A Summary of Research, Dialogue and Discussion Surrounding Health Insurance, October 2013

"The Big Bang for the Affordable Care Act: The End of Health Care Financing as We Know It?", presented by Networks Financial Institute at Indiana State University on October 18, convened employers, politicians, academia and policy makers for discussion on how the historic legislation is impacting health care insurers, service providers, employers and American health care consumers.

Indiana State University College of Business Dean Brien Smith welcomed participants and noted the role Networks Financial Institute (NFI) has played over the past decade in advancing research and dialogue concerning the U.S. insurance sector and its regulatory environment. "More than $32 million in funding has helped NFI engage thought leaders to examine and conduct regional and national insurance industry research over the past 10 years," Smith said.

Previewing the day's agenda, Dr. John Tatom, research scholar at Indiana State University, referred to the "big bang" noted in the forum's title. "The individual mandate requiring insurance is the biggest bang of the Patient Protection and Affordable Care Act, the ACA, with the employer mandate postponed for a year, but there are many others as well," Tatom noted. Citing a few examples of "lesser bangs" he referenced the end of exemptions for many medical programs that will affect low-wage employees, forcing recipients of tax credits for small businesses to join new small business exchanges, and the implementation of insurance exchanges to serve the individual marketplace. Looking further down the road, the implementation of higher penalties for violating the mandate, the 2018 implementation of a tax on so-called "Cadillac Plans" will also have repercussions in the marketplace.

"There are more changes coming that will impact the industry in the future, but now is the big bang," Tatom noted. Given the scope and breadth of the Act as well as the timeline for rolling it out over years, Tatom observed that the insurance sector and the public will need to keep an eye on the primary goals

of the ACA: ensuring *access* to health care insurance and ensuring *affordability*. "The Act will be evaluated in terms of whether it was successful at meeting these two goals," Tatom said.

Following are remarks from the forum's research presenters, keynote speaker and panelists.

David Kendall, Senior Fellow for Health and Fiscal Policy at Third Way. ObamaCare: Rocky Politics, Stable Coverage

Kendall began his remarks by noting that public misunderstanding coupled with mystery about what the ACA entails have kept people from focusing on what is ultimately desired—a stable health care system. Most Americans already have health care insurance through employer-based coverage or Medicare. The ACA will be most impactful for individuals, particularly those who were afflicted with pre-existing conditions prior to enactment of the ACA. The ACA is also impacting the health care marketplace when it comes to choice. Americans have traditionally had little choice when it comes to their health care coverage and simply accepted the programs offered by their employers. The challenge for insurers will become how to implement and comply with the ACA without upsetting the stability of the overall market.

The task may not be as unprecedented as it seems. "We've actually already climbed this mountain with Medicare Part D, enacted by Republicans in 2003," said Kendall. Although plagued by a lack of initial acceptance and low approval ratings, Part D has become a widely accepted program that has expanded drug coverage from 75 percent of seniors to 90 percent. Moreover, Medicare Part D now enjoys a satisfaction rating above 90 percent among those covered. Like the ACA, Medicare Part D suffered some difficulties upon implementation including technical difficulties, problems with call centers and payment delays.

The structural similarities between the ACA and Part D are significant, according to Kendall. "The ACA and Part D are like twins separated at birth, sharing the same DNA," Said Kendall in describing the similarities. He noted six "shared DNA" features of the ACA and Medicare:

> Shared DNA #1: Both ACA and Medicare Part D offer individual plan choice.
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> Shared DNA #2: Both the ACA and Medicare Part D provide guaranteed issue that requires all individuals to be accepted, removing concerns about pre-existing conditions via a "community rating" component.

Shared DNA#3: Both programs make risk-adjusted payments to healthcare plans and avoid penalizing companies that take on higher-risk individuals.

Shared DNA#4: Medicare Part D offers 75 percent subsidies while the ACA assigns subsidies based on a sliding scale that averages 50 to 60 percent.

Shared DNA#5: Both programs impose penalties for not having coverage.

Shared DNA#6: Both have been described as "entitlement financing" and caused dissent in the marketplace, most recently the Oct. 1-16 federal government shutdown fostered by Republican opposition to the ACA.

Shared DNA with Medicare Part D, however, does not assure stability for the ACA. Kendall reviewed specific threats to the Act's stability, including narrow, sliding-scale subsidies for those purchasing insurance through the exchanges, and less comprehensive mandated benefits for specific health conditions relative to the broad conditions covered under Medicare Part D. However, neither of these threats may be construed as fatal flaws in the ACA.

According to Kendall, the underlying problem threatening the ACA's stability is rising health care costs. As prices for health care continue to increase, the ability to finance health care will be undermined. By making soaring health care costs the common enemy and focusing on cost-restraint, Kendall stated that Democrats can avoid cutting benefits while Republicans can avoid raising taxes to generate additional revenue. Some of the opportunities for bi-partisan solution seeking he identified include:

- Doc Fix. Legislation is currently under review that would revoke the "tradition" of annual government pay cuts to the "fee for service" compensation model, replacing it with a "fee for value" compensation structure.
- Sequestration Replacement. Kendall remarked that as much as 30 percent of health care costs are wasted. In lieu of arbitrary, discretionary cuts to payments, a more targeted strategy of identifying and eliminating waste would be more productive.
- State Gain Sharing. This strategy would reward states with a percentage of cost-savings resulting from a more modernized approach (electronic records, etc.) to health care. The gains of cost-saving strategies currently benefit the federal government and a system of gain sharing would enable states to participate in the costs savings and be rewarded for their efforts and leadership in cutting costs.

- Tax reform. Tax exclusions for employer-based coverage are inefficient. By imposing a more equitable cost threshold on the value of health plans provided, employers would be incentivized to consider lower-cost options and would also encourage providers to keep an eye on restraining benefit costs.

Kendall summarized his remarks on a hopeful note. “Even though we’re at a moment of great angst, we can still create stability in the market,” he said.

Dr. Scott Gottlieb, practicing physician and Resident Fellow at the American Enterprise Institute: **How Obamacare Will Re-Shape the Practice of Medicine – Efforts to Transform Outpatient Medicine Will Put the Entire Health Care System at Risk**

Dr. Gottlieb's presentation emphasized that the ACA is shifting medical risk from insurers to providers, primarily through various forms of capitation. In the future, large employers, government and insurance providers will assume risk under the ACA, but a shift in risk will transfer it to providers. To facilitate this shift in risk, Obamacare is exerting a continuing effort to get physicians to consolidate their practices into integrated delivery systems. These systems are often aligned with a hospital that serves as the central hub.

According to Gottlieb, the genesis for Obamacare may well have come from a 2009 article published in *The New Yorker* by Harvard surgeon Atul Gawande, that highlighted regional disparities between cost of care and health outcomes. Based on data from the Dartmouth Atlas Project, the article served as the Obama administration’s intellectual foundation guiding many parts of the ACA.

The shift in risk from insurers to providers echoes 1990 capitation models which proved largely unsuccessful. By calling for the formation of Accountable Care Organizations (ACOs), the ACA creates large groups of providers who are allotted funds to care for their specified populations. The ACA bundles payment dollars into a lump amount including outpatient and inpatient care, with an expressed goal of achieving efficiency through consolidated care. Dr. Gottlieb noted that a central ACA goal is to end the practice of fee-for-service medicine. Under this model, the physician will determine what services, procedures or drugs are utilized and the patient may never know what options were denied him because the doctor made the decision.

The shift in risk is driving consolidation and a trend away from out-patient procedures and billing. Dr. Gottlieb pointed to the trend of specialty and primary physician practices being absorbed by hospitals

and a corresponding trend toward more procedures being performed in a hospital setting as opposed to an outpatient office.

The model that the ACA is based on is not new. Similar structures for consolidating care through hospital-based groups that acquired physician networks proved unsuccessful in the 1990s. Dr. Gottlieb noted that when the delivery systems of the 1990s failed, physicians were able to revert back to the former models, but that the enactment of the ACA will prohibit a return to previous patient service models.

Summarizing problems with the ACA, Dr. Gottlieb pointed to five central concerns:

1. Consolidating providers results in falling productivity. Many experts have predicted a decline of 25 to 30 percent in productivity as the ACA is implemented. The challenge for providers will be to make the system more efficient without reducing productivity.
2. A "magical" mindset in Washington, D.C. believes that consolidation will lead to better coordination of care through electronic records and other technologies. This view is somewhat myopic as hospitals have not historically proved skilled at integrating technology to deliver better care. Instead, transformative innovations have historically arisen from the entrepreneurial markets, driven by the investments of venture capitalists. In contrast, hospitals have traditionally not pioneered innovations, but have been adopters of technology. When looking at the venture capital markets, there have been almost no investments made in hospital-backed systems.
3. While some critics say that a fee-for-service payment structure caused doctors to over-utilize some treatments, the payment model incentivized doctors to stay on the cutting edge of treatments and therapies. Without the role of entrepreneurs, it is unlikely that hospitals will lead a wave of innovation.
4. Continuity of care will suffer. Studies have found that coordination between inpatient and outpatient care does not improve in an ACO environment. Simply accessing electronic health records is no substitute for the communication that occurs over time between a patient and her provider.
5. Prices will increase. Dr. Gottlieb referenced research conducted by Ezekiel Emanuel and Robert Kocher that argues that consolidated care effectively creates monopolies, driving up market prices. Under the structure of an ACO, a hospital can capture arbitrage between inpatient and outpatient billing systems.

Unlike the experiments of the 1990s with consolidated health care delivery models, the ACA will be very hard to unwind after the fact. The structures required to "go back" will no longer exist. The ACA takes away the very tools (i.e. underwriting) that insurers traditionally employed to manage costs, with the exception of managing the network. Under the ACA insurers will manage the networks very tightly and be extremely selective with the areas they cover and the providers with whom they collaborate to provide services. As a result, consumers will see a significant narrowing of network choice.

Panel Discussion: Health Care Financing Intermediaries: Indiana State University Associate Professor, Insurance and Risk Management, John Liu moderated a panel of industry experts. Following are excerpts and observations from each panelist's comments:

John Boss, Executive Vice President, Employee Benefits Consulting Group, AON Risk Solutions

Addressing the forum, Boss noted that over the past 25 years, employers have been inundated with new benefit laws including COBRA, HIPPA and Medicare Part D, among many others. As such, the ACA and its corresponding requirements did not come out of a legal or regulatory vacuum. Several changes to health insurance coverage have been leading up to the opening of the exchanges and the 2014 ACA enactment date.

Addressing reaction to some changes preceding implementation of the ACA, Boss noted the general public seems to like the removal of lifetime maximums on benefits provided. Other components that have been well received by the public include the provision that children cannot be denied coverage due to health conditions, higher drug discounts, coverage for children on parental policies until they reach age 26, and the elimination of out-of-pocket fees for preventative care. Yet each of these "benefits" has added to employer costs.

Looking at the ACA in 2013, employers must inform employees of their option to secure coverage in the exchange. Additionally, health care flexible spending account programs have been limited to $2,500 and deductions for expenses for retiree drug subsidies have been eliminated. A Medicare tax has been applied to high income individuals.

As 2014 approaches, the market will offer new choices for consumers, but most will fall into one of four categories:

1. About 155 million Americans are currently covered through job-based or governmental insurance. This equates to about 50 percent of the population and for many, retaining the existing coverage will be their best option.
2. For uninsured individuals and many small businesses, the federal and state insurance exchanges may enroll about seven million Americans.
3. State expansion of Medicaid may add another 12 to 15 million consumers, including 400,000 Hoosiers.
4. Some uninsured individuals will opt out of the exchanges and choose to pay a penalty, viewing the tax as less expensive than a monthly premium.

Boss cited several concerns employers have expressed regarding the ACA and how it may impact their organization. Many concerns focus on financial factors. Cost increases between three and six percent will continue. Small employers with fewer than 50 employees are likely to see costs increase between 40 and 110 percent, with the costs directly attributable to rising underwriting costs. Employers dislike the ACAs requirement that they pay a fee of $63 per covered person over a three-year period to subsidize the exchanges. Employer costs for this component of the ACA are projected to reach $25B over the next three years. All in all, employers will see $125B in cost increases over the next seven years, according to Boss.

In addition to rising costs, Boss noted that employers are concerned that the ACA was not based on facts and did not address real problems. He questioned the mandate and its implied stance that 55 million people desire health coverage but cannot access it. Boss also said that the widespread belief that individuals could not secure health insurance if they experienced a health setback was made mute by the enactment of HIPPA which allowed for continuity of coverage. He was skeptical of ACA assertions that preventative care benefits included in the ACA will reduce health care costs by $2,500 per person. The Congressional Budget Office has indicated the ACA will not be a panacea for “universal coverage”, estimating that 30 million Americans will still be uninsured in 2023. An aging Baby Boomer population will result in 37 more Americans being enrolled in government programs by 2023.

The emergence of ACOs may help reduce costs and stabilize the upward trend in costs, although the next three years will be critical and initial economic data is not encouraging. “This law will accelerate drastic changes to the health care delivery system,” Boss said. Of particular concern are the employment consequences that may arise from enactment of the ACA. Boss pointed to recent Indiana hospital systems that made significant job cuts in 2013. While part-time positions may increase, household

income is not likely to follow. Consumers have expressed little faith that the federal government can manage a sector that represents one-sixth of the entire economy; a belief underscored by the status of the federal government as fiscally "broke".

Despite many challenges, Boss said he is optimistic that employers will adjust and even overcome another law, but it will require more engagement between employers and employees to make employees more responsible health care consumers. Such engagement should focus on health improvement and pursue use of non-traditional health care providers. Consumers must demand more transparency. Network providers must deliver high quality performance and be compensated on quality, not on the value of the service provided. Finally, he noted there is a need to move away from a defined benefit toward a defined contribution as the ACA transforms health care.

Dan Grelecki, Director, Patient Protection and Affordable Care Act, Old National Insurance

The individual mandate of $95 or one percent of income per person not covered by health insurance is difficult to properly calculate. For example, children count as a half-fee and individuals who receive a tax refund on their 2014 tax return in 2015 will have the fee directly deducted from their return. As such, they may never realize the fee for failing to secure coverage was incurred.

The mandate that all individuals share in the cost of coverage will naturally present "rate shock" to the young and healthy that may elect to pay the fee rather than face the premium. As the penalty for not securing coverage increases to 2.5 percent or $695 per person in 2016, there may be some shift in participation behavior.

Employer experiments with the community rating model have yielded mixed results. According to Grelecki, the best reduction in costs was 42 percent; however, the worst increase in group costs represented a 414 percent increase. "Employers will look for a way out of the community rating model," Grelecki noted.

Within the individual market, the community-rating model may result in an average cost increase of 67 percent, although it will be much smaller for large groups, who can expect an increase of about eight percent.

The expansion of Medicaid into the states has created a major donut hole. The program is now available to adults who earn 50 percent of the federal poverty level. However, federal policy thresholds for

Medicaid participation stand at 100 percent. Grelecki noted that many Hoosiers do not earn enough to qualify for the state funding.

The mandate requiring employers to provide coverage – particularly the details in the mandate regarding size of workforce, full-versus-part-time and seasonality considerations – are an administrative nightmare for employers. A penalty of $2,000 per full-time employee (minus the first 30) for failing to offer health insurance could be devastating to a small business that miscalculated hours incurred by its workforce. Industries such as hospitality which raise and lower their workforces based on seasonality could be particularly hard hit. Some aspects of the ACA are particularly challenging for employers of low-to-moderate wage workers. For example, employers must offer insurance that is deemed affordable — defined as no more than 9.5 percent of household income. Yet employers usually do not know an employee's household income, nor are they permitted to ask.

Finally, Grelecki noted that the exchanges are not proving easy or productive in the early days of their existence. For example, Anthem had sold a miniscule number of policies between October 1 and the October 18 forum. Exchanges and the consumers they are intended to serve are struggling with the practical and technology issues more than the theoretical aspects of the exchanges.

Wes Mantooth, Principal and Employee Benefits Practice Leader, Gibson Insurance

As noted earlier, a key goal of the ACA is to increase access and affordability for small employers; those with fewer than 50 employees. Yet providing this access does not come without challenges. A key concern is the narrow networks that are available as mass consolidation continues. In order to maintain their margins, hospital systems have cut back on their employment numbers. Moving forward, we will see these forces creating an environment where the narrowing of networks results in health care costs that exceed discounts.

The changes afoot appear to be contributing to a decline in the physician pool. For example, a database search indicates 1,500 open physician positions in Indiana. This decline may result in delayed access to care. As such, the ACA is prompting more interest in community-based clinics. For employers, the establishment of such clinics is a way to secure health care for their employees.

The community rating is wreaking havoc on employers and creating intense compression as healthy and unhealthy, old and young, employees are pooled together. Additionally, employer rates are ever changing as employees enter and leave the workforce, and age during their career. Rates will

automatically be changing each year. There is also concern that employers will demonstrate a preference toward hiring younger workers, thus penalizing older job seekers.

Finally, an increasing shift toward government-based care is occurring. In 2014, 66 percent of the American population will be eligible for Medicaid or other government subsidies. Adding Medicare recipients into the analysis raises the total percentage of Americans receiving some type of government subsidy to 75 percent.

Summarizing the panel, Boss concluded, "For employers, it (the ACA) is a mess. It will add time, cost, energy and complexity."

Keynote Speaker, Jonathan Gruber, Professor of Economics, Massachusetts Institute of Technology

Jonathan Gruber is recognized as the architect behind Massachusetts' landmark reforms, and a key adviser to the Obama administration during creation of the Affordable Care Act. Before delving into his remarks, Dr. Gruber noted, "The law is misunderstood," and advised that it is legislation that has been in progress for nearly a century. "How we got here has been a nearly hundred-year process with roots in the Teddy Roosevelt administration," he said.

Misunderstanding surrounding the law typically falls into two camps. One group views the law as politically unrealistic as previous initiatives have built on an imperfect system that served most Americans well enough. Secondly, the health care industry represents a daunting $850B industry.

Yet widespread public complacency with the pre-ACA model cannot continue according to Gruber. He noted that the system does not work for uninsured Americans outside of employer or government-based insurance, nor does it work for individuals with pre-existing conditions.

Gruber worked closely with Mitch Romney when he served as Governor of Massachusetts to develop landmark legislation for universal health care coverage in the state. The program served as the model for the ACA. "Obamacare is Romneycare," Gruber said.

The health care coverage developed under the Romney administration is referred to by Gruber as incremental universalism. He used the metaphor of a three-legged stool to describe the model. The first leg of the stool is focused on insurance market reform, using a community rating model to avoid discriminating against the sick. The second-leg of the stool focuses on the individual mandate, with an assumption that the system will work only when all participants are required to play. The third leg of the

stool involves individual subsidies, defined in Massachusetts as three times the poverty line, and achieved through expanded Medicaid and tax credits to offset the cost.

Enacted in 2006, Gruber said the "Romneycare" model has worked well based on increased health care coverage for the population and a drop in premium costs of 50 percent.

Gruber upheld the universal coverage from a moral perspective. "Fundamentally, the U.S. is the only nation in the developed world that has allowed sick people to go bankrupt," he said. According to the Congressional Budget Office (CBO), 33 million Americans will get coverage as a result of the ACA.

From a budgeting perspective, how did Massachusetts pay for the program? Gruber credits a combination of spending reductions and tax increases for contributing to a $1B decline in health care costs over the program's first decade.

Spending was slashed as overpayments for Medicare were cut and a revised reimbursement program for hospitals was instituted. An increase in excise taxes on sectors that benefitted, such as medical device manufacturers, helped generate revenue. Gruber compared business opposition to the ACA tax on medical device companies to, "a gift of a $100 bill with the request that $5 be returned." The ACA would also enact a tax increase on American households earning more than $250K annually. "All-together, the ACA is deficit reducing," Gruber said.

Despite being a society that considers itself somewhat charitable, Gruber noted it's a "dirty secret" that American's don't care about the uninsured. Much of the complacency may have resulted from a system that has worked remarkably well for decades, particularly with regards to scientific innovation. The scientific advances have not come without cost. From 1950 to today, American spending on health care has quadrupled. Beyond technological and scientific innovation, the other key factor driving health care costs upward is waste, which Gruber identified as one-third of total health care spending.

Finally, runaway politics and rhetoric have also caused the ACA to be misunderstood. Discussions surrounding end of life patient-doctor conversations quickly morphed into media stories about "death panels." A 2009 Preventative Services Task Force recommendation that women in their 40's no longer have regular mammograms resulted in ACA language being added that specifies, "preventive services recommended before 2009."

How can the ACA's costs be managed? Gruber suggested five cost-cutting strategies:

1.) Impose a Cadillac tax on luxury health care plans. This will alleviate the unfair tax advantage enjoyed by individuals who receive "luxury" health plans, but are not taxed on the plan. It also would discourage individuals from having high-cost, but unnecessary services performed.
2.) Let the exchanges create a competitive marketplace, based on their success in Massachusetts. "It's worth noting that in the U.S. we have never passed a law this big and run the experiment first," said Gruber, referring to Massachusetts as such an "experiment" for the ACA.
3.) An Independent Payment Advisory Board (IPAB) can provide an independent body to make decisions about service fees and provider compensation. This would take subjectivity out of the system and create a body where decisions are made in an objective manner by a collective body; similar to a military base closing.
4.) Consider comparative effectiveness. By encouraging the system to evaluate comparable care and associated pricing, the cost of health care can be reduced by the economics of a free market.
5.) Reimbursing health care through ACOs. While the ACOs are not problem-free, they provide a better alternative to other models. "The problem with health care is that there is too much pretended certainty," said Gruber. "To do nothing is to take a step backward."

Moving the health care model forward will require an attitude of humility and patience. Gruber was quick to point out that neither attribute is enjoyed in abundance by politicians. He concluded with some thoughts on how the American health system can move forward.

As the ACA has overcome numerous hurdles, it is now time to become serious about implementation. During this phasing-in time, there is an opportunity for states to leverage their power and participate in federal government reimbursement models. Gruber noted the states are positioned to operate the exchanges more efficiently than the federal government, although it will take time for states to ramp up. Gruber also echoed David Kendall's remarks, comparing the popularity and widespread acceptance that Medicare Part D enjoys with what the ACA may expect in the future.

Finally, Gruber made the case that while imperfect, the ACA will leave 80 percent of American's better off than without the Act, while 17 percent of Americans will be unaffected and three percent will be less well off as a result of the ACA. Noting that 97 percent of companies with more than 50 employees already offer health care insurance, he said the law will specifically benefit those who do not currently have access to health care coverage.

Panel Discussion: Healthcare Financing Providers

An afternoon panel brought together Indiana employers to discuss how the ACA is impacting their business as well as how they are preparing for the ACA's implementation. The panel, moderated by Indiana State University Associate Professor John Liu, brought together panelists Jim Mills, vice president of human resources at Fairfield Manufacturing; Theresa Jasper, vice president of human resources at Hulman & Company and the Indianapolis Motor Speedway; and Seema Verma, president of SCV Consulting. Following are summary observations excerpted from each panelist's remarks.

Jim Mills, vice president of human resources, Fairfield Manufacturing

The ACA is steeped in uncertainty. The floating regulation has created a constant flow of changes. It is not certain what the delayed employer mandate means. Nor do employers understand related tax changes that may be required. The Act is particularly hard for a union-based organization that typically negotiates benefits over several years. The bottom line is the ACA is a huge failure and we're really disappointed in Washington.

The ACA will drive costs up faster than participation, and it is unsure how consolidation trends will impact access to physicians. There is a concern that family doctors will stop practicing and whether this situation might trigger the "utilization bomb". Employers also have to be aware of taxes that will support the expenses of providing health care. Beyond a three-to-four percent increase, there are additional non-outlier costs, and the uncertainty about what spouse/dependent provisions may mean in terms of cost.

Provider disruption is another consequence the ACA will impose. Networks are exceedingly narrow, limiting provider access. The narrow networks will force employers to develop self-provider status such as on-site clinics for the delivery of health care.

The ACA is certainly impacting staffing, even for organizations outside of health care. For example, organizations such as schools are starting to reconsider how they classify staff. The ACA is increasing the costs for employers to cover spouses and dependents while presenting numerous benefit redesigns. A new question arising is whether the exchanges will count as available coverage for spouses and dependents. The costs and uncertainties of the ACA could pose an employee relations nightmare.

Theresa Jasper, vice president of human resources, Hulman & Company and the Indianapolis Motor Speedway

As an organization that maintains several employee classifications including permanent, full-time; permanent, part-time; seasonal, part-time; and seasonal full-time; Hulman & Company had to be particular cognizant of ensuring compliance with ACA language regarding an employee's status. The company focused on three key objectives:

1.) Measurement and stability with regards to the period of time in which an employee's time is measured and the classification of his or her position (seasonal vs. full-time). As an employee's work hours may fluctuate dramatically based on special events, weather, etc., the company elected to evaluate hours worked based on a 12-month schedule.
2.) Strategy to ensure current enrollment based on classification.
3.) Continuing education and communication with employees. The opening of the exchanges requires employers to make employees aware of the exchange option. This task in particular has demanded significant time and attention.

The company's HR team developed thorough documentations to assign due dates, identify tasks and assign performance responsibilities. In some cases, employees' jobs were reclassified with an eye on ensuring compliance.

Seema Verma, president, SCV Consulting

Looking at the post-ACA environment, what is next for states? As the exchanges opened, the majority of states elected to implement the federal exchange option. The early troubles plaguing implementation have not come as a surprise to employers, especially considering that the political environment (2012 elections) created uncertainty and delayed distribution of information until following the election.

Efficiency has been an issue for the exchanges. For example, consumers frustrated with the web site may elect to dial a phone number to access a state exchange. Yet in some states, the application may be 30 pages long, requiring significant time for completion. At the federal exchange level, the Spanish language option was delayed until October 21. A central problem in evaluating the exchanges has been the inability to test prior to "going live". Additionally, little testing has been conducted for exception situations.

Looking at possible users of the exchange market in Indiana, there are potentially a half-million Hoosiers who might use the exchange to purchase their health care. Again, the networks offered are quite

narrow. Among the four carriers offered by Indiana exchanges, there are 241 plans. The narrow networks present concerns about adequate capacity to meet demand and potentially longer wait times.

Capacity is also a concern for the exchanges. There has been some concern that Indiana residents may not be able to get their insurance set up through the exchanges by January 2014. The exchanges face an uncertain timeline and their structures may morph over time. For example, some states have discussed partnerships to create shared exchanges.

Cost is a further concern, as the market tries to determine if states may be able to run exchanges more cost-effectively than the federal option. However, given the complexity of the Act, it is unlikely that states will rush in to the business of setting up exchanges.

Looking at the effect of the ACA on premium rates, health care will probably cost more in 2014 for individuals in good health and younger individuals. The community rating component is likely to provide cost savings to individuals in poor health.

The tax credit on insurance premiums is another factor to consider. Individuals insured through the exchanges will have a 90-day grace period before they can be dropped for failing to make a payment. All claims will be paid in the first 30 days, with payments suspended between 31 and 90 days if payment is not received. Inevitably, there will be some individuals who drop out of the exchange system.

Looking at Medicaid expansion into states, 23 states are participating in the program while 27 states have opted "no" or remain undecided. States are concerned about the long-term sustainability of Medicaid, the inflexibility of requirements, and their ability to assure provider access to new enrollees. In Indiana, the state will need to figure out how to pay for Medicaid – an amount of $2B over 10 years. Given that states have proposed 1,115 demonstration waivers to expand Medicaid, the question of how to create an effective and workable system remains.

Summarizing input from the panelists, Jim Mills stated, "In summary, the ACA is a big unknown with lots of question marks."

Copies of papers presented at the conference along with presenter PowerPoint presentations are available at http://www.isunetworks.org/events/aca2013 or http://indstate.edu/business/nfi/events/aca2013.