THE BROOKINGS INSTITUTION
FALK AUDITORIUM

WHAT'S AHEAD FOR THE INDIVIDUAL HEALTH INSURANCE MARKET?

Washington, D.C.
Tuesday, March 6, 2018

Introduction:

DAVID WESSEL
Senior Fellow, Economic Studies, and Director, Hutchins Center
The Brookings Institution

Presentation:

MATTHEW FIEDLER
Fellow, USC-Brookings Schaeffer Initiative for Health Policy

Moderator:

LOUISE SHEINER
Senior Fellow, Economic Studies, and Policy Director, Hutchins Center
The Brookings Institution

Panelists:

JAMES C. CAPRETTA
Fellow and Milton Friedman Chair, Health Care Policy
American Enterprise Institute

SABRINA CORLETTE
Research Professor, Center on Health Insurance Reforms
Georgetown University

MATTHEW FIEDLER
Fellow, USC-Brookings Schaeffer Initiative for Health Policy

PAT GERAGHTY
Chief Executive Officer
Florida Blue

KEVIN PATTERSON
Chief Executive Officer
Connect for Health Colorado

* * * * *

PROCEEDINGS

MR. WESSEL: Hi. Good morning. And welcome. I'm David Wessel. I'm Director of the Hutchins Center on Fiscal Monetary Policy here at Brookings. And on behalf of my Center and the USC Brookings-Schaeffer Initiative on Health Policy, I want to welcome you to our event today on: The Status of the Affordable Care Act.

A number of people may be joining us online, so if you fall asleep you may find yourself on TV. That's a fair warning. (Laughter) But I'm sure you won't because Louise is going to keep it lively.

The Affordable Care Act, as you many of you know, was passed in March 2010 with the primary goal of expanding the number of Americans with health insurance, partly through expanding Medicaid, and partly through creating marketplaces or exchanges for people to buy individual policies, people who don't have insurance through work, or through government programs, and in order to make the policies affordable, a set of subsidies was put in place.

Although the ACA actually embraced some ideas that have come from Republicans, our own Stuart Butler, formerly of the Heritage Foundation, now here, had been involved in some early designs. It was partisan right from the start, and Republicans have begun to dismantle parts of it, particularly by repealing the individual mandate and relaxing some of the standards on policies the insurance companies can offer.

Now, I'm pretty much convinced that many Americans don't have a clue what the ACA is. Some of them probably think it has been fully repealed. For what it's worth, the latest Pew Research survey in December found, for the first time, more Americans said the a ACA had a positive effect than a negative effect, although when you look beneath the numbers it was very partisan.

It seems if you're Democrat you think it was great for America, and if

you're a Republican you don't. Interestingly that half the people said the ACA hadn't had much effect on their families, and of those who said it had had in effect, they are evenly split between people who said it was positive and negative.

So, our attempt today is to shed some light, some facts, some dispassionate analysis on the controversy over the ACA, and particularly the status of the individual markets. The ACA may be wounded, but it is not dead. About 16 million Americans are buying individual insurance policies today, more than half of them on the exchanges. And that's what we are here to learn more about.

What the state of the market for individual health insurance? What has transpired in that marketplace since Congress and the Trump administration began to try and roll it back? And where are we going?

A moment about the plan for the program; we are going to start with a presentation by my colleague Matthew Fiedler. Matt is a Fellow here in the Center for Health Policy, before he joined Brookings in the beginning of 2017 he was at the Council of Economic Advisers as a Chief Economist where he worked a lot on health policy issues. Matt has a PhD in economics from Harvard, and a B.A. in math and economics from Swarthmore. After his presentation we'll have some slides, and they'll be on their website, if they are not already.

My colleague, Louise Sheiner, will moderate a panel. She'll introduce the individuals later, but it includes a health insurance company CEO, the Head of a state exchange, and three researchers with expertise but different viewpoints on the state of the individual market.

I do want to note that we invited a Trump administration official to participate and, unfortunately, he declined, so they are here in absentia.

Again, remember this is being webcast, and if you feel the urge to tweet about it, the hashtag is *TheFutureOfTheACA*. Matt?

MR. FIEDLER: So, thanks David. In the 15 minutes before we get to the panel, my goal is to just provide some sort of baseline facts and an overview of, you know, what's happening in the market and where we are potentially headed. So, do a quick refresher on what the ACA did, and where that left the individual market as we entered 2017. What the Trump administration has changed since the beginning of 2017, and what that's likely to mean for the future of the market.

So, just as a quick refresher, what did the ACA do? David did a little bit of this, but one of the main goals of the ACA was to expand insurance coverage: did that in two main ways, one was giving States the option to expand their Medicaid programs to more low-income adults; the main focus today will be the ACA's changes to the individual market which had three main pieces.

A set of regulatory changes barring insurers from denying coverage or varying coverage terms based on health status, and the requirement that insurance plans on the individual market meet various benefit standards, both in respect to what they cover in cost sharing. Subsidies to reduce premium and cost-sharing, premiums and cost-sharing for low and moderate income people, and then of course the ACA included an individual mandate.

The combined effect of these various policies was to sharply reduce the number of people without health insurance in the United States after 2013, and by 2016 the share of people without health insurance had fallen to about 9 percent.

About one-third of that overall increase in insurance coverage, after 2013, can be accounted for by an increase in enrollment in the individual market, the individual market enrolment rose from around 11 million people pre-ACA, to somewhat more than 17 million people by 2015 and 2016. Now, while enrollment in the individual market had expanded considerably by 2016, we also know that the market had clearly not fully adjusted to the changes in the institutional environment made by the ACA by

2016.

As we enter 2017 we saw substantial increases in individual market premiums averaging more than 20 percent nationwide, we also saw a significant number of insurers withdraw from the individual market, as reflected in the light-blue line here, showing that the number of enrollees, who had three or more plans to choose from, fell from about 80, more than 80 percent in 2016 to less than 60 percent by 2017.

So what was going on? I think the main driver of the disruption we saw from 2016 into 2017, this was not a profitable business for insurers over the first few years in which it was in existence. As you can see from comparing the dark blue line which shows insurers total per enrollee cost, to the darker-green line that shows their total per enrollee revenue. I'm sure we are incurring losses on average nationwide of probably about 6 percent in 2014 and broadly on the order of 10 percent of revenue in 2015 and 2016.

So, you know, what was going on here? I think it's not terribly surprising that insurers would have incurred some losses in the early years of the new market, the various reforms that the ACA put in place changed substantially who was in the individual market, both in terms of their health status mix, but also in terms of their income mix, predicting what average claims cost was potentially challenging. And so it's not necessarily surprising that insurers would miss, to some degree, in one direction or the other.

Whatever the reason for why these losses were incurred over the first three years of the market, we saw that substantial pricing correction in 2017. We don't yet have complete data for 2017, but based on the fragmentary data we do have, my best estimate is insurers will probably break even or slightly profitable, on average, in the ACA compliant market during 2017, reflecting that sharp increase in premium revenue, and relatively subdued growth in claims costs.

Now, that slow growth and claims costs during 2017 may be somewhat surprising in light of the stories that we were hearing from 2016 into 2017. You'll remember that there were concerns that the increases in premiums would cause large reductions in individual market enrollment, particularly among healthy people, so average per enrollee claims costs in the market would rise substantially.

That didn't happen, and I think it's instructive to think a little bit about why that didn't happen. I think the most important factor is that about three-fifths of enrollees in the individual market writ large received tax credits under the ACA. Those tax credits are structured so that when premiums rise the tax credit rises dollar-for-dollar, and so enrollees net premiums don't change.

For the other four-fifths of the market the data we have indicate there has been some attrition after -- during 2017, but at least from what we would have expected based on prior evidence, and it seems broadly consistent with the data we have today, that attrition has not been nearly severe enough that it would have caused a large increase in average claims cost in the individual market.

Indeed, if you put together sort of everything we know about how many people are subsidized, and how responsive we would have expected the unsubsidized population to be to higher premiums, we would only have expected that premium change to create maybe 1 to 2 percent of upward pressure on average claims cost in the individual market.

So, the bottom line is, you know, by the time we got to 2017, it looked like insurers had found a roughly sustainable price point in the individual market, probably varied from geography to geography, and insurer to insurer whether, in fact, they had found that price point, but the market as a whole was in the ballpark and headed towards an equilibrium.

There are obviously -- on the road to that equilibrium, we have seen

some substantial policy changes since the beginning of 2017, and so over the rest of my talk that's what I want to focus on.

I'm going to focus on three: the Trump administration's decision to end cost-sharing reduction payments, to repeal the individual mandate, and the tax legislation enacted at the end of last year, and the Trump administration's recent proposal to expand short-term plans.

I want to be clear that these are not the only three changes, policy changes towards the individual market that have happened since the Trump administration took office, but they are the three that I think are going to have the largest impacts. So in our limited time they are the three I want to focus on.

So, starting with the end of CSR payments, just a quick refresher on the structure of the cost-sharing reduction, or the CSR Program, insurers under the ACA are legally required to reduce cost-sharing for people with incomes below 250 percent of the poverty line, who purchase silver plans on the marketplace. So, that's through Healthcare.gov, or through estate-based exchange, rather than directly from an insurer.

The the federal government is then required to compensate insurers for the cost of providing that reduced cost sharing. Those payments were occurring until the Trump administration ended them in the in October of 2017 citing a lack of appropriations authority.

Now, with those cost-sharing reduction payments gone, the cost to an insurer of offering a silver plan is now substantially higher, and then so insurers' incentive is to raise premiums for those silver plans, but not necessarily for other plan types where cost-sharing reduction payments were not previously available.

In most states insurance regulators permitted this approach of so-called "silver loading" raising prices only for silver plans, or in many cases actively coordinated that outcome. The upshot is that, you know, in about, roughly, 9 in 10 enrollees live in

states where all insurers pursued this type of silver loading strategy. And about 7 in 10 enrollees are in states where premiums only rose for on-Marketplace silver plans. Again, those purchased through the exchange rather than directly from an insurer.

The silver-loading strategy has had some counterintuitive effects, so recall that the structure of the tax credit on the ACA is that it's based on the cost that the second lowest cost over our benchmark plan. So, when silver premiums rose, that meant the tax credit rose dollar-for-dollar.

If you are in a silver plan that means -- and eligible for subsidies, that meant that this was roughly a wash for you, your premium rose, but your tax credit rose. But if you were in a bronze or a gold plan, your bronze or gold premiums didn't rise because of the cost-sharing reduction cut off in most states, but the tax credit still rose along with the silver premium.

So, premiums for bronze and gold plans, for consumers eligible for subsidies often fell. That created two groups of winners, first with people who were buying bronze and gold plans before, but a second group of potential winners are people in silver plans with incomes between 200 and 400 percent of the poverty line. Because bronze and gold plans are now cheaper they potentially have the option to switch out of a silver plan they may be purchasing now towards a bronze or a gold plan, and potentially get a better deal as a result.

The number of people in these two categories is fairly substantial, so around one in three marketplace enrollees are either in that -- were already buying bronze and gold in 2017, or are in a silver plan, with incomes between 200 and 400 percent of the poverty line.

On the other hand, unsubsidized enrollees are largely, though not entirely unaffected, most unsubsidized enrollees are either purchasing coverage outside the marketplace directly from an insurer, or they are purchasing non-silver plans, so in

states that only -- where premiums only rose for on-Marketplace silver plans, they are just immediately unaffected.

Many other silver plan enrollees, even if they're purchasing an on-Marketplace silver plan, they have the option to switch and purchase an off-Marketplace silver plan, in many cases a very similar plan from the same issuer. So, this change -- this transition involves some significant hassle costs for them, but at least in most states didn't necessarily substantially reduce their actual coverage options.

Now, the flip side of the fact that subsidized enrollees are doing better is that the federal government is going to spend more. There's no magic here. In most cases if you want to improve affordability for consumers somebody else is going to be paying more for that.

So there's a certain irony in the outcome here. I don't think the Trump administration, when it ended the cost-sharing reduction payment was aiming to increase affordability for some subsidized consumers by spending more, but that's the outcome.

The flip side of that is, I think, you know, many Democrats who were, potentially, interested in spending more on subsidies in order to increase affordability, can be reasonably happy with this outcome.

The individual mandate: so the individual mandate will go away effective at the start of 2019, as a result of tax legislation enacted at the end of last year. As a qualitative manner, we have a pretty good sense of what the effects of this will be. Some people will drop their coverage, and we expect the people who drop their coverage to be healthier than average.

In terms of how we should think about that, I think we can think about two groups of people. One is the people dropping coverage themselves, those people are making a judgment that they perceive the benefits of insurance coverage to be lower than the cost of that coverage, so they're at least, potentially, better off.

Now that argument assumes that that compares that weighing of costs and benefits is fully rational, and I think particularly in the context of health insurance, there's some reason to question whether, in fact, decisions in that area are fully rational. But at least, in principle, these people could be winners.

The flip side of that though, it's the other people in the health care system. When healthier people leave the individual market, premiums in the individual market have to rise, so if you're somebody who's still purchasing coverage in the individual market and purchasing that coverage without a subsidy these are generally sicker people on average, you are going to pay more for that coverage.

Likewise, some of the people who drop coverage are still going to get sick, they're going to show up, you know, they're going to show up at hospitals, and in many cases still receive care but not be able to pay for that care. So, some of the incidents of those individuals' decision to drop coverage will end up on health care providers.

In terms of the precise magnitude of the removal of the mandate, I think that's considerably more uncertain CBO's estimate was that 13 million people -- fewer people in the aggregate would be covered in the long run, and as a result of repealing the mandate, about five million of those people are coming out of the individual market resulting in about a 10 percent premium increase in the individual market.

Surveys where you ask people: what do you plan to do if the individual mandate went away, generally, suggests somewhat smaller effects, but still meaningful effects on insurance coverage.

Just one other piece of evidence that leads me to believe that to repeal the mandate will indeed have a meaningful effect on the number of people with coverage, is the fact that the uninsured rate dropped -- fell fairly sharply among people with incomes above percent of the poverty line from 2013 through 2016.

So, remember that these people were not eligible for the ACA subsidies, so that can't be driving the increase in insurance coverage in this group, rather, I think the most -- there are a few potential explanations, but I think the most plausible explanation is that the mandate was affecting coverage decisions in this group. That leads me to believe that both in this group, and other income groups, repealing the mandate is likely to lead some number of people to drop out of the insurance market.

So, just as the final policy I want to touch on, is the Trump administration's role expanding the availability of short-term plans. So, these so-called short-term, limited duration plans, the reason they matter is that they are exempt from all insurance market regulations implemented by the ACA.

They can vary premiums based health status, they can deny coverage based on health status, they don't have to cover the essential health benefits, and they don't have to -- they don't have to provide the various protections against cost-sharing that ACA plans are required to provide.

Given how different the regulatory environment, for these plans are, it's really important, you know, what the definition of a short-term limited duration plan is. That term was actually never defined in statute, and so it's been defined in regulation.

The current rule is that a short-term limited duration plan is a plan that lasts no more than three months and can't be renewed. The Trump administration's new proposal is that a short-term limited duration plan could be a plan that lasts no more than 12 months with a possibility of renewal.

This is a fairly expansive definition, so I think what we are really talking about, if we the Trump administration proposal goes forward is creating a full parallel, non-compliant market. We can think about that having a few different types of effects.

For many healthy enrollees these short-term plans are going to look more attractive, because they can be offered a premium that's consistent with their better

health status, they'll often pay a lower premium, and if they're not eligible for a large subsidy that means they're likely to leave the ACA compliant market, and shift into these short-term plans. That will raise premiums in the compliant market, raising costs for unsubsidized enrollees who remain in the market and potentially raising costs for the federal government.

It's also the case that these short-term plans will likely provide somewhat less comprehensive coverage on average, given the lack of the various regulatory requirements, and the lack of risk adjustment in the short-term market.

The flip side of that, and what many advocates for this policy, the case they make, is that because these plans are cheaper they may lure some healthier individuals out of the uninsured population into short-term plans. How you are going to feel about this policy depends on how you trade-off these costs of pulling people out of the compliant market against the potential benefits of pulling people out of the insured -- uninsured population. I tend to believe that the costs here are going to outweigh the benefits, but this is the basic trade-off

So, just to wrap up, taking all of these policy changes together: what do we expect the market to look like going forward? The market will survive, and will find a new equilibrium. And I think the most important reason for that is that you have a large population of individuals who are eligible for very generous subsidies that rise as premiums rise.

So, even as premiums rise, and even with the availability of short term plans, they are still going to find it attractive to remain in the ACA-compliant market, and that will have a powerful stabilizing effect on the risk pool.

That's not to say that it will be all rainbows and sunshine. I think forecasting exactly what the risk pool is likely to look like after these changes to take effect, is hard, and that's going to mean that pricing for this market is harder than various

ways. That will probably lead to bumps along the way.

So, I think the bigger question is not, will the market survive, but what will the new equilibrium of this market be, and what how will it compare to the equilibrium that we are on our way to prior to these policy changes?

At a high level I think we are looking at fewer people covered, particularly adjusted for quality. So we are going to have some people in these short-term plans that may report being covered but have less comprehensive coverage than they did before.

We are likely to have less pooling of risk between healthier and sicker people, both the removal of the mandate and the short-term plan rule will have the effect, in many cases, of shifting costs from healthier people on to sicker people.

And then the final effect is that some subsidized enrollees, because of the end of the CSR payments will pay lower premiums. That will, in terms of overall effects on the market partially offset I think some of the effects on the risk pool and enrollment that come from fewer people -- from the repeal of the mandate and the short-term plan rule, but will likely not be sufficient to do so.

So, with that overview, I look forward to the discussion. (Applause)

MS. SHEINER: Hi. I'm Louise Sheiner, here at the Hutchins Center. And I'm very pleased to be moderating this panel, which I think should be very, very interesting.

Let me just briefly introduce all the panelists. So, Matt you've already met, David introduced him. My colleague here, Jim Capretta is a Resident Fellow, and holds the Milton Friedman Chair at AEI, next door, the American Enterprise Institute, and he's been studying health care for a very long time.

Similarly, Sabrina Corlette, she's a Lawyer and a Research Professor at the Center on Health Insurance Reforms, at Georgetown University's Health Policy Institute, and she also has been studying health insurance for a long time, and is very

aware of what's going on in all the states, which should be very interesting.

Patrick Geraghty, is Chief Executive Officer of Florida Blue, so he's our insurer representative. And prior to joining Florida Blue, he was president and CEO of Blue Cross Blue Shield of Minnesota.

And finally, Kevin Patterson, on my right, is Chief Executive Officer of Connect for Health Colorado, so Colorado's Health Exchange; and you have a long public service in Colorado in many areas of government. Okay. Thank you.

So, what we are going to do is basically kind of get different perspectives from the stuff Matt presented and then also go a little bit beyond it.

So, let me just start off with a question from the panel. So, Matt basically said, look, we saw a lot of turmoil, and people were worried about death spirals, and that the whole thing was falling apart, people were talking about in the ACA before 2017, before the recent changes, but he doesn't think that's right. That basically he thought the market, you know, had some rocky adjustment because no one really knew what the premiums should be, that they underpriced premiums on average, so premiums were going up, that had some effect on subsidies, but basically we were heading towards sort of a stable equilibrium.

Does everybody agree with that assessment of where we were before 2017? Or does anybody disagree? Let's put it that way.

MR. CAPRETTA: Well, I disagreed with one characterization, and I'm not sure if Matt said it, but just in your implication there, which is that, why were the premiums low relative to costs in the early years? I think some of it was of course uncertainty about how to price the market, I think some of it was, they were kind of beaten up by the administration and other people to be -- come in low to make market as attractive as possible.

So, there was a lot of pressure to come in with premiums that were

quote/unquote "affordable" and they underpriced the market by quite a bit.

MS. SHEINER: But do you think we were on the way to, kind of some -- a new equilibrium to make the price sustainable?

MR. CAPRETTA: Gee, I do think that, I think the characterization that the market was headed toward a death spiral prior to 2017 rolling around was not true, I think there's enough -- to be candid, enough money flowing in the system to prop it up no matter what. So, no matter what the premiums are, the subsidy structure is set up so that it really doesn't affect the main cohort of the consuming population, so they are going to be enrolled, essentially, regardless of what the premiums are.

And so there, by definition, you have, you know, probably seven, eight or nine million people who are going to always be enrolled, because their premiums are capped.

MS. CORLETTE: Yeah, I would generally agree with Matt that the market was starting to stabilize 2016 going into 2017. I do think that, just to drill down a little deeper, it's important to recognize that not all insurers approached the market in the same way going into 2014 and beyond, and not all of them faired the same.

So, for example we saw a number of major national commercial insurers fall flat on their face, whereas a number of former Medicaid-only plans that really focused in on that population between like 100 and 250 do very well, and in fact decide to expand their presence.

So, I think it's important to look at averages, of course, but also to drill down and look at the experience of different insurers. And this was a market figuring itself out, right. So, some insurers figured out a great formula that worked for them, and others really struggled, some dropped out, and some changed what they were doing in response to the market. So, I'll just pause there.

MR. GERAGHTY: So, let me follow on that and just say, for context,

Florida Blue now has about 1.2 million people in our individual markets. So, we are the largest single-state ACA player in the country, and we have been operating in the black since the very beginning of the plan.

So, we weren't a Medicaid player, although some of the Medicaid players have done well, and we weren't one of the nationals who came and went in our state.

Our view of the ACA was that it was far from perfect, it needed improvement, we kept banging our heads against the political process to get improvement, and in fact today it needs to be enhanced, and some of the things that Matt pointed out, I would not characterize as enhancements, but things that are going to undermine the ACA and its stability going forward.

But as of this moment, in a period of time with a 45-day enrollment period, we enrolled more people than we ever have.

MR. PATTERSON: So, I think there's a couple of things that we just haven't talked about; I think it is true, and Sabrina was getting there, that the individual market is just very different than the group market, and I think there are some plans that understood that difference and their model kind of worked with it, and I think Pat is talking exactly to how they approach it, in a way that the individual market is something that does make sense for their particular model.

But I also think that we had underestimated the pent-up demand for service in folks that just hadn't been able to get coverage before, and I think that's a big wild card in this whole conversation that we just haven't brought up. So, I think that's a big piece of this as well.

MS. SHEINER: Now, let's move on to the cost-sharing reduction payment. So, I think a lot of us were very worried that the ending of cost-sharing reduction payment was going to be kind of disastrous for the market, and turned out not to be the case. And now I think there's some disagreement about whether or not we

should pursue, you know, legislatively whether or not we should just stick with what we have now, or should we go for some of the legislation that says, no, let's actually fund this thing.

So, do you think it's true that somehow just they were -- that it was sort of seamless, almost seamless? Or how rocky was that ending of cost-sharing reduction? And sort of do you think that it's now sustainable as it is?

MR. PATTERSON: Seamless, okay. (Laughter) Okay. That's not -- yeah it's not the way I would characterize that. So, we were one of the states that did not silver load, we had talked to our friends at our Division of Insurance about what to do for CSRs, we had two sets of rates, we had loaded the rate without cost share reduction.

And then one Thursday night I'm in New Mexico with a number of my colleagues, all our phones began blowing up because we figured out we had to really refile, we had to just set up our entire exchange all again, and we did that in two working days. So, I'm really proud of my staff.

So, I think what we -- though, all we really did was we just shifted the cost of who is paying. And so is it going to be through the CSR, the Feds or, you know, you just put it across the rate at the state level? That ended up what we did, and it's really about, it just got more money into the system, it was just a shift of who paid.

MS. SHEINER: So, all of your rates went up, as opposed to just the silver plan?

MR. PATTERSON: Yes. And what was interesting is, it was only a 6 percentage point change, and so I think our carrier's kind of figured out, we don't think it's going to get funded, so they had already kind of baked most of that into their rate.

MR. GERAGHTY: So, would say to you what happened and what will happen going forward really varies based on where you are and what was going on in your state, because in our state we were able to put the pricing on the silver plan on the

exchange, and allow people to be off exchange in silver plans. So, those folks who are unsubsidized were protected, the folks that were in the silver plans the loading effect happened, for us it was about 31 percent, and that ends up coming back to you in a premium subsidy.

So it was probably not the intended impact from a spending at the federal level, but in fact it does create the offset, but it's a mixed bag. In 2017, in the fourth quarter, I find out I'm not being -- getting the cost share reduction, it cost us $200 million dollars in the fourth quarter, so create a business plan, and have 200 million of your revenue pulled from you with three months to go in the year, it's a big surprise. So, that's a disruption, and in fact I think unfair.

So there's multiple effects of this happening. As we go forward, because of the way our state is lined up I really don't need a cost share reduction to return to the market in Florida, but other insurers in other states have different circumstances.

So, there isn't one vanilla fix that will be the right policy going forward. I think you're going to have to allow for some state flexibility based on the rules in that state.

MS. CORLETTE: Yeah, I would -- I'm glad we have an issuer at the table who can speak to how disruptive that policy decision was last fall, and it wasn't just disruptive for the carriers I think it was incredibly disruptive for state regulators, state exchanges, as Kevin alluded. And the role of the state I think was really important.

At the end of the day we did see a majority, a vast majority of states pursue the silver loading strategy to essentially maximize the tax credit, and hold people as harmless as they could, but that wasn't the case everywhere. And some states were, instead of requiring it across the board, they were more permissive.

So, some carriers pursued it, some carriers didn't or they loaded up different model levels in different ways which can lead to some gaming of the market, so

the role of the state regulator for this is really important.

The second point I would make is, as we look at Congress considering a potential funding of the cost-sharing subsidies, I would say whatever Congress does it should be permanent, because we can't go year-to-year with this kind of uncertainty and disruption. If they do it this year you're going to see a lot of consumer confusion in the fall particularly for people who got goosed-up subsidies to buy gold or bronze, and some sticker shock for consumers.

And so, if they do it that's going to rip off the Band-Aid, but just make it a long-term thing, don't come back every couple of years and try to have this debate all over again.

MR. CAPRETTA: Just a couple of observations about the cost-sharing subsidies, in addition to what's already been said. The first is, I think just for those watching this, you know, what's the dispute. I think it's important to understand the dispute was really about a legal matter, whether or not the Congress had properly provided an appropriation for this or not.

And, you know, this isn't actually not a small matter, so it's not a just a simple question of policy differences I don't think, I think it really is a question of, you know, this may be I'm a little bit old-fashioned, but tidying up these things is kind of important.

You know, did the Congress provide an appropriation for this funding or not? I think on balance, the legal view is, probably not. So, you know, think of that for probably three-plus years we may have been spending a lot of money out of the Treasury without a proper appropriation, all right, so that's not exactly a great outcome either.

The second thing I'd say here is that it's true all that's occurred, and that the silver loading, and the making the best of a bad situation, I kind of agree with all that's been characterized so far, but I wonder about the stability of that. You know, candidly,

there's going to be a lot of people who probably don't even understand what happened, probably some even in the administration.

And once they wake up to the fact that they, you know, essentially, you know, not putting it too strongly here, but it's been manipulated to some degree, to provide the credit system to pay for this in a way that actually bumped up the credits across the whole system, and in a way where you have a very strange pattern a premium request from the insurers.

You know, the regulatory authority in the ACA is quite broad, and I could imagine the regulatory authority allowing the administration to look at this and say, you know what, this doesn't really feel like what -- it's the spirit of how these premium flows should be.

So, you know, for those who are hoping: hey, great, we've got this bump up in premium credits, and we can just live with this and, you know, onward and upward. I wonder about that, once they wake up to what really happened.

MR. FIEDLER: The thing is, I think I agree with everything that's been said, the transition was messy, and certainly this is never the way you would have designed a system. I think the question is now, we are presented with a set of imperfect options of, you know, we have, for the most part, made the transition to this new world, and so do we want to deal with the transition back to the old world given that, in many respects, we like the old world less than new world, and the risk that we might not be able to stay in the new world, depending on what the administration does.

But on balance, I would be inclined to stay where we are now. I think particularly because, to Jim's point, about can the administration change this going forward, conceivably, but I think, you know, that's almost certainly a process that's going to require rulemaking that's probably a couple years off, and so I think we might as well benefit from the larger subsidies in the interim.

MS. SHEINER: So, individual mandate repeal. I guess Matt thought that it was a big deal, but not a fatal blow. How important is the repeal, and how much changes are going to be made to the markets, and how much tumult are we going to see because of it? What do you think in terms of your, you know, how many people are going to show up?

MR. PATTERSON: So, I think we are assuming that there's one reason people are buying insurance, and I think it's a little more complicated than that, right. And I think there are some folks that are -- you know, if you just think of it in two buckets, this is how I try to talk to it at home, there's the folks that are saying, here's how much I have to pay, and I don't have another dollar above this; and here's the level of coverage that I want, and here's what I want.

Those are the ways I think people typically shop, and if they don't have some sort of condition or issue that they're trying to mitigate or manage, they have some -- you know, if they are trying to make an issue like that, they are trying to figure out: how can they get the best deal?

There are other folks that are like, look, they probably weren't playing in the market that much anyway, they were seeing -- in my state, some counties are seeing 44 percent increases in their premiums, outside of Denver because -- and they don't have a lot of options in terms of choice, and there's not the same competition because of distance.

So, I think, you know, for us that 10 percent might be about right, it might be a little bit less for us, because along where we have 75 percent of people living on the Front Range we've got the kind of competition I think, that will help mitigate that kind of cost.

MR. GERAGHTY: You know, I think in the first place pre-existing condition exclusion is not something that anybody really wanted to have in the

marketplace. From an insurer's standpoint you had to have it in the marketplace because people were picking and choosing to be covered. And so the individual mandate was obviously the proxy to replace pre-existing condition exclusion.

If you don't have an individual mandate you've got to have some other way of protecting the fact that you've got to take all comers. And I think there are some other policy choices that are in front of us, like continuous coverage, like a penalty if you don't stay continuously covered, like making sure that the special enrollment periods are tight with clear rules around them so that it doesn't become somebody waits, doesn't enroll, signs up, goes for a service, disenrolls, knowing that they've got an easy backdoor into the system later.

At the end of the day, if somebody can game the rules everybody else's price is going to be infected by it. Markets have a way of, you know, working themselves out, so if we want to have a clear understandable set of rules that are in place then we've got to stick by them.

MS. SHEINER: So, some of the stuff you mentioned, like the special enrollment, like, could be done by regulation, but some of the other stuff that you mentioned needs legislation, correct?

MR. GERAGHTY: Yes. I think there's a combination of things there.

MS. CORLETTE: So, just a couple quick points. One is that I think we've already begun to see the effect of the individual mandate repeal, a number of carriers around the country going into 2018 propose pretty hefty rate hikes, on the assumption that the Trump administration either would not enforce the repeal, or that consumers would simply believe that it had been repealed.

And we saw a number of carriers say, we are going to jack up prices 10, 15, 20 percent just assuming that repeal was going to happen or some iteration of it. So, so we've already seen the effect of it. I think the fact that there was a fairly robust open

enrollment season suggests that it's not -- it wasn't a death blow, although we still don't know yet sort of among those folks above 400, who are buying in the individual market, how much -- how many losses there were in 2018 of that population.

The other point I would just make is the importance of the state role here. Massachusetts has its own individual mandate, it has since 2007, a few states, a handful of them are actually thinking of adopting their own version of an individual mandate, or some other mechanism to try to keep healthy people in the pool. So, that will be an interesting thing to watch at the state level, to what extent states sort of step up and take that on themselves.

MR. FIEDLER: The one, just a comment I would add is, you know, obviously in trying to create a sustainable risk pool, the ACA had to balance between carrots and sticks, and so now we've taken away the big stick. You know, Pat alluded to some of the alternative ways you might be able to create a stick with late enrollment, penalties, or continuous enrollment incentives.

I'm personally not terribly optimistic that these sorts of structures where you have somebody thinking about a penalty some number of years in the future is going to be particularly effective in motivating behavior today. So, I think -- my view is that if we want to get to the same levels of coverage we were at before without a mandate, what we are really talking about is probably substantial additional subsidies, and substantially more federal expenditure.

That's potentially better than the alternative, but I'm not sure that was the -- necessarily the objective of people who turned away from the mandate.

MR. PATTERSON: I would sign on for that Matthew. (Laughter)

MS. SHEINER: Okay now, fine, let's think about the last thing that Matt mentioned that might kind of have a big impact on the market, which is this new definition of short-term plans. Is that basically getting rid of the ACA for people who don't have a

subsidy? Or is that something that could coexist with -- you know, with the ACA, or how bad could that be in terms of breaking up the --

MR. GERAGHTY: Well, for those of us old enough to have lived through as HMOs came into the market, and skimmed the market, this feels like something that can skim the market once again. Take good risk off, and start to bleed out the ACA to become just a high-risk pool. So, I think there's some real danger for the marketplace in these short term duration.

MS. CORLETTE: Yeah, I'd like to make a couple points there. I would agree with Pat on the risks to the market. Some folks might remember during the debate in Congress this summer over the ACA, Senator Cruz had an amendment that would effectively allow there to be a parallel non-compliant market alongside the ACA compliant market, and Congress ultimately did not adopt that approach.

So, this is sort of the administration's end run, I guess around Congress. With respect to the short-term plans, I think there are risks to the market, but I also think there are real risks to consumers who buy these plans. If you look at their marketing materials they walk and talk a lot like traditional, comprehensive health insurance.

And we have heard again and again from state insurance departments, and others that consumers buy these things thinking they are real insurance, thinking they will cover them when they need health care services, and find out that they are on the hook for thousands and thousands of dollars of medical bills, because these things simply don't cover anything.

MR. CAPRETTA: The only think I'd say about this, is that the -- you know, we have, obviously, deep disagreements in the country about health insurance regulation, and obviously the political divide in Congress was very deep and wide on this question. And with where things are now it looks like given this rule and its implementation the states are going to have a big role to play, in terms of whether they

allow these plans to occur, you know, be sold, under what conditions.

And so it is going to go back to the states to decide, do they want these plans out there in the market and under what terms. And given where we are there's this massive disagreement, and it's still in the political process about how to handle all these things, maybe that's not the worst thing in the world is to allow states to try, you know, what they want to do here.

By the way, that also includes changes to the individual mandate, if states wants to reimpose the individual mandate some states are working their way toward it, they can do so. If they want to imply continuous coverage penalties they can do so, they can restrict which plans are sold on the insurance market. They have a lot of authority here to still do what they want to do in terms of how they regulate the market.

And given the stalemate at the national level maybe we need a two or three year period where a lot of states try a couple of different things. And just to show my cards, I think the ones that think of totally deregulated market with anything goes, sold, isn't probably going to work out that well.

So, not to say that I don't -- I think on the flip side yeah the other argument being, ACA plans or nothing, is also probably not the best idea in the world, because there's a lot of consumer sentiment already out there that shows that they're not that happy with what's being offered.

So, the state that can find a way to thread this needle, make more affordable, better options available, maybe through loosening of these rules, you know, they might be the ones that come out ahead.

MS. SHEINER: So, when you think about all that the changes, and that you made a great point, which is that this is all basically things that the states can undo a lot of it, right, at the state level. So does that mean the future of the ACA is going to be 50/50 ACAs, and does that matter?

So, I think Jim is like, that's a good idea, we can experiment and see where we all end up. Is there a downside to that from either, and from insurer perspective of having different rules in every state? Or from people shopping from one state to another, or just whatever, you know?

MS. CORLETTE: I'd like to speak to that I think there are real limits to states' capacity, and frankly finances to be able to fill in the gap. I do think you need a sort of base, base of federal minimum regulation, federal financial help in order to allow the ACA to meet its coverage goals which was to expand coverage to the uninsured.

So, I think we will see some interesting state innovation in the next couple of years, and some divergence, potentially, of states going the regulatory approach, or an individual mandate, or other things, but there are limits to that, states cannot do it on their own. With no offense to you, Kevin, I'm sure Colorado could, but. (Laughter)

MR. GERAGHTY: You know, I'll just make a couple of comments here. I think it can happen in either setting, either with the federal regulation, or done at the state level. It will vary obviously, as states handle this, but I like to think of a couple of specifics.

One of the most important things to have a viable market is to have younger people, healthier people in the pool. You've got to have those folks in the pool. Before the ACA took place in the State of Florida, you could have a pricing range from one to seven times, the ACA forced us to one -- two or three times separation from top to bottom.

MS. SHEINER: Age, right, that's what (crosstalk), seven times the premium for the oldest people.

MR. GERAGHTY: Correct, seven times related to age. So, you were then saying, young people you are in a very big way paying for older people. Now,

philosophically we can say, well, that makes some sense, it only makes sense if the young people stay in. If the young people decide that their new price is too high, they leave, and now you're in death spiral.

So, I would be suggesting, as one of the things we ought to be doing, and in fact the State of Florida gets control to change some rules, is moving back closer to the seven times spread, maybe a five times spread, but moving away from the three times spread so that you give young people a chance to be in the pool which would then help older people because you now have the financial support of younger people in the pool.

MR. PATTERSON: Sorry. So, we are speaking as if there weren't separate insurance commissioners and state regulation before the ACA and during the ACA. So, there's going to be state differences on how this happens because the regulation is a very localized issue. You can speak to that more than I can, right?

And so this whole -- I mean like this whole thing about selling across state lines, okay, whatever. It's you regulate in state line, so it really doesn't matter what else you talk about on the federal level, it's how do you actually figure out in Durango, which is in the southwest corner of my state, the closest thing for them, they actually get their news out of Farmington, New Mexico.

And so for me, it's about watersheds in Colorado. They've got to cross one, two, three passes to get to Denver to get care, that they can't get close to them, so they are going down to New Mexico. So, they are just going to figure it out based on where the providers are, and where they can get access to service.

So, I mean this whole, are we going to have 50? I don't know that we don't already have that. I think the issue for me though, there was a national goal of expanding access in the Affordable Care Act, the question for me now is, what's the next national goal? Is there one? Or are we just going to say, you know, now it's: you guys

figure it out? Is it going to be about cost? Because that's going to be a whole different issue that I think exchanges in this whole conversation has moved us to actually begin to think about the transparency now that's in there.

And how do you just kind of try to manage that cost, because my good friend to my right now, gets blamed as the big bad insurance company, but a lot of what they have to do is just reflect the cost that they are seeing and what the provider networks are charging, and so they have to negotiate those kinds of things. And so I think we just have to really begin to think about what are we going to challenge ourselves to actually deal with?

MR. GERAGHTY: If I could follow on Kevin's comment. So, one of the things the ACA was, you know, paramount about was competition. Competition among health plans is part of the equation. In Florida, we compete against every national that you can name, and most of them have decided to leave the individual market of their own choosing not having done well, but they're in all of our other markets.

So, what is the competition on the health plan side really accomplishing. We, as a country have not looked at competition on the delivery side, so if you're in a rural area, and you've got one hospital, and they bought up the physician groups around them, they now set the market and they set the price, so we need competition there.

And that to me is one of the great promises of technology. Technology is going to allow for more at-home care, more remote care, more competition for the delivery of services in a setting where people will become very comfortable getting their care remotely and at home, and that will change the underlying economics of the delivery of health care. It isn't just about competition between health plans.

MR. FIEDLER: I think this points to a really important point, to talking about the underlying cost of care, is there's some, actually very nice work by folks over at the Urban Institute, comparing typical premiums unsubsidized premiums for individual

market plans to typical premiums for employer-provided plans.

And what you find is, there's a lot of variation state to state, but on average those two premiums aren't radically different, what's really different in the individual market is that people who aren't eligible for subsidies see the full cost, whereas their employer is paying a big chunk of it, on the employer side.

But I think what that -- the fact that those two premiums aren't that different indicates that there are things we can do to make the individual market work better in order to bring premiums down, but if we really want to bring premiums down we are talking about the private insurance space as a whole, which means provider prices, and ultimately means find new ways to reduce unnecessary utilization, and that's a much broader and harder nut to crack.

MR. CAPRETTA: Can I just say one thing about this? Yeah, first I really very much want to echo what Pat just said about competition on delivery side. I do think that that is critical to understand how to make that happen, and on a number of levels. You know, that also pertaining to when the consumer is involved in how they are picking their delivery system.

I would just; free advertisement for the administration, I think Alex Azar gave a very good speech yesterday about his vision for what he thinks the Department needs to do exactly that. What do they need to do to bring more intensive competition, more consumer role into the value effort? How to make health care more viable for the dollars spent. And so, you know, I'm hopeful that below the surface of all the politics, some progress can still be made on cost.

MS. SHEINER: Okay. Well, the whole discussion of how to lower health care costs, overall, is I think beyond today's discussion, although it's very interesting and huge. But actually, some of the things that's been said, it brings me to another question I had, which is, so on the one hand we are hearing how some insurers didn't know how to

deal with this market, the individual market or the population, is one thing I hear. On the other hand that says the premiums are kind of the same. So what is the big difference between sort of succeeding as an insurer in the individual market, versus in the employer market? What is different? Is that the people? Is it the market? How similar are the two?

MS. CORLETTE: Sure.

MS. SHEINER: Sabrina, sorry, yeah.

MS. CORLETTE: Sure. And I can speak sort of generally, but then folks that have actual on-the-ground experience should jump in. At a very high level I think what we have seen in the individual marketplaces is that -- and I mentioned the former Medicaid-only plans as being an example of companies that have done fairly well.

Well, one thing they did was they came on to the marketplaces and worked out contracts with their providers to reimburse them at sort of a Medicaid Plus reimbursement rate, which Medicaid tends to pay there a lot lower rate than commercial plans. So, that was the number one, so they just had lower unit costs then their traditionally commercial competitors.

I think the other thing they did was have a laser focus on the most heavily subsidized enrollees, so between 100 and 250 percent of the federal poverty level, those are the folks who are most incentivized to buy and keep their coverage. And then I think they also just placed a real emphasis on the backend, the sort of utilization management piece as well, and they were trained up real good in that Medicaid Program to do that.

So, which isn't to say that the traditional commercial carriers that didn't do so well in the early years, you know, aren't doing those things, I just think that the Medicaid-only plans tend to -- tended to do it better, at least in the early couple years of the marketplaces.

MS. SHEINER: So, let me just follow up. So, does that mean that this idea that the premiums are about the same, or a little misleading in some sense, or it might be same premiums but different utilization, like an actually different population, or?

MS. CORLETTE: I mean, in general, premiums are lower in areas where you have a Medicaid-only plan competing, but that's not in every area of the country. I think, Matt, you were made basically sort of talking at the national averages kind of level.

MR. FIEDLER: Yeah. I think it's absolutely the case that these are not exactly the same products, so I think the thing to take away from this fact is that they're sort of a similar order of magnitude, and that's telling us more about there's a sort of, you know, broad level of underlying cost, and that health care is expensive, that's explaining why these premiums are high, more than a sort of adverse -- solely adverse selection.

MR. GERAGHTY: Yes. So, if I could touch on two sides of this equation. Seven years ago I arrived in Florida and we went on a blitz to make ourselves a consumer company, and today we have more than half of our revenues coming from either, Medicaid, the ACA, or Medicare. So, we've taken what was a B2B company and turned it to a B2C company in a very real way that was --

MS. SHEINER: Is this business, business to consumer?

MR. GERAGHTY: Business to the consumer, yeah. Really focused on the culture change, the logistics change, it was a major transformation of the company on that side of the business, all the way down to, we have 20 retail centers around our state, you can buy individual coverage, but we also do customer service and clinical interactions in those retail centers.

So we were ready when the ACA came live, people could come into our center and actually enroll, and then have a health risk assessment done, same place, same day, which changed our understanding of the population that we were enrolling.

So, we very much committed to as much knowledge about the individual consumer as possible. So, I think that's key, because data-acknowledged information absolutely drives your ability to respond. So, that's one side of the equation.

The other side of the equation is we aggressively got into partnerships and direct ownership of parts of the delivery system, so we bought some medical groups, we partnered and created a joint venture, we now have 11 clinics in South Florida that we partnered with a South American firm to build those clinics, we put emergency medical facilities sometimes across the street from hospitals, hospitals that were using their emergency room as the front door to the hospital.

So, we transformed our delivery system at the same time as we transformed how we engaged our customers. You really, if you're going to be in retail you cannot put your toe in the water, you've got to go all out to be that kind of an organization.

So, we think we've positioned ourselves for success in a retail marketplace, we actually don't think we are going back, we may get some different policy changes, but we think the marketplace is going to become more and more retail as we go forward, and we are prepared for that.

MR. PATTERSON: Just real quickly. You know, we see a lot of just various carriers, and I think Pat's approach to this is the way that we hope to see more and more carriers kind of talk about this because, you know, you can -- the math of what we were talking about in terms of Medicaid, and you can drive down the average just because they are going to pay a lower rate.

So, I think it masks the ability for carriers to actually understand what their consumers want, and I think the more, the more that I'm seeing of what we've actually unleashed in the Affordable Care Act, is actually giving the consumer more of an ability to make his or her choices in a way that meets their needs.

And carriers that figure out ways to actually manage population health so customers and clients have better outcomes, and can help them understand how to reach those outcomes, and find ways that are cost-effective for them to meet those outcomes, are the ones that get people to, not just come back to them, but stay with them and be better participants, because they're getting something out of it which I think is the compact we have to have with our customers is, if we are going to say you have to do this insurance thing, here's what we know you should be able to get from it.

And I think we've got to move that conversation, versus saying, well, your premiums going up because you have to pay more. You've got to be able to convince people why they are paying more, and what they're getting for it, and I think that's the conversation we have to move to.

MS. CORLETTE: If I might just add one quick thing that I neglected to mention, I think the other piece is that we've seen this market evolved to essentially an entirely HMO or closed network model as carriers have, again, tried to figure out how to make the finances work. And I don't know about your companies in Florida but, in general, it is each year it gets increasingly difficult to find areas that have PPO or open network products in their marketplaces.

MR. GERAGHTY: So, just to comment on that, we have a mix, but obviously as you go down the continuum to tighter networks that's where the best value proposition is for the customer, and the customers have been choosing that.

The interesting thing is the difference between when we all went through the HMO conversion, is if a company selected the HMO that's the company selecting. When you are the individual, and you are making the selection, it's a very different choice, it's a very different philosophical orientation, and people make those decisions every day in all the products they choose, and so we see people willing to make that value trade-off proposition if it's their choice to make.

MS. SHEINER: So, we haven't talked about the employer mandate at all, and one of the issues that I think people were worried about many years ago, was whether or not -- or some people thought this was a good idea, that this would be the first step towards universal coverage where everybody would end up moving into the exchanges after. And I have this feeling, and I might be wrong, that people sort of see the exchange policies, like if you have employer-sponsored insurance that you think yours is better, in some sense. And maybe it's because you are less likely to have the networks.

But I don't know if that's right. And what do you see as like, whether or not these two systems just coexist how they are viewed? Do we think of it as sort of tiers of generosity of health coverage? Or do we think that they'll kind of, you know, move together?

MR. PATTERSON: I think it depends on if you're talking about a small business and large business, and I think that's where I see the real clear bifurcation, because we've tried this shop thing, right, it didn't work so well for me in Colorado, you know, I'm losing a million dollars a year on this. And when I talk to small business owners they tell me, look, I'm just trying to make payroll.

They try to figure out all these rules, it's too complicated, so what they end up doing is saying, okay, I'll do a simple mathematic calculation. How much is it for me to pay the penalty if I don't comply? Okay, I can do that. Tell my employees, go find something on an individual market, I don't have to deal with it because I'm just trying to run my dadgum business, and that's just the way they talked about it.

MR. GERAGHTY: You know, I was going to say, I think over time there will be a blending, certainly, at some parts of the marketplace the large employer, the really large employer, the multi-state employer, is going to hold out, and they've got a benefit proposition that they have with their employees. But I think more of the market it's

going to find their way there.

One of the things we did with our retail centers is say to benefit managers, send them down to our retail center we'll take care of that whole back shop for you, and they like that idea. So, it's sort of a blending of the two models when you start to think about it that way.

I'm glad you use the word "universal" though because one of the things I try and make clear everywhere I talk, is that we are absolutely in favor of universal coverage. Universal coverage is not single-payer, and some people use the terms interchangeably, so I think it's important in a forum like this that we are clear. Everyone, in my view, everyone in the United States ought to be covered; we ought to be figuring out how to finance that.

MR. FIEDLER: The one thing I would add is, you know, why? You know, I think there are a number of reasons why the transition, you know, from the employer coverage into the individual market didn't happen, I think part of it was the disruption associated with the first few years causing people to look at this market and say, I'm not sure I want to put my employees here.

But I think over the long run there were just real limits to how many people were going to shift out of employer coverage given the tax treatment of employer coverage. For, you know, modern and higher income people the ability to get that amount of tax-free compensation is an incredibly valuable benefit, unless and until that benefit is curtailed large employer coverage are going to stick around in very large numbers. And given the experience with the Cadillac tax of just trying to sort of deal with the incentives at the very high end for the very most expensive plans, I would not bet on the employer exclusion going away anytime soon.

MS. SHEINER: Let's just think a little bit about the exchanges and health insurance from the consumer's perspective. So, all of these changes that they're hearing

but there is a mandate that cut -- the mandate is gone, it's not going to be enforced, it is being enforced, the cost-sharing reduction, they are hearing about stuff. Like, how confused our consumers?

MR. PATTERSON: So, I mean I was looking at Matt's presentation and I -- you know, how do we find equilibrium? And I said, it's not how we find equilibrium, it's how do you find equilibrium when you're playing jingo, right? And so you're pulling something out, right? I mean it's just like all the time, it's like, okay, so what's the rule today?

And I think they're just immensely confused, because they like -- I read something yesterday, does this mean what -- I mean I went to go present to a group of African American Ministers in Denver, so it's a group I know pretty well. They're like, oh, Kevin, what are you doing here, we thought you were gone? And I'm like, oh, my -- I mean that -- no that's how confused they are.

MR. GERAGHTY: One of the beauties of having now gone through open enrollment a number of times, is we've built a broad network, we couldn't rely on our state to build that network or to advertise, so we built it, so now we have a number of churches, community-based organizations, YMCAs, you name it. We have a big network of people who carry the message.

So, one of the first messages we knew we had to do this last open enrollment is, the ACA is still here. And we did not assume that people knew that, and they didn't. They assumed that the President had ended it. So, we had to start from that and build from there. So, it's a very confused marketplace, but we are saturating it with a lot of information.

MS. CORLETTE: I think that's important to do, so thank you. My sense, and this really came to light I think over the last open enrollment period, unfortunately there are a lot of companies out there that are taking advantage of the consumer

confusion that is out there, and we have seen websites pop up that look a lot like Healthcare.gov, we have seen companies selling short-term policies or other types of products that are not insurance, that look exactly like insurance.

And a number of State Departments, of insurance, have put out warnings and alerts but, you know, not everybody pays attention to those. So, one concern I have is that a lot of this policy confusion is also generating some opportunistic behavior among companies that just want to take -- make a buck, and take advantage of people who don't know any better in terms of what they're buying.

MR. CAPRETTA: Just a comment on this, maybe taking a slightly different direction. I think that what's going on here is, you know, the consumer is, understandably, being confused in part because of the confusion at the political level, and the lack of agreement, and just the noise around health care generally. And my sense is that, you know, obviously we are in a very divided time these days.

And so who knows if this is even possible, it probably isn't, but at some point to bring stability to all this, is probably going to require some legislative approach, so that has both parties buying into it. May be in the short run, and then may be also in the long run.

And so, you know, I think we are still are going to be in a situation where there's going to be a lot of consumer confusion, so long as there's a swinging back and forth of policy leads, between the two parties. And just as a plug, another point of free advertising, I'm working with a group through the Bipartisan Policy Center trying to come up with some short-term approaches to stabilizing the market, and as only as a segue to a longer-term approach as well.

I think that's ultimately going to have to be the answer here because, you know, elections come and go, and the next cycle could swing back the other way, and it could go on and like this for another decade.

MR. FIEDLER: I think, you know, and with my policy analyst hat on, the consumer confusion also sort of has implications for thinking about how to forecast this market. So, right now there was some great polling, because the Family Foundation did about, whether the individual mandate has -- what been repealed. I think 40 percent of people thought it had not been repealed, the smallest response with people who got it correct, that it had been repealed effective 2019, and then the next biggest group was people who thought it had been repealed effective immediately.

That's going to mean that sort of, we will not see, you know, the permanent effects of this policy immediately, it will be sort of a gradual as people become familiar with the new environment.

MR. GERAGHTY: I'll just add here that some of -- our mutual friend, Governor Leavitt, speaks of a 40-year transition of the American health system, and that we are 25 years in, and we've got another 15 to go. And I tell him, well, you're not running a health plan, because you're just way too calm about this transition.

MS. SHEINER: The last question before I'm going to open it up to the audience. So, there may be opportunity for legislation in the next two, four, six years, depending on what happens politically? What do you think, if you had your druthers, do you think the most important changes should be? And what do you think the prospects for those are? And I'll let you all answer that one. So, why don't you start, Kevin?

MR. PATTERSON: Remind me not to sit next to the Moderator next time. (Laughter)

MS. SHEINER: Okay, you wouldn't have to answer any of them?

MR. PATTERSON: Oh, yeah, but I don't want to be first. God, there are so many things. For me, I think, you know, it's interesting, you know, my staff always asking about, well, I heard this piece of legislation, that piece of legislation. And so part of what I think I heard James talk about, you know, the swinging back and forth, I kind of

got a knot in my stomach, because again we, you know, we are trying to figure out how to explain this from a consumer perspective, in a way, that they know what to do, not just this year, but how this leads their kind of health journey.

And so for me, if we could just find a way to actually look for ways that this -- I think if we were just going to have states try to figure this out, I think it's maybe -- just maybe too much for us right now to challenge ourselves to solve this national debate, that we need to begin to think about.

And look to states for the kinds of innovations that we can take to scale, and take larger national carriers that are actually trying to do some really creative things, and think about how they work in areas outside of maybe their particular state, but look for ways to serve not just urban needs, but I think we've got to figure out how to solve this issue in rural America, and for a big chunk of America that feels disconnected to the political discourse.

I talk to them a lot, and I understand why they're disconnected, because they don't think that people are really listening to what they have to say. So, you know, that's what I would say about that.

MR. GERAGHTY: Well, I actually delivered a talk in Washington when we were in the midst of the health care reform discussion, and of course I didn't carry the day on any point. So, let me just say, let me just say to you again, I thought rather than boil the ocean we should try and get three principle things done. One, is established high-risk pools at the state level, one is to influence the move from fee-for-service to value by bringing the federal programs in line with that approach.

So, if Medicare goes for value it makes a huge difference. I think we've made a little bit of progress there, but we are long from there. And Tort reform, and in the discussion everybody wants to say, well, the Tort premiums are just small. No. If you know how the system behaves physicians over-test, systems over-test to protect

themselves from litigation.

There is so much of this defensive medicine that takes place. So, when we talk about unnecessary care, a lot of it is driven by the fact that people are protecting themselves from litigation. So, if we could just take those three things on, we would really be making a dramatic difference in the system, and then a lot of the rest of it can happen at the state level.

MS. CORLETTE: Well, Louise you said, what might happen two years from now, four years from now, six three years from now. To some extent my answer to your question depends on the timeframe we are talking about. In the short term I think -- what I think we need is to build on the ACA and shore it up, as opposed to radically change it.

So, I think that is going to require some injection of Federal money through reinsurance, or some other subsidization of the market, particularly to help those folks above 400 percent of the poverty line who, you know, these are middle-class people who are just trying to do the right thing, and protect them their families financially, and we need to do something for that population.

In the longer term, you know, it I think we are going to see that play out in the respective political parties. We clearly have a large faction of the Democratic Party that is interested in a government-oriented solution.

At the end of the day, there may need to be more leveraging of government power to make sure that people in rural areas or underserved populations get access to affordable care. But the degree of that, I think, I don't think there's a lot of consensus on that yet.

MR. CAPRETTA: Well, I guess I would say that in the scheme of things, what goes on in the individual market I know this panel is all about that and everything, but it's a small, very small part of what -- the problem here. And fundamentally the

problem is, that the country has to decide if it wants to have -- the system needs a lot more discipline in it, a lot more discipline across the board.

And this country is going to have to decide if they want that discipline to come through better aligned incentives through all the different complex arrangements we have today, or if they want the discipline just applied by the government in some, kind of, blunt instrument kind of way.

And, you know, I'm in favor of making sure, you know, we have a more multi-payer system with the right incentives lined up, and we are a long ways away from that, to get that to where we need to go we need to change the incentives around employer-provided health care, we need to change how Medicare works. Those are the two biggest ones. They drive the entire system, and you have to get those right to get the cost structure much more disciplined than it is now, and then they will have huge spillover effects in the individual market.

For the individual market, it's a remnant market of basically people who can't get health insurance elsewhere, and it's always going to have instability associated with it. I'm for doing what needs to be done to stabilize it in the short run, but only as a bridge to fixing our systems basic incentive problems, which is really, fundamentally, what needs to be fixed.

MR. FIEDLER: So, I agree with Sabrina. I think one of the things we are going to need to do is plow in some additional money I think, particularly, consumer side subsidies, above 400 but I think also below 400. I think there are still quite a few uninsured individuals below 400 percent of poverty, and I think part of getting those individuals into the system is going to mean larger subsidies.

I think there are benefits to creating a reinsurance program. I'm not actually sure how much dollars one needs to plow into a reinsurance program to really deal with some of the selection, and an entail risk from the insurer perspective, but I think

there is some value there.

And then I want to agree with Jim, that I think a lot of this goes beyond the individual market to sort of how we think about cost system-wide. I think the particular issue we've traditionally talked a lot about tools for reducing unnecessary utilization.

I think one of the -- and I think Pat alluded to this earlier as well; one of the big questions is how we deal with provider rates. We know that provider rates on the commercial market are much higher than those in public programs, and tend to be much higher than those in other countries, and thinking about what the solution to that is.

Is it, you know, promoting competition in various ways? Or is it antitrust enforcement? Is it, you know, one of the policy options that comes up in this area as introducing a public option? And then on the sort of most prescriptive side, it's various types of provider rate regulation, figuring out which of those approaches, or which mix of those approaches we think is going to be most effective in really reducing some of those unit costs at the provider level, I think is going to be an important question to tackle.

MR. GERAGHTY: Matt, if I could follow on your comment. Florida, obviously, didn't do Medicaid Expansion, and the pitch I've been making in Florida, and nobody listened to me, so I'll try it here, is that we should have accepted the Medicaid Expansion dollars and expanded with a caveat. And that caveat is we could have been on a 10-year journey to move off of fee-for-service to value-based reimbursement, with gate stages.

So, in X-number of years you've got to be at this percentage of the system having made the move. And if I were Governor for a day, I would have called in all the stakeholders, and put them on notice that the system was going to have to make these moves or we were going to abandon expansion, date certain.

And, you know, I know that's a difficult way to go, but that, to me, would

have made a lot of economic sense, it would have covered a million more people in our state, it would have brought $52 billion to Florida over a 10-year period of time, and instead we left that money on the table. Didn't take it, didn't expand coverage for a million people, and are in a place where we've got this dysfunction in the system where people are left out while others are being covered with less means than them, and more means than them. It's completely irrational to me.

MS. SHEINER: I'm going to open up to questions from the audience. And when I call on you can you please tell us where you're from. Here? Oh, the mics are coming around. Here, this gentleman right here?

QUESTIONER: Thank you. Lou Gagliano, Independent Health Care Consultant. Pat, a question to you: In terms of value-based contracting, which I think does change the dynamics of delivery, the important part is metrics, and how you are connecting quality outcomes, because better quality outcomes drives down costs, and it affects everybody positively. What role should an insurance company have in driving where patients should go for surgery, and potentially interrupting the relationship between his doctor and where he goes for care institutionally?

MR. GERAGHTY: So, there's a bias in your question, in interruption. Let me say this, we build delivery systems and the delivery patterns, and then we sell those systems to individuals. I think data should drive. I think the consumer needs to be armed with data about cost and outcomes, and I think the system has to, has to really get there in terms of being as transparent as it can be.

Both sides of the equation have to be transparent. I can tell you, not many docs want their costs and their outcomes published, but the system, on behalf of the consumer, needs to be in a place that we drive towards transparency, so that the consumer can then make the decision based on as much information as we can provide them.

QUESTIONER: David Rubin, Georgetown University. The purpose of insurance is to allow people to access health care, and remain healthy. Every year under the ACA premiums rose, deductibles rose, out-of-pocket of course rose, narrow networks were available. People who need care most, are those that are sick, particularly with chronic illness where they need continuing care. They are more likely to be lower income, more likely to be minorities, and we have higher rates of people who are underinsured relative to their income.

So, I would like you to speculate as to what may have happened over these several years in terms of increasing the number of people who are insured, but basically discouraging those that are most in need and most vulnerable from being able to access the insurance that they purchase.

MR. ELLSWORTH: Eric Ellsworth, Consumers Checkbook. Can you all comment on the short-term plans, and what you think will happen to consumers as they absorb those plans into the marketplace, because they are really distinct from ACA plans? And maybe as a segue to that, whether either, from the insurer side, whether there's an appeal to trying to enter that market, to recapture some of the risks that might have left the ACA market?

QUESTIONER: One thing everybody seems to be agreed on, is the consumers are confused. And that's probably not surprising, and it's inevitable in a multi-payer system probably, insurance is complicated, but one of the things that the Trump administration has done is cut back on the information flow to consumers, and the navigators and all of that. But I wondered how in an ideal world would you get information to consumers? What needs to be done? Because we are going to have to do this no matter what happens.

MS. SHEINER: Thank you. And so a question we have on how to get information to consumers, another question similar on short-term plans, and what is that

what's that going to do to the market and to consumers who take them. And then a question on whether not, even though we've seen this decline in insurance, so the people who needed it most, people who are chronically ill didn't actually get covered. So, Matt, do you want --

MR. FIEDLER: I can tackle that last one.

MS. SHEINER: Okay.

MR. FIEDLER: So, gains and insurance coverage in the ACA had actually been fairly broad based, so if you look across age groups, if you look across health status groups, you could look across racial and ethnic groups, and you look across income groups, essentially all population groups have seen gains in insurance coverage. I don't have data on gains, and ultimately access to health care, because I haven't looked at that.

I know in the aggregate we've seen substantial increases in access to health care that have been correlated across states with those increases, and access to coverage. But in general the data would say that there have been groups that have been left out. And in fact, if anything, particularly, people in worse health status have probably seen, if anything, larger gains in insurance coverage in the ACA, relative to healthier people.

MS. SHEINER: What about the question on how to get information to consumers. Kevin, do you want to?

MR. PATTERSON: By any means necessary, right? No. I'm serious that we -- You know, I think it's interesting, because I think James had a really good point that we are talking about a small population -- a percentage of the population, and so I think broad-based marketing is very difficult, because they are just in certain segments.

And so what we do is we go to those segmented populations, specifically. And so I think we do it a lot of outreach with assistance networks where we

work through community-based organizations, disaffected population, folks that just aren't represented in a bunch of different places. So, we try to make sure that we have them actually bring their groups together, and we just kind of talk to them about the different terms that they don't use in their normal language around the health insurance literacy.

And so we work a lot to do that. And so we do a lot of just groundwork on that, and we try to take their question of what they are confused about, and relate it to something that they can do about it. So, that's the way we try to make that transition.

MS. CORLETTE: Can I just? I'm so glad, Alice, you mentioned the Navigator Program, because I'd like to give a plug for the need for in-person assistance for many folks trying to buy on the marketplaces. Figuring out whether (a) you're eligible to buy marketplace coverage, (b) whether you're eligible for subsidies to buy marketplace coverage, and then (c) trying to figure out what type of plan is right for you, your health situation, your family, the drugs you use, the doctors you use, is so unbelievably complicated.

We used to provide, we don't do it anymore, but thanks to the Robert Wood Johnson Foundation, we provided back-office support to navigator groups, and we would get these incredibly complicated questions from people. And these are folks who don't necessarily have one job with one salary, they have multiple jobs. They have multiple different issues with tax households, it is so complicated.

So, the need to have these navigators or in-person assisters is so, so, so critical, and unfortunately that is funding that is being cut.

MR. GERAGHTY: So, you know, as the largest ACA plan in any one state, we've had multiple years where we had single-digit rate increases. Our most popular plan last year would have had a 7 percent rate increase, but CSR changed everything. When the CSR went away that pushed that plan into the 30s. So, that was a

policy decision, that wasn't any actual operation of the plan itself. And I guess I should comment on the short duration plans.

MS. SHEINER: Yes.

MR. GERAGHTY: You know, my biggest concern there is; what does it do to the rest of the market, because I think it will appeal to those who can pass, first of all a test to get in. Right? There won't be a pre-existing condition exclusion, so they'll be screened for that, which allows them to pay a lesser premium, and then anybody who gets out of the main pool, and gets a preferential rate because it's got lesser benefits, because they passed a test that they didn't have a pre-existing condition, that means the rest of the pool gets worse, by definition.

So that's my biggest concern is, if we start to do these things we need to be looking at the whole, and we are trying to solve for the whole, not for just one little subset group. Pretty soon you fracture it off, and you've got, you know, a mess in the marketplace.

MS. SHEINER: I actually want to follow up on that. So, Matt talked about there's sort of two issues. One is the one you just mentioned, and the other is without the mandate maybe the existence of these plans are what will keep some people having some insurance. And how do you balance that out? I mean is there an upside to that -- to this market developing too? Or do you think it's just basically --

MR. PATTERSON: To me, it's more about folks that can't afford an EHB, what do we give them that's not something that we think might be a consumer's nightmare.

MS. SHEINER: Essentially health benefit, a comprehensive coverage?

MR. PATTERSON: Yes. So, I mean it's hard because I think if you're going to say you've got full, the full boat of services you should be paying less. I mean that doesn't work anywhere else in our economy. We've got to give somebody a choice

that still gives them some level of benefit and coverage, but not something that looks like insurance but isn't. So, that's just where I think we should be careful.

MS. SHEINER: Okay. On that, I think we are going to end this panel. Please help me in thanking the panel. (Applause) And I also want to thank Anna Dawson for putting this together.

And do us a favor, please, if you have cups or paper underneath your seat, please take them out with you, and throw them in the garbage at the back. Thank you so much.

* * * * *

CERTIFICATE OF NOTARY PUBLIC

I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

Carleton J. Anderson, III

(Signature and Seal on File)

Notary Public in and for the Commonwealth of Virginia

Commission No. 351998

Expires: November 30, 2020