Webinar for Journalists: A year-end Update on the ACA Rollout and Looking Ahead to 2014

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PENNY DUCKHAM: Well welcome everybody to the sixth in a series of seminars for journalists, exclusively for journalists, to provide updates on the ACA and as with the previous webinars, this will be available on our website afterwards and a transcript will be available if you need to go back over any of the slides or the text. Just as a reminder, as in the previous webinars, the whole focus will be on the Q and A with every opportunity for you to send us your questions via chat or phones, so please make use of that opportunity. And with that, as you know, this is a year-end update on the ACA rollout and then looking ahead to 2014.

We're here today with my two colleagues, Jennifer Tolbert, the Director of the Kaiser Foundation's State Health Reform Program and Larry Levitt, the Co-Director of the Program for the Study of Health Reform and Private Insurance. And we're going to start with Jen, so Jen Tolbert, over to you.

JENNIFER TOLBERT: Great, thanks Penny. Okay, well as we get closer to January 1st, when coverage through the marketplaces and expanded Medicaid begins, we thought it would be useful to provide an update on ACA or how the implementation of the Affordable Care Act is going so far.

So I'm planning to discuss what we know about enrollment to date and my colleague Larry Levitt will discuss risk pooling in the marketplaces and he'll also identify key issues to watch as we head into the new year.

So just to refresh, the ACA expands coverage by creating new health insurance marketplaces and expanding the Medicaid program to cover more low income adults. States were given the option to build their own marketplaces or to default to a federally run marketplace. In addition, the Supreme Court ruling on the constitutionality of the ACA in 2012 effectively made the decision to expand Medicaid optional for states. Most states opting for a state based or a partnership marketplace are also expanding Medicaid while the majority of states defaulting to a federal marketplace are not moving forward with the Medicaid expansion at this time. These decisions, particularly the decision whether to expand Medicaid, will affect how many people ultimately gain coverage across the states.

The marketplace is open for enrollment on October 1st and although the rollout has been rocky, problems with Healthcare.gov as well as some of the state websites are being resolved and people are signing up for coverage. Because of the website problems, several key deadlines have been extended. People now have until December 23rd to select a qualified health plan or a QHP in the marketplace for coverage to begin on January 1st. In addition, HHS has requested that insurers give consumers until January 15th to pay their first month's premium. The open enrollment period will continue through March 31, 2014 so consumers have until that date to sign up for coverage through the marketplace. I should note that people can sign up for and enroll in Medicaid and the children's health insurance program at any point throughout the year.

As of November 30th, over 364,000 have selected a QHP across all states. This number includes people who have paid the first month's premium as well as those for whom the premium payment is pending. I should note we have updated enrollment data from Kentucky and Kentucky has now crossed the 20,000 enrollee threshold and joins California and New York in that dark blue category on our map, so go Kentucky.

Enrollment in states defaulting to a federal marketplace is lagging that of the states running their own marketplaces for a number of reasons including problems with healthcare.gov as well as the less concerted effort by these states to get the word out and encourage people to sign up.

Another way to gauge enrollment is to look at the number of enrollees as a share of the total population eligible to enroll in the marketplace. By this measure, among the six states with the largest enrollment in the marketplace, Kentucky leads having enrolled 6.9-percent of the eligible population into coverage. In Florida and Texas, while enrollment numbers appear relatively strong, enrollees account for less than 1-percent of the target population in part, because both are very populous states and in part because both have large uninsured populations. Despite enrolling over 100,000 people into the marketplace, dwarfing enrollment in all other states, California has reached less than 3.5-percent of the eligible population.

It's important to note these data are still preliminary. We know that the pace of enrollment has picked up this month and we expect a clear picture of enrollment to emerge in January.

The [inaudible] enrollment into QHPs has been lower than anticipated. Enrollment into Medicaid has shown early success. As of November 30th, over 800,000 people have been assessed or determined eligible for Medicaid or the Children's Health Insurance Program through state and federal marketplace websites but this only tells part of the Medicaid story. There are many pathways to enroll in Medicaid including through the marketplace, directly through the Medicaid agency, through fast track strategies being adopted by a number of states, and through transitions from existing coverage programs. While we don't have an unduplicated count of Medicaid enrollment to date, well over a million people have been determined or assessed eligible for Medicaid or CHIP coverage.

Much of the new Medicaid enrollment is in states that are expanded coverage but it also reflects those who are currently eligible for coverage in states not expanding the program. Many of the applicants assessed were determined eligible for Medicaid in states not expanding Medicaid are likely children given the higher eligibility levels for children in these states.

One area of concern is the coordination between the federal marketplace and state Medicaid agencies. Delays in transferring files between the federal marketplace and the states may hinder states' abilities to complete the enrollment process and ensure that those eligible for Medicaid are enrolled in the program. Mitigation strategies put in place by CMS should address these problems in the short-term.

What do we know about marketplace activity so far? Overall, three-quarters of marketplace applicants are eligible for marketplace coverage while one-quarter have been determined eligible for Medicaid. In state based marketplaces, a higher proportion of applicants are being determined eligible for Medicaid and CHIP compared to states with a federally facilitated marketplace. Integrated eligibility systems and the fact that all of these states are expanding Medicaid likely explain the higher Medicaid and CHIP determinations in these states. Today, about 40-percent of those eligible to enroll in the marketplace are eligible for financial assistance. This proportion is somewhat lower than expected though it's important, again, to note these data are still preliminary. However, it does raise some concerns about possible problems with the eligibility process, perhaps problems that consumers are facing in projecting income for the coming year and whether some determinations may have been done in error.

While there is strong interest in coverage through the marketplace as evidenced by nearly 3 million people who have completed the application process, fewer people have taken the next step of selecting a qualified health plan; only 16-percent overall and 9-percent in states with a federally facilitated marketplace. Website problems may have contributed to the local portion as well as people taking time to investigate and weigh their options before selecting a plan. We anticipate this percentage will increase.

Again, while these data provide a snapshot of enrollment, we should not read too much into these early numbers. Initial reports from December indicate enrollment is surging across all states. We will have a much clearer picture of enrollment in early January. As Larry will discuss, the composition of marketplace enrollees is likely as important to us as the total number. With that, I will turn it over to Larry.

LARRY LEVITT: Thanks Jen, I'm going to turn to this question of the mix of enrollment and why it's important to focus on that more than the total number of enrollees and why it matters, but maybe it doesn't matter quite as much as you think. I just want to provide a fair warning that there is some math to follow here. I promise to explain all this as clearly as possible and I certainly don't mean to scare you off or disparage the math skills of journalists.

Getting right into the math, the key concept here is the idea of a risk pool. People are part of an insurance risk pool if they're premiums are based on the collective use of that risk pool. Essentially, premiums follow risk pools. Before the ACA, there were frankly risk pools galore on the individual market. Each insurer had its own risk pool and, in fact, even within an insurer there were often multiple risk pools generally segregated by what is called a block of business or you can think of that as, essentially, a product. Each product the insurer had or each product family had its own risk pool and the premiums were based on the healthcare used or health data from people buying that product.

Under the Affordable Care Act, this change quite dramatically. First, each insurer must set premiums for all of this individual market business in a state as a single risk pool. This means that within a state, the insurer is setting premiums based on the health status or the health care use of everyone it is selling individual market coverage to and that's both inside an exchange or marketplace as well as coverage sold outside of the exchange. In fact, risk is further pooled across insurers within a state through the risk adjustment system. The risk adjustment system is essentially a way that transfers money from insurers that attract a younger and healthier group of enrollees to insurers within the state that attract an older and sicker group of enrollees. That, in effect, creates the risk pool as everyone in the state buying individual insurance inside and outside of an exchange.

There are a couple of groups that are outside of that risk pool, essentially in a segregated pool, and those are people with grandfathered plans. So, these are plans that existed prior to the Affordable Care Act passing and have not changed significantly since then and also what are called early renewal plans. These are plans that insurers have renewed prior to the end of the year so they continue into 2014 under the older insurance rules. Those are part of separate risk pools but everyone else who is buying coverage under the new ACA rules is part of a single risk pool within a state.

Just because people are in the same risk pool doesn't mean that they are necessarily paying the same premium. There are a number of factors still, the premium will vary by age, certainly a big one which we'll talk about, tobacco use, although some states have prohibited that as a factor, geography, they are rating areas within a state and rates will vary based on where you live. Some states have only one area up to states that have over 60 different rating areas. Certainly the level of cost sharing that people have so these are the tiers of coverage. If you buy a bronze plan your premium is lower than if you buy gold or platinum plans. Then also the provider network, insurers may be providing different products with different networks or providers and which of those products you chose will influence your premium.

Why does all this matter? It matters because who is in a risk pool affects the average cost of people buying insurance in that state and therefore the premium that insurers will charge. There are somewhat different issues for 2014, for the coming year, than for 2015 and beyond. In 2014, since the premiums are already set, there's no effect on premiums but there is an effect on insurer

profitability. If the risk pool ends up being worse than expected, if it's made up of sicker people then insurer profits will go down. For 2015 and beyond, when premiums are not yet set, then the risk pool is more likely to lead to a change in premiums. Again, if the risk pool ends up sicker than expected, premiums could go up in 2015 more than anticipated.

What is the potential effect on the risk pool? The first is what actuaries call adverse selection. This is the tendency of older and sicker people to be more likely to sign up or buy insurance than younger and healthier people. If that's the case then the average cost of people in the risk pool will be higher.

The second are some of the recent discussions about continuing policies either through grandfathering or through early renewal under the old pre-ACA rules. Since those people are part of a separate risk pool and because people who are sicker might be more likely to want to join the new risk pool under the new ACA protection, this continuation of old policies will tend to siphon off healthier people into a separate risk pool and raise the average cost in the new ACA risk pool.

Given all that, kind of thinking about what we know now and what we're likely to know and, frankly, what we won't know for a while and may never know, the first thing we'll know is the age distribution of enrollees in the exchanges or market places. I'll present some of that information but we're likely not going to know, at least for quite a while, the age distribution of enrollees who are buying ACA compliant plans outside of the marketplaces. Because there's a single risk pool, we'll only have an incomplete picture of the age distribution of enrollees. We're also not going to know anything for quite a while about the health status of enrollees. In the prior rules, people had to fill out a detailed medical history before they could get insurance so insurers knew a lot about their health status. Under the new rules, those questions are not asked any longer so we won't know, except for maybe surveys done after the fact, about who is enrolling and what their health is.

Turning to the issue of age which we will know something about and this issue of adverse selection or the tendency of older people to enroll and younger people to stay away, I did promise math, this chart shows two lines. The orange line is the average cost or the average premium prior to the ACA, before the rules went into effect, by age. Obviously, you can see it goes up as you go to the right, meaning older people have higher average healthcare costs than younger people, not a surprise. The blue line shows how premiums would vary by age under the ACA requirements which tell you that the premium for an older person, someone in their 60's can be no more than three times the premium for a younger person.

You can see that for younger people the blue line is above the orange line so that means that younger adult are paying somewhat more on average than they cost on average, so for producing a surplus in the insurance system. If you look at older people, to the right of the chart, you can see that the orange line is above the blue line so that means that older adults are actually paying

less, on average, than what they cost on average to insurance companies, what healthcare claims they file. Essentially, older adults are producing a deficit in the insurance market. What you really need is you need enough younger adults to produce a surplus to offset the deficit that older adults are producing.

Really what you want then, is you want the distribution of enrollees in exchange and nonexchange plans to look like the potential market. Ideally you want the proportion of young people enrolling to be the same proportion of young people that exist in the population that might enroll or that insurers may have expected to enroll. It doesn't matter how many people enroll in total, what really matters is the proportions. It's important to think about this potential market because it's different from the population as a whole. These are people who are currently uninsured now, who don't have an offered employer coverage, who are not eligible on Medicaid based on state decisions about Medicaid that Jen talked about. It also includes people who are already buying their own insurance and it largely does not include undocumented immigrants who are eligible to purchase coverage in the outside market, but they do so in pretty small numbers, but are not eligible to purchase coverage in an exchange or marketplace. Again, this market looks very different from the general population and the pie chart shows our analysis of what this market looks like, the key being the 18 to 34 year olds who represent 40-percent of the potential market. What you want is you want the mix of enrollees to reflect that 40-percent in an ideal world. If there are 7 million enrollees which is what the Congressional Budget Office projected would be the number enrolling in exchanges in the first year, you would want 40-percent of that, or 2.8 million, to be young adults. If it's 5 million, you would want, again, 40-percent of that, or 2 million, to be young adults. It's important to note that this is a national benchmark, this 40-percent may vary somewhat from state to state and certainly the enrollment will vary somewhat from state to state. What really matters is what happens in a state because that's where the risk pool will occur. If you get plenty of young people in California but you don't get many young people in Texas, those young people in California are not going to help you in Texas.

Keeping that 40-percent benchmark in mind, we have some early numbers from states that were helpfully compiled by the New York Times over the weekend and this shows the percent of enrollees in exchanges, again, just the exchanges, it's not showing what's happening outside of the exchanges, but the percent of enrollees who are 18 to 34. There is a big range here, it ranges from 10-percent in Minnesota to 37-percent in Massachusetts. I think this is constructive and we can certain see that it's falling short of the 40-percent so far. Although I don't think these early numbers tell us much and we shouldn't put too much faith in them, all expectations were that in the early going, particularly with all the technical difficulties, that older and sicker people would be more likely to be the first ones in the door knowing that they needed insurance and that younger people and healthier people would come in later, towards the end of the open enrollment period in the spring. That's what has certainly borne out in the early experience in Massachusetts when they implemented similar reform.

I think these numbers suggest that it might be that we're not going to hit that 40-percent target but I would not put too much faith in these early numbers.

What we did when we released that analysis today showing this, we looked at what happens if we do not hit that 40-percent benchmark for young adults. Again, the issue is if we don't get sufficient numbers of young people to produce a surplus then we end up with a deficit or not enough premium revenue to cover costs because of a disproportionate number of older adults. There is certainly an effect to that but frankly the effect is not nearly as big as I think conventional wisdom would suggest. We looked at two scenarios, one is if 18 to 34 year olds, let's say, are 25-percent less likely to enroll than everyone else, that would end up meaning that instead of 40-percent of enrollees, they would be 33-percent of enrollees. Now what effect that has, that leaves a deficit of just about 1-percent meaning if that carried forward into 2015 and that's what insurers expected to happen, premiums might only go up by 1-percent.

Even what I would consider to be a worst case scenario, that the young adults were 50-percent less likely to enroll, meaning that they ended up being 25-percent of the market rather than 40-percent, even in that scenario premiums would only have to rise by about 2.5-percent in 2015. This is certainly something one would want to avoid and I think if insurers looked at this it would cause them to not likely lose money but it would certainly diminish their profit. The thing to keep in mind, insurers have a profit margin or a target profit margin of roughly 3 to 4-percent of a premium.

This would certainly have a financial effect on the industry but it's nowhere near what is sometimes referred to as a death spiral and we would not have catastrophic consequences like that. Just for a few actuarial definitions here, a death spiral occurs when sicker people end up in the risk pool which in turns causes premiums to rise which in turn causes healthy people to further drop out of the market which, again, in turn causes premiums to go up even more. The idea is premiums start to spiral out of control. Because premiums still vary substantially by age, a death spiral is highly unlikely in response to the low enrollment among young adults and premium increases of even 2.5-percent would not come close to that. In effect [inaudible] enrollments by health status would have greater consequences and sometimes getting old invincibles into the market is as important as getting young invincibles into the market because while premiums vary by age, they do not vary at all by health status under the ACA.

Even if healthy people do stay away, there's still a number of shock absorbers built into the system that would avoid a so-called death spiral. There are risk corridors and reinsurance, and I can certainly go into these more in the Q and A, but very briefly, reinsurance is a federal pool of money, there's 10 billion dollars in the first year, that covers a share of costs for various high cost enrollees. That reinsurance program was recently made more generous under a proposal by the administration where any enrollee who has more than $45,000 in medical claims, the federal government will share in the cost of that enrollee with the insurer. Risk corridors work more in an aggregate sense with insurers. If an insurer has healthcare claims that are higher than

expected then the federal government will share in that loss. On the other hand, if an insurer has lower costs than expected then the federal government will share in that gain. The expectation originally was that this would be budget neutral, that the insurers having below average costs would offset insurers having above average costs. It's possible that some recent developments, particularly allowing cancelled policies to continue, might shift that a little bit and that risk corridor system might not, in fact, be budget neutral and might, instead, result in money coming into the insurance market.

There are other things that cushion the effect of potential premium increases. One is the tax credits, 60-percent of the people in this market are expected to be eligible for tax credits although they're not enrolling in those numbers as Jen discussed. Under the tax credit, people at different ages but at the same income pay the same percentage of their income so it really cushions the effect of any premium increases. People themselves who are receiving tax credits would not be in fact paying those higher premiums. Also the individual mandate where the penalty is pretty modest in the first year, phases into higher levels in the future years so there's an expectation that even if young and healthy people stay away in year one, they're more likely to come in later. Then finally is the competitive forces in the market. If healthy people sit on the sidelines in 2014, insurers are still going to want to keep premiums competitive in 2015 to make sure they get those young health people when they do come in.

Finally, I wanted to list out a few other issues that I think are important to keep our eyes on over the coming weeks and into January and then we can take your questions. The first area is, and there certainly has been plenty of coverage of this, the backhand issues, the so-called 834 transmission to insurers that provide enrollment information from healthcare.gov and the other state exchange to insurers. There are all indications that that system is working much more smoothly but it's still possible there maybe people in January who think they are enrolled who aren't actually enrolled.

There's also the question of whether people pay their premiums once they've picked a plan. All the enrollment numbers that Jen talked about are people who have picked a plan either in the federal marketplace or in the state exchanges but people are not actually insured until they pay their premium, until they get a notification from the insurer that the premium is due and they actually pay it. There have been anecdotal reports of a large percentage of people not yet doing that which I think was expected because no one wants to pay for something that doesn't start for a while but we're certainly getting to the point now where it will be important for people to make those payments in order to be covered.

Second is keeping an eye on outreach. There was news this week about insurers increasing their advertising dollars significantly. Many of the state based exchanges and the federal exchange have held off on outreach efforts until the systems were working more smoothly. That's now starting in earnest, so keeping an eye on whether that outreach is ramping up sufficiently to attract people to the market. Also, as people do come to the market, are the consumer assistance

resources, the navigators, the in-person assistors sufficient to provide help to people who need it as they're applying for coverage, particularly tax credit and also seeking a plan.

As Jen talked about, we're starting to see numbers of the percents of enrollees who are qualifying for tax credits and that seeks to be lagging behind both the percent we know are eligible for tax credits as well as what the Congressional Budget Office projected. Again, an important number to keep an eye on as enrollment ramps up is are people who are eligible for tax credit, the low and middle income people, enrolling in the same numbers as people who are higher income.

Then finally, once January 1st comes and people do start using their coverage, how do they perceive it? Do they find it to be a good deal? How do they feel about the deductibles? Does it provide the value of peace of mind in terms of protecting them against catastrophic expenses or do they perceive their out-of-pocket costs as too high under the plan? And also provider networks which there certainly has been a lot of discussion of recently. Do people perceive these as providing adequate access to care even if it's not providing them with access to all of the doctors or hospitals in their area or are they perceiving it as too limited and providing barriers to access.

With that quick tour through the map, we are happy to turn to questions.

PENNY DUCKHAM: On that operator, could you just remind everybody how to send in their questions by chat or to call in please?

MALE SPEAKER 1: Certainly, ladies and gentlemen, if you'd like to register for a question please press the 1 followed by the 4 on your telephone. You will hear three tone prompts to acknowledge your requests. If your question has been answered and you would like to withdraw your registration, please press the 1 followed by the 3. Ladies and gentlemen, if you'd like to ask a question please use the chat feature located in the lower left corner of your screen. We do have —

PENNY DUCKHAM: And on that —

MALE SPEAKER 1: My apologies, please go ahead.

PENNY DUCKHAM: And on that we are going to move ahead with the questions starting with one I think is perhaps for you Larry from Devon Dwyer of ABC News. Much has been made of the White House's target of 500,000 individual signups in October which was obviously missed and the CBO projection of 7 million signups by March the 31st, 2014. I understand that the mix of signups, young, healthy versus old, sick, may be the most important factor but is there a bottom line on the number of enrollees overall needed to make this work and how should we think about the 7 million figure and the comparisons to it going forward?

LARRY LEVITT: Well I think on the one hand the point of the program is to provide people with insurance. So for the program ultimately to be a success, people who are currently

uninsured and eligible for this coverage need to sign up. I don't think that needs to happen in the first year. There are certainly many examples of new government programs that took quite a while to ramp up, the Child Health Insurance Program being one of example where under 1 million kids enrolled in year one and that quadrupled over several years. I would expect that to happen here as well and certainly the ACA has been move divisive than CHIP was.

As I said, the mix of enrollment is much more important than the total number. The figures are not unrelated. If you assume, which I think is reasonable, that sicker individuals are likely to come in first, then a smaller pool is more likely to be a sicker pool. The best guarantee of a diverse pool is a big pool because that means you are likely reaching into the younger and healthier people.

I would say probably the biggest challenge with low enrollment in year one had to do with the funding of the federal and state based exchanges. Those exchanges have been funded by either appropriations or federal grants in the case of states in the first year but over time the exchanges are intended to be self-sustaining through user fees by and large. The smaller enrollment is the lower those user fees will be and might lead to some funding challenges by the exchanges over time.

PENNY DUCKHAM: Thank you very much. I think sticking with the numbers questions, now you've got us into the math, John Greenberg [misspelled?] is asking, does the CBO projection of 7 million include the Medicaid expansion population?

LARRY LEVITT: This is Larry, it does not. So, the CBO projected that 7 million people would enroll in exchanges in year one and that's a mix of currently uninsured people as well as people who are currently buying their own insurance.

The Medicaid expansion is separate. CBO has most recently projected that there would be a net increase of 9 million in Medicaid beneficiaries in year one.

PENNY DUCKHAM: Another math question, Larry you went through in quite some detail this whole question about death spiral, I love the “old invincibles” who are coming in, so here's the question from Jason Lang [misspelled?]. In your analysis of the report out today, if young adults make up 25-percent of enrollment, would it push up costs for insurers but not be enough to trigger a death spiral. What level of youth enrollment might trigger a death spiral?

LARRY LEVITT: Honestly, because premiums still vary significantly by age, just to give you a little bit of context, the average cost of people by age varies by about 4.9 to one we think, roughly five to one. So in other words, people in their 60s cost on average five times what people in their 20s cost. Under the ACA, premiums are allowed to vary by three to one so it's not as much variation which produces the potential issue here but it is still substantial variation. So honestly I don't think there is a level of young adult enrollment that could be low enough to

trigger a death spiral. The system is largely self-correcting because of the variation in premiums due to age.

Health status is a different question. If we ended up with only people very sick, people who are currently in high risk pools, that would be problematic. I don't think that's likely but enrolling healthy people is a much more important challenge than enrolling simply young people.

PENNY DUCKHAM: Okay, this question gets into the weeds. Matt London [misspelled?] is going to ask about risk corridors. Again, perhaps Larry you might need to go through this in some detail. If the risk corridor is not budget neutral, where does the money come from?

LARRY LEVITT: In effect it comes from the Treasury. It's automatic spending meaning that if insurers doing better than expected overall, then the Treasury would actually make money. If insurers end up doing worse than expected overall, then there would be a net flow of money from the Treasuryto insurers.

PENNY DUCKHAM: We're now going to take a call. Paul Demco [misspelled?] from Modern Healthcare is on the line, Paul?

PAUL DEMCO: Hi, can you hear me?

PENNY DUCKHAM: If you could speak up a bit please?

PAUL DEMCO: Okay, I have a question about renewals, the noncompliant plans for 2014. Do you have a sense of how widespread that's going to be and also how much of a risk that poses to the risk pool?

LARRY LEVITT: I don't think we have a good sense yet of how many people that would be. There are really several steps that have to happen for those people to maintain their plans. In some case insurers have already renewed coverage so that coverage will be in effect. If the insurance policies were cancelled then insurance commissioners have to allow those policies to, in effect, be uncanceled which not all are doing, and then insurers have to choose to continue those policies. So I think it will certainly be a minority of plans that are now in effect.

The effect on the risk pool comes from if people who are healthier than average stay in those plans but people who are sicker than average leave them and come to the ACA plans, that could produce an effect on the risk pool. I expect it will be quite modest, again, more in the few percent of the premium range even if it occurred in a widespread way.

The other thing to keep in mind is there is a lot of churn or turnover in this market. The individual market is a place where people buy when they have no other options and typically a lot of people, if you look at people who have individual insurance at any given point in time, within a year a lot of those people have left the market. They've gotten jobs with health benefits

or their spouse has gotten a job. A lot of people who may even be getting these policies renewed now would have left the market anyway within the year.

PENNY DUCKHAM: Okay, thank you for that. Our next question comes from Harem Helmy [misspelled?] and may I just add that if you have state specific questions at any point it would be helpful if you could just let us know which state you are most interested in. . How and when can we find out about the age distribution of enrollees in the federal exchanges?

LARRY LEVITT: This is Larry, it certainly has not been released yet and Jen I don't know if you have any sense of when it might be?

JENNIFER TOLBERT: I do not. I know CMS announced that they do not have any demographic data yet that they will be making publically available regarding the marketplace enrollees and I don't have any intelligence as to when those data might be available.

PENNY DUCKHAM: This is a question about children staying on their parent's plan. Since the law allows children to remain on their parent's plan until they are 26, do you think that has an effect on the enrollment numbers for those aged 18 to 25 and would it make sense to breakdown the enrollment of those "young invincibles" into two groups of 18 to 26 and 27 to 34?

LARRY LEVITT: Yeah, it certainly does have an effect although, in fact, the analysis we did which found that 40-percent of the potential market are 18 to 34 year olds, already reflect the fact that those adults up to age 26 have been allowed to stay on their parent's plan. Any movement for young adults to stay on their parent's plan are already reflected in those numbers but it certainly does have an effect on the risk pool. I mean that provision has been quite successful and popular, allowing millions of young adults to get coverage. If that were not the case, those young adults would be available to enroll in exchange and off exchange plans. Largely, any young adult who has been able to get on their parent's plans, most of them, I think, already have.

There is one other provision here that could have an effect which are the so-called catastrophic plans which only young people or people who otherwise find coverage to be unaffordable can enroll in. Those catastrophic plans have, in general, lower premiums than even a bronze plan but they are, in effect, a separate risk pool. Any young adults who do enroll in those catastrophic plans do not, in effect, contribute towards the larger risk pool.

PENNY DUCKHAM: Susan Brink [misspelled?] is asking a clarification point here. If people who remain uninsured through 2014 then have a costly health issue they haven't expected, can they sign up for insurance if it is past the open enrollment period? Perhaps you could just go back over the dates for the open enrollment program, at least as they currently stand and then when the next phase of enrollment is likely to open up again?

LARRY LEVITT: Sure, I think there is some amount of confusion about this. In the first year for 2014, the open enrollment period started October 1 and goes through the end of March. That open enrollment applies to people buying in exchanges, it also applies to people buying ACA compliant plans off exchanges directly from insurers or from insurance brokers.

After that March 31st date, unless there are special circumstances, like losing a job, people cannot buy individual insurance during the rest of 2014, not in an exchange, not from an insurance agent, not directly from an insurance company, until the next open enrollment period starts which was scheduled to be the middle of—Jen help me here, it was going to be the middle of October and was delayed to the middle of November?

JENNIFER TOLBERT: Yes, that's right.

LARRY LEVITT: The open enrollment periods do not apply to Medicaid. People can apply and come onto Medicaid anytime during the year.

PENNY DUCKHAM: Okay, here's a question from Guy Boulton[inaudible] in Milwaukee. Did the CBO project how many people had gained insurance this year? This estimate would exclude those with coverage who find plans through the marketplaces and is the real test next year? How can we know how this will play out until the effects of early renewal? [Inaudible] our requirements and you're going to have to go through this in more detail with us and how higher penalties and such play out?

LARRY LEVITT: The Congressional Budget Office's estimates, and the last ones they did were in May of 2013, in effect look at net changes in coverage by category. For example, we've talked about the fact that they projected 7 million people would enroll in exchanges, there would be a 9 million increase in the number of people receive Medicaid or CHIP. On that CBO projected that 14 million more people would be insured in 2014, meaning 14 million fewer people would be uninsured and they further projected that would ramp up significantly in 2015, at which point 20 million more people would be insured.

There have been some concerns that the folks getting their policies cancelled in the individual market could affect those numbers, could leave some people who were previously insured uninsured. It's certainly possible, but I think it's important to look beyond simply the enrollment in the exchanges for any information about that. Everyone who has gotten a policy cancelled, unless their insurer is exiting the market entirely, is getting an offer of default enrollment into some plan. That may be an exchange plan, it may be an off exchange plan. Also, many of the people getting their policy cancelled may be buying insurance directly from insurers or from brokers outside of the exchanges. The fact that exchange enrollment or marketplace enrollment is low doesn't necessarily mean that there are large numbers of people who got their polices cancelled who are going to end up uninsured.

PENNY DUCKHAM: Well on that, I think this is a good bridge to a question from Michelle Singletary [misspelled?]. What advice do you have for people whose policies have been cancelled and who don't qualify for subsidiess? Which choices do they have and what should they do?

LARRY LEVITT: People have substantial choices. Certainly, even if they're not eligible for tax credits, they can enroll in an exchange or marketplace and those systems seem to be working more smoothly now. They can also buy insurance directly from an insurer or through a broker and there are online brokers like getinsured.com, ehealth.com, that provide a list of some of those plans. And there are still opportunities for early purchases of coverage under the old rules again, either directly from an insurer or from an insurance broker and that's true in the vast majority of the states.

Even in places where the exchanges are not working well there are still options for people. Again the open enrollment period extends through the end of March so to avoid a gap in coverage people may certainly want to get coverage before January 1 if their policies are ending but there is an opportunity to enroll through March.

PENNY DUCKHAM: I think this is a clarification on that Larry, from David Eggert [misspelled?]. Is the 7 million figure projected by CBO the number expected or hoped to sign up by the end of March or by the end of 2014?

LARRY LEVITT: It's a good question. CBO has not provided a lot of detail about precisely how to interpret their numbers. I think it's reasonable to interpret their numbers to potentially a point in time and I would expect they—I can't speak for them, but I would interpret as a point in time after the end of March when open enrollment is concluded.

PENNY DUCKHAM: Sticking with states, Natalie Villacorta[inaudible] asks what problems will hit on January 1st for insurers and consumers and providers? Might they be overwhelmed with patients on January 1st and the beginning of the year and are they capable of handling the potential influx of new patients?

LARRY LEVITT: You know, for better or worse, the ramp up in enrollment means it's really unlikely that providers are going to be overwhelmed in January. Even if the full 7 million more people enroll in exchanges by the end of the year which is unlikely, and millions more enrolled in Medicaid, that's still a pretty modest percentage of the overall population. So it's unlikely to overwhelm providers. There could be some localized effects in low income areas where a higher percentage of the population is eligible for coverage so it could be a bigger effect and potentially some shortage of appointment time or access to primary care. I think that's unlikely to be an issue any time soon.

PENNY DUCKHAM: Steve Jordan [misspelled?] is asking, will CMS get any state by state data on people who enroll in ACA compliant policies outside the market or does it only find out about people getting marketplace policies?

LARRY LEVITT: I'm not aware of any data reporting for ACA compliant plans outside of the marketplaces. I think we'll certainly know that based on insurer filings to state insurance departments which will be available later in 2014. Then the following year, in 2015, insurers will be submitting reports to HHS for the purpose of determining whether they owe rebates under the Medical Loss Ratio rule and that will provide some data as well but I think it will be quite a while before we know anything about enrollment in nonexchange plans.

PENNY DUCKHAM: Okay this is a series of questions from Hayden Park [misspelled?] who is going back to Larry, your point about the shock absorbers built into the system. She asks if premiums go up in 2015 can you discuss which groups of people would most likely be affected, how much it affects people receiving tax credits and people not receiving tax credits in different ways? There a bunch of other questions going here. I don't know if you want to start with those ones and take more, but it's basically going back into these questions about 2015.

LARRY LEVITT: Unfortunately, this will be a return to a little bit of math but I will keep it as straightforward as possible. Certainly if premiums do go up higher than expected in 2015, that will land most significantly on people not eligible for tax credits. That's largely people with income over four times the poverty level. For people receiving tax credits it gets a little bit complicated. There is an indexing provision in the law that says that if premiums rise faster than income does, on average, then the subsidy schedule adjusts a little bit to compensate for that. In other words, the percentages of income that people are responsible for under the tax credit schedule, those percentages would rise a bit if premiums rise faster than inflation. The net result of that is that if premiums do go up faster than income it means that individuals receiving tax credits would pay a portion of that increase but the government would end up paying the lion's share of that increase through higher tax credit.

None of this would affect people, for example, with employer based coverage which is the majority of the people with insurance. It certainly would not affect people receiving Medicaid or Medicare. It's really just folks buying coverage on their own either in exchanges or outside.

PENNY DUCKHAM: This is another question from John Leopard. To the extent that the risk pools are insufficient to cover plans cut for 2014, prompting higher premiums for 2015 and nonbudget neutral l net corridors, do you expect that ongoing political pressure next year could put added pressure on premiums further eating into insurers' profit margins? In short, what is your sense that insurer margins could face pressure for years to come?

LARRY LEVITT: I think this is unlikely but if it turns out that enrollment is very disproportionally among sick people, I think there would be some continuing discussions into next year about how to deal with that. Again, I think that's unlikely. I do think that it has been

somewhat underestimated how competitive this market is and that certainly has resulted in lower than expected premiums in the first year and I think that competitive pressure will likely carry forward into following years as well.

If you compare it to the individual market preACA where it was very hard to comparison shop for insurance, you really didn't know even what your premium would be until you filled out a detailed medical history. The market is really different. You can go on an exchange or even any of the private online brokers and see exactly what you would pay for insurance and see exactly what plans are available in your area. That's likely to have a very significant competitive effect. I think it will be interesting to see if we start to get information about which plans people are enrolling in, whether people are overwhelming enrolling in the lowest premium plans which I would expect largely to be the case though not exclusively.

There is in some sense a built in cap on insurer overhead costs and profits through the medical loss ratio and I think over time that will tend to stabilize the market but will, in effect, prevent windfall profits and will likely keep profit margins modest for a number of years to come.

PENNY DUCKHAM: We're going to have a couple of state specific questions, this one from Oklahoma, Warren Vee [misspelled?] says I went through the signup process in Oklahoma. I was presented with 61 policy options, it was overwhelming, my assistant couldn't provide advice. What resources do people have to compare plans? Jen, do you want to take that one?

KAREN POLLITZ: Actually, I could try to jump in on that, this is Karen Politz [misspelled?]. There is, I'm sorry, I'm getting close to the mic. There is another requirement in the Affordable Care Act that summaries of plan coverage be made available to people, they are supposed to be available on the website. Mostly when I've looked I've seen them, sometimes they're missing but it's a standard and simpler chart explaining what's covered, how the deductible and co-pays work for each essential health benefit for service that's covered and then providing illustrations of how all of the components of coverage would work together to cover some illustrative examples. One is a noncomplicated pregnancy and one is day-to-day management of type II Diabetes. Those examples kind of add up everything that the deductibles and co-pays and so forth against the stock amount of care for each of those illustrations and then give consumers the bottom line, the plan would pay this much for the pregnancy leaving you to pay that much; the plan would pay this much for the Diabetes care leaving you to pay that much.

In addition to any plan compare features that may be available on the website, those summaries of coverage are also a tool for consumers to help understand the differences in how plans work.

PENNY DUCKHAM: Thank you very much, that was Karen Pollitz in our Washington office. Sticking with state questions, this is from Jodie Guntz [misspelled?] in California. We just heard that the percentages of subsidized and unsubsidized numbers for October were transposed by California and the question is do you know if that is happening elsewhere?

LARRY LEVITT: Boy, I hope not.

PENNY DUCKHAM: Anyone heard that that has happened anywhere else? I think no—

JENNIFER TOLBERT: I have not.

PENNY DUCKHAM: Is no.

JENNIFER TOLBERT: Right.

PENNY DUCKHAM: We don't have a lot more time left so we're going to take one very detailed question and then one rather general question at the end. This one is from John Leopard [misspelled?]. At what point would you think the administration might begin seriously to discuss an expansion of open enrollment or other mitigating factors of a more substantive nature than the delays and extension announcements so far?

LARRY LEVITT: I think we're just now starting to see enrollment numbers that I believe are indicative of what's likely to happen for the rest of the open enrollment period. The federal website was not working well through November and those were the numbers we've seen so far. I think December numbers will start to be much more informative.

My suspicion is that as long as enrollment is continuing to ramp up and people who want to apply are able to apply, I think an extension in the open enrollment period is unlikely. It produces some logistical challenges in terms of running up against when insurers have to actually estimate and submit their premiums for 2105 so they would like the certainty of knowing who's enrolled before they do that. I think there are also concerns in the industry about the precedent of extending open enrollment. I mean the point of having a limited open enrollment period is to encourage people to sign up for insurance upfront and to discourage or prevent them from waiting to sign up for insurance until they know they need services. I don't think a short expansion of open enrollment would have serious consequences, in fact, I think it could even have some beneficial effect of giving more time to reach out to young and healthy people but I think the industry would be concerned about the precedent of a longer, or maybe even open ended enrollment system.

PENNY DUCKHAM: Just to wrap this up, we're going to ask a very broad question to you Jen Tolbert, Karen Pollitz, if you would like to come in too and to Larry. This is a question from Tammy who asks, what are your main concerns about, she calls it Obamacare, I'm going to say the Affordable Care Act? This is pretty broad, we could also have a wish list perhaps for 2014. Jen, in that kind of crystal ball mode, do you want to comment on your main concerns at this point?

JENNIFER TOLBERT: Yes, I actually think that Larry did a good job in laying out the key things to look out for in the new year. I think he highlighted some of the issues and perhaps some concerns that we have. Obviously, as improvements are made to the websites, people will

have an easier time to enroll in coverage. There's going to be a group of people who have little experience with enrolling in private health insurance and they're going to need a little more hand holding to make it through the process. Making sure that there are people on the ground, enrollment assistors who can provide that level of assistance, I think, is going to be really important as we move through the next few months. I think those enrollment assistors are quite available in states that are running their own marketplaces where they have the resources to invest in these programs and to contract with a variety of organizations to do this work. I'm a little concerned that in states where there's a federal marketplace that these assistors may not be quite as available to the degree that's needed to get people enrolled.

I would say that's one of my main concerns looking forward.

PENNY DUCKHAM: Karen, do you want to comment?

KAREN PULITZ: No, that was good.

PENNY DUCKHAM: Okay, Larry?

LARRY LEVITT: I would just add, I think at this point the websites and enrollment systems are, in effect, functioning how I expected them to function in the beginning of October. They are not working perfectly, not working as well for people with maybe more complicated family or financial circumstances. And, in some cases, complicated for people; a lot of choices to sort through and difficulty figuring out what you may be eligible for.

I would echo what Jen said that now I think going forward it's important to, obviously, keep making improvements in those systems but also make sure the consumers have access to resources to help them and navigate them.

PENNY DUCKHAM: We need to wrap this up at this point. There are a few questions still out there and unanswered and we will respond to you as quickly as possible via email or by phone. As mentioned, this whole webinar will be available shortly and posted on our website and the slides will all be available and a transcript will be posted sometime next week. Thank you again, very much, for your attention and good luck with your reporting. With this, we're going to wrap up this webinar.

[END RECORDING]