THE BROOKINGS INSTITUTION

WHAT WORKED AND WHAT DIDN'T IN OBAMACARE INSURANCE MARKETS?

NEW RESEARCH ON FIVE STATE-LEVEL MARKETPLACES - LESSONS LEARNED

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Welcome and Overview:

RICHARD NATHAN
ACA Network Lead, Five State Study Project Coordinator

The Five State Study: Summary Findings:

MICHAEL MORRISEY
Department Head and Professor, Health Policy & Management
Texas A&M University

Competition in the Marketplaces: What We Learned in Five States:

Moderator:

THOMAS GAIS
Director, Rockefeller Institute of Government

Florida:

PATRICIA BORN
Payne H. and Charlotte Hodges Midyette Eminent Scholar in Risk Management & Insurance, Florida State University

North Carolina:

MARK HALL
Director, Health Law and Policy Program, and Fred D. & Elizabeth L. Turnage Professor of Law, Wake Forest University
Nonresident Senior Fellow, The Brookings Institution

Texas:

MICHAEL MORRISEY
Department Head and Professor, Health Policy & Management
Texas A&M University

Michigan:

MARIANNE UDOW-PHILLIPS
Executive Director
Center for Healthcare Research & Transformation

California:

MICAH WEINBERG
President
Bay Area Council Economic Institute

The Future of Health Insurance Competition in the States:

ALICE RIVLIN, Moderator
Senior Fellow, Economic Studies
The Brookings Institution

LINDA BLUMBERG
Senior Fellow, Health Policy Center
Urban Institute

STUART BUTLER
Senior Fellow, Economic Studies
The Brookings Institution

CYNTHIA COX
Associate Director, Program for the Study of
Health Reform and Private Insurance
Kaiser Family Foundation

MICHELE LUECK
President and Chief Executive Officer
Colorado Health Institute

KOSALI SIMON
Herman B. Wells Endowed Professor
Indiana University

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P R O C E E D I N G S

MS. RIVLIN: Good morning and thank you for coming. Welcome to this session, which is a joint session of the Brookings Institution and the Rockefeller Institute of Government. And we're going to talk about the results of a five-state study on how competition is working in the Affordable Care Act marketplaces and what we might learn from this study and how we think about competition in the marketplaces going forward.

To officially open us up I welcome my colleague Richard Nathan from the Rockefeller Institute to the platform.

MR. NATHAN: Thank you, Alice. I don't work at Brookings so maybe I shouldn't welcome people, but I worked here 11 years and it's a while ago, and this is one my favorite places to work with colleagues.

It is a pleasure today to welcome you to this conference, as Alice said, the Brookings and Rockefeller Institute field network study of the competitiveness -- she mentioned this -- of marketplaces in health insurance individual, non group health insurance marketplaces in five states, California, Florida, Michigan, North Carolina, and Texas. And we have a summary report and we have five reports almost big enough for a book from the five authors or author groups of the individual states that I just mentioned. The author of the summary report is Michael Morrisey. Mike is at Texas A&M, did the Texas field research and is the author -- this is my plug, Mike -- of a widely used -- and I would add current -- it's current, it's informative, and it's helpful -- textbook on health insurance. He is my teacher. I know a lot about the subject, which isn't the subject that I grew up on, but I learned a lot.

He is the lead author of our summary report and Alice Rivlin, who is Co-Director of the network with the Rockefeller Institute. Tom Gais, the head of the Rockefeller Institute is here. Worked there a long time too. Alice is a Co-Director with me of the Rockefeller-Brookings field network research and is the second author of the summary report that Mike is going to present. The writing group includes other people,

me and Mark Hall, and Mark Hall is here. He's the author of the North Carolina report. You'll hear from him twice. Mark is the Fred D. & Elizabeth L. Turnage Professor of Law at Wake Forest University in North Carolina. Copies of the summary report are here today and I want to add as I tell you that that Caitlyn Brandt and the staff of the Brookings Institution Center on Public Policy Research have done a wonderful job on organizing this conference and producing these reports in a form that I think is very accessible. And I hope you'll download all of the reports and read the summary report and it will be helpful and contribute in this turbulent time for health insurance policy making. I've never seen the like of it.

The five states that we're studying -- and there are 40 states in our whole network -- the five states we're studying are different. The story of what is happening in the country, throughout the country, in states, but not only in states as Micah Weinberg, our California colleague, often reminds me, in local markets. Tip O'Neill said all politics is local -- is, he said -- and indeed health insurance markets are local, even within markets there are differences that we've learned about and we've written about. We're out in the field, in depth, interviewing experts, using every piece of economic, demographic, and program data we can bring to bear to understand institutional change. When something as big as this happens, institutions change, governments change their roles, state governments, federal governments, health insurers change their roles, providers change their roles, advocates change their roles. So you need to not only know the numbers, but you need to know the numbers and put them together with understanding of what is happening in implementation. And that's a big subject that I'll just touch on.

But anyway, this is typical of American federalism and we will have a chance today to hear next from Mike to present our summary findings and that will be followed by a panel of individual field researchers. What they see, what they wrote about, how their story fits into the overall story. That panel will be moderated by my colleague -- we've spent a lot of time working together -- Tom Gais of the Rockefeller

Institute. Alice will chair a second panel of national experts on health insurance, people who can look at our work and help us think about what we're learning, along with two of our associates, Michele Lueck from Colorado, who is the head of the Colorado Health Institute, which is a very strong group. Many states have health institutes and they're very valuable resources for the kind of work we do because they have all the expertise and all the local and state and regional knowledge to understand what is happened to any policy as it plays out in a country as big and complicated as ours with a federal structure.

Our new studies focus on the changed role particularly of insurance companies. They're doing something different now. You've got a moment in which they're banned from doing medical underwriting, and so everybody can come in, pre-existing conditions, and guaranteed issued. That is fundamental to the health insurance and the health insurance is big if not bigger than any other industry and sector in our economy. So we've been -- for five years I've been -- I started this five years ago -- and I thought I retired, my wife said, no, you really didn't -- set up this network. We have 40 people on the Rockefeller Institute website, Bob Bullock from the Rockefeller Institute is here. We've issued 27 baseline and follow-up reports on what states decided to do. We expected most of them would say we're not letting the feds in here; we're going to do it. But indeed the feds are operating most of the marketplaces.

So this gets to the heart of how American healthcare has changed institutionally and relying heavily on many sources of data and many people's expertise. We've examined 25 local markets, 5 in each of the states. And you can read in the reports, you can read about that.

So I turn next to my colleague, Mike Morrisey, and my teacher. He will describe what we have learned collaboratively about health insurance market competition based, as I said, on closely examining national, state, and local economic, demographic, and financial data and extensive interviews with different people in different places in the

world of healthcare in America. How have the exchanges worked, how are they working now, how are they not working, what do we know about the exchanges that affect the cost and character of healthcare, which most of all of course affects millions of people who in these mammoth systems, which isn't the whole of it. There's a lot more to health insurance than what we're looking at, individual non-group markets, but that's where the big changes are.

So, Mike, the platform is yours.

MR. MORRISEY: Thank you, Dick. I'm delighted to be here and if I knew you were going to do that sort of introduction I guess I would have prepared a midterm for you.

What we'd like to do is walk you through sort of the highlights of what we've done with the five-state study. As Dick has indicated this is really a team effort. And I have to say it really sort of relied heavily on Alice Rivlin's ability to sort of put all of this together and keep us focused and keep our feet to the fire in answering the questions that we were charged with. And I can't say enough about Dick Nathan and his ability to sort of put together a network of field researchers across 40 states, calling people up out of the blue to say we're doing this interesting project, would you like to be with us. And people have just joined right in. And then we've got a really strong set of field investigators throughout these states and, as Dick has indicated, across all the states.

So, what are we about? What we want to do is begin to understand the experiences in the states and how the ACA has affected the insurance exchanges in those areas. We want to describe the potentially idiosyncratic nature of the marketplaces in each of the states and indeed, it was our presumption going in that the states were going to be very different. And thirdly, we want to develop hypotheses about how the exchanges have evolved and how they might evolve and to offer those as sort of testable opportunities to other researchers, but also to perhaps sort of serve as a road map for all

of us as we look at repeal, replace, and repair.

There isn't much background that I think I have to provide for this audience, but there are a couple of key things that I think are worth focusing on. As we all know, the ACA marketplace has just completed their fourth open enrollment period. What our field investigators did was to examine all of the open enrollment periods from the beginning through the opening of this, the fourth one. It's important to appreciate that within the ACA there are rating areas in each of the states. Rating areas are geographic areas in which an insurer if they offer coverage in that area must quote the same premium to people of the same age and smoking status. But the thing to appreciate is the states are very different in how they've configured their rating areas. Some use individual counties, others metro areas are their unique rating areas and the rural counties make up sort of the last of the rating areas in the states. And others use geographic sections of the state. But it's important to appreciate that all of the states approach their definitions of the market somewhat differently. And it's important to appreciate that insurers don't have to participate in all of the rating areas, nor do they have to participate in all of the counties within a given rating area. So it's important to appreciate just from that that states are potentially very different and very different kind of insurance responses within the states because of the flexibility that's granted by this rating area approach.

So, why these states? We chose California because it's a Democratic state that expanded Medicaid and it adopted a state based exchange of the active purchaser variety. And in fact, it's the only state that has done that. We chose Michigan, it's a state with Republican leadership that expanded its Medicaid program in late 2014 and adopted a partnership model of exchanges. Florida is an oppositional state that didn't expand Medicaid and uses the federally facilitated exchange. And the particularly interesting thing there going in, it's one of two states in which each county is its own rating area. North Carolina, another state that was politically opposed to the ACA. It

didn't expand Medicaid. It too used a federally facilitated exchange. And the reason for wanting to include North Carolina is that there was early evidence there that insurers were working with local providers to co-brand products that would allow them to complete with a dominant insurer and we wanted to see how that was working out. Texas is indeed an oppositional state. It didn't expand Medicaid either. It uses the federally facilitated exchange. It's also one of the few states that doesn't approve premiums, or for that matter, assist the exchanges in essentially any way. Early evidence though suggested that there was the potential at least for some substantial competition in some areas of the state. And so we wanted to see how that all played out.

So overall, we've looked for some geographical diversity. As you see from the states, there's also some racial and ethnic diversity in all of this. And we look for places where we had strong research teams. So we've got what I think is a very good set of places to observe.

A little bit on methods. I'm an economist and do a lot of regressions kinds of things and a lot of policy analysts do that same sort of thing. Field research isn't like that. Field research actually asks people who potentially know something about -- and they do know something about the questions at hand, to talk to people in the communities who know something about what's going on. And so it's an opportunity to sort of build on local expertise. The team developed a series of discussion questions; they focused on insurer participation and withdrawal from the markets. It looked at issues of structuring the networks within the insurer plans, and it looked at changes in the environment that potentially took place as we watched the four years unfold.

But having said that, it's not just sort of a set of questions that we follow by rote, it's a more fluid discussion that follows from the discussion that precedes it into where the issues are from the point of view of the people on the ground. And so we come away with I think a very nuanced and rich sense of what the states look like.

The field teams conducted 15 to 90 minute interviews, some in person,

some by phone, with health insurers, with providers and provider networks, with state insurance regulators, with insurance agents and brokers, and with navigators, and with other policy experts, sometimes the media in the states. Now, of course there's a point of generalizability here. You can't generalize from five states, and particularly you can't generalize from five states when one of your key conclusions is they're all very different. (Laughter) There are, of course though, a number of themes that emerge from what we found, and that's what I want to tell you a little bit about now.

First, as Dick indicated, the key finding in all of this is that health insurance markets are local. Now, I've been looking at health insurance markets for 20 years or more and it's only in the last 3-4 years, and certainly through the fieldwork that we've been doing here that I've appreciated just how local these markets are. It's a mistake to sort of think of Idaho as a market, it's a mistake to think of Texas as a market. The insurance markets are much more local than that. And what that means is what we found is that there's a lot of divergence within the states. Certainly, it's the case that the extent of competition differs between urban settings and rural settings. But that's just the beginning of it. There were big differences between urban areas as our individual state reports show. It turns out, for example, that the nature of insurance competition in San Francisco is much less intense than it is in Los Angeles. It's the case that Miami is much more competitive than Tampa, that Detroit is more competitive than Flint. The nuances matter and the nature of the local markets matter. And the reason they matter is because insurers are managed care entities, they form networks. And to be able to be successful in a local market you have to have a network of hospitals and physicians and other providers who agree to prices that you believe can make you competitive. And so if it's the case that you can't establish a network it's, you know, (inaudible) impossible to be able to offer an insurance product in that setting. Clearly, that's the case in lots of rural America. It's also the case in modest sized urban areas. There's a single network, sometimes a single hospital. You decide you want to come in and compete against the

dominant carrier in the state; you've got to be able to negotiate meaningful prices with that provider. And that turns out to be difficult to do to give you a competitive advantage in the insurance side. It also turns out to be a problem sometimes in large metro areas. In Texas, for example, we talked to one insurer who had said well, you know, we were pretty successful in putting together what we think was a very good network in Houston, but we could never get something to work in Dallas.

So it's not just a matter of sort of we are here, we're in the state, and because we can provide it to you on the eastern side of the state, we can provide it on the western too. It depends on the local market. Some big implications there. First, it's unrealistic to expect that you're going to find similar results or, indeed, that there are similar solutions everywhere. Second, premiums, as we have found, are lower in areas where there are greater numbers of hospital and other providers. Without that competition at the provider level, it's difficult to see lower prices at the insurer level. And, indeed, we've been told from our interviews that, you know, the decades of consolidation that we've seen going on in the provider markets have made it difficult for insurers to compete.

Having said that, if indeed these markets are local, that suggests that there's opportunities for regional insurers and other insurers who co-brand with local providers to establish a successful niche in their local market where they can compete pretty successfully, or at least we think they can and we've seen some evidence of that. The other point though is if indeed these markets are local and they depend on the nature of those local networks of providers, that says, at least to us, that meaningful interstate competition among health insurers may be very difficult to achieve. It's not enough that, you know, regulatory barriers are reduced, it's putting together the networks, and that's the difficult thing.

Second major finding, claims costs substantially exceeded the insurer's expectations. In the first year or two of the exchanges, the insurers actually had very little

information. They hadn't been insuring this pool of individuals at all. They had some information perhaps from their existing individual market, they had some information from the small group market, maybe they went to national data, like maps, but in any event, they had remarkably little data on these individuals. And as a consequence, a lot of them were very timid about entering the market. But after that first year where they saw that premiums sort of drove enrollment and that enrollment was relatively low, we saw lots of new entry in 2015, again on the expectation that they could experiment in the market. And we saw entry and we saw potential for real competition there. But then 2016 rolled around and insurers had data that their actuaries believed and those data were scary. They were high utilization largely across the board, and that led to concerns about high utilization and adverse selection, it led to withdrawal from local markets and from states. And it's important to point out here it isn't just that, you know, some national carriers withdrew from full states, it's also the case that carriers who remained withdrew from some markets, from some counties in rating areas, and withdrew some of the products they were offering while still remaining in the exchanges. And it was also the case, as you all know, that we've seen substantial premium increases as a consequence to all of that.

The implications of this is that there's certainly an open question as to whether those rather large premiums that we've seen in 2017 are able to sort of get ahead of the losses that the insurers have anticipated. There's concern about the extent of adverse selection relative to the general sickness of the risk pool and what carriers are able to do about it. And there's an open question about those special late open enrollment provisions. As I'm sure you've all heard, there are opportunities where people can enroll in an exchange plan after the open enrollment period closes. And some insurers have argued that that was an enormous drain on them, that late enrollees were extraordinarily expensive. And the administration past and present are sort of working at alternatives to tightening those. And it's an open question as to how meaningful those

sorts of claims are, both in terms of the original assertions and whether or not changes would make a difference.

It turns out that there were, from our review, mounting losses that stemmed from high utilization, and that those losses can overwhelm competition. In all of our states we saw the withdrawal of insurers. In North Carolina and Texas, some metro areas went from five to nine insurers to suddenly having only three. Florida had three insurers withdraw. Michigan and California also saw withdrawal of carriers, although their view was that this was sort of not as big a problem as elsewhere. We saw the plateauing of alternative forms of insurance innovation. And certainly, insurers have viewed themselves as having enrolled sicker folks.

And that suggests that there's an issue of risk mitigation. And certainly there's view across many of our states that the risk adjustment mechanisms and the short-term other transitional mechanisms were inadequate to deal with the adverse selection that they saw. Particularly true in Florida and Texas. As one insurer told me in Texas, so in the first year we set our premiums relatively high and we got -- in my words -- a sick draw of the population. So we lowered our premiums to try to attract more people and a healthier draw and we did, but six months -- and we made money, and then six months later, we got the risk adjustment fee and we lost money. So we set our premiums high and we lose money, we set our premiums low and we lose money. They withdrew from the market. The risk mitigation issues matter. And I think the point there is if we want to prohibit insurers from using pre-existing conditions to set premiums, as the ACA does, and as many have said must continue to be the case in the future, that means we have to somehow deal adequately with the risk adjustment, risk mitigation problem. Maybe that's the better funding of some of the existing mechanisms, maybe that means looking at other mechanisms, like high-risk pools.

Another finding is clearly, what we've seen in all this is a shift to narrower networks. And all of this is well underway. There's very good evidence over the last 20

years that narrower networks allow insurers to negotiate lower prices with providers by essentially trading volume for price. Clearly, that is in the minds of insurers as they have moved largely from PPOs to HMOs. There's an underlying thread in all of this as well though, and that has to do with whether or not moving to a narrower network can affect adverse selection or your fear of attracting high-risk folks. So if one excludes premium providers potentially that leads people with those related diseases to seek insurance elsewhere. There is some evidence of that, but there's also evidence that premier providers are some of those who have been working with insurers to co-brand. And it's certainly the case that Medicaid managed care plans, while they have their own relatively unique nature of their networks they have also sort of provided access to coverage in some of the premier providers. So narrower networks continue.

There's concern amongst brokers and agents and policy experts that consumers are only beginning to be aware of what they narrower networks mean to them. There is pretty good -- well, actually there's very good evidence that narrow networks are cost reducing, but in some sense this can be misleading given the nature of the local markets that we've talked about. As one provider said to us, so we're the only hospital in town, the insurer moved from a PPO to an HMO, really didn't have much of an impact here.

Outreach to consumers may be critical to enhancing enrollment. Insurance is complicated, even for those of us who have employer-sponsored coverage. Consumers have been largely focused on price, but increasingly the navigators tell us that they are able to appreciate the nature of deductibles and co-pays. The new challenges have to do with narrower networks, with balanced billing, and with plan withdrawals and having to move from one plan to another. Some states have been very good at outreach, Florida in particular, California and North Carolina as well. It's important also to appreciate that it isn't just the navigators that provide information. Safety net providers often play a critical role in opportunities like enrollment fairs to

encourage enrollment. And brokers and agents certainly feel that they have lacked the incentives to be able to participate. The ability to increase enrollment in the plans I think we conclude depends critically on the ability to have an informed set of consumers and to provide mechanisms to do that.

An additional point is that insurers may indeed be waiting in the wings. Yes, we've seen a lot of withdrawal from the changes, but for the most part insurers who have withdrawn from the exchanges have remained in ACA compliant off exchange plans. Much of that has to do with the fact that if you withdraw from the state entirely it's five years before you can come back. And so there's a sense in many of the communities we've looked at that insurers have hedged their bets. They've withdrawn from the exchange products but they've kept off exchange products there so that they can sort of rejoin the fray if the economic and political circumstances change. And so what that suggests is a replaces, repaired ACA may see relatively rapid re-entry of insurers. And, indeed, that if that's the case much of that new growth may be local and regional insurers rather than national players.

The other interesting finding has to do with Medicaid managed care type of insurers. They have been particularly successful where the more conventional insurers have struggled. It's an open question as to why that's the case. The Medicaid managed care type insurers tend to have narrower networks often made up of safety net providers. They also have a pool of enrollees who often transition back forth from Medicaid. And the relevant question is to what extent that kind of experience can be generalized to the rest of the populations, and, indeed, whether or not it can.

Finally, while the individual states don't sort of talk about the effect of Medicaid expansion per se, when you look across our five studies what you see is those states where there was a Medicaid expansion the role of that expansion in the exchanges was not discussed, but in the other three states it was. And the assertion by people in the field was that a Medicaid expansion would have helped, it would have taken those

people at the 100-138 percent of the poverty line, but them into Medicaid and arguably taken them out of the risk pools that the insurers faced. And it may also be the case that the provision of Medicaid expansion brought people in, they discovered they weren't eligible for Medicaid but they were eligible for a subsidy and they enrolled. In any event, there seems to be a very strong sense that Medicaid expansion matters.

There's also a point in North Carolina that was emphasized about -- as you may recall, in the first year of the exchanges states had the option to allow non-compliant plans to continue or not. And the argument is by preventing those from continuing that mitigated some of the potential adverse selection problems.

So, future research for us. We think that we need to know a whole lot more going forward about how insurance competition is going to fair post repeal, replace, repair to ensure (inaudible). If they can offer a wider range of coverage how does this affect availability, premiums, enrollment, how do new risk adjustment mechanisms work? Do more flexible interstate insurance opportunities enhance competition or, as we fear, not do much? How do local insurance markets evolve? Do local regional insurers grow and prosper? Does continued provider consolidation inhibit competition? What about ACOs? Do they enhance competition, do they retard it? Will we see a rise of COBRA ending with providers? And what's the future of narrow networks? To say the obvious, there's much to learn and little time.

Thank you. (Applause)

MR. GAIS: Thank you very much. I'm Tom Gais. I'm Director of the Rockefeller Institute. And we will have our State Panelists.

SPEAKER: Where are we going to start?

MR. GAIS: You can sit anywhere you want. I will tell you who goes when. I think it's fine just to sit here. Is that okay with everyone?

SPEAKER: Yes.

MR. GAIS: All right. Thank you very much. There's always been a

discussion about the field research network, and how they operate. We've been doing this -- Okay; we are getting adjusted right now. Thank you very much. We are adjusted.

I do want to thank Brookings. I want to thank Alice, Dick, Kaitlyn, Madeline, everybody else here who has been really wonderful; and Bob Bullock, at our Institute, in putting this together.

The Rockefeller Institute does have a long history, many thanks to Dick Nathan for putting together these field networks which we've done in Medicaid, we've done it in welfare reform, workforce development, and many other areas as well. And we've often had some very good researchers in our research teams across the country when we have these multi-state systems.

But this team is particularly great. We have some very distinguished folks, and they are all quite diverse too, and that's one of the nice things about it as well. This is a kind of inductive research approach and it's nice to have people with different backgrounds, different disciplines, to be able to have -- develop insights, different types of insights in understanding and observing how these national initiatives are implemented on the ground.

This team in particular, and especially the five people here, do have a lot of differences. We've got differences in disciplines, we have two economists, we have a political scientist, a lawyer, and a public health specialist. And their careers have been different as well.

Three of them are traditional academics; or not too traditional. They've also been very applied, very active people. One non-profit research ethics organization; and then one former top government executive who is now leading a research center at a major university. So, all of them bring different sensitivities, different trainings, actually, to bear in their thinking.

What I'm going to do, since you do have your bios of everybody, you've already been listed in terms of the major titles. I will just simply say that we are going to

start off with just a few minutes of a summary of their major findings, for each one of them. And then we are going to have a series of questions. I'll ask a few questions, and then at some point I'll let everybody else ask questions as well. And your questions will be brief and to the point when I give you that opportunity.

We are going to start off with the Blue State of California; we are going to end with the Red State of Michael Morrisey and Texas. Michigan will be second, third will be Florida, fourth will be North Carolina.

Micah Weinberg is President, Bay Area Council Economic Institute. For Michigan, we have Marianne Udow-Phillips, Executive Director, Center for Healthcare Research & Transformation at the University of Michigan. Patricia Born will talk about Florida. She is the Payne H. and Charlotte Hodges Midyette Eminent Scholar in Risk Management and Insurance at Florida State University. Patty, since we've already used 15 seconds of your time, you'll get a little bit (crosstalk) time.

North Carolina, we have Mark Hall who is Director of Health Law and Policy Program, Fred D. & Elizabeth L. Turnage Professor of Law, Wake Forest University, and a Nonresident Senior Fellow of Brookings. The same with you, Mark?

MR. HALL: Mm-hmm.

MR. GAIS: And then finally, we have Texas and Mike. So, Micah, start off.

MR. WEINBERG: All right. Well, I'm intending on winning the Oscar for Best Presenter today. And to do so, I'm going tell a story about La La Land. Now, in this case, by La La Land I mean Region 16 covered California, California's ACA marketplace. That is the western half of Los Angeles, and what I talk about will really reinforce the conclusions that Michael just shared with the entire group, but I'll give you some local flavor.

So, the Western Region of Los Angeles actually, in and of itself, has 5 million people who live in it, so it's as large as many states. A very diverse population,

obviously a very urban area, and there is both a lot of provider competition in Los Angeles, as well as a lot of insurer competition.

On the provider side, and the broader Los Angeles area, there are actually over 80 hospitals. There's not as much hospital consolidation in Los Angeles as there is in places like San Francisco and other urban areas.

And on the insurer side, there are actually seven different insurers competing in this area, and they are of many different types. So, you've got Kaiser Permanente, which is our sort of closed network, integrated delivery system. You have some conventional insurers putting together PPOs and HMOs, are sort of Anthem plan, our Blue Shield plan.

You have Oscar, the plan sort of new wave, we are going to use a lot of Telehealth, and be run by Jared Kushner's brother. The plan hasn't done very well. But I'm sure we are going to tweet to get more enrolment and (crosstalk) here, pretty soon, because that's a totally legitimate thing to do.

And then you have, very interesting, a couple of Medicaid-managed care plans. And so the state -- active purchasing exchange did a lot of different things. Active purchasing isn't just negotiating with insurers for prices, it's really thinking about: Do these marketplaces work? Do they have enough competition, and is there something we can do to bring more competition into the marketplaces?

The funny thing about California is, so it's a bunch of people that would like -- prefer to be implementing a single-payer system, but actually did the best job at implementing a market-based reform. Right? They said, all right. Well, I guess we like this now. And really thought about, you know, if we are going to have competition we need to have competitors. No competitors, no competition.

You know, HSAs don't make competition where there is one hospital in your town. So, a lot of competition in Los Angeles, and one of the really interesting things is, so you hear these arguments, these big headlines, you know: insurers raising

premiums 45 percent.

Of course, almost everybody doesn't pay that because they are subsidized, but in Los Angeles, a big issue was that last year Molina is an insurer that lowered its premium. Actually in absolute terms, Molina is primarily a Medicaid-managed care plan, competing in the individual marketplace in California, and actually lowered their premium.

Now, the issue with lowering your premium is that means that all of your competitors, you know, who are raising their premiums, and the people who are purchasing through your competitors actually see, like a real substantial premium increase. And we've seen that consumers increasingly are shopping on price. In the first couple years in California, they didn't do it, because they know what was going on, and like, that's just a fault the brands we had heard of, but in the last couple of years, they've really started shopping on price.

So, they'll buy Molina, they'll buy L.A. Care, they don't need to buy, you know, Blue Shield of California just because that's a name that they are familiar with. And they seemed fairly pleased with these networks. That's something that folks are finding, which is that like -- ultimately most health care doesn't work and you die, right? So, no matter what facility you choose, right, ultimately you are going to be disappointed with this consumer product, because you will be dead, right.

So, you know, they choose Molina, they choose L.A. Care, and they seem, you know, fairly happy with this product, and it's substantially lower priced. So, this is creating a tremendous amount of pressure on the higher-cost hospitals in Los Angeles, and we are seeing them negotiate absolute rate concessions with the insurers to remain competitive in these networks.

So, this is actually bending the cost curve. There's a lot more to say, but the thing that just makes me, like completely want to tear my hair out. You know, I ran into Mark Hall yesterday. He was like: Micah, your beard is lot more gray than the last

time I saw you. I was like: thanks Mark. But the reason that it's more gray is that I actually see, like shocker, you implement a law and it works, right?

So one of our conclusions is, if you just don't do this huge part of the law, the Medicaid expansion, maybe it doesn't work that well. Well, surprise, right? If you are an oppositional state, and do everything you possibly can to keep a law from working, then you complain that the law isn't working. It just makes no sense.

You've got somebody, you know, you want them to run 100-yard dash, and you cut their legs off at the knees, and then you're like, they are not running quickly enough. This is a failure. Right? Well, I mean, if you actually focus on making the Affordable Care Act work, then shocker, it might actually work. And if we repair and replace, and do whatever, but then all the blue states decide: we are not actually going to do this, we are going to fight it in the courts. It's not going to work their either.

You actually need to choose a system, and implement that system, and when you do it in a place like California, it can work. But the important thing, you know, that I'll just conclude on is, again, local markets, local competition. So, you can't put together competing networks in an area with only hospital system. Right? So, if we really care about competition, we need to care about competitors. And the competitors we care the most about are actually not the insurance plans, but rather the providers.

So, you know, you've got somebody like David Brooks, who should know better, writing a column about: Can you shop in health care? And like talking about like: Do HSAs work or don't they work? That's beside the point. You can't shop in health care if you have no choices to shop among.

That's what we should care about, if we care shopping, and markets, and all the rest of these things, and that's something that's totally non-ideological, that's going to be important for the Better Way, and it will be important for the ACA, and it's important for whatever kind of policy framework you put in place. And Los Angeles shows it. So that's my comments.

MR. GAIS: I just have to say, you can tell who is not the academic in this group. (Laughter)

MR. WEINBERG: Academic by training, but I thought I would have some fun.

MR. GAIS: Marianne.

MS. UDOW-PHILLIPS: You're definitely (inaudible) California in this group, because I am not the academic, but I'm not competing for the Oscar, because I am from the Heartland, right? I'm from the Purple State of Michigan, you may not blame us for where we are today, but we have had a contribution. So, I want to add something too. You know, I thought Mike's summary was fantastic. And actually, Micah, what you said, I totally agree with.

But I want to add something to the perspective that Micah gave you, because I think it's really fundamental to understand in part why it's unfortunate we are in the change discussion that we are in right now, because health care markets, health insurance markets take time. And to build something takes a tremendous amount of time, and where we are today in the Affordable Care Act is very much built on the history of where, I think, all of our states have come from.

And to see what's happening now, you have to understand the history. So I want to go back a little bit in history for you to understand a little bit about Michigan. In many ways I would say Michigan is kind of the model of what the Affordable Care Act intended the health insurance marketplace to look like. Right?

We are a state, that even we have a Republican Governor and an all-Republican legislature; we are a state that actually approached implementation of the Affordable Care Act tremendously pragmatically. We were not a state -- as you'll hear from some of the others -- that was oppositional; we are a state that really wanted to make it work.

Our governor, Governor Snyder, is a businessman by background, his

focus was on the economics of it, he got the economics of it. In fact, he said, after the law was passed, even amidst all of the rhetoric about -- early on about how terrible the law was, he said, if it had been up him, he would have created an exchange independent of the federal law, because he understood that it would make health insurance easier for consumers, and he wanted to make the market work better for consumers.

So, he and his administration always approached the health insurance exchange market from that standpoint, in a similar way they approached the Medicaid expansion, from that standpoint. It was controversial with the legislature, passed by only one vote, and actually that was the vote that switched from a no vote to a yes vote after three hours of horse trading. But we did get the Medicaid expansion, which was implemented in April of 2014, so there was a little bit of a gap, but mostly early on, we were one of the early -- certainly one of the first Republican states to go for the Medicaid expansion.

And, again, it was a very pragmatic decision, based upon the economics. There was a coalition built across the state that included all the business leaders, all the providers, all the consumer advocates, all the health plans. I mean, there was just widespread support because of the economics. So, it's a state that got the Affordable Care Act, and as a result we have actually a fair amount of competition even today with the Affordable Care Act.

We have 10 insurers in 2014 when the Act passed, we had 13 issuers in the state so, yes, we lost a couple, we lost the co-op, none of us ever thought the co-op was ever going to succeed to begin with. We lost a couple of the national insurers from the exchange, but they were very small in the marketplace to begin with. They were sort of irrelevant to the market. And frankly Aetna, United, they don't really know how to work with the individual market, right. We never really expected that they would be successful.

So, we continue to have a robust market, we now have -- I think we started with something like 70 different plan options among the 13 insurers today, we

have 167 plan options. So, it's a robust market. Yes, not everywhere in the state, the Upper Peninsula of Michigan which some people think it's better aligned with Wisconsin, but they are part of Michigan today, and trade for Toledo, they have two insurers, actually both blues, Blue Care Network which is HMO, and Blue Cross and Blue Shield of Michigan, the PPO.

So, there's not tremendous competition, and as a result, indeed, premiums are higher. That's how the market works, right. But they still have choices of plans and we've just completed at our center, some consumer surveys we've actually been surveying consumers since 2009, and actually consumer satisfaction on the individual market is higher than it's ever been with the plan choices they have.

And I think there's been sort of some collective memory loss about how bad markets were before the Affordable Care Act for people in the individual market. So, few words about the history of Michigan so you can understand why we are in the place we are today, and then I'll turn over to my colleagues.

So, Michigan has always been a state that has provided coverage on a guaranteed-issue basis for the individual market. And actually if you want to know what will happen with the requirement for preexisting conditions to be covered with guaranteed issue without a mandate, look at Michigan. Because Blue Cross and Blue Shield of Michigan, since it was formed in 1939, was required to be the insurer of last resort, and to cover all commerce, and could not exclude anybody based upon health status, and as a result they had the thickest population, and indeed a failing individual market.

The rates were heavily regulated, and they were losing millions of dollars, and had been lobbying the legislature for years to change their structural status to become a non-profit mutual insurer which they achieved in 2014 with the passage of, and the implementation of the coverage expansions of the Affordable Care Act.

So they dominated the individual market, it was a very old and very sick market. I think the average age in their individual market, prior to the Affordable Care

Act, was 55. And as I said, they were losing millions in that market; they had 72 percent of the individual market. With the advent of the Affordable Care Act many new entrants came into the market predominantly, as Mike said; managed-care plans. Many of whom had been predominantly serving the Medicaid market.

And I think that's the other piece of history that's important to understand in Michigan. Michigan Medicaid converted to a predominantly managed-care market in the 1990s that has really heavily gone to managed care in Medicaid. And so those plans were ready with the networks that they needed to serve a population like the individual market.

I think that's why they've been successful. Many of them are making money in this market. The blues are not. The blues have lost market share, actually they are happy about that in the individual market. The health plan, the HMOs, have gained markets. So, blues, I think now are something like 60 percent of the individual market while the managed-care entities have gone up quite a bit.

But they are all staying in the market, we can talk a little bit in the questions about what is going to happen in 2018, very pessimistic about, just because of the chaos that is happening in the market right now, and some of the utilization trends we are seeing of consumers who are afraid they are going to lose coverage in the market.

So, I can answer your question now. The rates that were set in 2017 -- for the 2017 market, Michigan went up 16.7 percent prior to subsidies; the subsidy is 87 percent get subsidies in Michigan. Those rates are underpriced now for the utilization we are seeing, because of the fear that has been sown in the population. So, lots to talk about for 2018, but a little bit of a picture of Michigan.

MR. GAIS: Thank you very much. Patty?

MS. BORN: Okay. Well, I want to give a little bit of context on Florida as well. Now, moving from states that supported the implementation to an opposition state, and give you, first, the main take away from my research in Florida, is that despite the

support of the state with the Affordable Care Act, and any real active efforts by the regulator in Florida, it's been a real success story over most of the state.

So, I want to tell you a little bit about the main points of the things that I think kind of have led to that, have drawn out this kind of success, but I want to give you some of the history, what's going on in the state, a little bit about the market. I'll talk about my main points and then -- you can tell I'm a lecturer right, so I tell you what I'm going to tell you here first.

And then I want to go through some of the concerns that I got from the stakeholders that I interviewed with. Some of which might be kind of common to all of our research here, but some specific things that might have been a concern of the stakeholders I talked to in Florida.

So, Florida is the third largest state, it has population of 20 million, and 8 percent of the population is receiving insurance through the marketplace. That's a pretty big percentage. We opposed to the implementation of the Affordable Care Act, also opposed the expansion of Medicaid. By default, the rating areas that were selected for the federally facilitated exchange are the counties.

So, we have 67 counties; that's the most rating areas in any state. I think Southern California is next with about 46 rating areas. So, I have 67 different markets to try to evaluate, and just in case you're wondering how they every thought about trying to combine any of these, the regulators said, no, he's really not interested. A very passive approach to this, that was the default, they stuck with the default, they never, have gone back to revisit whether adjacent rating areas might make a better market.

So, the state also had, prior to the implementation of the Affordable Care Act, one of the highest uninsured rates in the country, and although the rate is still higher than the national average, it's dropped from about 20 percent to 15 percent, at least by 2015. The market, we have about seven carriers that are participating statewide, but

only one carrier that participates on all the exchanges, and that's Blue Cross and Blue Shield of Florida, through various different names: Florida Blue, Florida Select, different plans that they are offering. Most of these carriers are also offering coverage in the individual market off the exchange.

Blue Cross and Blue Shield, I want to say a few things about them. They have been the dominant carrier in Florida for seven years, operating in the group market as well as in the individual market, and they also rank highest in consumer satisfaction in studies, so people are really happy with the coverage that they are getting from Blue Cross and Blue Shield. They have reportedly, in my conversations with different representatives from them, they've been very happy with their experience on the exchange, with the ability to form networks.

They already had a lot of networks in place. They had relationships with providers all over the state for their individual members, it was very easy to just expand that, and say, we'll start offering the exchange plans. So, for them, participating on the Exchange was not a really big question as it was for other insurers that didn't have as much of a presence in the individual market.

There are four other carriers in Florida that did not have a very big -- were not really active in the group market, or the individual market, but were very active in Medicaid-managed care. And those plans have also become key players in the exchanges. So, I know this is a point that's come up several times now, but these plans that have Medicaid experience and I would add to that, plans that have a lot of individual coverage experience in the state, are the ones that have been best suited for the Exchange and maybe experiencing the best success there.

There have been some major withdrawals in the exchanges, so between the first year and the second year, there were several carriers that joined, and then the next year, some carriers backed out again. Cigna, UnitedHealthcare and Aetna have all withdrawn from the exchanges across the state, and Blue Cross and Blue Shield, I

mentioned, is the only plan that's actually -- is the only carrier that's operating everywhere statewide.

So, let me get to my major points, and I kind of touched on at least one of these. Blue Cross and Blue Shield had strategic advantage in negotiating with providers. I think that points to some success there in Florida, that you may not see in other places. Another major point, maybe this comes across from specific conversations I had with navigators, is the importance of a navigator network.

There was a lot of money put into -- through grants to University of South Florida, where there is a particular person there, Jodi Ray, who is a shining star there with implementing the exchanges, getting people enrolled. She has formed alliances across the state in rural areas, in urban areas, and some of these Florida chain, Family Healthcare Foundation, the Epilepsy Foundation. She has made alliances with all of them to reach out to people, and I think that that's probably one of the key reasons why we've had so many people sign up for the exchanges in Florida.

My other major point, I guess I already touched on too, had to do with the Medicaid providers. Major concerns of the stakeholders, so let me just come around to some of these. The navigators are not that concerned about what's happened with competition, they said there are plans available for people everywhere. Even in the rural counties like Gadsden County, which was one that I focused on, there are 13 plans, they are all being offered by one carrier, but the navigators said people are satisfied with being able to choose one of those. The prices are high, but the navigators did not express a lot of concern about that.

The regulator also was not that concerned about the number of carriers that are in the market. It's not doing anything actively to try and even encourage them. He said conversations -- Most of the carriers say, we just can't make money. And he says, okay, I understand. So that's been maybe a problem, and maybe a problem going forward.

However, the regulator and some of the stakeholders argued that they do not think that -- that even though they see a potential for a death spiral with the prices rising and more carriers dropping out, that it will level out. But most of them, and the regulator especially, said that he thought that this next year, we would start to see the premiums leveling out and the utilization as well leveling out.

I think I'm running out of time. So, I'll move on, because I think touched on most of the main concerns I had to address. Okay. Thank you.

MR. GAIS: Yes. Thank you.

MR. HALL: Yes. And so when I made that crack about who is the academics, I didn't mean substance of style, I meant that only academics have notes in their lap, and the -- (Laughter) And to read my notes I'm going to put on my glasses here.

So, North Carolina is similar to Florida in many ways. It's only about half the size, but many of the features are the same, including oppositional state, no Medicaid expansion, high on insured rate previously, but very high take up, very effective navigator outreach, and so Florida and North Carolina are often ranked side-by-side, in terms of the largest percentage of eligible population who have enrolled; but also very high prices.

And so, to paraphrase Dickens, I think that North Carolina is sort of the best of markets and the worst of markets. So, some context of both; and so, despite having very high prices, and surprisingly so, because the health care cost index is not among the highest in the country, but the ACA premium rates are among the highest.

Much of that is buffered because almost 90 percent of the enrollees are subsidy-eligible, and almost two-thirds of those are below 250 percent of poverty, so it receives substantial subsidy. So the effect of prices remains quite affordable.

So some of those themes that you just from Patty, I heard as well, but I want to focus a bit more in term of market structure, and entrance and exits because -- in particularly the kind of networks that formed, to kind of add to the dialogue a bit more.

So, somewhat in Florida Blue Cross is the only statewide carrier, prior to

the reform they had 90 percent of the -- 85 percent of the individual market, and the other carriers have less than 5 percent, so there was effectively no significant competition previously, people would say, well, Blue Cross owned the market and dominates, and what have you.

Post ACA, Blue Cross' share dropped from 85 to 65, still, you know, the largest, but Aetna and United each rose up into the middle to high teens in terms of market share; sort of similar market shares to become quite significant. And so Aetna was there from the beginning, mainly in one-quarter of the state that composes half the population, the major population center, Charlotte, Raleigh; and where I'm from, Greensboro, Winston-Salem. And then Aetna, which had nationally stayed on the sidelines the first year, entered the second year, and interestingly, they each entered with quite distinctive market network structures.

So, Aetna's strategy was to partner with named health care systems, this co-branding that Mike referred to. So, initially with Duke, in the Raleigh area, and then with one of the premier systems in the Charlotte area, Carolinas Medical Center that also covers part of South California. And, you know, was sold as the -- the Coventry was the corporate entity that subsequently was acquired by Aetna, but it was sold as the Duke Coventry/ -- I forget the trade name.

And then when United entered, they came out with a gate-keeping HMO, they sort of went back to old style 1990s plan structure. And part is a way of creating a network, because contractually they were able to do that, focusing on the physician contracts by just selecting a certain of primary care physicians, they thought would be good gatekeepers. And then putting in, you know, referral requirements for specialists, and didn't have to go out and renegotiate networks at hospitals that way.

And so that was an interesting move and so you had these sort of standard PPOs, the Blue Cross offered side-by-side with really sort of an accountable care organization structure, because the Coventry/Aetna idea was to really embrace the

new thinking of population health management, and value-based payments and such. And I heard stories of really using the ACA as an opportunity to create this new type of ACO-based type of product, with the critical mass where you could put it out there, and sort of, if you price it right, be pretty confident in getting, you know, 20- 30,000 lives which is enough to kind of get the thing up and running, and then start to sell it to small groups, and then eventually large groups.

So, really, you know, sort of a health policy dream come true. I mean Alain, I almost called up Alain Enthoven and say, hey, managed competition is working, just the way, you know, competing a brand of health systems being driven by, you know, sort of defined contribution, consumer level shopping. And that also fell apart. So, Aetna pulled out nationwide for the corporate reasons that we've read about -- I mean, United pulled nationwide first, and then Aetna pulled out nationwide. And of course there's controversy about Aetna's reasoning.

Many people feeling that it had to do with the merger, or review by the Department of Justice, but in any event I heard a sort of a (inaudible) about why Aetna didn't selectively remain in some markets including North Carolina. But as Mike said, they still were on the sidelines, suggesting this potential of reentry. And some of these networks that have been formed still exist in the group market, and so you kind of have this positive spillover -- I kind of used the negative words to convey positive ideas like -- spillover sounds bad, but it's actually good.

So, when something good happens in one market then it spills over to the other, you see that happening with some of these networks. And the other important kind of spillover thing that happened; was that Blue Cross responded to these new network structures, by creating its own limited networks. It created two forms of limited networks. One a straightforward price discounting, and the other was more in this ACO type of model, partnering with designated health centers.

That said, all this vibrant competition was happening primarily in the

urban areas, as Mike said, that you don't see this happening in the rural areas where there's only one system, or one of group of specialists to deal with. And even in the urban areas, it wasn't consistently true, it was more so true in the Raleigh area, and then secondary in Charlotte, and less so in, you know, some of the other areas.

So those themes are all -- resonate with what Mike said, but as far as distinctive points, I think one of the things about competition in North Carolina is that principally, aside from the blues, the carriers were national carriers. We don't have local and regional carriers. These health systems haven't yet formed, you know, insurance companies, but that might change -- It's not a win. Decisions were made nationally; they impacted our state market across the board. Prior to that, you saw these national carriers actually expanding their state reach, so they weren't contracting.

So, United started with about half the states and expanded -- have the counties and expanded to three-quarters, Coventry started with about a quarter, and was expanding to about a third, but then the national entities pulled them both out. So, there weren't any sort of local regionals to kind of fill that void, but many people I spoke to said that that's inevitable. That those condition of Blue Cross being the sole carrier just -- well, as long as the market stabilizes, as long there's a potential to remain profitable.

So, again, the big, open, you know, $64,000 question; were the two years of state price increases sufficient to stabilize the market? You know, we'll find out soon enough, I think. Or maybe not soon enough, but we'll find out soon. But if that's the case, most people felt that there would be new entry to the market. So, Aetna is still poised to reenter.

Importantly, Medicaid hasn't expanded, but the traditionally Medicaid in our state has not managed care, but we've recently embraced Medicaid Managed Care, we have a Waiver Proposal in with CMS right now, to implement Statewide Medicaid Managed Care, so there's a lot of activity right now forming. New carrier entries or national carriers looking at our state, and the thought is that they enter the state for the

Medicaid Managed Care market, there's a great chance they'll also enter into the exchange market given the symmetries we've seen elsewhere with that ability.

So, it's an interesting thing, where, at the moment, there's very little or no competition among carriers, but everybody seems to think that there's this potential competition, that it's poised for more -- In fact, Cigna did enter the Raleigh market for this current open enrolment, just a single rating area.

So, no one said that this market isn't, you know, viable, that there are sort of regulatory barriers that keep people from doing business. The rate increases proposed, were generally approved, it does appear to be mainly just a process of the actuaries catching up with utilization. The points that Mike made about not knowing what the population was at first. And then the next year, having to put in your rates before you really had good data, and by the third year, the reinsurance -- the risk quota payments were frozen by Marco Rubio, and then in the fourth year your reinsurance has phased out.

So, you know, every year there's something else to catch up with, and so, you know, the point you already know, there's, you know, reason to believe it's found equilibrium, but there's also reason to be concerned that it hasn't.

So, I heard, you know, both stories, but I think the ideas that prior to the Trump election, people at least were, you know -- carriers were looking, continuing to watch this market carefully, and remain sort of flexible in terms of reentry or new entry. And meanwhile, what developed with the network, the provider networks was really, I think, most encouraging.

MR. GAIS: Okay. Thank you very much. Mike?

MR. MORRISEY: So, I suppose the best sort of single line about Texas that really plays off of Mark's comment is: and then it all fell apart. Texas is certainly and oppositional state, it didn't expand the Medicaid Program, it uses a federally facilitated exchange, it enacted legislation requiring additional training for navigators before they

could go into the field. And indeed, there are only a handful of former navigators throughout the state.

But I wanted to make one point before going into the collapse, and that is the nature of those individual markets truly are sometimes very unique. One of the features with Texas, is we have a number of border counties. And there, the challenge is, so let's see, I'm an insurer, and I'm selling a bronze or maybe a silver product with a rather large deductible, and then access to U.S. providers.

And the majority of the Hispanic population in McAllen, for example, many can cross the border where there's a vibrant health care market, where they get a favorable exchange rate, and where prices are lower. And it's really difficult with that sort of opportunity for alternative sources of care, to make an exchange product of the sort that we've talked about: do they really work?

And I just want to throw that as an example of the sometimes very different markets that insurers are trying to function in. Then the talk about sort of the nature of the collapse in Texas; Alice keeps saying to me, you are too negative, you are too negative. I was very enthusiastic about what was happening in Texas over the first two years. In the first year, as I indicated more globally, there was some reluctance on the part of insurers to enter into the market.

Blue Cross and Blue Shield is the dominant carrier, present in all 254 counties, but after that first year, we saw substantial entry into markets. We saw expansion by those who were already there. We saw carriers lower their prices relative to the Blue Cross Blue Shield prices, and to appear to be competing pretty significantly at least in some markets; certainly, for example, in Houston and Austin where we saw eight to nine carriers competing by the second and third year.

But then the data became available and when the data became available, as Mark indicated, big indications that there were losses. And it was those losses, together with the perceived inadequacy of the risk adjustment mechanisms that

led to withdrawals. So, Houston, depending on how you count, third or fourth largest city in the country, had eight insurers, they now have three; Blue Cross Blue Shield, and two Medicaid Managed Care plans.

The other thing that went on is the shift from a variety of PPO offerings, Blue Cross Blue Shield offered PPOs in all of its markets along with HMOs. Very quickly, it decided to withdraw from the PPO offerings, as did all of the other carriers. You cannot buy a PPO product on the exchanges in Texas. HMOs are the only ones there. There is certainly a view of significant adverse selection, and that it was the sicker folks who enrolled, and as a consequence, that undermined the premiums that the carriers had set with, with a high degree of uncertainty.

And I would say, given the Michigan experience where there's not a sense of a death spiral, there is a sense of a death spiral in Texas. And had the election not occurred, and the additional complications layered on top, there was, from my sort of back-of-the-envelope calculations, sort of a 50/50 sense among the people we talked to that Blue Cross Blue Shield would still be in the market next year.

And Blue Cross raised its premium rather substantially. You know, 40 to 50-plus percent. You know, in the first year they appeared not to have known what the utilization experience was. They announced that they've lost $440,000, they responded by moving from PPOs to HMOs, which is sort of classic response that an insurer would make to deal with those kinds of cost problems. And they lost $770,000 in the individual market.

So, clearly there is concern and, you know, they have responded with rather large premium increases, and as you said, it's an open question, whether or not those are going to be adequate to deal with the utilization experience that they've seen.

Now, having said, that, the Medicaid Managed Care plans truly are, you know, a surprise. And I think a surprise even amongst themselves. As one of them said, we have succeeded beyond our wildest dreams, in terms of the sorts of enrolment that

they were able to garner. And they said, you know, we basically didn't know how to price particularly, we followed Blue Cross, it may have been a mistake. But their premiums have remained low; they actually rose up in the middle years and have come back down.

Molina, as others have indicated, have lowered their prices every year, at least in some of the markets in Texas. So, there are bright spots, and there are those carriers, potentially, waiting in the wings to reenter. But Texas is a market that I had great hopes for early on, because I saw lots of entry, and I saw price competition, and all the sorts of things that an economist would say, you know, this is all moving the way you would hope it to move. And I guess better data quashed that.

So, what can I say, Alice? It's the best they could do. (Laughter)

MR. GAIS: Okay. Well, very good. Well, even though it's not the case that it works it seems to be -- the system seems to be working in all these situations, it does seem that from what you've been saying that the ACA model seems to work best in urban areas with non-concentrated provider communities. Now I wonder, and not that it works in all urban areas, with non-concentrated community -- with unconcentrated provider communities, but I wonder what can be done to make this model work better in the other communities?

It's the rural communities, or maybe the smaller city communities that might have more concentrated providers, or a small number of hospitals. Or increasingly, since the industry seems to be consolidating anyway, a lot of our cities, even pretty sizeable cities are going to have a fair amount of concentration. I wonder, I mean, is it something that will be done within the ACA itself? Or should we be doing something about really building up our provider infrastructure with a separate set of policies? So, what? What do you think? Anybody --

MS. UDOW-PHILLIPS: I actually think it was very clear, you know, I think all -- frankly all of the issues that we've experienced in, I think, all of our states were fixable issues. Now that is not what's happening right now. And in fact, as I've said,

there's a lot of chaos in the market. But this was very clear on what we could have done, if we had the political will to do it, and that was the public option.

I mean, you cannot overcome, and I can't remember which of you said, maybe it was you, Mike. But, you know, when you have a limited number of providers in a community the health plans don't have market leverage to negotiate lower rates. Right?

MR. GAIS: Yes.

MS. UDOW-PHILLIPS: You need to give them market leverage, so look at what's happening with Medicare Advantage, the Medicare Advantage has worked very well in many of those communities, and it's because they have the leverage of the Medicare rates. So, clearly I think that would have been a way to fix it, I think we are not going anywhere near that at this point.

MR. GAIS: Yes. Yes. Mark, did you have --

MR. HALL: The same thing. I mean, you know, we planned all this much earlier in the year and did most of the interviews in the late summer to early fall. So, prior to the election at that time, we thought that there'd be discussions of the public option. So, we actually asked people, and what we heard, and in North Carolina, so the eastern part of the state, which is thinly populated, and where there's the least sort of provider competition, I mean, more often than I expected, in a fairly conservative state, not just from the liberal advocacies. Well, I suppose there's nothing left other than the public option, you know.

And who knows exactly what that mean. Does it mean you just buy into the state health plan, you know, for the state employees? Or some -- much left up in the air, but there was sort of more openness to thinking about some version of a public option than I expected to hear. Now, we didn't pursue that in great depth, but suffice it to say that, you know, it's not -- it doesn't even -- merit mentioning in the final report, because it seems so far off of the relevant policy field.

So that's one answer. Is that if this model of managed competition, which is I really think what we are talking about, isn't viable, then that's the logical alternative.

MR. WEINBERG: I don't know. Let me swing to the other side maybe, in your perception of my political preferences. Public option is giving up on the system and blowing it up. Right? If we allow one of the quote/unquote "competitors" in the marketplace to have a completely different -- essentially a set of rules, and to leverage the combined purchasing power of the state and all the mechanisms of the state. It's not a competitor at all, and it's not setting up a fair system of competition. And it doesn't address your question, right?

You look around the world, you know, they've got single payer system, you couldn't find a -- you know, more market leverage. Yet they've seen substantial trends, upward trends in their health care premiums and, you know, utilization, and so on and so forth, the issue is still competition. Right? Not of provider -- Not of plans but of providers, so this is a really important issue, whether or not we move to a single-payer system or, you know, do a very interesting ideas from the folks on the right wing of essentially blowing up employer-sponsored health insurance, and having effectively exchanges for all, we still need to think about what do you do in non-competitive marketplaces.

You know, you could be actually be serious about antitrust and urban areas, but you can't, you know, really -- antitrust doesn't work that well when there's one hospital. Right, I don't know if you can put a tape down the middle of it, and be like: you guys are over here. It's really important and, you know, Telehouse may be one way to get some traction on that issue, and there are others, but this is going -- these are like the real issues. Not the imaginary ideological policy issues, but like the real issues that are going to matter if we want to be successful with any system that we choose.

MR. MORRISEY: Let me pick up on that, because I agree with you. If

the issue is the lack of competition amongst providers one of the things we've seen is, over the last couple of decades, is really the willingness to allow providers to consolidate. You know, so let's revisit the antitrust issues, let's revisit some of those consolidations and see to what extent we can sort of unscramble the egg.

And in some markets we may be able to do that; in rural areas, probably not. But there are middle-size urban areas that have consolidated into single networks that presumably could be at least revisited, because the issue is competition, it's not the other stuff.

MS. UDOW-PHILLIPS: So, let me say one other word since I spent 25 years of my career at a health plan, you know, doing all of this negotiation, et cetera. And the other way to think about this problem is back to, actually, a point that you raised about the specificity of the rating areas, right. So when I was at Blue Cross and Blue Shield and we looked at the market as a state-wide market, rather than an individual regional market, the rural areas were not as big a problem, because we were essentially letting them be cross-subsidized by the other regions. Right?

MR. GAIS: Right.

MS. UDOW-PHILLIPS: A very small population, there is relatively small impact on a health plan's profit margin in total. And so we could afford to pay higher rates to the providers and still keep premiums lower, if we looked at it from a statewide basis. The way the ACA is set up now, each market stands on its own. And so another way to look at this problem is to think about rating area structure, and think about statewide plans, where there can actually be some cross subsidy.

SPEAKER: Absolutely!

MR. HALL: And you don’t want to get bogged down in this one, but I was in the discussions when we came up with our 16 rating areas, and we talked about; do we have 100 counties? Do we have, you know, whatever, four? Do we have whatever? And a lot of the balance was explicitly about this cross-subsidization where --

and the counter point is that, well if you -- too broad a rating area, and too much cross-subsidization, then you don't really reward the plans that do negotiate the discounts with the more centralized health systems. And so, there are tradeoffs, but that would be the other approach, yeah.

MS. BORN: Yeah. I mentioned that in the beginning in my discussion of Florida, that 67 rating areas may just be too many. In fact, one that I chose is the poorest county in Florida, Gadsden, but it borders Tallassee and Leon County, which is where the legislature is. It's where Capital Health Plan has great networks of providers. And in fact people in Gadsden that need services can drive 25 miles to all the best hospitals and providers in the state. But the network that's there, offers them one hospital over in that side of their county, and the consideration here of merging those counties in some way, and the fact that that's not on the -- it's not being considered just yet, surprises me.

MR. GAIS: Well, another thing, I mean it does seem as one major theme that comes out of your discussions is that when you do have something like the ACA which is a very complex, market-based initiative, that it's going to take a while for all the different actors, the consumers, the providers, the insurers, the regulators, everybody, to sort of adapt to one another, and sort of understand things. But it also seems that the consumers, in particular, still need quite a bit of help in this system.

And I know Patty talked a bit about the -- what sounded like a very good program coming out of the University of South Florida, but I was wondering if you have other suggestions about how -- you know, are there ways in which we can actually, sort of, help consumers not only understand how to get into the system, but how to use the services in a way that is more efficient, more effective, than they have so far?

You know, are they getting particularly good practices, do you think that ought to be spread or, you know, do we need a lot more person power in doing this sort of work? How can we improve consumers in dealing this complex system?

MR. MORRISEY: Well, one approach is, the agents and brokers have

largely been excluded from all of this, and when they were participating, admittedly, most of the focus is in the small group market, not in the individual market. But these are folks that have a depth of knowledge on how insurance works, and how it could work for you.

And it seems to be that one of the things that could be considered in that much broader milieu of, you know, what are you going change, and how are you going to do it? Is to reconsider the roles of brokers and agents and give them some skin in the game to be willing to help people make informed decisions on the individual, and indeed the small group market, on the health side.

MR. WEINBERG: Yes. And Mike and I are just going to spend the whole panel agreeing with each other.

MR. MORRISEY: While we sit on opposite (crosstalk).

MR. WEINBERG: Yes. I spent all this time lobbying the -- you know, covered California. And I'm like: so, you are setting up an insurance sales marketplace. Maybe work with insurance sales people, you know, crazy idea, and we actually did compensate them a little better in the early going. Competition has sort of gone down, it's the brokers and agents in California are almost doing this as a charity at this point, but they are doing a tremendous job, and they are actually still providing a lot of the enrolment in the system. So, that's a piece of it.

MR. GAIS: Okay.

MR. HALL: Just, you know, chiming in on the broker/agent situation. It came up a lot in discussions in my reviews, and in North Carolina like in other states, where United decided to pull out they stopped paying commissions, or took them down to 1 percent or whatever. Particularly during special enrolment, because they cleared out open enrolment and they said, you know, no more commissions. And once they did that, then Blue Cross did the same.

And when Blue Cross zeros out commissions the brokers are really worked up. And they only did it during special enrolment, but I think it's because, you

know, we can't be the only ones in the market paying, you know, commissions during the period when we think we are getting adversely selected. Now they reinstated the commissions during open enrolment, but at a lower level. And so, brokers who had been engaged which were, you know, a minority, were saying, we are pulling out.

So, that is a problem. And I think it really does pose concerns for the ongoing. And now, you know, if it becomes more profitable, and there's more competition, there's no reason that broker commissions couldn't go back up. Meanwhile, the role of navigators has been critical, and I think one of the things that I learn from this is that the navigators weren't important just to get (inaudible) to ensure people are educated about insurance, and deductibles, and things like that.

But year by year, because of this sort of shift in pricing that, Micah, you referred to, where, applying one year's low price and then another plan drops lower and that price becomes much, much higher because it's relative to the subsidy, which, the subsidy amount shifts, and people don't really know that dynamic. Suddenly people are having to take another look, and when they change, they are changing providers, and that gets pretty confusing.

So, you could call that turmoil, but you can call it sort of active purchasing, you know, price driven, but whatever it is, it requires more than just sort of punch it up and seeing who has got the best price this year.

MR. GAIS: Marianne, sure.

MS. UDOW-PHILLIPS: I just want to add one more thought to that dialogue, because it comes back to something Mike said earlier about the states that expanded Medicaid and the states that did not. So, in the states that expanded Medicaid, there actually is quite a robust network of organizations and individuals who are helping people get enrolled in Medicaid, and they are actually serving the same function for the exchanges. So I think this is another case where you can see, when you expand Medicaid it has spillover effects into the individual market.

MR. GAIS: Okay. Good. Okay, before I turn it over to everybody, I'm going to just ask one question, and you can -- or one combination question, and I want you to answer briefly.

SPEAKER: Lightning round?

MR. GAIS: The lightning round question. So, I mean, I have heard some discussion about the ACA, some interest in possibly changing the ACA at the national level. So, I was wondering if you could offer your suggestions, or your thoughts on what element of the ACA do you think is absolutely necessary to sustain? Or, what element should be strengthened? Or what element could be jettisoned without too much trouble? And you don't have to answer all three of these, anyone, but if anybody has any thoughts, any recommendations based on your research, based on your own state's research. Marianne?

MS. UDOW-PHILLIPS: So, on the jettison side, I do think the employer mandate could be jettisoned. I think it has not served much of a function, it was sort of a throw-in anyway, at the end, and it's very much of an irritant to the employers. They are maintaining coverage; we have not seen a drop in coverage from the employers despite the prediction. So I think could jettisoned.

On the maintain side, again, the idea, you have to have some incentives for people to enroll. You have to have a mix, we can spend quite a bit of time on talk about why high risk rules will not work as proposed; why health saving accounts are not the answer, you've got to get healthy and sick people in the markets. That is how health insurance works. And so, you know, if it's not going to be the individual mandate that people hate, I'm very concerned about the continuous coverage requirement.

Or, frankly, the idea that we can do it like Medicare Part B. We need to strengthen, I think, the individual mandate. You know, clamp down on special enrolment periods and some other things that really cause problems.

MR. GAIS: Well grounded in Michigan's experience for Blue Cross Blue

Shield.

MS. UDOW-PHILLIPS: Yes.

MR. GAIS: Okay, very good. Patty?

MS. BORN: I was guessing, and I'm going to pull this from the main concerns that the stakeholders I talk to conveyed, we've got to find ways to keep enrollers from opting in and out of coverage. There seems to be a sense, especially among the regulators, that people are signing up during open enrolment. They are using the first few months to get things care of and they stop paying. And trying to convince individuals, you are still bearing risk if you are not insured, and you should consider paying for the whole year; so, some ways to incentivize people to stay in.

And as far as something -- I don't have anything I'd really want to jettison, but I think the risk adjustment mechanism needs to be reconsidered somehow, so that we can encourage those providers that -- the carriers that are getting adversely selected against -- somehow there's some time period in which they can recover and stay in the system, rather than feel like they didn't get really compensated for the risk that they bore in a given year and decide to leave the market altogether.

MR. GAIS: Okay.

MR. HALL: Before somebody takes my one idea. Let me jump in on that, which is --

MR. MORRISEY: (Laughter) That would be me, I guess.

MR. HALL: I do think that the -- particularly the three Rs, and we could spend all day about what each one means, but just to emphasize two of three Rs are transitional risk corridors in reinsurance, and it struck me through this process that the three-year transition was too short. Of course the risk corridors were never adequately funded and even with reinsurance. I think the market needs another year or two, to kind of really get caught up and get comfortable with the level of risk and the pricing for the reasons that we've talked about.

You can look to Medicare Part D and Medicare Advantage, where the three Rs are actually permanent. And that's where the ideas came from. There, too, you had a very similar managed competition type of idea where it was not hostilely opposed, and it was embraced, and all elements worked together to try to make it work. But importantly, the risk mitigation things, and I don't know that they need to be permanent but, you know, only three years in a hostile opposition environment, and only partly supported versus, you know, the other experiences of Medicare Part D.

MR. GAIS: Okay then. Good.

MR. MORRISEY: Well, I would put two things on the list to worry about and keep. One is the exchanges themselves. They don't have to be run by states of the federal government, but this idea of a single place where you can go and see what all of your options are is worth preserving. And it can be preserved privately. I mean, eHealthInsuranc.com, prior to the ACA was able to do that sort of thing. And there's no reason that private entities couldn't do it, you know, as well, maybe better than state and federal entities.

But the idea is to insist that everybody who is offering coverage, you know, be on the exchange and be explicitly described as what they are doing. And secondly, is improving somehow the issue of dealing with adverse selection. I mean, as both Patty and Mark have talked about, that's a really big issue, and if you are not going to allow people the charge -- insurers to charge a higher premium for sicker folks, and lower for healthy folks, then you've got to find some mechanism to account for that difference in expected utilization.

Maybe it's the three Rs being improved, and they well may be. Maybe it's looking creatively at things like high-risk pools, but in any event, that issue has to be dealt with, if any of this is to succeed.

MR. WEINBERG: I guess, very quickly, you know, guarantee issue and community ratings, you know, are what I hope gets preserved. So, as long as -- if we do

those, then you can move the pieces around a little bit. I think what could be jettisoned is a lot of the complexity. I mean, like the second lowest silver plan with the percentages, and the cost-sharing subsidies, and everything, and talk to so many reporters, and they'd be like: premiums are going up.

And I'm like: No. They are not. It's actually way more complicated than that. They are like, yeah, we can't possibly explain that to our audience, right? (Laughter) So if you have a law that you can't possibly explain, that might not be a feature. So, you know, certainly looking at how we can simplify this and maybe simplify the broader health care system more generally.

MR. GAIS: Excellent! Well, thank you very much. And now, anybody. Brief, I'll get to you in a moment. Yes, ma'am.

SPEAKER: Yes, very brief --

MR. GAIS: We have a microphone for you.

SPEAKER: Hi. My name is Denine Rhooms from the American Speech Language Sharing Association. Earlier, it was mentioned that interstate sale wasn't really a viable option, but could you explain a little bit more why it's a viable option?

MR. MORRISEY: Well, it's a testable hypothesis that it isn't, and I, early on, well, thought that indeed there's a lot of potential there. The problem is that if I'm an insurer and I want to be successful, I've got to negotiate prices with providers, and those providers exist in local communities, and so if -- you know, if I'm headquartered in Tennessee and I'm offering insurance in Texas, I've still got to go to Midland to negotiate a contract. And that's time consuming, and I don't know what kind of market, I just don't think you see much of that happening, at least very quickly.

MR. WEINBERG: Yes. The sale of insurance across state lines either does nothing or does something we don't want it to do. Right? If it is just like people being able to sell in other markets, they kind of can already do that. They'd have to abide by the state regulations and they, you know, have to figure these things out.

However, if sale of insurance across state lines means there is a state that allows you to sell junk insurance, and so you can now, everywhere in the United States sell a plan that has a yearly maximum, well that will get you to a lower premium, but in a disastrous way. So, it's either nothing, or it's a big problem.

MR. GAIS: Okay. Good. The next question; right over there -- Yes?

SPEAKER: Thank you very much. I'd like to ask a question about the impact of dominant employers in states or regions. If you were in Wisconsin it would be, potentially, Kimberly-Clark; Ford potentially in Michigan. And they had employer plans, and R.J. Reynolds in Winston-Salem if they still have their headquarters. They still offer -- Yahoo or Facebook, they will offer their employees health plans. Twenty years ago they would have offered them, kind of, one health plan, whether you were an engineer or a janitor.

So, I have two questions: one, to what degree did having a dominant employer impact these various districts and states? I mean, even Houston and Dallas have some dominant employers. And second of all, if there were a repeal of the ACA, how would that impact these employer plans?

MS. UDOW-PHILLIPS: I can comment on the dominant employer, because I think it goes to what I was trying to communicate earlier about the history of the states and how important that is, and what got set up under the Affordable Care Act.

So, for example, in Michigan which was, for many years, dominated by the auto companies and the UAW in terms of the way health benefits were designed, because they concentrated their insurance market into Blue Cross and Blue Shield of Michigan, it gave Blue Cross and Blue Shield of Michigan tremendous leverage in negotiating with the providers in the state. That's what set the ground level, and that's what kept premiums relatively competitively and relatively low in Michigan.

So, they are less important now because, you know, for a variety of reasons, but I think that they set up the foundation of what we are dealing with in the

states, and it became very important. I don't think they are directly affected very much by the repeal. I mean they may be by the (inaudible) benefits or whatever. They are 100 percent offering benefit coverage. Most of them are moving to high-deductible health plans; that is independent -- I mean, people are confused about this -- it's independent of the ACA. And I think they are still on that journey.

MR. WEINBERG: Yeah. I mean, just one more question, quickly, actually the ACA has been fantastic for employers, and particularly in states that did the Medicaid expansion. So, in California, as an example, two-thirds of the adults who were enrolled in Medicaid are actively in the labor force. They are employed full-time, part-time, there are people that weren't necessarily on the employer-sponsored health plan.

Well, what happens when you have Medicaid? You are more productive, you know, your health status is better. So, there are lots of positive impacts for the employers and for the economy of having these plans in place, and for the people whose -- you know, may not be covered by employer-sponsored insurance. They have family members that are covered by individual, so it's not costless for employers if we get rid of the ACA.

MR. GAIS: Thank you. Dick?

SPEAKER: I'd like to make -- (inaudible) have lived with these wonderful characters for a long time, and they did a great job I think. I was pleased, Patty, that you mentioned Florida is number two in enrolment despite the politics. Vermont is the only state that has a higher enrolment. I was pleased, because we both were there, the navigator, Jodi Ray, you mentioned her, she's quite special. The second point that I would just like to make as a quick point is that in regard to rural areas, and low-density areas, Alice will remember, Mike will remember, we did a five-states study for the Assistant Secretary in HHS, ASB, including Alaska.

And Alaska now, and we have a field researcher there, and we know the field people and the state people, and he was a state official, like Marianne, they are

trying to do something new in Alaska and that's one of the kinds of things that didn't come out as much here, because Alaska -- in fact, when they asked us to cover Alaska, we thought: my goodness, it's so different. But all states are different.

The final point I want to make is a sort of philosophical point, and Micah mentioned, you mentioned David Brooks' column, where he talked about Kenneth Arrow saying, people should choose, they should decide what they want; what's really here, the competition that's really here. And then you mentioned Alain Enthoven, is competition among the plans, it's more than just insurance, it's more than just carriers, there are a lot of ways in which entities are playing a new role.

In his book, which I like, Zeke Emanuel, at the end, has a section about how fundamentally; eventually insurer roles are going to change. It goes way beyond anything we are seeing here, but they are changing, and we start talking about institutional change, talking about institutional change on the part of insurers is not just the government stuff, it's not just government stuff, it involves both sectors, public and private. I thought you guys did a great job, by the way.

MR. GAIS: Thank you very much. Okay. We have, I'm sorry, just a couple of minutes, so please -- I'm going to ask you to each state your question very briefly, and then I'll let them talk. Okay. Yes, sir. It will be over, just a second.

SPEAKER: Larry Checco. I'm just wondering, would we all be sitting here, had the ACA been universally embraced by all the states? And what would that have done for competition premiums and risk pools. Thank you.

MR. GAIS: Okay. Yes, sir? Over to the other side, this gentleman over here; it's coming, it's coming.

SPEAKER: Lou Gaglini. To the extent that the premise is wrong, that the current pricing, properly adjusts for the risk pool, what should federal policymakers take away from the higher utilization rate, the impact it had early on in terms of structuring a replacement bill? Thank you.

MR. GAIS: And right over here; and this will be the third.

SPEAKER: Can you just take one of his?

MR. GAIS: I'm sorry. Okay, two more.

SPEAKER: Hi. Fiona Greig -- just quickly -- What do we know about the impact on out-of-pocket expenses for families? You know, obviously utilization might have gone up, but they are now paying a premium, and maybe deductibles and so, just what is the state of play from the consumer budget standpoint?

MR. GAIS: -- for your question. And one last one, right behind there.

SPEAKER: I'm just wondering when the discussion, or essentially, the broader focus moves to effectively lowering the cost of service, and essentially making the talk of premiums and subsidies which are essentially cost shifts irrelevant.

MR. GAIS: Yeah. That's very good. Okay. Some of these will have to be answered, I think in the next session, maybe, or be addressed. But does anybody have any quick comments on any one of these questions. They are all great questions.

MR. WEINBERG: Well, I mean, just quickly, like we are talking about the actual cost of care, when you are talking about competition among providers, right, if you are just talking about health insurance and cost sharing, and so on, you are just moving the deck chairs around on the Titanic, if you are not actually dealing with the big issue, which is: Is there competition in your marketplace?

So that's what we are focused on, that's what any policy approach is going to have to focus on, just quickly, so the question about out-of-pocket cost, there is an irony here, which is that the one thing that consumers have said they absolutely do not want more of, in whatever the replacement plan is, is higher out-of-pocket costs. But the only move that the Republicans have proposed is higher out-of-pocket costs, so there's a disconnect that's going to have both policy and political consequences.

MS. UDOW-PHILLIPS: So, on that point, you know, the cost-sharing subsidies were extremely important, so many people who had very low income scales

have really benefited tremendously by -- which of course are under attack in the courts at the moment -- so we'll see what the Republicans do with that. That is fundamental to the health plans that those cost-sharing subsidies stay in effect, and they really -- you know, we really have under-reported the financial of how people have gotten through the tax credits, and those cost-sharing subsidies, they are really important.

I'll comment on, if everybody had embraced the plan, I think we would have such a different conversation today, because there so many elements of this plan that are fixable, and we are really not focused on what is fixable. These issues about people coming in to coverage for short periods of time, in our case, people getting Sovaldi and then they drop their coverage, and that has had significant impacts on the affordability for everybody, and just raised the premiums for everyone.

So, there are a lot of things that are fixable if we had embraced it as a country, we would be in a very different conversation now.

MS. BORN: And I want to extend from that, too, and say, if we had embraced it the Affordable Care Act addressed financing issues, and we are talking about costs still being kind of high. What needs to be considered, still, is what we are doing in the health care community. Pushing for more efficient health care services, Affordable Care Act did not address incentives to providers as far as it could have, to find cost-effective treatments to address places where there might be more efficiency in the health care system.

There are some, but I think we could go further in that direction, so even if we were sitting here saying, everyone's got insurance, we'd still be wondering: everyone has got insurance, they are paying for it, but the prices are high. What are we going to do next? Well, now we've got to figure out why is everybody spending all this money on health care?

MR. HALL: Or, maybe we'll bid for pharmaceuticals --

MR. GAIS: I don't think we can.

MR. HALL: Will that work?

MR. GAIS: No. I think we have to, we have to cut it off. But I really appreciate; and I appreciate the extra 8 minutes. So, thank you very much. (Applause)

(Recess)

MS. RIVLIN: We're going to try to keep on schedule here, so there's no such thing as a short coffee break, but please take your seats and we will get the second panel started.

We got into the future a little bit on the last panel, but this panel is going to do even more so. The basic question is what have we learned from the experience of the Affordable Care Act in the last three years, either from these studies or from other research which will be well represented on this panel on the Affordable Care Act? What have we learned that would improve insurance competition and affordability as we look ahead?

And we have a very qualified group of people here to help us answer that question. We have three researchers who have been doing research on health and health insurance markets and health care generally, and the ACA in particular, over quite a long time to help us assess what we have learned in this study and elsewhere. And we have two members of the network from states we haven't heard from until this moment, namely Colorado and Indiana.

So we will hear first from Linda Blumberg. Linda is a very distinguished health researchers who spent quite a long time researching these issues at the Urban Institute where she's a senior fellow in the Health Policy Center.

We will hear from Stuart Butler, my colleague here at Brookings, a senior fellow in the Economic Studies Program, who actually spent quite a long period researching these same issues at the Heritage Foundation, and his point of view has not changed so far as I know in moving from one place to another.

We have Cynthia Cox, who is the associate director of the Program for

the Study of Health Reform and Private Insurance at the Kaiser Family Foundation. I don't know what we would do without the Kaiser Family Foundation. None of us would be very well-informed about health care or these issues.

We have Michele Lueck, who is the president and CEO of the Colorado Health Institute, who has done fascinating work on what's going on in the mountains of Colorado and in the plains as well.

And we have Kosali Simon, who is at the University of Indiana, in my home state. I'm a Hoosier, and Hoosiers are big these days. Very important to pay attention to what's going on in Indiana. Kosali is the Herman B. Wells professor at Indiana University.

So Linda, start us off.

MS. BLUMBERG: Okay, great. Thank you so much, Alice.

So when we look to what the future of competition is going to be in insurance markets, it's actually very hard to know right now, obviously, as you all recognize, what policy changes are going to take place and how fast they're going to be implemented and in what stages. But what we do know is that there is a very different general direction in the policy proposals that are being put out at this point. There's a fundamental, philosophical shift at play here in terms of how sharing of healthcare costs would be done in private insurance markets. The Affordable Care Act is firmly grounded in the objective that healthcare costs be shared more broadly across those who are healthy and sick than was the case prior to 2010, and in almost every state, that meant for the first time that there could be competition in the way economists think about competition in the private nongroup insurance markets, which is to be trying to promote competition based on price, based on network, based on customer service, other quality measures, and that was really catalyzed for the first time by these changes under the Affordable Care Act.

So, for example, the Medicaid expansion, the premium and cost-sharing

subsidies. These all are mechanisms for spreading healthcare costs through the tax system more broadly, the whole taxpaying population. Guaranteed issue in the nongroup market, limits on premium variation by age, prohibitions on medical underwriting, essential health benefit requirements, actuarial value standards, and on and on, the individual mandate were all ways to share healthcare costs more broadly across the population enrolled in private, nongroup health insurance policies. And those who were healthy at a particular point in time were then, as a consequence of this broader sharing of risk, potentially going to spend more money depending upon their eligibility for different subsidies, but the cost for those who had health problems went way down.

In contrast, when we look at the types of policies that are included in the proposed alternatives to the ACA 201 they would move us further towards segmentation of healthcare risk, the separation of the cost of the healthy from the sick. And it's a highly consistent philosophical framework that we're looking at in all of these proposals and their components, and this has very substantial ramifications for the ability to create real economic competition. What it does is these segmentation approaches are going to promote competition based, again, on what we saw before the Affordable Care Act, which was insurers trying to get the best healthcare risks, not becoming the most efficient providers of medical care.

So just a couple of examples, but there's a lot. The elimination of essential health benefit requirements and actuarial value standards, for example. These approaches are going to reduce the comprehensiveness of insurance packages that are offered in the private nongroup insurance market. We'll see higher deductibles and premiums are going to be lower as a consequence, yes, but there is going to be a much higher share of healthcare costs that are put on the individuals who need medical care when they need it. You eliminate prescription drugs or mental healthcare or other benefits from an insurance package, and again, the premiums will come down, but for those individuals who need those particular services, they have to incur all of the costs of

that particular care themselves, and for many of them, that means they won't be able to afford it at all. So these are, again, shifts away from sharing of healthcare risk to separating healthcare risk between the healthy and the sick.

In addition, when you think about any promise of preexisting condition exclusion protections, they ring really hollow in a world without essential health benefit requirements because what does it mean if I'm not getting excluded from my policy based on the fact that I have cancer, but my policy doesn't cover chemotherapy and it doesn't cover radiation. It's a pretty meaningless protection.

So another example, age-related tax credits instead of income-related tax credits. When you take up an amount of federal dollars that you're going to use for financial assistance and you spread it over all individuals in that market, not just those who have low income, each individual is going to get less amount of assistance than they would have if it was income related for those who are eligible. So again, people who are middle, lower income can only afford policies that have higher cost-sharing requirements, lower benefits. Again, separation of risk. In addition, we see in those proposals, at least the ones that have specifics in them, that while there are increases in the assistance that are available based as your age increases, those increases in assistance do not increase as much as the premium. So if you go from three to one to five to one age rating, a 64-year-old can be charged five times as much as a 20-year-old, for example, but the tax credit only goes up two and a half times. Then, the affordability of care as you need it, as you begin to need more healthcare services, goes way down. Okay, so again, separation.

I could go on and on with regard to high-risk pools, continuous coverage requirements, individual health pools, expanded wellness programs, across state lines sales of insurance. All of these things end up separating risk more. We could put in place instead an array of strategies that would be more towards allowing us to have better competition in these markets in the way that economists think about real

competition. Some of these have been mentioned before. I'll mention a couple more.

We should be doing more to increase enrollment. We're not doing enough to bring in enrollees that are out there in terms of both improving the financial assistance, the subsidies, but also doing more outreach and enrollment activities. We should be fixing the family glitch, bring more families into the nongroup market who need that for affordability. We also should be regulating noncompliant plans that are pulling some of the better risks out of the pools.

In addition, for those markets that are highly concentrated with insurers or providers, we should, in addition to the idea of the public plan option that was mentioned before, I'll mention another option which would be to use, based on the Medicare approach, where Medicare Advantage insurers cannot -- no provider can charge an insurer more than the traditional Medicare rate even if the individual goes outside of the plan, outside of the network. Basing something on that, Medicare plus some percentage for nongroup insurers could create more competition in these very highly concentrated markets.

I'll stop there. I have other ideas we could talk about later but I've run out of time. So, thank you.

MS. RIVLIN: Okay. Thank you very much.

Stuart, you've been focusing a lot on state flexibility and the potential for increasing that, which we haven't talked about very much in the previous panels. So I wonder if you would focus on that.

MR. BUTLER: Yeah, well, I will. And of course, you've asked us to think about, what does all this mean, what we've heard this morning for the idea of an ACA replacement. Or I guess today we were talking about an ACA repair. Although my favorite sort of expression would be an ACA extreme makeover. I think that's a much more Trumpian kind of way of thinking about this.

But anyway, and I think there are two things that have come through very

loud and clear this morning. One is -- it's not just politics but markets are local, certainly between states and within states as we've heard, sort of locality. And also that markets change over time. As we heard with Florida and others, things may work in a certain way at the beginning but they change over time. So I think when we start thinking about what should the federal government do, how should the federal government's role change in any revamping of the ACA, I think it's clear we can't have much confidence that some pattern will work everywhere or that a pattern, in fact, will work in the same way over time. And that certainly leads me to think about the role of states and the role of state flexibility in this.

I would say there are kind of three broad approaches if you think about it at the 50,000 feet, or three broad things that are needed. First is, I think, for the federal government itself, not to try to do too much. Socrates told us many, many years ago that the first step to wisdom is knowing your limitations. And so I think we ought to recognize that the federal government is limited in what it can do to kind of micromanage the changes across the country. And Mike earlier on said you've got to have a federal law that you can explain even to a journalist, and I think that's important to bear in mind. So sort of simplicity.

So it seems to me that in thinking about this, the federal government's focus in the future would be thinking much more strongly about what are the goals and what are the protections that have to be in place, some of which have been mentioned already, including by Linda. And also that, yes, the federal government should do its best to try to design things at the national level, and many of us have put forward proposals, including Alice and I and (inaudible) recently about ways we could tweak, change the ACA.

But the second point I wanted to make after that is that in so doing it should allow the states maximum opportunity to find the best ways and to experiment with best ways to reach those goals and protections. As you know, I think in the existing

Affordable Care Act, we have a section 1332, which says essentially, if you don't like the mandates, if you don't like the exchanges, if you want to reorganize all the subsidies, go ahead, providing you maintain certain protections of financial and other four individuals. So we have actually within the Affordable Care Act now an enormous opportunity to have wide variation and experimentation at the state level. The Obama administration was both slow and narrow in giving any kind of interpretation of that section, but a Trump administration, actually at the stroke of a pen, could significantly widen what states can do in this area. And I think it's very important to encourage states to take use of this provision. Also to interpret it if I can use the term more liberally in terms of allowing the budget neutrality, for example, to be available across programs rather than narrowly within programs, which is what the administration argued. That means that you can start looking at combining or looking at Medicaid and the subsidies and so on together and figuring out what is the best way to get people covered and to deal with some of the adverse selection issues. So I think there's enormous opportunities in that.

The third area I would just say very quickly in wrap up is to say we've got to do a much better job at allowing states to learn from each other. This very project that we're talking about this morning in terms of looking to states is one step to do that and that's important. Kaiser Family Foundation helps us as well. The National Governors Association and its central best practices is looking at what's going on in the states. But we've got to do a lot more to allow a learning process between the states so that if we give opportunity for experimentation, then we really can learn from each other more effectively.

So I think there are things that the federal government can do, even within the existing legislative framework, let alone changing it in the future, and we need to make maximum use of that.

MS. RIVLIN: Stuart, can I ask you just to respond a little bit more explicitly to Linda, because she made the point that a lot of these regulations and

narrowings that you worry about spread risk over the sick and the well, which was the objective. Are you buying into all of those protections at the state level? Suppose with this increased flexibility that states said, well, we don't care about the essential benefits?

MR. BUTLER: Well, I think we've got to be very clear about what the protections and what the bottom line is. I think there can be a debate over whether the essential benefits package is both too specific and too large. That's a reasonable debate. My point is that I think that's -- what those general protections would be is an appropriate debate at the federal level and it's a national issue. It's a values question to a large extent. But we ought to allow maximum opportunities for states to figure out how to reach that through essentially a waiver process, which as you know means that it's got to be plausible. There's got to be a clear plan presented for federal governments. Not every state just does whatever it wants. And I think as part of that process you always do have to look at are the protections and requirements that we're putting forward at the national level, are they viable? Are they achievable across the states? That's got to be part of the ongoing conversation it seems to me.

MS. RIVLIN: Cynthia?

MS. COX: Well, I guess I would start by doing a bit of a postmortem on the ACA and what we've learned -- not that the ACA is dead yet, but I think before we can really look forward into what the repeal or the replacement or the repair would be, I think it helps to look back and see, as we've been doing today, what worked, what didn't, and so I would just add some takes that I think go along with what we've already talked about this morning.

But did the Affordable Care Act really fundamentally change the nature of competition in the individual health insurance market? We went from a system where insurers by and large would compete by trying to avoid sick people to one where there's guaranteed issue, guaranteed renewability. But not only that, but consumers now are enabled in a way to shop around for coverage in a way that they never could before, and

in fact, are encouraged to do so by the way the tax credits are structured in the Affordable Care Act. And we heard earlier about how the tax credits are quite complicated, you know, with the second lowest cost silver plan in a given county or rating area. And it is complicated, but at the same time, I think that it did work. I think there is evidence that this structure worked to encourage consumers to be price sensitive and to shop around based on premiums, and that insurers saw quite a bit of incentive to offer a low cost plan. And, in fact, maybe it worked too well because looking back at premiums, in 2014, premiums came in on average nearly 20 percent lower than what the CBO had projected they would be, and at the time that was hailed as a success of the ACA and success of competition in this market. But with 20/20 hindsight, and now knowing that many insurers have lost a lot of money in this market, those premiums were likely too low. And I think the question becomes, you know, was that because the people who signed up were sicker than what insurers had expected? Or was it that they had underpriced, maybe intentionally, to try to pick up market share? And I think it could be both. I think it's maybe a combination of the uncertainty that insurers faced in entering into this newly reformed market and the inability to accurately price early on, but also it was likely because of the tax credit structure that existed in the Affordable Care Act.

And we can look at specific states, especially where premiums came in exceptionally low, to see in many cases this was actually damaging to the market and we've seen significant premium increases in some of those states where premiums came in too low. But even putting aside the premium increases which have been quite large this year, you know, I think there's reason that we knew that premiums would increase in 2017, not only because of inaccurate pricing but also because the reinsurance program was phasing out in 2017 and because 2017 was really the first year that insurers had this accurate data on which they could base their premiums. And so while there's been a lot of concern over the viability of this market, I think that a lot of these issues that we've seen come up around premiums and participation were foreseeable, and in some cases

may be preventable, but at the same time, you know, just looking at the dollar amount of the premiums in 2017, they're really quite similar to what we would have expected 2017 premiums to look like at this point. I think premiums just started out low, stayed flat, and then increased very rapidly in the last couple of years rather than increasing more gradually. And so that gives the appearance of instability or looks very risky from an insurance company's perspective or from a perspective of whether or not this law is working. But at the same time, you know, kind of taking that step back we can see that really, as far as premiums are concerned, the market is maybe where it should have been to begin with.

And what states or the federal government could have done differently maybe to mitigate some of this, you know, we can look at the rate review program. As we've heard also, you know, there is the risk hoarders program was underfunded. Outreach enrollment maybe could have been stronger to get more people in, especially the young and the healthy people, and also states that had implemented transitional policies and did not implement the Medicaid expansion tended to have sicker populations in those states. But I think that if the election had gone a different way, and this maybe goes without saying, but we would likely have a very different conversation today around technical changes to the law, and I think that we can still have those conversations, too.

MS. RIVLIN: But we are where we are.

MS. COX: Yes.

MS. RIVLIN: So the question is what happens as we move ahead and what would best improve competition?

Michele, do you want to talk about this question?

MS. LUECK: Sure. Yeah. Good morning from the Centennial State, and thank you, Alice, for the opportunity here today.

I approached my preparation and homework for this panel a little bit differently, and I went out and talked with three state leaders. And the first person I

talked to was a Senator who is part of the Republican leadership of the Colorado Senate, and I asked him sort of what all this means. And Senator Jack Tate said, "We are doing absolutely nothing. We're taking our cues from Washington. We are in a watchful waiting mode." The very next day they issued a repeal of the exchange, the legislation in the state, so I don't quite know how that adds up.

I talked to the Director of Medicaid who sits in Hickenlooper's cabinet, and she said, "We are moving ahead. We are full of momentum and we are going to be going so strong and so fast and so energetically that there'll be no stopping us when repeal, replace, or repair comes along."

And then I spoke with the lieutenant governor and asked her the same questions. And Donna Lynne shared with me, she goes, "Well, we can go on our merry way. We are going to be the staunch democratic state that we are currently, although we're very purple, but we are led by Democrats." And she said, "But we have to have a plan B in our back hip pockets. We need to be able to file for waivers and sort of turn on a dime when things happen at the state level."

And so when I thought about how I would summarize all this for you, I thought about this being sort of cognitive dissidence, if you will, playing out in Colorado. But the longer I thought about it, I thought of it as just being dissidence. I mean, what's happening on the ground is really very, very hard to report on at this stage.

We are a purple state, and we also characterize ourselves as being an "all in" state on the Affordable Care Act. We expanded Medicaid. We built our own exchange. We applied and won lots of CMMI SIM innovation model grants, and we dabbled at having our own health insurance co-op. And we are very much at the Colorado Health Institute thinking through what it means to reverse all that and become an all-out state. And how that is all transpiring is very hard to tell, at least in Denver.

I thought about the report that's been released today and wanted to share three observations about how it's the same and different than what's happening in

Colorado. And the first sort of hypothesis that the report issues is that health insurance markets are local. And I would suggest that we put a big asterisk next to that and also comment that health insurance markets may be local, but health insurance carriers are certainly not. And we've seen in Colorado three health insurance providers that are local, regional, not-for-profits either go under or are struggling immensely. The co-op was around for about 12 months and then sort of dissolved just about as quickly as it came into existence. Rocky Mountain HMO, which has been in the market for about 50 years, it's a local, regional provider, didn't have the cash reserves at the end of 2016 and was merging now with United Healthcare. And our other regional player is Colorado Access, which comes from a Medicaid history, and that organization has put out two cash calls to its owners in order to come up with the reserves that are necessary to keep it in existence. And so I would really -- I'd like to think about the interplay between the markets and the carriers because it's a very different scenario when you're looking at the carrier environment.

The second observation is that I think that the consumer confusion that was hinted at at the first -- in the first panel cannot be underestimated. In Colorado, consumers did not know where to buy health insurance, and so more people buying on the individual market but off the exchange rather than on the exchange. And they didn't know what to buy. And in Colorado, the bronze plans -- we have the second highest level of bronze plans purchases, and we think that that's an indication that the other shoe will drop when people don't understand that they've only bought a plan that represents 60 percent of actuarial value.

And then finally, my third comment about the report and sort of thinking and casting that into the future, is that affordability continues to be the elephant in the room. In the health insurance premiums in Colorado, it increased last year in 2017 by 20.5 percent, but the range, if you look at these county variation, ranges from 16 to 42 percent. And that's a heavy lift for consumers. And I don't think that we see a lot of

attention paid to how we're going to not just create the shell game of reallocating regional markets or rate so that the cost shift is absorbed by different people at different times, but how do we get to fundamental issues about the true cost drivers within the system is something that I think needs to be reconciled in the extreme makeover. Thanks.

MS. RIVLIN: Thank you. Do you want to give us just another couple of sentences about the true cost drivers? Where would you go with that?

MS. LUECK: Well, we have -- the ski resort communities in Colorado have some of the highest health insurance premiums in the country.

MS. RIVLIN: It's a dangerous thing to do.

MS. LUECK: It is dangerous. Lots of knees need to be replaced, apparently. It is politically unpalatable to subsidize the residents of Aspen and Vail, Colorado, for obvious reasons. And I think that we've played around. CHI was commissioned to do a one geographic rate study, like what if everyone is in the same rates. We've reconfigured the markets a couple of times and I think that just changes frankly, who calls legislators to complain about their rates. And so sometimes the western part of the state is absorbing the cost, and sometimes the eastern part of the state is. But until we think about things like competition and lack of competition in those markets, particularly around hospitals and providers --

MS. RIVLIN: Provider markets.

MS. LUECK: -- it'll be a problem.

MS. RIVLIN: That's certainly been a theme.

Kosali, tell us about Indiana.

MS. SIMON: Yeah. So for Indiana, it is, relative to the five states that have been profiled, close to Michigan, and I'll talk about in what ways it's close and what ways it's different. So both have Republican leadership. Both have been very active in designing state-based solutions to Medicaid, but Indiana has been different in using a federally facilitated marketplace, whereas, Michigan used a partnership model.

So Indian has been especially active in coming up with the Healthy Indiana plan, and so that's a way in which I think we'll talk about how is Indiana different because as was mentioned, the spillovers between how a state approaches Medicaid and then its market.

In terms of carriers, Indiana started out with about as many carriers as we currently have. There was a change in the middle where there was more entry, and then from 2016 to 2017, an exit of some carriers. But in terms of premiums, we started out in 2014 with premiums that were higher than the national average. But we've had slower than nationally average growth, as well as reductions in the benchmark average premiums over those last few years so that currently, Indiana's average plan premiums are actually lower than the national average. So Indiana was in the news in October of last year when 2017 rate increases were announced as having -- the state having three percent of a reduction, whereas nationally there was a 22 percent increase in those benchmark premiums.

So in terms of how many people we've got, we've got a state of about seven million. We've got about 170,000 people in qualified health plans, in the marketplace plans, about 83 percent with subsidies. Not surprising in those kinds of areas. The carriers are present in many of the counties, so most of the counties in Indiana have three or more carriers that are competing. The insurers that left cited profits that were negative and also the risk of reinsurance going away as reasons for exit, although those insurers did stay in the wings as was mentioned because they participate still in the off-exchange market. There are only HMOs as in many markets that are available as choices.

And I'll close by mentioning the other thing that Indiana has been in the news for lately, which is that last week the state filed an extension waiver for the current Healthy Indiana plan, and that went in on January 31st, so there's a 30-day period of public comment and then after that we'll see discussions between the state and CMS.

And that continues many of the features of the current Healthy Indiana plan but then adds on more incentives for healthy behavior, especially smoking cessation and enhanced substance abuse disorder treatment. And the managed care carriers that are operating in the Medicaid plans are also very active in the marketplace plans. And so we can talk more about to what extent is it that the successes of the plan that I've just described where there is still a substantial number of insurers and competition relative to national insurance premiums that are not rising, how does that play with the Medicaid expansion?

MS. RIVLIN: Kosali, tell us a little bit more about Indiana used the waiver -- not the 1332 that Stuart referenced but the original 1115 waiver -- to change its Medicaid plan quite considerably and to emphasize health savings accounts. Right?

MS. SIMON: Yes.

MS. RIVLIN: How has that worked?

MS. SIMON: Enrollment has been pretty high and it has been along the lines of what was projected. So there are about 400,000 people in the Healthy Indiana plan, all except about 40,000 who -- the 40,000 is about how many were in the original Healthy Indiana plan 1.0, which was the basis for the expansion. So projected enrollments came in in line. The reports about the valuations show high customer satisfaction. A lot of people paying into -- as you might recall, there is the two options of the plan, and those two options exist only for those under the poverty level. For those 100 to 138 percent of the federal poverty level, there is only the Plus Plan option. So in one option you pay into the power account which is the HSA and then you get an enhanced set of benefits. You don't pay cost-sharing at the point of service except for inappropriate ER use, but then you make these monthly contributions in.

MS. RIVLIN: And the state made a substantial contribution to the HSA?

MS. SIMON: Exactly. Right. So this is along the lines of the kind of health savings account that some employers offer where a large part of that deductible amount in the HSA is contributed by the employer. So in this case it's the state making

that contribution and then the individual makes a portion, too, up to two percent of family income.

MS. RIVLIN: Good. I would certainly entertain questions back and forth in the panel. But let me start by focusing more on the future and where you think competition -- what you think would best facilitate competition going forward. And there has been in the previous panel a good deal of discussion about the high-risk people and the problem of the end of reinsurance. What would you do about that if you were designing the next round of reform? Would you do high-risk pool? Would you do reinsurance? Would you keep the corridors? What would you do? Linda?

MS. BLUMBERG: I certainly wouldn't do high-risk pools. It takes the highest cost, highest risk individuals out of the pool in order to give them adequate access to the medical care that they need. You would need to infuse huge amounts of federal dollars to make that coverage adequate and affordable for them. And that's not the way the conversation has been going. So the levels that have been proposed for these alternatives are basically not barely a drop in the bucket for what you would need federally in order to make that work.

So I would go a number of routes. I would go -- I would put a permanent reinsured program in but I think recognizing the fact that not all of these markets are being adversely selected against. Some of them surely are. It's very obvious in Alaska. You know, there's various different places where it's really obvious, but not all of them are, and we've seen, you know, premiums that are either very close or below adjusted to comparison for employer-based insurance, which is a very broad pool. So, but I would put something in place that would kick in when it was necessary. I would do a lot more investment --

MS. RIVLIN: And subsidize it?

MS. BLUMBERG: Right. It would be paid for through some broad-based tax, whether the same as it was originally through the ACA on all private insurers

or through general revenues of some sort. But it would only need to kick in when that selection was actually happening.

I would also do much more, as I was alluding to earlier, on outreach and enrollment and increasing financial assistance, because when you bring more enrollees in, you necessarily, you know, will tend to improve the risk pool substantially. And so additional outreach and enrollment assistance investments, more subsidies, fixing the family glitch. Those kinds of things will bring more people in.

And then I think you need to, you know, deal with then the concentration issue of the insurers and the providers separately, but I think those are the big issues that we'll address, the areas where there is selection.

MR. BUTLER: It seems to me that you've got a certain number of tools in the toolbox that you can use dealing with these high-cost people. One is insurance regulation, to say we will charge people more towards the same no matter what their risk is. We know there's all sorts of issues associated with that, with adverse selection.

You've got certain subsidy changes. We can change the structure of subsidies to make it more affordable for people who are higher cost and their premiums more available. That's not easy to do, and you're right that if you use, say, a high-risk pool, which was going to be the third thing I was going to say, you can put people into another group in some way, such as Medicaid, which we heard earlier, in terms of which serves that purpose in some states, actually, or high-risk pool or something else. And then you've got to calibrate what are the subsidies. It's going to cost you more for those people but it's going to cost you correspondingly less for the others.

So I think, you know, you've got several moving parts and we've got to experiment with it. And this keeps bringing me back to the idea; we don't know the right combination. We don't know what will work in very place and at every time. And that's why I think within this toolkit we've got to give states maximum opportunities to kind of deploy these different tools and see what actually happens.

MS. RIVLIN: So that suggests, with respect to risk, that you would, through a waiver process or something, allow states to do with federal money --

MR. BUTLER: That's correct.

MS. RIVLIN: -- to try out various versions.

MR. BUTLER: That's exactly right. And, you know, the 1332 provision does allow a state to use subsidies differently. As I said earlier, if you do that and then you also give much greater opportunity to use Medicaid waivers such as you have in Indiana and allow that to be blended together as a strategy so that the money can be, you know, it's porous between Medicaid and whatever you do to deal with these high-risk people, you've got a whole set of possible options to attempt, to experiment with. You know, I don't know what the right answer is. But I don't think anybody does with certainty. And that's why I think it's important to be as flexible as possible on what a state can try.

MS. COX: I'd say there's probably two ways to answer that question. On one hand, if we are going to have an individual market with guaranteed issue and guaranteed renewability as exists under the ACA, then I think there's reason to believe that the individual market is going to be sicker than the employer market. And part of the reason for that would be that in many cases people who are in the individual market would be too sick to work, but there's also maybe not that incentive for younger, healthier people to come in. And so because there is the sicker market and because healthcare costs are so high, I think you would need to have a heavily subsidized market for that to work, not just subsidies for the people who are signing up, and maybe more broad subsidies that go beyond what's in the ACA to include people who are higher income, but also some sort of cross subsidization for the insurers that are participating in that market through reinsurance. So maybe a permanent reinsurance program as you mentioned would be key to keeping that market functioning.

I think the other way to answer that question is if we're not going to have

guaranteed renewability in the context of these repeal and replace kind of conversations, or guaranteed access where insurers can deny people coverage if they have not had continuous coverage, then for that system to be equitable, then there would need to be some sort of high-risk pool. But for those high-risk pools to work, they need to be adequately funded. And they need to be, again, heavily subsidized for those markets to work and for those markets to be affordable for high-risk people. And I think the question becomes how to pay for that through the tax system if there's not some sort of funding mechanism to finance those high-risk pools.

MS. LUECK: Alice, I would say on the political side there's a lot of appetite and interest, at least in Colorado, on these high-risk pools, and I don't know what makes them sort of politically more feasible than other alternatives, but --

MS. RIVLIN: They sound nice.

MS. LUECK: They sound nice. And the irony for the institute where I am is that we were involved in the dismantling of the high-risk pool about three years ago and now we're being commissioned to do studies about how this might come back into existence.

And I would also share that I think that provider competition is something that we should also look at as bringing change to the marketplace as well. So Kaiser is driving up a specific corridor, highway corridor in Colorado, and that's really changing their driving town provider, both physician and hospital rates in those markets. So I think that the report indicates that this sort of balancing or encouragement of competition is something we should look at more extensively.

MS. RIVLIN: Why is that happening? I mean, the history of Kaiser over many years was it did very well in California, not very well other places.

MS. LUECK: Right.

MS. RIVLIN: Why is it doing so well in Colorado now?

MS. LUECK: Well, I think that it might be that the new lieutenant

governor comes from Kaiser Permanente, so there might be some, you know, the sausage-making element of this. But they also have a commitment to expanding the population and are doing relatively well, except with their Medicaid population in the market, so they have identified this as sort of a deliberate strategy for them moving forward.

MS. RIVLIN: And then other providers have to compete.

MS. LUECK: That's right. So we see others sort of entering that market, but we have seen the rates that are being offered to providers are significantly lower than they have been before.

MS. RIVLIN: Let me pick up on the health savings accounts because Kosali's report of what's happening in Indiana really goes against the stenotype of health savings accounts are fine for rich people but they don't work for lower income people. And you're saying this experiment is actually working and it has satisfaction levels that are high.

MS. SIMON: Let me clarify that. It's a health savings account in the sense that there is a contribution towards it, but it also can be thought of as a premium payment because you pay in an amount and then the rest is paid by the state. And that characterizes the model of a state that has a premium contribution. So it's using that terminology but it doesn't mean that you are exposed to a very high level of exposure the way you would in an employer health savings account to which your employer doesn't give the whole deductible. So IU, Indiana University, has a high deductible plan, but we are given the entire deductible. So this is common in the state but it's maybe not what you would think of as health savings accounts more broadly.

MS. RIVLIN: So then how dies to fit though with the image of a health savings account however financed forces the consumer to shop around for -- among providers? It doesn't really do that.

MS. SIMON: Yeah, because the amount of the contribution that is paid

in by an individual, so at the lowest level of income you are putting in a dollar a month into the health savings account. And then everything above that is going to be paid by the state. So that looks also like just a plan where you just have to make that contribution in. It doesn't mean that you've got a lot that you will gain or lose. There is the rollover provision if you don't use any -- if you only use preventive care, then you get to rollover a lot of that contribution, and just recently, there are some statistics on how much that rollover happened. I think it was something like 60 percent of enrollees had something to roll over. But that, I think, makes it very different from the kind of health savings accounts where because individuals have to be responsible for the first $5,000 of health care, they have a lot of need to compare prices.

MS. SIMON: Can I jump in on --

MS. RIVLIN: Yes, do that, and then I want to throw it open to audience questions.

MS. SIMON: Great. I just want to mention on the ways in which savings could occur in the future. It's striking to me that we're not hearing a story of there's one national insurer that has figured it all out. It seems like the identity of the insurer that seems most successful is really region-specific and it goes to everything is local. So to the extent that insurers learn from these successful insurers what is it they're doing, I think there's a lot to be learned.

MS. RIVLIN: So questions? Right here. Wait for the microphone. And as usual, a short question.

SPEAKER: Sure. I'm a little surprised not to hear anything about the small business or large employer markets in the future of this. And likewise, can you all comment on the possibility of ending the employer tax subsidy? Maybe I'm using the wrong word, but can any of you talk about that in this context of the future of the ACA?

MS. RIVLIN: Stuart?

MR. BUTLER: I think the parameter we used, I think all of us, was what

is likely given the circumstance right now. And I think given the bipartisan opposition to the Cadillac tax, for example, on high-cost plans, even though I personally think we ought to be going much more towards eliminating the tax exclusion and essentially using that funding for a direct tax system, I don't think it's in the cards anytime soon. So in that sense I think it's not -- I mean, I don't know. It's possible within the discussion of tax return but it seems unlikely to me that we would go in that direction. I don't think that's a good thing. I just think that that's the reality that we're dealing with.

MS. RIVLIN: That's a missed opportunity in my opinion that Republicans have favored the capping of the exclusion in the past.

MR. BUTLER: That's correct.

MS. RIVLIN: The Democrats failed to pick it up.

Yes, certain.

MS. LUECK: One more thing on the tax exclusion. I mean, we've done a lot of analysis that shows that the distributional effects of the tax exclusion are mostly the same as the Cadillac tax, and I don't mind that as a way to be financing healthcare reform. I think the issue is if you start to unravel the tax exclusion quickly and you then start to unravel the employer-based insurance market and you have -- which is something that seems to be underlying some of the intent of these alternatives, and you still have all of the problems that I was talking about about risk segmentation in the nongroup market and you don't have protections, you don't have more pooling; you just have more people potentially in a bad situation when they get sick. And so if you're going to unravel the employer-based insurance market, you better have in place a broad-based system of pooling that allows people to get affordable access to adequate coverage or you're just victimizing more people as you go along.

MR. BUTLER: Can I just ask you something on that regard though? I agree with that. Unraveling, of course, suggests a chaos, which is not what any of us want to see. But wouldn't you agree that in general over time you'd want to see small

employers, people who move from employer to employer frequently, you'd want them really more and more in a broad state market, a broader market, than being tied to the employer-based system.

MS. LUECK: I don't have any disagreement with that, but it depends on what the nongroup market looks like.

MR. BUTLER: I agree with that. I sure wouldn't risk that now, and I wouldn't risk that under any of these alternative proposals that have been floated. I mean, we were talking about that with regard to eventually under the Affordable Care Act you could get there but none of us felt like even when we were having this conversation, that even under the reforms that pool risk more broadly under the ACA, that those markets were stable enough at this point to risk that. You really have to have a good, stable, adequate, accessible market for these people to move into in order to make that an option.

MR. BUTLER: I agree with that.

MS. RIVLIN: In the back. Yes.

MR. POSER: Yeah, Carl Poser.

I think to really examine this question, also in the context of state flexibility, you need to really step back and look at the architecture of the Affordable Care Act and ERISA, the Employee Retirement and Income Security Act that regulates employer-provided coverage, and it creates a very powerful federal preemption that has kept states hands-off of employee benefit plans. When that law was started in 1974, all the employer -- employers provide most of the coverage and they have the best risk pool. Natural selection. All their lives virtually were fully insured and under state regulation. The employees figured out they can come out of state regulation by self-insuring, and now most large employers and most of the lives are out of state regulation. So a state is going to come and ask for a waiver. Can we get our arms around the whole employment base population? But that's politically going to be very hard because the employer

lobbyists have always resisted that. In fact, one of the reasons why they put the preemption in in 1974 was I think Hawaii was considering universal coverage at the state level and they wanted to block it. So that's a critical issue. It's come back again.

MS. RIVLIN: Yes? Just a minute.

SPEAKER: The future of insurance companies will be based on their health, pun intended. And their health is based upon managing their risk profile better. And MACRA, under the value-based contracting has provided a basis for that, and some of the early indications from some of the insurance companies that are using value-based contracting is that there are positive results, not just on race but on healthy outcomes of patients. And I would add to that the ACO, Accountable Care Organization. So how might those be used within the insurance industries to promote this work, irrespective of what goes on with any replacement of the ACA?

MS. RIVLIN: Does anybody want to respond to that? We have not focused on payment reform in this panel, though I would suspect everybody is for it and for moving ahead with it faster. And, but it can't be entirely divorced from this conversation about coverage.

MS. COX: I mean, I would say that I think it's really important to have the right incentives in the market in place in order to promote the innovation that you're seeing with payment reform. If the insurers have no interest in managing care effectively because they're going back to selecting the best risk, then you lose the incentive for the ACOs and the other types of management. You really need good economic competition incentives in order for that to continue to develop, I think.

MS. RIVLIN: Great. We can take one more and then we will run out of time. Yes?

MR. BULLOCK: Bob Bullock from the Rockefeller Institute.

Stuart, you had talked, and I think you're absolutely on point here about the importance for the federal government and they're trying to repair, not repeal and

replace, to not try to do too much, and yet now we have a president who has come out and said we're going to create a healthcare system that's going to do everything and it's going to do it more cheaply. If you're one of the Republican architects who's already working behind closed doors to try to come up with something, what kind of political calculus can you engage in to try to roll out something that's reasonable without looking like you're walking away from your party's standard-bearer?

MR. BUTLER: Did you ask me if I am one of the architects?

MS. RIVLIN: If you were.

MR. BULLOCK: If you were.

MR. BUTLER: Oh, if I were. Well, I've written on this just very recently and said if I were it would be very much kind of go very slowly. And I think if you think about the general challenge of trying to redesign this, not just technically, but politically, how you can square all the campaign promises, I mean, I don't know the solution to that. I think it's an impossible puzzle to try to solve.

But that said, it seems to me that politically what makes sense is to make, first of all, maximum use of what is in the existing wall, to begin to start going down. That's why I think 1372 is really important. It's in the law. It allows lots of experimentation. That then allows a lot of things to be tried out at the state level. It would give the federal government a sense of where the states are going if they're given this opportunity and what is needed at the federal level.

And so I'm a conservative in the sense of saying, you know, I'm not a radical. I don't think that making big change quickly is the solution either to creating a system or trying to repair or revise it. So I think using existing laws, interpreting the existing law as broadly as possible to allow change. And then, you know, trying to tackle some of the issues, like the Cadillac tax, trying to hold the line on that, although I suspect that's not going to happen in the administration. But trying to do things like that to at least get the basic incentives, you know, the best you can given the political pressures as well

as with the technical challenge we have to face. I think that's kind of all you can do at this point to have a chance of being successful. I think big change right now is almost certain to be wrong, not just technically, but politically. And that's why I think going slowly is really important. So 2018, that's what the president just said. Maybe we'll roll over to the next year. I don't know if he heard me or whatever.

MS. RIVLIN: Well, that may be a good note to end on because I do think that the idea that this is a complicated interrelated set of things and can't be blow up suddenly has come across as it did not in the campaign, and we can hope for a serious effort to work on these problems.

Let me thank you all for coming. And one more hope for this immediate future is that you will pick up your trash and carry it out. Otherwise, we will have to do that.

MR. BUTLER: Alice has to do it all.

MS. RIVLIN: Thank you for coming, and join me in thanking this wonderful panel.

(Applause)

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