



**Affordability and Health Reform: If We Mandate, Will They (and
Can They) Pay?
Alliance for Health Reform
November 20, 2009**

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ED HOWARD: Good afternoon. My name is Ed Howard with The Alliance for Health Reform. On behalf of Senator Rockefeller and Senator Collins and our board of directors, I want to welcome you to this program to examine the affordability factor; the extent to which the reform plans being considered by Congress would make decent health care coverage more affordable for different groups of Americans.

It sounds like a fairly straight forward topic but you're about to see it has an awful lot of moving parts. It involves market-based tools like an insurance exchange. It involves government subsidies to both families and to businesses, insurance reforms, and a whole lot of other stuff you're going to be hearing about and of course, it involves different approaches and different spending levels in the House passed bill and the one soon to be considered by the Senate, we think.

It's also a topic that hasn't gotten the attention we think that it deserves. It's not an inflammatory social issue. Now there are surely areas of controversy, and I'm sure you're going to hear about them today but mostly it's a question of numbers. How much will different folks pay and for what and comparing that to what they would have had to pay if there were no reform legislation.

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Now some of you may have seen a piece this week in the Columbia Journalism Review blog by veteran writer Trudy Lieberman on how this topic is being covered by her fellow journalists. I think it's worth quoting a couple of sentences, if you'll bear with me. Here's what she had to say: "The media," she said, "have talked about affordability mostly in the context of whether the country can afford reform."

"It's easier for a reporter to write about homogenous numbers like \$900 billion or a trillion dollars and give the arguments that those sums will or won't add to the federal deficit than it is to spend several hours with the Jones' in Peoria finding out where, in the family budget, they're going to find \$8,000 to pay for health insurance." Now that's not the only affordability concern that's raised and addressed in this reform debate but it's certainly one that we are all concerned about.

Now our partner and cosponsor in this briefing is The Commonwealth Fund, which has both commissioned and done some very good analysis of the reform bills as they are emerging. You'll hear from my co-moderator, Rachel Nuzum, in just a second.

A couple of logistic concerns, a lot of background information in your packets including speaker bios and PowerPoint presentations when we have them, although we may

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have had superceded PowerPoint presentations and Rachel will say more about that in a moment. On Monday, you'll be able to view a webcast of this briefing along with the copies of the materials you have in your packets. That's on kff.org. I'll spit it out in just a second.

The electronic versions of the materials you can get on our website, allhealth.org and a few days after that, you'll find a transcript available. The green question cards in your packets, you could use at the appropriate time following the presentations. There are also some microphones that you can use to voice your question.

There is a blue evaluation form that we'd ask you to fill out. If you've been to a lot of these briefings, you might not bother looking at it. We actually have a different question we want you to address on that form. So if you would take a look at it and share your views with us, we'd appreciate it.

What I'd like to do is to introduce our entire distinguished panel, if I could, at the same time. The first panelist we'll hear from is Sara Collins, the Vice President for Affordable Health Insurance at The Commonwealth Fund. She's an economist, lengthy list of publishing credits and Congressional testimony.

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She's been an editor of *U.S. News*. She also happens to be the lead author of a paper that is forthcoming analyzing various aspects of the proposals as they now look in the House and the Senate and has spent most of the last 48 hours furiously revising her slides in the wake of the introduction of the new set of reform bill on Wednesday.

Then we'll hear from Stuart Butler, Vice President of Domestic and Economic Policy Studies at the Heritage Foundation. Stuart's completing his third decade at Heritage. He's well into his second decade as a panelist at Alliance events, I'm pleased to say. He describes health care as his abiding passion and advocates a reform of the U.S. system based on consumer choice and state-led innovation.

Then finally, we'll hear from DeAnn Friedholm who is the leader of the Health Reform Team at Consumers Union. In her earlier incarnations, she served as Medicaid Director for the state of Texas and Commissioner of the state's Department of Health and Human Services. She's helped the government of South Africa reform its' social grant program. She's been part of the respected health policy consulting group, Health Management Associates.

We're going to turn first to Rachel Nuzum. She's a Senior Policy Director for The Commonwealth Fund and its Commission on a Higher Performance Health System. Many of you

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may know Rachel from her days on the staff of Senator Kentwell a few years ago and let's get started. Rachel, glad to have you with us.

RACHEL NUZUM: Great. Thank you so much Ed and we're pleased to be here to partner with the Alliance for Health Reform on this really important topic. Just when I think we can't get better at kind of identifying the topic for the given time, we hit another one kind of right at the right time. So thanks to Ed and his staff for helping us to identify the right topics for the question of the day.

In September, the Census Bureau reported that 46.3 million people lacked health insurance in 2008. We know that another 25 million insured working age adults face out-of-pocket health care costs that are so high they qualify as being underinsured. We also know that the high cost of health care is a burden that faces the uninsured and the insured alike. Eighty-million adults with insurance and without reported difficulties paying for coverage and for actually going without coverage because of the inability to pay.

We know that health care coverage isn't the same as health care but we do know that the two are linked together and having coverage clearly impacts the ability to access the system, the quality of the care that you receive, and the

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financial burden placed on the individual, the community, and the nation.

Our discussion today focuses on the issue of affordability. Indeed, even the highest quality health care isn't effective if it's unaffordable. The work you'll see presented here today is a part of a body of work that the Fund has been doing to analyze the leading reform bills and help gauge their impact and that work is led by Sara Collins, who you'll hear from in just a moment.

On our website, you'll find the forthcoming reports on how the bills deal with coverage and affordability as well as system and payment reform reforms, provisions, and overviews of the legislation and how far they go to achieving a system of high performance and the angels are back. So I need to say one comment about the slides.

As Ed mentioned, these have been frantically being revised in the last 24 hours. The slides that you'll see on the screen have been updated and are accurate, which is helpful in this one since almost no one can read it but the handouts in your packet are a little bit outdated. We will point out when there are pieces that have yet to be updated. There's one specific area on this chart and in the individual mandate when it talks about the level of the hardship exemption in the Senate bill. That should read eight-percent, not 9.8. I

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believe your handouts say 9.8. Sara will talk a little bit more about that as we get into this.

While much has been made of the differences between the bills and the areas of controversy, many of the essential elements are similar in the House and the Senate approaches. While there are substantive differences between the two bills, both would preserve the current mix public/private system and build on the parts of our system that work well, the large employer model, Medicaid, and CHIP.

Both bills also seek to improve the parts of the system that are not functioning optimally, the small and non-group markets. Both bills would enact new rules for the private insurance market; pre-existing conditions could no longer be a reason for denial of coverage. Everyone that applied for coverage would now be accepted. Both the House and Senate bill established a new insurance exchange that would offer the choice of both public and private plans that meet the requirements set forth by the exchange.

All individuals would be required to have insurance under both the House and the Senate bills. Premium assistance is offered to help with the cost. Again, Sara will go into more detail on how each bill handles the individual requirement and the subsidies available.

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In addition to expanding coverage, the bills are estimated to reduce the federal deficit over the 10-year period, 2010 to 2019. In the Senate, the cost of improving and expanding coverage is offset by system savings of \$491 billion over 10 years and new revenue including the excised tax on high-cost health plans. In the House, the cost of coverage expansion is also offset by savings from delivery system and payment system reforms in addition to new revenue sources including the surtax on the high-income households.

We're in a historical window of opportunity to advance reform. The President laid out his principles for reform early this year and the Committee for Jurisdiction have reported out bills that meet these principles ensuring stability and security of coverage for those who have it, providing coverage for those who do not, and slowing the rate of health care cost growth for families, employers, and government.

The Commonwealth Fund's Commission on a High-Performance Health System has also laid out an integrated set of policies needed to move our system towards one of high performance and has included that coverage for all is not just a moral imperative. It's actually the economic cornerstone of health care delivery reform. If done right, covering the uninsured can be the key to aggressive health care cost containment by making it possible to change the way we pay for

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care and limit spending growth without concerns of excluding the most vulnerable from needed care or undermining essential components of our system.

Reforming our health system is not an easy task and at roughly \$900 billion over 10 years, it's certainly not cheap. However, the cost of reform needs to be considered in the context of total health system spending, which is roughly \$35 trillion over the same time period. If the investment can improve the efficiency of the system, returns can more than offset the federal investment. Now we'll turn to Sara to discuss the coverage and affordability provisions in the House and Senate bills.

ED HOWARD: Sara? I should say that the revised slides will be posted on our website as soon as we get back to our office after the brief.

SARA COLLINS: So thank you so much Ed and Rachel. I am going to focus again as Rachel said on what the implications of the two different bills on coverage and also premium costs and out-of-pocket spending. These are the most recent estimates from the Congressional Budget Office. As you can see, both bills would substantially decrease the number of people who are uninsured, increasing coverage to about 94-percent to 96-percent of legal residents in the country

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reducing the number of uninsured from 30 to 36 million people, so major effect on the uninsured.

The bills also provide protection from premium costs for low and moderate-income families in several different ways. Number one, major increases in eligibility for Medicaid: increasing eligibility to 133-percent under the Senate bill and 150-percent in the House bill.

New federal regulations that address problems that people have and small businesses have in individual and small group markets, restrictions against underwriting, no rescissions, and also no lifetime limits or annual limits on benefits, what plans will pay for benefits, and importantly, minimum benefit standards through the exchange, so people know what they're getting when they're purchasing a plan now. Right now, you often don't know what you're getting when you buy a plan on the individual insurance market.

Then premium subsidies for plans that are purchased through the exchange, both bills would provide subsidies for people who are buying coverage through the exchange starting at 100-percent of poverty up to 400-percent of poverty in the Senate bill. The Senate caps people's expenses on premiums as a share of their income starting at two-percent and rising to 9.8-percent for 100-percent of poverty or about \$88,000 for a family of four.

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In the House, the premium subsidies start at 133-percent of poverty and rose to 400-percent of poverty starting at, capping premium expenditures at one-and-a-half-percent of income and rising to 12-percent of income. In terms of what these look like in dollar amounts, the premium caps translate into total premiums of about \$2,700, \$2,400 for a family of four who are earning about \$44,000 a year and about \$6,500 for families earning about \$66,000 a year.

The provisions in the bills, in both bills, allow for indexing. So as premiums grow over time, whatever you are paying as a share of your income, that premium share will stay with you over time. So as premium costs grow, individuals and the federal government share in the cost of that premium growth. So this really does underscore the need for the system reforms in these bills and for other provisions that will lower the cost trajectory both for individuals and the federal government.

This is a somewhat complicated slide. In addition to premium subsidies, both bills reduce cost sharing for people with low and moderate incomes. Premium subsidies are linked in both bills to plans with an actuarial value of 70-percent meaning that the plans would, on average, cover about 70-percent of someone's cost, total medical cost leaving policy

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holders with about 30-percent of cost on average, for their medical bills.

Under the Senate bill, cost sharing subsidies are lower out-of-pocket maximums, so both bills specify out-of-pocket maximums and they're lowered for people at lower incomes. This has effective increasing the actuarial value of the plans to about 90-percent for families earning less than 150-percent of poverty and about 80-percent for those earning between 150 and 200-percent of poverty.

So we examined what this means for a standard population. We know across the U.S. population that costs are concentrated among the top 50-percent of that, of the distribution. So most health care costs occur among a relatively small number of people. Most people are relatively healthy. They account for not a lot of the costs overall. So when we take that distribution and apply it to the population that would be enrolled in these plans, making some assumptions about what deductibles and co-insurance would be.

You can see on this slide the silver plan, which is the 70-percent actuarial value plan in the Senate bill potential out-of-pocket costs for people across the spending distribution looking at sicker, at the very top and down to the healthiest people at the very bottom of that distribution, and you can see

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how costs would decline with the cost sharing subsidies across lower income households.

Under the House bill, you can see that if you look at this, you may have to take this home and look at it a little more carefully, I think DeAnn's also going to address this; she has much simpler charts, which will help a lot. The House bill has much more generous cost sharing subsidies and caps out-of-pocket costs at a much lower level than the Senate. So consequently, people are much more protected against out-of-pocket costs.

For example, if you look at the column, 150-percent to 200-percent of poverty, people with the highest costs, people who are the sickest would spend no more than \$1,000, about three-percent of their income compared to nearly \$2,000 or six-percent of their income in the Senate bill. People whose costs are just above the median would spend about \$700 in the House bill compared to about \$1,900 in the Senate bill.

People who are very healthy, over the year would spend about \$75 in the House compared to about \$240 in the Senate. Each bill requires that people have health insurance. This is a really essential part of this approach to health care reform. We still have risk pools that are separated, employer group, Medicaid and this new insurance exchange. You have to have a mandate to keep all those together. There are some penalties

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for noncompliance in the new Senate bill. The penalties start off at \$95 per person in 2014. They rise to \$750 by 2016.

The House bill will charge about two-and-a-half-percent of the difference between people's modified adjusted gross incomes and their tax filing threshold. So this fee rises with income. You can see it on the chart, what happens to that fee.

So it starts at about \$242 for a family between \$20,000 and \$30,000 and rises to about \$2,500 for a family earning between \$100 and \$200,000; and it's capped at the average national premiums. So for an individual, that's approximately \$3,500.

On your chart pack, I have the wrong exemption level for the Senate bill. We originally thought it was 9.8 and it's actually eight-percent as it was in the Senate Finance bill. So the exemption from the mandate occurs if you can't find a premium that's less than eight-percent of your income.

The small businesses benefit, do very well under the three bills. They're eligible, first of all, to buy health insurance for their employees through the health insurance exchange. They're exempt from the shared responsibility requirements in both bills. The House bill has a requirement to both offer and contribute to your employees' benefits and the Senate bill has a penalty if you have an uninsured worker who gets a premium subsidy through the exchange.

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So small employers in both bills are exempt from those penalties. They're also eligible for tax credits. They're very similar. Their tax credits are targeted to very small low-wage firms. So the full credit is available to firms of 10 with average wages of about \$20,000. The credit phases out up to firms of 25 and average wages of about \$40,000.

The major difference between the two bills on this is the amount of premium contributions employers have to make in order to qualify for the credit. It's only 50-percent of the premium. The full premium in the Senate is 65-percent of the premium cost in the House. These are also time limited. So they're only available for a couple years. I believe in the Senate bill they're available and I'm not sure about the House to check but I think they're available before the rest of the insurance reforms go into play. I will stop there.

ED HOWARD: Very good. Thanks very much Sara. Let's turn to Stuart.

STUART BUTLER: Thank you very much Ed. It's a pleasure to be here and I just want to compliment Rachel and Sara not only on their work here but also their ability to keep up with changing circumstances. I got the first major revision I think the morning after the Reed bill was introduced. So it is true that people at Commonwealth never sleep, which is what I always thought.

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Also, it kind of reminds me of trying to work in this area in health care policy reform these days is a little bit like, the problem of it is a little bit like Churchill said the problem was with studying history. The problem with studying history is that is they keep adding to it all the time [laughter].

Of course Churchill also said that history is really one damned thing after another. Those of you who are Republicans in the audience may feel that is also characteristic of health care reform but anyway, when we look at the idea of, or the issue of affordability, it does have several dimensions. What I'd like to do in my opening remarks is kind of broadly look at this idea of or this issue of affordability in three dimensions or three ways, only one of which was looked at in the study.

First of all, when you look at the idea of affordability, there's sort of, there's both a numerator and a denominator. One may make changes that make something affordable to people in a more obvious sense, subsidies and so on as we discussed but if you do also things like taxes or regulations that apply in health care that have the effect of changing the compensation that people have causing them to have lower cash income in the future because of other changes that are taking place, you may well erode the advantages you have

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with improving affordability at the front end, in other words to dilute the subsidy. I'll say more a bit more about that in a moment.

Second, affordability as is pointed out in this study, is very case-specific that when you look at any piece of legislation, it's important not only to look at the ranges of attempts of affordability as we see here but also to just look at some of the more troubling or areas of affordability between different people that may cause some concerns in terms of looking at the legislation and I'll mention those.

Finally, affordability can also apply to the country as a whole and from one generation to the next. When we do something in health care like other areas, we may well make changes that have effects on people right now but if that has an implication over the long haul, goes to people's costs over the long haul, but also any changes in our ability to fund other areas of our public policy work. That also has implications in terms of affordability. I just want to touch on each of these very quickly.

The first, the idea that people's compensation, as a whole, is an important thing to take into mind not just their affordability of health care. The fact is if you look at these bills, there are a number of things from explicit taxes on so-called Cadillac plans and so on to mandate on employers to

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provide certain levels of coverage and therefore, as part of the compensation their employees influencing their decisions with regard to cash income. That is very likely and will indeed alter the pattern of cash compensation in the future and therefore, the general affordability that individuals have to look at health care and other issues.

For example, the so-called Cadillac tax hits people who have those plans even if they have moderate and low income, if they're in companies that have very generous plans on over time because of the indexing feature of that particular provision which is not going to be indexed as rapidly as health insurance itself will rise. You'll see more and more people who have modest and even low income finding that employers start to adjust their cash income over time. That will affect their ability to afford not just health care but other issues in the future.

I think it's very, very important to look at that. Indeed this is a major item in fact, over time, in these bills or in the Senate bill. So it's very, very important to look at that. It's not just a premium and affordability with regard to actual expenditures on health care.

It is also an issue of what does this mean for your pattern of cash income in the future. If that is reduced, if

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the pace is reduced in the future, that has an effect on your affordability of health insurance and other things.

The second point I wanted to kind of draw your attention to think about is this issue of variations among households, how affordability will alter, under these bills, depending on your situation. As Rachel and Sara focused on, the difference for people at different incomes is very critical and very central to all of this.

It's an issue that's been raised very widely in terms of looking at these two bills, in particular, the way in which the House bill tends to focus more on people who are modest and lower income people and less on people who are higher income.

While the Senate bill, as has been pointed out, puts caps, rather more generous caps, in the sense of more help for people three to 400-percent of poverty and less help than the House bill to those at the lower end and it's an issue that's been raised by groups like FamiliesUSA and others in terms of looking at the two bills. I think that's very, very important.

I think it's also very important to recognize that there are big differences between people who are inside the exchange system, which is really what we've been focusing on up to now and those people who remain in the employer-based system. There are big differences in terms of horizontal equity between people who are similarly placed with regard to

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income but in the future may have coverage through the exchange compared with those who have coverage through the place of work.

There's a differential at the highest amount of between six to \$7,000 difference in terms of the subsidies that are available to people in those two situations. Now it's true that people who are in the employment-based system do have the tax exclusion but for people who are modest income, that's a very little value. It only really affects their payroll tax. So you do see very sharp differences between similarly situated people who are covered in different ways through the exchange system and all through the employment-based system in these bills.

That's very, very important and all kinds of perverse implications can come from that not only in terms of this obvious sort of horizontal inequity. But when you look at for example, the free-rider tax, the fact that if some people who provide, some employers provide coverage and a number of their lower income eligible people decide instead to get coverage through the exchange system then the employer, perhaps seeming reasonably, will be hit with a \$3,000 tax as a so-called free rider so they're not really sort of getting something for nothing by their employee leaving. That can have lots of implications in terms of hiring patterns.

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If you are essentially a middle income employer, in other words, most of your workforce is more middle income and you only have a few low-income employees, you get hit with this tax whereas if you got a larger number of low-income people, it's a different and lower situation.

That means that if you are an employer who has predominantly middle class people, your openness to actually hiring people of modest income, low-income potential employees and low-household income who might be people who would use fewer services, you're going to be discouraged from hiring those people. That's something that's been pointed out by a number of organizations.

So when we look at this issue of affordability, we see these horizontal effects as being very important and really need to focus on and look at that a little bit further.

Then the third area I will just mention is this issue of affordability over the long-term, and also affordability to the nation as a whole. There was a lot of talk about bending the cost curve and it has indeed been bent under these bills, bent up rather than bent down. Of course, as the cost goes up of health care relative to other parts of the economy, we will see pressures making it more difficult to afford other goals and other important things that we see in our society.

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I occasionally speak at conferences at the state level on education and it's just like a constant refrain at the state level of people who deal with education saying the cost of Medicaid in our state is squeezing out the ability to have funds available for education. That is also true at a national level, the more that total costs that health care go up as they will do under these bills, the more that squeezes the affordability of other goals that we have in our society and it's very, very important to bear that in mind.

Let's also remember when we look at this effect over time that as the years go by and particularly as we go beyond the 10 years, which incidentally is really only the first six years actual implementation of this legislation because really nothing much happens for the first three or possibly even four years depending on the bill. You see a bigger impact over time. The actual outlays -- the actual spending in this legislation -- if you look at the CBO's analysis of the Senate bill for example, is about \$1.2 trillion.

There are callbacks and so on associated with that and some of those figures are netted out in the CBO analysis but the actual expenditure is that over time but that assumes a number of things including things like the doctor fix basically disappearing after a couple of years. So doctors start getting

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large reductions in their fees and so on. If that doesn't happen then these costs go up very significantly.

As I said, it only looks at the first six years. If you look at the first full 10 years of implementation, so 2014 to 2023, you see a total cost of more like \$2.5 trillion of actual costs that have got to be financed in some way. So this is a major level of spending that is going to affect the affordability of other things that we want in our society.

If one also looks at not just the spending level but the implications for future generations, if this spending is not fully covered in terms of unfunded obligations that means that money available for future generations to deal with their own personal costs as well as the costs of the nation. If we don't see the savings that are being suggested in these pieces of legislation, that also adds to that implication in terms of costs and therefore affordability for people in the future.

Certainly the Congressional Budget Office and very recently, last week, the actuaries of the Department of Health and Human Service, Rick Foster, the Chief Actuary there, have been very skeptical about whether we will see the offsets to reduce the net effect on future deficits.

The Medicare Advantage plans, for example, the reductions that are proposed there that Rick Foster points out that this would have to mean a reduction in enrollment he says

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for up to 64-percent of people. You have to ask yourself is this likely to happen in the future?

We also, in the Senate bill, the assumption is that we will see reductions in doctor fees after the first year of 20-percent and then held after that. It's never happened before and it's very unlikely, in my mind that it will happen in the future. I think it's delusional to think this is going to happen and if it doesn't, we are going to see high costs spread on into the future.

The CBO also says that a lot of the major savings are dependent upon the independent Medicare Advisory Board, this so-called supercharged MedPAC actually being able to achieve reductions in Medicare over time. I would only just remind you of the kind of outrage that followed a federal taskforce on mammograms merely advising that perhaps there should be a reduction or elimination of this for women aged 30 to 40 just an advisory on that led HHS Secretary Sebelius to say no way is this going to happen in any program.

So you've got to imagine despite this that somehow major, radical changes are going to occur in the future to keep the costs under control. I could go on. There are a number of these but the bottom line is when you look at affordability over time, there are a lot of assumptions that are based in these bills of things that really anybody who's been around for

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a while, not even as long as I have, looking at these things are going to be very skeptical that there are actually going to happen. That has big implications for affordability for people in the future.

So in conclusion, when you look at this issue, I just want to emphasize this, all of us on this panel and all of us really engaged in this debate want to achieve the goals of reform. It is an outrage that in this country, we have millions of people who are uninsured and face these kinds of costs and go bankrupt.

So there's no argument about that but when we look at correcting this issue and looking at trying to bring affordability down for people, it is important, in my view, to look at it in at least these dimensions that I've mentioned not only the specific day-to-day sort of impact, the most obvious impact that you get from these bills. Right now, it seems to me that we've got to look a lot harder at this legislation to be comfortable about those wider aspects of affordability.

Thank you.

ED HOWARD: Thank you Stuart. Let's turn now to DeAnn Friedholm from Consumers Union.

DEANN FRIEDHOLM: Good afternoon. I am not an economist. I'm a practitioner. I've run big public programs. I've advocated for individuals, worked in the legislative

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process and so the perspective I'd like to bring to this is slightly different than the previous two speakers and that is stopping and just stepping back from all of the facts and figures and numbers and very important points that Dr. Butler and Sara have made and just say how are people going to fare if anything close to what is being talked about in the House and Senate actually becomes law.

I want to do that in, part by, talking about some of the families and individuals that we have worked with over the past year. CU stated a major initiative on health reform a couple of years ago. We have collected tens of thousands of stories from people around the country. We took a bus out around to collect stories and meet people.

We have an activist network of people in all 50 states. We've done analysis. We do polling frequently and we've written a number of articles, I think six or seven articles now in *Consumer Reports Magazine* about the issues and problems that consumers are facing.

So one of the things that we find and it's important to keep in mind in all of this is that Americans have very kind of schizophrenic thoughts about health reform and where they stand in it.

We heard this summer frequently quoted different polls that say Americans in the 80-percentiles, they varied a little

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bit but close to four out of five Americans who had insurance, either public or private, were satisfied with their coverage. Some people wanted to use that as an example of why we didn't need to do comprehensive reform but in our polling, those very same type of people by similar numbers at three out of four, 75-percent, showed enormous concern about their situation.

So even though they might say that they're satisfied, they have grave concerns and fears for loss of job that would end up in a loss of their insurance having some kind of major medical problem that ended up financially ruining their family, being denied coverage if they were to lose their insurance through their work, on and on, those kinds of things that seem to be saying two kind of different things to us. So I hesitate to sit here as a representative of consumers and pretend that there's any one consumer view. There isn't. I just want to kind of walk us through some of the elements of reform and how it might affect.

You know the problems that people face in the system. We don't need to spend time. One area that we have heard a lot about and that was not as prevalently understood before is that a lot of people and these are a huge proportion of the stories that we've been told, are individuals who have health insurance and thought they had good coverage until they found out that they didn't, until they had a major medical problem, illness,

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cancer, accident, and they had to actually use their coverage for significant health care.

The numbers that are estimated, Commonwealth had a poll, our poll was similar, somewhere around 25 million people in this country, if you looked at what their coverage today would be, considered to be underinsured.

The count is among those numbers that say they're insured but when they really had to use it, it would not cover substantial parts of their cost. The problem is they find that out too late. I want to talk through two or three stories here.

The first is Janice and Gary Klauson [misspelled?] they were, in their early 60s, she lost her job as an accountant. They therefore lost their insurance. They went shopping on the market. They're well educated people. They're knowledgeable. They shopped around. They picked a \$500 a month policy.

They knew, they knew that the limitation on this policy was \$50,000 a year, but they had no idea how expensive health care was that they would be having to use. He got colon cancer. Their costs ended up costing over \$200,000 and their costs to them even though they had insurance were \$150,000. As they said to us, they expect that they will spend the rest of their life trying to pay off these medical debts.

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Another example is a young woman, Katherine Howard; this is kind of going to be a tale of two women who got breast cancer. Katherine Howard, a San Francisco freelance film producer, 29-years old, she couldn't afford a really comprehensive plan.

So she shopped around and bought one of those great high-deductible, low-premium plans with a \$2,500 deductible and 30-percent copay but she didn't expect to get sick. She thought she might break her leg snowboarding or something. She's 29. She's healthy. What's the problem? Well she was diagnosed with breast cancer.

What she found out in that process was that while it covered things like hospitalization, it didn't cover chemotherapy. It didn't cover outpatient services. She tells the story of watching one of the chemo drugs going into her vein knowing that it costs her \$600 every single time. She had those drugs daily for a number of months.

Today, she's paying off her debts, \$1,800 a month out of her paycheck to try to pay off her own debts of over \$40,000. The contrast, which I think brings into focus, the kinds of changes that we're trying to talk about is another young woman who lives in Massachusetts.

She was a waitress in her family's restaurant, 27-years old, no health care and then Massachusetts passed its' reforms.

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She was required to get insurance. She went and based on her income which was quite low, she was eligible for Commonwealth Care and after she got Commonwealth Care, she went in to have an annual physical and they found breast cancer, 27-years old.

She was able to be treated with very little out-of-pocket costs for herself in contrast to Katherine's situation and she has told us if she had not had any insurance, she would have never made that appointment. They would have never turned up her cancer until it was much too late and she probably would not be alive today, so differences of experience in the way that the system is treating people.

I guess one of the first things we have to say is that affordability and I think Stuart mentioned this or touched upon it as well, affordability really depends on what your circumstances are and it's all about compared to what. If you're a person who is uninsured right now facing any of these premium amounts up to 12-percent of your income or 9.8-percent of your income in the Senate bill, at a 400-percent of poverty, so if you're uninsured, that's going to be a sudden major hit on your family's budget that you're not used to.

We have had people in our network of people who were hanging on, waiting for health reform because they don't have coverage. They can't get it and when they hear that they would be likely to be required to spend 10 to 12-percent, they find

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that to be a huge change, a huge hit on what their family's income is.

On the other hand, if you're uninsured and you have any kind of illness and you're not being able to get coverage like many people that we've worked with, the idea of 12-percent is golden. They've been being quoted \$2,400 a month, \$3,600 a month to get coverage. So any of the kinds of plans be it the House or the Senate look very good to them.

The other thing is that people's circumstances are very different as Dr. Butler said. You can have two families, same family size, same makeup, same income levels, one of them has grandparents who are going to pay for their kids to go to college and the others don't. They have to try to save for it. So every single family will view these things and whether they are affordable or not from their own perspectives.

All of that being said, there are a lot of really important changes in the bills that Sara pointed out. I'm not going to go through those but when we think about what is affordable, we at least at CU when we're looking at these, what is it that we're really looking for? You're looking for insurance that is secure, that is available, always there for you, and somewhat predictable especially if you have a major life health care problem.

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The legislation that's being talked about goes a very long way, House or Senate bill, goes a long way towards addressing some of the biggest concerns that consumers have expressed to us and financial problems. You will always be able to buy something. If you lose your job, you'll be able to go into the exchange.

The ending of lifetime and annual maximum benefits, which really hurts families who find themselves battling high-cost problems, the different ranges, the different levels of benefit packages in the exchange, for example, that let you make your choices about the tradeoff between how much premium you want to pay versus how much out-of-pocket exposure you would want to have, a comprehensive kind of essential set of benefit package, this is very important.

It helps consumers make better choices and have available better choices and then all kinds of other consumer protections, the ending of rescissions. All of these are very important. They are part, in our estimate, of affordability, an important part of insurance, which is to help you handle a major expense that you otherwise would not be able to.

We do have concerns and as I've said before, that in the various bills, depending on what your income level is, you may have a stretch at being able to afford the premium. The House bill is better for people who are in that 100 to 200-

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percent of poverty range. It's a lower maximum for your premiums.

The Senate bill, on the upper end of the subsidy level, the Senate has a lower amount but basically, the ranges that the House and the Senate are talking about are well in the range for lots of people and much better than what they have today. So it's all comparative.

Many will still face high out-of-pocket costs. One of the things I want to kind of focus on and wrap up with is how important it is that as we move to a new system such as being envisioned that we make sure that consumers are given the kinds of information they need to avoid the problems that we just saw that Katherine had and the other couple had when they were trying to make a good choice of insurance.

One of the issues that we are a little bit concerned about is the use of the actuarial value as one of the ways to compare and contrast the different levels of plans in the health care exchange. This is a simplified version of the chart that Sara had but basically what we want to point out is that people may think that the actuarial value means that, for example with the silver that 70-percent of their costs are going to be covered but this is based on averages.

So if you are a healthy young person and you don't use a lot of health care, throughout that year, you're going to be

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paying 100-percent of your health care until you get up to that maximum. So you really haven't had 70-percent coverage of your health care whereas if you're a high user, if you encounter a medical problem or have a high expense, you will end up being better off. So it's important for people to understand, for consumers to have these kinds of terms explained to us. We have a paper that was available out on the table if you want to understand more of that.

Final point is and I think, I really appreciate a lot of the points that Dr. Butler made but all of this affordability, premium subsidies, what your total out-of-pocket or your total costs are going to be in a year are in trouble if we don't get control of the overall health care costs as the years go by. It won't be affordable if they continue to rise faster than our incomes.

We need to have good information for consumers to be able to compare plans based really on apples to apples competition. Some of the thought is that the reason prices have continued to rise so much is there's not a lot of real competition in the insurance industry but we are going to have to really have comparative information between plans if you're going to avoid the kinds of problems we have today with insurance companies designing plans to cherry-pick for the healthier and avoid the sicker population.

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We do believe a public option, a robust one, would help to improve the competition in the system and we have pressed very hard to make sure that we have common definitions of terms. We don't want hospitalization to mean after your first stay in the hospital, which is one of the stories we had. They thought they had hospital covered. They did but it started after the first day, which is almost always the most expensive.

We should have one standard plan in each of those levels in order to, the bronze, the silver, the gold, the platinum so that every insurance company, at least on one plan, has to have exactly the same things so you can compare them face-to-face. We need to let people be able to get estimates of what their costs will be.

The Plan D program in Medicare, you can go online and you can do estimates of what your costs are based on your utilization. That kind of thing really needs to be available. I will stop with that except to say that we do believe that the costs, overall system costs, have to be brought down. That can't be done just by trying to control costs in Medicare and Medicaid. It really needs to be in the private sector and across the board. That's the nugget that I think is the most difficult for us to solve in terms of affordability. Thank you.

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ED HOWARD: Very good. Thank you so much DeAnn. We are now at the point where you get a chance to enter into the conversation. As I mentioned, there are some microphones in the front of the room you can come to. There are also green cards that you can hold up and someone on the staff will bring it up forward. We'll try to get some answers from our panelists. "

Sara, while we're waiting for that process, I wonder if you could say a few more words about the slide that is entitled "Percent of Income Spent on Premiums," from your presentation? How is it if there are caps on the percent of income that you are going to be required to spend that those caps seem to be exceeded in the years after the initial ones?

SARA COLLINS: The way the bills are defined, I believe the Senate Finance was definitely structured this way and I believe the same is in the Senate bill but I'm not entirely sure. I know the House bill has an indexing provision but essentially, if you receive a premium cap, say at six-percent of your income, if you're at that income level and in the following year, the premiums rise, the share of the premium that you paid under that cap would stay the same, which means that if your premium grew as the amount as a share of your income would also grow.

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So the idea is that the federal government share would stay the same and individual enrollees would stay the same. So it really does underscore this need to keep premium costs down.

ED HOWARD: Very good. Thank you. So what they guarantee is that you won't pay any higher percentage of the premium, which may amount to a higher percentage of your income over time. I see. Okay. Yes, would you identify yourself please?

CHRIS SCHAY: Yes, sure. Chris Shay with the House Republican Conference. We've heard a lot of the discussion today talking about the underinsured in the private health insurance market. I'm curious how many people are underinsured in government-run health insurance, either because Medicare does not have a catastrophic cap on expenses and so you have to keep paying and paying and paying or you go out to AARP and buy Medigap policy for that or in the cases where many state Medicaid programs, you just can't get access and you have to wait for a month or longer, something like that.

We saw that Diamante driver in Prince George's County tragically a couple of years ago. I know the fund has put out numbers on the underinsured in private health insurance on several occasions. If the fund and others think the government-run health insurance that this should be an option for everybody then why don't we have a study saying how people

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are underinsured in government-run health care and how low that is compared to private health care?

ED HOWARD: Sara, you want to take a crack at it?

SARA COLLINS: Thank you for the question. It's a great question. When we did the analysis of the underinsured, we looked at the under 65 population and we did look at the difference between employer and individual. I think Medicare certainly has issues in terms of what people's out-of-pocket exposure is.

We've done, John Gable has done some analysis looking at Medicare parts A and B and then as you add in the supplements, you increase the actuarial value of those plans. So it really is important in a Medicare program to have these supplements to reduce your out-of-pocket costs. There's no question about it.

So I think when we think about offering plans through the exchange that the public plan would look like the private plans that would be offered through the exchange so that they would be subject to the same benefit standards, had the same cost sharing tiers, same premium subsidies, and cost sharing subsidies. So those would apply in the bills to both the private and public plans that would be offered through the health insurance exchange.

ED HOWARD: Anybody else? DeAnn?

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DEANN FRIEDHOLM: With regard to Medicaid, I think you're making a really good point. Medicaid is probably the richest benefit package of any plan anywhere maybe in the world.

CHRIS SHAY: If you find somebody who's willing to take it.

DEANN FRIEDHOLM: But the problem is that the reimbursements, in most places, are significantly lower than even Medicare. Medicare usually is lower than private. So it is an issue. The House version of reform includes funding to try to assist states because states set that policy not the federal government. It's the main thing that the states have complete control over in Medicaid.

The Senate bill, I don't think, well I can't speak about the most recent version but before, they did not have, yes. So it is a huge problem. When I ran Medicaid, I used to say that a Medicaid card was a hunting license, gave you a chance to go try to find a doctor. Some states are better than others but it's a good point.

ED HOWARD: DeAnn you're up again. The questioner observes that you presented three cancer cases. Two cost about \$150,000 in Iowa and California but the case in Massachusetts cost \$200,000. aren't we assuming that wider coverage will reduce, this says a spread of costs but reduce the overall

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costs, I think is what we're trying to get out, by reducing uncompensated care and is that happening in Massachusetts? Have studies been done? If costs are rising in Massachusetts, are the providers gaming the system?

DEANN FRIEDHOLM: I don't hold myself out as an expert on the Massachusetts program in terms of any kind of studies that have been done. In Jaclyn's case, it was literally within about a month or two after the program had started and she had gotten coverage. So any positive effects of getting rid of or reducing uncompensated care, helping the cost for people with coverage would not have kicked in by then.

We all know that some states are more expensive than others. As it is right now, the number of states, I think Massachusetts is one of the more expensive, overall health care costs states. So you really can't compare between states even for similar types of medical problems. The point that I was making with those stories is just the impact on the individual and how they would perceive that insurance being adequate or affordable.

ED HOWARD: Stuart, you've done a lot of work in Massachusetts.

STUART BUTLER: Yes. I just might comment on that too because I think Massachusetts has some other cases also indicate that in order to get wider coverage and affordable

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coverage, part of the presumption in much of this debate is that you will see a shift in the way people get health care in particular and this is emphasizing Massachusetts and also of course by Commonwealth, among others, to say we've got to move health care more towards the family practitioner, the first responder so to speak in the health care system more.

We've got to be able to bring about that shift in order to get a lot of these savings. That presumes that you can do this. Massachusetts, first of all, underscores the problem that if you don't have an existence right now a large number of primary physicians and so on relative to specialists, that in itself is causing a problem in Massachusetts and may well mean that the cost, the actual price you have to pay in terms of salaries and so on to get an adequate supply of them moves up.

It also means that over time, you do actually want to see a shifting of resources away from certain parts of the health care industry to another part.

Now Peter Orszag is pretty good at getting up and saying: assume this happens and you get all these savings; well unfortunately it doesn't seem to happen that easily. You seem to see all kinds of efforts on Capitol Hill and in state houses to make sure that you don't see switching in this way from one sector or from one specialty group to another.

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I think the more that is a factor in the future, the more we actually see it difficult to do this, the more it's going to be difficult to achieve this objective of not only affordability for individuals in terms of the prices they pay but affordability for the country as a whole in achieving this because the actual price somebody pays directly for a service or for insurance, as in these cases, is sort of in many ways, just the tip of the iceberg in terms of what the actual cost is for the society as a whole. Therefore the effect is elsewhere.

Therefore, I think Massachusetts underscores as well as the kind of debates that we see here in Washington, it underscores the difficulty of getting the structural changes in the health care system so that we can actually meet these targets of affordability for individuals out of reasonable costs to the society as a whole.

ED HOWARD: Rachel do you want to?

RACHEL NUZUM: I just want to add one thing on Massachusetts. I think I would certainly agree with Stuart's assertion that the primary care system has been grossly undervalued and underreimbursed for a long time. We sponsored several evaluations of Massachusetts and we saw that even after the first year of reform, people especially low-income individuals, although the system was not really prepared for thousands and thousands of new folks to be insured and moving

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into the health care system, they did have an easier time accessing providers before than they did before reform.

Each year that gets easier and easier for people to do. They've gotten 97-percent of their populations insured. It has taken some time to get the infrastructure built up. Both bills start us down the road of paying primary care differently. I think that it's a down payment. We need to do a lot more but they are a step in the right direction towards getting our incentives aligned for their primary care services and the more integrated services that we think could offer more value.

ED HOWARD: Let me just add a small commercial. There is, on our web site, a bunch of materials related to a briefing we did several months ago that, in part, focused on the access questions in Massachusetts. I know Sharon Long from the Urban Institute has done a lot of work that is chronicled in that briefing. She spoke at that briefing. I would urge you to take a look at some of that information. Yes, would you?

JESSICA BANTHAN: Hi. My name is Jessica Banthan. I'm from The Agency for Health Care Research and Quality. I have a question for Stuart that's a little technical but leads into a broader question that I think that all of the panelists might want to comment on but before I ask the question, just as a follow-up of the earlier question from the young man over there.

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We have a paper under review at *Health Affairs* and we've already presented some preliminary results that look at Medicaid families with high out-of-pocket burdens. The preliminary results that we've presented at the ARC annual conference show that most of those expenses come from drugs and that the access problems are particularly acute in buying prescription drugs among Medicaid families and that sometimes the formulary rules possibly aren't being implemented correctly.

They're denied the drug or have to go back and get prior approval or something like that and instead decide to purchase the whole thing out-of-pocket and pay the full price. We've done that analysis with the medical expenditure panel survey.

So Stuart, I have a question concerning overall compensation, which I think is very important. If we adjust, in the employer group market, if we do implement things like taxes and so forth that affect, eventually affect worker compensation, how do we know how employers will reduce or adjust compensation according to general, let's just say age groups or health status groups.

They're not allowed to charge premiums differentially for health or age groups at the moment but we know that most of the young people here in this room who have health insurance

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through their employer do not actually cost their employer that much, the federal government, and yet the older ones of us actually cost, who have family policies, cost quite a bit.

So if, in the extreme case, a large group employer stopped offering health insurance, they would adjust people's compensation upwards but in what ways? They might adjust older workers' compensation not at all and younger workers' up considerably more. I'm not sure we know how to anticipate how they would do that.

That leads into my final broader question: do we have affordability standards that matter by age group? Is that an issue especially in this environment of a mandate?

STUART BUTLER: You're absolutely correct of course. There isn't a simple answer because it depends in the situation. I mean obviously in say for example, large self-insured or unionized firms, this would be negotiated. I mean how, if you have any form of tax, if there's a Cadillac plan tax or something like that, how that shows up in terms of compensation changes will depend on the bargaining that goes on in that particular firm.

So I don't think there is an answer. It just underscores the point that the effect on individuals will depend on where they are, what their situation is, and so on. Your general point is absolutely correct that in general, we're

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clearly seeing a difference in cost to the employer of any mandate or anything like that depending on the age range in general.

So the only factor with the age range is of their employees. That's kind of one of the reasons I mentioned this issue of the so-called free rider tax because I would imagine that if you got a firm that has predominantly middle income people and therefore would face that tax for low-income individuals, that is going also to make that employer be more hesitant to higher, a younger person.

I mean if you don't have that tax and the person is insured by the employer and it's an 18-year old, the marginal additional cost of bringing that person on and insuring them is going to be relatively low. If that person comes on and because of their income decides to go into the exchange, you get hit with, in all probability, a much higher cost than you would've paid had they stayed with you.

So the very fact that somebody in these cases can move to the exchange will discourage you from hiring that class of person, but it's a complex issue. I don't want to suggest otherwise at all. It is hard to do this. I think the best we can do is sort of give, kind of draw some notional conclusions and generalities about how this might impact people.

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ED HOWARD: Can I just ask somebody on the panel whether Stuart, you or Sara or somebody, to explain in relatively simple terms exactly how the free rider penalties work because triggering the large penalty is sort of counterintuitive.

STUART BUTLER: Well let me try to answer and be corrected by the others I suspect because I can't remember the exact details but basically the issue is, let's say you're an employer and you're providing coverage to someone like that and there are certain categories of people, low-income people in general and I forget the exact numbers and you can maybe tell me this, below a certain level that could decide instead say I want to go into the exchange and get the subsidies associated with that.

So the issue is well why should an employer get a quote free ride? They have somebody but that person goes and gets subsidized somewhere else, and they don't have to pay for it, so a tax is looked at. There are two classes, two levels of tax as I understand. One is to say if you got predominantly low-income people, so it's a big issue if you like, you pay relatively low, I think \$750, whatever it is, the per-person tax.

On the other hand, if you are predominantly employing middle-income people and only have a few low-income people then

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it's a much higher tax, \$3,000 and therefore, if you're in the hiring business, you're profiling. You're going to be looking at people and thinking about now what's going to happen if this person comes and then goes into the exchange? So that's why this issue arises.

I don't know how large of an issue it's going to be, although for big firms, that's a significant factor but maybe you can correct me if my numbers are wrong on that but that's the issue I was getting at.

SARA COLLINS: I think that is right. One important piece of this though, if you are working as a low-wage worker or anyone in a firm that offers you coverage and your contribution doesn't exceed 9.8-percent of your income then you're not eligible for a premium subsidy through the exchange. So there is a firewall between the exchange and employers. On the other hand, if your contribution is really high and you go into the exchange then your employer is subject to a tax.

STUART BUTLER: If I may add though but one of the issues here is whether that firewall can hold over time because clearly it may well be that you're not eligible to go into this because of that percentage but if you look over there and the guy over there in the exchange, the guy who works for the firm next to you, it's getting a large subsidy in the exchange, a six, seven, \$8,000 subsidy and you're not because you work at

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Dunkin Donuts or something like this and the exact cases are being looked at.

There's enormous pressure in round two of reform to say get rid of this firewall and if you don't get rid of the firewall, it's heavily inequitable between two equivalent people facing the same medical situation, the same basic income. One can get in the exchange and one can't. There's a huge difference in the subsidy and therefore, affordability level that they face.

SARA COLLINS: Just to look at what CBO, how they're looking at this issue and they look at 2019, they're seeing a very minimal decline in employer-based coverage. So only in the Senate bill only dropping by about five million people and the House bill actually increasing the employer mandate has a big effect on this. It actually increases coverage of people in employer-based plans so that employer-based coverage will remain the, at least under the CBO scenarios, the primary source of coverage for most people.

I think in terms of overall financing too, you can see really what it means to have employers in the system on the CBO estimates between the House and the Senate is a much bigger offset from employers in the House bill in terms of revenues than in the Senate bill because of the mandates. So it's

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important, from an overall financing perspective, to keep employers in the system.

Most employers offer coverage now, especially large employers and CBO's obviously expecting that that is likely going to continue. On the age rating issue, the report that we have coming out in the next few days, we actually do, I think this is an important issue, so the age rating in the Senate bill is now at three-to-one. It was four-to-one in the finance bill, the House bill.

ED HOWARD: Could I just ask you what does that mean, three-to-one, five-to-one, two-to-one?

SARA COLLINS: So an age ban means that as an older person, your premium cannot be more than three times what it is a younger person's premium.

ED HOWARD: I like that.

SARA COLLINS: So right now in the individual market, you could be charged a lot more if you're older than you can if you're younger. It's a good deal for younger people but not so great for older people but the way that works out, just in terms of numbers, someone who's aged 60 and this is the basic plan or the silver plan in the Senate bill.

And this is someone who is not eligible for premium subsidy, so his income is at 500-percent of poverty or whatnot, is about \$7,900 for someone who's 60 compared to about \$2,600

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for someone who's 20. So there is still a large difference between the two.

In the House, the difference is two-to-one so that the way it works out in dollars, someone who's aged 60 not eligible for a subsidy is at about \$6,300 premium. Someone who's aged 20 is half that, so about \$3,000-\$3,100. So it is an important issue. The subsidies work to offset that. So the subsidies will help people who are older by offsetting that rating issue but for people who are outside the subsidies, it is an issue.

ED HOWARD: Maybe come back to that because we've gotten a couple of questions about it specifically on some cards but we've been very patient standing at the microphone.

DAVID RAVEN: David Raven, Georgetown Medical School. A critical issue with health insurance has been a rapid rise in the underinsured. It's particularly critical for chronically ill people who are the expenditure people. They are much more likely uninsured and the way they use services as compared to the insured.

They don't use the drugs. They don't get the follow-up tests. They don't go for initial examinations and they end up with higher complications and avoidable illness. I know no one knows but I wonder, particularly from the Commonwealth people who have helped focus on this issue, what is your sense of the issue of the health care reform as currently conceived on, over

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time, the proportion of people who will be underinsured particularly those that are chronically ill and have high medical expenditures.

RACHEL NUZUM: The slide that I showed earlier gives a complicated kind of analysis of these cost sharing subsidies. So importantly, even without the subsidies that the minimum benefit standards are a huge issue in terms of protecting people, knowing what you're getting, and then having each bill also places out-of-pocket maximums for people who are just buying that plan without a premium subsidy.

There is slightly lower in the House for the full population. The House bill has more generous protection from out-of-pocket costs than the Senate bill does. You can, it particularly occurs in this 150-percent, 200-percent, 250-percent of poverty range where people in the House, covered under the House bill, would be much better protected than under the Senate bill.

What both of the bills technically do, what they mean by cost sharing credits is that they raise the actuarial value of their basic plan for people in lowering ranges. The House bill raises that up much higher to almost 97-percent for people in very low-income households above the Medicaid eligibility level and then drops it down at a much lower rate. So as you go out up the income scale, you're paying somewhat more of the

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out-of-pocket costs but it's less than you do in the Senate bill.

Both the out-of-pocket maximums really do protect people who have high expenditures. Just to give you an example, people when the very top one-percent of the spending distribution under these plans maybe have an unexpected cost of \$90,000, so someone who gets really sick, so that if you didn't have health insurance coverage, that would be your cost even without the premium subsidy under the basic plan in the House bill. You would be capped at \$5,000. In the Senate bill, you'd be capped at about over \$5,000.

If you are earning about \$44,000 under the House bill, you'd be capped at about \$1,000. So it is, for people who's under high expenditures, this is a significant improvement over what plan that they could likely purchase in the individual market. So there is a significant attempt in both those bills to address the underinsured issue.

ED HOWARD: Let me come back now to this age rating question. As I understand it, the Senate bill has a range of two-to-one, three-to-one, and the House, five-to-one?

RACHEL NUZUM: Two-to-one?

ED HOWARD: Two-to-one? Okay. I had it exactly right [laughter]. The five-to-one actually appears in the question because the questioner writes that five-to-one is what the

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Academy of Actuaries has previously said is about actuarially fair. I wonder if two things, one is we're hoping to do a briefing on this in January, so we're very happy that you have a report coming out, but also didn't Massachusetts have a sort of ameliorating available only to very young people barebones policy that was supposed to take some of the pressure off the age differential? Is that working or is there a parallel in any of the legislation that we're kicking around?

STUART BUTLER: I don't know if it's working. I can respond another way about that but I mean I think the general issue you're raising is a very important one. You look at something like the federal employee system, it's a one-to-one. I mean you're basically in the same premiums.

One of the impacts of this is the more you narrow that, the more for example, somebody who is younger looking at the penalty compared with how much they might pay themselves out-of-pocket if they weren't insured or have barebones insurance or just paid a fine but not having insurance. The more they're inclined to drop out of coverage, the wider if you have say four-to-one or three-to-one, fewer of those people will drop out.

So you got this sort of, it's like all these things, it's so many moving parts, you do one thing and it has another effect over here that the more you narrow that, it's great for

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the people at the top end, I mean the older people but the more you narrow that, the more people who are younger resist and don't see in their economic interest to be insured.

They're more likely to say let me just pay a fine and then if they're this younger person you mentioned who has paid a fine and isn't insured and gets breast cancer, they're even worst off than they are now in a sense because they've been fined for being not having coverage.

So you got a lot of these things to kind of look at when you look at different people in otherwise, equal situations. We just got to, as we're doing here in this panel, focus on this and realize this and realize that when we talk about this legislation to people generally, we must not imply, it's sort of like a homogenous effect. Everybody's going to be basically the same in terms of these numbers. It's going to make big differences.

We've got to be really aware of that and think about what we're going to do when these differences show up and people start systematically acting, if their behavior patterns change in a clear pattern as a result of it such as younger people saying I'll just pay the fine because this mandate just doesn't make any sense at all for me to get insurance.

SARA COLLINS: I just want to add one comment to that.

In the bills and this is true in Massachusetts as well, in

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terms of young adults, the young adults benefit in three different ways. The expansion in Medicaid eligibility first, up to 133 and 150, most young adults who are uninsured are under 200-percent of poverty so that will be a big improvement for young adults and a lot of them will end up covered through the Medicaid program.

The state, being able to stay on your parents' plan, both bills now have that provision and I believe it starts right away in both bills and then this ability to buy, through the exchange, for the age rating issue comes into play.

ED HOWARD: Thank you. Yes, go right ahead.

ANNA SUMMERS: Anna Summers, University of Maryland. I just have a clarifying question and probably a follow-up question regarding the penalty that employers would pay. So if we just go back to that example that Stuart Butler had of the midsize firm with very few low-wage workers who would be subject to a penalty if the low-wage worker did not pick up the insurance and wanted to go into the exchange.

The penalty you referred to, which some of the panels have been saying \$750 and then you mentioned perhaps it would be as high as \$3,000. First of all, is that an annual penalty or a monthly penalty? Okay, I think it would helpful in the literature to clarify that over and over again because I think that makes it a big difference.

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So for a midsize firm facing this penalty of \$750 annually, that's less than \$75 monthly. So if they're offering employer-sponsored insurance already and most of their workers are picking it up, they're probably already paying for those other workers a share of the premium on behalf of those workers. That's probably higher than \$75 a month. So they aren't paying it for that low-wage worker who's not picking it up. So you had said that this \$750 penalty could have a big impact on hiring practices.

STUART BUTLER: Let me just correct that. I didn't say that, no. I said when there's a relatively small number of low-paid people and therefore the second level of penalty kicks in, that's where I see the big impact not on firms that predominantly hire low-income people. See what I'm saying?

ANNA SUMMERS: Okay, what's the second level of penalty?

STUART BUTLER: The second level is when you have a firm that only has a small number I forget how they got the percentage but a relatively small number of low-income employees. That faces a higher penalty if any of those employees move out or they hire someone—

ANNA SUMMERS: The \$3,000 you mentioned?

STUART BUTLER: Yes.

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ANNA SUMMERS: I think it's related to the national premium. So the average national premium and I think you have a lot of workers, the idea was not to overburden a firm. So the smaller number of workers, that fee might be less than it would be if it was spread over the whole range of your-

STUART BUTLER: I know this is using the cases to underscore the fact that your actual situation, who you happen to work for or where you try to get a job or whether you're in an exchange or out an exchange, the same family ends up in a very different situation in terms of probability of being hired in the cases that I just mentioned or what you actually will pay. That's just important to kind of recognize.

It's not a nice seamless sort of picture here. It's affected enormously by just situations you're in with regard to employment or whether you're eligible for the exchange.

ANNA SUMMERS: So just my final comment here is then it seems that also the thing that affects us is whether the business is offering employer-sponsored insurance and what premium they're already paying for those workers because we talk about this cost to the employer as \$750 or \$3,000 but really there's a marginal cost.

STUART BUTLER: No, you're absolutely correct and the marginal cost is important. So for example, let's say you are a predominantly middle-income firm and you're thinking of

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hiring somebody who's a low-paid person. If that person, for example, is very young then you would think okay, if I hire this person and cover them, it's not going to cost me a lot really because they're probably not going to particularly if you're a self-insured firm, it's not going to cost me very much.

On the other hand, if that person you hired and then they say well when I look at it, I'd rather be in the exchange, you get stuck with a \$3,000 cost. So it is, at the margin, you're discouraged from hiring somebody like that. It's just important to kind of understand that as opposed to say an older, more experienced worker who you might be considering where you might say yes, it is actually worth sort of paying.

This is the kind of, I don't want to kind overthink this but I mean it's those kinds of cases where you'll see actual decisions significantly influenced by the design of this legislation.

ED HOWARD: Yes? Go right ahead.

ANGELA VANDERHUFF: Hi, my name is Angela Vanderhuff and I'm with the PECO National Network. I have a question about the hardship waiver. So I heard you say it was at eight-percent but there are families in the exchange that are getting subsidies up to 9.8, and so I'm wondering are there families in

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the exchange that can take that hardship waiver, in a sense, aren't getting health insurance?

SARA COLLINS: That's right. So there is the premium subsidies are capped at 300-percent and 400-percent of poverty at 9.8-percent of someone's income. However, you are actually exempt from the mandate if your premium expense is more than eight-percent of your income.

So there is a recognition that they've come up this far on the premium subsidies but this might not actually still be affordable to DeAnn's point, for a family who's looking at doing this. So they lowered that exemption to eight-percent. The House bill doesn't have. They have some unspecified language about a financial hardship exemption but they don't specify what it is.

ED HOWARD: so the people in that window would have a choice about whether to take the subsidy, get the coverage, or simply go without?

SARA COLLINS: Right. Right and the other provision the Senate bill too and this is to the skimpy policy or what they're calling the young adults policy in the Senate bill, which is like what they have in Massachusetts would also be available for people who take the exemption and they can buy a catastrophic plan.

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ED HOWARD: Okay. We have a few more minutes and I just want to give you a chance to pull your blue evaluation forms out and start filling them out as we finish these last few questions. This one refers to insurance companies in rural areas. In those rural areas where one or two dominant insurers exist, are employers and individuals expected to leave their employer-based coverage for the exchange or public plan?

In such an environment, will the public plan have a substantial competitive effect given the likelihood that there may be one hospital serving the market? Speculation from our economists?

STUART BUTLER: Well as an economist, we say all other things being equal, you would anticipate that if there are only one or two insurers that people would tend to go into a public plan if it's available, if it becomes a law.

On the other hand, as economists would say, the CBO Points out that in the Senate legislation that because in the new Senate legislation it's a negotiated premium in this public plan, they predict that probably the premium will be slightly higher in general partly because of selection issues in terms of sicker people choosing those plans and also because the public plan is not expected to have the kind of utilization controls that are common in private plans.

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Therefore, in that situation, an individual may not, assuming there's a public plan, a person may not see a particular advantage of being in that public plan, which causes some people to say well why have it but, that aside for now, but so it's not like most things, economists can give you five answers. Thank you.

SARA COLLINS: I think this is a really important point and it applies not only to rural areas but applies to urban areas as well. We know that insurance markets are really concentrated. We know that provider markets are really concentrated so there just isn't a lot of price competition right now. Hospitals can charge kind of what they want and insurers, because they're not facing competition, can just pass that price off in the form of a higher premium.

So the bills are very different in how they structure the exchange, which is a way of approaching this problem. Aside from the public plan issue, under the House bill, the exchange is set up in such a way that there would be more opportunity to lower premium costs over time. It's a federal exchange. It's a full replacement of individual insurance market as opposed to Senate bill, which would allow the insurance market, the individual market to continue operating.

Another very key provision in the House bill is it allows the Commissioner of the exchange to negotiate premiums

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and can reject premiums from carriers that it considers too high. It can reject premium increases. So there is some significant authority that exists in the House bill that is not quite as apparent in the Senate bill. So I think that this is a really big issue. It affects this premium trajectory that we see both individuals and the federal government paying over time. So I think that's going to be an important issue as this goes forward.

ED HOWARD: Yes? Okay. Maybe DeAnn is the right person to kickoff anyway in trying to respond to this question. It is decidedly non-academic. An average family earning \$55-65,000 a year would have to pay four or \$6,000 in premiums let alone copays and other out-of-pocket expenses. What happens if they just can't afford that much without losing their homes or giving up other essential things? That is kind of the affordability question in its essence.

DEANN FRIEDHOLM: Well if they can't afford it, I can't do the percentages off the top of my head that were there but obviously we have the hardship exemption that people could but then they end up without insurance. That's one of the problems of affordability is you want people to be able to get the coverage and these provisions that are really political reality that there will be people, because of their circumstances, that they can't afford even a subsidized premium and with limits.

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They will end up without having insurance paying a penalty and basically maybe a little bit more worst off than they are right now.

On the other hand, right now, they face similar problems of not being able to afford anything that's out there. So it's a dilemma. We have too many very low-income families in this country relative to the costs of the health care system and our ability to subsidize.

ED HOWARD: Anybody else want to try that? Well one question that actually I won't disguise it, I actually wrote this down myself as I was listening to Stuart talk and it goes back to your argument or the argument rather for a Cadillac tax and you properly pointed out some of the potential impact of that kind of a tax.

I know that a lot of economists are really quite positive about that provision, as maybe including Peter Orszag, about that provision because it is a way to give an incentive to move to more effective or efficient health care plans and ultimately bend the cost curve. I wonder if you wanted to try to address that kind of an argument in favor of.

STUART BUTLER: I don't think it's true to say that a lot of economists are enthusiastic about it, certainly the ones I know. Their first preference is for a very different arrangement. They tend to say: well if we can't have what we

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really want, this is probably the second best or maybe the third or fourth best solution; but as I said, the problem with a quote Cadillac tax is that it affects everybody who has coverage. It trickles down to everybody in the form of higher premiums throughout.

The alternative approach is to say: let's look at the tax exclusion that people have, which is a very generous, as you go up the income level, increasingly generous exemption from taxation including payroll taxes as well as income taxes for the value of your employer-based coverage.

I think the preferred approach of most health economics who are interested in the tax area is to say that that exclusion should be limited or capped for people above certain incomes who have plans above a certain cost. In other words, it's like an income-adjusted Cadillac tax, maybe put it that way. That could be what we eventually have. It would be a way of squaring this circle. If you do that then a low-income person who even has generous coverage today would not pay more.

On the other hand, because upper-income people in a firm including its owners would face an actually a higher level of tax penalty than they would even under the Cadillac tax in a lot of instances. They would have an incentive to renegotiating the plan, organizing the plan differently.

That's kind of the idea of that.

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Without getting into a lot of detail that the issue is which approach is more likely to not only raise revenue, which is part of the objective but to get a sensible restructuring of plans. The argument that most economists say unless that is felt individually in some way rather than in a hidden way implicitly like a Cadillac tax is, people won't be open to change in their behavior and in their negotiation. That's why you got this issue of which is the better type approach.

I'm not sure that is as clear as it should be but that's the issue at hand here. You want to get people to change their behavior, but if they don't sense that they, as individuals, are getting the burden of that tax, and they think of it as just somehow my premiums cost more or over time actually my cash income is less because I don't even know how much my employer is paying.

You're not going to get that acceptance of the kinds of changes that are necessary, if there's an overlimit on the exclusion, which is why politically the tax exclusion is a much harder sell because it is so obvious to people whereas the Cadillac tax and the other taxes, premium taxes and taxes on certain services and so on, are easier to sneak in if your only objective is revenue but you actually dull the effect on getting people to be open and to push for changes in the insurance structure itself.

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RACHEL NUZUM: I just wanted to add to what Stuart said about the excise tax. I think one important thing about that is the revenue source is that I think 80-percent of the revenue that it generates comes from this assumption that employers will stop offering these plans and that they will redirect the compensation through taxable income. So that is assuming a huge shift in the way employers are operating in the plans that employees are demanding. It kind of begs the question about the chronic conditions.

What about the employers that are offering plans that just have a slightly older, sicker workforce? So you're not looking at an actual Cadillac plan. You're just looking at perhaps a more basic plan that just happens to be more expensive. So there are some provisions to account for, areas of the country that are higher cost and there are some provisions to account for very high-risk, high-cost professions but probably not enough to address the fact that you could just have a generally older population that works for you and a more expensive population to insure.

So I think that's going to be something that if this does make it through as a major revenue raiser, we definitely want to track, over time and make sure we have the sense of what influences had on and the plans that employers are offering and people are accepting.

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ED HOWARD: Sounds like you were channeling our honorary chairman, the junior Senator from West Virginia there who has, as constituents, a lot of coal miners who are older and in a dangerous profession. We've got one last question. Are there any provisions in either the House or the Senate bill that you think are important or even crucial that are missing or some that you think are absolutely anathema that are present?

STUART BUTLER: Yes [laughter].

ED HOWARD: I'm shocked. Do we have time for you to list them [laughter]?

RACHEL NUZUM: Your top three.

STUART BUTLER: Well let me put it, I'll say one thing generally; and it's not really actually, in a sense, an answer but it is in another way. I think that a general issue is that in order to get the goals that we need to get, there's got to be big changes in the health system. I'm somebody, for example, that thinks that over time, you have to see employer-based coverage essentially, if not disappearing in this country, certainly going down and that people should be getting their coverage through an exchange system predominantly properly designed, et cetera, et cetera, et cetera.

There are other things. We've got to transfer funding in some way. People who got very generous subsidies today, to

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get back to the tax item, there are people who have thousands and thousands of subsidies, people like Bill Gates, for example. I don't think he really needs it. There are people who don't. We've got to bring about big change.

One of the general problems with these pieces of legislation is there's an attempt to sort of hide what you're really doing. The more you do that, the more you come up with these incredibly sort of jerry-rigged processes like Cadillac taxes that don't work the way you want. You're trying to sort of get savings whilst disguising what impact they're going to have.

I think that's what sort of gets you into this sort of constant briar patch that we have in health care where people are really just pushing back and upset about it. So that's a way of answering, a multiple and they have a generic component, which is not really doing in an overt way what needs to be done and doing it in a covert way and thereby having all these perverse impacts and inequities that we've just been discussing.

RACHEL NUZUM: Sure. My colleagues are waving this around. This was on the table out there. I mentioned the Commonwealth Fund's Commission on a High Performance Health System. As I said before when we started, I think there are pieces in the House bill and the Senate bill that go a long way

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towards starting us down the road of high performance and we clearly see universal coverage as the cornerstone to moving in that direction.

There are certainly areas such as stronger payment policies and redesigning the way we pay, we think, could go a lot further moving to a more integrated delivery system, we think could help get us there. We clearly see payment changes as a way to drive the integration of that care. There's a lot of, like I said, a lot of things that go a long way.

There's some things that we think are a good start and then stop just short of what we really need to actually to save significant dollars. It's not a coincidence, as Stuart mentioned, that things that save money are the things that are most difficult to do. So we put out a report in February called The Path to High Performance that if only everybody would pick up that report and put it into law, you could save \$3 trillion over the course of time.

The problem though is that they're the very things that make everybody kind of cringe and wince when we're out talking to constituents. It's that tension of the politically difficult things are the ones that are most likely to save real dollars because you are talking about redistributing what we spend; although I think we could all agree that we're not getting all the value we could out of the health care system.

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Right now, it is one of the pieces of our economy that continues to grow. In a lot of areas of the country, it's the only part of the economy that's really flourishing. So it's a difficult discussion to talk about redistributing resources especially in a time of economic uncertainty but stronger payment provisions, as a driver, to reorganize the health care system, I think is a piece that we'd like to see and consider this just a down payment.

ED HOWARD: DeAnn, do you have some final words?

DEANN FRIEDHOM: Our question would be: are there enough changes in the competitive market place to change the way that insurance companies act so that they would start on their own beginning to make some of these kinds of changes. None of these delivery system, payment system, accountable care-type suggestions that are in the law under the context of Medicare trying to test them out to see what works and doesn't, all of those things could be being done right now if the insurance industry had any reason to, the assumption is that in those small measures because they're not in a truly competitive market place, I don't know if that's right or not.

I'm not qualified to but we had industry, we had the health care industry go to the White House in May or June and say that they could save \$2 trillion over 10 years. You don't see that in this legislation anywhere. There's a hope and a

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prayer that enough of this will incentivize them to do it but it does raise that question, which is does the legislation do enough to create the incentives or requirements or rewards to the various providers in the system to do some of the things that they could be doing and not wait for Medicare to prove out in five years.

ED HOWARD: Okay. Well a very thoughtful comment at the end of a very thoughtful discussion. That was not only thoughtful but also very detailed and precise at certain points. I think we understand maybe the reason for 1,800 of those 2,000 pages anyway [laughter] as we try to encapsulate some of these details.

I want to take this chance to thank our friends at The Commonwealth Fund not just for helping us put this together but obviously making big contributions to the quality of the conversation itself. Thank you for sticking through some pretty tough stuff to slog through for us non-economists and ask you to join me in thanking our panel for a very, very good discussion [applause].

[END RECORDING]

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