absolutely key and one of the things that we need to make sure we talk about is affordability both for people on exchanges getting subsidies and the about half the people in the individual market place that are off exchange receiving no subsidies. So a very important piece. Effective market and outreach and finally, change of the delivery system.

So let me go through each of those briefly, after reminding you about how big of a change this is – the Affordable Care Act, besides exchanges. This is a chart for California. This is actually a year old. The orange bar is MediCal – which is the Medicaid program in California. There are now 14 million people in the MediCal program. California is one of the 15 or so states that expanded Medicaid. One out of three Californians under the age of 65 are now in Medicaid. So, there has been a huge growth there as well as the growth in the exchange. The other note though, on the middle bar is we talk about exchange, but only about – we have about 1.4 million people in Covered California, about the same number buy off exchange. They are in California, buying the exact same products, exact same networks, exact same prices as on exchange, but with a subsidy. We are creating a market that is working for them and helping them keep more affordable prices. But one of the debates is, how do you have benefits of more designs and where are the subsidies for it?

We have in California quite a bit of choice. Eight percent of our consumers only have two plans to choose from. None have only one plan to choose. The vast majority – 92%,

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have three or more. We actually think that three or more is good, but four or more, not clear that that is a real advantage. So when you talk about consolidation, three or more plans, we think is great, but I would also, with all due respect to Aetna and United, in California I care a lot more about regional plans than I care about the big nationals. And this is true in many of your states is, in San Diego, Sharp Health Plan is a big plan. In L.A., L.A. Care is a big plan. In Sacramento, Western Health Advantage is a big plan. So lost in the discussion of the big nationals is healthcare is local, including local plans.

Affordability. You all know this, but for the people with subsidies, the subsidies matter and they matter a lot. The thing that I remind you about, of benefit design mattering, it's not just the subsidies to get the insurance in the first place, it's the subsidies to reduce your cost sharing. So almost 20% of our enrollment are people that have not just a silver plan, but the silver plan where they are paying \$3 for an office visit co-pay, because they have a cost sharing reduction. So, I just want you all to remember, when we think about affordability, it's about both premium and the at the point of care. And I would encourage you to look at this mix of enrollment. 24% of our folks are in bronze. Well, some states have 40% in bronze. And that is people making bad choices. Why are they making bad choices? I think because they aren't using patient centered designs. You probably followed the feds at Federal marketplace, have adopted a simple choices product to say, have all the plans in the Federal marketplace offer a standard patient center design? I would have you focus far more on the issue of patient centeredness than on the issue of standard. And what patient centered is, is if you – and the shade of blue is not subject to a deductible. You hear a lot of discussion about high deductible plans, I care a lot more about what the deductible applies to than the size of the deductible. So, if you have a silver product or above, no outpatient care to go see your doctor is subject to a deductible. And this is really important for risk mix. If you are a healthy person and you bought a product and you are thinking you got a good deal and you go see your doctor and they say, well, that's not a covered benefit until you spend \$3,000 – are you apt to keep your coverage or say, screw it – that's a technical term – I'm going to pass on that coverage. We think having patient centered design encourages good risk mix over the long term. It also encourages people to get the right care at the right time. So, we have got patient centered designs. We allow plans to offer alternate designs, they aren't doing it in California. They are saying, we would rather compete on network and price than on benefit design, obscurant. So think about this when we talk about what competition is about. Affordability is about premiums.

Now, California experienced higher rate increases this last year or will in '17, then we have in the past. We have had two years of four percent rate increase. Our average increase in '17 will be about 13%. That is not a good number. Liz noted the main factors, I would underscore, number one in California is the removal of reinsurance. A one-time hit. And it's a one-time only hit. Once insurers bake it in, it doesn't come back next year between 4 to 7%. If that 7% comes off, it brings us to about 6%. Now, should it have been a four-year policy instead of a three year? Maybe. As Sabrina and others noted, you need to talk about reinsurance on an on-going basis, but the fact that it's going away is a major hit. The other thing that none of the panelists have spoken about as a non-

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California issue is about 35 states did not make a common risk pool as of 2014 like California did. That meant people that had grandmothers plans, off exchange, are not part of the common risk pool, plans did not know how to price, so they got it wrong. That is going to work itself through the system over the next two years. California did that in 2014 and about 15 other states did. So that one risk pool matters.

I'm going to go through a couple other notes and I will go over just a moment is, Liz mentioned the cost of the fees of being in an insurance exchange. I want to note that I like to think of exchanges, if they do their job, as the cheapest date in town. And what I mean by that, Covered California has a 4% assessment of on exchange enrollment. But that works out to 2% because they spread that premium across on and off exchange. The Federal marketplace assessment is 3.5%, but that is not new money for a health plan. Rather, before we came along, health plans were spending about, almost 8% of their premium on bringing people into the individual market. We are now costing about 6%, so that is actually lowering the cost of acquisition of member's individual market. If the Federal marketplace, if state exchanges are taking that money and investing it in market and enrollment, which is exactly what we are doing and getting results to show for it. So this next year, 2017, we will spend about \$100 million and not one penny of that, this next fiscal year, is Federal establishment funds or state funds. This is on that plan assessment, it is a cheap way to get good risk, because we are marketing across the populations to get them all in. And we are working with insurance agents, et cetera.

So I am going to fly through to a couple of other points I want to make before I can't. I want to note a fact point, which is really important and Liz noted this, is churn in the individual market. So the average period of enrollment in Covered California is 25 months, which means we have about half of our people turning over every year. The big question is, where are they going? We know that the vast majority are going to employer based coverage, to MediCal, to Medicare, et cetera. That is good news. Every exchange should be tracking data like this. If a lot of people are going to be uninsured, the theory behind some of the concerns around people coming in for four months of coverage and then going off the exchange, that is a problem. 85% of the people leaving Covered California are going to other insurances. That is part of what marketplaces need to be working for and doing. We actually have a very good risk mix. 38% of our enrollment this last period were 18 to 34 year olds, which is right about where they should be and it's a combination of the factors. Spending a lot on marketing, having competitive markets in place, the subsidies being well promoted. But this is a piece that – good things breed good things and what we are doing is actually leading to a good risk profile.

Final note, we actually do a lot of issues on delivery reform. We require our 11 health plans to pay differently for patient centered medical home. A lot of the things we are doing out of the gate are risk mix. But over the long term, if we don't change the delivery system, we are all going to be toast.

Finally – and these are up here and Sabrina already noted most of these, but you do need to think of the lessons learned and where we take that for policy options. My quick six is,

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subsidies matter, they matter a lot. We clearly have fewer people enrolling that are 250 to 400% of poverty. Smaller subsidies. But also reinsurance is a form of subsidy that benefits off exchange people no subsidy. And I'm very worried about those people being priced out, because that will hurt the risk pool. Competition and choice. California has choice in every market. The issues of, what are the option if you have one plan, which I know is in the teens nationally. That is a real problem. Competition drives plans to be better. Benefit designs matter a lot. This is a challenge – I'm a big free market believer, but consumers need to be able to shop. And what do they shop on? Not on tweaks on co-insurance design, they shop on network design. They shop on price. Market and outreach. We should be spending hundreds of millions of dollars nationally. This is not the general business of government to sell something, but good risk doesn't happen by accident. Good risk is bought by marketing and sales. It's on the margins. People who are healthy and thinking, maybe I don't need it. You've got to be doing a boatload of marketing. And this is something for the Federal marketplace and the state based marketplaces.

Finally, as I noted earlier, the delivery system needs to be focused over the long term because if exchanges aren't part of change in the underlying delivery system cost, we will be toast in a few years. So with that, thanks for having me – us, and I look forward to the discussion.

MARILYN SERAFINI: Great, thank you to all of our panelists for a very informative start to our discussion. We are going to turn to the Q& A portion of our program. I hope that everyone in the room will stay to the very end. If you have to leave us, please fill out the blue evaluation form before you leave. Okay, again, we have mics in the room, you can fill out a green card for questions, tweet your questions. I'm going to start off by asking all of our panelists a question about risk adjustment that has come up several times during the discussion. Sabrina, you said the risk adjustment program is not working as it should. Liz, you talked about the young, healthy folks and you seem to be indicating that financially speaking, it's not quite what we expected it to be. So I'm wondering if we could talk just a little bit more about that and are you actually saying that insurers are losing money on the young and healthy? What are we supposed to think about that?

SABRINA CORLETTE: I will start. So there is evidence at this point that the risk adjustment program as originally designed is under compensating some carriers for some sick individuals that have enrolled at the same time that it may also be undercompensating for healthy. And I'm not an actuary so there is a lot of methodological issues behind that, that I will say [unintelligible] is responding to and trying to address and they have gone through a process to do that and take an input from stakeholders, but proposed for 2018 are a number of changes that are designed to try to make the risk adjustment program more – what is the word I'm looking for? Precise in the diagnosis that it captures and then compensates for. Liz, I'm sure you can probably explain it in much more technical terms than I just did.

ELIZABETH HALL: Actually, I don't know that I will much more technical than you since I am not an actuary either, but I do know and can say that the things that actuaries

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like is they like predictability and they like certainty. That is going to help them price more accurately and part of the intent behind a risk adjustment program is to help offset some of the adverse selection that you might get in the system. So if a plan does have a disproportionate number of very high cost individuals, those will be offset in part by funds that are received from plans that may have a higher percentage of lower cost individuals or healthier individuals in their book of business. I think risk adjustment works well when it is fairly accurate. When it does a pretty good job of trying to predict and accurately adjust for those who are higher cost or lower cost. And if you think about the marketplace pre-ACA, there was – one of the things that we were trying to do is predict risk, manage risk and it was more difficult to purchase health insurance in the individual market if you had a pre-existing condition. That was something that Congress and lawmakers said, we want to change. And as a result, there is a risk adjustment mechanism. One of the things that I will point out though about risk adjustment in the ACA context, is that it operates differently and a lot of people come at risk adjustment from a Medicare advantage experience or a Medicare advantage perspective. Under Medicare advantage, you get paid a higher amount from the treasury if you have higher risk individuals and that seems to be appropriate under the way that that model is working. Under risk adjustment within the Affordable Care Act, it is a transfer between plans. So it really is a question of, we are going to take money from some plans and give money to other plans through a complex and pretty involved process. I think for the most part, the model is a good model to have in place. I think we need to have risk adjustment in place. We do want it to be as accurate as possible. So as we said, there has been a lot of discussion. You can have one very, very high cost individual in your plan and that can upset your pricing. So whether it's a million-dollar hemophiliac or a transplant or something, and we are supposed to be working towards and planning to manage that risk. And that is really the goal of a health plan, is to be able to make sure that we have got funds to offset those very, very high cost individuals. The way that we see the risk adjustment program currently is that it is calibrated a little bit – we think it needs to be recalibrated. We do think that we are paying more in for healthy individuals and if you look at our costs in the end, we are paying more in than we should. At the same time that we are getting more than we should, for the moderately unhealthy – I'm not talking about that end of the curve – million dollar cases. I'm talking about everything under that. Again, I think that the goal and the intent is great. We want to make sure that those who have moderately unhealthy, are getting compensated appropriately for those folks. We just think it needs to be tweaked a little bit and there has been a lot of conversation with CMS, a lot of conversation in the industry. I will also say it's challenging and hard to do. Where you are positioned in the marketplace, depending on what you are receiving or paying under the risk adjustment methodology will color your perspective on this. So I think it's a discussion and a dialogue that needs to continue. However, we think if you are going to get to stability, you need to make some more adjustments than what has been proposed for 2018 and not just wait till 2019 when we start – when the models start to use actual data.

**PETER LEE:** I just note that – agreeing with everything said, that the regs out of comment have significant changes in the risk adjustment process and to my mind, there is

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a structure of the three R's – risk adjustment is there for the long term and its CMS's job to adjust it and use technical tweaks to get it right. The other two have gone away and this is sort of your job to say, what we do we do in the marketplace writ large to say, should reinsurance have gone away when it did? What is the overall mix? So agreeing with everything you said, that there is a mechanism and most people that I have heard that have had concerns about the risk adjustment model, think that CMS hears the concerns, is looking at making adjustments to make it better and I hear from both plans and CMS that we are in the right place, let's not have plan competing to avoid risk. Let's have risk adjustment work. And that is coming back to a core change in the individual market. Plans used to win by avoiding sick people. Risk adjustment is about saying, compete to get everyone in and not have that be game. My - to my mind, it's in the right technical place for technical fixes and we are moving to a new place.

MARILYN SERAFINI: Okay, question at the microphone, if you could identify yourself please?

AUDIENCE MEMBER: Sure, Carl Schmidt at the AIDS Institute. I really want to thank California for focusing on patient affordability and plan design. We are still finding a lot of plans putting prescription drugs on a very high co-insurance, like, 30, 40, 50% and California is addressing that by capping co-pays beginning next year. And you mentioned the simple choice plan for the Federal exchange that is being implemented this year. Unfortunately, it's only voluntary and secondly, they are still allowing high co-insurance for the specialty tiers. So I'm just wondering what the panelist's views are on actually requiring at least the offering of one plan with co-pays for prescription drugs instead of co-insurance.

SABRINA CORLETTE: I am a proponent of co-payments as opposed to co-insurance whenever possible. I think they are much easier for consumers to understand and also to ultimately predict what their out-of-pocket costs might be for a given service or drug. We did an analysis last year, I think there are about six states, if I'm remembering correctly, that have tried to cap the co-payment or the spending for a consumer, particularly for that high cost specialty tier of the formula. And I think that those policy decisions are tough because it's like a balloon, right? So if you are pushing down on one side of the balloon, another side does need to pop out and the policy choices that people need to make about who is going to be the winner and who is going to be the loser on the balloon, are often very, very difficult to do whether at a national level or at a state legislative or other policy levels. So, generally all four co-payments, I just think that those conversations need to be done in a very careful evidence based way.

ELIZABETH HALL: I think I will just add my comments to yours. I mean, we work very hard as plans and have a pretty rigorous process to go through with our pharmacy and therapeutics committees and looking at where we place things, trying to make sure that we are putting effective, necessary drugs where they should be. I think I would say that we welcome a dialogue when folks think that we have not put them in the right place and talk about the factors of why and it is a very careful balancing act to make sure that

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we are maintaining affordability broadly for all of our members, but we welcome a dialogue if there is concern about where something is placed on a tier.

CHRISTOPHER HOLT: Can I just jump in? On the balloon analogy, I would just say, I am all for squeezing the balloon less, because balloons pop when you squeeze them too hard and so in general I think the less that we restrict how these things are sorted out, the better.

PETER LEE: And I just note a couple things. One – I actually do work with the balloon analogy, although I don't want it to pop either. But the balance that we have done at Covered California with the [unintelligible] on both ends, is for people to get outpatient care without a deductible, but people that have very, very high cost specialty drugs, to have ceilings and caps. But it is a – it means the premiums are a little bit more for everyone. I worry about carriers offering only one plan with co-pays versus co-insurance, because of the selection bias it's going to have of people that have specific conditions, picking that plan. So the issues of having a common product that consumers are choosing amongst makes sense. And I would note that yes, the Federal marketplace simple choice plans are voluntary, but they are seeking comment on displaying those plans first that have them. And I see no rationale in the world and I have had discussion with my plan colleague's friends, on why a carrier would offer six different silver products in a region. It makes no sense. Consumers aren't picking between those and rather I have those engaged policy and ethical and market discussions on what is the right benefit design.

MARILYN SERAFINI: Okay, let's move to this microphone.

AUDIENCE MEMBER: Hi, Chris Jacobs with Juniper Research Group. I'm just curious because we are talking about exchange coverage, how many, if any, of the panelists actually have exchange plans themselves. I know the exchange, the individual market is very residual market and so it's a small percentage overall. But I also recognize that with the exception of some Congressional staff who are here, a lot of people on the exchanges aren't the demographics that you see in this room. The relatively affluent aren't enrolling. I know, because this is very tangible to me, I am on the exchange as a small business owner. I have to be on the exchange, DC abolished their individual market. I don't know what the – what my plan options are going to be when I get the letter in the mail in the next month or so. I'm curious how many actually have exchange coverage themselves, because for many people, I think policy people in DC, this is a very abstract, academic discussion, whereas for me, it's tangible and it's very real.

CHRISTOPHER HOLT: I am on the DC shop as well and it definitely has been helpful in making all of this a little bit more real. So I'm sympathetic. I mean, the plan that we were on last year, in theory, continued into this year, but it was a completely different plan. We ended up choosing a different plan. We probably didn't choose as wisely as we should have, we have been dealing with that throughout the year. So no, I think you are right. I think it is easy to lose sight of what it is like to actually be on these exchanges, but

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I would also say the shop exchange is very different than what people in the individual market exchange are experiencing too.

PETER LEE: I am a state employee, I have choice for state options, but it's really important to note that all the data you hear about exchanges says, a small percentage are more affluent. But that is losing the picture of off exchange individuals throughout most of the nation are buying on exchange products, same price, same networks, et cetera. So the issue about every carrier that is offering a product on the exchanges, needs to offer in most places, the same product off exchange. So the issues in California, we have more than one million people that are buying exactly our products at our price, unsubsidized. And we take that really seriously. So I think the issues of looking at affordability, network design, et cetera, are broader options and I think that the issue when you talk about who is being affected, the fact of – we have 1.4 million people now, over 1.1 million Californians have had our coverage and now have employer coverage. They move in and out. And so that experience is one that we are seeing across the economic spectrum. And it is very challenging for middle class people that are not subsidy eligible to afford health insurance. I mean, and many of us that have employer based coverage wouldn't take it if we didn't have our employer coverage. So it's a challenge that I think is apparent and visible to a lot of Americans.

SABRINA CORLETTE: I'm a spoiled academic and Georgetown thankfully has an absolutely fantastic health plan to which they, as an employer, contribute a great deal. I would say one of the goals of the Affordable Care Act was to lift the standards for individual market products so that they look more like what we lucky folks get who work for a large employer and so certainly when I look at these issues, I do try to think about them. You know, if I were an expecting mother who needs prenatal care, what kind of health insurance would I have? Or if I'm a dad who just found out that my 17-year-old has schizophrenia. What kind of health insurance would I want? So by no means are the exchanges perfect or the individual market perfect but it certainly was an attempt to raise the standards so that it does look a little bit more like the employer coverage that many of us are lucky enough to receive.

ELIZABETH HALL: I will just add that I am not on the exchange, but have very close family members who are and I have worked with them and would not have been able to get individual coverage pre-ACA.

MARILYN SERAFINI: Peter, you mentioned briefly and this is not exactly along the same lines, but mentioned off exchange insurance and we have a couple attendees here today ask about the sale of policies off exchanges and they are asking about the idea of stabilizing exchanges by requiring that all individual plans be sold on exchanges, sometime that Henry Aaron of Brookings has been talking about and our questioners want to know whether that is a good idea, requiring that all individual plans be sold on the marketplaces.

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PETER LEE: Well, I'll be the first to take this, and others can, is that I don't really care that much. What I care is a vibrant risk pool and that can be on or off the exchange. It is under the Affordable Care Act the individual enrollment, whether on or off the exchange, is one risk pool. And this is why it's part of my job, so to speak, to care about what happens to rates, even for unsubsidized people because if rates go up 30% who stops buying insurance? Healthier people. Who keeps buying insurance, you know, that woman with cancer, that guy with diabetes. So, and that does damage to the risk pool that then affects the federal spend, etcetera, etcetera as well as more people insured. So, you don't need to be on exchange to make sure that you, as an exchange, are having a good set of products on and off exchange. So, and that's, you know, my little diagram on how we spread out costs. California, we assess our fee on exchange enrollment, but since plans have to offer the same products, same prices, that's spread across the entire pool anyway. So I think it's a distinction without a difference.

SPEAKER: I would agree with Peter on that.

ELIZABETH HALL: I'll third that. I think it's really important to underscore. It is a single risk pool on and off exchange, so I think it's not well understood and it's really important in the whole discussion.

CHRISTOPHER HOLT: And I would be interested, actually, Liz, if you have thoughts on this, but I would be concerned. We've seen instances where a plan has pulled out of the exchange but stayed in the state and I'd be uncertain of what this would cause in that case. Would it keep people on exchange or would it cause them to leave the state altogether, and I think it's hard to predict. So I just think it's probably a little bit dangerous.

SABRINA CORLETTE: A number of those carries, I think, may just be doing that because of HIPAA's 5-year bar, so they may not be actively marketing those off [Crosstalk].

CHRISTOPHER HOLT: I think you're right.

MARILYN SERAFINI: Okay, a question.

AUDIENCE MEMBER: I'm Ron Manderscheid from the National Association of County Behavioral Health Directors. I guess we're surprised that there's so little comment on the panel about the nature of the benefits versus the cost. As an example, if you want young and healthy people on the plans we need to have benefits that are directed toward them. We need to have prevention and promotion benefits for healthy people who are not ill. On the other end, we deal in mental health and substance abuse. If we don't have good mental health and substance use benefits, then the cases become much more costly because many people with those illnesses also have chronic physical conditions. So, we'd appreciate comments on the nature of the benefits, not just on the nature of the costs.

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SABRINA CORLETTE: So, as I'm sure you know, the Affordable Care Act requires plans to cover preventive services with no cost sharing. I think there are probably arguments about what specific services are included in that list of preventive benefits, which is, for the most part, set up by the U.S. Preventive Services Task Force. I think one of the things that California is doing and, as well as a number of other state-based exchanges and a little bit now the federal government, is looking at putting more services pre-deductible including some primary care, sometimes urgent care, generic drugs. Those are all really important, not just because they're good things to do but also, as Peter noted, I do think it helps with retention and makes people feel the value of the insurance earlier in the plan year than they might otherwise. And, yes, I think one of the best things the ACA did was mandate that coverage of mental health and substance use services and I think a lot of people are benefiting from that.

ELIZABETH HALL: I would add, as well, I mean, we cover, because of both essential health benefits and also trying to make sure that we are providing a set of benefits that are going to really promote healthcare and coverage of what our members need, we have pretty extensive benefits under our coverage. I think one of the challenges within the ACA is we do have a population who's new to using those benefits and we, as plans and the plan community, need to be doing a better job of explaining those benefits. And I think we've got some things, you know, coming that we will be putting in place to try to do a better job of that, you know, whether it's being more innovative in our use of technology, more innovative in our language, I think it's something that we are getting better at and you will see much more of through the next open enrollment period.

MARILYN SERAFINI: Okay. Question?

AUDIENCE MEMBER: Hi. I'm Matthew Sonduck from the National Business Group on Health. Three of the four of you advocated for a return to the re-insurance program but how would you propose funding that because a lot of that funding came directly out of the pockets of self-funded employer plans who don't have people on the exchanges, so they're the ones who are help mitigating your risk, so we'd just love to hear your comments on that.

SABRINA CORLETTE: I think there's a strong rationale for re-insurance continuing. First of all, I think that the individual market is likely to be always a somewhat sicker place than the group market because of people who aren't able to work due to disability or other factors, so I frankly think continuing the funding structure as it's been, there is a rationale for that. I understand why that might not be well received by the self-funded employer market, but when you do have a market that is going to be adversely selected against – on a long term basis I think there's a reason for that risk transfer.

PETER LEE: Noting this as an option, I wasn't advocating for it specifically. That my state employee disclaimer. But I also note that one of the issues that we've had multiple years of quite low insurance premium increases. Part of that that's benefited the employer

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sector, self-insured and not self-insured, is the huge reductions in uncompensated care. And we aren't doing a good job at measuring the benefits of the Affordable Care Act that are system wide. We also aren't measuring the benefits to employers that is a mixed issue for some employers of the now absence of job loss. What's benefiting the economy by not having people feel they have to stay in a job because they won't get insurance. So there's other benefits to employers, to the economy that are pieces to look at. And if we were to have a re-insurance program, exactly how and what nature it would be funded, luckily, you folks get to wrestle with, not me.

MARILYN SERAFINI: We have several folks who are asking about the best ways to market – bring more people into individual insurance in the marketplaces. So what form of marketing is the most effective? How are you especially going to get the younger healthier folks into the market?

PETER LEE: I think that's somewhat coming to me, and this is where there's no one answer on this but I guess the biggest thing I would say we should all be asking is how much are you spending? What percentage of the premium dollars are you spending on marketing and outreach activities, and then, are you doing it well? So with our health plan contracts we actually see what the health plans spent on their marketing dollars. We look at what they're spending on insurance agents, looking at what we spend, and I'll give you an example of one of our lessons from that. I say our health plans we contract with share their marketing strategies, say here's how we're spending our 60 million dollars, which is all part of the premium, just like our assessment is. They were doing no in-language advertising for the Asian American California community. No specific outreach in Chinese, in Korean. Huge populations. We spent a boatload of money there and complimented their spending. And so there's not a one answer. You should be doing all channels. You should be doing TV, you should be doing radio, you should be doing on the ground, should be working with Asian communities. You know, we have, in California, 600 storefronts. Now we don't pay a dime for that. If you want a store front with Covered California's name on it, you've got to follow certain criteria. They're paid commissions by the plans for the people they enroll. They want to be known as Covered California because we have a good brand. That'll get business to come to their store front. So, I note there's not a single answer here but the main thing I'd ask you to look at is what are you spending? You know? We are spending about, you know, 1% to 1.5% of premium dollars on marketing and outreach on what we're spending at Covered California, and I'm worried that the federal marketplace isn't spending enough. I'm worried that many states that are operating not as an independent business in some ways that we operate as but subject to their legislatures appropriations are being [Unintelligible] on marketing. Don't spend that. We're going to cut your marketing budget. And that is phenomenally penny wise pound foolish. This is a you buy good risk, and it's a whole range of things that go into that.

SABRINA COIRLETTE: Can I actually use this also as an opportunity to push back on some of the statements that suggestions have been made around special enrollment periods. Right now about 85% of people who are eligible for an SEP are not even aware

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of their coverage options or the fact that the marketplace is a way for them to get coverage. There is nothing inherent about an SEP, like getting married, or turning 26, or losing Medicaid coverage that would make you an inherently sicker person than your average person. So right now, unfortunately, there's very, very little marketing dollars being spent on reminding people or telling people that they may be eligible for a SEP and getting them enrolled. So when a carrier comes into a congressional office and says we need to clamp down on SEPs and make it harder for people to enroll, that can actually backfire because what you're going to do is make it more difficult and more challenging for healthy people to get enroll but who are the very people that we want. So I would ask that lobbyist to tell you how much money are you spending on marketing to get people enrolled into SEPs? Because that, right there, you know, go to citizenship ceremonies. There are hundreds of people getting sworn in with citizenships. Why don't you have a booth right outside signing people up as they walk out that door?

MARILYN SERAFINI: Okay. Question here?

AUDIENCE MEMBER: I'm Tommy Ratliff from Evolent Health, and kind of in line with that, I actually wanted to talk about a few policy proposals. One thing that I didn't hear from anybody today was maybe tinkering with the individual mandate penalty. I know that's something we crunch some numbers and someone like me, the amount of penalty that I would pay would probably be the equivalent of about 3 month's premium. So maybe there's thought, the young invincibles, if you will, taking the risk without healthcare and saving money by not having health insurance. So that's the first one. And then, in advance of tonight's big event, maybe discussing some of the policy proposals we've seen, one side from Hillary, you know, tinkering with the family glitch and then maybe expanding towards undocumented immigrants on the exchanges. Trump, the policy specifics are hard to nail down but in lieu of that, maybe deferring to Paul Ryan for some of his policy proposals on the healthcare side.

ELIZABETH HALL: So, I'm going to start on this one and somewhat respond because I didn't jump in fast enough on the SEPs. I think that our goal is to make sure that the fundamentals are working. That the risk adjustment program is working well. The people who qualify and can verify are getting coverage whether it's open enrollment or special enrollment period, and that we are cutting down on jumping in and out and having that bind to use behavior. I think some of the things that you are talking about outside of that I think are fine to be looking at, but we still don't have all the fundamentals down yet. And I think that's really where our focus has been and where we are working towards. Once that happens then you can look at all of these other things, consider them, but it's the fundamentals that we need to make sure are working and working well if this is going to be sustainable in the long term.

PETER LEE: The penalty is something that you guys are going to take up next year, but part of the framing that I'd look at it through is the Affordable Care Act is not a universal mandate. It's an incentive based program with carrots and sticks. And if, in the employer coverage, you could opt to take home cash instead of coverage we would have 30% fewer

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Americans with health insurance. It's not an option. So the issue of dialing up or dialing down is something we need to look at. I'm not sure what the right formula is. But the bigger issue on the mandate, the mandate is never—the penalty, excuse me—is never going to be as big as what the premium is going to be because the premium is actually buying you something. And if we aren't communicating what that value is we're toast.

Family glitch, we've done modeling on what it would mean in California. It means a lot of people. The family glitch is, you know, probably would be about 10% increase in our enrollment, about 100,000 plus people in California. That's a lot of people and what you guys need to wrestle with is what's it cost, because it actually is more people being enrolled, that needs to be scored, etcetera.

Undocs, you may have all heard, California will be submitting a waiver request to allow undocumented Californians have coverage, non-subsidized. I want to be really clear. I don't want any confusion about this, this is today, undocumented Californians can buy our coverage off the exchange but they can't buy it on exchange. All our waiver would do is say you can buy it either place. Full freight, no subsidy. And we think that'll make it easier for mixed status families, families that have some undocumented, some documented to get coverage but it would have marginal effect on enrollment because the real issue is affordability. Just to touch on some of your questions.

CHRISOPHER HOLT: I would say I'm not an advocate for the individual mandate so don't read this as calling for a stiffer penalty, but I don't think there's any question that the penalty is insufficient to motivate the young invincibles, to motivate that population to buy in. You're going to have to sell it to them on some other grounds because the penalty just isn't significant enough.

MARILYN SERAFINI: Okay, a question here?

AUDIENCE MEMBER: Yes. My question is for Peter. I'm Dr. Caroline Poplin. I'm a primary care physician. How does the risk adjustment work in California where you said of the people who are unsubsidized half are on these exchanges, half are getting the same plans at the same prices off the exchanges? Or, if you're a California insurer, can you not be on the exchange and just offer off exchange plans without regard to the requirements under the ACA?

PETER LEE: So, two-part question. First I'm going to answer them backwards. You can sell off exchange and not be in Covered California. And the reality is, though, that I think Aetna has about 3,000 covered lives. I mean, the plans that are in the individual market recognize that being on the exchange is a good thing for them, so there's virtually no one that has sought to be on that is a substantial player, but they can be. And similarly, the plans that are on exchange can offer different benefit designs that meet the central health benefit standards off exchange. They are choosing not to. They say that these benefit designs are selling well, why would we do otherwise? But the risk adjustment piece is it's all one risk pool, and that's the case for 15 states in 2014 said we're going to convert to

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ACA compliant plans in 2014, meeting the central health benefits. States that didn't do that, and Sabrina knows these, and Liz probably know the details better than I do, but is that didn't do that have a three-year grandmothering of non ACA compliant plans that are working their way through the boa constrictor now and will be coming out – that's not a very pretty picture – is, in the next 2 years. And so as of 2018, across the nation, every state will have one risk pool, whether or not you're on an off exchange. But California and about 15 other states have been there since 2014.

AUDIENCE MEMBER: So, for clarification, you have say 15 insurers in California, some are on the exchange, some are selling different things off the exchange. Do you look at that whole group of—

PETER LEE: Absolutely. For the risk adjustment. The risk adjustment looks at – doesn't parse at all whether people are bought through Covered California or not. And that's true in all the other states. It's a common risk pool. If it's an ACA compliant plan, it's part of the common risk pool. So the risk adjustment cuts across the entire individual market. Now, right now, today, there's about 35 states and many of the ones are places where plans got it very wrong in terms of their pricing where they had 40% or 50% of the individual lives that they weren't sure if they were going to be in the market or not in terms of risk adjustment. They weren't, so it was a lot harder to price. That's going to go away. That's one of the other pieces where you hear about we're still in a transition period. That's one of the other big transitions that is working through for a majority of the states.

AUDIENCE MEMBER: Let me say, I've heard you present several times. Covered California is the only thing that makes me believe that the ACA could actually survive. I'm a Medicare for All person. When you have Medicare for All, this problem of risk adjustment disappears.

MARILYN SERAFINI: Okay, so let's go ahead and I have a question here that's specifically for Chris about risk quarters, and this questioner wants to know whether you think that Republicans will be able to embrace, could embrace, any kind of risk quarter program or any kind of risk mitigation program for private insurance.

CHRISTOPHER HOLT: Well, first of all, we have because these programs exist in the Part D program and so I think an important thing to keep in mind when we're talking about risk quarters and re-insurance because they've become so politicized, and I should also mention, we have a primer on this that you can find on our website that I really wish I'd reviewed before I came here today all of a sudden, but our website is [americanactionforum.org](http://americanactionforum.org), you can go search for that primer. These are tools and so risk adjustment, re-insurance, various risk mitigation provisions are not good or bad in and of themselves, and I think that's important to keep in mind. They're just tools and I think Republicans should keep in mind that if they did ever engage in a large scale repeal replace proposal they would likely need to employ them because they're important in controlling risk when you're rearranging a marketplace.

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They're over now, so I think on some level it's kind an irrelevant question at this point. But I mean Republicans have endorsed them and they could endorse them. I think largely the frustration, and I'm speculating a little bit here, but grows from the way that some of this was scored and a feeling that there wasn't necessarily some honesty in the argument to make, that the ACA was paid for, that these provisions weren't sort of properly accounted for. And so as they come up short on money, well, that's because we were trying to say that we'd save money through the ACA.

MARILYN SERAFINI: Okay, question?

AUDIENCE MEMBER: Hi. Jim Slattery with Wiley Rein. I guess my question should most appropriately be directed to Peter. I'm just curious of what others' comments might be. I'm curious why California and HHS has been so reluctant and almost hostile to the idea of private online health insurance marketplaces like eHealthInsurance, for example, and others, why they have been so hostile to encouraging the private sector to really help us aggressively enroll people at no cost to the government. And the whole concept would be that these private companies would be compensated only when people enrolled. Why would we be hostile to that idea?

PETER LEE: First, I don't think that we have any hostility at all. We work with a lot of agents that do online enrollment.

AUDIENCE MEMBER: I don't think eHealth is really involved really significantly because of failure really to – and others – to be able to work it out with the California program.

PETER LEE: So, again, our biggest agents sell online. The big issue is the costs and benefits of new enrollment and online enrollment is brokered enrollment. It's cost to the insurance dollars. It's paying – we work with 14,000 insurance agents, some of whom work for online sorts for others, and it's part of the premium dollars. There's more dollars spent going to the individual agents and the groups that represent them than go to exchanges, and so we look at where do we put investments that are going to have marginal net new enrollment because of the marketing outreach spend that we're going to get. And so we operate as a business saying where do we put opportunity costs to make investments to say we're going to get new enrollment. And, not to speak any specific businesses, but some online agencies are buying the same words we're buying in terms of how you do – the earlier question, how do you do marketing and outreach, do you do buy words on the web, etcetera, etcetera. There's not a magic sauce in terms of necessarily getting young people in. We're actually doing it pretty effectively. So the issue for us, then, is how do others—

AUDIENCE MEMBER: How can you do it cheapest?

PETER LEE: Pardon me?

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AUDIENCE MEMBER: How can you do it most efficiently?

PETER LEE: But most efficiently but also what's their experience going to be? And one of the things, and you know this well, but I'd encourage folks in the room to look at the comments that are being sought from HHS on expanding their use of web-based entities. Some of the issues are how does the display of a consumer's choice made to that consumer? Now, we spend a lot of time with consumer advocates, with health plans and others, to go into what's the right display for the ranking of plans? What information is provided? And I'm a huge believer in the free market but I've seen some – some web entities that do a really crappy job. I've seen some that do a great job. Are we going to have federal subsidy dollars that may have people leaving dollars on the table for picking bronze when they could've picked a cost sharing subsidy reducing plan? And these are some of the things that we take very seriously and I think the comments being sought from HHS are to get at just those issues because it's not just – as soon as you say we're going to have a web-based entity, facilitate a choice. It is facilitating a choice of how major dollars are used and how, again, I take you back to our pie chart. Twenty-four percent of people pick bronze. Now, of the people that are eligible for the biggest cost sharing reduction, subsidy, which is, we call that a silver 94. Less than 8% of them that are eligible for that pick bronze. Eight percent pick bronze and it's a reasonable choice. Back to the free market, I want a consumer to say I could pick a bronze plan and pay zero premium but am I making an informed choice? It is a mix of how different entities make that information transparent and useful to consumers, and it's a big job, which is why the Feds asked for comments on how to oversee web-based entities they might use.

AUDIENCE MEMBER: Thank you.

MARILYN SERAFINI: Okay. Two more questions so get your evaluation forms ready, please. Okay, what regulatory changes would you propose to tighten grace periods for premium payments? And this question is directed to Liz, but all of our panelists are, of course, we encourage you to weigh in.

ELIZABETH HALL: So I think we think, and this is a broad industry consensus, that the number 1 thing that you can do on addressing the grace periods is right now you can enter a grace period. You can forego paying a premium, but you can still re-enroll the next year. You never go back and pay. So you could basically pay for coverage 11 months out of the year and receive 12 months' worth of coverage. So I think the number 1 thing is just if someone has gone into a grace period and goes to re-enroll that they would be required to pay back premium before they re-enroll. It's maybe not the most elegant solution, but it's one way to encourage people to maintain coverage. And, again, we need to get the young and healthy in, we also need them to maintain the coverage and that's one way to do it. There are other things that you could do, but that's where there's broad industry consensus right now.

SABRINA CORLETTE: So I actually have pretty strong concerns with that. I think it's important to remember, and there was a gentleman earlier who asked, who of you has

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exchange coverage. I think it's important to remember these are often very, very low income people who are maybe struggling with their rent and their groceries and a lot of issues and I think it's, frankly, a violation of the ACA's guarantee to issue a requirement to require somebody to pay huge, potentially huge back premiums from that grace period before you can issue them a policy. So I actually think that would require a legislative change, not a regulatory change, but I also think it's really important to remember that this is a population that is struggling with a lot of issues and so before we start messing around with the grace period I would look at a number of other fixes before we tackle that.

MARILYN SERAFINI: So we have come to just about the end of our time. I'd like to ask each of our panelists to answer one more question. We've talked about a lot of potential policy changes and I'd like to ask each of you what is at the top of your list and why. Are you telling us a particular item because it is most easily done; because it is the most important; what do you think should be the first focus, and why don't we start with you, Sabrina. We'll put you on the spot first.

SABRINA CORLETTE: I think it should be boosting enrollment, absolutely. I think it's the low lying fruit. Certainly should be noncontroversial, and I agree with Peter. I think it does take a pretty all hands on deck investment, both in terms of the marketing and sort of general outreach, but also in person assistance. Evidence has shown that for a lot of people it's that in-person help that makes the difference between enrolling and not enrolling.

ELIZABETH HALL: I'm going to violate and give two, but I'm going to give them because we think these are the things that could be done most immediately to stabilize, as well as to impact, premium which we think, in turn, will bring more people into the program, and that really is getting risk adjustment right, number 1; and number 2, addressing the special enrollment periods. Again, making sure people who qualify get them but also making sure that those who don't necessarily qualify and are buying to use are encouraged to go to an open enrollment period and maintain coverage.

CHRISTOPHER HOLT: I would say Age Bands. Changing the ratio on the Age Bands for a couple of reasons. One, it's not – to go from 3 to 5 maybe isn't a huge journey for friends on the left to make. It's not like we're asking to get rid of them. And, two, because in private conversations, at least, with many I've gotten positive feedback on that from Democrat health economists, from folks on the Hill that that might be something that's do-able, and it seems like it could have an immediate impact on the marketplace.

PETER LEE: I will bookend Sabrina's note. I mean, there's a lot of things to be looked at in terms of subsidies and age bands, but the marketing and outreach is so countercultural to government, being as a sales function, and you've got to sell it. And having very robust, big dollars. You know, one of the great fantasies is the idea that we're now just reaching higher in the tree. The metaphor I use is every single year fruit's coming down the branch. It's lower because there's so much turnover. Which means, if you've done a

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good job now, doesn't matter. Next year you've got to enroll another, for us, 700,000 people. So if you aren't having very big marketing outreach spend and investments you're going to have risk mix problems a year from now. So that issue is something that I think should be looked at across the board.

MARILYN SERAFINI: And we're going back to Liz for a third.

ELIZABETH HALL: A third. I'm sorry. The health insurer fee. I mean, premiums are going to increase 3% to 5% just because of that, if that does not get extended so a moratorium, extending that another year. If we don't do that, that's a direct premium increase.

MARILYN SERAFINI: I'd like to thank Ascension, again, for their support of this briefing and I'd like to thank all of you for being here. And please join me in thanking our panelists for a very informative discussion.

(Applause)