Health Reform for New Health Reform Reporters

The Affordable Care Act: What Do Consumers Need To Know About Health Reform's Changes?

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RAKESH SINGH: Good morning, or good afternoon, depending on where you are in the country, and welcome to the first webinar of the Kaiser Family Foundation, covering health reform series for the media. I'm Rakesh Singh, the foundation's Vice President of Communications. The foundation's media scholarships program is organizing this series, to help you all respond to the public's desire for information on the Affordable Care Act, as open enrollment begins in October, and runs through March of 2014. As we learn from the August health track and poll we released today, the most common source of information for the public on the ACA, within the last 30 days has been the news media, by a wide margin. We'll be drawing from across the foundation's program areas for experts to present on topics, and intend to have a webinar roughly every two weeks. We have two more dates and topics solidified, and another nearly finalized. I'll tell you more about those briefings a little later.

Let me now introduce you to today's presenters, two very good—two experts on the ACA, who will be providing an overview of what consumers need to know about health reform's changes. Their full bios are available at kff.org. Our first presenter is Jennifer Tolbert, who's Director of State Health Policy at the foundation, and also oversees our State Health

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Act team. Our second presenter is Karen Pollitz, who's a senior fellow with the foundation's program for the Study of Health Reform and Private Insurance. They will present briefly, and then we will open it up to a question and answer discussion for the rest of the hour. Now, let me turn it over to Jen.

JENNIFER TOLBERT: Great, thank you so much Rakesh, and good afternoon everyone. We will go ahead and jump in, to save as much time for the Q and A portion of the webinar as possible.

One of the main goals of the ACA is to expand coverage to those who are currently uninsured, and to improve the quality of coverage for those with insurance. It does this by building on the base of employer-sponsored coverage, and filling in the gaps in our current system. It expands the Medicaid program to more low-income adults, and creates new health insurance marketplaces, where individuals and small employers will be able to go to shop for and enroll in private health coverage. Federal subsidies will be available through the marketplaces, to make this coverage more affordable for consumers.

These changes are made to work by health insurance market reforms that prohibit insurers from denying people coverage, or charging them more if they are sick. Finally, the

law imposes new requirements on individuals with some exceptions to purchase coverage, and on employers, to offer affordable coverage to their employees. The rest, we will hear from Karen in a moment. The employer requirements have been temporarily delayed.

Today, the majority of Americans obtain coverage through an employer, and that will not change under the ACA. The ACA will, however, provide new affordable coverage opportunities for the nearly 48 million people who are currently uninsured. When we examine this group, based on their income, we find that over half have incomes that would qualify them for the Medicaid expansion, and another 39-percent may be eligible for premium subsidies in the marketplaces. The remaining 10-percent have incomes above 400-percent of the poverty level, and will be able to purchase coverage through the marketplaces, but will not be eligible for premium subsidies.

ACA fills in current gaps in the Medicaid program by establishing a uniform eligibility threshold of 138-percent of the federal poverty level, which translates to about 15,900 for an individual or 32,500 for a family of four. Through the Medicaid and children's health insurance programs today, we do a pretty good job of covering low-income children and pregnant women, and the expansion will extend that coverage to other

low-income adults. The Federal Government will pick up 100-percent of the cost of covering those who are newly eligible for the first three years of the expansion, phasing down to 90-percent by 2020.

The Supreme Court ruling on the ACA last summer upheld the constitutionality of the law, including the Medicaid expansion. However, it did limit the ability of the Department of Health and Human Services to enforce the Medicaid expansion, thereby, making the decision whether to expand the program optional for states. To date, 25 states are moving forward with the expansion, while 21 states are not moving forward at this time. Debate is ongoing in five states. The Medicaid expansion goes into effect on January 1st. However, states can opt in or out of the expansion at any time.

The major implication of the Supreme Court decision is that there will be significant gaps in coverage among low-income adults in states that do not expand the Medicaid. In these states, uninsured adults with incomes below the poverty level, who are not currently eligible for Medicaid, will not have access to affordable coverage, and will likely remain uninsured. That is because the marketplace subsidies are only available to those with incomes above the poverty level, which is about 11,500 for an individual. It is estimated that as many as 6.2 million uninsured will not be covered if all 26

states that are not currently moving forward do not adopt the Medicaid expansion.

In addition to the Medicaid expansion, new health insurance marketplaces are being implemented in all states. These online marketplaces will enable consumers to apply for coverage, compare available qualified health plans using standardized information, select a plan, and enroll in coverage. As I mentioned, premium subsidies will be available for those without other coverage, who have incomes between 100 and 400-percent of the poverty level. The streamlined application and enrollment process will screen for Medicaid and CHIP eligibility, as well as the premium tax credits. The initial open enrollment period begins in just over a month, on October 1st, and runs through March 31, 2014. Coverage will begin on January 1st.

Sixteen states in the District of Columbia are running their own marketplaces. Another seven states are partnering with the Federal Government, while 27 states will default to a fully federally run marketplace. There will be a marketplace in every state that, for the most part, will offer consumers a choice of plans and a similar ability to apply for and enroll in coverage. What may differ across states is the level of assistance and support available to consumers, to help them learn about and navigate the new system. States running their

own marketplaces have had access to a great deal more resources to invest in integrated marketplace and Medicaid eligibility systems, call center staff, enrollment assistors, and outreach and marketing activities, while the Federal Government has been working with a much more constrained budget. These investments are needed to get the word out to consumers about the new coverage options, and provide them with direct assistance to help them enroll, which will be critical to meeting enrollment goals.

With that, I will turn it over to Karen.

KAREN POLLITZ: Thanks Jen, and hi everyone. I'm going to talk next about the non-group market for coverage, the smallest source of health insurance coverage today, and the one that will undergo the most dramatic changes, starting next year. The non-group market is the residual market, for people who are not eligible for health benefits at work, or for public programs like Medicaid. Most people in those situations today find they can't buy coverage in the non-group market, because it's medically underwritten; that is, they might be turned down or charged more, based on their health status, or because policies don't cover what they need. Many non-group policies today are missing basic benefits, like prescription drugs or maternity coverage, or they have exceedingly high cost sharing, such as 10,000 dollar a year deductibles.

Mostly, people have trouble have buying non-group coverage today because they simply can't afford it. Currently, this market is unsubsidized and, as Jen showed you earlier, the vast majority of uninsured people have low incomes. Starting next year, insurance will be prohibited from discriminating based on health status. Policies will have to cover essential health benefits. All will have to limit cost sharing; the most an individual will face in deductibles for copays and coinsurance next year is 6,350 dollars. And for most people, subsidies will be available on a sliding scale.

People will continue to have choices when buying coverage on their own. Not all policies will be the same, but differences will be made more apparent and easier to compare. In particular, non-group policies will offer a range of cost-sharing options. In the exchange, plans have to be featured in standardized cost-sharing tiers, that achieve different actuarial values, and actuarial value is an overall measure of a plan's cost sharing. These tiers will be described as bronze, silver, gold, and platinum. The highest cost sharing will be under bronze plans, with less under silver, even less under gold, and platinum. This slide shows you examples of what deductibles and coinsurance might look like under these different metal tiers. As you can see from these examples, there will still be some high cost-sharing plans offered

through exchange non-group markets, but they won't be as dramatically high as some of the non-group policies that are offered today.

What will health insurance cost next year? The Congressional Budget Office has estimated that the annual premium for a benchmark silver plan will be just under 4,000 dollars, for a 40-year-old. Premiums can be adjusted for age, within limits, so, for someone in their twenties, that benchmark silver plan would be just over 3,000 dollars. For someone in their sixties, that benchmark plan would cost about 9,000 dollars.

Bronze plans, which have higher deductibles and cost sharing, will have lower premiums, as you can see up here, in these unsubsidized premiums. These are the sticker prices, or the unsubsidized premiums. Most people won't pay the full premium, because starting in 2014 subsidies will be available on a sliding scale, based on income. The lowest income participants in the exchange will be limited to paying no more than 2-percent of their income for the benchmark silver plan, and their premium liability will increase to a cap, up to incomes of 400-percent of poverty.

As this chart shows, a fast food worker, who is working fulltime at the minimum wage, which would be about $14,500 a year, actually, in a state that expands Medicaid, that person

would be able to go into Medicaid. In other states, they could buy the benchmark silver plan for just under 300 dollars a year and subsidies would pick up the rest of the cost.

At higher incomes, for example, a home health worker earning about 200-percent of the poverty level, wouldn't have to pay more than about 1,600 dollars a year for the benchmark plan; subsidies would pick up the rest. On the Kaiser Family Foundation website, there's a subsidy calculator that you can use to explore what people are likely to pay, taking into account the subsidies, and we will show you a link to that at the end of this presentation. In addition to premium subsidies, people with incomes below 250-percent of the poverty level will also be eligible for cost-sharing subsidies that will reduce the deductibles and copays that would otherwise apply in a silver plan. Those cost-sharing subsidies work a little differently, and I am happy to talk more about that during the Q and A, if you have questions.

Now, just a few words about employer-sponsored coverage; that's where most non-elderly Americans get covered today. That will continue to be true next year, and non-group coverage will change the least next year. Under the ACA, the biggest change in job-based coverage is that it becomes mandatory for a large employer to provide health benefits. Today, it's voluntary, but well over 90-percent of large

employers provide health benefits already. As you have already heard, the administration has delayed enforcement of the large employer mandate for one year, until 2015. The ACA also set some new standards for the content of job-based coverage. Starting next year, all employer plans will have to limit cost sharing for covered benefits. The same limits that apply in the non-group market will also apply in employer plans. However, this has been partially delayed. If employers hire a separate administrator for their pharmacy benefit, they will be allowed to apply a separate cost-sharing maximum for that benefit, just for one more year.

In addition, next year, all employer plans will have to eliminate any annual dollar limits on covered benefits. Next year, small group health insurance policies will be required to cover essential health benefits, just like in the non-group markets. Then, other ACA changes to employer-sponsored coverage are already in effect. Those include the requirement to cover preventive services with no cost sharing, the requirement to cover dependents to age 26, and the prohibition on lifetime dollar caps on covered benefits.

Just to wrap up, let us review some key dates on the horizon. Open enrollment begins October 1, five weeks from yesterday. Everyone's focused on that big date, but remember open season last six months, and probably, every one of those

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days will be used, as people figure out these changes, and make their decisions. After enrollment, there will also be special enrollment opportunities for people to sign up for coverage if they have a qualifying change in circumstances, such as losing a job, or a change in their family status. People can also come back to the exchange throughout the year, to adjust the subsidy that they're receiving, for example, if their income changes during the year. People can enroll in Medicaid at any time they become eligible, not just during open enrollment.

January 1 is when new coverage takes effect, and the mandate to have coverage takes effect as well. If people wait until March to sign up, that's okay. Short coverage gaps of up to three months will not trigger a penalty.

This time next year, the second open enrollment period will begin, on October 15th, and go through mid-December. By then, all of us will be experts on all of this. Enforcement of the large employer mandate has been delayed, and will take effect January 2015.

That's the end of our slide presentations and, at this point, I will turn it back to Rakesh, and your questions.

RAKESH SINGH: Let me make one announcement, before I hand it over to the operator, to repeat the Q and A instructions. A lot of you were asking whether the slides will be available after the call; they will be, along with the

actual webinar, so you can find both of those at kff.org, so do not worry. We will send out an announcement to that affect, as well.

Now, of the operator could repeat the Q and A instructions.

OPERATOR: Well, certainly. Ladies and gentlemen, if you would like to register for a question, please press the one, followed by the four, on your telephone. You'll hear a three tone prompt to acknowledge your request. If your question has been answered, and you would like to withdraw your registration, please press the one, followed by the three. Once again, to register a question on the phone, please press one four on your telephone. One moment please for the first question.

Our first question from the line of Tammy Luby [misspelled? 00:17:24]. Please proceed with your question.

TAMY LUBY: Hello, and thank you for offering this. Can you explain a little bit about how people actually sign up for ACA? Will it be through—if you could explain particularly, are all the agents going to be independent, or are some of them going to be allied with specific insurers, and those that are allied with insurers, will they only offer that insurance company's plans, or will they be able to sell all of them et cetera? Just a little bit more of the mechanics.

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JENNIFER TOLBERT: Sure, that's a really good question. There will be multiple avenues for people to apply for coverage. Probably the main avenue will be through the marketplace website, either healthcare.gov, for federally facilitated marketplaces, or people also have the option of going through the specific state websites, in states that are running their own marketplaces. They can go through the application process online, through that web portal. Consumers will also be able to apply by phone, by calling the call center, and they can apply using a paper application, and submit it through the mail. As I mentioned, there will be enrollment assistors available in every state, to help people navigate this process, and those enrollment assistors are called navigators, as well as in-person assistors, in some states. Most of these individual navigators and in-person assistors will be independent. However, agents and brokers will still be permitted to assist people with enrolling in coverage and helping them find a plan that meets their needs. In addition, insurers will be allowed to assist people as well and, while there is a general requirement that these assistors identify themselves and their affiliation, and make available all information on all plans to consumers, it's not quite clear that it will exactly play out that way. Clearly, insurers will have incentive to steer consumers to their particular plans.

Again, a lot of this, we'll have to wait and see how it plays out, as implementation begins.

TAMMY LOUBY: I thought that the navigators were specifically not allowed to enroll people, or am I wrong about that?

JENNIFER TOLBERT: No, the navigator's job is to facilitate enrollment, but people can also go through private brokers, the way they've done in the past, traditionally. The brokers and the insurers, when people go directly there, are not required to show everybody the full range of policies that are offered through the exchange, although, they are required to let people know that the exchange is there, and show them the link to the website, so that if they want, on their own, they can explore other policies. Does that answer your question Tammy?

TAMMY LOUBY: Yes, thank you very much.

JENNIFER TOLBERT: Okay.

OPERATOR: Our question comes from the line of Jane O'Donnell [misspelled? 00:21:00]. Please proceed with your question.

JANE O'DONNELL: Hello, I'm very new to this subject and I am wondering, two very broad questions. One, where each of you sees, potentially, the most confusion among consumers,

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and also where you—what you think some of the biggest problems are going to be, I guess you can take that anywhere you want.

KAREN POLLITZ: Sure, this is Karen. I will take a crack at that. I think the biggest confusion still has to do with a low level of knowledge about the ACA. Our polling shows people still—they know something's coming, but they don't know how it works. Like anything else that's new, this is going to require a little extra effort and assistance, for people to figure it out. That's why I emphasize that I think we'll use all six months of open season. People don't need to feel pressured to make a decision right in October, or even by January first. They can take the time and wait on assistance. As Jen mentioned, the budget for consumer assistance is more limited in states where the Federal Government is operating the exchange, so there may be a queue, and that could pose a problem or cause some anxiety for people, if they can't get their question answered right away. Again, the open season is longer, so keep at it, don't give up.

Then, in terms of the most difficult cases, a lot of people have really interesting lives. Their income changes, they're in and out of work. Maybe they're contractors, their family status changes, and, so forth, so a lot of people's lives don't fit the cookie-cutter pattern. I think there will be some questions about how do I count my income, or whose

income do I count, or who's in my household, and some of those questions will be puzzling for people, and so they'll want to call on the call center, or the navigators, or other assistors, to try to get those answers.

JANE O'DONNELL: Okay, and the potential for fraud; like what areas there's more potential for fraud.

KAREN POLLITZ: This is Karen again. I know the FTC has already begun investigations into fraud, and I had trouble sleeping the other night, and saw a late night cable ad that made me a little nervous, so I think there may well be some unscrupulous folks out there that are trying to offer assistance, and are really interested in gaining access to you personal identification. I know that's under way, but I think it will be very important for people, when they're not sure, to go to their exchange website. All of the exchanges will have a listing of who the recognized certified assistors are and, when in doubt, that's who you should go to, so that you know you're dealing with someone who's officially there to help you, and who's been trained by the exchange.

JANE O'DONNELL: They'll be personating navigators? People saying that they're navigators, basically.

KAREN POLLITZ: I know that there's some of that going on already, yes.

JANE O'DONNELL: Okay, great. Okay, thanks.

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JENNIFER TOLBERT: Next question please.

OPERATOR: Our next question comes from the line of Karen Bouffer [misspelled? 00:24: 31]. Please proceed with your question.

KAREN BOUFFER: Yes, hi. I actually have two questions. The first is just because Michigan's summit, actually last night, approved the Medicaid expansion, and it's already been passed by the house. It still has to go back to the house, so it's not a done deal yet, but it looks like it is going to pass in Michigan. Naturally, I was on the Kaiser website last night, trying to figure out whether Michigan was going to be the 25th or the 26th state to have expanded Medicaid. Anyway, as of July, on your website it said that 24 states had expanded Medicaid, so I just wanted to clarify, you had said that 25 states, so are you saying because Arizona was added, and you hadn't updated your website yet.

JENNIFER TOLBERT: I'm sorry, if we can go back to the map, but yes, we updated Michigan today, and are in the process, based on the—I'm sorry this is Jen. We updated Michigan to reflect that Michigan is proceeding with the Medicaid expansion.

KAREN BOUFFER: Okay, so you are counting Michigan as the 25th.

JENNIFER TOLBERT: Yes, we are counting Michigan.

KAREN BOUFFER: Okay, okay. I was just checking that I had got that right.

JENNIFER TOLBERT: Right.

KAREN BOUFFER: Okay, good, thank you. The other question I had was, other than the delay in the mandate, the employer mandate, I was wondering if you could explain the cap that is delayed, what exactly that is. I wanted to ask, also, if there are any other rule changes that consumers need to be aware of.

KAREN POLLITZ: This is Karen. The cap is the overall cap on cost sharing that can be applied to covered benefits under the plan; that's the deductible, the copays, the coinsurance. All of those have to sum up to a limit and, once you've reached that limit, all of your covered benefits have to be covered 100-percent for the remainder of the year. What was delayed for employer plans was to give them more time. Many employer plans today hire a separate vendor, separate from the main insurance company that runs the major medical benefits. They hire a separate vendor to administer their pharmacy benefit, and the employers said it's going to take them more time to figure out how to get that vendor to communicate the cost sharing. Every time you go CVS, you lay down another twenty bucks for a prescription, and then that pharmacy benefit

manager needs to talk in real time to the major medical insurer, to make sure that you don't inadvertently pay an extra copay, when you've reached your limit this afternoon, and so you should stop. They've given employers one more year to work all of that out, and they've said that during next year, its okay for the pharmacy benefit to have a separate cap of 6,350 dollars. Then, starting in 2015, all of your benefits together have a cap on the copays, deductibles, and other cost sharing.

KAREN BOUFFER: Okay, thank you. Is there any other changes that consumers need to be aware of?

KAREN POLLITZ: In employer-sponsored plans?

KAREN BOUFFER: Just any other real changes that have been handed down by the Obama administration, things that have been changed.

KAREN POLLITZ: No, I think the big changes are the new protections, and benefits and subsidies that are coming; that's what they need to keep their eye on.

KAREN BOUFFER: Okay, thanks.

RAKESH SINGH: This is Rakesh. We are going to take a few chat questions now. I'm going to try to group them together by subject. The first question, Patricia Schultz [misspelled? 00:28:42], if an individual has an employer coverage, can they choose to opt out and purchase something through the exchange?

KAREN POLLITZ: This is Karen. I will field that one. The general answer is no. The non-group market and the exchange is still supposed to be the coverage of last resort. If you're eligible for benefits at work, that's where you should go. If you're eligible for public program coverage, like Medicaid, that's where you should go. There is an exception. If your employer offers benefits that are unaffordable, or that don't achieve a minimum value, then you're allowed to come to the exchange and apply for subsidies there. Unaffordable means that what you're required to pay exceeds 9.5-percent of your income. If your share of the premium is that unaffordable, you're allowed to come to the exchange and apply for subsidies. Similarly, if your employer cost sharing is very, very high, which is very unusual, but say your employer plan had a 10,000 dollar annual deductible, you'd be allowed to come to the exchange as well, and apply for coverage there. I should just add, anybody who wants to can come to the exchange and buy their own policy. However, if you want the premium subsidies, that's where the exchange is supposed to be the last thing that you look at. If you can get subsidized coverage through work or through a public plan, you should there first.

RAKESH SINGH: Okay, there are a couple of questions on navigators that I'll read. Rose Hoban [misspelled? 00:30:25],

and I understand navigators and CACs are not supposed to be taking money for their help, true? Can insurance brokers charge for assistance? She also asks, can you explain the difference between a navigator and a certified application counselor?

JENNIFER TOLBERT: Sure. Navigators, certified application counselors, any assistors that are working for the exchange will not charge you, must not charge you, to assist you; that's free help. Private insurance brokers, I suppose they can charge you. I think, mostly, they don't. Mostly, brokers get paid a commission from the insurance company that they place you with. The main difference, I think, brokers are great and smart and, I think, will continue to provide good health to people, but the main distinction between navigators and other assistors, versus brokers, is that the navigators and the assistors aren't trying to sell you anything, and the broker is trying to sell you something, because that's how he get paid.

In terms of the difference between navigators and assistor, I think, from the consumers' perspective, it's probably not that big of a deal. You should see all of their names, or at least their organizations' names on the website; that's how you'll know, that they're officially recognized by the exchange. I think their training is a little different.

The assistors are pro bono and they tend to work for a non-profits, like clinics and community health centers, and groups like that. They will all receive training, and they'll all— their job is to help you answer your questions.

RAKESH SINGH: Two more questions, one is from Matt Mikus [misspelled? 00:32:30]. Are there regional officers to deal with questions for the states with federal market places? Then, Sue Rothman [misspelled? 00:32:29] ask what happens if a person moves from one state to another, and has insurance through a state exchange.

KAREN POLLITZ: This is Karen. I actually don't know. The regional offices, I know, are involved in the administration of the federal marketplace, so I suppose you could go through them if you wanted to, but probably your best bet is to go right to the marketplace and pose your question, and then let them worry about who else to engage, to get it answered.

In terms of moving, if you move, that's a qualifying event. If you start out the year in Ohio and then later, you move to Illinois, you will have a special enrollment opportunity to sign up for coverage in Illinois. You should always buy your insurance, if you're purchasing through the marketplace, in the state where you live, and if that changes, then you'll change too.

RAKESH SINGH: Okay, I think we're switching back to some more phone call questions.

OPERATOR: Okay, our next question comes from the line of Michael Booth [misspelled? 00:33:53].Please proceed with your question.

MICHAEL BOOT: Hi, thanks for having the seminar. If you could talk a little bit more about the individual mandate, what the penalty is looking to be, the difference between the actual dollar amount and the percentage of income that the penalty could be, and just what the consumer who is thinking about that, especially the so-called people who are independent and not necessarily needing the insurance, or think—the invincibles, who are not sure they need it, what they should be thinking, and what the outreach will be to them.

JENNIFER TOLBERT: Sure, this is Jen. I'll take that question. The individual mandate penalties will be phased in over three years. Initially, so for 2014, the penalty will be the greater of either 95 dollars or 1-percent of taxable income, and then it will phase up to 695 dollars in 2016, or 2.5-percent of taxable income; again, it is the greater of those two amounts.

I should note that there are a number of exceptions from the penalties. Individuals who are incarcerated, as well as undocumented immigrants are not subject to the individual

mandate penalty. People with religious exemptions are also not subject to the penalty and those who cannot find affordable coverage and, in this context, affordable coverage is defined as costing 8-percent or more of a person's income. If someone can't find a coverage that would cost them less than 8-percent of their income, they also would not be subject to those penalties.

When it comes to the young invincibles, and whether or not they choose to pay the penalty or obtain coverage, I think one thing that's important to note for a lot of young adults, who are just starting out in their careers, or maybe partly in school, partly working, they tend not to have high incomes. These are people who are likely going to qualify for significant subsidies in the marketplaces, or even, perhaps qualify for Medicaid, because their incomes are low enough. I think it will be slightly different calculation, because it won't be 95 dollars, versus 4,000 dollars, for a policy. It's going to be 95 dollars or, maybe, 200 dollars, and with that 200 dollars, that invincible young adult will actually have insurance coverage, and pretty decent insurance coverage. I think , while there may be some people who will choose to go without coverage, and pay the penalty instead, I think, with the availability of the subsidies, it's going to make coverage

much more affordable for people, which is actually the main reason today why people are uninsured. Next question.

OPERATOR: Our next question comes from the line of Sarah Hansford [misspelled? 00:37:18]. Please proceed with your question.

SARAH HANSFORD: Hi, thank you. Do you have any figures that you can site as to how many people are—I guess this would be—how many people in the individual market today are above say, 250 or 300-percent of the poverty level, because as I understand it, based on studies that the actuaries have put out, above that level, the increased cost of the insurance, the increased cost will be more than the subsidy. Do you have any figures on, along those lines?

KAREN POLLITZ: Sure, this is Karen. We just put out an issue brief a couple of days ago, estimating, overall, how many people in the non-group market, who are in there today, they are already buying on their own, they're self-employed or between jobs, and so they're in this market now, and we've estimated that nearly half will be eligible for subsidies. Another million or so will be eligible for Medicaid, so they can just get out of this market altogether, and get free coverage under the Medicaid program. Of the remaining, I can't break out for you right now, sort of the incomes strata, but of the remaining, there will be people who still pay less, and

people who pay more. The individual market skews older. People in their 50s and early 60s participate disproportionately in this market, for a variety of reasons. They may be too sick to work, or they may have retired earlier, whatever. For those people, the age rating caps are likely to provide some substantial relief. As a 55-year-old, I wouldn't want to be buying non-group coverage today; that would cost me a whole lot of money. The age-rating limits, even if you're not eligible for subsidies, will produce a break for people. There are other folks -- self-employed people, farmers, ranchers -- who've been in this market for a long time, who've seem tremendous volatility and big increases in their rates over the years, because they were maybe healthy when they bought the policy, and now they're not any longer, but they're stuck. They are stranded because they can't pass underwriting anymore, so all they can do is hang on for a dear life to the policy they have. They've seen their rates go through the roof, and probably seen their deductibles go through the roof too, as they've tried to offset year-to-year premium increases. They are going to see great relief, so it's going to be a mix. You can't just look at the sticker price. You have to look at what people are actually paying, and what the new sticker price will be under reform, even without the subsidies. We've

estimated, I think, that most people will end up paying less next year, because of subsidies, or because of market reform.

SARAH HANSFORD: Okay, so you don't sound like you think it's too much of a concern that there might a lot of people who are in the individual market today, who might drop coverage because the cost goes up so much, and they can't get enough of a subsidy to pay for it, you don't think that will be a big problem, I take it.

JENNIFER TOLBERT: I've not seen any estimates of that. The CBO estimates don't reflect that as well. A lot of things are changing, the market reforms and the subsidies, as well as the Medicaid. I think a lot of the people who drop out of this market are going to fall into Medicaid.

RAKESH SINGH: Alright, next question.

OPERATOR: The next question comes from the line of Monisa Palmiss [misspelled? 00:41:14]. Please proceed with your question.

MONISA PALMISS: Hi, thanks for taking my question. I know the focus of this is to get uninsured people covered, but can you break down what would be changed for people who are insured though their employers, what they would see?

KAREN POLLITZ: Sure, this is Karen. People who are already insured probably aren't going to see a lot of changes. The biggest one will be that there will become a cap, a

comprehensive cap on their out-of-pocket spending, although, that's been delayed, unfortunately, that has been delayed, so they may not see that next year. If they are in small group policies, the small group policies starting next year, or as they renew next year, will pick up the essential health benefits; for example, if they were missing pediatric dental for their kid, that will appear, starting next year. Otherwise, yes, people who are in large group health plans aren't going to notice a big difference next year.

MONISA PALMISS: Okay, thank you.

KAREN POLLITZ: Sure.

JENNIFER TOLBERT: Next question.

OPERATOR: Our next question comes from the line of Chris Young [misspelled? 00:42:47]. Please proceed with your question.

CHRIS YOUNG: Hi. Thanks for all your resources. Are you—is Kaiser actively tracking which marketplaces will not have full functionality of their websites on the exchanges, come October 1st, where people actually won't be able to sign up for coverage on an exchange—marketplace?

JENNIFER TOLBERT: Yes, this is Jen. We have heard from a couple of states that they may not be ready for people to actually apply through the website. Oregon, in particular, is developing a backup plan that will rely on paper

applications during the first, say, two weeks, or so. I think while some state marketplaces may not be immediately ready on October 1st, to process these applications through the website, there will be, obviously, other mechanisms by which consumers will be able to apply for coverage. What we're hearing from the states is that any delays will likely not be very long, so that within a couple of weeks, certainly by the end of October, the systems should be fully operational, and will enable consumers to actually apply through the web portal. I think we'll start to get a better sense over the next few weeks, whether there are other states that are anticipating some delays, but right now, Oregon is the only one that I've heard of, coming forward to say yes, we're developing a contingency plan for the first couple of weeks.

CHRIS YOUNG: If the Federal Government says, they will be fully operational with the tax implications; that's all good, IRS stuff, security?

JENNIFER TOLBERT: Yes, that's certainly what we're hearing from the feds at this point, is that those federal marketplaces will be ready.

CHRIS YOUNG: Good, thank you.

JENNIFER TOLBERT: Next question.

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OPERATOR: Our next question comes from the line of Eileen Ambrose [misspelled? 00:44:56]. Please proceed with your question.

EILEEN AMBROSE: Hi. I was wondering if you can explain how will the government know that people did buy insurance. Some places, I read, that it will be on your tax return, but if people don't file returns either, they don't have to file a return, how will the know?

JENNIFER TOLBERT: If you have coverage from any source?

EILEEN AMBROSE: Yes, that you've met the mandate.

JENNIFER TOLBERT: You will have to, ultimately—you will have to fill out information on your tax return. If you don't file, I suppose they won't know, but you also won't be liable for a penalty, because that's a broad class of exemption.

EILEEN AMBROSE: Right, so—

JENNIFER TOLBERT: You do have to report and then, during the year, if you're coming through the exchange, there will be real time reporting through the exchange of who's enrolled in what plan. Most people will be under job-based plans. You started to see information about that on your W2 that we get, but there will be a new line on the tax return,

when you fill out your 2014 return, where you have to indicate at where you are covered.

EILEEN AMBROSE: Could you just—

JENNIFER TOLBERT: There will be reporting from employers to verify that. Sorry.

EILEEN AMBROSE: Oh, no-no, that's alright. Can you explain how the subsidies work? Will they always be paid directly to the insurance company, or can a consumer have it paid to them, or how will that work?

KAREN POLLITZ: Sure, this is Karen. Either one works. If you are applying for subsidies in the exchange, you can indicate that you want that subsidy to be paid in real time, each month, right to the insurance company, so you don't have to come up with the cash flow to pay the rest. You can, if you can swing it, pay the whole premium on your own, and then just claim the subsidy directly to you, as a tax refund, when you fill out your taxes at the end of the year, or you could do some of both. If you're not quite sure in estimating your income, you could guess a little high, and take some of it upfront, and then reconcile with the IRS when you file your returns, and get the balance as a tax refund.

EILEEN AMBROSE: Thanks.

KAREN POLLITZ: Sure. Next.

RAKESH SINGH: Before we go to the next question, I just want to remind folks that the next scheduled webinar is on September 10th, which will cover premiums and tax subsidies available for coverage purchase through the marketplace or exchanges. Larry Levitt and Gary Claxton, from the Foundation, will be presenting at that briefing. You should be able to sign up for that briefing right now, on your screen, if you'd like. Additionally, we'll have the webinar upstate, and Medicaid expansion scheduled for October 8th, and we're working on a topic for late September.

Let's go to the next phone question, while I transition to some chat questions coming up.

OPERATOR: Perfect, certainly. Our next phone question comes from the line of Dianne Sirchester [misspelled? 00:48:04]. Please proceed with your question.

DIANNE SIRCHESTER: Thanks so much to all of you again for your help over the year. I wonder if you could talk a little bit about the involvement of groups like Enroll America, how political they are, if they are at all, and what we, as journalists, ought to be looking out for in working with them, writing about them.

KAREN POLLITZ: This is Karen. I can't really talk too much about Enroll America. I know they're a newly organized

non-profit and they're working on stuff, but sorry, I can't tell you too much.

JENNIFER TOLBERT: Yes, this is Jen. I'm not sure. This is an all hands on deck effort. As evidenced by our most recent tracking poll, there's a great deal of lack of awareness out there among people, particularly those who are likely to most benefit from the changes from the ACA. I think a lot of these groups that have traditionally been advocates for low income populations, when it comes to health insurance coverage, basically took it upon themselves to come together, form Enroll America, to help get the word out to consumers. I can't speak to the politics of it all, but they are a 501c3 organization, an independent organization, that was formed simply to inform consumers about the changes and the new coverage opportunities.

DIANNE SIRCHESTER: Can I just ask one other really good question and see if anybody can talk about what I'm hearing as the myth of the young invincibles, that they truly do want insurance, they just haven't been able to afford it.

KAREN POLLITZ: Actually, this is Karen. Our tracking poll last month asked young adults about their coverage preferences and, overwhelmingly, they said they wanted coverage if they could afford it, and that affordability had been a big issue, so take a look at our tracking pole from last month.

DIANNE SIRCHESTER: Thank you very much.

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RAKESH SINGH: This is Rakesh. I would just like to discuss a couple of our embeddable resources, because the question came up about why they appeared on external sites. We have noticed that our interim subsidy calculator and our animated video are very popular resources. They're for the public. We decided to make it available to external websites for free. They're both embeddable. We know it drives a lot of traffic to our site and as educators and informers to the public, we thought we should make it available to external organizations as well. We do not cut fields or get paid for placement of the calculator on external sites. You're free to use it, and if you have any questions, please follow up with us. We're happy to help you out. It's a free resource, in our role as educating not only the news media, but the general public, about our policy issues.

Now, let's move on to some chat questions. I'm going to, again, try to group some of these together. Stacy Singer [[misspelled? 00:51:52]; will consumers be able to tell if their doctors are in the networks of the plans sold on the federally facilitated exchanges?

KAREN POLLITZ: This is Karen. The exchanges are supposed to make information available about health plan networks. There's supposed to be a link to the network

directory, so that you can look up, to see if your doctor's in the plan.

RAKESH SINGH: What is the course of action for legal immigrants who don't qualify for Medicaid? Jan Eismyer [misspelled? 00:52:29] is asking this question.

JENNIFER TOLBERT: Okay, so for legal immigrants who don't qualify for Medicaid, typically, because they have not been in the country for at least five years, which is one of the requirements for Medicaid eligibility. Those individuals will be eligible to go into the marketplaces and receive subsidies, regardless of their income. Even if their income is below 100-percent of the federal poverty level, they will be able to go into the marketplace and obtain a subsidy to help them afford coverage. That presumes that individuals would have to live in a state that is actually expanding Medicaid, so they would have to, otherwise, qualify for Medicaid, except that they had not resided in the country for five years. In states that don't expand Medicaid, those legal immigrants with incomes below 100-precent of poverty would not be eligible for the subsidies, unless they qualify for Medicaid under the current rules.

RAKESH SINGH: Okay, I have a question about explaining the cost-sharing subsidies in more detail; that's from Barbara Anderson [misspelled 00:53:53]. I also have a question from

Mary Sheddon [misspelled? 00:53:57]; premiums on the exchange are significantly higher for people who smoke. How will this affect people like the young invincibles and other, and whether they choose to get insurance at all?

JENNIFER TOLBERT: Okay, so, the cost-sharing subsidies are going to be based into the silver plans. If your income is below 250-percent of poverty, there'll be several alternate versions of silver plans, based on how below 250-percent of poverty you are. Those plans will already have reduced deductibles, copays, and annual out-of-pocket limits. If you go back to the slide, there, I showed you—sorry I don't have that. I guess I can do it, except I'm not left-handed. Alright, so you can see here, silver plans might otherwise have a deductible of about 2,000 dollars, some will be more, some will be less. Insurers have options for hitting that actuarial value target. If you're at 150-percent of poverty, your deductible might only be 250 dollars, for example. Plans will offer versions for low income individuals with the subsidies baked in. The premium subsidies, I should mention, you can apply those to any plan. You can determine the benchmark subsidy for the silver plan. That might get you, if you're very low income, down to paying 300 dollars a year, as I mentioned before. You can also take that subsidy and apply it to a bronze plan, which is cheaper, and so get the premium down

even farther. The cost-sharing subsidies are only in silver plans. If you try to spend your subsidy to get the premium down on a bronze plan, you just need to know you're buying in to that much higher bronze plan deductible, and you won't be able to avail yourself of the cost-sharing subsidies. The cost-sharing subsidies are only in the silver plans. The premium subsidies can be applied to any plan. Then the only thing to know, we didn't really talk about this too much, but your subsidies are based on your income next year, in 2014, which some people will have to project, and if they're wrong, they might have to pay back the overage. There's no payback on the cost-sharing subsidy. If you accidentally claim a cost-sharing subsidy, and then your income slides over 250-percent of poverty, you won't have to pay that back. Does that answer your question on that—oh, that was a chat question, okay.

The other one was on tobacco. Insurers aren't allowed to charge you more based in your health status, unless you're a tobacco user, and then they can charge you as much as 50-percent more for your premium and those premium subsidies will not offset the tobacco surcharge. The 4,000 dollar benchmark silver plan for a 40-year-old would become 6,000 dollars and that additional 2,000 dollar increment, that's on you. The subsidies won't help you pay that back. A couple of states, at least California, have decided not to allow tobacco surcharges

for that reason. The prevalence of smoking tends to be much higher among lower income individuals and there's been some concern that that's going to render, yet again, unaffordable coverage for people, even after it's been subsidized. Otherwise, those tobacco surcharges can take place.

OPERATOR: We'll go now to—sorry go ahead.

RAKESH SINGH: I think we have time for one more question.

OPERATOR: Thank you, and our next question is from the line of Adam Ayer [misspelled? 00:58:04]. Please proceed with your question.

ADAM AYER: Hi, thanks for doing this. I had two quick questions. One is just about the rules that were released yesterday. Was there anything particular surprising about the initial mandate rules that were released, it seemed like—that you guys saw, anything that was new. On general enrollment, I'm curious as to whether you foresee any sort of disparity between the states—enrollment numbers we are likely to see in states that have opted to set up their own exchanges, versus states that have defaulted to a federal exchange. Do you think we'll see significantly higher enrollment in states that received lots of federal money to market on their own, rather than states that are relying on HHS and the Federal Government's efforts?

KAREN POLLITZ: Well, this is Karen. I didn't see anything eye-popping in the individual mandate rule that was finalized yesterday. I haven't read every single word, but I don't think there were any big surprises in there. It's very similar to what had been proposed, a couple of technical changes in a couple of areas.

In terms of enrollment state by state, my crystal ball's not that good. I do expect that in federally operated exchanges there may be a longer wait to get to an assistor, and so there may be more reliance on the insurance industry and brokers, and other for-profit assistor who are trying to tell you something, which isn't necessarily bad, but people may just need to rely more on that kind of current avenues of assistance and on insurance company marketing. A lot of the states that aren't running their exchange also aren't electing the Medicaid expansion. If you compare the two maps that Jen showed you, and I don't know what that might do in terms depressing enrollment, but I think the big difference in the federally versus state operated exchanges is the resources that will be available for call center operators and other assistors, and you'll just have to wait a little longer in some of the federally run exchanges.

RAKESH SINGH: Okay, we've come to the end of our time, but as we wrap up, let me remind you that you can ask us

questions after the webinar. Feel free to contact us individually, or you can always send us your questions via ACA webinars at kff.org. If you don't already get our announcements, you can let us know to sign you up. Additionally, we welcome feedback and suggestions for future topics, so we can help you all inform the public about these important changes.

Thank you and we'll talk to you next time.

[END RECORDING]

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