THE BROOKINGS INSTITUTION

(DE)STABILIZING THE ACA'S INDIVIDUAL MARKET: A VIEW FROM THE STATES

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P R O C E E D I N G S

MR. GINSBURG: My name is Paul Ginsburg and I'm really pleased to welcome you to this conference which we call "(De)Stabilizing the ACA's Insurance Market." And, you know, in Washington, we tend to think of the ACA as a national program, but individual and small group insurance varies a great deal by local market and by states, particularly by states, because the important role that state regulators play. And we know that the ACA is playing out differently in different parts of the country.

So to really understand how the ACA's playing out, you need to go out to selected states and localities and not only look at their data, but, importantly, to talk to the people there. Such field research is the essence of the project that's the focus of this conference led by Mark Hall and funded, the project and the research, by the Robert Wood Johnson Foundation and this event by the USC-Brookings Schaeffer Initiative for Health Policy.

In addition to extensive national document research, this project tapped into the ACA Implementation Research Network at the Rockefeller Institute of Government to interview leaders involved in the individual and small group insurance markets in 10 carefully suggested states. And I want to give particular mention to Richard Nathan, who created and leads the research network and has played an important role in this project. He could not be here in person, but is watching on the webcast.

Finally, before I introduce our lead speaker, Mark Hall, I want to mention that we've been busy running meetings and we have two of them next week. On Wednesday, we're having a conversation with Scott Gottlieb, FDA commissioner, about biosimilars and have an outstanding panel of three experts to react to his remarks. That's going to be on Wednesday afternoon, 1:30.

Also, at the end of the week, we have a conference on the experience with MIPS. I can't remember what M-I-P-S stands for, but those that are interested know

it very well. And the experienced with MIPS to-date and the policy options to address its shortcomings.

So without further ado, let me introduce Mark Hall. (Applause)

MR. HALL: Thank you very much. It's been a quite interesting project and I really appreciate the support that we've gotten from the Brookings Institution as well as Robert Wood Johnson and then the advisors at AcademyHealth who administer the program that it was funded under. And also thanks to Dick Nathan, who, again, was a real leader in generating the structure that allowed me to do this work.

So the gist is that as you look over sort of the arc of how five years or so of open enrollment that things got off to a bad start with the web problems, but once the web problems were dealt with, there was a good amount of competition in most states, existing carriers, new carriers, and prices were remarkably low in the view of many people. And as it turns out they were underpriced. But the market was pretty vibrant for the most part.

But then troubles really started to emerge in 2016 as carriers realized they had overpriced or weren't competitive, withdrew, big price hikes. And then leading into 2017, the question was, was that going to continue?

And there's a sense that perhaps the market was reaching sort of a new equilibrium with fewer carriers and higher prices, but one that could sustain itself. But then we began to sense that destabilizing forces were still at play, not just financial, but now sort of policy shifts under the Trump administration. So this sense of destabilization first arising from the fundamental market dynamics and then moving into the policy shift arena gave impetus for this study to see what's happening in a variety of states with regard to market stability, efforts to maintain or improve stability, or effects of destabilizing influences.

And just to remind us what those policy shifts are, and not to give this undue influence, but just sort of this is the latest round of challenges to the market.

Ending the payments for cost-sharing reductions was a big blow to the market in the sense that that's a large amount of funding stream that was built in -- assumed by carriers' pricing and it was suddenly going to go away with unknown effects. Repealing the individual mandate, which has up to now been seen as fundamental to the structure of the ACA and, therefore, how could the market function without that. And then the introduction of greater availability of noncomplying ACA plans, the idea that you would have sort regulated and unregulated markets unfold side-by-side. Short-term plans is what we focused on, but you can also talk about association health plans or (inaudible) ministries or farm bureaus, those sorts of things.

So those are sort of the three major developments that emerged over the past year, but other important changes, there are a variety of sort of more I don't want to say minor changes, but, you know, secondary changes that shortened the open enrollment period and made it more difficult to enroll through special enrollment by increasing the verification requirements. Mixed views, positive and negative, about that.

Reduced spending for outreach, and just this week greatly reduced spending for navigators. Association health plans, as I mentioned. And then a set of measures that were introduced early in the Trump administration labeled as stabilization measures that provided more flexibility to carriers in terms of how they set the standardized plans or how they're assessed for their medical loss ratios.

So that's a lot of detail, regulatory detail, but just kind of as a first sweep, a lot went on over the past year. And the question is, how did all that play into the underlying sort of market dynamics that had emerged the year before?

So I'm reminded sort of the metaphor of the three-legged stool. And this is -- Charles Gaba's, you know, handiwork here in terms of -- and don't take in the details, but the idea is, you know, you start with a three-legged structure, which is the regulatory requirements are complemented by the subsidies to purchase, which are necessary in order to comply with the mandate. So as you sort of chop away at one

piece, the stool gets to be wobblier. Maybe it'll still stand, but not quite as sturdy, we don't quite know. And so we could go through the whole list, but each of the things I mentioned is a -- and somehow meddling -- this is actually with regard to the ACA replacement bill. So a lot of these aren't actually current, but you can visualize your own version of that.

And so that gives rise to what do we mean by "stabilized" as I introduced the topic? And stabilized is in the eye of the beholder. So even if the market had reached a stable point in 2007, 2008, 2010, it's a much different market that what we started out with. Stable might mean less competition or stable might mean a sort of a plateau of very high prices.

So we defined it this way, but we allowed informants to sort of use the term the way they wanted to. And so it's remaining in the market, covering all the market is important to stability. Prices are always going to increase, but hopefully it won't increase a great deal more than general medical cost inflation when a metric for that would be are prices increasing more than they are for other kinds of insurance, for group health insurance? And hopefully, avoiding steeper sustained declines in enrollment.

So extreme forms of this you would call a death spiral. Death spiral, you know, is a frequently used term. Even if a death spiral has not happened, is the market getting weaker in ways that reflect these dimensions?

And all these points are up for discussion and question, but I'm just sort of laying out the premise in terms of a more conceptual map. And here are the 10 states that we chose, a nice variety of locations and also structures and demographics and such. Here's a quick rundown. We had a mix of state exchanges and federal exchanges, states with and without Medicaid Expansion, and states that were higher or lower priced. And I won't go through all the details, but there they are and they're in the report.

I should say in terms of the report, I think a summary has been

distributed and a full copy is online, just released today. And for those who want an autographed copy I'll be signing at the back on the way out. I think we have a small set of the full version in hard copy on request.

So starting with enrollment, so as you probably all know, folks in this room are pretty well up to speed, we were pleasantly surprised by the absence of any big dip in enrollment given all the uncertainty about the future of the ACA, all the sort of controversy over its repeal and replacement, cutting open enrollment in half, cutting outreach funding by however the amount. Many people expected a big drop-off, but not only did we not see a drop-off, we actually saw an increase.

So these are the latest figures just released last week in what's called effectuated enrollment. So like all these data, you got to pay a lot of attention to where they come from and how they differ from different sources. So a few months ago, we were looking at initial sign-ups and those had dipped a bit. But when you get to the actual people who pay their first month's checks or who have not yet been kicked off for failure to pay their checks -- and I'm not quite sure how they measured effectuated; somebody in the room can tell me -- but using that as a measure, your insurance is actually taking effect, we actually saw an almost 5 percent increase this year over last year as of the end of February or the beginning of February. Anyway, February something. Don't hold me to the details.

And you can see in our study states a -- does this give me a pointer? It does. Can you see this pointer? No. I can see it here. Well, anyway, if I move is that bad for the -- it is. All right. If I had shadow puppets I could still see.

Quite a range. So some states had big increases, some states held level, no states had a big drop. And we'll hear more about why that is. And then on the right-hand column is how things went the year before, so you can see that Minnesota had a big increase. And we have Lynn Blewett here to tell us a bit why. And Arizona had a big drop last year, but it increased this year, and so I'm here to tell you a bit more about

that. But right now we're just looking at the national pattern.

And so this relative success and sort of continuing enrollment, it was attributed to a number of things. Number one, the publicity itself about the ACA was thought to bring in people. The idea that it might be jeopardy, so if you need it and want it, you better get signed up, it was actually a motivator.

The amount of free press, what's the phrase, earned media -- meaning you work for it, you don't have to pay for it, I think is the concept, you know, for the phrase -- shot way up, measured 100, 125 percent increase in publicity about the ACA around open enrollment. And so that helped bring people in.

But also, just sort of the fundamental resilience, the word "resilient" was used over and over again, of the subsidy structure. The idea that most enrollees through the exchange are subsidized, over half of them are highly subsidized by the various metrics. And as prices go up, their subsidies go up. And so, you know, it's just a good deal. And if you have limited open enrollment, people know they better get signed up. And that structure seems to be working quite well to keep the basic boat afloat.

But that was only with respect to the subsidized portions. So for the unsubsidized portion things are quite different. As prices go up, they have to pay the full cost. And so over and over again I heard that -- when I say "I," I'm channeling my field researchers who took detailed notes and wrote it up, so "I" means "we" -- over and over heard that the market did surprisingly well for the subsidized portion, but for the unsubsidized it's really in trouble. Enrollment is dropping off quickly, and this is where you're more likely to hear "impending death spiral" and things like that.

Technically, it wouldn't be a death spiral because, what's the phrase, single risk pool means the prices are the same across subsidized and unsubsidized, but those prices become increasingly unaffordable for the subsidized, giving rise to this metaphor of a subsidy cliff. And so the idea is that the subsidies cap the cost of insurance at roughly 10 percent of household income up to 400 percent of poverty, which

is roughly $100,000 a year for a family of four, $50,000 a year for a single.

So if you started out in 2014, 2015, in insurance costs, roughly say $5,000 for a single and say $10,000 for a family, being at this border of subsidized/unsubsidized wouldn't make much difference. Ten percent of your income is roughly what insurance would cost without the subsidies. So you might get a little bit of benefit for being just below the subsidy level, but you wouldn't lost very much if you were just above.

But insurance prices have basically doubled more or less since the beginning or since year two or whatever. And so now if insurance costs $10,000 for a single or $20,000 for a family, you suddenly lose a $5,000 or $10,000 subsidy by earning $100 more than the subsidy level, which is, you know, extraordinarily uneconomic, as you know, but it was just a structure that was put in place initially. I'm sure everybody thought things would be revisited and revised. But this structure given those percentages that -- no longer works well given the prices we have in the market.

So that means that if you're above the subsidy cliff or not just if you're above, but if you're at risk of being above, because if you think, okay, great, I'm safely at 380 percent of poverty, so I'm capped at 10 percent, but, gosh, when you do your tax return for the next year you ended up at 410 percent, you suddenly owe a $20,000 subsidy refund bill, I'm not quite sure how all that works, but it's theoretically possible. It really means that if you're anywhere sort of close to that borderline, you're going to think very, very carefully about that full sticker cost, and that's where the sticker shock is happening. And so we heard that over and over again. And so you see, again, just released within a week, I think, the drop-off in unsubsidized enrollment.

Now, here we're looking at only ACA plans, so the problem is the lamppost only shines on the ACA market, but there's also the non-ACA market. But even for the ACA plans, not counting the grandfathered, grandmothered, and noncompliant, we see a 20 percent national drop off in one year. And in some states we see a 30, 40,

50, even 70 percent drop-off in a single year. Okay, now we are in death spiral territory if you've got a 70 percent drop-off coupled with if you've got 50 or 60 percent rate increases. And so this is an area of great concern.

Here you see the same point. The top line shows subsidized enrollment holding steady over the last couple years, but the bottom line shows a dropping off suddenly starting in 2017, which is when the big rate increases really started to go in. And this is Charles Gaba again, trying to extrapolate onto that a rough estimate of the non-ACA plans, that would be the top bar, and making the drop-off even sharper.

That said, you have this split between subsidized and unsubsidized. You also have a less prominent, but still distinct, split between state-based and federal exchanges. And so for the last few years, through various measures, the states that run their own exchanges have done somewhat better than those that rely on the federal exchange. This shows that point with regard to enrollment increase and also with regard to loss of subsidized/nonsubsidized enrollments. So on the right column in particular the loss of unsubsidized enrollment in 2017 was twice as large in the federal exchange states than in the state exchange states. And that is potentially due to a number of reasons that we heard from the field interviews.

First of all, state-based exchanges invest more in making the market work. They have the structure. They have the money on their own to pay for the outreach and marketing and navigation.

There's also sort of the social-political climate. So these exchanges tend to be in more of the blue states that embrace the principle of the Affordable Care Act and state-based; federal exchanges tend to be the most hostile states. And so that plays out I think in terms of the basic social-political dynamic, as well as a set of regulatory provisions. So the state-based exchanges were more likely to not allow the transitional plans or the non-ACA plans to continue. And the federal exchange states were like, you know, we'll do whatever you want.

So those things I think build up over time, and you can see that. Now, they're not dramatically different, but there's differences there to note.

All right, so moving on to insurer participation. I have a lot of ground to cover and I realize I've already, you know, used over half my time, so I better start moving faster. I'm already talking fast.

So we have seen drop-offs in insurers, but the big point is that the major drop-off was the year before and the drop-off in 2018 was about half as much. Various versions of that story in various other states, but over half the states had very little drop-off and for 2018, the only one with a big drop-off was Iowa, and we'll hear more about that.

But the gist is that, yeah, insurers enter, insurers leave, and we have a big retrenchment around 2016, into 2017. That retrenchment continued to some extent into 2018, but we're hearing now that it seems to have leveled off. We're not hearing any concern about bare counties or big withdrawals, at least as of say two week ago, before the latest news dropped.

But among reasons that insurers left was ability to sustain profitability, but here's a conceptual chart. These aren't representing actual numbers, but you can think in terms of market-wide averages versus fluctuation for particular insurers. And what we saw in various themes, and I'll elaborate more in my separate talk, is that maybe on the whole enrollment has held steady or increased, or maybe prices in general have been on a steady and then steep climb and then leveling off. That would be the orangey line. But for a particular insurer they can experience quite a bit of cyclical volatility and that is due to the fact that the change in the reference plan for the subsidy can differ each year, as well as in the first couple years there's a lot of shake-out in terms of the market moving from the traditional PPO plans to more narrow network HMO plans. And then as that happened, insurers would find that they would suddenly get a big influx of enrollment they didn't expect or they would lose a bunch. And it was hard then for actuaries to really

peg the numbers they need.

This was the kind of volatility that things like the risk corridors were intended to buffer. But, of course, when those weren't funded, that made the amplitude of these changes even greater. And so some version of that we heard in a variety of different ways, which I think caused a number of insurers to pull out and say we don't know if we can get a sustainable price that's competitive or not, or we've tried it and we couldn't.

And so you had the market sort of settling in on a smaller set of insurers, but they seemed very committed to the market because, again, there's this bolus of subsidized enrollees that will come back year after year, plus the state regulators have let them get the rate increases that they need to maintain profitability. So if you've 8, 9, whatever million subsidized people and you can price at a level that's profitable, those price increases just go back to increase subsidy, why not stay in the market if you're in a position to sort of have the competitive price? And that's the gist.

And so actually going into 2019, in initial rate filings we've seen market reentries, so the Blue Cross plans that had previously pulled back in Iowa, Maine, and Ohio, are either entering or suggesting that perhaps they might reenter. Oscar and Bright Health, which are two startup insurers, look like they're going to be moving into additional states. Even Alaska, you've got the potential of reentry by a previous market entry.

So in some states we see a story where the market's sort of settled in on a single carrier structure. Maybe not just one carrier for the whole state, but one carrier for most of the rural areas and maybe one or two in the urban areas. And that seemed to be a more stable structure for a while and is the reason that states were able to cover the potentially bare counties is that you offer up to insurers, you know, there's some subscribers. Charge what you need to. Money to me made. And so the prospects of bare countries don't seem very likely.

But the question is, is there going to be multiple insurers in most of the

states and most of the markets? And one of the issues is, is this market structure really conducive to a large number of insurers competing side-by-side? And I think views are still kind of open on that.

So looking at prices increases, can you get your prices? This is a lot of data, but let me stress the gold premiums because that kind of reflects what's happening in the unsubsidized part of the market. They tend to go for the gold package and that's the price. It isn't influenced by the subsidy structure key to the silver premium.

And so you see the gold premiums' going up less than the silver premiums for reasons that you're already aware of. You also see a difference in state versus federal exchanges again. But you see a wide variety across the different states. And again, this is too much to absorb in one sweep, but you see actually premium reductions in Alaska and Arizona for particular reasons, but then pretty significant increases in Colorado, Florida, and the rest. We'll go to the specific stories later. But the point is two years in a row of mid-20 percent increases, you know, this is not sustainable. And the question is what happens in the future?

But one result of these increases is that insurers have become profitable and perhaps handsomely profitable. So this is released by the White House Council of Economic Advisors recently. And it shows that insurers in the individual market are now more profitable as of 2017 than they were prior to the ACA. That is they are earning a larger margin than they were before and they're earning it for a lot more people. So to the point that there's money to be made, that's -- and so having achieved that, the assumption is then premiums could then begin to level off at the rate of general medical inflation as long as things don't get rocky again.

So it's capable for this market to achieve a delicate balance between, you know, the right type of competition and the right type of pricing, but obviously the point of this is, as somebody said, the market's still on ice, it wouldn't take much to disrupt it. And so the question is, are there disruptive signs ahead? And of course, we

now know that there were.

It actually was the sense from a number of our informants as of -- I think we wrapped up these interviews back in May or so, that, yeah, I think we're hitting a stable place. So, you know, I think it's okay to come back into this market or I think next year's going to be much better.

But since then, the Department of Justice said that if that Texas suit is successful, we're not going to force the guarantee issued community rating rules. Or last month, CMS said, you know, well, we're not sure these risk adjustment payments are done right, so we're going to just suspend $10 billion in payments. We'll get back to you on that later. And then, of course, this week's news on Navigator funding. And who knows what's next?

So part of the problem is an experience insurers had last year is they just don't know what shoe is going to drop next. And this adds to not only their reluctance to enter the market, but also their pricing decisions. They have to price for what they know as well as what they don't know, and sort of the known unknowns, and we go back to that, or the unknowns and all that. You know, what is an actuary to do, really? I mean, it's hard enough in terms of the cycling of your enrollees and your risk pool, but then you throw in this an unstable set of market rules, and not just not knowing what the rule is, but the time it's going to take to know the rule's effect.

And so the point is that you have to file your rates roughly six months in advance of the next full year. And so you won't get the data from the change for at least another year and sometimes that data's not in until you can do the following year's increases. And so that make it hard enough, again, for normal actuarial science, but you throw into that political science or something it really makes it quite difficult.

So case in point, ending the cautionary reduction payments, of course, this was a market disruption where the story had a somewhat happier ending because most states figured that they could load that increase onto silver plans only. That

happened in the great majority of states and it resulted in this phenomenon people have heard about, which is that this actually increases the subsidy because the silver plan determines the subsidy. So you start out, and I won't take the time to go through these numbers, but basically a phenomenon where because the silver plan subsidy goes up, you can get a gold plan cheaper than last year and perhaps cheaper now than even the silver plan. And your bronze plan, which last year maybe cost 100 bucks, now maybe perhaps it's free because if you dig down in the details your subsidy went from $500 to $650, an increase greater than the actual increase in prices.

So as a result, you can see the effect of silver loading back at this chart that you saw before where the overall average premium went up in the mid-20s, but the silver premium went up in the low-30s and, therefore, the actual goal premiums, the unsubsidized premiums, if you will, went up closer to 20 percent on average. And you see that pattern in most of the states except for Colorado, which didn't have the silver loading, or Alaska and Arizona, which had rate decreases due to their reinsurance programs. So if you look at the other seven states you see this pattern of the gold increase being significantly less than the silver increase.

So ultimately then, many of the subsidized people are better off because they got a free bronze plans or they could buy gold at the same price. Unsubsidized were largely unaffected, they just had to go through the hoops of maybe moving off the -- from on the exchange to off the exchange. There's further complications that Louise can tell us about because if their income changes in the middle of the year, then they're kind of trapped off exchange. It's more complicated than we're reflecting, but essentially they had options that reflected what they had previously. But the federal government ends up spending $30 billion more, roughly speaking, because, again, subsidy amounts went up.

And so at the end there was all that and insurers were comforted to hear that the silver loading would be allowed for this year. And, in fact, when it was proposed in Congress that we restore the desperately needed cost sharing reduction funds that

everybody decried the loss of, public interest groups said, whoa, whoa, no, no, we don't want that money back. It's actually working better now without that money. And so the story was very, I don't know, interesting.

Mandate repeal, I'm going to pick up even more speed. It's less destabilizing than everyone thought it would be, mainly because folks are signing up due to the subsidies and that the mandate wasn't that strong to begin with. Everybody already thought that enforcement was going to be weaker than it had been and there were a number of exceptions and things. So at the end of the day, the kind of estimates that come from the CBO that perhaps will add 5 to 10 percent to premiums seem about right.

Now, that might end up driving a million or two out of the market, which is significant because if those people become uninsured, that's a big bump up in the uninsured. And if you spread those premium effects, and I'm focusing just on the individual market, but if they also affect -- the mandate affects enrollment in Medicaid and in group plans, then you could end up with several million fewer uninsured people. It's just that those people weren't part of my study. So that's not to say that the mandate wasn't important, and a number of people thought that the mandate could be helpful. And if there's any flaw with the mandate it was that it was too weak and we could have used a stronger mandate.

So there is some interest in -- and Commonwealth just released a report I think yesterday sort of summarizing all this and using various assumptions about behavioral responses, so you can get a wide range of estimates. So there's some interest in having a replacement for the mandate, but none of our states were pursuing that and a few others are.

So what about reinsurance? You've heard a lot about that recently. Can it come in and fix the market? As you know, the ACA had reinsurance for three years. The start was rocky enough that more than three was reasonably needed. In Medicaid --

Medicare, I'm sorry, reinsurance is a permanent feature, but it's a much more stable market than the ACA, so there's certainly good reason to have reinsurance not only for a longer transitional time, but have it a permanent feature as it is in Medicare. And this could help deal with that ongoing actuarial uncertainty caused by the annual fluctuations in which plan is the best deal each year and in the areas where there's less actuarial data, and so encourage insurers to enter or remain in more of the rural areas.

And particularly attractive is you can use the Section 1332 waiver to sort of get supplemental funding called "passthrough payments," whereby the state-funded reinsurance reduces the federal subsidy hit, then the Feds will free up that money to add to the reinsurance pool. So you get a small sort of multiplier effect by state investments in this. But there were problems.

First of all, if you modeled it, the amounts that realistically were being proposed you're only looking at a 10 to 20 percent rollback in otherwise increases. And that would be just a one-time effect, so that's enough to sort of counter one year's kind of rate shock, but what about the other years? And, therefore, it would seem -- people kept on saying either stop gap or Band-Aid or something, something we're desperately -- something, and this could help, but a sense that it wouldn't be sort of the final fix.

Also, there was a fair amount of frustration with the federal review process that was sort of encouraged and then bogged down and a lot of technical reasons and back and forth, and here maybe some of that from the Minnesota example. The realization that to get your 1332 waiver the state really needs to invest in the program and, of course, states that are hostile to the ACA are reluctant to do that, even those that support it. Finding substantial new sources of funding is not an easy task.

And ultimately, I love this phrase, the insurers were reminded and policymakers that, you know, they lost the risk of quarter funding, they lost the CSR funding. Who knows what else is going to come through next? The 1332 waiver process wasn't as easy as was promised, and so, you know, if we put all this investment into it is

the federal government just going to yank the football once again?

And this is actually heard in Maine. I think they've sort of calmed down a bit, but there was some sense in Maine that seeking a 1332 waiver, did they actually want to implement it? Because as they look around is the federal government really going to follow through with the promised funds? I mean, that was a serious concern that was expressed. And so I love the raise to kind of capture that concern.

Another issue is, okay, if we're going to invest in stabilizing the market, is reinsurance the best way to do it? It lowers the price market-wide, but most of those are subsidized, so its effect on the unsubsidized is somewhat diluted or indirect. What if we took the same money and actually reduced the prices for the unsubsidized through some type of rebate or extended subsidy fashion? And so that idea was suggested, but not developed.

So let me sort of get to my final topic and sort of borrow five minutes and I'll give it back on my other presentation. We have these noncompliance plans that I mentioned. They're popping up in various ways. We did hear a fair amount of concern about destabilizing effects through market segmentation based on adverse selection. If only the healthy people can get these, it's going to pull them out of the regulator market, you know, raising prices even more. And you add to that the repeal of the individual mandate penalty, so before you had to pay the penalty if you pursued a noncompliant option. Now you don't have to pay the penalty, so that makes it even more attractive to explore.

But other states thought -- or other informants, there's mixed views in all the states, but some more than others, thought this might be worth trying. So, for instance, folks at that subsidy cliff really don't have any affordable options, so at least this gives them something. And to the extent that prices do increase in the regulated market, you've got the premium subsidies to shelter most of that.

The problem, though, is -- oh, and simulation models actually show that

because things like short-term plans are considerably less expensive because they're less protective, still the number of people signing up will actually go up by a million or so. And the estimates are all over the board, but they don't show an overall decrease in the number of insured. They show an increase. And the rate increases for the ACA market might be rather moderate, all things considered.

So this does leave as sort of the final thought there's I think a real fork in the road or the potential for a split market that some states where the market's done fairly well might still want to try to keep it all together and discourage these non-ACA plans, and that might be more likely for the state-based exchanges for the markets where things are already in deep trouble and not likely to get better. This might be the least worst sort of path forward, at least worth considering.

But the question is, what about the unsubsidized uninsurables? For them, they're left worst off. And so there's this bright idea that I read somewhere, maybe somebody in the room came up with it, what if we taxed the noncompliance plans to help subsidize those who otherwise wouldn't qualify? So the unsubsidized portion of the ACA market is really becoming a high-risk pool, so high-risk pools need a subsidy. So if you think about it that way, you know, maybe some type of sort of way of dealing with the free rider issues of split markets, some Solomonic splitting of the market maybe could be the best path forward for some states. So there's more to flesh out there, but I think it introduces kind of a final theme of an uncertain path forward.

I won't dwell on this slide because my time's up, but the bottom line is, gosh, it sure would be nice if we could take the politics out of this and just sort of work together to see if we could make these markets better.

So I invite the panelists up forward to see if that optimism might prevail in any states therefrom and then open things up for audience discussion. So thank you. (Applause)

MS. RIVLIN: Good morning to everybody in the room and everybody

who is watching us online. I'm Alice Rivlin; I'm a Senior Fellow here at the Brookings Institution and I'm delighted to be chairing this panel, which will take us more deeply into what is going on in particular States. Dick Nathan -- who has been mentioned as the sort of father of this kind of field research -- Dick recognized when the Affordable Care Act passed that this was going to be a huge opportunity to observe a national experiment, an experiment in expanding health insurance coverage to a large group of uninsured people and in a novel way. The expansion of Medicaid was not novel, but what was novel was creation of these exchanges or marketplaces on which people could go and look for what options they had for buying health insurance and also what subsidies they would get under the new Act and what it would cost them to buy health insurance. A very modern and interesting idea.

But the States are very different in this country, in case you haven't noticed, and insurance regulation is a State function. The federal government has not been a regulator of insurance. So it was clear that this law was going to play out very differently in different States, both because the States had options -- they could expand Medicaid or not, they could run their own exchange or rely on the feds, and because they're very different and they have different histories of how they have handled health insurance.

So this was an opportunity, and Dick had the wisdom to say, we ought to seize this and set up a network of experts in as many States as possible and get them feeding back information about how this experiment was working. And this project is one of several that have benefitted from that insight.

Mark has given us the overview and now we're going to get a chance to look at four States in some detail. We couldn't have had 10 people up here, it's too many, they wouldn't fit, and you don't want to listen to that many people anyway, so we selected four States that were quite different in a number of dimensions.

We're going to talk first about Colorado and we're lucky to have Louise

Norris. Louise is a healthcare writer and she also sells insurance. She's been on the ground, she knows how to do this stuff. But she writes about it very lucidly in a number of national publications. But in this case she was our expert on the ground in Colorado.

We will hear next from Brad Wright. Brad is a Professor in two departments at the University of Iowa, both health management and public policy, and has a long history of publications writing about health insurance. And Brad is going to talk to us about Iowa, which is actually a less happy story than Colorado, so we didn't put him first. (Laughter)

And then we have Lynn Blewett who is going to talk to us about Minnesota. She did the field research on Minnesota. Lynn is a Professor of Health Policy at the University of Minnesota in the School of Public Health and she has also published widely about all sorts of health insurance matters and been on the front lines both in Minnesota and here in Washington as health coverage expanded.

And, finally, we will hear from Mark Hall who has already been introduced, but the remarkable think about Mark at this moment is although he hangs out at Wake Forest, where he's a Professor of Law and Public Health, he's going to talk to us about Arizona. We thought we needed a fourth State and he had worked on all of them.

So, let's go to Louise first.

MS. BLEWETT: Good morning. So Colorado, we have a pretty stable market. We did have some significant rate increases this year, but we have seven insurers in our exchange, and that is the same as we had last year. And enrollment was slightly higher for 2018 than it was in 2017.

So I just briefly wanted to talk about what Colorado has done, both long-term and more recently to facilitate that market stability. So Colorado does have a hands on, proactive approach to healthcare reform, and that has been long-term. Before the ACA required like maternity coverage and banned gender rating, Colorado had already done that via State legislation. For many, many years Colorado has limited short-term

plans to no more than six months, non-renewable, and you can't get a short-term plan if you've had more than one in the previous twelve months. So kind of preventing people from stringing together a series of short-term plans to substitute for regular health insurance.

As soon as the ACA was implemented Colorado went ahead and expanded Medicaid, set up a State run exchange. They also terminated grandmothered plans, transitional plans, after just two years. So we did allow grandmothered plans to continue in 2014 and 2015, but then cut them off at that point. And there were about 75,000 people on those plans at that point who had to -- if they wanted to remain insured they had to switch to the ACA compliant market. At this point now in 2018 there are still about 30 States that are still allowing their transitional plans to continue and to continue all the way into 2019. So cutting off those plans early was part of Colorado's strategy to stabilize the market.

For this year, for 2018, if we look back to 2017 what was going on, obviously last summer there was a lot of justifiable concern on the part of insurance carriers over what was going on at the federal level and I think Colorado, our division of insurance, really took a proactive stance to reassure the insurance companies that, why, you know, we know there's a lot of uncertainty at the federal level, but we're going to do whatever we can to implement regulations and communicate effectively so that you know that at the State leave we're doing everything we can. And so they really worked with the insurers all summer last year to keep them in the market.

And, as Mark mentioned, Colorado was one of the few States that did not do the silver loading for CSRs, but instead they broad loaded, they had the insurers add it to all the plans. But part of their strategy was to communicate that early to the insurers. They were getting this information out to the insurance companies like in May and June last year. I mean we had some States where silver loading was happening, but it was happening in October. And so what Colorado regulators wanted to do was make

sure that the insurance companies knew, back when it was still just very uncertain what was going to happen, hey, we have a strategy for you. You can go ahead and add the cost of CSR, add it to all your plans, because they weren't sure at that point whether CMS would allow them to just add it to silver plans and they didn't want to leave the insurers hanging if that ended up being the case in October So even though it was a broad load, which we know now doesn't help consumers as much as a silver load, it definitely helped to stabilize our market because it gave the insurers -- you know, they knew there was a strategy.

And then Colorado was also very early out of the gates in terms of announcing that they would extend open enrollment for 2018. They kept it all the way through almost mid-January. And our enrollment did end up slightly higher in 2018 than it had been in 2017. So if we're looking at 2019 now, our rates are actually -- rate filings are being published today in Colorado and our insurance commissioner has said that the rate filings indicate a stable market going for 2019. Now, the risk adjustment -- you know, the risk adjustment issue could be an issue with that, but for right now for what we have, the rate filing does look stable. And we are switching to a silver loading strategy for 2019, which will further stabilize the market because premium subsidies will go up. People who don't get subsidies will find their bronze plans and their gold plans are maybe potentially even less expensive than they were this year.

So things are looking pretty good, but I don't want to paint the picture that it's all just sunshine and roses in Colorado because there are still issues with affordability for people who don't get premium subsidies. And we are a purple State, so we have a democratic majority in our house, a republican majority in our senate. And so there were additional measures that were considered this year. During the legislative session lawmakers in the house passed a bill that would have directed the State to submit a 1332 waiver for reinsurance and another bill that would have created a State based subsidy for people who earn between 400 and 500 percent of the poverty level. And that second bill

was actually considered in 2017 as well. It's the second time we've gone through this. Both of those bills passed the house, did not pass the senate. And there was -- when I've talked with lawmakers and the division of insurance there is a general reluctance to commit funding to help people who earn more than 400 percent of the poverty level because there's this feeling that these people don't -- they're already well enough off that they don't need help, but if you look at what they're actually paying for their health insurance -- if you're earning just a little bit over 400 percent of the poverty level and you live -- Colorado has some very disparate rating areas; we have some very expensive areas -- if you're a little over 400 percent of the poverty level and you live in one of those expensive areas, and particularly if you're older, we see lots of people who have to spend in excess of 35 percent of their income on health insurance if they want to buy ACA compliant coverage.

So although we have a pretty stable market, the issue of affordability for people who don't get premium subsidies is certainly still an issue. And ideally it would be addressed on the federal level, but I think you'll continue to see Colorado trying to address it on the State level as we move forward.

So, that's me, that's Colorado.

MS. RIVLIN: Thank you very much, Louise. Brad, tell us about Iowa.

MR. WRIGHT: All right. So it's fun to talk about Iowa in a non-presidential election year, to have this much attention focused on us. Granted, as Alice kind of already alluded to, I'm here sharing what I would call bad news not great news.

So for a while people have been asking the question of what's going on with Iowa with regard to the marketplace. And I think one of the most noteworthy kind of notorious stories out there is when Wellmark Blue Cross Blue Shield made their disclosure, and one might say possible HIPAA violation, about the young man in Iowa who has this rare form of hemophilia and was costing them $1 million a month in claims. And that's a great story that gets headlines. That's not really the story of what's wrong

with Iowa. It's far less sensational than that and it really comes down to the fact that Iowa's marketplace has been unstable from the beginning.

There were I think it was four different insurers that participated in our marketplace at the start, but you may remember our co-op, Co-Opportunity Health, which was the first co-op to go under in the country. So we have that distinction. Fortunately we're not alone; pretty much all the rest of them folded up shortly thereafter. But we were liquidated -- Co-Opportunity Health was liquidated that first year. And a small part of the story of what's wrong with Iowa is geography. So as a rural state there are issues -- Mark talked a little bit about the problems of smaller rating areas, and so insurers hesitating to go into those areas. Also their ability to negotiate with providers. So if there's only one community hospital within reasonable driving distance, it makes it pretty difficult to exclude that hospital from your network. So those two things kind of combine and drive up prices because insurers aren't able to negotiate lower reimbursement rates.

But that's really a small part of the story. The bigger part of the story I think gets into what -- wanted to call it socio political and political science type issues. So I think it's a politics story. So our then governor, Terry Branstad, who is now our ambassador to China, was an opponent of the ACA. And so the short version is he essentially deliberately underinvested in outreach and enrollment efforts. We are one of the federally run exchanges, and so that lines up with the data that you've already seen. And so the enrollment of individuals eligible for our marketplace in Iowa is actually the lowest of any state in the country at just 20 percent. I think that figure is from 2016 for the Kaiser Family Foundation.

So that's part of it. And then the flip side of that, a very related issue, is that we have a really high number of individuals in these non-compliant plans, these grandfathered plans and grandmothered, or transitional plans. So whereas the national average for that, for people that are purchasing coverage on the individual market sits at around nine percent, in Iowa that number is between fifty and sixty percent. So we have

many more individuals covered that way than have ever actually even been enrolled in our marketplace. So we have this segmentation of the market in that way. And all of those individuals, for the most part, are insured by Wellmark, which is our dominant insurer. And it's worth noting that Wellmark sat out of the exchange in 2014, 2015, and 2016, dipped their toe in the water in 2017, is back out in 2018, and is now talking about going back in in 2019. And I'll talk about what I think that maybe is about towards the end of my remarks.

So these kind of broad dynamics have set up what faintly resembles -- although again technically is not a death spiral -- it has certain driven healthier individuals, especially those who are not getting the subsidies to leave the marketplace and it's also driven insurers to leave. So we've had I think a total of nine insurers that have participated in our marketplace at some point since 2014 that have since left. And, as you know, it looked like we were going to have no insurers at all this year before Medica stepped up and said we'll take on the job of insuring folks in the marketplace in Iowa, but we'll do that by hiking premiums 57 percent. So it's a good job if you can get it, right, because you don't have any competition and you can set the prices where you need them to be to ensure you make money. So one of the people actually that I spoke with, who I won't name, when I was doing this research, said I wouldn't be surprised if Medica brings in $60-120 million this year. So, again, a good business model.

As all of that was unfolding, it was looking like we might be a bare market, we pursued a 1332 waiver to do what was known as the Iowa Stop Gap Measure. And that was going to do essentially two things, one was reinsurance. So we were looking at what Minnesota and Oklahoma and others were talking about at that time and saying we'll do that too, but we're also going to get rid of our marketplace because what we want to do is establish an off exchange purchase of insurance and it's going to be just one type of plan. Any insurer that wants to participate in this -- for lack of a better word -- scheme can do so, but this is the one type of plan that they can offer. The

rationale behind that being we're not going to have a lot of time between getting approval of this and the open enrollment period, so we want to streamline that process as much as possible. And the reason that it goes off exchange is because they wanted to change from the subsidy model to a sort of a premium credit model which would be available to an Iowans, so it doesn't top out at 400 percent, but it is adjusted for age and income. Pretty much anyone that was following this said this doesn't meet the guardrail provisions of Section 1332 of the ACA, so we were wondering if this gets approved are we then going to be set up for battles in the courts and so on. And, unfortunately, we don't get to know the answer to that because Iowa withdrew its application. And the story there -- I've heard mixed reports. So from folks in the State it was CMS informed them that basically if this worked and if enrollment started to increase in the marketplace they weren't going to get any additional federal dollars. So Iowa was going to have to pick up all of that excess cost, and they weren't willing to do that. And so they withdrew their waiver. That's the story they tell. Other stories that were in the news were that President Trump actually went and talked with Seema Verma and said don't approve this waiver because this is all unfolding at the time that the Senate was talking about repealing the ACA, and so could maybe this be a way to further sabotage the struggles that Iowa was going through to begin with. I don't know, but what I do know is that Iowa has had roughly double -- if we're speaking in proportional terms -- the cuts to outreach and enrollment dollars from the federal government that other States have experienced. And of course we've had more cuts announced this week. So we do seem to be getting picked on a little bit in that respect.

But the upshot here is that Iowa has a terribly segmented market. And Mark talked about this a lot, about that subsidy cliff. So the Iowa insurance division has actually put out some numbers on this, so I'll give you an example. A couple that's age 55 that lives in Iowa City, where I currently reside, who is earning $64,798 a year -- so that puts them about 399 percent of poverty -- because their premiums are capped by the

affordability provision at 9.69 percent of income, they pay $523 a month. If you bump that up, if they earn an additional $324, so that brings it to $65,122 a year, and now that puts them at 401 percent of poverty, now there's no premium cap to protect them. Their premiums would go to $2724 a month. And that's approximately 50 percent of their household income for the year.

So obviously that's a problem. It's especially a problem in a place like Iowa where we have farmers who have variable incomes. That was something that a lot of people talked about and how they want to handle that so that they don't get these surprises come tax time. An obvious fix would be for insurers to discontinue their grandfathered plans, for the Iowa Insurance Commissioner to say no more transitional plans. There was an analysis from the Wakely Consulting Group that basically said if you do that your enrollment will go up between 55-85,000 persons, and the premiums will decrease 8-18 percent. So that's not a total fix, but it would be a step in the right direction.

And, unfortunately, what we're likely to see is going to exacerbate the issues rather than ameliorate them. So the most recent development in Iowa is the passage of a law to allow Farm Bureau to sell health plans that are not considered health insurance. And so that stands to -- if you pay $55 right and become a member of Farm Bureau you get access to these plans, which are going to be cheaper because they're not as robust of an insurance product -- bottom line. So that may be great for these individuals that are out here above 400 percent of poverty and not subsidized. I don't have a crystal ball to tell you what will happen to maybe some of the younger and healthier people who are in the subsidized market and maybe want to move to an even cheaper plan. But that's kind of where we're headed.

And, just to finish up, as I'm over time, Wellmark has said it's going back into the marketplace in 2019, so it's partnering with Farm Bureau to offer these plans. And I think what that suggests to me is they're actually now figuring out -- "they" being

Wellmark -- how to play to both the subsidized and the unsubsidized market. So they can potentially end their transitional plans, and for the group that would be qualified for subsidies they can pursue them there in the marketplace. But for other individuals who are in better shape, you know, healthier, younger, maybe not subsidized, they can go after them through these Farm Bureau plans.

And I'll leave it there. Thank you.

MS. RIVLIN: Thank you, Brad. There was a famous book called "What's the matter with Kansas?" I think we just heard the sequel, what's the matter with Iowa. (Laughter)

Lynn, tell us about Minnesota.

MS. BLEWETT: Okay. We'll try to do this in 10 minutes. So Minnesota, like other States, has had a very volatile individual market. We're a very small market. So when we started with the ACA implementation we had about 300,000 people. That has diminished to about 160,000, so we've lost a lot. And it's just -- it's unique. States who are smaller, you know, so we have -- and rural -- so we have 300,000 people compared to 1.5 million in California's individual market. So it creates like a different dynamic. It's a smaller number, smaller problems, but also very volatile, and not enough numbers to spread risk. So it becomes a really -- you know, it's very important to think about Minnesota and Iowa and others that are very small, very rural.

We also had one of the largest high risk pools in the country -- 26,000 people doesn't sound like a lot, but when you think of our individual market as 300,000, now 160,000 -- 30,000 people is a lot of people. So that transitioned into our individual market which, you know, has played a part in the discussions of what's going on and contributed to the volatility and the risk profile of the market.

We also have a basic health plan in Minnesota. So that's the ACA option. New York and Minnesota has a BHP which is between 138-200 percent of the federal poverty level. So that's funded by the federal government, primarily through 95

percent of what would have gotten in the individual market. So what their APTC -- 95 percent of what their premium tax credit would be. So that's financing the BHP. That's about 80,000 people that's not in the risk pool for the individual market. So, again, you can see how this gets complex very quickly, even with a small market.

The BHP also creates very strange incentives because the financing is based on the premiums, because the APTC are based on the premiums. So as the premiums go up we get more money from the federal government for our BHP. So stabilizing premiums gives us less money for BHP. So people who want funding for low income populations, you know, go ahead, raise the premiums in the individual market, let's get that federal subsidy in. If you're doing a federal maximizing strategy. So it creates really weird incentives. That's like not good public policy, for all you young people. (Laughter) I mean it's just the -- you know, it's in contrast to two different opposing incentives there.

Because we have the BHP the CSR, the cost sharing reduction, was not a particular big issue for Minnesota. So because 138-200 percent are covered under our basic health plan program there's no co-pays or deductibles, we don't get CSRs for those. So when other States were worried about the CSR reductions, it wasn't -- it's not an issue for Minnesota. Only about 13 percent of people in the QHP market got CSRs.

Minnesota also has a very active regulatory and legislative environment, and has for many years. We're very proactive in terms of -- you know, I guess right now we're not keeping ahead of changes but we're reacting to changes. And so over the last couple of years the legislature and the insurance department have been very active in terms of, you know, okay, what changes, what can we do to ameliorate and get people covered basically, and get affordable coverage to people.

So we started with some of the lowest rates in the country and had to play catch up. So in 2017 the premiums in the individual market increased between 50-60 percent. So this was a huge shock to everybody because we just hadn't had those

levels of rate increases. Now, the subsidized market was fine because they received subsidies from the federal government, but those outside, above 400 percent, really faced the increase directly with no subsidy. So in 2017 the legislature passed a rebate program to allow for a 25 percent rebate based on -- for those above 400 percent of the individual market. So that was sort of a quick fix. Both republicans and democrats agreed and the governor signed it. And that was, you know, an opportunity to help the people above 400 percent. That was just a one-time deal, they allocated general fund money to support it. The problem was it wasn't passed in time, it was right at the end of open enrollment. So the take up wasn't as great as it could have been. But there's also the precedent of talking about a rebate as an option, a State funded rebate or tax credit for those above 400 percent.

Along with the legislation we have republicans on the senate and the house side who added in to allow for profit health plans in Minnesota. So one thing unique about Minnesota, we've been a very closed market and have not allowed for profits. We're the only State in the Union that has had that regulation. So all our health plans are not for profit. So we now allow for profit plans and that has not been an issue yet, but United is certainly poking around and so is Aetna. And so we anticipate that that's going to have another change in impact. And that was a part of the package with the rebate and that was an agreement between republicans and democrats to let that go.

And then we also provided for ag co-cops. So agriculture co-ops, so tied to the agriculture industry. So to allow for agriculture co-ops, which are still insurance, but they're more like a self-insured product. So they still are, you know, traditional insurance products with a premium. Land O'Lakes has one and then there's another one. And they're marketed around the healthier parts of the State, I'll have to say, but they did get some take up. Not a lot, about 1000-1500 people. So, again, it's like strategies to get people affordable coverage.

So that passed in 2017, those activities, and then the legislature

authorized the departments to go ahead and apply for a reinsurance waiver, a 1332 waiver. So that was approved in the fall. It's 50-250,000 corridor with the 80-20 co-insurance. And that went into effect for 2018 rates. It came out very late -- late August, and so the rate filings across the country were like with CSRs or without CSRs, in Minnesota it was with reinsurance, without reinsurance. So that's how the rates were filed. We did achieve our -- you know, it was approved, which allowed the pass through funding to fund the reinsurance and the State contributed a portion to fund the reinsurance. That had an effect of decreasing the increase in the rates by about 20 percent and had an impact on the market.

And I think it also demonstrated one of the things we learned in talking to the insurance companies, which was it demonstrated the State was willing to work with the insurance companies and to figure out solutions. And so again, it's this I guess active regulatory and legislative infrastructure that could work as a community and sort of public-private partnership to figure out what are we going to do and then actually passing legislation.

So with the approval of our reinsurance we also asked -- so the BHP funding that we get with APTCs for our funding, we ask for the pass through for that to continue. So when the premiums went down we lost a significant amount of funding for our BHP, and so we asked for our reinsurance that that pass through money for our BHP funding be continued. And that was not approved. And that was a significant blow to -- and our governor in a letter called it nightmarish -- because we gained federal financing for reinsurance but we lost a significant in our BHP financing. Again, it's that weird dynamic of the incentives not being aligned. So we got money for -- what the advocates will say -- we got money to subsidize the insurance companies but we lost money to subsidize programs for the low income populations. But it was too late in the process to change anything in legislation, or we just -- we were stuck with it basically. But it was a significant amount, I think $150 million. For Minnesota that's a lot of money.

So the other thing that's going on is our -- so most reinsurance is financed by a -- most of the 1332 reinsurance waivers are financed by an assessment on insurance. That's typically how reinsurance is financed. In Minnesota we used a State designated fund that is called our Healthcare Access Fund. It's financed through a provider tax. That was also very controversial. So that's a tax that was used to support our State funded programs, Minnesota Care. And because we have our federal funding financing the basic health plan, we haven't had to use that money, so it's like piling up. And when the legislature are doing their things they see a big pot of money and it's like, oh, we can take that and use that. So that's what was used to finance reinsurance. So we only financed it for two years. Again, that's a two percent provider tax that's funding reinsurance for the State.

So, again, this is going to come up in the next legislative session of is that appropriate use of State dollars, is there a better way to finance it. We'll probably be talking about a rebate or there was a proposal introduced last bipartisan to do a tax credit, so like a State APCT. But we wouldn't do an advance premium tax credit, it would likely be a tax credit through the tax code that would be State financed. Now, that's assuming we have State money. And that provider tax is expected to -- well, it's expiring at the end of 2019. So if we don't have that resource, you know, I think a lot of -- I think we will be very limited in what we can do and we will not be as proactive. And that leads me to the midterm elections. So a lot depends on what happens. We have a governor's race and -- our previous governor, Tim Pawlenty, has reentered from the republican side and very contentious and we're considered a toss-up State. So it really depends what happens in the midterms.

And, I guess just to conclude, even in Minnesota with our collaborative approach and our history of working public-private partnership, there's increasing divisions between the republicans and the democrats and I'm hoping, as a Minnesotan, that that is short-lived and kind of move back toward a more collaborative approach. I

think there are sort of pressures from both sides to sort of go into your own camp and not to talk to each other and work at opposite ends. I think we've shown that we can be active and proactive in terms of reacting to the changes. And I think the insurance companies have -- one of the things they said is we could be stable if they'd stop changing the rules. So it's like every few months something changes. And so I think everybody is waiting for things to just settle down and let's figure out how we can move forward.

So, thank you.

MS. RIVLIN: Thank you very much, Lynn. It is reassuring to hear about a place where republicans and democrats have worked together and said we've got a problem, how do we solve it. Would that it would happen here.

Mark, tell us about Arizona.

MR. HALL: All right. And so why me about Arizona. I just thought about one of the more interesting States that couldn't be here today. But I did used to live in Arizona. Both my kids were born there and I started my teaching career there, so I have a little bit of credentials. But, still, everything I bring to you is learned from our field researcher there.

So Arizona has some similarities to Iowa. Also a pretty deep red State that was pretty hostile through the governor to Obamacare, but they did expand Medicaid, as Iowa did. And they also a lot of grandfathered and transitional plans in place. So sort of that lay of the land I'll just sort of state, but things have varied a lot from year to year in Arizona in interesting ways that I'll briefly describe.

Starting out Arizona had some of the lowest rates in the country, you know, quite a bit lower than the national averages. And they had a lot of insurer competition. There was seven or eight insurers right from the get go across the State. Certainly in the major metropolitan areas, which would be Phoenix and Tucson, you know, you had the most insurers, but there were four to five, or whatever, even in the

rural areas. And that was really quite impressive and part of what helped keep rates so low. Of course, they were too low and so the co-ops there also failed, and failed sort of catastrophically. The first year the co-op priced way too high, was 40-50 percent above the market and got, by some accounts, fewer than 1000 enrollees. And, of course the co-ops only business market is the ACA, so they were desperate in year two and they came in with huge rate reductions, not just held their rates but they reduced their rates quite a bit from what they had been, such that they now came in 40-50 percent below the market. Well, of course, this caused a huge swing in enrollment, so most people had been with the Blue Cross plan. Once you looked at your options and one of the issues is with prices that low the subsidies weren't as attractive. And so when you had a low-balling insurer -- I hate to use the word low-balling, because it seems pejorative in terms of a purposeful business strategy -- but an insurer who for whatever reason ends up much lower than the rest of the market and they have a couple of different products out there. IF that sets the target premium for the subsidies, then that makes all the other coverage a lot more expensive, which leads to the big enrollment swing. And so they had this big enrollment swing, but it wasn't sustainable. So by year three they had to actually leave the market. They were declared -- they were put in receivership and such.

So, meanwhile, the other thing that happened is that the market started out with traditional PPO plans that Blue Cross and Aetna and United and others had developed for their group market, but some other insurers had entered or established themselves in the market based on fairly narrow networks around provider systems, particularly in Phoenix and Tucson areas. So in Arizona you have a good level of competition among several different hospital based healthcare systems in Phoenix, and to a lesser extent in Tucson, but products that formed around those competing systems could offer prices on a narrow network basis that were considerably favorable to the traditional broad PPO networks. So quickly of the space of a year all the PPO plans dropped out and it was just HMO plans, which then caused further movements of

enrollees. So someone who had a Blue Cross or whatever PPO had to decide where do I go. And so they looked to say do I go to the Blue Cross HMO or do I switch over to the -- it was Health Net, now owned by Centene, that received a lot of enrollment.

So that caused further turmoil and also price competition that was excessive looking back, because they were suffering huge losses. And so by 2016 the insurers put in -- two things happened, most of the insurers left, except for Blue Cross and the now Centene owned Health Net product, and there were gigantic rate increases, the largest in the country -- 50-75 percent increases. And so suddenly Arizona went from almost having a bare county, so the first issue of bare country was in 2016 for Pinal -- whatever -- the County that's in between Tucson and Phoenix -- for a while looked like they might not have a carrier and the largest increases. And so it was kind of the first sort of poster case of a market going down the tubes. They got all the counties covered, but now the prices were exceptionally high.

But what interests me is it settled into the following pattern, the two carriers, Blue Cross and -- we'll call it Centene, because it's better known that way, had basically split up the State. And Blue Cross left the urban areas that had these narrow network based products and only concentrated on the rural areas where its PPO structure was to its advantage. And then Centene was left with the attractive markets in Phoenix and Tucson, but without any competition. And based on that, rates were actually steady for 2017 and 2018. I think both. And it seemed to have kind of settled into this kind of single carrier structure, two companies but dovetailing their market areas and sort of being willing to stay in the market because they'd achieved profitability, and it looked like they had kind of reached this -- trying to use a word that doesn't invoke the antitrust authorities -- but strategic decisions about dovetailing their market coverage areas. (Laughter) Which suggests to me that might be sort of the stabilizing solution for some states. I don't know. On the other hand, it's of note that this is a State where the two start up insurers, Oscar and Bright Health, have both said we plan to enter in 2019.

And that will be interesting to see if they follow through on that and, if they do, whether that will cause further disruption with the established insurers.

So, a State in contrast with the others. And, again, a very distinctive story and one that continues to unfold.

MS. RIVLIN: Thanks, Mark. We've had a lot of discussion about the so called cliff, the problem that arose with the subsidies cutting off at 400 percent of poverty. That is a really good example of an unanticipated public policy problem. There have been quite a few in this law, but this one, if you -- at the time the law was written it seemed reasonable to income test the subsidies and to gradually phase them out. And it was gradual. And 400 percent of poverty is a reasonable living standard for most people. And so there didn't seem to be a cliff problem, but one has arisen because of the increase in the premiums.

I wanted to ask each of you, if were asked what do we do to fix this, what would you say?

MR. HALL: I think in theory there's a simple solution, just no one pays more than 10 percent. And I'm wondering what Louise things, because can we put it in a way in which we're not subsidizing the 400-500, we're just saying wherever 10 percent kind of meets, you know, the income level, that's where your subsidies phase out. Because that was sort of the original design, that to get to the phase out you -- you know, given what insurance premiums were you needed to get up to 400. And if that phases out at 500-500, whatever, you're just sort of saying as a general principle no one should have to pay more than 10 percent, but you get less help the better off you are.

MS. RIVLIN: Seems reasonable. What's wrong with that?

MS. NORRIS: So I would agree that structure basically covers everybody. And even with our current structure, especially a few years ago, not as common now, we do have -- there are people who earn less than 400 percent of the poverty level who don't get any subsidies at all because coverage is already in the --

affordable as a percentage of their income, even though they don't earn 400 percent of the poverty level. So if you just were to say, you know -- like because right now it's a lot smaller percentage than 10 percent of your income that you pay if you're well under 400 percent of the poverty level, but it's a little below 10 percent if you're between 300 and 400. If we were just to say above 300 percent you don't pay more than 10 percent of your income for the benchmark plan you would have people in some areas who may be get a little bit of a subsidy above 400 percent of the poverty level, but maybe don't get any. You would have people in other areas -- like in the mountains of Colorado you would get a premium subsidy at 1000 percent of the poverty level because you would be paying, you know -- a family of four earning $100,000 a year in Pagosa Springs, Colorado is paying $30,000 a year for their health insurance. So, you know, whereas if they were earning $98,000 a year, you know, they'd be getting a $2400 a month premium subsidy. So it's a -- you would cover -- you would sort of cast a wide net and catch everybody. The one downside to that is there isn't any sort of restriction on costs there, so by just saying we'll just -- here, you get money and you get money and you get money, you know, it's like you aren't doing anything to bring down the premiums. You're helping things for the people who are suffering having to pay, you know, 30 percent of their income for health insurance, but you're not addressing the root cause of the problem, which is the cost of healthcare.

MS. BLEWETT: I think that's exactly right, which is, you know, none of this addresses healthcare spending or costs. And to pay $1500 or $2700, whatever a month for health insurance is kind of crazy. So I mean something is not working.

So I'll just throw out a very maybe radical -- but why not pool the individual market and put it out for bid? Have it be its own pool. Right now I mean we're still like -- it's almost we're selling to individuals. There's not care coordination, there's no monitoring of their care, there's no disease management. It's not managed, it's just you buy insurance and you're basically -- it's maybe indemnity insurance. So why don't we

pool it, maybe even pool it with the small group market, say here's my 300,000 people -- or Minnesota now it's -- they're going to kill me if they're watching -- 160,000 people, put it out for bid and negotiate prices for the pool. And start to do some care management and value based purchasing and think about what you're purchasing.

MS. RIVLIN: And then you'd have a single carrier that won the bid.

MS. BLEWETT: Yeah.

MS. RIVLIN: And if you did that, you know, that's an interesting idea. Reactions to that? (Laughter)

SPEAKER: Go for it.

MS. RIVLIN: Let's go back to the family in the mountain town of Colorado that would be charged $30,000. That's the problem of very sparsely populated rural areas and we've got a lot of those in this country. If you were designing a system that basically sticks with the -- if you were amending the Affordable Care Act law -- it sticks there -- what would you do to mitigate this problem of sparsely populated rural areas?

MS. NORRIS: Well, one thing Colorado has actually considered is combining the whole State into one rating area because we do have -- you know, the bulk of our population is along the I-25 corridor, Denver, Fort Collins, Colorado Springs, that area, but if you go into the mountains or if you go out into the eastern plains you have much more rural areas, you know, fewer hospitals, there aren't as many providers, so they sort of all have to be in the network. You don't have the sort of leveraging that you get in the Denver metro area. And so we have -- you know, our rating areas, the rates are all over the map really. And the mountains and the eastern plains are really high. And there was actually a study, Colorado did a study on should we merge everybody into one rating area. And they actually came out and said no, because there just wasn't enough -- there was too much resistance to it along the populated area because everybody there said, wait, that means our rates are going to go up to bring the rates of

the lower populated areas down. And so the State stopped short of recommending that and instead recommended that we pursue other avenues to try to actually bring down the cost of care. But you do have -- you know, in the mountains everything is more expensive. The cost of providing care is more expensive, you're overhead costs are more expensive. I mean that's -- I don't know, I guess that's the million dollar question. But we did consider merging everybody into one rating area and decided not to do it.

MS. RIVLIN: And you could have done it, because that was the States that set up the rating areas.

Mark?

MR. HALL: Well, if I recall correctly, one thing that was in the reinsurance bill that didn't move forward but I thought was a nifty idea, was to set up the reinsurance formula, the ban and the percents such that it was more generous to the rural areas than the urban to give added rate relief to those areas.

MS. NORRIS: And also the State subsidy bill that they were considering would have only applied to people in our three most expensive rating areas who had to pay more than 20 percent of their income for health insurance. So we have considered some targeted things to try to address specifically those high cost areas, but we haven't done it yet.

MR. HALL: Well, anyway, in particular, for reinsurance there's no given reason it has to be the same formula throughout the State. You could for specified reasons have varied formulas.

MS. RIVLIN: Before we throw this open to audience questions, let me ask each of you to say if you were in charge in your state, what is the most important thing you would do to stabilize the markets going forward?

MS. NORRIS: Well, I think I gave my idea. (Laughter)

MS. RIVLIN: Okay.

MS. BLEWETT: I would love to see those pieces of legislation pass. I

know funding is an issue and I know there's no free money, but if we could implement a reinsurance program and provide some state funding to help out the people who are a little over 400 percent of the poverty level, I would like to see those bills implemented.

MR. WRIGHT: So I think two very simple things -- simple assuming I have, you know, a magic wand that can make this all happen.

SPEAKER: (off mic).

MR. WRIGHT: Yeah. So it would be to end, you know, the grandfathered and grandmothered plans so we get those individuals into the marketplace, for one. And then I think to revisit the stop gap measure and get rid of all the things in it that weren't reinsurance and just do the reinsurance piece, which seems to be successful in places like Minnesota. And I think it would be in Iowa too.

MR. HALL: For me I think it would be the capping insurance at 10 percent for everybody, plus the thing that Lynn mentioned, that we heard repeatedly, was just leave us alone for a while. (Laughter) Stop making these changes.

MS. RIVLIN: All right. Well, let's throw this open to audience questions. Yes, Sabrina?

SPEAKER: Thank you. This has been a great panel. I have a question for Brad. I'm just sort of curious if you have any thoughts on whether the way Iowa did its Medicaid expansion -- in other words, running that population through the exchange -- had any effect, either destabilizing or a positive effect?

MR. WRIGHT: That's a good question. I didn't talk about our Medicaid expansion at all. I don't think I can tell you kind of one way or the other, other than to say I think the fact that we had the Medicaid expansion means that there are some individuals that would have been, you know, in like sort of the 100-138, right, that are in our Medicaid program instead of in our marketplace. I mean they started out in the marketplace and then they got moved over. It started out being called marketplace choice, right, and then the co-op closed down and then there was no choice, and so then

you had to scramble to say, okay, well we can go into this one plan on the marketplace or you can go into the traditional State Medicaid. But now we've moved everybody over into managed care, which is -- we could have another panel on a different day about that.

So it's hard to get a read, but I think it might contribute somewhat, right, because you've got a group of individuals at this point in time at least that are not in the marketplace that would have been.

MS. RIVLIN: Louise, is that true in Colorado too? Because you expanded Medicaid.

MS. NORRIS: We expanded Medicaid, but it's just straight Medicaid expansion. But, yes, the people who -- between 100-138 percent of the poverty level are in our Medicaid program instead of our marketplace.

MS. RIVLIN: Yes, right here. And tell us who you are when you get the microphone.

MS. O'CONNELL: Good morning, June O'Connell. Thank you very much. It's great to have people representing various diverse parts of the country before us.

Part of the development of the Affordable Care Act was that employers were offering different plans in different States and it was uneven to the extent of whether or not people were covered through their employer plan. So my question to you all is what insights do you all have into what's happened with the employer component of the markets in your various States? And to what degree that reinforces the rural versus urban divide, whether or not private employer coverage has increased or decreased in your States, that sort of thing.

MS. RIVLIN: Thank you.

MR. HALL: So one thing is we didn't really take a close look at that, although we have experts in each of the States. Since I'm not an expert in Arizona I don't know. But nationally it has been notable that the employer marketplace really has not

been strongly affected by the Affordable Care Act, and in particular the small group market. So most of the attention that we're discussing now, market stabilization and all, prior to the Affordable Care Act we were talking about the small group market, and that's the market that had all these problems and whatever, and can we fix them with State based small group reforms.

There's been almost no mention of small group markets since the Affordable Care Act. So whatever the ACA did to that market seemed to have been taken pretty much in stride. And more so for the large group market that really seems to be driven more by the overall, you know, economy than anything in the ACA.

It will be interesting to see though with this new rule on association health plans, I think it will have a much stronger effect on the small group market than the individual market. I think the individual market will be affected more by the short-term plan and the Farm Bureau type things.

So I do think we need to stay tuned on the -- particularly the small group side of the employer market to see if it continues to -- it's not like it's vastly better than it was before, but it doesn't seem dramatically worse either.

MS. RIVLIN: Any other reactions to that? Louise?

MS. NORRIS: I would say our small group market in Colorado was already -- Colorado had actually already gone through reforms about a decade ago for community rating in the small group market. The market has been stable. We haven't really seen sort of the volatility that we see in the individual market.

As far as from an insurance brokerage standpoint, a lot of our big insurance carriers in Colorado have stopped paying commissions in the individual market, but they're still paying commissions in the small group market. And they still -- like we have some insurers that have just completely eliminated their broker support staff for the individual market, but they still have a solid broker support staff for their small group market, which just kind of gives you an indication that like they're very happy to still

be selling small group plans. So, yeah, our small group market is good.

MS. RIVLIN: Good. Other questions? Yes, back here. And tell us who you are.

MR. HANSEN: Dave Hansen, Duke University. And you all had mentioned several aspects of different numbers of insurance in the State. Was there any convergence on like the optimum number of insurers within a region? Anywhere from one to eight or nine is some of the numbers that we heard. Like what were your (inaudible) telling you?

MS. NORRIS: So in Colorado we have 64 counties in the State, there are 14 counties that have just 1 insurer. That's the mountain area, a lot of the areas in western Colorado. Eastern Colorado is mostly just two insurers. Up and down the Front Range corridor we range from two to six. So like the Denver metro area has -- most counties there have four to six. So, yes, it very much depends and it's mostly correlated with population.

MR. WRIGHT: So I think there's a general sense we want competition, right, in the market, but that said, folks that I spoke with seemed to indicate just having the one insurer was sufficient. We didn't have any bare counties. So there was an option for people. And your question depends on whose perspective we're asking about, because if you're Medica, it's a really good business model. (Laughter)

MS. RIVLIN: Paul?

MR. GINSBERG: Thanks. I'm Paul Ginsberg. Something you said, Lynn Blewett, about many of the plans in the individual market in Minnesota are kind of indemnity like plans, very passive plans. I was under the impression, given the data on the proportion nationally of individual plans in the exchanges that are narrow network, that this was a highly managed environment. Is Minnesota the unique or is that something across the country?

MS. BLEWETT: You know, I may have used that term loosely, but there

-- I wouldn't say Minnesota is unique. If they're a narrow network, that's like the sole managed component. And they're still negotiating discounted fees. That's how a lot of our managed care negotiate their prices with the providers. It's not a capitated, you know, managed risk kind of profile. So that's what I meant. It's basically just paying the bills and not managing the care.

MS. RIVLIN: Yes?

MS. CORDON: Hi, I'm Cynthia Cordon. I'm a high school student from Arizona actually and I had a question for you. How do you think the large Native American population plays into the market in Arizona? I guess maybe for Colorado too. If you think that has an affect at all.

MR. HALL: So that is a weakness in my coverage of Arizona, that the population is quite large and the rules are somewhat different for them. And so I don't have a good sense of that. Maybe Louise does. Or, if you do, let us know. (Laughter) Field research. I am drawing a blank on that. I really don't know.

MS. NORRIS: I think -- and I don't have the notes on that in front of me, but I'm fairly sure I remember Blue Cross Blue Shield of Arizona was the only insurer that I saw last year in the rate filings that actually added the cost of CSR for Native American populations back into their premiums. In most States it was sort of insurers just ate that cost. But I'm fairly sure it was Blue Cross Blue Shield of Arizona that addressed the issue. So obviously it was going to be a large enough chunk of money that they added it to their rates, just like all the other States added CSR.

MS. RIVLIN: Back here.

MS. RIZZO: Hey, Ellie Rizzo from Horizon Government Affairs. I'm also from Iowa City, so go Hawks.

I was curious, there's a lot of flexibility in what you can apply for in a 1332 waiver, so I was wondering if any of you have a sense as to why so many States have decided to pursue reinsurance as their main avenue in their 1332 waivers instead of

another solution?

MS. BLEWETT: You know, one of the main reasons is that when Price was the Secretary he sent a letter to all the governors saying pursue reinsurance. (Laughter) So that was like a signal, we're open to this, this is a way that you can finance your reinsurance or a high risk pool. They mentioned both of those options. And Alaska was the first one and they said go look at what Alaska did. We're open to this. So I think that was one of the -- that was the signal to do.

The other thing, both Alaska and Minnesota, which is kind of interesting, had already built in infrastructure from their high risk pools. So they used their legislative -- they already had legislation on high risk pools, they just sort of morphed that into reinsurance, and they used their infrastructure. So we already had a high risk pool aboard and a high risk pool entity, it was already organized. And so that was another reason. It was like we could build in existing infrastructure. And I think that's why Alaska and Minnesota were out first, is that we already had some basis to go for.

MR. HALL: Yeah, Maine is another State that had a reinsurance infrastructure in place that's likely to restart it soon. One key reason in addition to what Lynn said, is just the math works under 1332. So the guardrails that Brad mentioned cited the State can redistribute the money as long as no one is worse off. So, you know, the economists would say it would have to be pareto-optimal -- no one worse off and some people better off. And it's hard to produce that if you just say we're going to take that and do the subsidies differently, because somebody will get less subsidy and then you don't meet the -- but reinsurance has the sort of magic quality that Lynn was describing where if you can reduce rates market wide then that frees up otherwise subsidy monies that can be put into reducing rates more market wide. And it doesn't go on forever, it reaches a new equilibrium, but you sort of are -- money materializes out of thin air sort of quality.

MS. RIVLIN: We can take one more question and then you've all earned

a coffee break. Let me go over here.

MR. SWEEZEY: Hi, I'm Victor Sweezey; I'm a high school student from Los Angeles. And I was just wondering, so under the last couple of years under the Trump Administration there's obviously been a decrease in funding and focus on promotion during the enrollment period, yet I know in a lot of State enrollment has stayed pretty stable or increased. So I was just wondering what strategies for promoting enrollment have worked in the past and what are some strategies that you all will be focusing on in the future to keep enrollment up?

MS. RIVLIN: Good question.

MR. HALL: Okay, I could start out on that. And California is notably not one of our study States, partly because it has been profiled a good bit -- to a large extent by itself (laughter) because they're proud of their success. But they should be. And they have a study out showing that there's a very favorable return on investment in more advertising. Not only do you enroll more people, but you enroll healthier people and you get more new enrollees, which is important to keeping the risk pool fresh because over time a risk pool tends to degrade. And so they have good reports, you know, establishing that.

The other thing is that in our study States we saw even the States that were federally based exchanges, like Florida, which has a very high take up, one of the highest rates of sign up, and as a result a larger enrollment pool than even California because they did not expand Medicaid, so they have more eligible people, it's due in large part to local community organizations that are very committed to this cause. Previously, those were supported also by federal grants for navigators and assistors. But Maine is another State where we heard that there was just a lot of local support for this type of outreach embedded organizations. A good number of them connected either with legal aid or with community health centers, you know.

MS. RIVLIN: Other reactions? Brad?

MR. WRIGHT: I can chime in and say I think it would be a great idea for us to do some outreach in enrollment in the State of Iowa. (Laughter)

MS. BLEWETT: In Mark's report, which you all should read, it was interesting -- and I don't know which State or where this was -- but that just the constant sort of ACA and barrage from the national level, all the we're going to repeal and replace, that actually had an impact of bringing people into the market because people were aware of it. So it's sort of like that unearned media, which was kind of interesting to me. Like it's still on the -- you know, it's on the top, it wasn't like outreach enrollment strategy, but just that it was part of the news cycle was kind of interesting to keep people aware, oh, that's (inaudible), you know, what is that and how do I go about that.

So I think States are going to have to step up and do their own enrollment and outreach. And I would imagine insurers are going to too, especially to those who are making a ton of money right now on the subsidized market.

MS. RIVLIN: Yes, they have every reason to. Well, thank you very much. And join me now in thanking these panelists for their efforts. (Applause) There is coffee, and we will reconvene in 15 minutes.

(Recess)

MR. LEVITIS: Okay welcome back. My name is Jason Levitis and I'm a nonresident fellow here at Brookings. I also spend a lot of time providing technical assistance to state officials on healthcare issues on behalf of a Robert Wood Johnson funded project called, State Health and Value Strategies. In my previous life, I led AC implementation at the Treasury Department and I am very pleased to be with all today.

So in Mark's presentation, and in the earlier panel, we heard a bit about the federal landscape and then what a selection of states have done in response and how that has worked out for them. This panel is going to take a step back and look at the bigger picture on the individual market and provide some more context and analysis. To do that, I present you with some of the biggest and best thinkers on health insurance

markets today. Each of them will give a short presentation and then we'll try to reserve most of the time for discussion and for audience questions.

First, you'll hear from Matt Fiedler. Matt is a fellow here at Brookings. His research covers a broad range of health policy issues, including a focus on health insurance market conditions. He is the former chief economist for the White House Council of Economic Advisors where he led the agency's work on healthcare. Matt will delve more deeply here today into the federal policy landscape that states are facing with analysis of how the different moving pieces may effect individual markets.

Second, you'll hear from Sabrina Corlette. Sabrina is a research professor at the Georgetown University Center on health insurance reforms. She is the leading expert on health insurance regulation and policy and also regularly assists state officials in developing policy options. She will provide a broader look at how states have responded to the turbulent policy landscape.

Third, you'll hear from Cynthia Cox who directs the Kaiser Family Foundation's program for the Study of Health Reform and Private Insurance, a name that I assume they took because the Center on Health Insurance Reform was already taken. Cynthia's research focuses on individual market conditions including pricing, enrollment and competition. She is also one of the lead developers of Kaiser's indispensable premium tracker tool. She will provide more detail on individual market trends to date and what we know about 2019.

Finally, you'll hear from Thomas Miller, a resident fellow at the American Enterprise Institute. Tom's research and analysis covers a broad range of health policy issues including health insurance markets, the ACA coverage provisions, high risk pools, Medicare and healthcare cost growth. He will provide some deeper analysis, synthesizing what we've heard to try to develop a meaningful outlook for what is ahead.

After that, I'll get the discussion started with a couple of thoughts and questions and then we'll leave plenty of time for discussion with you folks. With that, I will

turn it over to Matt.

MR. FIEDLER: Thanks, Jason. So as Jason laid out, my charge is to talk a little bit about the federal policy landscape. I think Mark's opening presentation and the prior conversation has given a pretty good overview of what the major issues are. So I want to go deeper on an analytic issue related to one of these and then flag one other issue that I think is flowing a little bit before the radar.

My first point is just about the impending disappearance of the individual mandate. I think there is a correct view that disappearance of the individual mandate in 2019 is not going to be the end of the individual market. The presence of subsidies means that the market will stabilize at premiums that are somewhat higher and enrollment that is meaningfully lower but the market will find a new equilibrium.

What I think is just important to keep in mind is that doesn't mean that the repeal of the individual mandate is not a quite important event. I did some research several weeks ago looking at the sharp decline in the uninsured rate that we saw among people with incomes above 400 percent of the poverty line as the ACA took affect from 2013 to 2016. These people weren't eligible for subsidies and as you dig into the data, the most plausible explanation for why we saw an expansion in insurance coverage in this group is that the individual mandate was indeed shaping insurance enrollment decisions in an important way.

If you take that estimate of how effective the individual mandate was and you think about what does that imply for the population as a whole, you conclude that roughly an eight million additional people had health insurance in 2016 because of the mandate. And one would expect most of that affect over time, most or all, probably all of the affect to disappear over time once the mandate is gone.

Other analysts have reached similar conclusions based on their synthesis of both the pre ACA and post ACA experience. CBO's revised estimates are that mandate repeal will reduce insurance coverage by eight to nine million people in the

long run. And RAN's central estimate from an analysis they released in the last several days is that it will reduce the number of people with insurance coverage by six and a half million people in the long run.

So I think it is absolutely true that this is not existential for the individual market. It is also true that this is a fairly important event in our nation's health insurance system and that meaningfully fewer people will have insurance coverage at the end of this. My personal view is that for a variety of reasons, that is a bad and significant outcome.

The other less analytic point I want to flag is just one other policy change that I think has been a little bit below the radar to date. Which is, last year's President's executive order included three policy directions. One was related to association health plans, one was related to short term plans. We have a good sense of where those are going. But the third was a direction for federal agencies to consider allowing employers to purchase individual market coverage for their employees via what are called, health reimbursement arrangements. Because the individual market is community rated, large employers potentially have an incentive to shift some of their sicker workers, if they can, into the individual market because the community rated premium is substantially less than paying the claims cost of somebody who is very sick. Related, you could have situations where an employer, their overall workforce is quite sick, it might be financially attractive for them to move people into the individual market in that way.

Because of the size of the employer market, even if a relatively moderate amount of this type of activity occurs it could have important impacts on the individual market. Whether or not this actually ends up coming to pass is going to depend in a substantial way on how the Trump administration goes forward with this policy, if it even does go forward with the policy given that we haven't seen rules so far. I think this is a sleeper issue that is worth watching as we think about how the individual market is likely to develop going forward.

MS. CORLETTE: Thank you. So I'm going to just talk a little bit about how states have responded to, as Jason said, some of the turbulence that has been federal policymaking over the last 18 months or so. So there is some good news. Several states are really leaning in to try to shore up and protect their markets and their consumers from market instability, higher premiums et cetera. And I'll just tick off a few examples. I would like to acknowledge the Commonwealth Fund which supports the research that we do at Georgetown to track at a 50 state basis, everything that is going on in state legislatures and at departments of insurance with the state based exchanges. Without them, we really would have a less vivid picture of what is going on.

I do want to acknowledge that with respect to, for example, the individual mandate that Matt just talked about, a few states have stepped up and enacted their own state versions of the individual mandate. These include D.C., New Jersey, Vermont for 2020 and, of course, Massachusetts which was the model for the ACA which was enacted back in 2006 has its own state version of the individual mandate that will continue to go forward.

With respect to these alternative coverage options that the administration has been promoting like short term plans known as AHP's. Similarly we have seen a number of states step up and attempt to limit these as an attractive alternative to ACA coverage. Of course, there are states like Colorado, as Louise mentioned, that pre ACA had limits on them as well. But some states, since the President's announcement in October have either in their legislatures are pushing for or have enacted limits. That includes states like Illinois, Hawaii, Maryland, Vermont and California's bill looks highly likely to pass.

Of perhaps broader interest and appeal as the prior panel discussed is action on reinsurance. So we've seen a really interesting mix of very blue states as very red states pursue that option. So Oregon, Alaska and Minnesota, of course, have implemented theirs pending before CMS including Maryland, New Jersey, Wisconsin and

Maine. I also think it is an interesting mini trend of states that currently operate on healthcare.gov or the federal marketplace platform that are pursuing a shift to a state run platform. That would give them potentially a lot more flexibility over the operation of their marketplace and be able to do things like extend open enrollment, support outreach and navigator programs more robustly. These include Nevada, New Mexico and potentially Oregon.

On the flip side, there are states that are embracing a new environment at the federal level that encourages regulatory rollbacks of some of the ACA protections. So folks may already be familiar with Iowa's situation where they essentially exempted certain health plans from the insurance regulations. So they get a free pass from all the ACA consumer protections. Another state that is pursuing what they're calling state based plans is the State of Idaho. We expect to see an announcement on that very soon. We've also seen North Dakota and North Carolina look at this as well.

I think it is also important to be aware of the limits on states capacity to really step in and fill the role that the federal government has played to date. So reinsurance may work for some states but not for all. Some may lack the ability to generate the resources, the funding the state match that is needed. Some may not have the built in infrastructure that, for example, Minnesota or Alaska has. And then there are other options that are just really tough in terms of political capital that would need to be expended in order to get those policies through. I'm hopeful that we will see more states lean in and step up to maintain and stabilize their markets. I wouldn't underestimate the challenges that lie ahead. Thank you.

MS. COX: At Kaiser Family Foundation, we've been looking at insure financial reports over the last several years. When we're talking about ACA stabilization, I think one thing to keep in mind is that at least as of midway through this year in 2018, insurers in the individual market are really having their best year yet. Their performing better in 2018 than they have in any year since the ACA was implemented and really

probably since even a few years since the ACA was implemented. That's on average. Of course, there are still some markets that are struggling that could be local rural areas or certain states where insurers on average are still losing money. On the whole, I think the takeaway is that 2018 is shaping up to be a very positive year for insurers on the individual market.

Part of that is that they overshot their 2018 premiums. When they were setting the 2018 premiums, it was in the midst of a lot of political and regulatory uncertainty last year, as you may remember. So they guessed high and now they are bringing in a lot of money. Looking ahead into 2019, given how profitable insurers in this market are right now, you would think the premiums for next you would be staying flat or maybe even dropping in some parts of the country. Instead, we're seeing premiums go up again. So we're tracking premiums in 2019 for states that have complete rate information that is transparent and available for the public. So it is only about a little over a dozen states. But what we're seeing so far is that silver plans and bronze plans are going up by about 12 percent next and gold plans are going up a little bit less by about 6 percent. We're seeing on average high single to low double digit rate increases for next year at a time when insurers are by enlarge profitable.

So the factors that are driving these rate increases for next year, what Matt was describing, there is the individual mandate repeal which is adding maybe five to ten percentage points onto the premiums for next year. There is also the likely expansion of loosely regulated short term plans that are likely to draw away healthy people from the ACA compliant market. And the people who are going to be paying these higher premium increases are the people who are off exchange. The people who are middle income or upper middle income, some of whom have already been priced out. We might start seeing more people getting priced out next year.

The subsidized exchange market, on the other hand, is looking like it is going to be strong in terms of enrollment. There is more and more insurers who are

entering into this market for next year. I think that is one of the really notable findings that we've seen looking ahead into next year. Mark Hall had a few examples. We've actually found over a dozen insurers entering into states. Again, we don't have information on a lot of states yet but there is over a dozen new entrants or returning insurers into the market for 2019 onto the exchange markets and we haven't seen any exits. That's a complete 180 from where we were this time last year. Last summer, we were looking at several dozens of counties that were at risk of having no insurance company because insurers were fleeing the market last year. I think the insurers are starting to have a much more favorable outlook for the individual market despite the continued political or policy uncertainty that they face.

MR. MILLER: Thanks for the opportunity to both concur and descent. Full disclosure and a caveat, for many years I served as the ranking minority member of the Right of Center Consensus Group. I do want to offer my congratulations to Mark Hall and his researchers. I've learned a lot from Mark's work for many years. Some of the interesting points about deflating and taking some of the air out of the balloon of reinsurance.

But particularly in this case, how insurers and policymakers and defenders of the all CN regime still think and believe whether or not very complex and mixed evidence plus a lot of subjective speculation actually turns out to be the case. The arranged shotgun marriage between the ACA's previous designers and implementers and private insurers has been disrupted but the old flame still flicker out of mutual desperation if not passion.

On the other end of the spectrum, in health policies in many other policy areas, the movie script for the Trump administration appears to be, Our Brand is Crisis, as the 2016 campaign rewinds on a continuous loop. The Trump version is getting bigger box office in the 2015 version, however, some of the reviews in the international markets, particularly one that have been more mixed lately.

Before getting to the partial disequilibrium model outlook for the individual insurance markets, let me suggest a few other reasons besides the sabotage rationale, and decenters. From the view that the greatest risks come from departing and more recently from the original ACA architectural plans for the individual market. We've already had a lot of deviations from what was supposed to launch in 2014. Individual mandate and employer mandate enforcement, grandmothering full service health exchanges, co-op insurance plans, risk protection funding, administration of risk adjustment formulas and the list could continue. The original design was far from resilient and it bouted a number of places to political stress testing, adaptive mutation in the midst of environmental climate change.

Another point is that stabilization is a relative term subject to different perspectives and frames of reference, particularly since 2014. Many Republicans have been more concerned and aggrieved by the ACA related destabilization and nonsubsidized individual market both inside and outside the exchange based coverage. Not everyone links the baseline for stabilization to the same times at which subsidies and regulations were changed.

Third, development of the ACA individual market lacks officially broad political buy in. Now certainly a wide cross section of health policy theorists may believe this stuff was going to work and others were stuck with having voted for it or having to cope with it while running their businesses. But those who never got on the bus had little incentive to push it forward or keep it out of the ditch.

Fourth, the worst case scenarios for the individual market either are not bad enough to scare and activate political majorities or they just did not materialize. Although they did provide polar opposite talking points and opportunities for blame shifting for either ends of the political and policy debates. So regarding the future of the ACA and individual markets, the outlook, I used to quote Mr. T's clubber in Rocky III. When asked for a prediction about the fight ahead, I predict pain and sometimes I pity the

fool.

The outlook is actually more of a series of chronic conditions with dull aches but far from life threatening. Subsidies, higher prices and deficit financing paper over a lot of affordability and operational problems, at least for the near term. And as we know in the long run, baby boomers believe we are not dead, we just go on Medicare indefinitely. I've written many articles suggesting the limited but targeting value of better subsidized high risk pools and I'd like to thank the ACA architects for moving closer to developing our largest ones yet.

Yes, there has been too much overcharged rhetoric, fake threats and government created risks but enough about the Obama administration. On the other hand, private insurers increasingly try to run away from and shed just about every kind of risk, leaving behind taxpayers to pick up things as default risk barriers. That's not going to stop until the flow of subsidies and regulatory protections slow. The ACA shaped individual market cannot be killed or even be put into a politically induced coma, it just slowed down to a much lower growth path if not plateauing at a slightly lower level. As long as subsidies flow, someone is staying in business, just not a particularly competitive market environment. Even if all the legs of the three legged stool get chopped down or cut off, remember it is sitting on top of the subsidy cushion which can also be used as a flotation device.

One way or another, various probes to evade or escape some of the ACA's remaining edicts will continue because the latter insists on trying to force at least some insurances, providers and consumers to commit unnatural acts against the perceived self-interest and values, so the parade goes on. Thank you.

MR. LEVITIS: Thank you to all our panelists. That was extremely enlightening and at times, entertaining. I'm going to just throw out a few thoughts sort of pulling together what we heard here as well as a bit what we heard on the earlier panel. I'm going to start with some questions for the panelists and then we will take questions

from you all.

So I just want to highlight some themes that we've heard throughout the day about what is going on and what may be ahead. One is certainly a lot of uncertainty and tumult and questions about what the landscape will be but that has sort of abounded, as Tom was just pointing out, by the subsidy structure of the ACA and the structure more generally that seems to be resilient. Where the individual market may contract and it may have higher premiums but it is likely to continue in some form and be useful, at least, to subsidized individuals.

A second theme we've heard again and again is divergence, divergence among the states. States going in different directions and as part of that, and this is of particular interest to me in my work with states, there is just a huge amount going on at the state level in terms of where the action is on health policy. It is just difficult to keep up, notwithstanding all the great work by folks up here and on the earlier panel with all the different proposals, all the different legislative action that is going on at the state level. It makes it sort of a fascinating time to study health policy and to be working with states.

I would just note one sort of piece of color on this is that, of course, this is all affected by electro politics. If you look at the two states that had their main state elections in 2017, those of course were New Jersey and Virginia. In both of those states, you've seen changes in health policy with Virginia expanding Medicaid and making a bunch of other changes and New Jersey passing an individual mandate and reinsurance and making a bunch of other changes too. And it does sort of make you a bit excited like wow. If those elections led to all of that action, think of all the state elections that are coming this November and what might next year might mean in terms of what we see out there. So keep watching the states.

So with that, let me start with a couple of questions for our panelists and then I'll turn it over to the audience. One question would be, so the earlier panel was incredibly helpful focusing on those ten states and the four in particular and hearing what

is going on there. But, of course, there are 40 other states and D.C. Are there other particularly interesting stories that we should highlight, have out there that would be good to know about before we delve more into analysis. Are there other states that you think would be good stories for folks to hear about? Sabrina.

MS. CORIETTE: Yes. I think, as you say, lots of divergence, lots of variance. I do think one thing that we're seeing that is very interesting playing in state legislatures, particularly this past legislative session, there has been a tremendous pressure on legislators to address the needs of the unsubsidized, the folks who really are facing these unaffordable premiums. So we're seeing legislatures respond in different ways to that. But at the same time, we're seeing at state level consumer advocates, patient advocates, insurance companies and others step up in coalition to counteract some of those forces.

So one example would be North Carolina where there was a bill that was moving very quickly through the legislature to adopt a sort of Iowa style farm bureau type of proposal. And what was interesting there was the coalition that really came up to try to kill that bill out of concern that, in fact, well there would be a number of folks with preexisting conditions, particularly in the unsubsidized population that would be harmed by that initiative. And they were successful. I think particularly on the advocacy side, there has been so much focus on Medicaid expansion that they've been a little slower to move to some of these private insurance issues but they are starting to step up to the plate and North Carolina is a great example of that.

MR. LEVITIS: Thank you. Any of our other panelists have any state highlights, specific stories you want to share?

MS. COX: Yeah. This state just kind of came to mind when Alice was asking about rural areas in the last panel. I think that's really where the ACA individual market has struggled is how to attract insurers into those markets. When we were look at bare counties or potential bare counties last year, it was almost always a rural county that

was at risk of having no insurer. I don't know if any state has really come up with a good solution. I would be interested to hear more about what is happening in New Mexico because that is one state where they haven't had that problem and I don't know why that is.

On the other hand, Nevada had an interesting strategy at first which was to try to make it so that if an insurer wanted to participate in the Medicaid managed care market, they had to also offer on exchange. So that was helpful in keeping the insurers in the exchange but they all wanted to offer coverage in Las Vegas, not in the rural parts of the state. Nevada ended up being one of our states where almost the entire state was at risk of having no insurer except for right around the metro center. So I think that highlights how even states that are trying to address this issue, it is very hard to find a way to overcome it.

MR. LEVITIS: Great. Next question. So we have heard a lot about a set of actions that many states are taking between reinsurance and, in a few cases, state individual mandates, potentially subsidizing about 400 percent and that seems to be the normal game plan states are taking. Oh and then, of course, with non ACA compliant plans, on the one hand, some states are trying to close them down, other states are embracing them. So that's the game plan that seem to be out there right now. Do you all have thoughts on what other state policies might be coming down the road or should be coming down the road? What should states be thinking about? What might be the next big thing that states are doing if we were to have this discussion a year from now? Sabrina.

MS. CORLETTE: I have some thoughts. So one thing we haven't spent a ton of time talking about are two pieces of litigation that are moving their way through the courts that could dramatically affect the individual market. One is a lawsuit in Texas brought by the Texas Attorney General. The Department of Justice recently provided a brief in that case suggesting that they would like to see the court strike down the

preexisting condition protections that are in the ACA, specifically the guaranteed issue and community rating protections.

That is a situation where if the Department of Justice position prevails, a big chunk of the ACA that protects people will fall. There are some states that adopted the ACA consumer protections into their own state insurance codes but it is a minority. So one thing that states could and should be looking at in the short term if they care about this and want to protect people with preexisting conditions, would be to bake those protections into their insurance codes.

The other new development, of course, is this New Mexico case where CMS has in response say that they would suspend risk adjustment transfers. I won't get into the details of the case except to say that it has perhaps raised some conversation at the state level about whether, particularly for state based market place states, whether they should look at running their own risk adjustment program. That is certainly something Massachusetts did when they enacted their own law in 2006 but then turned it over to the feds.

MR. MILLER: I would just point out that risk adjustment is a good example of what was assumed and what turned out to be different. There were almost no state takers for risk adjustment even though it has worked out in a very bizarre way with a lot of intended or unintended counter affects.

The one area that I think I've been disappointed in not seeing any further movement on, now admittedly the very confused record of the Trump administration on waivers in itself tends to put a chill on getting more experimental or exotic. It has been sitting around for a while to basically overturn Obama administration guidance saying you couldn't basically pull off a 1332 mega waiver. It doesn't meant that they're come up with anything innovative but as long as you put a bigger pot of money together, you can slosh it around and pretend you're saving by mixing it across a wider base. There are ways to move subsidies in one place over to the other parts of the market, a bit of a mix and

match, way beyond the creative accounting of Arkansas. That would seem to be a missed opportunity for at least confusing more people about things and finding out whether we can truly reach bounded irrationality.

MR. LEVITIS: Thank you. And, of course, folks probably heard that a few months ago, there were rumors that there was indeed, revised 1332 guidance coming out of the administration at some point. We still haven't seen it but that may be something on the horizon revisiting some of those constraints that you're talking about.

MR. FIEDLER: I think the encouragement to think of new solutions is valuable but I also think part of the reason there is a standard list that exists is because those are implementable actions that can tackle the problems. Your goal is to reduce premiums for unsubsidized people. You can do some things to improve the risk pool through an individual mandate or change enrollment but your main problem here is that health insurance is expensive. So either you've got to find ways to substantially reduce the underlying cost of care, which is an issue that is much broader than the individual market. And is not, I think, we should not wait to have our optimal healthcare delivery system to be the solution to the problem or you're going to have plow additional dollars into the individual market. You can do that through a reinsurance program, you can do that through subsidies above 400, they are all just different tools for achieving the same thing. So, I think, new thinking is great but I think we also need to understand that there probably are no magic solutions here either.

MS. COX: 100 percent agree with Matt.

MR. LEVITIS: Okay one last question from me and then we will take audience questions. So Cynthia provided helpful information quantifying the state of the individual health insurance markets. I want to get into something a little bit more subjective here. Insurer decisions about where to participate and how to set rates has a strong non-quantitative element in terms of insurer optimism or pessimism for what is going on. A lot has happened to raise concerns but again there is also the growing

feeling that the market overall is pretty durable. Given all that, what is the mood of issuers out there? Are they feeling worried, are they feeling hopeful, are they feeling like they should get in to please certain regulators. What is the state of mind out there in the insurance community given all that is going on?

MS. COX: I think I'll say that this question of the qualitative view of how insurers are thinking about the market is really important. I want to bring back up two points that I made earlier which is that 2017 ended up being a profitable year on average for insurers in individual market. As you may recall, in 2017 was when insurers were fleeing the market. They weren't necessarily fleeing the market because they were losing money, they were fleeing the market, in large part, because they didn't know what the rules were going to be in the individual market. They didn't know if the individual mandate was still going to be in effect, whether cost sharing subsidies were still going to get paid. Whether the ACA was even going to exist or not.

So this fear that insurers may have that Congress or the administration isn't working to provide them with concrete answers about what the rules of the game are going to be, is going to shape insurers decisions. About whether or not to participate in the market and whether they need to bake in an extra cushion into their rates for next year. Just like one example of that for just this week was the question of whether the risk adjustment program, those payments were still going to get made. And looking into 2019, in theory, those payments shouldn't be a question but the administration didn't directly address 2019 at first. We saw at least one insurer say that they were going to up their premiums relative to what they were going to be because they didn't know whether risk adjustment was going to be in effect in 2019.

MS. CORLETTE: Yeah I would say if you had asked this same question two weeks ago, I would have said that there is an increasing sense that the market is going to stabilize if they weathered the worst of the storm. I think the decision on risk adjustment is so inexplicable from both a litigation and policy perspective it has reignited

this tremendous lack of trust that insurers have that this administration is operating this program in good faith.

So I don't know what is going to happen over the next few weeks. There is a real timeline here. Rates need to be locked in in the next six to eight weeks. Insurers have to sign contracts by the end of September. If you think back to last year, it was October when the cost sharing reduction subsidies were cut off causing all kinds of scrambling and revisions. We're on a clock and I'm sensing a shift a little bit in insurer's levels of confidence.

MR. MILLER: There is a quite a market for anxiety in this space. An ample supply and demand somewhat induced. But from the perspective of insurers, what would be their political strategy in saying everything is fine we can get through this. You want to always be aggrieved and besieged and you'll have your defenders come there. It also plays into the other side that says this is great, we're really causing a lot of trouble. Ultimately, there are certain boundaries on this. If you can depress some of the fake theater and look at what tends to go on, I think we've had a bit of an over shoot in terms of anxiety.

Also, you look at different markets where if you have computing insurers, they may take different perspectives on this in terms of just the way in which they actually view what their rates are going to be. So shoot high and figure out where you end up afterwards.

MR. LEVITIS: It sounds like there is a world cup flopping analogy at play here. Okay thank you, that's really helpful. Let's open it up to the audience and get some questions.

QUESTIONER: Hi. So I just want to add another strategy states have considering New Mexico and Minnesota which was the public option buy in. So buy in either to Medicaid or the basic health plan and actually offering a state option on the exchange. So that depending again on the elections, that could be a viable strategy.

That actually was considered for rural areas where there weren't very many options and it could also be for the about 400 percent.

MS. COX: I would just respond to that that there are cautions to consider with the public option. Lynn, you made this point earlier about the basic health plan in Minnesota attracting enrollees away from who would otherwise be on the exchange market. And then you have a smaller market and fewer people to spread the risk over. It can also be a disincentive for private insurers to go into rural areas if they know that there's going to be some other option there. I do think that in some cases we saw states gently twisting arms of insurers to go back into rural areas and it ultimately worked.

MR. FIEDLER: One thing I'll add on a public option is my suspicion is that public options are going to be tricky to make work at the state level. I do think they are potentially interesting options at the federal level. I think it is important to understand that the main thing many of these public options are bringing to the table are some variety of administered pricing. That's how they generate their savings. Private insurance rates tend to be far, far higher than the rates paid in Medicare and particularly higher than the rates paid in Medicaid. So the play here is you are able to introduce a lower cost option by having an insurer in the market that has an ability to pay doctors and hospitals a lot less.

In general, my view on the evidence is that prices we're paying in the private insurance space to doctors and hospitals are well in excess of marginal costs and so well in excess of the efficient level. So that is likely a good thing but that is fundamentally what these tools are doing for you.

MR. LEVITIS: I'm going to ask another question now because I don't see any hands. Oh, is there a question back there? Great. Everyone else think of questions.

MR. LINDYEAR: Hi, Kevin Lindyear. So Mark Hall's executive summary

mentioned strategies like auto enrollment, assessment on non-compliant plans and mid-year rate corrections for insurers. Could you comment on some other strategies that states could also implement.

MS. CORLETTE: So with respect to auto enrollment, I don't know if Tom wants to comment on that because I know some of you are colleagues at AEI.

MR. MILLER: They don't want me to comment. I'll just leave it at that.

MS. CORLETTE: Some of your colleagues at AEI have put out some very thoughtful pieces on this. I do think there are some administratively tricky elements to that but it is certainly something a state could look at. I think one of the challenges particular to the individual market is it is a market with a lot of churn, with people transitioning on and off coverage throughout the year. You mentioned three things. One was mid-year rate changes. Somebody over here needs to remind me, I thought those were prohibited, at least through regulation.

MS. COX: I think the context of this was if policy changes mid-year, allowing insurers to change their rates. Like if federal policy changes.

MS. CORLETTE: Federal policy changes. I'd have to go back and look at the regulations governing rate setting at the federal level. There may be limits on a state's ability to do that without a federal regulatory change. I don't remember the third thing that you said, I'm sorry.

MR. FIEDLER: The last one was taxes on non-compliant plans. I think you could think of this as basically a very indirect way of expanding risk adjustment of a sort to apply to non-compliant plans. At the point where what you're trying to do is to ensure that the differences in premiums between compliant and non-complaint plans don't reflect the different health risk of the two pools. I think there is frankly more a straightforward approach which is to have one pool and operate risk adjustment within it. So I think this is a somewhat indirect way of undoing the problem you created by allowing the short term plans in the first place.

MR. LEVITIS: Alice.

MS. RIVLIN: Alice Rivlin: Every conversation about the Affordable Care Act is very, very complicated, including this one. The Affordable Care Act was trying to fill a niche problem. We had a lot of people covered by Medicare and Medicaid and by employer based insurance but we had a bunch of people who weren't covered by anything. The idea was to subsidize them to buy insurance in the individual market from private companies. It has turned out to be really hard. Should we give up and do something else?

MR. FIEDLER: I think the structure in a stable policy environment can basically work. I think we saw in 2017, insurers could get the pricing right and I think that would have led to -- I mean, given that we're seeing entry even in this policy environment this year, I think we would have seen much more significant reentry over the subsequent years in a counterfactual world. Now is this perfect, absolutely not and I think there are things we could do. I tend to think that introducing a public option in this market would be a good idea. I tend to think that larger subsidies would be a good idea. I think this type of managed competition framework can function.

Certainly we've seen, while there are some important differences, we've seen a sort of managed type of competition type structure function in the Medicare Advantage program. I think we have plenty of reasons to believe both in theory and practice that this is a viable policy structure.

MS. CORLETTE: I agree with Matt. I think ACA is not perfect. There are certainly some things you could do to make it better, particularly around the affordability of the insurance. I would hate to throw the baby out with the bath water.

MR. MILLER: I think there is a lot to be said for giving up. I'm not sure about doing something else in terms of getting agreement. Most of our health policy involves trying to find a way to stick the cost somewhere else that no one else can see. We most had the individual market as the residue of that while taking care of everyone

else. What happened with the individual market is we're not that generous to go ahead and subsidize everyone so someone still had to get shafted for budget scoring reasons and that tended to be people in the unsubsidized part of the individual market. Now they didn't have the leverage necessarily to unravel everything but that's what some are responding to through these various halfway measures. You can push and you can pull and you can try to find money from somewhere else or shift it around but ultimately not everybody goes home happy. Our health policy debate is basically trying to find the least objectionable parties being the ones that are unhappy.

MR. FIEDLER: Just one comment related to that. I think it is important to keep in mind, if we wanted a market proposal to extend the 10 percent of income cap above 400 percent of the poverty line, that is probably an order of magnitude $100 to 200 billion over ten year type of expenditure. That's a lot of money, that's not chump change, but that's also well within the range of the types of money one could imagine the federal government spending. So this is very much within the realm of achievable policy. Certainly if you compare it to the amounts of money that we've been moving around in recent tax legislation, it's chump change.

QUESTIONER: Could you comment on what exactly is going on with risk adjustment and then will that have an impact on offerings in the market for this fall. Both in terms of who shows up in the prices or is it going to have an impact.

MS. CORLETTE: So just a little bit of context. Everybody is familiar with the risk adjustment program. It was one of three premium stabilization programs within the ACA. It is the only permanent one. It is used basically in a Medicare Advantage, Medicare part D, a lot of states use it in their Medicaid programs when they have competing and Medicaid MCO's. It's the idea that if you have more than average risk then your competitor has to give you money. So you receive money, your competitor pays money, it is sort of a rob Peter to pay Paul program. There is no taxpayer money at stake.

The New Mexico co-op which was a small startup plan, sued over CMS's risk adjustment formula. It gets very arcane very quickly but essentially they felt like they were paying too much to essentially Blue Cross Blue Shield which was on the receiving end. They felt that the formula disadvantaged small startup plans. That may be true. CMS has rejiggered the program over time and it is not a perfect formula by any means. The court, when the New Mexico co-op sued, the court agreed with the co-op in part but disagreed in part. One of the things they've said in their decision was CMS, you have to provide a public rationale for why you chose the formula you did. We don't know necessarily if your formula was right or wrong, you just have to publish through a notice and comment rulemaking, your reasoning.

So there are some odd things about the way the DOJ, which was representing the government in that case, has pursued its litigation strategy. The most logical thing to do would have been to file an appeal and ask for a stay pending decision on that appeal. Instead, they filed a motion to reconsider with the district court. I'm not a litigator, I can't explain the thinking there. And then, of course, earlier this week they announced a decision that they would just suspend all payments under the risk adjustment program. Not just in New Mexico which would be one thing that they could do, but nationwide.

This is a big deal. There are insurers like Blue Cross Blue Shield of Florida that are owed in excess of $660 million for 2017 alone. That is just one insurance company. Now they may have huge reserves and it's no problem, no cash flow issue. But there is a little tiny co-op in Maine that is owed over $12 million. I don't know how long they can hold out without that expected payment. The court's decision covered 2014 through 2018. In the most recent payment notice for 2019, the administration says that they've fixed the problem by providing a public rationale. People say that was in a final rule so there was no notice in comment. It may not be on the most solid ground but there is this question about 14 through 18.

MR. MILLER: Keep in mind, this is a process foul rather than a substance foul. You've got other opinions and other court decisions including in Massachusetts with Minuteman Health which went in the opposite direction. Risk adjustment is a great concept and a great ambition. In this particular area, it is incredibly mixed. I think this is another case of one of those, let's roll this one out and see if it scares a few people. By the time we get into the fall, I think they'll back off from the brink on this. The fact that they put out the risk adjustment report with the numbers that insurers have to use to being to do the calculations tells you there is a little bit of a mixed equivocation on this.

MS. CORLETTE: Yeah but I would say I think that if it were just CMS making the decisions here I would have Tom's view that we should not worry. The problem is, it's not just CMS making the decisions for the administration here.

MR. MILLER: Come on, we're supporting Teresa May this morning. It changes in 24 hours.

MR. LEVITIS: I think I saw the hand in back there first.

MR. POLSER: Hello, Carl Polser, I'm a long time health policy analyst. I'm read in this great report about overall cost increases being in the single digits. I think this belies some more inquiry in that in the bit of sloppy thinking in the health policy community, it tends to rate itself on cost by looking back at itself instead of at the rest of the economy. A single digit cost increase whether in the individual market or the whole of healthcare, can be three times the growth of the economy or four times inflation. That is the biggest instability in the whole thing. We have just the cost of care can't be supported by the economy at the rate it is growing. So the question is, if you're going to have a policy that is going to create universal coverage, don't you really need some kind of administrative pricing at some point to stabilize cost. Certainly, building on the weakest part of the market, the individual market to do the job is not enough. Just a question, thanks.

MR. FIEDLER: I don't have strong views, honestly, on what the right year over year change in overall health spending is. Over the very long run, we know that much of the reason that healthcare spending is larger than it was in the past is we have many more medical technologies, we know how to do many more things and people are healthier for that. Now I think it is absolutely true that there are some big inefficiencies in our system. I think one of them is particularly on the commercial insurance side that the market power and the provide side means that prices are very high. I think there are also areas where we have substantial inefficient utilization.

I would think about it less as trying to reach a particular target growth rate for healthcare spending because I don't know what that is and I think it is very possible that we should be spending a larger share of our GDP 20 years from now then we are today on healthcare. That said, I think there are plenty of things we can do both on the provider pricing side. And in terms of moving forward with various efforts on payment reform that aim to give providers stronger incentives to eliminate lower value utilization that we can and should be pursuing.

MR. MILLER: Carl, most of our public policy tries to have healthcare spending despite what we say, go higher and succeeds at that. The reason we have those public policies is we don't think people privately will spend enough. So until we change that political stance, there is always going to be someone paying the bill, even if it is disguised through multiple channels.

MR. LEVITIS: Okay I think we have time for one or two more questions and then I have a final question to wrap it up. Yes, go ahead.

QUESTIONER: Yes do you think that the rules regarding the guaranteed issue are here to stay or how serious is the threat in light of the Texas lawsuit and actions of the administration. And what would the insurance landscape look like in states that don't have preexisting conditions written into their healthcare code if those rules were repealed.

MS. CORLETTE: It is hard to say. When you're dealing with the federal courts, it can be a little bit of a crap shoot. The Texas attorney general forum shopped for this particular district judge in Texas who is known to be pretty antagonistic to the ACA. So it is potentially likely that they'll get the judge ruling in their favor. So this could work its way through the courts for a long, long time.

California led a group of AG's to intervene on the argument that the federal government was not going to defend their interests. There is an interesting wrinkle there where the Texas AG has said that if they court agrees with the Department of Justice opinion he should just enjoin the ACA in the plaintiff states, so the red states. Which could mean that the preexisting condition protections would only fall in those states which is, I think, 20 states. But for states like California, New York, other states that are not plaintiffs to the case, it would be status quo. We don't know what the court is going to decide.

MR. MILLER: I think it is a great prank case because basically they took the arguments that first in terms of justifying the individual mandate and then took the brief from the solicitor general in terms of what was defending. Well, in the event that the individual mandate goes, because this is so tightly wound together, we've got to get rid of guaranteed issue and community rating. Now is a higher court going to actually swallow this, no, they'll come up with a new rationale if it comes up from the district court.

But in the meantime, I think the more narrow conspiracy view is that they might try a settlement before a full decision in the case and slow down the ability to appeal this for some period of time, let alone its application only in the states that wanted it. And that could slow down what goes up to a higher court.

MR. FIEDLER: I will say, if you read some of the legal commentary on the logic behind the case that has been filed in the Texas court, it really does not hang together. And you've got people, including people who are behind many of the prior legal challenges to the ACA saying this case simply does not make any sense. I think

Sabrina's point on this is a very carefully selected judge is an important one. But at least I would hope that the courts still have the ability to look past the particular type of sophistry that is reflected in this argument.

MR. LEVITIS: Okay I want to ask one last question and then we do need to wrap up. So we have spoken a lot about the administration actions, we've spoken a lot about state actions, we have not spoken very much about Congress. Obviously, Congress tried to do a variety of things last year. First repeal and replace and then various stabilization measures and nothing was able to pass. We've seen little bits, there was just this markup for some HSA related legislation. Is there anything helpful to say about what are we likely to see out of Congress, if anything? Are we just going to be in the status quo until there is a new Congress or new President or is there anything that might be an area for consensus, might be an area for compromise in Congress?

MR. MILLER: You're searching for trace elements.

MS. CORLETTE: Nothing before the mid-terms.

MR. FIEDLER: I think after the mid-terms if Republicans hold the house and pick up a couple of seats in the Senate. My expectation is that we would see another effort at passing more comprehensive ACA repeal legislation. That's my guess. I think short of that, it's likely to be stasis. I think the truth is, this is not primarily about the two parties squabbling, this is primarily about the two parties have fundamentally different policy objectives and visions for where the country should go with respect to healthcare. I think those types of disagreements are going to be very difficult to bridge.

MS. COX: And the harder Congress tried to repeal the ACA, the more popular the law got.

MR. LEVITIS: Great. Let's give a round of applause to our panelists. Thank you. Thank you for being a wonderful audience.

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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.

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