AARP PUBLIC POLICY INSTITUTE

LAUNCHING INSURANCE EXCHANGES: WHAT ARE STATES DOING?

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SUSAN REINHARD: Good morning, and thank you all for coming. We know that people will be coming – you know, drifting in, dealing with traffic and all those things you do on a Monday morning. But we want to honor your time and those of our panel members. So I’d like to get started.

My name is Susan Reinhard. It’s my pleasure to direct the Public Policy Institute at AARP, who conceived of this idea because our goal is to be helpful to states at both the state and national level to help implement aspects of health care reform that are very important to members, people who are 50-plus but to all people.

And this particular panel was really shepherded by Gerry Smolka, who is sitting here in the front, a member of the Public Policy Institute, as well as Lina Walker who directs the health team and Rick Deutsch who is our director of communications. So I want to thank them because it always takes a lot of work to pull everything together.

And also my dear friend and colleague, Chuck Milligan, who you’re going to hear more about his instruction a while ago – but I reached out to him last fall I guess it was to start a discussion could we collaborate on this particular topic. And you’ll hear why with his extensive experience.

Just a few words about these solutions forums, these are on the record. The Public Policy Institute has two kinds of convenings of thought leaders. One is off the record. Those are roundtables. This is on the record and it’s also being webcast. It’s being webcast. It’s live right now and it will be available archived at about 2:00 on the AARP.org/PPI for anyone you want to let know to see it.

But as Rick has warned me, if you don’t want to be seen, then don’t get in front of the camera. (Chuckles.) Otherwise you will be captured.

I did want to point out a few things in the packet. There are three fact sheets that have been updated by the Public Policy Institute, one of which is directly related to this, the health benefit exchanges but also changes in insurance rules and availability of health insurance and I also want to thank Lee Goldberg – where are you Lee – there he is in the back of the room – for bringing copies of a very recent toolkit on designing an exchange.

Thank you very much, Lee. This is helpful. I was just talking to Gerry Smolka who says she’s been using it in guiding states on what they should be doing. So we thank you.

So with that I just want to introduce John Rother who is our executive vice president of policy strategy and international affairs. John will speak for a bit and introduce the panel and please welcome him. (Applause.)
JOHN ROTHER: Good morning. Thank you, Susan. And thank everyone for being here on what I think is an extremely timely topic and an opportunity maybe for the first time to get a report from the front lines on developments in the states on the important topic of health exchanges.

So my job this morning is to lay out some consumer concerns and questions for the panel. And I think I’ll start with a few little facts about the current situation. People who do not have employer-based insurance or are not enrolled in public insurance today have a very difficult time finding insurance coverage at an affordable level.

A recent Commonwealth Fund survey found that about 2 out of 5 adults in that category found it difficult or impossible to find a plan with coverage that met their needs. Three out of five found it difficult to find a plan that was affordable and one in three were turned down, charged a higher price or faced exclusions in purchasing health insurance.

We know that AARP’s younger members report that they have very serious concerns about finding coverage. Those between the ages of 50 and 64 who apply for coverage in this market – almost a third – somewhere between 20 and 29 percent – are turned down. Another one third are offered coverage but at a higher premium due to health statutes. And 8 to 11 percent are offered plans that exclude coverage for preexisting conditions.

So these consumers – people in the individual market – can look forward to health benefit exchanges in a way that I think can respond and solve many of those concerns. The exchanges can be a gateway for a new marketplace for non-group insurance and for public coverage as well.

We hope that millions will gain or be able to gain coverage – either private coverage or public coverage through the exchanges when they first become effective in 2014.

Now, the Affordable Care Act does many things to address the challenges that these people face. Today, we’re just going to focus on the exchanges. But I do want to point out – excuse me – that the exchanges have multiple responsibilities and roles. They negotiate to offer coverage options that meet benefit cost and transparency standards. They’re to provide consumers with information about benefits, cost, provider networks, quality rankings.

They’re charged to develop access tools to get that information through web portals and telephone assistance lines. And they’re a point for accessing the new premium and cost-sharing credits that are designed to make coverage more affordable.

Putting the policy – thank you – putting the policy, legal, organizational and systems infrastructure in place to make all this happen involves a lot of work and launching these new marketplaces is what HHS and states are engaged in through planning grants, legislative and administrative activity. Consumers, although many may not know it yet, are depending on the success of these efforts.

So we are very happy to have the panel with us today. I’m just going to pose some questions to set them up and then introduce them and then turn to our moderator. So what are
key consumer concerns? What questions should consumers bring to this discussion? First, do consumers have a strong voice in the creation of exchanges? And secondly, once built, how does the exchange incorporate the ongoing input of consumers and customers in decision making and governance?

Third, will the exchange have the authority it needs to maximize the value of coverage offered and to simplify choices? And specifically, will the exchange have the ability to negotiate with plans and select offerings that it judges serves the public interest? Now, here’s a tough one. How is the coordination with public coverage options integrated into planning and operation for the exchanges?

Ideally we’d like the exchanges to be a one-stop shop for coverage. But this is obviously a very complex task. Another question is are plans available through the exchanges operating on a level playing field with their competition outside the exchange because we know that if not, then we have the prospect of adverse risk selection if insurance plans outside the exchange are able to undercut the offerings that are developed within the exchange.

And finally, how would the exchange products be launched? What kind of education and outreach will be critical, particularly in the first few years of open enrollment? A widespread campaign may be necessary that takes into account linguistic and cultural needs within the diverse population.

So we’re hoping our panel today will address these questions and others. We know that at the end of the day their success is going to be critical to the achievement of the goals of health reform. And let me introduce our panel moderator and our four panelists who are up here today very briefly.

Chuck Milligan is our moderator. Chuck, until recently, has been the executive director of The Hilltop Institute, which is a leading think tank working with states to develop health exchanges. Then we have Dr. Rex Cowdry from Maryland. Dr. Cowdry is the executive director of the Maryland Health Care Commission.

We have Representative Jim Dunnigan from Utah who is the chair of the House business and labor committee in the Utah state legislature charged with developing exchanges. We have Dr. Bill Hazel from Virginia who is the secretary of health and human resources in Virginia.

And Joan Henneberry from Colorado who’s the director of the health insurance exchange planning effort in Colorado. And we’ll be joined later by Joel Ario who is the head of the office for exchanges at HHS who will provide a federal perspective on these questions. So we hope there will be plenty of time for your questions and for lots of discussion with the panel. With that, I’d like to turn it over to Chuck. Thank you, Chuck. (Applause.)

CHUCK MILLIGAN: Well, I thank you very much. And John, those are great questions. I think states would be more than happy to have you provide TA along the way. And the state representatives here I’m sure are very grateful to have a day of asylum here from the work back at the states.
I will just try to tee up some things and to offer you a spoiler alert. There’s a lot of work to be done and a lot of work being done. Fortunately, there is a lot of help out to the states. The state associations like the National Association of Insurance Commissioners, the NGA, National Association of Medicaid Directors and others are helping. Some foundations – including AARP, Robert Wood Johnson and others – are helping as well through grantees like the national Academy for State Health Policy, state coverage initiatives and others.

So there’s good support. There are good federal grants coming out to help with planning activities. There’s a lot of work to be done. One of the things I think you’ll hear is that states, as they’re pursuing a lot of the exchange development and policy work, are really trying to develop ways to tailor the exchange to each state’s individual market dynamics, employer dynamics, insurance carriers as well as their individual state cultures and individual state philosophies.

So I’m hopeful and I expect that we’ll have quite a nice variety of approaches mentioned here that really reflect some of the variation and flexibility out in the states that’s being used to target and tailor these programs.

Today we’re going to be talking about some high level issues, governance among them. We’re going to be talking about adverse selection and selection, kind of the market dynamics between the exchange and the external market.

We’re going to be talking about things like public accountability and public transparency. We will talk a little bit about how these exchanges link to existing public programs like Medicaid and like preexisting state high risk pools that many states will need to fold into the exchange in time and how the community rating will affect that.

And we also will talk about some of the strategies and roles of how to make sure that consumers are involved, engaged and have a say at the table. So I’m just going to do a very big high level overview to kind of set the stage for the discussions you’ll hear about in a minute.

With respect to governance – starting with governance, which is when the exchange gets created, first of all what is the form of the exchange, what type of entity is it and how is it governed. The vast majority of states that have enabling legislation that’s pending now are pursuing what are called quasi-governmental entities or independent public entities.

And what this means is they are public – they are public sector organizations in the enabling act but they’re not traditional executive branch agencies. They might be more of an authority or a commission or that sort of thing. And what states that have pursued this – and this is really the majority of the enabling act – states are pursuing it for a few reasons.

One is it creates the accountability and transparency of being a public entity subject to open meetings laws, public information requests, certain criteria about procurement rules that make sure that federal and state dollars are accountability awarded in contracts. But it also – in most of these states they’re looking at ways to avoid some of the difficulties with an executive
branch model like slow hiring decisions, very slow and lack of nimble behavior in terms of other components of executive branch and state government.

There are exceptions to this. Some states are going in the executive branch route where it’s really going to be an exchange that’s part of the executive’s structure. Examples like that include the District of Columbia, Vermont and South Carolina.

And there are states that are pursuing it in a more nonprofit model where a nonprofit organization would be the exchange. And in those states what they’re really looking for is something that has even more nimble behavior and an ability to not be a government entity. States pursuing that model include Indiana, North Carolina and Mississippi.

Typically in these enabling acts the boards are in the size of about eight to 14 people – broad expertise, broad representation typically. Second topic I want to mention is selection. One of the things I think you’ll hear a lot about and certainly when Joel gets here we’ll hear from Joel about is how to make sure that it’s a fair market once the exchange is up. And I’ll mention just a few things.

One is how do you try to encourage individuals to enroll, period, so that you don’t have the people who are typically healthier and typically don’t expect to use health services staying out, paying the penalty – the individual mandate penalty – and so that you have all of the people who are enrolled tend to be a little bit sicker and the premiums are a little bit more expensive. So one of the selection issues is just take-up, who participates and who doesn’t.

Second level selection issue is how to make sure that there’s something of a level playing field between the products and carriers inside the exchange and the products and carriers who are selling outside the exchange in the external market and how that – how that selection issue and level playing field issue is addressed by different states in different ways to make sure that all of the riskier people – higher cost people don’t find themselves in the exchange where the external market, the product development and the marketing approaches and others try to recruit the healthier people in general.

A third aspect of selection is how to make it fair, one carrier against another carrier so that one carrier doesn’t really clean all of the healthier people and leave the other – their competitors with higher risk people. So there’s a lot of components to selection.

States are approaching it in different ways. For example, by requiring carriers in the exchange to offer products at each tier, each metal tier – the bronze, silver, gold sort of thing – so that they don’t only include certain products in the exchange in a way to try to drive people based on the price differences.

States are also looking at the extent to which products and carriers in the exchange and out of the exchange have to offer products that are somewhat similar to each other in and out so that they mirror each other so that there isn’t product differentiation that drives selection.
And one of the other things states are looking at is if some carrier only offers products in the external market that they’re not allowed to offer a catastrophic product which tends to attract people who don’t anticipate using a lot of services or are willing to have a high deductible tend to be healthier as a way of driving selection in that way.

The third thing I’ll just give a high level overview and then I have four and then I’ll turn it over to the panel. In terms of public accountability and transparency, states are looking at a number of features. I mentioned a couple – open meetings laws, public records act requests, the way they conduct business with procurements, the way they conduct business in other ways.

States are also looking at trying to have public accountability and transparency by the kind of data they require exchange carriers to post and publish and make available including things like enrollment and disenrollment statistics, including things like their financial reports, including things like their policies about out-of-network access and cost sharing to go outside network and including things like the volume of denied medical claims and physician claims – to just hold some of those things accountable.

As well as posting – even if this isn’t a factor by which carriers are allowed to offer products in the exchange – including things like posting quality report card scores and those sorts of things. And finally the one I’ll mention is the extent to which the exchange coordinates with public programs like Medicaid and as I mentioned perhaps preexisting sate high-risk pools.

I’ll focus on Medicaid for example – I’ll focus on Medicaid now because that’s really one of the big areas of state policymaking and state decision making. The first thing is – and this is not optional – states have to make sure that there’s a single entry point into Medicaid’s expansion in the Affordable Care Act but also into the exchange where the subsidy programs, the advanceable tax credits will help individuals between 133 percent of poverty and 400 percent of poverty get some form of subsidy to buy coverage.

Now, there has to be a single entry point application process, screening process so that when somebody comes in – if they’re Medicaid eligible, they go to Medicaid and if they’re exchange eligible they stay in the exchange and they know which subsidy level they’re at and what of the size of the subsidy is and how that will drive their selection of a product.

That part has to be done, the entry level eligibility screening has to be done. But where states are ally thinking in other ways about policies between Medicaid and the exchange is should Medicaid and the exchange have a common purchasing strategy so that if a state has a Medicaid managed care program that contracts with Medicaid managed care organizations, should those same Medicaid managed care organizations be allowed to or required to offer products in the exchange.

So that as people change incomes and go perhaps from 150 percent of poverty in the exchange and then maybe lose a job or lose hours or become part-time and then find themselves with a lower income and Medicaid eligible, that they can stay with the same insurance company as they make those transitions.
So states are trying to think through one of the issues is whether there should be common purchasing strategies. But shy of that, if states don’t want to go that far, there are these boundary issue when people change income from 100 percent of poverty in Medicaid to 150 percent of poverty in the exchange. If they have to change carriers as they make that divide because the products and carriers are not identical in the programs, how is that hand-off going to be made.

People might have chronic illness, existing providers, specialists that they have established relationships with or they might be pregnant and four months into a pregnancy at the time they make a shift or they might have a prescription drug regimen that people do not want to see disrupted if they go into a new carrier that’s going to use its own prior authorization and screening and formulary approaches.

So one of the things states are thinking through is how do you coordinate that hand-off in a way that serves the consumer so that there isn’t tremendous disruption in a provider system – their traditional providers, their approved care plans for therapies, medications, prenatal care, all of that – as well as the other real main coordination issue between Medicaid and the exchange is the extent to which and whether a state pursues the basic health plan option that is an option in the affordable care act.

So these are all a very short list of many of the issues that states are confronting. The four people that I’ll be now turning the microphone over to are working through these issues on a daily basis and our first speaker is Rex Cowdry from Maryland. Thank you very much. (Applause.)

REX COWDRY: Well, It’s a pleasure to be here and we greatly appreciate the role of AARP, both as a convener and also as an educator about reform. And all I’ve got to say is, Chuck, if this is asylum, it must be part of a deinstitutionalization. I’m going to assume –

MR. MILLIGAN: (Off mic.)

DR. COWDRY: (Chuckles.) Either that or it’s church asylum and we’re somehow, you know – I’m not sure which. So we’re going to assume some of the virtues of the fundamental principles – improved access through assistance to low income individuals and help for chronically ill individuals, better structured market through information, early stages of payment reform and that this is incremental. This is not radical change – and talk a bit about the process in Maryland and then about some particular issues.

Now, obviously you’ll see a great diversity here across the states in the spectrum. We start with a lot of advantages. We’ve got a Democratic state. We’ve got a Democratic legislature. We have a supportive Democratic governor.

We have federal funding in the face of large projected state budget deficits and we’ve got Chuck Milligan who has just laid out the fundamental issues that I now don’t have to go through except to point out that we’ve solved – none? We’ve solved the government’s part of the equation that he laid out and I’ll tell you a bit about that.
Nonetheless, even with those advantages, obviously there’s a diversity of competing interests here whose concerns need to be addressed – perhaps most notably in our state, the state employee unions, our insurance producers and our strong third-party administrators. The day after the legislation passed, Governor O’Malley established the Health Care Reform Coordinating Council and a variety of workgroups to gather and report public views.

I’ve got to say early does not mean fast necessarily and there’s been a lot of time devoted to public meetings, gathering, hearing views and whatnot, culminating in legislation which can best be described as establishing the governance and keeping most of the key policy issues in the study.

So that’s what it is for governance. We shamelessly borrowed from governance features from the earliest states to act. It’s an independent agency for transparency and accountability. It’s got a small board – nine members – and one of the goals there is to have a board that – whose members don’t see themselves as representing a specific constituency but rather as a small working group that sets policy for the state.

It’s a – (inaudible) – it’s got three government members. It’s got three consumer representatives of small business or employees and individuals using the individual exchange and then a third with substantive expertise in a variety of areas of health policy and insurance. And we get the input with large technical advisory groups that report to the board. Chuck reviewed the personnel and procurement authorities that you need to get in place in order to be able to hit January 1st of 2014.

And we have a lot of studies coming up in the next seven months about key issues – about market rules, the role of navigators, outreach and education and of course we’re also awaiting – like everyone – federal guidance about key issues, particularly the guidance about the exchange in general, the shop exchange in particular, the essential benefits package and risk adjustment methodologies which are going to be so crucial to make key parts of this reform work.

So what’s the area of insurance market reforms? And Chuck, you’re going to have to kick me when I have one minute left, okay?

MR. MILLIGAN: Okay.

DR. COWDRY: All right, good. Interim action, we have the state’s – we have the nation’s third largest and fastest growing high-risk pool. So it was naturally – natural that we would only take on the MHIP federal plan. We have the usual complexities in the individual market.

Does the exchange IT go forth from social welfare eligibility and enrollment processes or is it much more tightly tied – and this is I think our answer and many folks’ answer – to health insurance and both public and private and that’s its primary focus with a later goal to include eligibility and enrollment issues in social welfare programs.
The approach to relation inside and outside the exchange that we all think is going to be so crucial – study and report. One of the key issues that’s going to be what do you do about choices? Do you limit choices or do you have as much of a diversity of choices and richness in benefit design as possible?

Key issues – there are advantages to each and I don’t think we’ve sorted that through. If there is limitation is it done through selective contracting or do you limit choice to help people make choices by saying the carriers – you can offer four plans, choose your best rather than dictating what those plans will look like.

So I think there are a number of key issues there in terms of what inside and outside the exchange looks like. Market merger kicked down the road – although I think most of us feel that the first two years of transition are going to be crucial. We are not sure what the impact on rates are going to be.

So there’s some virtue in waiting both on issues of market merger and on issues of expansion of the small group market. We have at least one co-op market at a formative stage. Other than governance, what’s going to set a co-op apart from the other issues in the market? Well, in this case, possibly a commitment to value-based benefit design. But we’ll see more as this shapes up.

Shop exchange – a particular passion and interest of mine and my neighbor to the right, I think. The potential transformation of the small group market to something that is different, a different model of offering insurance, an alternative that is not there currently that offers employee choice, affordability and employer-defined contribution I think is going to be a very interesting option.

Will it resonate? Will it resonate with small employers and with employees of small employers? I think we have to make it as smooth and appealing as possible and that’s going to be the challenge. We know in a sense what needs to be done in the individual market. It’s going to be extremely complex. But that’s known. I think the issue of how to make a shop exchange work is more of an unknown and in some ways more of a challenge.

MR. MILLIGAN: This is your one minute warning.

DR. COWDRY: Okay, a one minute warning. So I talked a bit about insurance producers. I think those are absolutely crucial to the success of the small group market exchange. But how does that square in terms of the way they’ve traditionally been paid with the notion of navigators who are paid by the exchange? What does that mean and how do we – how do we engage and make producers our partners?

Finally, cost and value – we’ll just touch on that because I think in a way the biggest challenge will be one that is not necessarily directly connected with the exchange at all unless the exchange does selective contracting and even there it is not clear what can be accomplished. But the other elements of the law are going to be crucial to making these exchanges work, the kind of
moves to payment reform and particularly toward reform of provider delivery systems into functioning accountable care organizations.

I think there will be interesting questions about how we change our insurance designs to respond to that. Can we make value-based benefit design more acceptable to people so that they like it not only when they’re well but also when they’re ill. Will plans emerge with very narrow low cost networks or with provider tiering as a way of dealing in part with cost issues?

And of course in Maryland, as in many places, there’s a lot of interest. We have a multi-payer patient-center medical home program that’s starting up at this moment and of course there is a lot of interest in accountable care organization designs and we will be eager. We now have some guidance. Now, we’ll see what those actually shape up to.

So I think in a funny way part of the success of the exchange lies outside the exchange. It lies in how much progress we can make in these other areas of reform of delivery systems and reform of payment mechanisms. Thank you.

MR. MILLIGAN: Thank you, Rex. Representative Dunnigan?

JIM DUNNIGAN: Good morning. I’m very pleased to be here with you today, not the least of which as I left six inches of freshly fallen snow in Salt Lake City yesterday for above average temperatures here. So it’s a win-win so far for me.

In 2009, Utah began to lay the groundwork for its – the Utah health exchange and we began as a pilot program, opened it to the marketplace in January of 2010 on a very limited basis to try to get a few number of employers in and try to work out the bugs. We had about a dozen businesses sign up and they began coverage in January of ’10.

And it gave us an opportunity to kind of work through many issues that have been mentioned – marketing, risk selection, adverse risk selection, the products, the number of products. So we worked through those issues in 2010 and in January of 2011 our exchange opened to all takes, all comers. And each month – the first of each month businesses may apply and enroll into the Utah health exchange.

So to date we’ve had about 100 businesses that have signed up that are now participating in the exchange. It’s certainly optional. So they participate if there’s something that attracts them to the exchange. It’s a market-based exchange under the direction of the governor’s office of economic development. And it’s growing at about 20 percent per month.

So of those 100 businesses, they cover about 3,000 bellybuttons, as I call them. So these are the total members and continued enrollment by groups. The exchange in Utah is available to small businesses with between two and 50 employees. So we are focusing and targeting small businesses. The smallest group in the exchange has two employees. The largest is 49 and the average is 13. So the average employer size is 13.
When we rolled out the exchange initially for an effective date of January 2010, we said: You must use an insurance producer in order to access the exchange. This go-around on the open enrollment that’s each month of the year we did not require insurance producers to be involved in accessing the exchange. However, 95 percent of the businesses that come to the exchange do so through an insurance producer.

Just by way of information, 50 percent of the businesses in the exchange have between two and 10 employees and a fourth have between 11 and 20 and another fourth are 21-plus. Another thing that we discovered is that 20 percent, or one-fifth, of the businesses who have health insurance now in the exchange did not have health insurance for their employees prior to participating in the exchange.

Utah’s exchange functions on what we call a defined contribution concept and so what this means is the employee says to the employee: Here is x number of dollars a month. You go to the exchange and you buy the coverage that fits you or you and your dependents’ family with this set dollar amount.

And we have over 60 products – 60 plan products available in the exchange. We have taken the position that choice is good for the consumer. So we have fairly rich benefits plans and we have high deductible – federally qualified high deductible HSA plans available, top to bottom, quite a broad range in selection.

Of course, this has caused some examination of adverse risk pool selection. We do some risk sharing within the exchange both on the front end and on the back end. But so far it seems to be working. The defined contribution where the employer gives a fixed dollar amount to the employee is designed to give the employer a set cost in his expense sheet that he knows his health insurance is going to cost him or her. And by way of information, the lowest contribution that an employer that’s actually in the exchange has selected is zero. I call that the good luck contribution. You’re an employer, go to the exchange and do your best.

The highest month – and these are monthly contributions by an employer is $1,683 and the average is $360. So with that $360, the employee goes to the exchange and decides if they want single, two-party, family – or employee and children and then determines how far that money will go plus of course they can put money from their own contribution in it as well on a pre-taxed basis. In Utah in general we have a young, healthy population.

Of course, we have our share of senior citizens but if you look at the average demographic, we’re relatively one of the youngest states in the nation as far as population, a lot of children and relatively healthy and among the lowest health care and health insurance costs in the country. Even so, insurance consumers in Utah think that health care and health insurance costs are too high and many times unaffordable. They are very price-sensitive.

We have tried – and we do talk about quality but price, price, price. It’s like real estate, okay? The most three important factors are cost, cost, cost, price, price, price. And then if we can get past that, then of course they’re interested in quality. But if they cannot afford the
coverage, it doesn’t matter how good it is or how good the outcome is because if they don’t get
the policy and access, the rest doesn’t do them any good.

In the coming months – and this year we’ve been tasked with melding the mechanism to
get Medicaid and CHIP and the other government-sponsored programs eligibility in with the
exchange eligibility to get to what we want – or and I’m sure you’re calling it perhaps the “no
wrong door” approach where a person can go to the exchange, enter the information, as has been
mentioned. If they’re eligible for Medicaid of CHIP, it will take them down that path.

If they’re not, it can take them into the private or the commercial sector. Now, we have a
good public program, software and mechanism that Utah’s invested probably $90 million over
the last several years to create eligibility for Medicaid and CHIP and UP, which is a Medicaid –
(inaudible) – program that we have going in Utah. We now have to fit that in with the exchange
and then try to work in the available subsidies.

That’s not an easy task. It’s taken years and $90 million to get the government program
eligibility working and now we’ve got to fold that in with the exchange. We’re also working to
make the exchange consumer friendly. Insurance – health insurance – is a complicated product
and, you know, it’s challenging with over 60 products.

When we started at the outset, many of the – we have an exchange advisory board. And
members on that and on other committees had said: We want choice, we want the consumers to
have choice, we want them to be able to design and find their own product. And I agree with
that. But that also makes it more complicated. And when you sit down, as I do, with people that
are shopping on the exchange and you lay out over 60 different options, it can be very
overwhelming. And so now people are saying: Well, that’s too many options.

We need to try to figure out something – or at least put them in categories so if you think
you’re healthy, go for this plan. And so I do believe in choice and I believe that the consumer is
better served to have the choices, but it is complicated. I believe that it’s very important that
states be allowed the flexibility to design and implement their own exchanges.

Exchanges by themselves really do nothing to control cost. They are a marketplace and
in Utah, by statute we have said that the underwriting rules and the rate rules for the health
insurance must be done and administered the same by the health insurance carriers inside the
exchange and outside the exchange. So it’s a level playing field.

Whatever case characteristics and underwriting guidelines you’re going to use in the
commercial or the open market, you must use in the exchange to try to avoid any advantage one
way or the other. However, the more that we layer on government regulation, it just tends to
drive up administrative cost and does not lower the cost of health care, health insurance.

And with my friend here on the left, I agree that if we’re going to control health care
costs, we’ve got to get to delivery payment reform and some other things that actually address
cost. So as I said, we do have an advisory board with consumer representatives on it. Our
meetings are open. We are trying to serve the public and I’m excited about the 20 percent
growth that we’re seeing every month. We run the Utah exchange on a budget of about $600,000 a year.

We partner with our insurance carriers that participate and they fund an actuary for us. So we have done it. It’s a lean – a lean-operating program. But thank you for letting me to present to you this morning.

MR. MILLIGAN: Thank you. (Applause.) Next up is Secretary Hazel.

BILL HAZEL: Thank you. Is this on now? Can you hear me? Thank you. I appreciate the opportunity to be here and to learn – being the third wheel here, so to speak, is there isn’t much about the actual technical building of an exchange that hasn’t been brought up as a problem. This is a great, great situation for policymakers because there are a lot more questions now than answers. And that keeps us really busy.

I want everybody to understand that I come at this a little differently than the rest of this group. have you all heard the rumor that Virginia doesn’t like the PPACA? I didn’t know whether the word had made it across the Potomac ocean here or not. But we generally have not been enamored of the PPACA. And I get the job as secretary – I’m a practicing orthopedic surgeon, or I was. I have now been in recovery almost 13 months, almost 13 months. And we come in and I believe the governor hired me because of health system reform. And we immediately get into the legislative session and have four bipartisan bills that basically says, nope, we’re not going to do this. And then we have this little matter of the lawsuit.

And, you know, silly me, I thought I knew something about health policy. But what we have fallen into here is a constitutional argument about what are the federal rights and what are the state rights and what are individual rights. And of course Virginia has been doing that since the first Constitutional Convention. So we are very experienced at trying to – (laughter) – at trying to advocate for the individual rights in all of this.

Now, what I would – instead of getting into some of the questions that they’ve already addressed which we have too, but I would say we have some real practical issues. Number one, we have to build a consensus in Virginia for whatever we do. And we look at this as part of the bigger bill. This is a big step. But it is part of the bigger bill. And we don’t think health reform is an exchange or is Medicaid.

It’s about delivering payment, which these two gentlemen have already alluded to. So when we set up the Virginia health reform initiative last year, we had six task forces. And the key is delivery and payment reform. We will not get value in health care at the level of how we set up an insurance exchange, I don’t believe. I think we have to break what I would call the stranglehold of our current payment formulas to encourage innovation.

Innovation for most institutions today is a loss leader. You do innovation to make yourself more effective and more efficient. There is example after example of institutions doing that and their reward is loss revenues because there’s less testing, there’s less surgery, there’s
less physical therapy, less medication. And when you lose your revenue stream, it’s hard to maintain your organizational mission.

So we don’t want to get that lost in the exchange and also it’s an important part because as individuals buy insurance, we don’t necessarily know today what they’re going to need to buy in five years. So how do you get some base set of rules in place that then allow the innovation and the competition and the choice that we think is so important in the exchanges? So the first issue is actually doing health reform.

And part of our initiative is actually bringing in purchaser groups to talk to them about are you looking at something other than the bottom line? Are you looking at the health of your workforce? Are you looking at the accessibility of care, time out of work? Are you asking the insurers to buy health care in a way that’s actually optimal?

And the answer is probably generally no. So that’s a big thing. We certainly are looking at technology. We’re looking at workforce issues and we are looking at the insurance regs and of course Medicaid which I’ll get to.

But some –a couple of questions – the first question is this really doable in the timeframe that we have? I’ll explain a secretary’s dilemma. As of today or as of last year, we went to the legislature and said: We need you to own this thing because we don’t want to get into fighting each other in the state about whether we’re going to have an exchange and it’s Virginia-run.

The health reform initiative can only say one thing with certainty. We want to control our own destiny. We will set up our own exchange. So you have to get the general assembly to buy off on that and the state and they did. They’ve told us to plan it. So we will use the same health reform initiative. We are hiring the consultants to do the actuarial studies and all of the things that we need to do.

We’re going to do an employer survey to see what they know about it. One of the problems is we don’t know actually who is going to end up in the exchange because of the – how business responds to the penalties and how individuals respond to the rewards of moving out of employer-based into an exchange is a big deal.

The next problem we have is we don’t know how do you ensure that Medicaid is something that people benefit from but still want to get out of and want to be responsible for their own purchasing and move up the ladder and that we don’t end up with Medicaid expansion as a result of having a better Medicaid benefit than a lower end insurance exchange.

So we needed the general assembly involved. So they are involved in this. They’ve told us go do it. But we have to come back and sell it to them next year. So at the best we have a 60-day session next year. So the best chance I have of getting a bill passed to set up the exchange in Virginia is mid-March.

If the governor signs it the day it’s passed, it will be mid-March. emergency regulations in Virginia take 280 days which means that I will not have regulations in place until 2013 and if
I’m not mistaken the feds want to be able to approve our plan. They want it in beta in 2013. So this becomes a real challenge for us just to actually get the thing done.

And it doesn’t help – I’m not picking on Joel because he’s jumped into this thing too with the rest of us. but we really don’t know yet exactly what’s going to be acceptable and even more as we start doing the planning and I understand the reason because we’ve chatted about this offline. What’s this basic benefit package going to be? We don’t know. We just – we just plain don’t know and those are actually not just minor technicalities.

Those are real things. So as we go down our list, we said – sorry – so what is the – how do we harness market competition to be responsive to the public and the consumers? We actually feel in Virginia that consumers are actually people who use their own money to pay for insurance too. It’s been interesting in some of the comments that consumers – that the title tends to go with people who are on public programs. But the fact is that people who spend their own money are consumers too and we need to include them.

What is the public role? Realistically, do we set up an exchange? Do we buy an exchange? Do we partner with Utah to do it? What we know that we have to do is figure out how to deal with this eligibility problem and the tie between Medicaid.

We are – we had money in the budget this year. We are actually actively now trying to build the eligibility portals and what I envision we would do as a state is create an electronic certificate that says, yes, this is Joel Ario and this is his benefit. This is his eligibility benefit and we would email or fax or whatever that certificate to whatever exchange or exchanges might be out there competing in an ideal world as a way to give choice.

I don’t know that we can top-down design an exchange perfectly the first time. I wonder if maybe we shouldn’t give a state more than one and let the consumers decide which one they want to have. So these are just little tricks we have to work out. But we are using – we will use the Medicaid administrative match to build the eligibility portal.

And we’ve got our money set aside to begin that process and we will extend that through and take advantage of that to build not only eligibility for Medicaid but for social services and build a case management and informatics portal on top of that. Virginia has another odd quirk. We don’t necessarily look at it as defeat and state money and people say, well, you know, this is not state money. It’s federal money.

But it reminds me when I used to take my daughter to the toy store. She said: Daddy, can I have that? And I said, Sure, Suse, you can have that. She said: Well Daddy, am I buying this with my money or your money? (Laughter.) And it makes a difference in terms of the purchasing but the fact is all the money comes from the same place and I don’t know yet how to speak Chinese.

I’m not likely to learn. So we do have a real federal budget issue here and the artificiality of the situation is we’re trying to – well, federal money versus state money and the guy who’s
writing our tax checks, it’s all the same to them. I mean, really it’s an interesting thing. I’ve already mentioned the little debate we’re having on the constitutionality versus health policy.

It’s like – hey, it’s like walking into this as a health policy guy – it’s like bringing a knife to a gunfight. It is very, very interesting how that works. Now, I could go on but what we are even now in Virginia having issues with is with our bill to establish the exchange – we get into social issues. Is it going to cover abortions or not? It’s not a debate that we necessarily welcome but it’s one that you get when you start discussing this and we’re already arguing about that.

And we don’t even have a consensus for sure that we are going to build this thing. So it’s a tremendous, tremendous challenge. Now, that being said, we do have – we will have our marching orders. We are working on the eligibility. We are in the process of hiring contractors to look at, again, the actuarial issues, the governance structure and so forth.

I would hope that as we go forward we will see – go forward, we will see the flexibility on the federal side to maybe approach things a little bit differently. We need to learn from each other. We really do and if we think that we can design something that works across the country and we’ve already kind of conceded that’s not likely to be the case.

We have to allow for regional variation. Well, Virginia’s got regions too that are very different. We’ve got southwest Virginia which is Appalachia and we’ve got the high-tech northern Virginia which is very wealthy right across and it’s not clear that one exchange is an optimal situation for Virginia. So we’ve got – we’ve got a lot of work to do and I’ll be happy to take questions. But I’m more interested now to hear what Joan’s going to say.

MR. MILLIGAN: That’s your cue, Joan.

JOAN HENNEBERRY: Well, the idea of having to create two exchanges is pretty horrifying to me. (Laughter.) I don’t – okay – the good news –

DR. HAZEL: Well, we might let somebody else create them and just regulate them.

MS. HENNEBERRY: Yeah, the good news about being a purple state is that everything you’ve heard on this panel, you hear in Colorado because we also have a very diverse feelings and opinions about health reform and exchanges.

But I will say even in the absence of federal health reform, we probably would be having the very same conversations that we are having today and whether we would go the Utah route with a defined contribution exchange with no government subsidies or look for ways to provide government subsidies to cover the individual market.

There was a commission that met in Colorado in 2007-2008, submitted their report to the legislature in January 2009 and one of their recommendations was to look at – at that time – the Massachusetts model and what Utah was planning at the time and think about an exchange for Colorado as a solution to helping cover the uninsured.
So we’re about 11 weeks into our formal planning. But I will say we actually began our planning last year, last summer in 2010. We saw the writing on the wall from the language that was in the Affordable Care Act, especially around stakeholder engagement and planning. So we did most of our stakeholder work – although we’re continuing to do that.

Last year we did 10 town hall meetings around the state, thousands of people attending those meetings. And used that information and feedback from the carriers, from the producers, from the consumer groups, from the provider groups to craft the legislation that’s before our legislature right now. So on one hand we’ve made great strides. In terms of stakeholder engagement, data analysis, economic modeling is well underway.

We’re continuing to engage stakeholders though very formal technical workgroups, a workgroup on data analysis and setting metrics for achievement, a workgroup on small employers and a workgroup on eligibility verification and enrollment. So that’s all the good news. All of that stuff is well underway and we’re pleased.

Where our concerns lie, many of which I share with my colleagues from all states that we’ve talked about and I’ll tough on them a little specifically to Colorado. So we’ve worked a whole bunch of people worked for about four months starting last probably November to craft our enabling legislation and very much like Maryland we wanted to keep this first piece of legislation focused on governance.

We didn’t want to get into some of these important policy decisions that do need to be made because we want the board to do that. We want the board to make those recommendations to the legislature. We worked very hard, got a bipartisan bill and the night before the bill was introduced into its first committee hearing last week, the Republican House sponsor decided that it would be very hard for her to support her own bill as it was currently written.

And the tension here – and I don’t think this is unique to Colorado – the tension really is how do you move forward on this concept of an exchange that seems to be very attractive to many parts of our society, to small employers, to the business community, to the carriers. How do you do that without – can you do it outside of the political rhetoric and tension and toxicity in this particular town around federal health reform. And how do you do it knowing that we’re getting closer and closer to a big election year?

And that’s really what the tension is about for us, that people who love the idea of an exchange, whether it’s Utah-like exchange of a Massachusetts-like exchange, they like this notion of creating a new marketplace and a place where especially small employees can come and find a way to provide coverage to their people. But to do that and have it look like you actually supporting a larger policy agenda that they don’t support is where the tension lies.

So we continue to work. It won’t stop our planning. But if we can’t come to an agreement sooner or later, it will be very hard to continue next year, especially because we have to address these policy discussions in 2012 that you’ve heard about. We have to talk about plan selection. We have to talk about the size of the market.
Our current definition of small group is 50 or under. We heard – I think we heard loud and clear in our stakeholder meetings last year that we want to continue to address that market size only. We don’t want to take the federal option and go up to 100 employees for lots and lots of reasons. But we need the board in place to guide us and help make those decisions. So getting that legislation, it won’t – if it doesn’t pass this year, we’ll continue to plan. We’ll do all the things that we’re doing. But sooner or later we need the general assembly to bless something so that we can proceed.

The issues you’ve heard about – this intersection between eligibility and enrolment in the public programs and the exchange – this really is – people have heard me say this a thousand times. This is what keeps me up at night.

This is really, really hard stuff. And the systems that most states, including Colorado, have been operating under in their public programs – unless you’ve invested a lot of money recently, like Utah and a handful of other states, you’re working off very old legacy systems. They were never, ever, ever designed to be this nimble, to be able to adopt policy changes really quickly.

So how do we figure out – we can build, buy or borrow a really slick, wonderful system to get people into the exchange, especially given that, remember, all of the federal rules are going to be the same, all of the standards for determining eligibility are going to the same. That’s not what I’m worried about, but how you marry that up with your current eligibility system for the public programs and make sure people get into the right house.

I think about this as sort of adjoining – three adjoining town homes, if you will, with doors intersecting. And people get to come to any one door, but getting them into the right house and keeping them in that right house is going to be very important for lots of reasons, both for their benefit design and what they have access to, how you coordinate that with other social programs, if they’re eligible for those.

But frankly, I think our federal partners care about this a lot, because the money that moves around in the backroom is really important to them, that the right person is married up with the right matching rate and the right source of funding. And that’s important to us as well.

So this is hard stuff. This is where I’m most concerned we won’t be ready. We’ll be ready on the policy side. We’ll have all of our administrative stuff up and running. And then when we’re ready to flip the switch on the exchange side, the Medicaid folks will say, well, our eligibility systems aren’t ready yet.

Switchers – what we call switchers – and we actually have an RFP out on the street right now to do our data analytics and our economic modeling, but we know that low-income families, the people that are close to that cutoff line at 138 percent of poverty – in our state, anyway, these are working families who have many jobs, part-time jobs, a full-time job. One parent works full-time, one part-time; they both work part-time.
Their income fluctuates constantly throughout the year, and they’re going to be – their income would be floating, if you will, up – above and below that line constantly. And I feel very strongly that we allow for continuous eligibility right now for children in CHIP and Medicaid. And once we get someone in the door and in the right house on the day that they’re enrolled in whatever program they’re in, we have to keep them in that house for that first year even if that income changes.

And that puts additional administrative burden on us to figure everything out in the backroom of that house. But if we have to move people back and forth, back and forth between a public program and a private plan, it will be chaotic administratively. And frankly, how will we ever be able to hold those plans accountable for improving the health and helping us drive down the costs?

Now, if you have the kind of market that Maryland is talking about where the same products and the same plans and the same networks are sold to the Medicaid program as well as into the exchange, that’s great. But many of us don’t have that, and there’s no way we will have that. That’s a great goal to have, but that structure will not be in place by January 2014, not in Colorado, anyway. So that gives me a little heartburn.

The issue of ongoing public engagement and meeting our target enrollment in that first year is really, really, really important. I mean, we have to know exactly – we have to use the best evidence-based outreach and marketing we can possibly find, because I joke with people – what I call the technology resisters.

You know, the young, healthy people, they’re going to be enrolling on their smartphones by 2014. I mean, they don’t – they don’t want a face-to-face encounter. This is voluntary. This is not an entitlement program. They’re not coming to us to be case managed. They’re coming to buy insurance. And they’re very tech savvy, and they’ll look at some information and they’ll make a choice. And I do fear that many people will choose based on price and not look at a little more detail.

But how we market to that population versus the early retirees versus the chronically uninsured people who are closer to that Medicaid cutoff line, these are completely different techniques, completely different types of people that we will pick as navigators to reach out to those populations and who will engage those populations. So we’ll be figuring that out, but I think it’s a really important thing to focus on.

And continuing then to engage people – if people haven’t bought insurance before or it’s kind of a new concept to them and they’re paying a premium every month and they’re just very fortunate and they’ve stayed healthy that whole year, convincing them to enroll in year two and continue to spend that money that they haven’t used is going to be a challenge for people who aren’t used to having insurance.

So we can overcome – I believe we can overcome all of those things, and the way we’ll do that is to continue to engage people who are smart in all of these areas and pick best-of-class vendors to work with and community organizations and producers. I think they know a lot more
than we think they know about how to make this successful. So I think we can do it. I’m a little nervous about our enabling legislation and what will happen if we don’t get that passed this year, but we’ll keep plugging along.

Thank you. (Applause.)

MR. MILLIGAN: OK, thank you.

In the interest of getting us in the direction of a schedule, what I’m going to do is I’m going to ask a couple of very discrete questions of the panel, and then turn it over to Joel, who I’ll introduce. And then we’ll make sure to have ample time for all of you.

There’s one question I wanted just to put to all of the panelists and ask for your brief comments about it, which is, in your state, one of – what is the most significant change you anticipate in the market that you need to take into account?

Whether it’s the way that the community rating provisions is going to – are going to change some of the underwriting or rating programs, how you’re planning to try to keep large employers in the mix, how you’re planning to try to market to small employers, how you’re trying to deal with selection based on your carrier and employer dynamics. And I’m just interested in – part of this is to tease some of the state-specific market dynamics, and if you could just briefly touch on that in your states. And maybe we can kind of go in reverse order.

Joan, if you don’t mind taking the first crack at that.

MS. HENNEBERRY: Sure. I think the plan selection is – I think it’s this benefit design, because none of what we’ve talked about so far directly will impact the cost of coverage, and we are one of those states that we have this mysterious phenomenon of being one of the most expensive states in the country in terms of health insurance yet we’re also one of the healthiest states. So we do not fully understand even the current dynamic that is causing our premiums to be so high and to continue to rise at ridiculous rates every year.

So the basic benefit design and what that really looks like, I think, is going to be critical. And then how we use that and how we have a – we’re going to have a very tense conversation in Colorado with our consumer advocates who will want us to force the plans sold on the exchange to add state – existing state mandates that we don’t think will be in the basic benefits package. And I don’t believe that’s the right choice to make, plus we don’t have the money to do that. So I think that’s going to be the biggest.

MR. MILLIGAN: Thanks. Bill.

DR. HAZEL: I could almost say ditto. I mean, the fact is, Virginia is sort of a purple state, and we have some of the dynamics that Colorado has in terms of expensive insurance. We do not – arguably, we do not in all areas of the state have enough competition in the insurance market, and not to mention driving down into the provider market and so forth. So we have similar things.
If we wanted a number two just for the sake of conversation, I think the challenge that we’re going to have is actually redesigning Medicaid so that it ties in. I’m kind of with Rex. I think that we are going to have to completely overhaul the Medicaid program if we’re going to make this rational, and that’s one of the reasons that we are looking at – it’s so important that we have the waiver issues around Medicaid redesigned, but then we get into knowing how much that costs. And to have a seamless set of benefits that still promotes individuals’ desire to get into the private sector is going to be a trick.

MR. MILLIGAN: Thank you, Jim.

MR. DUNNIGAN: I’m going to focus on cost, because, well, for those of you who don’t know, I’m an insurance producer by profession, and I have sold health insurance primarily to small businesses for over 30 years, and they’re very price-sensitive. I mean, they – you know, they’d sell their mother-in-law if they could save 1 percent on their premium but probably a half a percent for their mother-in-law. (Laughter.)

But – so some of the time bombs that I see coming – community rating. In Utah, we have a slope mandate that could be no more than 5-to-1, meaning the 65-year-old could not be required to pay more than five times the 20-year-old. So we have this range of premiums. In the ACA, the slope is limited to 3-to-1, so let me just tell you what that does.

To the 65-year-old, if you compress the 5-to-1 to the 3-to-1, it lowers the – or the 64-year-old, it lowers their premium by 22 percent, so it brings them down, brings the younger folks up. But because the dollar cost is such a difference there between the older folks and the younger folks, the 20-year-olds will see a 133 percent increase in premium. That’s a killer. 

These are the young immortals that really don’t think they need health insurance. They’d rather have a motorcycle or a big screen than pay for insurance premiums. They’re very price-sensitive. The fact that there’s going to be a law saying that they have to buy insurance will mean nothing to them. They don’t care. If they get caught, they’re college students. They don’t pay much in the way of income tax, many of them, so the penalty will be nothing. They’ll choose to go without, knowing that if something happens to them, they can go to the emergency room and they’ll be taken care of.

I’ll give you a brief example. In Utah, we have a Utah Premium Partnership, which is the state gives an employee some money to help buy the – pay for their health insurance through their employer. So we’re leveraging. The employer contributes an amount, the employee puts an amount, and then the state will contribute an amount to try to help people before – below a certain income level be able to buy into the insurance. As I go out and present to employer groups, I have a certain percentage of the employees that won’t sign up, and I say – and I just – this was a week ago.

I went out and said, you know, between what your employer is going to pay and what the Utah Premium Partnership subsidy is going to pay, this won’t cost you anything. Now, just – it’s your choice. Why aren’t you enrolling for the health insurance?
They said, if we need – if we need health care, we just go to the emergency room. We don’t want to mess with this. We know they can’t turn us away. And they have, you know, many of them, minimal assets, so they’re not worried about the bills coming. So cost is going to be a factor. I’m also concerned about the essential benefits package that will be proposed by the HHS secretary.

One of the challenges we have as you go state to state is all these mandates that either by the regulation or by statute have been required by the states to cover in their health-insurance product. And now we’re going to have the federal government level come in and say, this is what you must have in essential benefits. And it will be a piling on of every invested, vested party or interest group that says, as in Utah, this next year we’re going to study reimbursing for spiritual healing, OK. So how do you control that?

Dental care, should it be part of a basic health-care plan? So all of these and many of them certainly good programs – you get it so people can afford it. It doesn’t matter if you have the nicest benefit plan out there. If people can’t afford it or don’t think it’s worth the value, then they won’t participate. So cost still remains very concerning to me.

MR. MILLOGAN: Thank you. Rex.

DR. COWDRY: Well, I’m going to go all actuarial on you, because I think – right now, we have the small group market with a ratio of 3-to-1 and a broad, standardized benefit plan. I don’t think it’s going to change much. I mean, it will go out of business and be replaced by sort of the federal design. And I don’t think there’s going to be an issue there.

The issue lies with the individual market. Right now we’ve got an individual market with 20-plus percent denials, full underwriting ratios north of 7-to-1. So what happens to that in 2014? And what are the dynamics going to be between a small group market where employers, even up to 100, probably won’t face penalties but they will be kept in by the tax credits, two years of up to 50 percent tax credit?

But how does that interact with the individual market and subsidies? I think this is going to be a very interesting challenge. And I got to tell you – risk adjustment, reinsurance, the risk corridors are – that are built into the ACA are going to be absolutely vital to this transition. But I got to confess: I don’t understand how that’s going to work. So I think we have an interesting process of modeling that to try to produce the best results ahead of us.

MR. MILLOGAN: Thank you. And I want to close with one question I also want to put to all of you and take us back to where John started us, which is, what do you think is the most essential policy to include to reflect consumer engagement, consumer accountability in the policymaking in your states? And maybe I can kind of just go back this direction. Rex.

DR. COWDRY: Active participation both at the board level and particularly in these technical advisory groups, so it’s going to – I think it’s going to involve identifying the right people to serve that role and to speak vigorously.
MR. DUNNIGAN: I would agree. We have made an effort to involve consumer groups and to get their input. It’s not perfect. We have a food fight going on right now between I represent consumers – no, they don’t; I do – and you know, everybody wants a seat and the table, and there’s a limited number of chairs.

Another challenge with consumers is they don’t – many of them don’t understand health insurance. You know, we had two consumers on our advisory board, and we said, we want to simplify the census to make it easier for businesses to get a quote. And they said, what’s a census?

And so, you know, you really have to have varying degrees of understanding. We need their voice, but – so we have consumers. And I agree it’s important to get the right ones on there to participate.

MR. MILLIGAN: Joan.

MS. HENNEBERRY: I agree. One of our challenges is that most of the consumer groups – and they’ve been very, very engaged with us – they represent – they’re more likely to represent uninsured individuals who are currently eligible for public programs and not enrolled. There really is no organized body that could claim to be the voice for people that, I think, are going to come to the exchange – maybe at the lower income levels but not at the middle level at all.

So we certainly have relied very heavily on our small employer chamber groups as well, including – NFIB, who you know as part of the national lawsuit, sits on two of our work groups. They’re very important to our work as we think about how to engage small employers and their employees. So I would urge people not to forget about that side of the consumer voice as well: the employees of small employers.

DR. HAZEL: I mentioned earlier that the consumers in this case are people who are paying with their own money, and the same experience with Joan. The consumer advocates have a different agenda primarily, typically. A couple of thoughts: First of all, at the end of the day, the consumers – I agree with Jim – are going to vote with their feet. If it’s not worthwhile, they’re not going to pay for it and, mandates or not, there’s no enforcement that’s meaningful, so we’re going to have something that’s going to fail.

So I think that getting a realistic understanding of what the rules are going to be and then how people are going to respond to those rules is going to require quite an effort. We are undertaking and designing now an employer study, because we really don’t even think employers could get it yet. And it’s hard enough for us sitting here who’ve been doing this now, you know, full-time since the bill was written or before. But for people to actually understand what is in there and what it’s going to mean, we’re a long way from knowing that.

MR. MILLIGAN: And I mean, it’s also true that consumers look to a lot of sources for information, including their doctors, including other organizations. I do want to now move it
along and then introduce Joel. We will have a chance for Q&A from all of you after Joel’s remarks.

Joel Ario works at the Federal Department of Health and Human Services. He’s at the center for Consumer Information and Insurance Oversight, easily called CCIIO. Joel is a tremendous expert. His job is really to bring up these exchanges in all of the states to help the states bring them up, as well as to ready the federal government if they need to be the fallback. And Joel is also a force of nature, and I’m sure he’ll share a lot of light into the conversation now.

Thank you for coming, Joel.

MR. ARIO: Is that on? (Off mic.) OK. Thank you, Chuck, and thank you, panelists. I’m really happy to be here with all of this – wonderful answers to all of the solutions for the exchanges.

It reminds me of one of my favorite stories. A priest gets out of an airplane looking to relax after a tough week out visiting a number of his parishes. A college kid gets into the seat next to him with his backpack on and notices the clerical collar and kind of lets into the guy – you know, pedophilia in the church. You know, you won’t ordain women. You got all these big buildings in poor neighborhoods, blah, blah, blah.

Finally, after a half hour, the kid takes a breath and the priest puts his hand on his shoulder and says, my son, after 50 years in the church, I got to tell you, it’s a whole lot worse than you can imagine. (Laughter.)

That’s, I think, some of what we’ve heard here today. There are a number of challenges here. We forget that our health-care system is broken. We spend twice as much as any other country in the world, and we get not-great results for that. So the challenges are big here, but I believe the states are up to this in a partnership with the federal government, and I think what you see in the four panelists we have today is some of why I have that confidence.

We have a couple of doctors here – Bill Hazel, Rex Cowdry – both of whom could tell you about how broken the current system is. I’ve listened to them speak eloquently to that in other forums. Today they’re focused on, you know, how difficult the challenges are of fixing the system, but they’re both eloquent on how broken our delivery system is and how badly we do need these reforms.

We also have Joan, who I’ve known for a while now, a state official par excellence, knows the Medicaid world, knows the exchange world increasingly now and understands how much we have to move from a system in which you start in these public programs over here.

And in most states, if you come just above the eligibility level for those, you fall off a cliff and there’s nothing for you until you get into employer-based coverage or have enough money to buy as an individual, and then you have to be healthy in order even to buy if you have
money. So this system promises, you know, a no wrong doors, seamless coverage, lots of promise between Medicaid and the exchange world there.

I have not met Representative Dunnigan before, but I was going to say, Jim, that you’ve learned an awful lot about health insurance pretty quickly out there in Utah, but I find out you’re an agent, too, so I see some of where that expertise comes from. But you’re cut from the same cloth as everybody I’ve met out there in Utah, whether it’s Norm Thurston or the former speaker, Clark, everybody’s very earnest about these issues and put together, I think, a model that a lot of people look to around the country.

I always – and Juan’s (sp) my phone buddy, and I always tell him that I’m thankful that we have in the country both a Massachusetts model, which is an inspiration for some of the states around the country, but also a Utah model. There are – there are many things that Utah needs to do; there are many things Massachusetts needs to do to meet full compliance with the ACA, but you both provide visions and models for an exchange that show the diversity of the country and some of the cause for hope for me.

So I obviously can’t deal with all of these questions. And most of them, frankly, still are questions and challenges, and the states will have to work through them in partnership with the federal government. I can tell you that our general orientation towards most of the kind of issues that got worked out today is those are really good questions.

How can we be helpful to you working through these, not, we’re going to give you an answer that’s a one-size-fits-all for the whole country. They’re mostly questions that do, as I think were reflected in most of your remarks, depend on the specifics of your individual state markets and how you can put together the best proposal in your market.

I’ll say just – tick off four or five things, though, why I think that the model that we have here is so much, so much better than where we’d be without this law to build on: first of all, the consumer friendly approach to insurance. Today, you’re in an individual and small-business world. You have a dickens of a time figuring out even when what your options are, much less how to sort through them. With the exchanges, you’re going to have a world-class shopping experience where you go to a website.

And people say, well, not everybody goes to websites. I will tell you that even the people who themselves don’t use websites that well, which include me, I will use my kids or I’ll use somebody to help me work it through on a website, because websites give you such a range of choice and a range of considerations that you can’t get in any other kind of forum.

And people will go up – be able to go up there and look at a number of different choices. They’ll be overwhelmed. Even in the states – the so-called managed or active purchaser states, they’ll still be overwhelmed with the number of choices they have. They’ll have tools to be able to compare all of those choices, so there’s a front-end kind of consumer-friendly experience there.
It’s secondly, pretty much, I think, clear that the exchanges are a good strategy proven in Massachusetts to expand coverage. It’s a combination of the different reforms that are part of the Affordable Care Act – put together a package that will expand coverage. They expanded it 97 percent in Massachusetts. I believe they’ll expand it significantly above 95 percent in all states.

There are some issues that have been focused on here. But part of the issue with the Affordable Care Act is, we are all in this together, and if we don’t have broad shared responsibility across our culture for the kinds of issues of coverage, we’re going to have trouble under any kind of proposal.

Third, we are doing something very significant – we’ve done it for a few people so far, and we’ll do it for everybody in 2014 – which is that your access to health care doesn’t depend on whether you’re healthy when you walk through the door. You are – we end discrimination by health insurers against sick people. That has implications. Some of the challenges have been raised here, but we aren’t going to reform our health-care system if we still live in a world in which the people who most need health care are the ones that can’t get it when they walk through the door.

Fourth, this is a private-market solution. Everybody on the panel has spoken to the fact that this is a market-based approach to this, that the private insurers are going to be actively involved. They’re critical partners, next to the states, that are the most critical partner to making this all work, and we’ll continue to work with them.

And it’s basically a very good opportunity for the insurance world to come together and show that we can in America have a solution that has got a government piece to it but also has a very active private-market piece – different, unique than any other country has, here.

And then finally – this is the broadest vision that inspires me more than any of the other kind of visions here – is that the exchanges are going to organize up the individual and small-business part of the market that is the broken – the most broken part of our market. If everything worked like large group insurance in our society, we wouldn’t have the – we wouldn’t be having this whole debate.

That part of the market works pretty well. There are cost issues there, to be sure, but that part of the market works pretty well. The individual/small-business side doesn’t work so well. And if the exchanges come together, organize that part of the market, then the exchanges suddenly can speak for that part of the market, and they’re going to be, as any good business operation, speaking for their customers, the individuals and small businesses. They can be part of the discussion about improving quality delivery system reform.

That’s, I don’t think, the first goal of the exchanges. They’re more about expanded coverage in the way they’re set up, but they – once they expand that coverage, then they are there to speak to the issues around quality and delivery system reform.
And just like things now that are proposed in Medicare are proposed by large employers – Jim, you say, you know, it’s all about price in the market. That is true in the small-business and individual side. But today in the large-business side, it’s not true. What large businesses say is, we know we’ve got these broad populations.

We’ve got to improve the system so it’s not just about cutting one-half a percent off the insurance. It’s about improving the quality, the delivery system reform across the system. That’s how insurers sell to large businesses. With the exchanges, it will be how they sell to the individual and small-business market over time. Price isn’t going to go away, but it’s going to have to be addressed. But those issues will come more into play, and I think everybody on the panel will agree that’s really where we need to expand our reforms as well.

So with that, I’ll stop and look forward to the questions.

MR. MILLIGAN: Great. Thank you. OK, your turn. A couple of things – there are two microphones. If you have questions, please come to the microphone. Second, if you want to offer a question, please identify your name, your affiliation and just who you’re directing the question to if you can. So is there anybody interested in getting us started today?

Q: Were you expecting a bashful group?

MR. MILLIGAN: I was expecting an extremely bashful group. Thank you for getting us started, Pat.

Q: Yeah, I’m Patrick Willard with AARP. And from what we’ve seen going on in states like Colorado and Georgia and South Carolina where the legislation is not moving forward, I guess the question is, is there another approach that states can take for executive orders or something else to not just get the process going but to make some of these decisions in this short time frame that we’re looking at going forward? And I guess I’d ask Joel that, as well as the other panelists.

MR. ARIO: Well, I think we can hear from others here too. There are different approaches. There’s the legislative approach, but there’s also, I think, an executive-action approach that states are looking at. And then in terms of the specifics necessary to stand up exchange, many of those decisions aren’t really broad public-policy decisions as much as they’re administrative kinds of decisions. Today, I think maybe the IT issues in general are the most time sensitive, in some ways, the biggest lift for people.

And we have something called the Early Innovator states now – seven different states from Oregon to Wisconsin, Kansas, Oklahoma to Maryland, New York, Massachusetts – a pretty broad range of states working together on different kinds of prototypes for the IT function that then other states can borrow from.

So not much of that work goes on sort of independent of these broad public-policy decisions that are being debated in legislatures. And much of it is necessary improvement under anybody’s scenario for improving health care, because it’s about modernizing the Medicaid
systems and figuring out how to integrate that Medicaid population with the – with the broader populations that have trouble with affordability of health care.

MR. MILLIGAN: Did others want to jump in on that question?

MR. DUNNIGAN: Yeah, I can. For us, it’s hard – Joel knows that we were interested very much in an Early Innovator grant, at least at the level of the bureaucracy, meaning the secretary level and above, but that was not deemed politically palatable to go after that money early. I think that it’s not just where the legislator is, but you also have to have your executive branch and your legislature in agreement for a lot of people right now.

What we have done, though, is, number one, we have clearly made the case that we needed to do health-system reform independent of what happens with the PPACA and other things. And it is clear that health care is on an unsustainable course.

So I’ve spoken to our bias to looking towards delivering innovation, and we actually want to set up and are in the process of trying to get an innovation center set up so we can do projects that sort of break the linkage between our current payment systems and some of the delivery reforms. So that’s an area where we are working.

We are – we are going after the technology. And the best argument for getting the technology in Virginia has been – is that – fraud and abuse. Everybody, you know, likes – we’ve got to get rid of fraud and abuse. Yeah, well, basically fraud and abuse is the error rate. A large part of it is the error rate on the medication application process because it is so outdated in most states. It’s a largely, you know, paper – computer-assisted process done by social-service agencies, which are overwhelmed.

Our Medicaid enrollment went from 835 (thousand) to now it’s about 911,000 last week in Virginia just in the last year. And that’s 1.1 million applications to Medicaid that have to be processed by the same people who are processing SNAP benefits. Eight hundred and thirty thousand SNAP enrollees are another 1.1 million applications a year to keep that cycle up.

Now, we are thinking with health system reform, you got all these people coming in. A number of – the smallest number we – and the number we use officially in Virginia is 275,000, but that is probably low. Probably the Kaiser numbers or Lewin numbers, there are over 400,000. A 40 percent increase plus is likely to happen. It’s going to hit us like a tidal wave. And so what we have sold is no matter what happens, we have to do the eligibility part and get that right. So that’s how we’re moving it in trying to fast-track it.

MS. HENNEBERRY: The legislation for us this year, we’re still hopeful that we’ll have a bill. We think it’s certainly something the governor wants. He worked hard on a bipartisan approach. We think the General Assembly needs to go on record saying they support this. There’s nothing in the federal requirements that prohibits us from continuing with our planning, and we will continue to do that. And you could have – there are some states who have done everything under executive orders, but we felt it was important to engage the legislature, and we’re still optimistic that they’ll come through for us.
Q: Hi, Dave Chandler with the Center on Budget and Policy Priorities. I think most of the state bills that have been out there right now, there’s about 25 or 26 states that have these bills to actually set up the exchanges and then a handful of states that indicate they’re going to do that maybe next year. The majority are looking at these quasi-government entities or nonprofits. They have this independent, you know, expert-type board or some type of other stakeholder board.

And even in Utah and in Vermont, they’re going to have some – you know, with Risk Adjuster Board in Utah and with Vermont, they’ll still have – despite it being executive branch, it will still have some kind of policy-governing board. And a large part of that is because you want experts handling this very complicated and in some ways novel decision-making that’s going to happen, but many are arguing it’s also to immune the entities from some of the politics in the state.

And I think we’d generally recognize why that’s important, and a handful of states do that with Medicaid already with, you know, Kansas and Oklahoma and Washington state and Oregon. And yet so much of what the exchange is going to have to do will in fact govern some core state functions, whether it’s the Medicaid side with the integration or really the private-sector section of the, you know, individual and small-group market standards.

And so while the exchange entities are going to have some level of regulatory authority in setting good decisions for what’s under their control, clearly the legislature will have a role, the governor’s office will have a role in all of the functions outside of the exchange. And yet the success of the exchange is inextricably linked to those functions.

And so I’m wondering how you foresee in your states or even from the federal level recommendations to make sure that the exchange will be its entity but it can’t be on an island, and it sort of needs to be able to work in harmony. And most bills – I’ve had the pleasure of reading all the state bills – don’t talk much about how the exchanges will function on a – on a policy-setting side that falls outside their purview.

And is it going to be that every year post-2012, 2013 and down the road, they’ll be having political debates of issues not under the exchange entity but, you know, affects its success. And (I was ?) wondering how states see their way to set that up. Or is there a language to introduce to ensure the best decision-making process between legislatures and the new exchange boards?

MS. HENNEBERRY: Well, on a very high, superficial level, our board – we have nine board members, and the board members are skill-based, so we didn’t want to dictate you got to have one of these and one of these and one of these, and then you also have – we have a very strong commitment to geographic diversity and rural diversity and ethnic and racial diversity. So when you’re only appointing nine people and you have all these criteria they have to meet, you know, it can get tricky.
So in addition to the nine board members, three state officials will be nonvoting ex-officio members of the board: the state insurance commissioner; the secretary for the Department of Health Care Policy and Financing, which is the public insurance agency, and the director of the Office of Economic Development in Colorado. So I think the governor is very clear that he wants there to be integration on a policy level.

From a practical perspective, I think you are—we are going to be having policy discussions every single legislative session for the next 10 years probably. I mean, there’s a lot we don’t know yet, and we’re going to have to go back and rethink some of these things. So I think that’s—not only is it inevitable, I think if we—if we just embrace it and engage people in that, it actually could be helpful.

MR. MILLIGAN: Joel, were you looking to jump in?

MR. ARIO: I think Bill was going to get in, and then I’ll respond.

MR. MILLIGAN: OK, yeah.

MR. ARIO: I think Bill was going to get in, and then I’ll respond—always safe to after Bill.

DR. HAZEL: Thank you. Appreciate it. He’ll tell you what I meant to say. Now, normally, I have a deputy here to do that, but to tell you how it’s going to work in Virginia would be to presuppose an outcome of a process that we are just initiating. What I can tell you, though, is Virginia has a long history of public-private partnerships. We do this with a lot of groups. We’ll set up something legislatively and put it out there, and so that’s likely to be what happens here. I would think it would be our tradition. And you might have also heard we’re traditional in Virginia. So there’s a high probability we’ll get to something like that.

I would agree, though, with Joan. This thing isn’t leaving the legislature. The legislature in Virginia plays wherever the legislature wants to, and I don’t mean that in a critical way. It’s just, they do. And so the likelihood that this is done and good, it isn’t happening.

MR. MILLIGAN: Joel. And I’ll come back to you, Jim, in a second.

MR. ARIO: Yeah, I think the exchange is going to do a number of things directly but a number of other things, it’s going to be more of a catalyst for. And just to give you one example along the lines of what you were asking about, in the Medicaid versus exchange marketplace, if you think about people, as Joan was saying, they’re below 133 now and then they’re above and then they’re back below and so forth, that is going to encourage states to look very carefully at integrating those marketplaces better.

And I can tell you that there’s probably not a consultant out there for the insurance industry who isn’t talking to his or her clients about the opportunities on the Medicaid side of the ledger here. And I know the Medicaid MCOs are constantly in to see us to talk about ways they
can expand their business above the line into the commercial market space. We want that. It would be nice if we had an integrated marketplace there where not everything turned on whether you were at 133 or 150.

So all of those pressures will come back at the states. The secretary’s been very clear that Medicaid at the state level – states have a lot of flexibility to redesign benefit packages and that sort of thing to look more like the commercial marketplace. And I’ve sat in meetings in Pennsylvania where the Medicaid people came in and taught the insurers a thing or two about different forms of cost control that they’ve done on the Medicaid side of the ledger.

So I think that kind of cross-pollinization (ph) is just one example of the many ways in which exchanges will catalyze people to think about how policy in new and ways that actually will solve some of the problems that have been festering for years.

MR. MILLIGAN: Jim, go again.

MR. DUNNIGAN: In Utah, we’ve been working on the exchange governance for a few years now. And it is modified every year. We learn a lot. And to some degree, I think that’s very good. I think it’s good that we’ve had a measured ramp-up, because certainly if we’d had a lot of money and put it going down one path, we found out that that needs to be modified and that it’s even more expensive to change direction. So I think in Utah, the legislature is establishing the policy and the framework and the executive branch is trying to bring the different governmental entities together to make it work.

MR. MILLIGAN: And I’ll now turn it over to the next one. I do want to mention a couple of things. One is, as Joan mentioned – I mean, as Joan mentioned – the governance, representation, sort of touching into those other players who will have a say in a delivery system and cost-containment reform that go outside the scale the exchange has is important.

Massachusetts, as people know, a lot of the enrollment was driven by the reform, but it didn’t end up into the exchange. And the second thing I’ll mention is that one of the reasons that a lot of states have not elected to proceed with nonprofits as their governing structure is they want to have it more integrated with the other – with state employees, as well as Medicaid. We’ll turn now to the next folk.

Q: Sure, hi. Lee Goldberg, National Academy of Social Insurance – and I appreciate that the states really have to focus on governance as sort of a threshold issue. And so this is a little bit down the road, but, Chuck, actually you just touched upon it. Given that everybody’s so concerned about adverse selection, I’m wondering if either your states or if any of you know of other states that are thinking about how to increase more average risk into the pool, whether that’s through state employees or local employees or other kinds of people that the state or local governments may have some influence on where they buy insurance from.

MR. MILLIGAN: Anybody want to take a shot at that? Joan?
MS. HENNEBERRY: Well, we think about it, but you know, until the board – this is why we need a board. We need a group of experts to begin having that public discussion. I mean, we could do it, but then you get into this tension of, you know, the executive branch is trying to make all the decisions without input, all of that kind of craziness.

So – but I think we will have that discussion in Colorado. I would be stunned if the – as we speak, the people running the state-employee benefits plan aren’t – don’t have that in the back of their head thinking about, does – will that make sense down the road and for local communities as well for governmental entities? Whether or they’ll do it not, I don’t know, but I know we’ll have the discussion.

MR. MILLIGAN: Bill and then Joel.

DR. HAZEL: We – because of the Virginia Health Reform Initiative, we’ve already put together the group that’s been working, and I do not want to have to put together another group. So it’s likely to be – (chuckles) – it’s likely to stay the same, and they have been working on this now for the better part of the seven or eight months they’ve been up.

What I would say is that we look at the 115,000 state employers as one of our potential drivers for delivery reform. There’s no doubt about that, because when we’re buying Medicaid for 900,000 and 100-and-some-thousand, you’ve got a million people – one of eight Virginians right there – that you’re buying for. So it has not escaped us that it’s an opportunity to look at how you’re purchasing insurance and so forth. Now, we have not gotten to the discussion about how you might intermingle state employees to mitigate adverse risk selection.

MR. MILLIGAN: Jim.

MR. DUNNIGAN: We have – there’s discussion about putting the state employees in the health exchange. I’m personally not in favor of that. I think that gives an artificial growth to the exchange that I’d rather see the exchange attract business in its own manner. What we’re doing in Utah is the groups or the businesses, the employees that go into the exchange, there are some upfront risk sharing amongst the carriers in the exchange.

And then also there’s a back-end risk adjustment. So if one carrier got more than perhaps their share of the risk, there are some offsets there. By statute, we are also requiring the carriers to have their exchange risk pool combined with their small – their non-exchange risk pool, so it’s one risk pool. We have prohibited them from having a separate class of business just for the exchange business, so they’re in a much larger – tens of thousands of belly buttons in the larger risk pool that helps to spread that risk out.

MR. MILLIGAN: If I could just add one thing in Maryland, as people may know, in the law there is the authority to create co-op plans in every state. In Maryland, one of the dynamics is a local government, a county government is trying to lead the effort to create a co-op, and they’re trying to recruit other local governments to throw in with them. And so if the co-op reaches critical masses and meets all the other standards, what they’re hoping to do is to offer a
product through the exchange, and have had some level of commitment from local governments that that would be the purchasing vehicle that they’d use.

I’m going to – let Rex jump, and then we’ll take these last two folks who have been waiting patiently, and then we’ll get to the wrap-up phase of things.

DR. COWDRY: I think the issue of enlarging the pool is a really problematic one. I don’t think that adding our state employee and retiree population to the pool would help the risk profile. I think that expanding 50, you run into significant problems of risk selection because of ERISA and because of stop-loss policies and because of challenges there and some forms of self-insurance that are not really self-insurance. So I think there are some interesting policies there. I think we agree, enlarging the pool would be desirable, but that particular enlargement just leads to greater potential for risk selection into the pool. So I think there are going to be challenges there.

But of course, the positive side is that we will have our members of Congress and their staff in our pool.

MR. MILLIGAN: (Chuckles.) Welcome to Maryland. Yes, please.

Q: Chris Jacobs, Republican Policy Committee. My question is for Joel. The statute regarding exchanges applies exchanges to qualified health plans, but I’m sure you’re aware that there are other types of health insurance out there. For instance, there are about 9 million seniors right now with Medigap plans. There could be more as a result of Medicare advantage cuts in PPACA.

There has been bipartisan concern about the Medigap marketplace centers. Reed and Baucus sent a letter last year talking about significant premium increases, yet PPACA has exempted Medigap plans from the pre-existing condition discrimination provisions as well as CCIIO regulation exempted Medigap from rate review, released back in December, the NPRM.

So my question is, if states decide to expand Medigap choice and competition by including that on the exchanges, will that be something that CCIIO looks favorably upon? And then more broadly, if these consumer protections are so good for the under-65 population, why haven’t they been applied to the Medigap consumer plans for seniors?

MR. ARIO: Good questions. I can’t answer specifically on how Medigap might or might not play in the market. I’m happy to take that question back and try to give you more specifics.

I can say as a general matter, coming from my 15 years as an insurance regulator, when you start talking about, kind of, regulating major medical to make sure that it works as an effective marketplace, you run into this issue of all the different – it’s a big, vast country, and people have all of these different, kind of, arrangements in the marketplace. And we certainly don’t want to sort of try to put everyone shoehorned into one approach to dealing with all forms of health care. It would kill my wife, with all of her alternative-medicine ideas, and so forth.
So you end up with a need to decide this matter of, you know, what constitutes major medical and what’s outside? That backdrop is part of this law and it’s part of the backdrop to your question. And that will continue to be a part of the legal landscape here.

MR. MILLIGAN: Okay. And our final question?

Q: Thank you very much. Julie Schoenman with the National Institute for Health Care Management. And my question is going to the risk pool and the tremendous risk that the exchanges are going to face in 2014 for a variety of reasons I could go into, but I think you’re all aware of it.

So it’s – my question is really, at the state level, what are you thinking with risk-adjustment systems, risk – reassurance risk corridors? My impression is, it’s a lower level – I mean, it’s certainly something you’re thinking about, but you don’t have the nut cracked yet. And just trying to get a feel for where you are on that. And then my question to Joel is, what support can the feds provide to the states? Where are you thinking you could help the states in that regard? Thank you.

MR. MILLIGAN: Anybody want to volunteer to go first?

DR. HAZEL: Yeah, I guess where fools wade in, huh? (Laughter.) Yeah, we don’t know. We really don’t know. One of the issues we have in Virginia – and I’m going to take you back to where I started – is the lawsuit about the mandates. You have a very public – very public posture about a supporting lawsuit, and part of the problem you get in Virginia is that nobody – every bill gets amended that says, well, if the PPACA is deemed unconstitutional, everything goes away. And that’s what – there’s your driver, politically, there with that, which makes it harder.

What’s going to happen? We’ve encouraged the Rule 11 appeal to the Supreme Court. We believe that at some point, Justice Kennedy is going to have to tell us what the rule is going to be. And the sooner Justice Kennedy gives us some guidance, then the easier it will be for us to solve some of these problems. But I could see that going now – you get your appeals court this year and then it gets to the supemes next year, so you’re looking at the end of ’12, having to have this decided by ’13 and not even knowing what the rules are going to be. I think that’s really tough.

MR. MILLIGAN: Apparently we omitted a panelist for today.

MR. : Yeah we did. (Laughter.)

MR. MILLIGAN: Joan?

MS. HENNENBERRY: Your instincts are correct, that we just don’t know the answer to those things yet. And I will say, this is where the – why creation and engagement with stakeholders and experts is so important at the state level.
If you hire someone like me, whose knowledge is much more weighted toward the public-insurance side, I’m not an – I’ve never been an insurance commissioner, we don’t have an insurance commissioner yet in Colorado. So we have a big hole in terms of expertise that we have to be able to pull from the industry and from business and from producers. We need them at the table to answer some of these kinds of questions.

If you go the other way and you hire someone who has much more of the insurance background to bring up your exchange, you’ve got to engage the people on the public-sector side. So none of us know how to do this perfectly. We’ve never done it before. So we’re relying on one another and we have to be able to engage the experts in our state, even if some people think that may be a conflict of interest. I don’t think we’re at a place right now where we have to worry about that. We need everybody at the table to help us.

MR. MILLIGAN: Rex?

DR. COWDRY: Just to reiterate a point I made earlier, I think one of the many virtues of the ACA is that it does have tools. It recognizes that there are going to be transition issues in 2014-2016. It provides a series of tools. We don’t know the details of the tools yet, but we know that they are basically well-targeted tools aiming at reinsurance and risk corridors and then the continuing issue of risk adjustment of premiums within the pool.

So I think these problems were anticipated very well by the crafters and that our challenge is to figure out how to use those tools to ease the glide path, both to, but particularly in those first couple of years of the exchange.

And then of course, the second issue is, we have to be out there explaining and marketing and having the right marketing partners for each of the markets to make this work and to bring in the people who otherwise think they are the young immortals. We’ll find a good name for the design of the plan to attract those folks, the – what are some of the plans, like the calculated risk-taker plan or something like that? (Laughter.) But it will appeal to exactly the kinds of people that we need to pull into the exchange.

MR. MILLIGAN: Jim, did you want to jump in on this one?

MR. DUNNIGAN: We have done some of that. We’ve had one year of risk adjustment, because we started our pilot program in January of ’10. But we had a dozen groups in there, so it was able to be worked out. It’s going to be more of a challenge this next year. And I am a believer, and in Utah, we’ve taken the position that choice is good for the consumers. And we have a lot of choice.

Drawback to that is, it does allow the consumer to choose what they want. The healthy ones think they’ll never use it. They may choose a catastrophic plan. The high users are going to choose one that has richer benefits. And it’s really difficult to offset for that with some risk-adjustment mechanism that’s going to equalize that. So I’d have to – we’re working on it, but it’s a work in progress for us.
MR. MILLIGAN: And I know the question also asked Joel to talk about the federal risk adjustment and risk corridor, sort of, approach to this.

MR. ARIO: Yeah. In any, I think, sophisticated audience like this, the issue of risk comes up because it is the challenge – the biggest challenge, probably, with exchanges. They always attract the people who need the care, and it’s harder to attract the people who don’t need it today but need it tomorrow, potentially.

So these are critical, critical issues. I do think the whole backdrop of this law is so much better than anything we’ve had before, and I think you look to the Massachusetts experience to see how that works out with the same kind of tools as this law. They have – I’m not saying they’ve solved all the problems with risk selection, but they’ve certainly done better than a lot of people predicted they would.

So that’s a starting point, and then I do think you have to look at this issue of the back-end tools to address this. Some of this is fundamentally about the insurance industry. If the insurance industry wants to continue to try to slide around the law and do as much risk selection as they possibly can, it’s going to be a challenge.

But if they take up what’s offered in this law, compete or price and quality and actually follow the rules of the law by pooling and so forth without – with minimal, kind of, resistance to that, then I think you can see that the risk-adjustment tools and these other tools do provide an effective backdrop for addressing some of the issues.

And yes, the federal government does have a lot of work going on in this area. There’s not a week that goes by in D.C. where there’s not a very high-level meeting, most of them public, with different people talking about the models. We have Medicare models, we have Medicaid models. They need to be tweaked and changed for the commercial marketplace, but we will provide from the federal side some very clear models.

The states will have the ability – and all the states that have exchanges – Massachusetts has some interesting rules around level playing fields. California came up with some interesting ones along catastrophic plans. Utah has an interesting model on how to involve the insurers in the risk-adjustment function. There are going to be many different models, but there will be a federal baseline that people can look to as a starting point on this.

MR. MILLIGAN: Thank you. So I want to close by thanking AARP for hosting this, for Jerry (sp) and Rick (sp) for pulling things together, Elaina (sp) and Susan for hosting it. And I think Susan, you have the final comments.

MS. REINHARD: Thanks, Chuck. Just a few words: First, I want to thank Senator Mikulski, who was able to secure this room for us, which is wonderful to be in this central location on the Hill. So thank the senator. Thanks, all of you, to come. And again, I want to thank Chuck and the Hilltop or joining with the Public Policy Institute in creating this panel. And certainly, to Chuck for doing a great job moderating this panel.
I also want to note that on June 13th, our next solutions forum will be held. I’m not sure where yet, but it will focus on rural health and will be done jointly with the Robert Wood Johnson Foundation and the Center to Champion Nursing in America. So stay tuned for that information.

And then you know, I just want to remind you that this whole forum you can watch again or let others know about it. It’ll be available on the AARP Public Policy Institute website after 2 o’clock.

So let me thank John Rother, Chuck Milligan and the entire panel for coming, and again, all of you. Thank you. (Applause.)

(Offside conversation.)

(END)