

**Kaiser Family Foundation Media Availability on Senate Health Bill  
Tuesday, June 27, 2017**

Drew Altman: Hi, everyone. It's Drew. It's Drew Altman. With me is Molly Brodie and Diane Rowland and Larry Levitt, and thousands of other Kaiser Family Foundation experts who are here on the call, it may feel before we're done like thousands of experts. We're here post the CBO report and also many of the analyses that we've recently put out that I hope you've all seen, mostly just to answer your questions, if we can answer your questions. We're certainly going to try. And that's because your coverage is going to be so important as we get to crunch time this week on this legislation.

We're actually-- I thought about this, and decided we're actually not going to make any presentations. And I'm going to play-- I don't know-- traffic cop or triage nurse, as we go through this. So let me just say-- I'm going to say one thing, which is just that in all my time in the field-- which is now much longer than I will tell you-- I've actually never seen legislation like this. It's not just the unusual process that it's taken in the Senate. It's also the legislation itself, which to me is unprecedented. It certainly achieves broad Republican goals, and those are things like fulfilling the promise to the base of repealing Obamacare and capping Medicaid and cutting taxes. But it also produces 22 million more uninsured. It raises premiums. It significantly raises deductibles. And I would say uniquely among any major piece of legislation I can recall, it would produce many more losers than winners, which is pretty unusual, which could come back to haunt Republicans in upcoming elections if it passes.

So we've been with you, I'm guessing pretty much all of you, if not all of you, for many controversial pieces of legislation in the past. But this time we're seeing both the process and the legislation itself, a legislative animal itself, which is really not like anything that I've seen before in a very long time in the field in watching major legislation go by.

So that's just my brief introduction. We do just want to get to your questions. And then we'll try and answer them. So, let's get going. Who's first? Who's up?

Operator: Our first question comes from Kris Mamula from the Pittsburgh Post-Gazette.

Kris Mamula: Hello, Drew. Kris Mamula from the Post-Gazette in Pittsburgh. I'm interested specifically in the impact of this legislation on older people. If you could just take a little deeper dive into this age group in 55 to 64. Pittsburgh has-- population skews older. So it's going to have a larger impact, I think, in the Pittsburgh area. Can you tell me about that?

Drew Altman: Yeah. Thank you, Kris. And that actually has both a marketplace dimension, and also could have a Medicaid dimension. But let me turn that to Larry to start on that question.

Larry Levitt: Hi, this is Larry. So on the private insurance side in some marketplaces, older adults, and particularly low-income older adults, are the hardest hit group from the changes in the Senate Health Bill. There are really two factors. One is changes in aging. Under the ACA, older adults can be charged 3 times what younger adults pay. But under the BCRA, older adults could be charged 5 times what younger adults pay, or some other ratio that a state may set. So premiums would tend to rise for older people, and fall for younger people.

The other big change is the way that tax credits or premium subsidies work. The bill shifts tax credits so that older people have to pay a higher percentage of their income than younger people, so that will tend to increase even for subsidized enrollees, what they have to pay for premiums. And so just to put that in numbers, we put out analysis last night that shows that 55 to 64 year olds would pay 115% more for equivalent coverage under the BCRA compared to the ACA. And that's even more extreme for low-income older adults who would pay 294% more after taking into account tax credits, meaning that their premiums after tax credits would almost quadruple.

Drew Altman: And on the Medicaid side, both the phase-down of the expansion and the per-capita cap put real pressure on the Pennsylvania budget and Medicaid budget. And of course you know that spending for long-term care or nursing home care is a major portion of any Medicaid budget. Governor Wolf will do what he can to protect that. He's committed to that. But I think you have about a \$2 billion hole in the budget--I could be wrong about that-- and a legislature which will be a real challenge. So I think there will be an issue on the Medicaid side as well. I don't know whether Diane or Robin want to add anything to that?

Diane Rowland: This is Diane Rowland. One of the other issues to remember about the Medicaid expansion is that many of the low-income individuals who were adults without dependent children who qualified for the expansion were in that 50-to-64-year-old bracket. And so when the expansion is phased out, it puts that low-income group of pre-Medicare people really at risk for their coverage. I know that in Arizona, a third of the expansion population came from that age group.

Kris Mamula: Interesting. Larry, could you just elaborate a little bit on that-- you're talking about the premium after-tax credit for lower-income people. They would be looking at a premium that is 294% higher?

Larry Levitt: Yes. That's right. So for 55 to 64 year olds in the marketplaces, with incomes below 200% of the poverty level, which is roughly \$24,000 for a single individual. The premiums they would pay for a Silver plan after taking tax credits into account, would rise 294%.

Kris Mamula: And the deductible would be roughly?

Larry Levitt: So the deductible would be-- this would be for equivalent coverage. So faced with premiums almost quadrupling, many of these low-income adults would tend to either go without coverage entirely, because it's unaffordable, or gravitate towards a plan with lower premiums and higher deductibles. And importantly, the benchmark for premium

tax credits changes under the Senate bill from the equivalent of a Silver plan, which have average deductibles of about \$3,600 per person to something akin to a Bronze plan, which has an average deductible of about \$6,100 per person.

And in addition, low-income people now receive cost-sharing subsidies, which for the lowest-income people lowered their deductibles to \$255, and those would be repealed under the Senate bill.

Drew Altman: Go ahead.

Kris Mamula: I'm sorry. I don't want to monopolize, but just to finish up, so Larry, we're talking about basically a tripling of the premium and approximately a doubling of the deductible. Is that correct?

Larry Levitt: Actually, almost a quadrupling of the premium, and deductibles, I mean it depends on the choices people make. But clearly with premiums quadrupling, people would not be able to-- many people would not be able to maintain the same level of coverage, and so would-- if they could afford coverage at all-- would tend to buy plans with much higher deductibles.

Kris Mamula: Okay, thank you.

Drew Altman: Okay. Let's just go on a little longer, because I think we were dealing with issues-- questions a number of you will have. Let's go to the next question.

Operator: Thank you. Our next question comes from Katie Watson from CBS.

Katie Watson: Hi. Yeah, I was wondering, looking forward or past, I should say, the Senate Healthcare Bill, if the Senate is unable to come to some sort of agreement and we're just kind of left with the Affordable Care Act indefinitely, what are some of the things that we might expect to see happen in terms of coverage in different counties, as well as looking forward to what the Trump Administration may or may not do with the subsidies, really looking at some of the potential impacts to health care then.

Drew Altman: Good question. I don't know if it's Larry or Cynthia's on the phone somewhere--

Larry Levitt: I can start and then Cynthia Cox should certainly jump in.

Katie Watson: Okay. Is this Larry, sorry?

Larry Levitt: Yeah, sorry. This is Larry Levitt. I threw away my crystal ball long ago in this debate. So we-- I think a lot of analysis, including ours, showed that the marketplaces were stabilizing. And the Congressional Budget Office said that they believe the individual insurance market would be stable in most of the country, either under the ACA or the BCRA. And I would tend to agree with that. But that depends crucially on decisions by the Trump Administration, in particular whether to pay cost-sharing subsidies to insurers and enforce the individual mandate.

And we've seen insurers pull out in the face of the uncertainty created by the Administration, and we've also seen insurers propose significant premium increases due to that uncertainty. So I think if the Senate bill fails, I think there is just tremendous uncertainty about what the Trump Administration will do in running the marketplaces for 2018. And we could certainly see more insurers pull out or raise premiums significantly in the face of that.

Katie Watson: Sure. Thank you.

Diane Rowland: This is Diane Rowland. I think it's also important if the Senate bill fails, nothing changes about the Medicaid expansion or Medicaid doesn't end up with per-capita cap, it goes on as it does under current law. But there we're likely to see much more activity from the Trump Administration around waivers and around changes to the Medicaid program through the administrative waiver process.

Katie Watson: Thank you.

Drew Altman: Next question?

Operator: Thank you. Okay, our next question comes from Maureen Groppe from Gannett.

Maureen Groppe: I have a couple questions, and one follow-up on the last question on market stability. I couldn't tell from the CBO score whether they were saying that the pockets of instability would be greater under the Senate Bill than the areas around the country that might not have options under the current law. And if there are counties, I'm looking at some counties in Indiana that don't have an insurance provider right now. What is likely to happen to those areas? And thirdly, if I could also ask about the effect on people who have coverage through their employer. I know the score said-- that CBO said that some employers would no longer offer plans. But what about claims that are being made that this would have an effect on people who get their coverage through workplace losing some patient protections?

Drew Altman: Gary, are you there? You want to take that one?

Gary Claxton: Sure. This is Gary Claxton. In terms of people losing patient protections, it's a rather complicated argument that depends on whether or not they change the essential health benefits, and then whether or not employers can rely on those changes to apply changes to how they treat those benefits that are taken out of the essential health benefit definition and exclude those from the out-of-pocket limits in plans, or maybe be able to put annual or lifetime limits on them.

I'm not sure, though, that that analysis would apply. It will depend very heavily on how the Administration writes rules once-- if this bill were to pass.

Cynthia Cox: And this is Cynthia Cox. I can answer the question about Indiana. So at this moment, we're tracking counties right now that are at risk of having no insurer next year. I should emphasize that this is an ongoing process, and the states and insurance companies will continue to negotiate their premiums and participation over the course of the summer.

So this is not at all set in stone. But at the moment there are nationally 47 counties with 33,000 people enrolled in those counties. These are in Missouri, Ohio, and Indiana. Four counties in Indiana with about 4,000 people signed up currently have no insurer as the result of a couple of-- in terms of the access.

So if there is no insurance company on the exchange, then people in those counties would not be eligible for financial assistance under the ACA. If they can afford it, they could purchase coverage off of the exchange. And if it's available, then there could be ACA compliant coverage that would have to take people with pre-existing conditions off of the exchange. But again, people would have to pay full price for that.

It's also possible that in some parts of the country there may not be ACA-compliant plans on the exchange. In those parts of the country, there may only be short-term policies that are not compliant with the ACA and do not count as coverage under the Affordable Care Act.

Drew Altman: Okay.

Maureen Groppe: Thanks. And then my third question was whether there's much-- CBO said there's much difference between a number of places in the country that would not have good options under the Senate Bill versus current law.

Larry Levitt: I can-- this is Larry. I mean CBO indicated that some areas of the country may have no insurers under both the ACA and the BCRA potentially for different reasons. Under the ACA, it's some continuing instability and also uncertainty about the payment of cost-sharing subsidies and enforcement of the individual mandate. Under the BCRA, it's the fact that subsidies are scaled back significantly for marketplace enrollees. But I don't believe CBO kind of quantified that. So I think it's fair to say that CBO's judgment is that markets would be similarly stable under both bills, under both scenarios.

Maureen Groppe: Okay, thank you.

Drew Altman: Okay, great. Next question?

Operator: Our next question comes from Harris Meyer from Modern Healthcare.

Drew Altman: Hey, Harris.

Harris Meyer: Hi. Good to talk to you. There's provisions in the Senate bill, one that would allow states to seek waivers from a variety of ACA rules. And then there's a provision allowing some sort of association health plan. So I guess I'm wondering is the CBO talked about the state waiver and also the association health plan, and suggested there would be uncertainties and instability associated. Could you play-- spin that out a little bit about how that could affect the availability of affordable and comprehensive health insurance across the board?

Drew Altman: I'm not totally sure which of the various waivers you're talking about. But let's see if Gary wants to handle this-- or is Karen here? Karen, are you there?

Karen Pollitz: I'm here.

Drew Altman: All right. You could also take it.

Karen Pollitz: Okay, so this is Karen Pollitz. So let me just start with the waivers. The Senate bill would allow states to waive the requirement to cover essential health benefits and other standards related to qualified health plans that apply under current law. CBO suggested-- this was a guess-- but that half the population could end up living in states that exercise this essential health benefit waiver authority, and that this might lead to instability in those markets, depending on the nature of those waivers.

If insurers have to take people, as they're not allowed to-- states aren't allowed to waive guaranteed issue-- if they have to charge them the same premium, they're not allowed to waive community rating, then the tool remaining to insurers to avoid high-cost people in their claims would be benefit design. So there's a concern that there could be kind of a race to the bottom as insurers would try to stop covering benefits that they know would attract expensive people, and those could be things like maternity care and mental health care and substance abuse and prescription drugs possibly, and possibly other benefits. So that would lead to lower premiums, but it could also leave patients who need those services unable to get coverage for what they need.

The association health plan provision in the Senate bill is a different provision, and that relates to small group coverage. And it would allow small employers to buy coverage through these new association health plans, which the bill defines as existing in the large group market. That's important because the rules that affect the large group market are different than for the small group market. In particular, the large group does not have to use community rating. Insurers can charge employers more based on the health status of their claims experience of their covered workers, and the essential health benefit standards also don't apply in the large group market.

So the concern there is that small employers might travel back and forth between these association health plans with different rules, or lesser rules, while their employees are healthy and don't need to make many claims, but then go back to the regulated small group market if somebody gets sick or has a premie baby or something like that, where they need more comprehensive coverage and the protection of community rating. And that kind of adverse selection, traveling back and forth across markets, depending on which rules are more advantageous, I think could really destabilize the small group market.

Harris Meyer: So what I'm trying to get at is these are-- the AHP thing applies to small groups. The state waiver applies to states that take it. But I'm wondering if there's any sort of broader leakage of those erosions of protections to the broader market.

Karen Pollitz: Well, I'm not sure if this answers. But the association health plan option, that's not a waiver. That's just a new federal rule. So states actually wouldn't have anything to say about this. The secretary would certify these plans, and then small employers could move the way they want to.

Drew Altman: Specific states are preempted.

Karen Pollitz: States, yeah, would be preempted from stopping the establishment of these plans. So states wouldn't have anything to say about that. The small group market, it's worth noting, is already kind of shaky. Because small employers currently, a lot are staying in these pre-Obamacare kind of transitional plans, or they can move in and out of the market rules into "self-funded plans" that aren't very self-funded.

But I think this would just be another tool that would increase the shakiness in the small group market. So does that answer your question, Harris?

Harris Meyer: Yeah. But the other part was how the state waiver could bleed over into, say, affecting states that the pressure, for instance, on states to take this up, to apply for these waivers, pressure from insurers; do you have thoughts about that?

Karen Pollitz: Well, I mean I think this would turn into a 50-state debate. So there would be pressure, I think, in every state for legislatures to adopt these waivers. And how that would work out would really depend on who's got more clout in the state capital, and what else is going on in the state. But I think insurers will want, given that they do have to take people and charge them the same premiums in a voluntary market, I think they will want that added flexibility to defend against the adverse selection using benefit design, and they'll make the argument that premiums will be cheaper if they don't have to cover all these benefits, and that will just play out 50 different ways. It's hard to predict in CBO's estimate of half the population suggests they think it could be a coin toss in any given state.

Harris Meyer: Okay, thanks.

Drew Altman: And this is Drew. And they have a lot of clout in many state legislatures. Okay, next question.

Operator: Thank you. Okay. Our next question comes from Daniel Chang from the Miami Herald.

Daniel Chang: Hi.

Drew Altman: Hello, Daniel.

Daniel Chang: Hi. Thank you for taking my call and for holding this conference call. I wanted to ask specifically if you could help me understand a little better how the per-capita caps would be calculated by state. I don't know if that's in the CBO bill or not. And if you might speak to how cuts to the Medicaid program might bleed over into the individual market or maybe even large group coverage; would it have the impact of perhaps raising premiums as hospitals saw more uncompensated care and that kind of thing?

Drew Altman: We can do that. Diane, Robin, who wants that one?

Diane Rowland: Robin.

Robin Rudowitz: So under the bill-- oh, this is Robin Rudowitz. Their states would work to develop a base. And they could pick these eight consecutive quarters from 2014 to the beginning of 2017. And then that base amount per enrollee per group would be inflated to 2019, and then after 2019 the bill specifies different indices, the medical component of the CPI or the medical component of the CPI plus 1 percentage point for the elderly and disabled for 2020 through 2024. But then starting in 2025, all per-enrollee amounts would be inflated at the general inflation rate. So that's sort of a-- and then these are-- the overall cap is calculated based on those per-enrollee amounts per state multiplied by the number of enrollees. And then to the extent that states spend more than their cap, there's a claw-back in the following year to recoup monies that were overspent.

So it's a complicated formula, but there are-- the Congressional Budget Office estimates that all groups, the anticipated growth under the baseline would be higher certainly than the general inflation rate, which applies starting in 2025.

Daniel Chang: Okay. And in terms of the potential impact from cuts in Medicaid, people losing Medicaid coverage, perhaps states reducing reimbursements to providers or whatever manners they choose to try to get within those caps, could that have the impact of potentially making coverage more expensive for folks who either get it through their workplace or buy it on the individual market?

Diane Rowland: So this is Diane Rowland. So obviously one of the choices states have is they, say their per-capita caps squeeze down, is to reduce provider payments rates to try to change the mix of services so that they can live within their cap. And if medical expenses are going up faster than the per-capitalcap will allow for the growth in the federal dollars, there will be a shortfall there.

In addition, the Senate also tightened down on the states' ability to use provider taxes as a way of supporting their state share. So there's an additional budget squeeze there from the states. And over time, the Senate also wants to bring some of the high-cost states down by reducing it. So clearly there will be a lot less federal money supporting state activity, which will result in less state monies being spent on these programs, and therefore more uncompensated care, and more problems in the hospital.

How that translates to other providers and payers, depends really on what they're able to negotiate. Many say that the effect won't be raise premiums for everyone else, but to close small rural hospitals, and to really put more hospitals in difficult straits.

Daniel Chang: Thank you.

Drew Altman: Daniel, this is Drew. This will not affect your state. But where you'll really see this question come into play is in the expansion states, where they will see their enhanced federal match phased down and phased out. And those states lose a lot of federal money, for example, in bringing in California, it's ultimately \$12 billion a year. It's amounts they cannot replace. And the theory then is that those people would be able to purchase insurance in the private market. Based on the kinds of numbers you've been seeing from us, from CBO, the kinds of numbers Larry just walked you through,

they will not be able to afford the private coverage. And so that's when you will really see that effect. But that's principally in the expansion states, red and blue. And that's different from the per-capital cap effects.

Daniel Chang: Okay. I wanted to piggyback one last question, which was mandatory versus optional services; I mean Florida has crowed a lot about how it has used optional services in home and community-based care to get seniors out of institutions like nursing homes, and into places where they're familiar with and they could have family around them. Are the optional and mandatory benefits likely to change under this bill? This is Medicaid.

Robin Rudowitz: Well, there's no-- this is Robin Rudowitz. There's no change in the statutory requirements. So that means that states would turn to optional coverage groups and optional services to try to reduce their per-enrollee amounts. And one of the things at risk are those home and community-based services, both in terms of the populations covered as well as that category of services.

Diane Rowland: This is Diane Rowland. And remember that with the per-capita cap, you're locked into what the mix of services is that created your cap or what your per-capita spending was. So in states that have an aging population or a lot of new baby boomers who become aged and want to expand and spend more on the long-term services and support, the benefit there per enrollee is going to be locked in and will over time under the Senate Bill grow at an even lower rate.

Daniel Chang: Okay. Thank you.

Drew Altman: Okay. Thank you. Next question?

Operator: Thank you very much. Our next question comes from Erin Mansfield for VTdigger.org.

Erin Mansfield: Hello. I am in a state where we use community rating, and everyone pays the same amount. I am wondering how premiums will be affected, given that my state is very unlikely to change its age rating. They're probably going to keep one-to-one rating.

Drew Altman: The great state of Vermont. Larry's nodding his head, so we'll go to Larry.

Larry Levitt: Yeah. So the-- I mean the Senate bill does permit states to have a different age rating ratio, either smaller as in Vermont, or potentially higher as well. For the vast majority of marketplace enrollees, the Senate Bill maintains the subsidy-- basic subsidy structure of the ACA, meaning that subsidized enrollees who make up the vast majority of marketplace enrollees pay a percentage of their income toward the benchmark plan. So kind of irrespective of what the underlying premiums are, subsidized enrollees are paying a certain percentage of their income, which ranges from just above 2% of income for the lowest income enrollees to roughly 17% of income for the oldest, highest-income enrollees. And so and importantly those percentages of income vary based on age as well as income.

So even though the underlying premiums may be the same for older and younger people in a state like Vermont, what those lower-income enrollees will actually pay will vary by age under the Senate bill, which they don't now. So there certainly will be an effect on older enrollees, even in a community rating state.

Erin Mansfield: Okay. And do you guys have any knowledge of what would happen to our Medicaid budget?

Drew Altman: It's Vermont guys.

Diane Rowland: We don't have-- this is Diane Rowland. We don't have any state-by-state specifics. But we know that most of the states' Medicaid directors are working aggressively to see what the impact would be, and are generally saying that the cuts, whether you're-- and especially Vermont with its expansion, would be very deep and hard to come up with state money to fill in the gap.

Larry Levitt: And this is Larry Levitt. I would just add that in the analysis we released last night on how premiums would change for marketplace enrollees, we have state-by-state estimates as well. So for example, for Vermont, we're estimating that-- I mean the effect is more modest, because of the community rating. But the average amount paid by marketplace per enrollee would increase 21% for equivalent coverage under the Senate bill.

Erin Mansfield: Thank you.

Drew Altman: Other questions?

Operator: Thank you. Okay. Our next question comes from Jeremy Olson from the Star Tribune.

Jeremy Olson: About prescription drugs, just because so many polls (inaudible). And I wanted to get your views on what (inaudible) if anything, regarding prescription drugs, whether it's going to make things better or worse.

Unidentified Speaker: Sorry. Could you repeat your question? You cut out at the beginning.

Drew Altman: You kind of broke up.

Jeremy Olson: Yeah. My apologies. My questions was dealing with prescription drug costs and whether this legislation does any (inaudible).

Drew Altman: We're sorry. Just for some reason, you must be on a cell that is having-- we're having a hard time getting-- hearing your question.

Jeremy Olson: Okay-- can you--

Diane Rowland: This is Diane Rowland. Is your question whether the legislation does anything about the cost of prescription drugs?

Jeremy Olson: Yep. It's that simple, period.

Diana Rowland: Tax, Medicaid tax will make it more difficult for states to be able to afford the prescription drugs that they need, especially to address things like the Hepatitis C problem. But there's nothing in this legislation that changes the cost for prescription drugs or changes how pharmaceuticals are paid for or reimbursed.

Larry Levitt: And I would just add-- this is Larry Levitt-- the legislation makes it relatively easy for states to change various provisions of the ACA, including the essential benefits requirement. And while most individual market plans included prescription drug coverage before the ACA that coverage was sometimes limited, for example, to generic drugs or it put limits on that drug coverage. And that could certainly happen under the Senate Bill.

Drew Altman: I would also add-- this is Drew-- that if you're paying much higher deductibles, it makes it harder for you to pay out of pocket for anything else. It could be prescription drugs. It could also be your heating bill or your gas. So there's that kind of byproduct effect.

Okay, great. Next question?

Jeremy Olson: Thank you.

Operator: Our next question comes from Donna Rosato from Consumer Reports.

Donna Rosato: Hi. Yes, thanks for holding this. I have two questions. I wonder, is there any way to estimate out-of-pocket costs, so the deductibles, but also including co-pays or coinsurance beyond the averages in the CBO report? To do that-- to compare them against, I guess BCRA versus the ACA.

Larry Levitt: This is Larry Levitt. There's not. Under the BCRA, like under the ACA, insurers have to offer coverage in tiers of actuarial value, which determines the share of cost paid by insurance and by enrollees. But insurers have flexibility in how to structure their plans within those tiers, whether through deductibles, or co-pays, or coinsurance.

So it's difficult to estimate how much, for example, co-pays will change. But just to give you sort of a-- I think the deductible is a very good proxy. I mean it's most of what people end up paying in out-of-pocket cost. And the benchmark plan that premium tax credits are pegged to under the ACA is the Silver plan, which has the deductible currently averaging \$3,609. Under the BCRA, tax credits would be tied to a plan similar to a bronze plan, which currently has deductibles averaging \$6,105. So I think it's fair to say that patient cost-sharing across the board would go up significantly, including deductibles and co-pays.

Drew Altman: And just review the actuarial value difference again.

Larry Levitt: Yeah, so the actuarial-- so the subsidies under the ACA are pegged to a plan with an actuarial value of 70%, meaning the insurance, on average, pays 70% of the cost. Under the Senate Bill, they'd be pegged to plan with an actuarial value of 58%. And

importantly cost-sharing subsidies which lower deductibles and co-pays for low-income people would be repealed entirely.

Drew Altman: Correct. So it's paying just over half of your cost without the subsidies, the cost-sharing.

Donna Rosato: Okay. And then the other question I have is just a follow-up on the waivers. Have any states who have applied for waivers under the ACA now gotten approval from HHS? I know a lot have made proposals such as opposing time limits on how long you could be on Medicaid and work requirements. So do you know? Have any gotten approvals from HHS? And haven't states like Maine and Alaska already made some changes?

Drew Altman: Diane, is MaryBeth there or do you want to take that, or Barbara?

Diane Rowland: Robin can take it.

Drew Altman: Okay.

Robin Rudowitz: Yes. This is Robin Rudowitz. There are a number of waivers that are pending either out for state comment or at HHS. And we haven't seen new waivers approved yet. There was guidance or a letter put out in March by the HHS and CMS jointly, inviting states to submit various waivers. That would include work requirements and other premium cost-sharing and other ideas. But we haven't seen-- so we don't know the direction yet in terms of what will actually get approved.

Donna Rosato: And the other part to that question, haven't Maine and Alaska already made some changes, but those are just with-- I don't know if this is the right way to put it-- but the Maine reinsurance program, for example-- I'm sorry, the Alaska Reinsurance Program was done with state financing. So have we seen any states do things that they can do at the state level?

Cynthia Cox: I believe you're referring to the individual insurance market. This is Cynthia Cox. So Alaska has a reinsurance program that they set up as a state. Minnesota does as well. And these programs are aimed at reducing premiums in the individual market by offsetting the cost to insurers that they would incur from very high-cost enrollees. So this can help lower premiums in an individual market.

Donna Rosato: Okay. All right. Thank you.

Drew Altman: I would think those waivers will be approved. But we will see. Next question?

Operator: Our next question comes from Jon Greenberg from PolitFact.

Jon Greenberg: Hi, guys. Thanks very much. So this morning Paul Ryan was asked about the 22 million people who wouldn't have insurance as covered in the CBO report. And his response was, he says, basically what they're saying at the CBO is that if you're not going to force people to buy Obamacare then they're not going to force people to buy something they don't want-- they won't buy it. So it's not that people are getting pushed off a plan. It's

they just don't want to buy something they don't want. What's your response to that in terms of what the CBO actually said?

Drew Altman: We know from all kinds of research we've done for years that people want insurance, and in some cases desperately want insurance. They don't buy it if they can't afford it, not that they don't want it. Would anyone else on the team like to respond to that? That was Drew.

Diane Rowland: This is Diane Rowland, but clearly one of the losses of coverage from this legislation is the rollback of the Medicaid expansion, and those are people who want insurance. They have insurance. But when the state has to phase out that coverage, they're going to lose coverage and become uninsured. And other people are going to be facing premiums in the individual market that are far more unaffordable with much less subsidy assistance than under the Affordable Care Act.

So people are going to become uninsured because they can't afford insurance anymore, just like they couldn't before the ACA.

Drew Altman: It's a pretty good point, the fact that 22 million of them had insurance is reasonable evidence that they wanted it.

Jon Greenberg: Do you have any sense of basically the CBO says about 7 million of those people who would be without insurance are in the non-group market, and there's sort of mix in the CBO analysis of some of those would be people who say, well, I don't have the individual mandate. I'm not going to buy. And others would be precisely as you say, facing the unaffordability. Do you have any sense as to what the breakdown might be? Is it going to be 50/50, do you sense in that CBO analysis?

Diane Rowland: This is Diane Rowland. I think if you look at the figure 3 in the CBO analysis, you see that many of the people who are going to become uninsured are under 200% of poverty. And so that is where the big rise in uninsurance is, which shows you the impact of affordability, and of the Medicaid expansion.

Jon Greenberg: Yeah. Okay. Thanks.

Drew Altman: Good question. Next question?

Operator: Our next question comes from Tony Pugh from McClatchy.

Tony Pugh: Thank you.

Drew Altman: Hey, Tony Pugh.

Tony Pugh: How goes? Hey guys, I was wondering if you guys could tell me what provisions of the Senate Bill would do the most to return the individual markets to their pre-ACA days when it was, I guess, a poorly regulated profit mill, I guess. And I'm wondering, is there any reason to believe that state insurance regulators would do a better job looking out for consumers this time around, if the Senate Bill becomes law.

Drew Altman: Well, I think we'll let-- Karen answer that question.

Karen Pollitz: This is Karen Pollitz. So the kind of big changes that the ACA made to the non-group market that this Senate Bill would start to roll back, one is it makes it mandatory. The Senate Bill takes it back to a voluntary market. Two, the ACA pretty heavily subsidizes non-group coverage, and the Senate Bill rolls those subsidies back. So that will create a lot of pressure to try to sort of give insurers more tools to avoid the costs of high claims. Three, the essential health benefit waivers, that's where I think that the pressure would happen in all 50 states to allow insurers to kind of roll back and start offering skinnier plans that don't cover some of the kind of critical and expensive benefits that people need when they're sick.

And then another change that's in there that hasn't been talked about a lot, but the Senate Bill does repeal the medical loss ratio standards for all private health plans, and leaves it up to states. So to the extent that insurers can find a way to offer skinnier plans more profitably, the state would have to decide whether they would continue to have sort of a minimum efficiency level required for health plans, or whether they would let that go as well.

Drew Altman: And Tony, states always vary on everything. And some state insurance regulators are very close to the industry, to put it nicely, and some are very independent and very consumer-oriented, and very tough. So there will be a lot of variation.

Okay. Next question-- oh, you have another question, Tony?

Tony Pugh: Yeah. I'm wondering would insurers be able-- you know short of-- if you could talk a little bit about how they can craft policies that would screen out the people they don't want to cover, and would this bill make it easier for them to do that?

Drew Altman: That sounds like Karen again.

Karen Pollitz: So that-- I mean the EHB standard is the main tool that they're given. The other thing that can be waived is the single-risk pool requirement. Right now, for example, maternity care only adds, what-- maybe 5% to the premium, and insurers are required to price their plans based on assumptions about what the entire potential marketplace might use, as opposed to just the people who sign up for that plan. If under a waiver, insurers could offer, for example, a health plan that covers maternity care and a health plan that doesn't, they could-- and if the state also waived the single-risk pool requirement, then insurers could price the non-maternity plan way less than 5% under the maternity plan. Because they could just assume that all the pregnant ladies would go to the plan that covers maternity benefits and take all their related claims with them.

So if both those things got waived, you could still see, for example, plans that cover maternity plan being offered. But they would just be prohibitively expensive for the people who need maternity care. There was actually experience with that before the ACA. The state of Washington had kind of a setup like that. And the market became

unstable very quickly, and the richer plans that covered things like maternity care and drugs and mental health care quickly became unaffordable within a year or two.

Drew Altman: Okay. We're going to take one more question. Who's got it?

Operator: Okay. Laura Saunders from the Wall Street Journal.

Drew Altman: Okay. Are you there?

Operator: It disconnected. Hold, one moment.

Drew Altman: All right. We're still offering one more question. Do we have one more?

Operator: Yep. We have Patrick McCreless from the Anniston Star.

Drew Altman: Okay.

Operator: Go ahead, Patrick.

Patrick McCreless: Yes.

Drew Altman: Are you there, Patrick?

Patrick McCreless: Okay, yeah. I was disconnected for a second, yeah. Yes. My question is how this bill can impact children on Medicaid, particularly in states like Alabama, or if there are some sort of exceptions for children on Medicaid?

Drew Altman: Good question. Diane, you want that?

Diane Rowland: Well clearly, this is Diane Rowland. Clearly, one of Medicaid's very important roles has been to provide access to care for children. And Alabama and other states significantly expanded their coverage through Medicaid so that many children in working families are now covered by the Medicaid program there. One of the provisions, of course, of the Senate Bill is to establish a per-capita cap on spending that would be for children. They have now talked in the Senate Bill about pulling out children who qualify on the basis of a disability. But that doesn't include many children who have special health needs and who need additional services.

So it could really cut back on the availability of care for children in Alabama. And of course another piece that's kind of unspoken right now is what will happen to the CHIP program, the Children's Health Insurance Program, which expires in September unless it's reauthorized. And that's not addressed at all in this set of provisions.

Drew Altman: Okay, great. We're going to thank you very much. We have no closing statements. We really promised you we wouldn't be making statements or even emphasizing our own studies and our own work. We just wanted to be a resource for you today.

So, thank you very much for joining us today. And we're happy to help each and every one of you offline as you do your stories in the next few days. I gather they've deferred action now until after the 4th of July, so a little more time to do stories. So, thanks very much. Bye-bye.

Operator:

Ladies and gentlemen, this concludes the conference for today. Thank you all for participating. You may now disconnect.