



**ACA 101: What You Need to Know
The Kaiser Family Foundation
Alliance for Health Reform
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ED HOWARD: Good afternoon. My name is Ed Howard. I'm with the Alliance for Health Reform. I want to welcome you on behalf of Senator Blunt, Senator Cardin, our board of directors to today's program on the Affordable Care Act, the ACA. We're joined in bringing you this program by the Kaiser Family Foundation, one of America's most trusted voices in health policy. And I want to give you a special thanks for braving the elements and the travel uncertainties to get here. If you've decided that staying home was the better part of valor and you're watching on CSPAN welcome to you too. I'm glad you're safe.

Early in every new Congress, in recent years anyway, the Kaiser Family Foundation and the Alliance have partnered to sponsor a series of briefings for Hill staff and others on some of the most important health policy topics that are the center of debate here in Congress, and for those of you trying to convey their views on these topics as well. After today's briefing on the Affordable Care Act we're going to be conducting three more of these premiers over the next month. They'll be held not next Friday but the two Fridays following that, the 20th and 27th, and then on Wednesday April 1st on Medicaid, Medicare, and healthcare costs respectively. Mark your calendars and we'll see you back here.

As for today's program one might ask why there's a need for a premier on a law that's a few weeks short of five-years-old and has been in the spotlight virtually every day from the day it was signed into law. Well, there are at least two fairly large reasons. One is this is a complicated law as some of you may have found with lots of different provisions. And even without major congressional action to amend, many of those provisions have changed since its enactment. Secondly, bright people come and go and sometimes come back here on the Hill. And even when they stay, their duties shift. And all of a sudden instead of the USDA they need to understand CCIIO or something like that. And we're hoping to help you understand the new language.

So we're going to dig into the Affordable Care Act. That's the Patient Protection and Affordable Care Act, to be proper, sketching out the main parts of the law, the ones you need to know about. We're not going to try to give you arguments for or against either the provisions or the law in its totality but we want you to be better informed about what the law actually says. The briefing comes at a timely juncture. We've just concluded the second open enrollment in the individual marketplaces. And we've heard oral arguments this week in the Supreme Court on a case that could radically reshape the scope of the ACA, maybe even threaten its continued existence. So we're pleased to have, as I mentioned, as a cosponsor of today's briefing the Kaiser Family Foundation, a source for tons of good information about the ACA and dozens of other health policy topics. And co-moderating with me today is Diane Rowland, the executive vice president of the foundation and herself, one of the leading health policy experts in the country. Diane...

DIANE ROWLAND: Thank you Ed and welcome to all of you. I want to share with Ed my appreciation for you braving the weather to be with us today. We weren't quite sure whether the audience would all have to be via media as opposed to in the present. But we really welcome you today. And I wanted to really emphasize Ed's point, that this is the basics not the debates about the Affordable Care Act. Although I noted Ed just said that we're going to talk about what the law actually says but we're not going to talk about the Supreme Court debate over state-based exchanges. Those topics will come up much later. What we want to do today is make sure the basic framework of the law is clear and that you have an understanding of where to dig deeper when you

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want to look at other issues. So with that, let's start. We have a lot to cover in a very short amount of time. And all the speakers have been given really short timeframes to talk about a very complex set of changes that really has revamped much of our healthcare system. Ed...

ED HOWARD: Terrific! Thank you, Diane. Just a little bit of housekeeping before we get started if I can. First of all, if you are in a mood to tweet, you can see the hash tag ACA101 on the screen there. Feel free to make use of it. In your packets you're going to find some important information including speaker bios more extensive than we have time to give them from the _____ [00:05:27]. And, you may have noticed that one of our speakers, Charlene Frizzera came dressed as an empty seat today. Charlene's flight back to D.C. got cancelled and her flight this morning was delayed. So since Charlene was schedule to cover the ACA's changes to Medicaid and CHIP we are very lucky that we have on the dias one of America's foremost experts on those programs, Diane Rowland, who in addition to her position at the Foundation happens to chair as many of you know the Medicaid and CHIP Payment and Access Commission. And she's graciously agreed to fill in for Charlene.

There will be a video recording of this briefing available Monday or Tuesday on the Kaiser website, www.KFF.org. And thanks very much to the Foundation for taking care of that very important aspect of our work. A few days later there will be a transcript that you can look at on the Alliance website www.allhealth.org. Those of you watching on CSPAN you may if you have access to a computer go to www.allhealth.org. It has all the speaker presentations. You can follow along as we go. And for those of you in the room, you can go back to the materials, all of the presentations, and as I mentioned, the biographical sketches as well.

At the appropriate time those of you in the room can ask our panel a question by filling in the green question card and it'll be brought forward or you can go to one of the microphones and ask it orally. And at the end of the briefing there's a blue evaluation form that we would very much appreciate if you would fill out so that we can improve these briefings and respond to your needs as well. So we have a great panel. And we're very pleased to start with Jennifer Tolbert. She's the director of state health reform at Kaiser Family Foundation and associate director of the Kaiser Commission on Medicaid and the Uninsured. As such, she's been playing close attention to how states are implementing the ACA. And we've asked her to lay out the major provisions of the law with an emphasis on its coverage provisions. Jen, thanks for joining us today.

JENNIFER TOLBERT: There it is. It's on. Thanks Ed. And thanks to you all for coming. It's a pleasure to be here. So I'm going to start with just a broad overview of the main coverage provisions of the law. And then my fellow panelists are going to dig a little deeper on each of these issues. But just starting off, one of the main goals of the ACA is to expand coverage to the uninsured and to improve the quality of coverage for those with private insurance. And it does this by building on the base of our current system, which is supported primarily through the employer-sponsored insurance. And then it fills in the gaps in the current system. Namely, it expands Medicaid to cover more low-income adults by establishing or raising the eligibility threshold to 138 percent of the federal poverty level. And just a note, the federal poverty level is \$11,770 for an individual in 2015. It also creates new health insurance marketplaces where people can go to shop for an enroll in private insurance. Through these marketplaces, premium subsidies are available to people without access to other coverage and who have incomes between 100 and 400 percent of the poverty level to make that coverage more affordable. And then all of these, the expansions, are

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made to work by health insurance market reforms that prohibit insurers from denying people coverage or charging them more because they are sick. It also imposes a new requirement on individuals to purchase health insurance with some exceptions and for large employers to provide affordable coverage to their employees.

So turning to the marketplaces, these are online marketplaces where consumers can apply for, shop around, learn what plans are available to them using standardized information, and actually enroll in coverage. And as I mentioned, the premium subsidies lower the cost of the coverage for many. And then, in addition, cost-sharing reductions are available to people with incomes between 100 and 250 percent of the poverty level. And that lowers the out-of-pocket costs that people face in the form of deductibles and co-payments.

So the law envisioned that all states would establish marketplaces but it did create a fall back provision whereby the federal government would establish a marketplace in any state that did not set up its own. And so to date, we have 16 states and the District of Columbia that are running their own marketplaces. In 14 of those states, the marketplaces are fully state run while three states, Nevada, New Mexico, and Oregon, are state-based marketplaces but they're relying on the federal healthcare.gov website for 2015. Seven states have adopted a partnership marketplace in which the federal government is ultimately responsible for the marketplace but the state is sharing in some of those responsibilities. And that leaves 27 states that have defaulted to a fully federally-run marketplace.

Now these decisions by states on how to set up the marketplaces have taken on renewed importance as a result of the latest legal challenge to the ACA as Ed mentioned. In the *King v. Burwell* case that is currently before the Supreme Court, the plaintiffs are arguing that subsidies can only be provided through states that are running their own marketplaces. So if the Supreme Court rules in favor of the plaintiffs it would effectively invalidate the subsidies that are currently made available to consumers in the 34 states with a federally run marketplace. And I think Sabrina is going to talk a little bit more in detail about this case and its implications during her presentation.

But turning to Medicaid, again, the idea of the law when it was enacted was that all states would expand Medicaid. However, a Supreme Court ruling on the law in 2012 effectively made the decision whether to expand Medicaid a state option. Currently, 29 states including the District of Columbia have expanded their Medicaid programs. Now importantly, states can adopt the expansion at any time. So that means that the expansion is actually under discussion in a number of states. And while most of the 29 states that have adopted the expansion, have done so through the traditional state plan amendment process, which is the standard process for making changes to the Medicaid program. There are actually six states that have received section 1115-waivers to implement the expansion in ways that go beyond the flexibility that was provided in the ACA. And notably, Arkansas is enrolling their expansion, their Medicaid expansion population through qualified health plans in the marketplace. And I think Diane's going to talk a little bit more about this as well.

Turning now to the impact of the ACA and what we know to date... the ACA does provide affordable coverage options for many. According to analyses of data on the uninsured from 2013, about 55 percent are estimated to be eligible for either Medicaid, CHIP, or subsidized coverage through the marketplaces. So again, over half of those who were uninsured in 2013 would be able to

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access affordable coverage options as a result of the implementation of the coverage provisions in the ACA. However, the decisions by 22 states not to expand Medicaid have left many poor adults in those states without access to affordable coverage.

And we estimate there are about 3.7 million people in the states that have not expanded Medicaid that have incomes that are too high to qualify for Medicaid in their state based on current eligibility levels yet they are too poor to qualify for subsidies in the health insurance marketplaces. And as a result, they have remained uninsured. Now we refer to this as the coverage gap. And you can see that that's the orange slice on this pie. In addition, undocumented immigrants are not eligible to enroll in Medicaid nor do they qualify or nor are they eligible, in fact, to purchase coverage at all through the marketplaces. So they are left out of the coverage expansions as well.

Millions of people have gained coverage through these coverage expansions since implementation of the law. As of February 15, 2015, which was the official end date of the second open enrollment period, over 11.6 million people had signed up for coverage through the marketplaces. Now that number has increased already because of extensions that were granted to people who were in line as of February 15th. And we expect it to increase even further due to announcements by the federal government and most, if not all, of the states to grant special enrollment periods to people who find out that they owe a penalty for not having insurance when they file their taxes his year. So those folks will be given the opportunity to sign up for coverage at that point. I should note that over half of people who signed up for coverage during this second open enrollment period were new to the marketplaces while about 48 percent renewed their coverage from 2014.

Growth in Medicaid has also been quite strong. There were 10.8 million people who gained Medicaid coverage compared to a baseline period from July through September of 2013, which was before the coverage expansions went into effect. Not surprisingly, enrollment gains were stronger in states that expanded Medicaid. The growth in Medicaid increased by 27 percent in states that expanded Medicaid compared to only seven percent in states that did not adopt the Medicaid expansion.

But one of the more important measures of the success of the ACA is its impact on the uninsured. While we won't know for a while the complete picture because of the lag in available data on the uninsured, initial data from the National Health Interview Survey, which provides data through June of 2014, indicates that there's been a significant drop in the uninsured rate. And while the drop has occurred across the board, the more important or bigger drops have been among the poor and near poor, among Hispanics and Blacks, as well as in states that have adopted the Medicaid expansion.

And just very briefly, we are focusing today on the coverage expansions in the ACA but the ACA was much, much broader than just its impact on coverage. It contains a number of provisions that attempt to reform the delivery system and how providers are paid as well as to expand the capacity of the healthcare workforce to accommodate the new people who are gaining coverage. One of the things that the ACA did was to create the Innovation Center at the Centers for Medicare and Medicaid Services. And this office is charged with testing new delivery system models such as accountable care organizations, providing coordinated care to individuals with high medical needs, as well as paying providers based on quality as opposed to volume of services, and testing innovative payment methods such as paying a bundled payment for services that include a hospitalization.

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And again, on the capacity side, it does a lot to increase payments to primary care providers as well as to community health centers to increase their capacity. And it makes investments in training of new health care providers to, again, grow the healthcare work force particularly among primary care providers. And so with that I will turn it over to Sabrina.

ED HOWARD: Thanks very much Jen. Sabrina, in this case meaning Sabrina Corlette from Georgetown's Center on Health Insurance Reforms, and in her spare time, adjunct professor at the law school at Georgetown. Her main area of interest these days you might infer is ACA reforms to health insurance emphasizing protections for consumers. And we've asked her to share with us her observations about the interaction among health insurance market reforms, the requirements that Jen mentioned that individuals have coverage, and the subsidies to help make that coverage more affordable. Sabrina...

SABRINA CORLETTE: Thank you Ed. Thanks all for braving the ice and snow to be here. So as Ed indicated I've been asked to talk to you about three of the essential legs of the Affordable Care Act's stool to provide private market coverage to the uninsured and ensure that that coverage meets basic standards of adequacy. So I'm going to talk about the insurance market reforms, the individual responsibility requirement or also called the mandate, and then also the financial assistance that's available for people to buy that private coverage and make it more affordable.

So first, the insurance market reforms. Generally when you look at polling on these reforms as taken individually, they tend to be very popular and actually very popular across the political spectrum. They were implemented in two primary phases. The first phase was implemented just a few months after the law was enacted in 2010 and included a suite of reforms that include things such as requiring insurers to allow young adults up to age 26 to stay on their parents policies, to provide free preventative care with no cost sharing or deductibles, a ban on lifetime and annual dollar limits on coverage, and new appeal rights for people who feel that the health plan has made the wrong decision about covering a benefit or paying a claim. January 1, 2014 was when we saw the heavy lifting take place...the significant insurance reforms that really ended the widespread practice in the insurance industry of risk selection. In other words, trying to keep away the people of high risk that had health problems or issues and only keep healthy people on the roll.

So first and foremost, health insurers are no longer allowed to deny people policies based on their health status. That's called the guaranteed issue provision. They are also not allowed to impose anymore something called preexisting condition exclusions on your policy. And this was a fairly common practice before the Affordable Care Act. If you signed up for a policy the company might say, well, we'll cover you but we see that you have asthma. Therefore, we will not cover anything related an upper respiratory condition or you had cancer five years ago and you're better now but we're not going to cover anything related to cancer. Those kinds of exclusions are no long permitted.

The law also requires companies, big insurers, to cover a basic package of what's called essential health benefits. There are 10 categories of coverage laid out in the statute. They include things like hospitalization, doctor visits, lab tests, drugs, maternity care, and it's designed to be modeled on your typical employer-based plan. And the idea is so that everybody can sort of have a basic standard of health benefits. Insurers are also not allowed to charge people more based on their

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health status or their gender. And they have to cap people's out-of-pocket costs over the course of a year. This year about \$6,700 is the max on the out-of-pocket costs that somebody would have to pay. They're also required to offer coverage at certain coverage levels that are commonly called the precious metal tiers or bronze, silver, gold, and platinum, bronze being the least generous level of coverage covering about an average of 60 percent of costs and platinum being the most generous at about 90 percent of costs.

But of course, to get these insurance reforms and ensure that we have a sustainable market with affordable premiums, the law included this individual mandate, the second leg of the stool. The basics of it are that you've got to maintain essential coverage over the course of the year or pay a penalty or a tax. For 2014, the penalty was the greater of 95 dollars or one percent of your household income minus the tax filing threshold. Now it's interesting, H&R Block recently came out with an analysis that said that on average the penalty that folks are paying is about \$170. So even though it's commonly banded about that there's this \$95 penalty, in fact, because the law says the greater of \$95 or one percent, for most people, the greater of is that one percent of income. Those penalties do grow; so eventually it's \$695 or 2.5 percent of your income and then indexed to inflation after that. People can get exemptions from the mandate. You can get an exemption if there's no coverage that's affordable to you and affordable is defined as over eight percent of your income. If you're not a citizen, and therefore not eligible for subsidies, you are exempt and also if you fall into that Medicaid coverage gap.

If you're going to require people to maintain coverage you got to have a place for people to buy it and a place where they can get it at an affordable price. Jen already talked a little bit about the exchanges or the marketplaces so I won't go into great detail except to say that I think the law's designers saw the marketplace as a way to have sort of managed regulated competition among insurers to encourage them to really compete on price and quality, and so that people could really see very clearly the differences between plans on dimensions like benefits and cost. The marketplaces, of course, are also the only place you can get the financial assistance that the law provides. First and foremost is the premium tax credits. And these are sliding scale subsidies based on your income between 100 and 400 percent of poverty.

And this slide sort of shows how they are somewhat progressive in how they are allocated. The subsidies are pegged to the second lowest cost silver plan that's available in your area. So you can take your tax credit and you can buy that second lowest cost silver plan or you can buy up--pay a little bit more, and buy up to a gold or platinum level plan—or you can buy down to perhaps a bronze level plan and garner more savings. However, if you do choose to do that you need to be careful because for people between 100 and 250 percent of the federal poverty level they are eligible for something called the cost sharing reductions or cost sharing subsidies. However, you only get to take advantage of those if you sign up for a silver level plan. So if you decide to buy down to that bronze level, you lose the advantage of these cost-sharing subsidies. And effectively what they do is they goose up that value of the silver level plan by lowering the deductible, lowering the cost sharing. So you have to pay less out-of-pocket during the year than you otherwise would.

The federal government reimburses insurers for the cost of those subsidies. And unlike the premium tax credits, which if you misestimate your income when you sign up for coverage, you do have to

pay back any extra tax credits that you've received. The cost sharing subsidies do not have to be reconciled at tax time. And so, you do not have to pay those back.

Lastly, I'd just say a couple of words about *King vs. Burwell*, which is on everybody's mind this week as the Supreme Court heard oral arguments. In case you haven't been following the litigation that closely, the crux of the issue is that there's a provision of the statute that says the federal government can provide financial help to people who buy coverage through exchanges that are established by the state. The King plaintiffs are arguing that because 34 states have exchanges run by the federal government that the tax subsidies provided through these exchanges are illegal. Now, it's important to note that almost 90 percent of people that have purchased insurance through the exchanges are receiving subsidies. So if the King plaintiffs prevail and subsidies through the federal exchanges are deemed to be illegal, you have the vast majority of people buying policies through these exchanges who will no longer be getting subsidies. And according to one study that was done by Avalere, these individuals will face, on average, a 255 percent premium increase.

The government, of course, in its arguments to the court is saying that if you look at the full text and context of the statute, it's pretty clear that Congress intended for all eligible to be able to receive the subsidies no matter who is operating the exchange. In effect, the way the statute is structured, Congress intended for the states to set up the exchanges, but, if for some reason they were unwilling or unable to do so that the feds would step in in their shoes. But, if you're eligible for subsidies because of your income, it doesn't matter who runs the exchange. The bottom line here is that if the plaintiffs prevail it knocks out the third leg of our stool making the financial assistance not available in those 34 states. But importantly, it significantly weakens that second leg of our stool with the individual mandate. And that's because most people who are currently getting subsidies, once those are taken away, coverage will be unaffordable to them and they will qualify for an exemption from the individual responsibility requirement. So if *King vs. Burwell*, if the plaintiffs prevail, we really have lost two legs of that essential stool. So with that I'll turn it over to Paul I think, right.

ED HOWARD: Thank you very much Sabrina. Paul Fronstin is, in fact, our next speaker. Paul's the senior research associate at the Employee Benefits Research Institute. And for all the attention paid to the exchanges over the past few years Paul is here to remind us that most working age Americans get coverage through their jobs. The ACA affects that coverage too, and Paul is going to explain those effects for us. Paul...

PAUL FRONSTIN: Thanks Ed. This is on, right. Great! You've already see two basic presentations and mine is going to be—I don't know where that eight came from on my presentation. But I'm going to talk about the basics of employment-based health benefits and how it's affected by the ACA. Note that I was at someone else's presentation on this on Wednesday, and I sat through their presentation, which was two hours long. There's just so much to cover on this which we just don't have the time to do it justice, any of us. So there are some extra slides in the packet for you to see during your own time.

One of the things to keep in mind is the environment before the ACA passed. And that is the percentage of—well, as Jennifer showed on her first slide employment based coverage is sort of the base that the ACA is building. Before the ACA passed, the percentage of workers with employment based coverage was falling. It was as high as 76 percent in 2000. By 2010 it was down to 69 percent. And when you look at where workers get their coverage from, we're actually at the point

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now where only 50 percent of workers get coverage through their own job. I don't know if that's some psychological level we may break through and what that means if we do. But I think it's important to point out. Though given what's happening with the economy, with the labor market, unemployment now being at 5.5 percent you shouldn't be surprised if you see this downward trend reverse itself in the near future.

I think the other thing to keep in mind is what was happening with benefits that were being offered, what workers were seeing when they were offered health benefits. You saw increasing deductibles. You saw increasing copayments for physician office visits, increasing copayments for non-generic prescription drugs, increased use of four tiers for pharmacy copayments, increased use of consumer driven health plans, though there were some exceptions to this general cost shift onto workers. Whether it was through value based insurance design, wellness programs or telemedicine, there were lots of changes going on with the benefits being offered to workers.

The next set of slides, some of this was already covered, but the next set of slides just goes through the timeline of all the different things that affect employment-based coverage. You have the slides. I'm not going to go through them individually but you can see—you saw 2010 was a big year for provisions affecting employment-based coverage. 2014 was a big year for provisions affecting employment based coverage, and even out to 2018 you've got the high cost, the excise tax on high cost health plans out there on the horizon, also known as the Cadillac tax, which we'll talk more about in a few minutes, and the few provisions that didn't have dates, effective dates, and the legislation that employers may have to address at some point.

So just a couple of items to go over. One, the employer-shared responsibility provision, I'm assuming you're all familiar with this. But it's worth reviewing. Either employer offers coverage or it pays a \$2,000 per full time employee—full-time equivalent employee--penalty if at least one full-time equivalent employee receives a premium tax credit. And that's the piece to really focus in on. An employer that doesn't offer coverage does not have to pay a penalty if none of their employees receive a tax credit. And that has implications for the Supreme Court case as well, which we'll talk about in a minute.

Currently, employers must offer coverage to at least 70 percent of their full-time employees. In 2016, that goes up to 95 percent. Employers with 49 employees or fewer are excluded. And when it comes to calculating the assessment the first 30 employees are excluded from that calculation. Only workers employed 40 or more hours per week are included in the assessment. And in the case where you've got somebody who owns multiple businesses and maybe they're all small businesses, there's a provision to look at whether or not those businesses are under a common control as to whether or not the businesses would be subject to the \$2,000 assessment. And the effectiveness date for this was moved from January 1st of last year to this year for employers with 100 or more full-time employees. And next year, it takes effect for employers with 50 to 99 full-time employees.

And keep in mind the environment before the ACA passed. In 2009, when you look at the employers affected by this mandate those with 50 – 199 workers 95 percent of them were already offering coverage. And among employers with 200 or more employees, 98 percent, just about all of them, were already offering coverage to their employees. So in some ways this provision isn't necessarily a mandate to offer coverage but a mandate to give an incentive for employers to continue offering coverage if they already were. But it also affects employers in the sense that not

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all of them offer coverage to all of their employees. They didn't necessarily offer it to all their dependents. And then you've got all the other provisions such as the requirement to offer affordable coverage, minimum value coverage that took affect as well.

And those are some of the qualifications here. For example, the definition of a full-time worker changed. It's now effectively 30 hours or more per week. Employers must offer coverage to not only workers but dependents but dependents are defined as children up to age 26. Dependents do not include spouses. Employers must offer the minimum essential value benefits and they must also offer affordable coverage. One of the things to keep in mind is this family glitch. Basically, affordability is determined by the premium for employee-only coverage. It's not determined by the family premium. So an employee may not be able to afford the family premium despite the fact that the employer is offering an affordable package as far as employees are concerned. And when that happens, when an employer offers coverage to the family that is not affordable for the employee, the spouse and children aren't necessarily eligible for a tax credit in the individual market. They may be exempt depending upon their income. They may be eligible for Medicaid or CHIP as well. But it's been estimated that between two and four million spouses and children may be affected by this family glitch.

Instead of a \$2,000 penalty there's a \$3,000 penalty that takes affect when the employer does offer coverage but at least one employee opts out, because coverage is either not minimum value or not affordable, and goes to the exchange and gets subsidized coverage in the exchange. If nobody opts out, nobody gets subsidized coverage, there are no assessments that are triggered.

When it comes to implications of King v. Burwell for employers, if the Supreme Court rules that tax subsidies are not allowed in the federal exchanges, that actually had implications for employers because employers are only required to pay the assessment when an employee gets a tax credit. And if it's deemed that employee in these 34 states cannot get a tax credit then essentially the employer doesn't have to offer coverage because there's no penalty associated with not offering coverage because their employees can't go out and get a tax credit in those 34 states. And there are all kinds of other issues that come up, especially for employers that operate across state lines and what this may mean for them.

There's a small business health options program, the SHOP exchanges. This is the marketplace for small businesses to shop for health insurance for their employees. One of the advantages of it is that it increases choice of carriers and plan options for both employers and workers, which is something that the small group market hasn't had a whole lot of. It allows employers to set a fixed or defined contribution. This was supposed to take effect last year but was delayed until this year. In 2016, it'll cover businesses with up to a 100 employees. And starting in 2017 the states may allow employers with 100 or more employees into the SHOP exchange, but that's at the individual state's discretion.

You've already heard about the different type of SHOP exchanges. There are tax credits available to small businesses. If a business has less than 25 employees and an average wage under \$50,000 those tax credits can cover up to 50 percent of the employer's contribution, if the employer contributes at least 50 percent of the premium. The credit is only available for two years. And it phases out, the larger the employer and the higher the average wage is. There are provisions for workplace wellness programs in the ACA. It allows employers to provide financial incentives of as much as 30 percent of the total cost of coverage when tied to participation and some type of

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wellness program. HIPAA already allowed for 20 percent, so it allowed for an increase. And it allows for 50 percent for interventions designed to prevent or reduce tobacco use. Financial incentives can come in the form of premium discounts, cost sharing, reductions or other benefits. And incentives can also be tied to participation in the wellness program and/or by meeting certain health related standards.

And finally, the excise tax on high cost health plans, also known as the Cadillac tax, takes effect in 2018. It's a 40 percent excise tax on the cost of the coverage that exceeds these levels, that exceeds \$10,200 for employee-only coverage and \$27,500 for family coverage. So there are higher thresholds for plans that cover early retirees and high-risk professions. There are adjustments for age and gender mix of workers that we haven't seen yet exactly how that's going to take effect. In terms of calculating the tax, it's not as straightforward as just looking at premiums. It also takes into account reimbursements from FSAs and HRAs, as well as employer contributions to HSAs.

Note that there was a release last week from the IRS that provided a little bit more information. And one of the things in that release is that if a worker contributes to their HSA through a payroll deduction, that's actually considered an employer contribution for tax purposes. And as a result, that would be counted towards the threshold. So there are all kinds of questions that still haven't been answered yet because we haven't seen regulations on this, but the effective date is 2018. I think that's it. Thanks.

ED HOWARD: Thanks Paul. Can I just ask a factual follow-up? When you were talking about the thresholds for applying this Cadillac tax if they exceed \$10,200 for employee-only coverage, for example, how does that compare with the actual normal cost of individual policies through the employer at this point?

PAUL FRONSTIN: Yeah. Well, at this point, I think the average from the Kaiser survey is about \$6,600 if I'm not mistaken. Obviously, there are people up here that could correct me for employee-only coverage and \$15,000 or so for family coverage, maybe \$16,000. So the average is well below the threshold. But you know with an average you've got those below it and those above it. So certainly there are some plans that are going to trigger it. It's not as straightforward as looking at the premium. So if you're counting FSA contributions or HSA contributions, that'll boost up how many plans may be above that threshold. I think the issue is that premiums have been increasing faster than general inflation, although that gap has shrunk recently. And the Cadillac tax is indexed to overall inflation after the first of the year. So the expectation is while there may not be a lot of plans affected by the tax initially, over time more and more plans will be affected by it if they don't make changes to avoid it.

ED HOWARD: Very good. Thank you very much. And Paul is exactly right. Diane's organization is the co-sponsor of the definitive survey of employer-based coverage that I commend to you if you haven't taken a look at it, the Kaiser HRET survey. A renaissance woman, Diane is stepping into the breach to pick up the thread of questions about Medicaid and CHIP. And I should say, we don't have her slides in your packets but we will have them mounted on our website after the briefing. Diane thanks very much for being so flexible today.

DIANE ROWLAND: You don't have the slides because they were done at 10:00 am this morning. [Laughter] Medicaid clearly as Jen's overview noted is a key building block within the Affordable

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Care Act. But one of the things to remember about the program is it's been around for 50 years. And it has a lot of other changes that were embodied in the Affordable Care Act. So today I'm just going to go over some very high level changes, and I urge you to come back for the Medicaid 101 to go in greater depth.

Clearly, one of the main things that the Affordable Care Act was doing was extending coverage to low income adults through the Medicaid program. It was also seeking to modernize the way in which eligibility and enrollment happened in Medicaid to simplify the process, to streamline the way eligibility determinations were made and the way income was counted. And it also provided substantial federal funds to the states to help them put in place the expanded coverage, as well as supported a wide range of changes in the delivery system not just for acute medical care but also for long term care services.

But the key piece of what the Affordable Care Act was seeking to do was to fill in the gaps in eligibility that had occurred for Medicaid, especially for adults. And one of those key provisions was that Medicaid was never available for childless adults or adults without dependent children unless they qualified on the basis of disability. So the Affordable Care Act changed the way in which Medicaid eligibility was going to be set, to be based solely on income and not on the characteristics of the individuals, and was going to try to put in place a uniform standard across all states, to eliminate some of the variation in who was eligible, on the basis of income to 138 percent of the federal poverty level or a little over \$11,000 for an individual.

And that was because of the tremendous variation that occurred in who was eligible for the program by income as well as category. And here you see the Medicaid program with its partner, the Children's Health Insurance Program or CHIP, provides very broad coverage for children across the nation. And virtually all states cover children to at least 200 percent of the federal poverty level, as well as pregnant woman. But there was a great disparity in the income eligibility standards for working parents or for jobless parents, and a lack of coverage for childless adults without disabilities.

So the Affordable Care Act sought to fill that, but the Supreme Court, not in the King vs. Burwell case but in it's previous case, decided that it was coercive on the states to require them to expand coverage even if in the early years there was a full federal financial participation for the cost of the coverage, and gave states the option to not provide coverage to the expanded adult population. So that would have been some of the working parents above the old income eligibility levels, as well as the childless adults who had previously not been covered creating a coverage gap between the Medicaid eligibility standards and eligibility for coverage in the marketplace.

And as one of the glitches that occurs when the Supreme Court intervenes and doesn't change a lot of other provisions of the law, only makes something optional, individuals below the federal poverty level were going to all be covered by the Medicaid program under the ACA vision. So they were, therefore, left ineligible for gaining access to coverage in the marketplace and for subsidies that have been talked about earlier. So anyone below the federal poverty level who was not already eligible for Medicaid by the old standards was left without coverage. Those who were between 100 and 138 percent of the federal poverty level could gain coverage in their marketplaces in their states and subsidies for the coverage.

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And so what you see is that in the states that expanded Medicaid there's a very nice flow. Childless adults get coverage through Medicaid and then they phase into getting coverage in the marketplace as their income goes up. Parents are covered equally and children have already had higher coverage. So there's no real coverage gap there. Yet in the states that did not expand Medicaid, those who are childless adults below the federal poverty level have no coverage option. Those who are parents can only be covered if they meet their state's very stringent income eligibility levels, sometimes it's 17 – 25 percent of poverty. Many of the states that did not expand had the lowest coverage levels income-wise for parents, and no coverage for childless adults. And, therefore, between poverty and the state standard they fall into the coverage gap. And then once they earn enough to be above 138 percent of poverty then they can go into the exchange--actually between 100 and 138 they can gain exchange coverage. And children again because of the coverage that CHIP and Medicaid have already provided remain covered at much higher income levels.

So nationwide as the result of the 22 states that have not expanded coverage, we see that about 3.7 million low-income adults fall into this coverage gap where they are too poor to go into the exchange for coverage and above the income eligibility levels for Medicaid coverage. And as you see, many of them fall into the southern states. And so we see in the states that had some of the highest uninsured rates, some of the highest poverty rates, that there is the most limited coverage for the poor.

Now in addition to the coverage, which has gotten all of the attention in terms of Medicaid's choices, every state did have to modernize and improve its application and enrollment process, try to coordinate that process with the federal or the state-based exchanges. And so you see that we've seen a great deal of effort put in to replacing paper applications, in-person applications, places where there was no data exchange about eligibility to try and have this vision of no wrong door-- anyone can go either apply at the marketplace or apply through the state—to simplify the way in which they get through, try and really keep the doors open so that the enrollment process is more available.

As a result, even in some of the states that did not expand Medicaid coverage, the process has become more consumer-friendly for people already eligible. And so, we have seen increases in coverage in those states of the people who were previously eligible but not enrolled, largely due to many of these improvements in the way the process works up front. And second, most of the states that have expanded coverage have been seeing some real benefits to their population, reductions in the number of uninsured as Jen's slide showed you. These have been particularly important among the low-income population and the expansion states have seen greater reductions in the uninsured than obviously occurred in the non-expansion states. But we've also seen increased revenues to providers, increased jobs in the healthcare sector, increased state savings in the expansion states as they began to be able to provide less uncompensated care, move some of the other services that had been provided to the indigent population onto Medicaid coverage, and increase state economic activity. So all in all, many of the states that adopted the expansion have done so with both economic success as well as better coverage for their citizens.

And in addition to trying to really focus on getting the coverage right and making the process seamless and easier for people to gain the coverage that they need, the ACA also thought to improve what happens after you get coverage to improve the access to primary care services, to improve the way the health system works for the low income population, and to try and develop

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other ways to provide services especially to the population in need of home and community-based services as an alternative to long-term care and nursing home facilities. So they boosted payment to primary care doctors under Medicaid. That was a two-year boost. Unfortunately, that is now expired though some states have kept that in place. They invested very heavily in expanding community health centers so that in medically underserved areas there would be facilities that could take care of the newly covered population. They really put a great emphasis on more preventative services and on public health activities and tried to develop within Medicaid, as well as Medicare and in the private sector, more patient centered medical homes and accountable care models that are now really being tested in many places, and new options for the elderly and disability population to be able to control more of their home and community-based services and options for care.

So we're really seeing at the end of the day both a coverage expansion in Medicaid and a real reform of the administrative structure especially for determining eligibility and determining how to get people connected to managed care plans into other health system reforms. And so it's a— Medicaid may be 50-years-old, but it's entering the next 50 years, because of the ACA, as a much more modern and changed program that is much more responsive to some of the ongoing changes in our overall healthcare system. The outstanding question, of course, that remains is what will happen with the states that are still on the fence about whether to provide the expansion or not. Many are seeking waivers or changes to try and be able to come in with a slightly different tilt to the Affordable Care Act provisions so that they can provide coverage to their citizens. But the juries are still out on where we'll finally end up. I would only remind us that Medicaid itself was phased in over many years. Not every state took up the option when it was first passed in 1965. Thank you.

ED HOWARD: That's terrific. Thank you very much Diane. One quick question for you too, if I can. You mentioned the standardizing of the income measurement as part of the eligibility changes that the ACA wrought. What happened to the asset tests that were in place for Medicaid recipients from the time of the law's enactment?

DIANE ROWLAND: Well, as the children's health expansions were enacted, the asset tests were gradually dropped as an eligibility determination mechanism for children, and with the Affordable Care Act, for coverage for low-income adults through family coverage. However, Medicaid also covers a substantial number of individuals who are elderly and have disabilities who qualify, some through the supplemental security income program and others through various provisions in the Medicare program that still do require the asset tests. So there's still an active asset test for many of the elderly and the disabled who qualify for the program, but not for families under the new determination of income called MAGI.

And I should also say, since I'm over my time I'll say it anyway, that the other provision that's now one very clearly coming to Congress soon is the Children's Health Insurance Program that actually has helped boost coverage of children that I showed and was funded through the Affordable Care Act through the end of 2015, which is fast approaching. And the requirement that states operate those programs continues through 2019. But Congress is going to have to make a decision fairly soon, very soon actually, about whether to extend the CHIP funding beyond 2015. And as they extend it, are they going to extend it as a straight up program the way it's currently structured or will they make other changes to it? We, on the MACPAC Commission, have recommended a two-year extension of the program just as it is and have also said that it's really important over the next few months, and in the next two years if that's the length of the extension, to figure out how to really

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integrate coverage for children and CHIP into either the exchanges and the Medicaid program or whether to continue the program as it is currently structured, as a middle ground program.

ED HOWARD: Thank you very much. And as you can infer from that response Medicaid itself is one of the most complicated programs that we have going. So let me reiterate Diane's suggestion that you plan to be here on the 20th of March for the specific primer on Medicaid. Now if you have questions that you would like to have addressed by one of our panelists you should either repair to one of the microphones or take out that green question card, write it down, hold it up, and we'll bring it forward. And let me just take advantage of how long it takes you to get into position. Oh, I spoke too soon. I would ask everyone at the microphones to identify themselves and to keep your question as brief as you possibly can so that we can get to as many questions as we can. Yes sir...?

TONY HAUSNER: Yeah hi, Tony Hausner, formerly with CMS and the last few years I've volunteered with the Affordable Care Act. So one of the things I've seen over the past year or so, and the Center for Budget and Policy Priorities helped to make it more clear to me that both the consumers and the navigators have an awful lot of comparisons to make regarding the deductibles, the coinsurance, different co-pays. There are quite a few different co-pays. And I was overwhelmed by how many things they have to compare. And I'm wondering, I've seen one tool, the Washington Consumer Checkbook who's done it for Illinois, simplify that. I'm wondering what solutions the panel has for that kind of dilemma that's confronting consumers who are signing up for the Affordable Care Act plans?

ED HOWARD: And we'll turn to Sabrina. But let me just ask, how many in the audience know what a navigator is? A good number but nowhere near a majority. You might remedy Sabrina.

SABRINA CORLETTE: Sure. So just quickly, the Affordable Care Act requires exchanges to establish a navigator program. Navigators are responsible for conducting outreach and education activities to let people know what's available to them and what their rights and obligations are under the law. And then the navigators are also supposed to help enroll people and help them figure out what they're eligible for. And as the gentleman indicated, because it sounds like you've been serving as a navigator or...

TONY HAUSNER: Working with them...

SABRINA CORLETTE: ...yeah, assist their function, and help them sort of figure out what's available to them and what is the optimal plan choice. And although the law does include within it some new standardization for health plans (in other words, they all have to cover the essential health benefits and they have to offer coverage at these precious metal tiers), there still is an enormous amount of flexibility for the carriers, particularly around cost sharing, but also around specific items and services that are covered. And as a result, it can be really overwhelming for consumers to try to figure out what's right for them and their family. There has been an effort, and Consumers Checkbook is a terrific organization that has done decision—has developed decision support tools, online tools, to help people filter down or narrow down their choices. And we're really hopeful that in addition to Illinois more exchanges will deploy those types of tools. But other states are actually looking at greater standardization of health plan options. In other words, really narrowing even further the kind of flexibility that the insurers have to, for example, vary copayments or deductibles for specific services. And so that may be something to look to in the future. I think some states did

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it the first year or the second year, but are looking to do it going forward now that we're kind of past some of these bigger operational hurdles.

ED HOWARD: Okay. Thank you. Yes ma'am.

DR. CAROLINE POPLIN: Hi. I'm Dr. Caroline Poplin. I'm a primary care physician, among other things. One follow-up to his question, has there been any study looking at whether the carriers are deliberately structuring their choices in such a way as to attract healthy people and push away sick, costly people since they're getting the same premiums for the healthy people as the sick people? My question was about employer-sponsored insurance and the requirements of the ACA, how do they compare? How does the benefit package compare? Do they have to cover the same—does it have to cover the same ten benefits? Or, can an employer get away with a much stingier, less useful package?

ED HOWARD: Good question.

SABRINA CORLETTE: Well, I can cover the benefit design issue, the first question you asked and maybe turn it over to Paul. Is that alright? So one of the shortcomings, of course, of having just ten minutes to present is I didn't really get a chance to cover all the provisions of the Affordable Care Act that affect benefit design. But one of them is a provision that prohibits insurers from using benefit design to discriminate against high-risk individuals. That said, there's not a whole lot of clarity about what discrimination and benefit design looks like. And there has been some early evidence that some insurers have been doing what you suggested, which was trying to design benefits to discourage sicker people from enrolling. For example, some insurers were recently sued because they put all of the HIV/AIDS drugs in the highest cost formulary tier, even the generic ones. And so, it's really incumbent on the federal and state regulators to perhaps put out some clearer guidelines about what discriminatory benefit design is, and then actually provide the oversight to prevent plans from doing that. And now, I'll turn it over to Paul for your other question.

PAUL FRONSTIN: Yeah. So I think your other question relates to the essential health benefits and whether it applies to employer plans.

DR. CAROLINE POPLIN: And I would add one other thing, out-of-pocket costs, and limits on out-of-pocket costs...

PAUL FRONSTIN: Okay. We'll get to that. The essential health benefits, it depends upon the employer. For employers that are purchasing coverage through an exchange, they have to comply with—by definition, they comply with the essential health benefits. For those outside the exchange that are fully insured, they have to comply with it. For those large self-insured employers, I don't think they do, but they still have to provide minimum value coverage so they have to cover 60 percent of something, and there was some guidance which basically requires them—makes sure that they don't not provide hospital coverage, which I think was the big issue. But when you look at what they were already providing, they were, for the most part, already in compliance with essential health benefits. So I'm not sure that that was a concern that needed to be addressed. As far as the out-of-pockets go, I think the employer plans have to comply with the same out-of-pockets as all the plans do.

DR. CAROLINE POPLIN: As the exchange plans do...

PAUL FRONSTIN: I believe so. That the limits—or maybe it's just the lifetime limits were removed and the annual limits as well.

ED HOWARD: Can I ask? Also, it seems to me we've heard a lot about what people call the three Rs. Is there an after-the-fact adjustment if you end up with a risk pool that's more sick or un-sicker than average?

SABRINA CORLETTE: I don't want to hog all the time, but yes. That's an excellent point because the health law provides risk adjustment, risk corridor, and reinsurance programs. So all three of them are risk mitigation programs designed to sort of help, in the early years, insurers that take on more risk than they anticipated. The risk adjustment is a permanent program so that if you end up getting more sick people than a competitor it actually is a "rob Peter to pay Paul" kind of a system. And the hope is that, for example, on your benefit design question, that it will actually encourage insurers to take on sicker people, chronically ill people, but if they can manage their care really well and keep them out of the hospital, they actually end up sort of winning under the risk adjustment system. But that has not gone into full effect yet. And so I think there are just a lot of questions about how it will work.

DR. CAROLINE POPLIN: Thank you.

ED HOWARD: Yes ma'am...

GERRY FAIRBROTHER: Hi. I'm Gerry Fairbrother, senior scholar at Academy Health. And I'm an adjunct faculty member at George Washington. And I have a question about the funding streams that were available before the ACA to cover uncompensated care—people who were not insured—the 330 funding for federally qualified health centers and disproportionate share of payments to hospitals. I believe that those were reduced or cutoff in the ACA because the presumption was that everybody would be covered. So I was wondering what the status was and what's happening in the states. And if they are reduced or cutoff what's happening in the states that still have these uninsured?

DIANE ROWLAND: Well currently, the disproportionate share hospital payments are scheduled to be reduced but those reductions have not yet gone into place, and the administration is charged with trying to develop a formula for how they would be reduced over time. Clearly, those provisions were put into the law with the expectation that all states would be expanding the Medicaid program. And now that it remains a state choice, it throws that kind of a provision a little bit down the road to be fixed or looked at. The availability of community-based services and the community health centers or the 330 program, as you mentioned, was substantially expanded by the Affordable Care Act. And that is kind of irrespective of which states expanded or did not expand, so there has been a real infusion of more assistance into some of the medically underserved areas where many of the low-income population live.

ED HOWARD: And Diane you have sort of dominion over the numerous cards that have been sent forward.

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DIANE ROWLAND: So Sabrina, one of the first questions that they'd like you to explain in depth is the difference between cost sharing subsidies and premium tax credits. If you could just clarify how those two work together and what they are.

SABRINA CORLETTE: Sure. I'll give it my best shot. So the premium tax credits are designed to make your premiums more affordable. So your premiums, of course, are those upfront, monthly payments that you pay for your health plan. They are available to people between 100 and 400 percent of the federal poverty level on a sliding scale basis. And essentially, you get your tax credit, you can get it on an advanced basis or you can wait until the end of the year and collect it at that point. Most people are getting it on an advanced basis, which essentially just reduces the amount of their monthly premium payment. The cost sharing reductions or cost sharing subsidies, often you'll see CSRs, are available to people between 100 and 250 percent of the federal poverty level. And they are only available if you enroll in a silver level plan. They are designed, as I said earlier, to sort of basically increase the value of that silver level plan by reducing deductibles and copayments. And again, just as with the tax credits they are provided on a sliding scale basis. So at a 100 percent to a 150 percent of poverty once you sign up for that silver level plan it actually goes up the value of that silver level plan to I think 97 percent. Is that right?

JENNIFER TOLBERT: 94...

SABRINA CORLETTE: 94 percent actuarial value, so that plan is really covering more of your copayments and deductibles. Between a 150 percent and 200 percent of poverty it's going up the value of your silver level plan to 87 percent. So again, sort of making it like a little bit more than a gold level plan. And then between 200 and 250 percent, it's just slightly increasing the value of that silver level plan to I think 73. Thank you, Jen for keeping me honest. It's 73 percent actuarial value. So essentially what it's doing is you get the—you're eligible for the premium tax credit. So your premium payments are reduced. But then when you actually are at your point of service, when you're going to the doctor or to the hospital, you're also paying less than your out-of-pocket costs. I hope that covers it in-depth.

DIANE ROWLAND: Jen, maybe you could also comment since this will be occurring April in the reconciliation process with the tax...

JENNIFER TOLBERT: Sure. Yeah, I was just going to add that point. And Sabrina had mentioned this earlier, but another key difference between the premium tax credits and the cost sharing reductions is that the premium tax credits have to be reconciled because they are a tax credit. So when people file—people who accept advanced payment of those premium tax credits they are based on what people project their income to be for the coming year. So people signing up for coverage in January projected their income for 2015, what they thought they would make. And then come tax time in 2016, the amount of the premium tax credit they receive gets reconciled against what they actually made over the course of the year. So if they made more than they projected they may owe some of that tax credit back. And they would pay it in the form of additional tax when they file their taxes. If they, in fact, made less income than they anticipated then they would get an additional refund on their taxes. And so, importantly the cost sharing reductions do not, are not, required to be reconciled in the same way as the premium tax credits.

RICK BLAKE: To follow-up on discriminatory health packages, to your knowledge is there data on the prevalence of these packages particularly in the case of HIV drugs? And two, are there any lawsuits against either the states or the providers to prevent these discriminatory packages?

ED HOWARD: And can you identify yourself...

RICK BLAKE: Oh Rick Blake with Strategic Health Resources...

ED HOWARD: Thank you.

RICK BLAKE: Yep.

SABRINA CORLETTE: So to my knowledge there is no data on how widespread potentially discriminatory benefit design is. HHS, Department of Health and Human Services, I think, has tried to put out some guidance to insurance companies about what they would think would be a discriminatory benefit design. But it's still pretty vague. To date, what has happened is that you have individual organizations that have been looking at some of these health plan benefit designs, which by the way, can be actually hard to get a hold of if you're not enrolled in the plan. And so we are aware of some lawsuits that have been filed with the Federal Office of Civil Rights at HHS alleging that the benefit designs are discriminatory. I believe some of those lawsuits have been settled. But I think that my personal opinion is that ideally you would have the feds or the states to put out some clearer guideposts or boundaries for insurance companies to prevent the practice in the first place as opposed to waiting for it to be litigated.

DIANE ROWLAND: This has been a particular issue in the state of Florida and there has been some in-depth look there at plan availability. And some of the researchers at the Kaiser Family Foundation are working on case studies that look particularly at the drug benefit offerings in different plans in five different states to see if there's any patterns there that would be discriminatory.

ED HOWARD: Very good.

AL MILLIKAN: Al Millikan AMA Media... Depending on how the Supreme Court decides, how many people would you estimate are going to be significantly affected by the decision? I was curious if all of you would have similar opinions about that.

JENNIFER TOLBERT: Well, when we look at enrollment in the 34 states with the federally run marketplace, there are about right now 7.5 million people who are receiving subsidies in those states. So the subsidies for those people would immediately go away. Many of those people would then no longer be able to afford that coverage. So the expectation is that they would immediately drop the coverage. But the implications go beyond that because, as Sabrina pointed out, when you kind of take away the legs of the stool, the requirements that insurers guarantee issue and restrict rates based on health status remain in place. And so what you're likely to have happen in those states is what's referred to as a death spiral in the individual market. In other words, with many of those people, young and healthy adults leaving the market, the people who are going to stay and do what they can to afford coverage are those who need it the most, so those who are sicker. And so what you'll see insurers doing to the extent that they can is increasing premiums and possibly and

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eventually without any changes made to the law, everyone or most people will be priced out of that market. So it affects not just the people who are receiving the subsidies but really everyone who's currently purchasing coverage in the marketplaces in those states.

DIANE ROWLAND: And from the low-income perspective, in those states that elected not to expand Medicaid coverage, many of the individuals between a 100 and 138 percent of poverty have gone into the marketplace and most of those are federally facilitated marketplaces. So we estimate that about two million people who would be covered by Medicaid if the states had expanded are now benefitting from being eligible for coverage in the marketplace and most of them would lose that coverage as well.

ED HOWARD: And one other aspect Jen, I'm thinking if you're an insurance executive and you're trying to figure out what to do for the rates you're going to file in 2016 to charge in 2016 you're facing sort of a strange time table, are you not? Sorry, Sabrina...

SABRINA CORLETTE: No, that's fine. That's one of the difficulties. The insurance companies have to file their rates for 2016 by May 15th of this year. That will be before the Supreme Court hands down its decision, so. And the rates have to be filed based on current law. So the insurance companies can't build into the rates a court decision in the favor of the plaintiff. So there is real concern that they could be locked into a rate that doesn't represent the risk status of their pool for all of 2016, which I can tell you is making a lot of these executives extremely nervous.

DIANE ROWLAND: One of the questions we got from the floor was what would be a plausible plan B if the plaintiffs prevail in *King vs. Burwell*? And then in parentheses, be realistic. Well, one plan B would obviously be for Congress to clarify the ambiguity and to say that the subsidies are available whether they're in the exchange or whether it's federally facilitated or state based. But I'll let my other panelists come up with a different plan B if they have one.

SABRINA CORLETTE: There's no good plan B. I mean the problem is, and I mean I'm not a budget expert but as I understand it CBO will almost immediately readjust the baseline. So if Congress were to go back and try to fix the language that costs money in the budget, right, so not only do you have a Congress that probably is not inclined to make a quick fix, you also have a budget problem, right. It's also not easy for states at this point to just, on a dime, establish a state-based exchange. There are significant costs involved. You have to have state authority, which means getting it through your legislature or even those that potentially could do it through executive order, there are questions about how you could raise the revenue to operate the exchange. So there's just a lot of unanswered questions. And I don't see an easy or simple plan B at this stage.

DANIEL: Hello. My name is Daniel. I'm with the Center for American Progress. I'm an intern. But I wanted to ask a little bit about have you all studied kind of what the ACA does in terms of cost savings and specifically kind of you had some numbers about how states have seen savings as a result of Medicaid and these insurance plans. But how much is that really from absolute savings as opposed to like the government giving them money and the states claiming that as kind of savings in that they're not spending the monies. And it's more the federal government giving the money.

DIANE ROWLAND: Well actually, some of the savings comes from programs that they've been operating for the indigent population that once that population gets insurance coverage they don't

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need to continue to operate that program. So it's that individuals with coverage are able to, as one of the earlier questions asked, go to a hospital and have their care paid for through the program instead of the state having to come in and provide uncompensated care to help keep some of its public hospitals and safety net facilities going. Some of it is community health centers being able to stretch the grants that they get to operate for care of the uninsured to now have more people with insurance who come in with Medicaid and provide some additional revenues to the community health centers. And we need to remember that there are going to still be uninsured populations because of the fact that many were excluded. The immigration issues excluded some from coverage. There are others who are not going to have signed up for coverage or will really need to continue to rely on some uncompensated care. But many of the states have also seen improved revenues from the fact that it generates economic activity in the state and that then gives the states better revenues which helps to offset some of their budgetary costs.

DANIEL: Thank you.

HELEN NEWTON: Hi. My name is Helen Newton. I work at HRSA. And this is actually for Jen Tolbert. Thanks so much for presenting sort of a breakdown of the 2015 open enrollment data. But I was curious if you had any estimation as to what percentage of rural residents were enrolled in 2015 plans?

JENNIFER TOLBERT: So I have not actually looked at this in depth for 2015. But there is data available from HHS by zip code. And when we did do analyses for 2014, enrollment in rural areas did lag behind enrollment in urban areas. I think there are a number of reasons for that. A lot of the people signing up for coverage especially those who are getting coverage for the first time needed the help of the assisters and the assisters are easier to access in urban areas. Now I think there were efforts put in place during the second open enrollment period to have greater availability of assisters in rural areas. So it's possible that when we analyze the data for 2015 we'll see that there was an increase in enrollment in rural areas. But I think it is still very much an area where we need to focus attention. Not only are the coverage rates a little bit lower, but access to care is also much more of a problem in rural areas.

HELEN NEWTON: Thank you.

ED HOWARD: We have only about five minutes left. So I would ask while you're listening to the last couple of questions if you would pull out the blue evaluation form and start to fill it out. It would be very helpful. Thank you. Diane...

DIANE ROWLAND: This is a question that I'm going to direct to Paul. If the federal government wants to encourage employers to offer health insurance to employees why would it include the Cadillac tax under the ACA, which discouraged high quality, employer sponsored insurance. What's the harm provided by employers offering coverage exceeding \$10,200 per employee or \$27,500 per family?

PAUL FRONSTIN: Yeah. That's a really good question. Employment based coverage has always benefitted from a preferential tax treatment in the sense that the amount that employers pay towards coverage on behalf of workers is not included in worker income in the amount that workers pay through payroll deduction reduces their taxable income. The concern is that because a dollar of

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health insurance is not subject to taxes and dollar wages are, workers prefer health insurance over wages to some degree or increases in compensation in the form of more generous health insurance. We know that more generous health insurance results in more use of healthcare services. And some of those services are good for people to be getting and some of those services may be unnecessary and therefore people may be over insured to some degree. So there's always been an interest as far back as the Reagan administration in changing the way health benefits in the workplace is taxed. And this Cadillac tax is one way that coming from the top down addresses high cost health plans that are often, though not necessarily always, but often associated with plans that provide very generous benefits. You may remember in the summer of 2009 I think the poster child for this tax was Goldman Sachs when it came out that they were spending I think about \$40,000 per executive for their health benefits. So it's a crude way of going about it. There are some issues with it. And there are some things we haven't seen exactly how it's going to be addressed. But the intent is to reduce these very generous benefits, or at least find a source of revenue to pay for other provisions in the bill by taxing these benefits.

DIANE ROWLAND: The last question here is really about the value of having health insurance coverage. Ann asks if we could speak to the cost benefit or cost avoidance by more people having coverage and eliminating costs by preventing medical conditions from becoming worse or people getting care in lower cost environments. And I think this question speaks to the purpose of the Affordable Care Act, which was to recognize that the uninsured population uses the health system very differently than people with insurance coverage. They often delay care, postpone care, end up in many cases sicker. And when they arrive for care they're often more expensive because of the delayed care. We know there are real health consequences in cases like early detection of cancer can make all the difference between being alive and being prematurely put to death by the fact that your condition was not treated when it was responsive to treatment.

So in that set of issues came the need to try and move people into the state of having insurance coverage and especially with the big focus in the Affordable Care Act on early access to primary care and to preventative services and the preventative services being available without cost sharing. And there were also—and we will get into that I know in the Medicaid section, in the Medicare section, and then in the health care cost section, about all the efforts to try and restructure the way the delivery system works to change the way the payment policies work to try and provide for more incentives to use the system in less costly settings but also to pay and reward care for performance and for value. So that's just an advertisement for the fact that the next three 101s are really going to deal with all these issues in a way that we could only skim the surface today. Ed...

ED HOWARD: Perfect segue... And it gives me the chance to say thank you, first of all, to you for providing a rich background of questions to illuminate a number of positions and provisions in this law and second, for showing up in the first place in a difficult set of circumstances. Thanks to the Kaiser Family Foundation, not only for cosponsoring but also contributing so richly to the discussion. And I'd like to ask you to join me in thanking the panel for giving us so much progress on this.

[Applause]

Don't forget the evaluations. And as Diane said, we'll see you in a couple of weeks to talk specifically about Medicaid. Thank you.

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