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## **Trends in Coverage and Affordability on the ACA Marketplaces**

**The Commonwealth Fund  
Alliance for Health Reform**

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MARILYN SERAFINI: Okay folks, we are going to go ahead and get started. I'm Marilyn Serafini, I'm with the Alliance for Health Reform and on behalf of our co-chairman, our honorary co-chairman, Senators Ben Cardin and Roy Blunt, I would like to welcome you to today's briefing on trends in coverage and affordability in the ACA marketplaces. The fourth open enrollment period is just around the corner, November 1<sup>st</sup>, and our speakers today are going to help us to understand what the experiences have been and also what to expect moving forward. We are going to hear about premiums, who has gained coverage, who remains uninsured and why uninsured individuals have not obtained coverage. We are also going to talk about considerations of health plans regarding marketplace participation.

I would like to thank our partner in this briefing, The Commonwealth Fund and particularly Rachel Nuzum, who is also going to be my co-moderator today. Before I turn the mic over to Rachel, I would like to take a moment to say a few words about someone who has been a special part of the Alliance team for many years. If you have been to some of our Alliance briefings in the past, you have surely been greeted at some point by Dee Burton. Dee has been an employee of the Senate Food Service Program for over 33 years. I'm sad to report today that Dee passed away on June 14<sup>th</sup>. We will greatly miss Dee and we thank her for her many years of service and friendship.

So to turn now to our briefing and again, before I turn the mic over to Rachel, I'm going to go over just a couple of housekeeping matters. First, if you would like to join us on Twitter today, our hashtag is #OE4, open enrollment four. So we will be live tweeting. You can also ask questions via Twitter. We welcome your questions via Twitter. After our speakers give presentations today, we invite your questions. We can take your questions in several different ways. We have mics in the audience and we can take your questions. You can stand up and ask your questions. We also have cards in your packets – green cards. And you are also welcome to write your questions on those cards and our staff will be around to pick up your questions and bring them up to me and Rachel and we will present those questions to our panelists. Or again, you can submit them via Twitter. Again, the hashtag is #OE4.

So with that, I will turn the mic over to Rachel, who will introduce the subject matter and our panelists.

RACHEL NUZUM: Great, thanks so much, Marilyn. I just want to add my welcome and thanks on behalf of The Commonwealth Fund, to you all for joining us today on a Friday afternoon. You are so close to making it to recess, so hang on, it's in your immediate future. But we appreciate you taking the time out to really focus on a critical issue with us today, and that is really, as Marilyn mentioned, focusing on what we know about how coverage trends are looking, how beneficiaries are faring in terms of affordability when it comes to their plans in the new marketplaces. And then really importantly, how stable are these markets? Are there plans available for folks and are the benefits there when they need them? All of these questions will be addressed by our panelists. So you all have complete bios. We have a large panel today, so I'm just going to give a few highlights,

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but I encourage you all to check out the full bios of our panelists. But we are going to start with Sara Collins from The Commonwealth Fund, who's Vice President for Healthcare Coverage and Access. She leads all of our surveys and has authored numerous reports and analysis, policy briefs, issue briefs and journal articles focused on health insurance access, coverage and affordability. Sara is going to be followed by Cori Uccello, an actuary and a Senior Health Fellow at the American Academy of Actuaries. She serves as the chief public policy liaison on these health issues and then my favorite thing about Cori is she is an actuary that actually speaks English that I can understand, so that is why we use her every July to bring this topic to you. Cori is going to be followed by Kevin Lucia, at the Georgetown University's Health Policy Institute, focusing on legal analysis of how states and the federal government regulate private health insurance, no small feat, with a focus on access, affordability and adequacy of coverage, looking at state and Federal laws, pending legislation and current market practices. He's a grantee of The Commonwealth Fund, which is also incredibly important for you to know and we are pleased to have him on the panel today. And finally, we will end with Justine Handelman, Vice President of Legislative and Regulatory Policy for Blue Cross/Blue Shield Association, a national federation of 36 independent community based and locally operated Blue Cross/Blue Shield companies. She oversees Federal legislative regulatory policy development and works on a broad range of issues important to the Blue Cross/Blue Shield companies: Medicare, Medicaid, SCHIP, Federal Employee Held Benefits Program, you name it. So with that, thank you again for joining us and we are going to start with Sara Collins.

**SARA COLLINS:** Thank you, Rachel and Marilyn and also thank you to the Alliance and the panelists for joining us today.

The last few years have brought significant change to the insurance coverage of Americans. There are 20 million fewer uninsured people than there were in 2010. This means that fewer people are exposed to the full cost of their healthcare and we are seeing early evidence of this phenomenon in both Federal and non-governmental data. CMS's estimates of U.S. health spending from late last year show a slowdown in the growth in consumer out-of-pocket costs and an actual decline in out-of-pocket spending on hospital care. Commonwealth Fund surveys and the National Health interview survey are finding nationwide declines in cost related problems getting needed healthcare and also problems paying medical bills. The new Commonwealth Fund local scorecard, which we released this week, finds declines in cost related problems getting needed care in 111 out of 306 local communities across the country. But future gains on these indicators are going to depend critically on the affordability of both health insurance and healthcare.

To get a sense of what consumers are experiencing in marketplace plans this year with respect to affordability, I'm going to share some findings from The Commonwealth Fund Affordable Care Act tracking survey, which interviewed working age adults about their health insurance coverage at the end of this year's open enrollment period. It is really clear, not only from our survey data, but from other analyses of marketplace plans, that marketplace enrollees are highly price sensitive. In the survey, cost was the most

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important factor in health plan selection among people who newly enrolled in 2016 and those who had switched plans in the most recent period. This price sensitivity has led to a very high rate of plan switching during the last two open enrollment periods. Of those, in the survey, about 46% of people who had had a plan since before 2016, said that they had switched their health plans at least once since enrolling. Of those, 40% told us they did so to get a lower premium. The vast majority, more than 80% of marketplace enrollees, have premium tax credits to help them pay their premium costs. We find that these premium tax credits have lowered premium costs for people with marketplace plans to levels that are comparable to those with employer based plans, among adults with low and moderate incomes. If you look at the second set of bars in the chart, 66% of marketplace enrollees with incomes under 250% of poverty, told us they paid \$125 a month or nothing for their single coverage plan. A similar share of people enrolled in employer plans reported paying that much. But if you look at the third set of bars, people with higher incomes paid more and they are paying more than people in employer based plans are paying. This is because the amount of the tax credits phases out as income rises. In contrast, people in employer based plans receive the same premium contribution, in most plans at least, regardless of their income.

We also find evidence in the survey that the tax credits are protecting many low and moderate income enrollees from premium increases. People's tax credits are equal to the difference between the share of income they are required to pay and the premium of the second lowest cost silver plan offered in their marketplace or otherwise known as the benchmark plan. This means that most of a premium increase that someone might experience year to year is going to be absorbed by their tax credit, particularly if people stay in or switch into benchmark plans. Fewer than half of marketplace enrollees with incomes under 250% of poverty, reported a premium increase over the time that they have had their plan, compared to 64% of people who had higher incomes. About half of marketplace enrollees told us that their premiums are easy to afford. This is less than the share of people in employer based plans who told us that their premiums were easy to afford. The difference widens with income. This reflects the phase out of the tax credits again, but also the fact that people in employer based plans, in our survey and just on average, have much higher incomes than people on average in marketplace plans.

The Affordable Care Act requires insurers who sell plans in the marketplaces to offer silver level plans with what are known as cost-sharing reductions for people with incomes under 250% of poverty. These reductions increased the cost protection of plans by lowering deductibles, lowering out-of-pocket limits and lowering co-pays. In our survey, the effect of these reductions is pretty clear among marketplace enrollees with incomes under 250% of poverty, 30% had deductibles of \$1,000 or more, compared to 68% of those who had higher incomes. New data released this week by HHS for 2016 Healthcare.gov enrollees, finds that 56% had individual deductibles of \$1,000 or less. This likely reflects in part the fact that about 60% of people in marketplace plans have these cost sharing reductions – have plans with cost sharing reductions. The flip side of this, of course, is that 44% of people enrolled in marketplace plans have deductibles that are \$1,000 or more. But it's important to remember and if you look at the pie chart on the

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left side, that many plans cover services prior to the deductible. So your service doesn't – you don't have to meet your deductible before you get a service. By law, no one has to meet the deductible before receiving a preventive care service, but the HHS analysis also finds that 80% of 2016 enrollees have pre-deductible coverage for services beyond preventive care, including prescription drugs, primary care visits, specialist visits, mental health and substance use disorder care.

Just looking ahead, to the 2017 Open Enrollment period, which is actually really close. Analysis of preliminary rate increases by carriers suggests that premium increases will be higher in 2017 than they were in 2016, and the other panelists are going to talk about why we are likely to expect this. But most marketplace enrollees won't pay large increases in 2017. This is because insurer premium requests are subject to review by state regulators and the majority of enrollees receive premium tax credits, which will absorb much of the increase that they will see in their rates. Particularly if people remain in or switch to the benchmark plans. Given past experience, consumers will likely shop around for the best deal. But there are definitely cautionary notes in our survey findings. As income rises, enrollees pay high premiums and they pay higher out-of-pocket costs. Affordability concerns are the most often cited reason uninsured people give for not pursuing coverage through the marketplaces. The House versus Burwell case, which has challenged the way in which the administration is financing the cost sharing reductions, put those reductions at risks. So policy adjustments are going to be needed to ensure the affordability for consumers going forward as well as the stability of the marketplaces. Thank you.

CORI UCCELLO: Thank you, Sara, and thank you to The Commonwealth Fund and the Alliance for inviting me to participate today. I will try to speak in English, I can't make any guarantees.

So my role this afternoon is to talk about the factors that are driving 2017 premium changes. Before I get to those factors though, I want to backup and just talk about the components of the premiums. So first is who is covered? What is the composition of the risk pool? Are the individual enrollees healthy? Sick? Young or old? That kind of thing. And then given the composition of the risk pool, what are their projected medical costs? In addition to medical costs, other premium components include administrative costs, taxes and profit. Then of course laws and regulations can affect each of these components. So in terms of the major drivers of 2017 premium changes, I'm going to highlight three factors. First is medical trend, which is the underlying growth in medical spending. So medical trend is expected to rise slightly higher than it has in the past, but still remain low relative to historical levels. There is still continuing concern however, that prescription drug spending is outpacing that of other medical spending. On average, I think insurers are assuming medical trend of mid to high single digits for 2017.

Let's talk about the impact of the reinsurance program, but I want to provide an overview of all three of the ACA risk sharing programs. The first of these is the Permanent Risk Adjustment Program. And that program is used to transfer funds between insurers based on the relative risk of their enrollees. So plans that have a relatively healthy enrollee

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population are going to be paying into the program. Those insurers who have less healthy enrollees will be getting money from the program. The reinsurance program is a temporary program, running from 2014 to 2016. And what that program does is reimburse insurers for a portion of the claims for their particularly high claim enrollees. And the third program is the Risk Corridor Program. Again, this is temporary, running from 2014 to 2016 and that program was intended to mitigate the pricing risk that insurers face when there is uncertainty in terms of who is going to sign up for coverage and what their spending would be. And that kind of program is particularly important during the first years of the ACA when there is so much more uncertainty.

So next, just talking in particular about the reinsurance program, which again, runs from 2014 to 2016, so it won't be in effect in 2017. So the reinsurance program declined over time. So what the reinsurance program does is offset a portion of claims. And because a portion of claims are offset, that means that premiums are lower than they otherwise would be. As the funding for that program declined over time, the offset to claims declined over time, which means each year, 2015, 2016 and 2017, premiums are going to increase due to the reduction in that program. So 2017 will be the last year where there is that uptick in premiums because of the reduction in reinsurance. So for 2017, I think we are expecting an increase in premiums of 4-7% due to that final reduction in the reinsurance program.

Here are just the program parameters of the reinsurance program. I'm not going to talk about it, but I'm happy to answer questions during the Q&A.

And the third major driver I will talk about has to do with changes in the risk pool composition and insurer's assumptions regarding the risk pool. So as I mentioned, premiums reflect insurer expectations regarding who was enrolling in coverage and what their health spending is. Now, premium changes reflect changes in those underlying assumptions, including the expectations of how the risk pool profile may change from 2016 to 2017 and also how experience to date may have differed from the assumptions that were underlying their prior premiums. So I will talk about both of these.

So insurers this year had information when developing their premium rates for 2017. They had information regarding their 2014 and 2015 enrollee demographics and health spending. And then this was the first year that insurers also had information regarding the market-wide risk profile for the 2014 plan year. And that information included the results from the payments and receipts under those three risk sharing programs. And information from those results indicate a couple of things. First, the risk adjustment data suggests that some insurers may have set 2014 premiums low relative to the market-wide risk. So insurers should be setting premiums that consider the transfers made under the risk adjustment program. So they should be kind of calibrating to market-wide risk. Second, the Risk Corridor Program data reveal that for many insurers, their 2014 premiums were too low relative to actual claims. And this is why you saw so many insurers expecting – after they saw their claims- expecting to get payments from the Risk Corridor Program. Now, 2017 premiums could increase to the extent that those results have not already been

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incorporated into the assumptions underlying the prior premium changes. So to the extent that insurers already recognize- for example, there was the transition policy that went into effect after the 2014 premiums were finalized- that they may have incorporated some of that into their 2015 premiums, but they may not have done so to the full extent they now think they may have to. I'm not sure that was English. So here is a chart from the Kaiser Family Foundation that shows that the premium changes for the second lowest silver plan. And this just really shows across different cities, that just on average, the premium change requested for 2017 is higher than that that occurred in 2016.

Just a few more things that we need to consider as we are looking at the premium changes that have already been requested and have been released and those that will be finalized and released in the future. First is that 2017 premiums in most states have not yet been finalized. So that is something to keep in mind, as Sara mentioned, that things may change when the final premiums are released. Second, as we saw from the prior chart, premium changes can vary tremendously across states. In addition, premium changes can vary tremendously within a state by insurer. And what we see in the news a lot when we see things about premium increases, they are really just average numbers. And I would just caution that those averages may not apply to any particular consumer. Consumers can face different premium changes due to the particular plan they are in, they have aged a year and so will face an increase in premium just due to that. They may have moved, they may have changed their family status and their subsidy eligibility may have changed. So all of those kinds of things can affect a particular person's premium change.

Finally, consumers can potentially find a lower premium plan by shopping around, but again, I think it's important that people look at not just the premiums of their plans, but also the cost sharing requirements. Look at that together when choosing a plan.

So here are just some papers that go into more detail from the Academy on this. But now I will pass it over to Kevin.

KEVIN LUCIA: Great, thank you. Thanks for having me and I really appreciate being on this panel.

So today, I just want to talk a little bit about insurer participation in the marketplaces, the level of plan participation and looking at last year and some caution about making any conclusions for this year. I also want to talk a little bit about some observations that we have seen in some recent research that we have completed, looking beyond United Healthcare and the dramatic exit that they have taken and we have heard about continuously in the news over the last couple months. And then some federal considerations and ongoing concerns of issues that probably do need to be addressed and are somewhat being addressed by the Feds.

So in 2016, and just so you know, at Georgetown we try to study how many plans – we really stay focused on the state based marketplaces and we try to really understand what

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is happening at the level of plans participating and why they are staying in or why they might be leaving. So, in 2016, insurer participation in the marketplace remained very stable from 2015. Nine of the SPMs experienced no change in issuers. Three saw a net gain- I think one of those was a new entrance to the marketplace- and five realized a slight decline. HHS reported a similar trend in the FFM and yet, at the same time last year, the news cycle was basically saying the world was falling apart in the marketplace in mass. So moving into 2017, I think it's important, you know, premiums haven't been finalized yet, so we are still learning about what plans will definitely participate and despite early announcements by United, the failure of a number of co-ops, we really need to kind of find out exactly what plans are staying in and be looking at new entrants, the plans that are maintaining in these marketplaces. Are they expanding their service areas? What is the local competition like? Do you need six issuers or can you tolerate four? So maybe a departure of one isn't so bad.

Then I also just want to remind the room, I think we have talked about this in other panels, that a number of the SBMs have actually used issuer participation rules as a lever for driving competition. For example, in Maryland, if you play on the outside market, you sell individual health insurance policies, you have to play in the marketplace. And so they have been able to maintain a very robust number of issuers in the Maryland exchange over the last three years and will continue going into 2017.

So, United comes out a couple of months ago and really makes this dramatic departure from the marketplace. It's important just to note that they were slow coming into the marketplace and then they expanded very rapidly into 2015. There is research out from Urban Institute that shows that when they did play, they didn't always play hard. They weren't necessarily competing aggressively on rates. And overall, United really did maintain a modest share of the marketplace enrollment when you look at it across the nation. So, just gotta kinda remind ourselves of that.

So, what we thought we would do is look at the largest publically traded issuers that were participating in the marketplace and we basically reviewed their first quarter earnings calls to find out what they were saying about the marketplace. And we realized that there is a lot of perspectives out there that go well beyond United's experience. So what did they tell us? So, insurers are not withdrawing in masse from the marketplace. There appears to be a long term commitment to the marketplaces on some of these larger for-profit companies. For example, Anthem noted that they are going to continue participating in 14 markets and suggested that they are looking for expansion opportunities. Marketplace enrollment remains stable for these large plans. In fact, some of them were seeing dramatic increases in their enrollment levels, so Aetna reported enrollment above expectation with a gain of 200,000 people. Molina, which had been a former Medicaid-only plan realized an increase of 420,000 new members from last year. So these are dramatic increases. What we also heard was, the risk pools continue to evolve, but unlike United, some of these other carriers are having a better experience with their risk pool. For example, Molina commented that its marketplace enrollees had been comparatively healthy and that may be because they are targeting enrollees that had

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either been prior uninsured or just coming off of Medicaid. And then another major observation was insurers continued to view the marketplace as offering them a unique business opportunity. So these larger for-profit companies weren't necessarily ready to be on the marketplace. They did point out a number of ongoing concerns: Complaints about the risk adjustment program, ongoing concerns about special enrollment periods, people coming in-between open enrollment periods and being high risk and high cost. But I do want to point out, in recent months, it seems like the Federal regulators are listening to the insurer concerns. They are offering changes to the special enrollment period rules. They are restricting the sale of short term durational policies, which may have been pulling away some healthy risk from the marketplaces. And there is an ongoing discussion about risk adjustment and the risk adjustment methodology.

So looking forward, I think it's important, especially when we think about United and if there are any other large carriers that pull out of some markets, that it's important to understand that there are many plans playing in these marketplaces. They come from all different directions and the former Medicaid only plans like Molina and Centene are actually having a much different experience than United and some of the other larger players. Not all issuers will thrive in this new developing market. I think that is really important to understand. Before the Affordable Care Act, we had an underwritten market and companies made money basically discriminating against people. And so we have new rules in place and it's going to be a tough environment to succeed in and it's going to require effective risk management and prohibiting discriminatory practices. And I think we are going to have some issuer scale because they can't compete in that environment. And I think that is okay. Then finally, I think there is a real important role right now for Federal and state policy makers to be looking for opportunities to kind of resolve some of these ongoing problems that we are hearing from. Carriers – I think we will hear some from Justine in a bit. And this is the moment. We are at the start of a marathon. We are only, what? Four years into the Affordable Care Act and many years to come, I hope, and over that time we will be working towards improving some of these underlying problems.

MARILYN SERAFINI: So, before we turn to Justine, our final speaker, I want to remind you that if you are following us, if you would like to participate in Twitter, the hashtag is #OE4, Open Enrollment 4. And also, after we hear from Justine, we are going to open up the Q&A portion of our briefing, so be getting your questions ready and, again, you will be able to ask your questions via Twitter, again, #OE4, live at the microphones and also that you have green cards in your folders that you can write your questions on so you can be starting now, even, if you like. So with that, I will turn it over to Justine.

JUSTINE HANDELMAN: Thank you, Marilyn and thank you, Rachel for having me here today. I really enjoyed sitting with the panel here and they have said many important things and hopefully will make my job a little bit easier. Just quickly before starting, I want to talk a little bit about Blue Cross/Blue Shield. We have been in existence for over 80 years and Blue Cross/Blue Shield plans serve every market – the individual, the small group, the large group. We are in every zip code across the United States. We also are in government programs, Medicare and Medicare Advantage Part D, the federal employee's

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health benefit program. And the plans are extremely committed to the communities in which they serve and the customers they serve, given their long history. My focus today is going to be on the experience of the marketplaces and then offering some recommendations of where we need to head and I think a lot of good groundwork has been laid by the other panelists and I thank them.

I think as Cori mentioned, we now have two years of real data. Of what is happening in the marketplace, who are the people that we are enrolling. And the data is based upon their actual medical claims experience. And we are beginning to understand the way these new enrollees are utilizing care- the care they need, the prescriptions they need and what that means. And let me just share a little bit, as I talk about it, how that impacts premiums and I think Cori did a really nice job showing how premiums are set. The newly covered have higher incidence of chronic conditions – hypertension, diabetes, et cetera, and they are using more medical services. Now that is not surprising. As was mentioned before and Kevin mentioned, before the ACA, health plans could deny people coverage if they had a pre-existing condition, or they could rate people that were sick higher. And the rules today do not allow that to happen.

What did surprise us when we looked at the new enrollees, because going into this marketplace, when we didn't have data about who was in there, plans felt that this marketplace would look similar to the group market, because in the group market, it is a guarantee issue market, especially as we look at the small group. So we expected cost to be similar to what was there. But what surprised as we looked at the data and did a study, is that the costs of those that came into the ACA marketplace in 2014 were 19% higher than those with employer coverage. And in 2015, 22% higher. So we saw that going up. So we didn't expect that to be that much higher. And I think Cori also mentioned, you do see a continued increase in medical trend and that adds to premiums as well, but premiums – you have to have enough cost to cover your claims, so the makeup of the pool, but in addition, what is the trend? And certainly we have seen in the last few years, significant increases in prescription drugs, generic drugs, as well as specialty drugs that has been adding to the costs.

I think as we all know, a key to affordability is making sure that everyone is in the marketplace. When you have rules that you cannot vary premiums based on health status, you have to accept everyone regardless of health condition, you need everyone in. You need enough young, healthy people to balance out those that may be older or sicker with conditions. Incredibly important. And we are concerned the existing rules today don't do enough to ensure that everyone gets enrolled and that they stay continuously covered. What is really important for health plans – and we have many innovations underway and I will talk about that – is when people do have conditions, you want to help manage those conditions and make sure they get the care they need to keep them healthy, to keep them out of the hospital, to make sure that they are doing the things that they need to do to stay well. But when people can jump in and out of the marketplace, it not only causes premiums to go up, but it also causes things to – people to not get the ongoing care they need.

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Of particular concern to us, and I think probably for many in the room who have been talking to us over the year, you won't be surprised. We have had significant concerns over special enrollment periods. And the intent of the law, I think as everyone knows, to make it work everyone has to be covered. There is a mandate to drive that. But there is also an annual open enrollment period and it's important that people come in during that period. But what we have been seeing is that the special enrollment periods have been misused where people are using them to come in when they need care and then even dropping coverage. So, not even staying in for the full period once they get the care they need. And kind of an analogy to think about it: You can't get your care insurance after you have crashed the car. Imagine if all of us could, how expensive our car insurance premiums are. The same is with health insurance. To keep it affordable, you need everyone in. When something happens, of course if you have a balanced risk pool, you can spread the cost.

We did a study – I'm just going to touch on, on the SEPs, that does show how significantly they have been impacting because people are able to come in. And we and AHIP worked with Oliver Wyman who collected claims data to see what was happening. And when you look at a per member/per month basis, claims costs for those that were coming in through special enrollment periods were 47% higher in the first month of coverage, in 2014, and 57% higher in 2015 for those coming in through an SEP compared to the open enrollment period. And then when you look at the first three months of coverage, again, those coming in through SEPs had much higher costs than those coming in through open enrollment. 24% in 2014, it went up to 41%. We did not have data for the full year in 2015, but looking to 2014, we know the impact of all of those people coming in through special enrollment periods. Their costs – those coming in through special enrollments- were 10% higher than those coming in through the annual open enrollment period. And we know special enrollments have been driving the enrollment numbers, in fact, in 2014 and 2015, nearly 20% of the overall enrollment in the total exchange population came through special enrollment periods. Now, I don't want anyone to walk away and think that special enrollment periods are not important. They are incredibly important. If someone has a life change, they move and they have had insurance and they need to get insurance in their new state, they have had a baby and they need to add the baby to their policy, they have had employer coverage and they have lost that coverage – absolutely. You need to make sure that that special enrollment period serves them. But what we believe needs to happen is that just like we do off the exchange or you see in Medicare Advantage, if someone has one of those changes that requires them to come in through a special enrollment, that they prove that they should be coming in. Kevin alluded that recently the administration did do some action to help, and they did take a first step. We don't think it's a step that goes far enough, but it is a first step. They changed the rule to require that if you move, you need to show that you had prior coverage in order to get in through a special enrollment period. So before that rule, you could be uninsured, you could move and then you could get insurance. So think back to my car insurance analogy. So they have said you have to now, for a move, that is the only one of the special enrollments you have to prove prior coverage. But where we don't

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think the administration has gone far enough is requiring upfront eligibility. Making sure that people are eligible before you enroll. Right now, it's presumptive eligibility, so we will be looking back in about a 60-day period to see if they were eligible. They will be enrolled, as you saw those numbers. They can come in and get services and if they weren't eligible, CMS will then say, well you can terminate. And we are concerned about that.

I will quickly go through a couple of things because I know I'm running out of time, but there are some other factors that we have been concerned about that have led to the increased premiums. Certainly we believe the difficult launch of healthcare.gov, many of the young healthy people that might have otherwise come in, did not come in and it's harder to get them. Again, we are seeing the makeup of the pool. Cori mentioned the transitional policies. We had set our premiums expecting to migrate many people over; when in November a rule was put out to say if you like what you have, you can keep what you have, many plans scrambled to allow that, but we didn't price our premiums knowing that would happen. That had a huge impact, and Milliman just put out a study that actually shows. There are grace periods where if someone stops paying their premium, they can't be terminated for three months. So the first month, they can still continue to get coverage. We have to pay for it and then claims are pended. We know that McKinsey has put a study out to show that people are actually doing that and then reenrolling. So we have seen an uptick there. So there has been a number of factors that have left us to be concerned.

And I know Cori spoke about the reinsurance program that is expiring. There has been some confusion and we can talk a little later if folks want. There is an early retiree reinsurance program that needs to refund Treasury at a temporary, it's all private funds.

But just moving real quick, what are we doing? We are working very hard to keep people healthy. Most health plans, and I won't go into it, but as Sara mentioned, are providing coverage outside of the deductibles to make sure people get the care they need. There are many ways that people can get primary care, specialty care, prescription drugs, before meeting the deductible and we are trying to incentivize them through patient centered medical homes.

But going forward, what do we need to make sure that this is a viable market? I think what is really important is that government needs to be a good business partner. When Medicare was enacted, certainly Medicare advantage and Part D, there were changes over time that were needed to stabilize. We can't go back and change the rules after they have been set and we have established premiums and contracts to provide services. There have been a number of areas, transitional policies – I have mentioned the risk corridors- where the rules were changed after the premiums had been set that have an impact. So we really need the government to be a good business partner. The premiums need to cover the cost of providing medical care. Health plans have no incentive to set premiums higher than what they need to cover, because we live under medical loss ratios. If it's too high, we rebate. Health plans need to get the premiums to cover those in their population. The

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marketplace rules need to promote continuous coverage. I have talked about some of those. Then health plans need to have the flexibility to innovate and make changes as they go forward. Having rigid rules and having to do things in a very cookie cutter way can make it difficult to provide the benefits that best meet the needs of the consumers in the population we are serving.

So as we look to the future, I just want to mention that we now have the data to inform what the marketplace looks like and we have ideas on how we can continue together to work for a strong, stable, affordable, private marketplace.

MARILYN SERFINI: Great. Thank you to all of our speakers and now we are ready to hear your questions. While you are gathering your thoughts, we are going to turn to Rachel to kick off the first question.

RACHEL NUZUM: Thanks, Marilyn and thank you to all of our panelists. Justine, you kind of opened the door to special enrollment plans, so let's just go through it. I would love to hear – because we have heard a lot about this in the press and we have heard a lot about it obviously from plans, they are obviously designed to fulfill a very specific need for beneficiaries. But Sara, and others, is Blue Cross/Blue Shield's experience common? Are we seeing these trends across the country? What do we know about the folks that are coming in nationwide through the special enrollment plans and are there steps that we should consider taking to kind of address some of the things that Justine laid out?

SARA COLLINS: So just a couple points and Justine obviously has the data to really look at who is coming in in special enrollment periods. But it's important to really think about why we have these. Most people in the United States have employer based coverage and a major source of uninsurance prior to the Affordable Care Act was people losing their employer based plans and not having a place to go. So these special enrollment periods were particularly designed for that problem – when people lose coverage because they lose their job, because their spouse dies, divorce, et cetera- having a place to go. Some analysis that the Urban Institute has done, found that only 15% of uninsured people who would qualify for a special enrollment period are actually using them. So there is really an underutilization of people, of those special enrollment periods. The other thing I just want to make sure that I'm clear on, I understand the fixes by the administration included requiring documentation for the most common special enrollment period, so I think it's more than moving. I think you have to fill out a set of documents verifying that you actually experienced a job loss or a qualifying for a special enrollment period. So it's a little bit more extensive than just moving, I think. The other thing that the administration changed is in the risk adjustment program, they are allowing for adjustment for partial year enrollment. So I think that – and Justine can address that too- but I think that also addresses carrier's concerns about higher than expected costs as a result of the special enrollment periods. A lot of that is newborn children, so babies are by definition, expensive. So when you cover them, they are just – it's just going to show up. But I think we have to really be concerned about tightening down on the special enrollment periods. It might actually backfire. We might actually end up tightening them

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down to such an extent that only the most motivated people, the most highest risk people, actually try to come in and people who are healthy may stay out of the pool, stay uninsured until they can pick up coverage someplace else. So just a few thoughts on that.

JUSTINE HANDELMAN: If I could just make one comment: Sara is right; the administration will require documentation for those coming in. However, our concern with the requirement is the documentation is after the fact that you have been enrolled. So you can't hold up a special enrollment until you get the documentation. That consumer will have, I believe, up to 60 days to provide it. So they can come in, get all of the coverage they need and then drop. So our recommendation is that that documentation should be submitted before you are allowed in. And one thing to the point – special enrollments, absolutely, they are important, but I think we need to really educate and drive people in during the annual open enrollment period so as many people come in and therefore don't have a need to wait. If someone has lost their employer coverage, absolutely they qualify for a special enrollment. But I think we need to do more to get people in during the annual open enrollments so that there isn't the misuse and certainly from our point of view, require that documentation before you are enrolled.

MARILYN SERAFINI: Okay, we have a question at the mic, could you please identify yourself?

HEATHER FOSTER: Sure, hi, my name is Heather Foster, I'm the Vice President of Marketplace Policy at the Association for Community Affiliated Plans and we represent a lot of the safety net health plans, Medicaid focused historically, and many of them have moved into the marketplace. It's been a relatively new space for them. I have two questions, I will start with the first one, which is for Sara and Kevin predominantly. In The Commonwealth's most recent brief that you put out, I know you stated that just under half of all of the respondents said that they found the coverage affordable and also that cost was the most important factor as individuals pick out their plans. And we have actually seen some other data from NORC and Commonwealth Fund that shows that the Medicaid plans tend to offer the lowest premiums and at least on average, sort of looking nationwide, and I think that is largely because of their experience with care management – a lot of this low income population, vulnerable populations. And we have also seen from some of our own analysis that we did, looking at QHPs in the marketplace, that about 40% of all QHP products, the issuer also offers Medicaid coverage. They are in both lines of business. And I'm wondering if you could both speak a little bit to the role of these types of plans with some of the Medicaid experience and if you have done any research looking into either consumer satisfaction by plan type or at all breaking out the different plan types and what the impact of that is on the market.

KEVIN LUCIA: You know, actually we are, at Georgetown, will be starting with Commonwealth Funding to look at a little bit more at the former Medicaid only plans that are participating in the marketplace and I think as there is research out from urban that shows that when they do enter a market, they end up being very aggressive on pricing and successful in pulling in share. A case in point, in Rhode Island, Neighborhood Health

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Plan came into the Rhode Island market, which had been dominated by Blue Cross/Blue Shield and I think they have over 50% of the market. Now, one question that I think all of us have to ask is, is this sustainable? Right? I think sometimes the – probably very often – they are coming into the market, riding off of reimbursement rates that are lower than your commercial plans. So will they be able to maintain those reimbursement rates, which drive premiums as they go into the future?

SARA COLLINS: Just on the Affordability issue. Perception – people’s perceptions of the affordability of the health plans. So we are seeing fewer – about half of people with marketplace plans viewing the premiums as somewhat or very easy to afford. It’s lower than what people tell us in employer based plans. So even when you look at what people are actually paying in marketplace plans, even though they are similar to what people are paying in employer based plans, at least for lower income, there is this divergence in the perception of the affordability of those plans. We also see among people who are uninsured now – so we have a good sample of people who are without health insurance coverage and we ask why they haven’t come into the marketplaces. And the primary reason is – if they haven’t visited the marketplaces- they are concerned that they won’t be able to afford the coverage. If they have tried to enroll, also cite affordability as the primary reason why they didn’t sign up. And the majority of people who are telling us this are actually in the income range that makes them eligible for tax credits and subsidies. So, I think there is perception among a large number of people who are in the marketplace plans, have them already and also are thinking about coming in, that it’s just not affordable for them. So I think that really is an important thing to think about and in terms of policy changes- education- but also making sure that these tax credits are in fact making plans affordable for people.

HEATHER FOSTER: Can I ask my follow-up question, which is actually for Cori? You made the point that issuers need to calibrate for the market in terms of risk adjustment and you need to calibrate for what the whole risk is throughout the market. But I have noticed, at least looking through the 2015 reinsurance and risk adjustment report that just came out, that many of these smaller issuers and Medicaid focused issuers have ended up being on the hook for millions of dollars and they otherwise would have been able to keep their cost down. And so I’m worried that perhaps once you start looking at that whole market wide risk, you actually might end up artificially driving some of those premiums up, particularly for those Medicaid plans that have been historically able to keep cost down. So I’m wondering if you can talk a little bit about that potential impact on enrollees as well as the stability for the marketplace.

CORI UCCELLO: So let me first back up and just kind of talk about the rationale behind having a risk adjustment program. So it’s there, again, it transfers money across insurers based on their relative risk. And it’s there to help reduce any incentives that insurers would have to cream scan, to just pick the healthy risks. So premiums then in general need to incorporate in them any transfers they are going to pay or receive. So yes, if you have got a healthier population, your premium is actually going to be higher than what

that population would indicate, because you are making a transfer to the other plans. So I think that is part of what is going on here.

HEATHER FOSTER: I guess what I'm trying to touch on is that that may well be the case, but for plans that have that ability to otherwise keep costs down, such as the Medicaid plans that have come in with lower premiums and have been able to offer lower premiums because they have either those lower reimbursement rates or more experience with care management, but ultimately you are artificially then, in order to respond to that risk, driving those premiums up higher than they otherwise might be. So you artificially drive the whole market up rather than keeping some of those premiums low.

CORI UCCELLO: I will refer people to our issue brief that was noted on our last slide, that we have looked at the risk adjustment program and one of the approaches that has been forwarded is, well, can you make the transfers based on the plan's actual premium instead of the statewide premium? On one hand it sounds like it makes sense because it would incorporate those different, if you can do better care management and just have lower costs, but there are some down sides to that in that it could create some not great incentives in terms of setting a premium. So I think it's kind of a complex issue, but we outline it in our paper with more detail.

MARILYN SERAFINI: Great, let's turn to this side for a question.

KARL POLZER: Karl Polzer, Health Policy Analyst. So this question is about the special enrollment period and it stems from an experience I had in February, trying to help somebody get on the exchange. And it has to do with, I think the concern that if you tighten them up for some people, it may cause an issue. Yes, there is a legitimate free rider problem- If you have no insurance and then you just go to get insurance when you get sick, hence the special enrollment period. But what if you already have insurance? This is a case where a woman's husband died of cancer, she became impoverished, she had expenses of \$18,000 – or income of \$18,000 all of a sudden and about \$25,000 of expenses every year. So we tried to get on the exchange and basically they said there was a lot of sensitivity – you are never going to do it. This is – she missed the open enrollment period. It turned out, she got on because of the staff on the – we went to the policy people and they said, no way, but the staff on the exchange agreed to it. But here you have a case where she had no major health issue, it's just a change in economic status and needed the government's money and I don't know what would be harmful to the industry – I mean, for people who have insurance already – why even have – even if it took underwriting, why even have an open season? All they need is the subsidy. See what I'm saying? They are not coming from no insurance to insurance.

JUSTINE HANDELMAN: Well, I think special enrollment is the way they are supposed to work in that situation, so I don't know the circumstances. It sounds like it worked as it shouldn't have. If someone had prior coverage and loses that coverage, they should absolutely be able to come in through a special enrollment period.

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KARL POLZER: Everybody I talked to in authority said it wouldn't happen. It was just the ladies on the exchange that made it happen. On the phone. You get a different one every time.

RACHEL NUZUM: We do have a question – there obviously has been a lot of news lately about the co-ops, obviously Illinois was the latest one that we have been hearing about. So there is a question from the audience about co-ops, kind of what is not working with those. Then it sets up a broader question about how can we – what do we know about the plans that are going to be successful on the marketplaces. Justine touched on a little bit about this. And what do we know about plans that will be able to be successful and what does this mean for new market and trends? Maybe if everyone can just take it quickly?

KEVIN LUCIA: Sure. So yes, a significant number of the co-ops have failed. I think it's a really incredibly difficult environment to become a new entrance in and these co-ops started from scratch with very little funding. They had a number of barriers that was kind of inherent into the program that they were set up on and I think one thing led to another and here we are, four years later and over – I think it's over half the co-ops – I think there are nine standing from the 22 that began. So, but speaking of how to bring more competition into the marketplace, I do think that when you look at the scope of plans that are out there that hadn't been into the individual market prior to the ACA, you are, as we talked about before, seeing success in some of these former Medicaid only plans and although a number have entered, there are many states out there that these plans still just participate in the Medicaid market. And so we probably do need to learn a lot more about how to encourage those plans to come in, what the barriers are for them coming in, what are the successful features of the plans like Molina and Centene, what are they doing right that is allowing them to have a successful run so far in the commercial market?

JUSTINE HANDELMAN: And I can touch on, if you want, the second half of what we need to do. Kevin just talked about the Medicaid managed care plans and I know CMS had a best practices conference and some of the Medicaid managed care plans were there. I think when you look at those plans, they pay lower rates to providers. They pay Medicaid rates and many of the commercial plans do pay a higher rate. So the message CMS has put out is you have to negotiate tougher and lower the rates to providers, tighter utilization. There is a lot more prior auth and utilization management that may happen on that end. Certainly we believe we want to see robust private innovation continue and it really pushes how do you make sure you have got continuous coverage. There is some gaming around third party payments where you have certain groups that may be paying the premiums for sick people or even seeing instances of people being shifted from Medicaid or Medicare to ACA plans because they get a higher reimbursement. That has caused some issues. The health insurance tax is another thing that just adds percentages, it was a moratorium for a year, which we were pleased to see, but when that comes back in, in 2018, that will add more than 3% to premiums. So I think we need to look at what are the things that are going to drive innovation and affordability.

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SARA COLLINS: Just a couple additional points on the co-ops. I think it's really important too to look – as Kevin says – to look at these as a special case. There is definitely provisions in the law that made it more difficult, even as new entrants, for them to come into the marketplaces and then their funding was cut dramatically after subsequent implementation, which also affected it. And the Risk Corridor Program was so important for new entrants, including the co-ops and not – and having the expectation that they were going to get risk corridor payments and then not getting them, was certainly devastating to many of them.

MARILYN SERAFINI: Question over here?

MICHAEL FIRI: Hi, my name is Michael Firi, I'm an intern. I wanted to ask a little bit about the components of the premium, growth or decline and the difference between the risk premium and loading fees that occurred after the implementation at the ACA. I didn't know if there was any research that discusses whether there is more percentage growth in the loading fee or if there is more percentage growth in the risk premium where insurers have to account for changes within the insurance pool. Within that risk pool.

CORI UCCELLO: I will take a partial stab at this. I don't have a direct answer to your question, so I will say that off the bat. I think the law has those medical loss ratio requirements. So the amount that a plan can spend on administrative cost, profit, fees those kinds of things. That amount is limited by the law. So I think that may have affected plans in terms of trying to get more efficient with the way that they were working, but I haven't seen any particular studies that look at that. I don't know if there are.

SARA COLLINS: I will just make a quick point on this. Commonwealth Fund published a piece by Mark Hall and Mike McCue earlier this summer. They looked at the performance of plans inside the marketplaces versus outside the marketplaces, so on the individual market, but not operating in the exchanges. And they find – what they find is that the medical loss ratio performance of plans inside the marketplace is actually better or more efficient than those that are operating exclusively outside the marketplaces. So there does seem to be a decrease of administrative costs in plans that are competing in the marketplace relative to outside, reflecting really this dynamic of competition in the marketplaces.

MICHAEL FIRI: Gotcha. Okay, thank you so much.

RACHEL NUZUM: Great. This question is directed to Cori, but I would guess that all of you might have a quick response. And that is: Thinking about the role that drug spending, especially high cost drugs, may potentially be having on premiums, what do we know? Do we know enough and if not, maybe this is just setting up our October 7<sup>th</sup> briefing on prescription drug pricing policy. Until we get there, do we know, do you have a sense, Cori, of kind of the percentage or the impact that drug pricing is having on premiums?

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CORI UCCELLO: I don't have, off the top of my head, what percent of claims are due to drugs. It's smaller than medical claims, but I think it's growing because the costs have been, as I said, outpacing the medical claims themselves. I think in the recent years, we have seen the high cost specialty drugs really driving the increase in prescription drug spending, but I think that the paper that came out just yesterday or a couple days ago from the CMS Office of the Actuary, I think they – do they expect that prescription drug spending would kind of level off – if I'm remembering correctly.

JUSTINE HANDLEMAN: I would just say quickly, I know – and we don't have the data, but we are looking to do some study in the space that prescription drug spending has been an increasing amount of the premium dollar. It's not – by far it's still in the low double digits, but it has been increasing. And the one thing I just point out that is difficult for health plans is that there is a lot of transparency around health plan pricing and premiums and how we file our rates and all of the information that goes in. There is not a lot of transparency on how a drug price is set. And when a drug comes out mid-year when you have already set your premiums and something – you may have a blockbuster drug. I know Sovaldi was an amazing drug that had a cure, but it came out mid-year. We didn't know the price and we didn't know the indication how big the population was going to be. And when that comes out mid-year and your premiums are set, it can have a really big impact when you have something so costly for so many people. So, greater transparency into when things are going through the FDA – what is the price and what is the indication, so we can make sure we are collecting the premiums to cover those, is really important.

LANGWOOD FERRELL: My name is Langwood Ferrell, I'm a Clinical Quality Improvement Analyst and this question is really about special enrollment. There is some stratification been done on the reasons for special enrollment. I think especially if we are talking about people losing employment and enrolling in the special enrollment period. And if that is the case, is there some specific mechanisms in place to take into account that they may return to work and leave that plan and go back to another employer?

SARA COLLINS: I can weigh in as well, but we do know this is the most common special enrollment period. So it's just by the sheer numbers of people that have employer based coverage and how easy it is for people to lose employer based plans. And we also know, just based on Urban Institute Analyses, that that accounts for by the far the largest share of people who are eligible for special enrollment periods, but it also accounts for the vast majority of people who are eligible for special enrollment periods because they lose employer based policy, don't actually sign up for a special enrollment period. So they stay uninsured either until the very end of the year, or they stay uninsured for a few months and then pick up coverage through another employer.

JUSTINE HANDELMAN: I will just add quickly: We have been asking CMS one thing that would be helpful to get exactly at what you were looking for. We don't often have the reason why someone is coming through when we get an SEP through the FFM, so we

have asked for a reason code so we can understand where they are coming in and are we seeing greater needs in one or different patterns in another. So that is something we have been pushing them to do, is let us know the reason so we can see what is happening and then see if there are policies to address.

PAUL HELDMAN: Hi, Paul Heldman, Health Policy Analyst with Heldman, Simpson Partners. I know Justine touched on this, but I'm curious whether you have any additional suggestions or other members of the panel, about what can be done via regulation or the administration acting without Congress to mitigate premium increases and to get more healthy people to sign up for coverage in the marketplaces and then also are there any areas of potential bipartisanship agreement legislatively to address this issue?

SARA COLLINS: I will start off as people are gathering their thoughts. I'm sure everybody has lots of thoughts. I think just in terms of enrollment and increasing enrollment, there is clearly a large number of people who are eligible, but not enrolled. Again, in our survey data, it is really concerning that the majority of people who are uninsured have incomes that make them eligible for the tax credits or Medicaid. So that indicates that we continue to need to have strong outreach in enrollment efforts going across the country. I think helping people understand in addition what these subsidies mean in terms of their reduction in their premiums, the media obviously, when there is a lot of – because of the rate increases that we are hearing, it does lend the sense to people that the premiums are skyrocketing and they are just not going to be affordable for them. So I think education for consumers is going to be very important. I think you also need to look at this whether or not the premium tax credits are affordable across the income distribution for people. That the premium tax credits as they are now structured, make health plans affordable across the income distribution. That cliff, that 400% of poverty, you are still looking at people who are earning about \$90,000 for a family of four. At \$100,000 a year, they drop off and they face the full premium. And we know from our data, that people are probably crowded right close to that income level and so do we want to think about increasing the premium tax credits either higher up the income scale or even increasing the generosity of those. I think the cost sharing is another area for some really strategic thinking about how we can make out-of-pocket costs more affordable for people.

JUSTINE HANDLEMAN: Can I just touch on really quick on the bipartisan side, the Energy and Commerce Committee actually has a few bipartisan bills that they were looking at that we thought we believed would be extremely helpful. One is on the SEP's to require more of the upfront verification as we talked about. On the grace periods, they were looking at either returning control to the states – states typically have a 30-day grace period before someone is terminated, so it's not three months that they can stay on, pay nine months of premium for 12 month of coverage. And then adjusting the age bands to five to one. And then I know the other issue that is at least talked about on both sides of the aisle is the family glitch, to make sure that families are actually getting the appropriate subsidies that they need and addressing that. So there are some things, and I agree with Sara as well, if you could look at the subsidy and how it interplays with the

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age. Right now an older person who makes more because of the way the age band works, may actually get more of a subsidy than a younger person who makes less. So, how you look at the rate incentives.

MARILYN SERAFINI: Yeah, we seem to be hearing more from some folks about changing the age band and we recently heard from the administration some about their efforts to bring young invincibles into- their efforts to get them to purchase insurance. I'm wondering if any of you can talk about their efforts, because Sara, you mentioned in your remarks that of course this is one area where we are still seeing a lot of uninsured- the young invincibles not signing up. So how do we get these folks insured and Justine, since you mentioned the age band, Doug Holtz-Eakin mentioned recently that by changing the age band, that he believed that that would lower premiums. So, what would be the impact of doing that and how do we get the young people to sign up?

SARA COLLINS: Just a couple comments on the age bands. Currently it's three to one. So carriers can charge older people three times what they charge younger people. This is one of the few places that carriers actually can adjust their rates based on the demographics of an enrollee. Some research was done for us by Rand, by Christine Eibner, looking at what it means to change from a three to one to a five to one band. And what they find is that the increase for older adults is much higher in terms of premiums than the decrease for younger adults and it results in a loss of health insurance coverage of about 800,000 older adults. And at a significant cost to the Federal budget of \$9.3 billion. So this is a very expensive proposition for the Federal government. It would lead to more uninsurance among older people and not really get much of a gain on coverage of young adults. I really think the issue for young adults is someplace else. If you look at the demographics of marketplace enrollees, about 30% of marketplace enrollees this year were between the ages of 19 and 34, so not that different from the overall representation in the population. They are over represented in the Medicaid expansion. So states that would expand their Medicaid programs would probably see a big surge in enrollment among young adults, since they are – uninsured young adults tend to have very low incomes, incomes in the range that make them eligible for Medicaid.

CORI UCCELLO: Another policy that I just saw in the paper this morning, and I'm not saying whether it's good or bad, is the perhaps intentional impact of allowing children to stay on their parent's policies until age 26, that that removes them from the individual marketplace. I'm not saying that's a great idea to not allow that anymore, but that is also impacting the risk profile of the market. But just in general, I think greater outreach, other things to try to get more healthy of all ages to enroll in the program is important. It's not just a young issue. I think it's a healthy of all ages issue.

KEVIN LUCIA: I would just say, and back to outreach. I mean, when you look at a state like California, which has been successful at maintaining the numbers, expanding their numbers, they have been able to, because of their diverse and expanded risk pool, they have been able to maintain lower premium increases. But they put a lot into their outreach. I mean, if you are in California, there is work being done on the ground, they

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have storefronts, there is a massive media campaign. You know when it's open enrollment and that's not necessarily true in all state based marketplace states and certainly not in the FFM states. So I think before you start tweaking with – or massively changing some of these market rules, I think it's important to do the groundwork that you have to, to make sure that we are expanding enrollment during open enrollment periods. I think Justine, you were saying the same thing.

JUSTINE HANDELMAN: Yes, absolutely. And the other thing I mentioned is we have done quite a bit of research around millennials and what drives them and how do you get them in. And we know millennials don't value healthcare as much as maybe I do for my family or my parents may. They want that on-demand care. So for them, seeing a primary care doctor might not be as important if the appointment is four days from now, then going into a retail clinic and getting what they need in the next hour. They want to be rewarded. If they feel they are eating healthy, going to the gym and exercising, doing the right things, they feel they should get credit for that in the research that we have done. And are there additional incentives we can put in? My latest idea is to reach out to Nintendo, because they have gotten more people moving in 48 hours than we have seen in eight years of Let's Go. Maybe a new app.

MARILYN SERAFINI: Maybe we could somehow connect it to Pokémon Go? Okay, so we have a question here about small businesses and what can small businesses offering small group policies do to contain health insurance costs, besides self-insure?

JUSTINE HANDELMAN: I could jump in with what health plans are doing already, is certainly putting innovative benefit designs around to encourage people to get care when they need care, get it in the right setting. We have been designing patient centered medical homes, accountable care organizations, there is a lot of different names. But to make sure that people are seeing the doctors and incentivizing the providers in the right way to provide the care that is needed. Keeping people out of the hospitals, preventing things that shouldn't happen. Taking their medications as needed to avoid further complications. So I think a lot of in the delivery system reform that incentivizes people getting the right care in the right setting and better managing their costs. And helping people get healthy and when they are sick, manage their conditions. We are learning a lot and the more we learn, we continue to innovate and I think that is really important to continue.

MARILYN SERAFINI: Ok, great. So we're coming- oh, we have a question at the mic.

AUDIENCE MEMBER: This was to address the outreach towards millennial and healthier people. I think one of the things you mentioned is millennials are not necessarily keen for healthcare, but they are more keen for healthier living. So one suggestion for insurers is maybe instead of tying healthier living to healthcare, tie healthcare to healthier living. So if you approach it from that perspective, you may find that people are a lot more receptive, especially the millennial population, than you would think.

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SARA COLLINS: I think that's an excellent idea.

JUSTINE HANDELMAN: I do too.

RACHEL NUZUM: We have a question about a proposed premium increase. Wellmark Blue Cross/ Blue Shield announced an increase of 38 to 43% for 2017 and indicated that at least 10 percentage points of the increase stem from the cost of a single extremely sick patient receiving really, really costly care. So this really gets to the high need, high cost individuals that we know are often driving a large proportion of healthcare spending. And so maybe Justine or others – are there things that plans are doing to really target and address that high need, high cost population to get at both the ability to deliver better care for this population, but also to keep cost down?

JUSTINE HANDELMAN: Sure. One thing I would point out, and I know it's had some controversy sometimes around town, is the reinsurance program was really designed to get just at that. There are some plans that do have very high cost individuals. In fact, I know of a plan that has a member with hemophilia. They are getting the care they need, but it's a million dollars a month. Twelve million dollars a year. You can see the kind of premium increases that has. The reinsurance was designed to help lower premiums. I think the real focus is, how do you make sure you have got the right balance? Those cases do exist. When the ACA went into place in 2014, the state high risk pools that cared for these people that could not get coverage went away. So you had many of these high cost people come in, but not enough of the balance of the people that don't utilize to make premiums affordable. And I think it gets back to the point of, how do we make sure that we get everyone in, that they get the care they need, so that they stay healthy and we can manage their conditions. Because if only those that are coming in that have needs, it's going to just keep costs going up. We need to find ways to bring everyone in, and that may require more innovative benefit design, as I mentioned, that appeals to those that might not have an ongoing health need that want to go to a retail center, that want healthy living to be a part of their healthcare. So I think that is what we need.

SARA COLLINS: I just want to ask, since we are on the issue of reinsurance and Cori had some analysis in her presentation about the effects on premiums this year, phasing out the reinsurance program. And then Justine has been talking about the need for ongoing reinsurance in this market. I just wondered what the – are there other markets that have reinsurance – like the Medicare Part D program? Is that a strategy of policy option going forward? Extending the reinsurance program for the marketplace or won't it be needed after this year?

CORI UCCELLO: So there are other markets that do have reinsurance mechanisms. So, Medicare Part D has a reinsurance mechanism. But the ACA reinsurance is kind of not your typical reinsurance. It's getting at – I don't have my slide in front of me, but for say, in 2014, it paid an 80% - or originally was going to pay 80% of an individual's spending between \$60,000 and \$250,000. So it's not going to get – that person who has \$10

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million worth of care because they have got some terrible condition or disease, it's not – that is not going to get at that. Typically, reinsurance, that is when it does come in. It comes in to pay those very high costs. The reinsurance program under ACA was partly intended to say, because those high risk pool people were going to be coming in, other high cost people were going to be coming in sooner than the healthier people into the ACA market, that this program could help offset premiums in the meantime while we were – the gradual enrollment of the healthy people came in. And they structured it that way, I think, in part because private reinsurance could also already be available to plans. And since the reinsurance program was just going to be temporary, they didn't want to displace that private reinsurance option, if that public reinsurance option was just going to go away. So I think it makes sense to think about whether a more traditional type of reinsurance program would make sense as the ACA moves on, as opposed to the particular kind of reinsurance it had from 2014 to 2016.

MARILYN SERAFINI: So as we wrap up our session today, I would like to ask each of our panelists to tell us what we should be thinking about during the few months that we have before November 1<sup>st</sup> and the beginning of the open enrollment period. What should we really be paying attention to? A lot is going to happen between now and November 1<sup>st</sup> in terms of premiums and review and insurance. There is just going to be a lot happening. What should we really be paying attention to? And while we give the panelists just a moment to digest that and to think about how they are going to answer, I would like to ask you in the audience to just pull out your little blue form in your folders and get ready to fill that out. It's the evaluation form. And we can do a better job if you just take a minute to fill that out. So, let's start down here with Sara and what should we be paying attention to?

SARA COLLINS: I think in particular, when you are hearing about premium increases, premium requests that are 65, 35%, it's really important to take the long view, particularly if you are helping people who are going to be enrolling in the marketplaces this year and want to understand what is going on. Last year, premium increases were projected to be on average, as late as December, about 10% higher than they were in 2015. We even had some analysis that showed they were going to be 6% higher across the country. And in the end, what really matters is the premiums for the plans that people actually buy. So the analysis that HHS did at the end of the open enrollment period, found that premiums rose on average for people who have tax credits, which is the majority of people in the exchanges, only on average of 4%. So, what really matters is the plans that people buy in terms of what that actual increase is. So I think it's really important to help people understand what they can expect when there is so much noise about premium increases.

CORI UCCELLO: I was going to say something similar. As I said in my presentation, we often just see averages, but we really need to dig deeper. As you are looking – as information comes out, don't just take the average and say, oh, that's what it is. I think there is a lot of things – there are a lot of things that underlie those changes, those averages, and there can be a tremendous variation across people, across states, across

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plans. And so it's really important just not to take that average at face value, but really understand where it's coming from.

KEVIN LUCIA: I'm thinking the same thing. You know, back to the United example about leaving the marketplace – some plans are not going to get the premium increases they want. And they are going to leave the market. But there is going to be a lot of other plans out there that are coming in and growing and emerging, and I think we just have to remember that an isolated example of an issuer leaving the market is not the end all and the ACA is a failure. Just be cautious and remember this. I don't know the exact number, but it's well over 100 plans that are participating in the marketplaces nationwide.

JUSTINE HANDELMAN: And I have to echo as well – ensuring that the plans get the premiums they need to cover the claims cost is incredibly important. I echo everything that has been said. And then the other thing I would point out is, those premiums and the products that will be available in open enrollment, have been set based on the rules in place and those rules can't change. We can't have what we have seen in some previous years where rules have changed and have been impacted. Whether it be risk corridors that we see in the past or reinsurance. We need to make sure that the rules are in place, the premiums have been set on those, carry forward for the contract year.

MARILYN SERAFINI: Okay, we have come to the end of our time and I would like to thank our panelists for a very rich discussion. We do have a lot to think about and I would like to thank The Commonwealth Fund for their partnership in this briefing. And we will see you next time, thank you.