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Making Sense of Healthcare Exchanges, and Their Future (with transcript)

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Case in Point: ***Making sense of healthcare exchanges, and their future***
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Tom Baker and Joel Ario look at what's working and what needs to be fixed in healthcare, what may change in the future, and what it means for you.

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Claire Wallace: Welcome to Case in Point, produced by the University of Pennsylvania Law School. I am your host, Claire Wallace. In this episode, we will be examining a key facet of the Affordable Care Act: America's healthcare exchanges. We will be looking at what is working, what needs to be fixed, what may change in the future, and what it means for you. This is, perhaps, a surprisingly complex topic, one not made any easier by the strong feelings of partisanship it stirs in some on both sides of the debate. So, we are going to have with us two experts who can offer some crucial insights into this subject.

First, we have tom Baker, Professor of Law and Health Sciences here at Penn Law, and author of the recent book, "Ensuring Corporate Misconduct: How Liability Insurance Undermines Shareholder Litigation".

And joining us from New York is Joel Ario, Managing Director of Manatt Health Solutions. Prior to his current role, Joel served as Director of the Office of Health Insurance Exchanges at the U.S. Department of Health and Human Services. He has also served as Insurance Commissioner for the States of Pennsylvania and Oregon.

Thanks to you both for joining us. Tom, can you tell us what an exchange is and what its purpose is?

Tom Baker: Sure. A health insurance exchange is really just a marketplace. People think about as a website, like healthcare-dot-gov, but it can be a place you call on the phone, it can be a place that your broker signs you up. It's really just an organized marketplace for buying insurance. And what's important about it is that it helps us solve a bunch of economic problems that made the private insurance market for individuals not function very well before we had health insurance exchanges.

Claire Wallace: Joel, if you could talk about the creation and structure of the exchanges and the difference between the state healthcare exchanges and healthcare-dot-gov.

Joel Ario: Well, the starting point is that each state had the first option to create an exchange. Sixteen states went ahead and did that, plus D.C. If the state chose not to, which is what happened in the 34 other cases, then the law required the federal government to step in and create the exchange instead. So, we have 34 states today that are healthcare-dot-gov, which is the federal website, and 16 states there the state runs the website. And Tom is right that it doesn't have to be on a website, but websites certainly make it much easier to provide the information to consumers to help them sort through the information and get to what most consumers are looking for, which is the best match for their healthcare needs.

Claire Wallace: Can you tell us why the 34 states didn't sign up?

Joel Ario: When I got to HHS back in 2010, all 50 states had taken planning grants, and at that time it looked like we would have good take up among the states. The 2010 election went to

Republican opponents of the Healthcare Law, and it's basically gotten more and more polarized since. I am just surprised at this, but since 2010, the steady direction of this has been in the direction of more polarization between the two parties, and so that has made it very difficult to make much progress in the states that are led by Republican governors or Republican legislatures. And we still have that with us today. Otherwise, I think we would have, but for that polarization, ended up with most states setting up their own state-based exchanges.

Tom Baker: From my perspective, one of the ironies of this is, of course, that the state running its own exchange means the state is being autonomous and exercising its sovereignty. And so it is ironic to me that states that have traditionally been very interested in maintaining their sovereignty have been the states that have, in fact, turned over the exchange to the federal government.

Claire Wallace: What are the options, Tom, for uninsured people? Particularly low-income individuals and families?

Tom Baker: Sure, well, the exchange fits into a graduated health insurance system where people whose income are below a certain amount, it's supposed to be a hundred and thirty percent of poverty, were to be eligible for Medicaid. And that was the Medicaid expansion part of the Affordable Care Act. And then people whose income were higher than that, up to four hundred percent of the poverty level, were eligible to have subsidies in the form of tax credits available to them through the exchange.

Since a variety of the states chose not to expand Medicaid, that was the upshot of the first Affordable Care Act Supreme Court case, the Sebelius case, that means that in some states there is actually a gap for the very poorest people who are not eligible for Medicaid because of some category, such as being a mother or a child or a disabled or a senior citizen.

Joel Ario: And then if you look at in big picture terms what's happened since the Affordable Care Act passed, we have had a huge dent in the uninsured rate in the country. About a third of those who were previously uninsured are not insured. That's about thirteen million more people

insured. And then if you look at kind of how the populations divide, there are about thirteen million new people on the Medicaid program. There are about – well, as of the close of open enrollment, there were eleven million people in the public exchanges that had signed up for insurance that way. Eighty percent of them had gotten subsidies to sign up. And there were another eight million people who signed up for better healthcare, and healthcare that matched the minimum standards of this law, outside the exchanges. So, a total of thirty million people now have better healthcare and of that thirty, almost half of them were previously uninsured.

Claire Wallace: Just to step back, if you could talk more about the differences between the state and federal healthcare exchanges, and why someone would choose one over the other.

Tom Baker: Well, it depends on what the state has elected. If, in the State of Pennsylvania, for instance, there is a federal exchange. And so, someone who lives in Pennsylvania, if they want to buy insurance on an exchange, has to do it through the federal exchange. Similarly, in New York, which chose a state exchange, there is not federal exchange in New York. So, each state made a choice to do an exchange themselves or to have the federal government do it. And the exchanges should be very similar. There is a variety of policy choices that individual states can make, and we have been tracking that here with our Health Insurance Exchange Research Group. And so, there are differences. But the overall structure is the same between a state and a federal exchange.

One difference might be, for example, the state exchanges, some of them have chosen to be more actively involved in selecting the plans that will be offered on the exchanges. Whereas the federal exchange has taken a little more of a take all comers approach. And so that is an example of a difference between a state and a federal exchange. But it is not due to the fact that it is a state exchange or a federal exchange, it's just that the particular state made that policy choice.

Joel Ario: For the average consumer, though, they shouldn't be able to know the difference. They go on a website; they will look basically the same whether it's a state or federal website. And if you look at the results so far, it is hard to distinguish the federal from the state exchanges. California was the leading state in the first year with about one-point-two million people signed

up. This year, Florida and Texas had the most sign ups – though Florida and Texas are federal exchange states. So, the federal government is doing a pretty good job at this. The states that are doing it are doing a pretty good job. Overall, eleven million people have signed up.

Claire Wallace: And what are the main differences between the private and public exchanges?

Tom Baker: Well, so we have been talking so far about the public exchanges. The state exchange and the federal exchange are both public exchanges. Private exchanges come in really a couple different flavors. One is just simply a web broker, like eHealthInsurance, or Get Covered. These are just websites, which are places that you can sign up to buy insurance. And they are in the individual market. There are also private exchanges in the employer market, which would be a large employer might contract with a healthcare benefits firm to set up an exchange that its employees could access in order to make choices. And so those are the main kinds of private exchanges.

Joel Ario: When I had started with the agency, I would have said that the public exchanges are going to dominate in the provision of health insurance. But now, five years out, both the public and private exchanges are flourishing. The private exchanges have very adroitly benefitted from the attention on the public exchanges to offer the same kind of consumer experience. And it is really that web experience, I think, that is going to revolutionize the way people buy healthcare. I envision a future less than 10 years out when most people will simply look at their iPhones, or the current version of an iPhone, and be able to very quickly identify what plans are available to them. There will various vendor, both public and private, who will help them sort out their choices. You could probably press a button and pretty quickly get a recommendation from your – somebody on what might be the best health plan for you. It won't be much harder than a Google search. People say, it's not going to happen that way, healthcare is more complicated. But most people, frankly, do not want to explore all the details and look at even four or five different choices. They want simply to be able to go on a website and have someone, after they give some basic information, say, here is what I think would work best for you. Make a recommendation.

I, as a former insurance commissioner, had a tough time picking between two plans. I eventually asked my agent to help me sort out those two plans to find the best one for me and my family. In the future, that will be done through web technology.

Tom Baker: Yeah, and as you said on the phone, I'm thinking back, Joel, to 2010 when we first met to talk about this. And some people were talking about how people might use their phones to buy insurance. So, that seemed just odd and unlikely just five years ago. And so, you know, look where we are now. People, I think, really are buying plans on phones. And it's still not as easy and as smooth an experience as we would like it to be, but we are definitely moving in that direction.

Joel Ario: And it could be that if it works the way it looks like it's going to work, it will be the great equalizer in healthcare because if you look at consumer spending patterns, one of the first things that any household, particularly with young people, purchases is an iPhone. That comes ahead of a lot of other instruments and purchases. So, I envision a day when the poorest kid in the poorest neighborhood in town will be able to tell his mother what kind of insurance they should buy just as readily as the richest kid in the richest part of town will get – they will both get the same information over their iPhones at the same time.

Claire Wallace: What were the launches of the state public exchanges like, as a comparison?

Joel Ario: It wasn't a pretty picture in the Fall of 2013. I remember being on [unintelligible] Show and predicting a smooth roll out and about a week later, I was pulling my hair out as it just wasn't working very smoothly. In the second year, it is much more improved, it went from – 76 screens is what it took to get through the application on the federal website in the Fall of 2013. And most people couldn't get through all 76 because of technical glitches. Today, it's 16 screens and a pretty smooth experience.

So, there was certainly some very painful moments in that first enrollment. But by the end of that first enrollment, the federal government had actually achieved more than its goal of seven million. They were at eight million.

And the other thing to point out here is that as this improves, the private exchanges will work with the public exchange. EHealth, Get Insured, some of the private sites are entirely capable of giving people the same kind of consumer experience, offering them the same choices, that over time the technologies will work that you will be able to go on any of those kind of sites, in addition to the public exchange sites, to purchase your insurance and even to get your subsidies. There will be some back office connections that you will have to get to determine eligibility, but basically, public and private sites will be accessible to people.

Tom Baker: So, Joel that actually brings up something that we have been looking into is this double redirect technology. It looks like right now the private exchanges haven't been able to connect directly to the public exchanges so that they can actually sell the subsidized plans, which are, of course, the plans that people want to buy on the exchanges.

Joel Ario: Yes, there have been problems. EHealth came, actually was the initial one that came to us back in 2010 and said we've been doing this for 20 years. If you can provide a connection point to us, people can come on our site and then we can connect to you to get the eligibility determination and then people can be transferred back to us. It could all be a very smooth process.

As the technologies go, it hasn't been. It's what you referred to as a double redirect. Two back and forth maneuvers. A lot of people getting lost. But if you look at some of the sites today, some of the private sites, it's a pretty smooth experience. In fact, it is smooth enough that some of the web brokers who have signed up for the connection point have called me and said we think so-and-so has got a special deal with the federal government because they have a better access than we do. And I have called those people up and said are you guys in some sort of pilot? No, we have just figured out how to work with some pretty cumbersome technology better than our competitors.

So, this is all improving. The federal government still has to make it easier. Some of the state exchanges see the private exchanges as competition rather than as another way to broaden the

number of entry points for consumers. All of that, I think, will have to work itself out over the next few years. But I will predict a future in which there will be multiple ways to access health insurance, even for people who are subsidy eligible.

Tom Baker: Yeah, and one of the things that we are looking at are the different ways that the exchanges are financed. And that can affect that view that you were describing. A state exchange that gets a fee only for people who sign up through the exchange is going to feel differently about a private exchange than a state exchange that is financed through general revenues or some other means. And do you expect that will be changing as we go forward? In other words, that states will want to finance their exchanges in ways that encourage competition with private exchanges rather than discourage?

Joel Ario: I think they will all do it the way the federal government does, which is whether you come through eHealth or whether you come through the federal site, you pay that same three-point-five-percent user fee. So, the federal government actually gets the same fee from these other portals, which gives them an incentive to cast a broader net. And I think all states would be smart to do the same thing.

In fact, I think states would be smart to do something like D.C. does, which is to say it not only applies to people who – the fees not only apply to people who come through the exchange site, the subsidy site, they also apply to people who purchase outside the exchanges. And furthermore, in D.C., they apply to anybody who purchase other health insurance products. There are some politics to spreading the fee that broadly, but to my mind, the public good of having everybody be able to easily access health insurance helps all these other types of health products out there because people who buy the health – the basic health coverage, they are more likely to buy some additional products as well. And so, I think the case is there to have much more broad-based fees like the D.C. exchange does.

Tom Baker: Yeah, I would say from a health economics perspective, the case is a pretty easy one because it's the exchange that makes the whole market possible. And so you are benefitting

from that market whether you are buying through the exchange or, frankly, even buying a product directly off of some insurance company's website.

Joel Ario: The private exchange is the way some of my friends on the public exchanges say it sounds like you don't think we are important anymore. Nothing could be further from the truth. It is the public exchanges that are sort of like a public option, if you will, they set the baseline. They create the basic expectations around access to all different sorts of products on equal terms. You know, they set the rules of competition. They determine who is going to be in the market and not in the market. So, they are an incredibly important baseline. They should not go away in any stretch. But once they are there as the baseline, I think adding on some of these other options is a good idea.

Claire Wallace: What are the business and legal roadblocks to integrating private insurance exchanges with public exchanges created by the ACA?

Tom Baker: Well, Joel earlier talked about a little bit of the, call them, technological roadblocks. And I think those are being worked through. And other business roadblock is the question about does a state exchange see the private exchange as competition.

As far as legal roadblocks, I am not sure there are any that are all that difficult to surmount. I mean the federal government has said that they are perfectly comfortable with the web brokers interfacing with the public exchanges. I think there are some complications related to the fact that some of the web brokers may not have contracts with all of the insurers. And so one of the things that we have been looking into is are there states that have what is known as any willing producer laws, which says that any broker who is willing to sell the products that are on the exchange are able to do that. And that sort of law can enable a web broker to be able to offer all of the plans that are available on the public exchange, not just a few. Joel, what do you think about that?

Joel Ario: Well, I believe that we are headed to a world in which all forms of health insurance, including even Medicare, will be provided through an exchange-like environment. It's an

interesting idea that even Paul Ryan, who the Democrats don't like at all, is basically proposing the same core idea as the Democrats have with the ACA, which is that people get a certain subsidy, and they go to a marketplace and they purchase Medicare from a private insurer. The difference between Paul Ryan and the Democrats is that the Democrats think that Paul Ryan's subsidies are way too small and they think that they should be a defined benefit where the government has more of the risk rather than a defined contribution where the older person has more of the risk. So, there are disputes about the kind of subsidy and the amount of subsidy. But there is broad-based support for the notion that you have a marketplace, regulated by the government to some degree, and then, private insurers competing for customers.

And when people say well, that can never work in Medicare. Well, let's see, actually what is Part B – the drug benefit. Older people go on a website and look at many, many choices of different drug benefits. They search through to find out what drugs are on what plan, and so forth. And they pick a plan on a website. And Medicare Advantage, which is more popular today than traditional with the new Medicare enrollees, same idea, people say, instead of traditional Medicare, I am going to pick an HMO-style carrier called the Medicare Advantage carrier that is a private carrier and they are going to provide me something more like what I got from my employer before I retired. So, even inside of Medicare, this idea of exchanges is starting to be more widespread. I, frankly, see a day when even Medicaid, as it moves more to a kind of insurance model, away from a welfare model, will have the same kind of exchange.

So, one of the interesting ideas with Medicaid is the Republicans who proposed let's have some premiums and some ---- in Medicaid, they've generally got a good reception from the White House in terms of support for those kind of alternative Medicaid proposals. But – because is making Medicaid is making Medicaid more like traditional insurance. But when they propose let's have work requirements on Medicaid, the White House says no, that doesn't really work. We don't have work requirements in association with insurance. That's a welfare concept. We want to move Medicaid away from a welfare concept.

So, I think the exchange concept has the potential to be the way that all of our different forms of healthcare are provided.

Tom Baker: One of the things that we have looked at is comparing across countries. And the Netherlands has been running their public health insurance through a private exchange model somewhat like ours. But what is interesting is in the Netherlands, there is no public exchange. There are just private exchanges. And what the government role is essentially one of packaging the information and making sure that the, let's call it the plan administration aspect, and all of the sales and distribution through the webs are through private exchanges.

Claire Wallace: Should a consumer choose a private or public exchange?

Tom Baker: Well, right now, the difference between a public and a private exchange differs by state. So, if you are in a state where the private exchange is able to sell all the plans that are available on the public exchange, then it really doesn't make any difference. If you are in a state where the private exchanges haven't been able to connect with the public exchanges, then for those consumers who are eligible for the subsidies, which is going to be most of the people buying insurance in the individual market, then they really need to buy on the public exchange.

But I think that is really a transition problem. And so, on a going forward basis, I think people are not even necessarily going to be that conscious of whether the exchange they are buying on is a private exchange or a public exchange. Do you agree, Joel?

Joel Ario: Yes. I mean another way to look at this is the largest part of the market is the employer-based market. A hundred and sixty million people. They really pioneered the concept of an exchange. It used to be a booklet that you got that you looked through these different options in the booklet and picked your health plan. Most large employers offered you many different choices. And really the exchange concept came from a friend of mine who was the Washington, D.C. Insurance Commissioner who was looking at his booklet one year as a public employee and said, this really should be available to everybody. This should be available on the individual market in addition to in the group market. And that really is the concept of the exchange. It's changed now from a booklet to a website. If the employer offers you anything on

paper, it's a piece of paper that says, please go to the following websites to find out the details about your plans.

So, the employer-based market is really where the most – much of the most innovative work is being done around private exchanges. If you work for GE or somebody like that, you are going to have a very sophisticated form of a private exchange offering you different choices with a lot of very cutting-edge consumer decision tools. Now, I am happy, again, that there are public exchanges, because they are pioneering on some of the issues about how do you make sure that everybody has equal access to these kinds of exchanges. And how do you make sure that the competition between the carriers is a level playing field and fair. Those are issues that GE might not care about quite as much as we would care about it from a public perspective.

So, I think it's the interaction between public and private. But certainly, private exchanges are, you know, a bigger and bigger feature of the landscape for the hundred and sixty million people who are in employer-based coverage.

Tom Baker: Right. You know I am teaching a seminar this year on the regulation of private health insurance exchanges and one of the things that we are looking at is what is the role of a public insurance regulator in a world in which there are private and public exchanges competing with one another? And they are some of the things that you mentioned, Joel, I think are going to be really important. Which is that how do we make sure that the choices that are available on the private exchange are adequate? How do we make sure that the decision tools and other mechanisms that people use on those sites in order to make a choice are fairly balanced and don't steer them to plans where the web exchange gets paid higher commissions. That there is going to be plenty of work for lawyers and insurance regulators in this brave new world of private exchanges, I think.

Joel Ario: Yeah, if I put on my insurance commissioner hat for a minute here, one of my biggest concerns would be that the exchange be equally accessible to people who are young and healthy and people who are older and sicker when they come to the marketplace. It used to be the individual market was not that way. If you were not in an employer-based plan, and you

tried to buy individual insurance, if you had a health condition, a pre-existing condition, either you couldn't get insurance at all. And ten, twenty, thirty percent, depending on the state were excluded because of their pre-existing conditions. And the rest of the people, even if it was a relatively simple condition, were priced way up based on that condition. So, it was incredibly important in the ACA to say no more discrimination against people with pre-existing conditions. No more pricing people up.

That has, interestingly enough, been a principle of the employer-based market. When you get into the employer-based market, they don't get to say, gee, you're one of my least healthy employees, so I am not going to provide your insurance. Employers have traditionally provided insurance to all of their employees on an equal basis, a community-rated basis, if you will.

I will tell you right now, though, as the technologies improve, a lot of employers start asking these questions of gee, if I had this private exchange that really is very sophisticated at distinguishing different populations, can I find a way to identify my most expensive population and just put them over there in a different risk pool. I will still take care of them, but put them in a different risk pool and offer them something different. If we allow that, I will guarantee you that prices will come down for most people because there is a small number in any given year that cause most of the problem. We will all be there some day, though, so we all have an interest in having equal pricing and fair pricing across the board. And that is one of the things, as Tom says, that the public regulators are going to have to continue to police.

Tom Baker: Right. And there is also going to be – so there is how do you make sure that the plans are equally accessible? But then, you know, with these more sophisticated decision tools that help me get to the plan that is the best for me. Well, the plan that is best for me may relate to my risk status. And so there is some concern about what I call risk classification by design. Or risk selection by design where plans are either intentionally or not designed in a way to appeal to a particular slice of the risk pool. And so, to the extent that happens, which I think, to some degree, is going got be inevitable. There is going to need to be some back-end regulation to make sure that the plans that end up with more of the healthy people provide some payments

to plans with the less healthy people so that we don't get what amounts to risk-based pricing, but just through people selecting into different plans.

Joel Ario: But we are getting way into the weeds here, but risk adjustment is an incredibly important concept here. We can never figure out all the different ways that insurers could discriminate against people who have pre-existing conditions. So, ultimately, you need a big hammer which is at the end of the year we have a mechanism to size up is your risk pool average or better than average or worse than average? And the way risk adjustment work, this is already done in Medicare, if you have a better than average risk pool, you are going to owe monies, and in the future it will be billions of dollars, potentially, to somebody else who has a worse risk pool. So you are trying to say to the insurers, you don't get any reward if your figure out how to get healthier people. We are going to figure out through risk adjustment how to take away that incentive.

But it is incredibly important because all you have to do is tweak a few things to make the HIV drugs a little more high-cost sharing than not and all of a sudden you will not get any HIV patients in your plan because they will look at their drugs and they will say this is the wrong plan for me. That is going on right now, and the matter is being addressed by our regulators.

Tom Baker: So, there is going to be plenty to do for our students in the healthcare field as we go forward; that's for sure.

Claire Wallace: So, how is this exchange going to change the marketplace for healthcare services going forward?

Joel Ario: If the exchanges can make healthcare equally accessible to everybody, and there is not discrimination based on the person's health conditions, then we have a world in which we can really focus on risk management, not risk avoidance. One of my favorite clients that I have had in the private sector now in the last couple of years is a company that used to specialize in helping individual market insurers identify the people that were high risk. In the old marketplace, that was done for the purpose of excluding them. So, it was kind of not such a

great business from a public welfare perspective. They were, literally; his business was trying to figure out who most needs healthcare and trying to make sure that those people didn't get healthcare because they couldn't get into the market.

Today, he has a much better business from a public welfare perspective because those very same insurers want him to do the very same thing. The reason today is they want to identify those people who have high needs, because those are the people that can be most profitably treated and their conditions can improve. You can't do something for somebody like Tom, who is in perfect health. But if you got somebody who has got a chronic condition, you can improve and reduce cost quite a bit by managing the risk.

So, insurers today want to know about who's got high risk because they want to figure out how to manage the risk and reduce it and do well on those risk adjustment scores and as opposed to trying to figure out how to exclude the risk.

So, that's the kind of marketplace we want in the future.

Tom Baker: Yeah, I mean I like to say that when the exchanges are working well, they are going to change the way that insurers compete with one another. From competing by being the best at keeping out the sick people to being the best at managing the costs of sick people and having a – you know, compete on price and quality rather than risk selection. That is really the goal of an exchange and the thing that will happen as long as we get these other things right, the making sure that there is not too much risk classification by design. And making sure that we've got a good enough risk adjustment process so that we can police that market, so the carriers are competing on cost and quality rather than keeping sick people out.

Joel Ario: If you center the risk adjustment formula that somebody who has diabetes is on average, you know, fifty percent more expensive than an average customer. And you know, as an insurer, that that's how the risk adjustment process is going to work, there is much more opportunity to take the diabetic community on and save a lot of money against that average fifty-percent difference, and then get rewarded for it and people – it could be to the point where

nobody wants the healthiest people because those are the ones that there is not much room for improvement on. I don't think risk adjustment is danger of getting so effective that it does that. But it certainly can be effective at reducing the incentive to keep the sickest people out of your pool.

Claire Wallace: So, what does that mean for an individual's care?

Tom Baker: For someone who has a chronic condition, it means that the insurer now is really aligned with them in helping them to manage their cares. Because, you know, we all want to be a low-cost person in the healthcare world because if you are a low-cost person in the healthcare world, as long as that doesn't mean you are dead, it means that you are not spending a lot of time with doctors and not spending a lot of time in the hospital. And so giving an insurer an incentive to manage those high-cost care cases is good for a patient.

Joel Ario: It also means that there will be more attention to keeping people healthy. In today's system, you basically, there is not much intervention to try to make sure that people who are in the sixty-five percent of the population, who need very little care, there's not much incentive to try to spend time trying to make sure that they stay healthy by promoting exercise, trying to make sure people stop smoking and doing other things that are bad for their health.

But if you, in the future, are responsible for a population of people, your goals will be to keep as many as healthy as possible. I heard one hospital executive describe how, in the current system, the old system, you know, you want to get as many people in your hospital, fill up your beds as quickly as you can. In the new system, you would to keep as many people out of the hospital. You would want to reduce the number of hospital beds you had. And he described it as basically you want the five percent who are in need of most intensive services to do really well with those as best as you can. You want the next fifteen percent who have chronic conditions to be managed so they don't end up in the fifteen percent. And most importantly, you want the other seventy-five percent, or whatever it is, to stay as healthy as possible so they don't get in either the chronic or the intensive care part.

But one of the reasons we, as a society, would support all that is that it's not like driving where you say, do you know what, if I have been driving for 50 years and now I have two accidents in my seventy-fifth year, I do understand why my insurance company would jack up my rates and maybe talk to me about not driving anymore because that's how that should work. But I don't know any American who says if I have been paying health insurance premiums for 50 years, and now I get cancer when I am 75, I expect to be kicked out of the marketplace. We know that we are eventually, unless we die suddenly at an early age, going to need healthcare and we want it to be done fairly. So, all do have a stake in a system that does – that treats healthcare different than some of the other types of insurance.

Claire Wallace: What does the future hold? At least in the near term?

Tom Baker: Well, does that mean we have to talk about the Supreme Court decision that is presently looming? I know, Joel, you are thinking a lot about that.

Joel Ario: Yeah, my life consists of worrying about the next big drama in the ACA, and we seem to have at least one drama play every year. This year, it's a case called King v. Burwell where the Supreme Court may read four words in isolation from the rest of the statute to say that the subsidies that, again, eighty-percent of the people on the public exchanges get subsidies, they may read those and say you can't get those in the federal exchange states. That would be 34 states, about eight million people if the Supreme Court rules in favor of the plaintiffs here, would lose their coverage. So, you have all kinds of skirmishing and the Republicans in the congress now are saying we are going to find a fix to this. We will have some leverage against the president, and we will get him to change the law to make it more flexible and so forth. And you have the Democrats saying we're not going to make any changes in the law, we will fight it out until the 2016 election.

So, if this case does go the wrong way in the sense that the subsidies are lost, there will be potential for congress to fix it. But it could end up being, and this is most of my business today, talking to the states, the same way they now have to do Medicaid expansion, one by one, 28 of them have done it, 22 don't – there are much worse health results in the 22 that haven't – we

could have the same thing with the exchanges and the cleavages between the have states and the have-not states could get a lot deeper.

So, you know, this law is destined to be a political football at least through the 2016 election. And this Supreme Court case could throw a real snare in it. But it won't change the fact that this law has redone healthcare in America. And it will be a setback, but not a – it won't change the fact that this law will continue to survive and flourish in the states that embrace it.

Claire Wallace: Thank you, Tom. Thank you, Joel.

Tom Baker: Thanks. Thanks, Joe.

Joel Ario: Thanks, Tom. Thanks, Claire.

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