SENATOR USIE RICHARDS (USVI): Our next speaker. Could we have your attention, please? Thank you kindly. The next dialogue we're about to bring to you is the subject matter of the affordable health insurance exchanges on the subject matter of creating an open and competitive marketplace. We do have a speaker that you will hear from in the person of Dr. Eric Wright who directs the Center for Health Policy. He's also a partner with the Indiana University School of Medicine, Department of Public Health, and interim chair for the Department of Public Health. He also holds some adjunct appointments in the Indiana University School of Medicine in the Department of Sociology, the School of Liberal Arts. He's also a medical sociologist with research interests in the Center of Social Responses to Health Problems, health policy, and a social organization and effectiveness of health services and public health programs. Please welcome to the microphone, Dr. Eric R. Wright, Dr. Wright.

DR. ERIC WRIGHT: Well, good morning, and it's always a difficult spot to be the last speaker before lunch. And we're going to try and fit a group project in there as well to engage in some conversation about what is a very complicated issue. I did bring a packet of information for your interest, and it'll be available to you after the session at some point. And in the interest of time, I'm going to whiz through some of the slides, most of which, the first few of which you probably are pretty familiar with, but I thought it's important to always talk about background and why, in fact, we are going through this very, what seems to everybody regardless of party, a very complicated process of reforming the US healthcare system.

The core problem is, in fact, one that has been talked quite a bit over the last few years, and that is the rising rate of healthcare costs. This is a graph of the percentage of GDP (Gross Domestic Product) in the United States that is attributable to health care. In 2011, it was attributed or estimated to be about 17.9%, which is much higher than we expected. The targeted projection about ten years from now is about 20% of the gross domestic product. Rounded up, it's suggested about 20% of the US economy is somehow connected to healthcare. And that's an important number to keep in mind because in fact this is the problem that a lot of folks think we should – that need to be solved.

I will add one caveat about this number, that back in 1971, President Nixon when he proposed the Health Maintenance Organization Act, which created HMOs for the first time, his chief economic adviser at the time, Stuart Altman , predicted that if this percentage actually ever reached 12%, the US economy would collapse. So if you look back now, obviously we're -- some argue we are on the brink of disaster. Others suggest that this actually may be a sign of economic growth as the US economy changes, becomes more focused on live science and high technology, that in fact this may in fact be a

good number. What is clear, however, is that the reality for the bottom line for the average consumer, whether that's an employer who pays health insurance premiums or consumers who pay it on their own, the cost is becoming more and more out of reach for the vast majority of Americans as evident by the per capita estimated health expenditures.

One other note you should keep in mind is this number, $8,666 for -- $666 represents the estimates the cost of that number for every man, woman, and child in the United States. That is about two and a half times any other country in the world. So we spend two and a half times more than other countries, and the result unfortunately is that we don't have as good outcomes for our healthcare system as one might expect when you're spending that much money on every man, woman, and child.

I won't dwell on the rising cost – implication of these costs because, in fact, there's a lot of changes that are happening by virtue of the way the system is trying to adapt to these rising healthcare costs. The biggest change in the last five years has been a more and more the cost being shifted directly to the individual person. So you see, in fact, data all across the board indicating that patients are paying more and more out-of-pocket costs for their healthcare.

Now the Affordable Healthcare Act came along at a time in history that's important, and President Obama deserves a lot of credit for having get this through Congress. This was in fact the eighth time the US had a major conversation about health reform. It was the only time it made its way all the way through Congress. Now that – having said that, it's probably – you don't have to be a rocket scientist when you start realizing that when 20% of the US economy is related to healthcare, there's a significant amount of economic interests around this debate, which makes it a very politically challenging topic to address.

In your packet when you pick it up, you'll get this copy. This is my favorite political cartoon of all time because it is the only cartoon I've ever encountered that actually depicts the sentiment of every single American, and that is in fact, it doesn't matter whether you're a democrat or a republican, everybody is frustrated with the healthcare reform act. Nobody likes it in its entirety, and thus it stinks. And this aptly sort of describes the historical process we've gone through over the last couple years and where we are in terms of the reality of what we're trying to address.

Now this – I've stolen a couple of slides from the Center for Budget and Policy Priorities – I went to a talk and they had a really nice set of graphics, so I'm going to share a few of those with you. This is probably the most important one for you to keep in mind. The Affordable Care Act, for as much as the

political rhetoric as you hear, is like a very much a speeding train. We are moving ahead, the federal government and state governments across the country are moving ahead with reform unless it's you think this is just a governmental issue, it is driving a huge transformation in our healthcare system.

Just in Indiana, which the state I watched the closest, we've seen a huge consolidation of health systems, hospitals and health systems and provider networks are buying up each other like right and left. And that reflects, in fact, where the health system thinks the system is going. And this train of health reform has actually really spawned a huge amount of change, much more than the average person really truly realizes in the extent of – that's happening. These are some critical dates because the Affordable Care Act outlines some specific deadlines that have to be met, and that's why I'm here today to set up your conversation about some of those key decisions that US state legislatures – state legislators have some role to play in shaping those conversations.

I will say that probably the most important thing here is that the door is starting to close if you follow the Affordable Care Act timeline, even with all the hiccups in the Supreme Court. The door is starting to close on the ability of state legislators to have input on this process. Most of the legislative action that was assumed by the Affordable Care Act needed to happen last year. But there's a couple of more deadlines where in fact you can still have an effect before some of the processes begin to kick in. Now, back in 2009 when we were talking about this, everybody thought 2014 was so far away, but when you start to realize how much time has passed, there was a lot of lead time to prepare us for this major transformation, much more than there was in Massachusetts when they launched a very similar proposal.

And so we've had a lot of lead time, but unfortunately the political rhetoric and the debate around this has gotten in the way of actually doing a lot of the very challenging detail work that's necessary. Monday, where this red bar here, we passed an important deadline. That was the deadline that all states were supposed to communicate with DHHS (U.S. Department of Health and Human Services) their recommended essential health benefit package for their state. I'll make one comment about the package, it seems to be surprising to a lot of people. And I respond to a lot of reporters' inquiries on both sides of the aisle, and one of the interesting questions I get is, when people actually dive into the details, one interesting question was asked to me by a reporter out of Fort Wayne, he says, "Where is this government takeover of healthcare?" Because the really surprising piece of this legislation is that the – it was designed actually to give this responsibility to the states. And what's happening is really a case of, in my mind, a kick the can where the states and the Feds are simply playing

this game of who's going to do it first. And now that's what's probably the most challenging political dynamic which is where, in fact, legislators have a really great potential to have an influence on what's happening in each of the individual states.

So we passed the deadline on Monday for defining essential health benefits. Now the Feds are also telling us that these are, quote, soft deadlines, which no one exactly knows what that means. But the law does require everything to start working on January 1st, 2014. There's a very hard deadline on January 1st of 2013, that each state has to have their plan approved by the secretary of health and human services and if they don't, the law says the federal government will do it for the states. Here's in place where in fact legislatures need to sort of be involved in the conversation.

The next major deadline, which is very – coming up very quick, is November 16th. And this is where, in fact, states are supposed to provide a blueprint for their health insurance exchanges. So you've got about a month to influence the process and depending on what state you are, you may be in better or worse situations in terms of trying to shape the conversation.

So I've – in most of my slides, I've analyzed them in-- in terms of three critical questions where legislators can have an impact. The first is whether or not to create a state insurance exchange. Many states have actually made a decision, some not to do anything, though these are the ones depicted here in the darkest yellow, Texas, Louisiana, Florida, South Carolina, Alaska, and Maine. On the other end of the spectrum, you have the blue states which have already begun, in fact mostly by legislation, establishing health insurance exchange and done a lot of the necessary work to make exchanges begin to happen. So states are in varying states of preparedness if you will for preparing for health insurance exchanges.

Now there's – the law allows for several options for states in terms of how to do this. On the one end of the spectrum state-based exchange, this is the model that I think actually, when the bill was passed, everybody thought the states would want to do because this actually gives the states the greatest amount of authority to actually exercise or change their own healthcare system. And in fact in the packet, which you can get on the way out, we actually wrote back in 2010 a plan for the state of Indiana which unfortunately didn't go anywhere because we were probably perhaps too aggressive and perhaps and more aggressive than other states might want to be. But states can choose and think about the different issues for their particular states.

But the bottom line is, if you choose to make a state operated exchange, that means that a state has to set up all the infrastructure of a large, corporate HR office. The way to think about this is when you think about a large company who operates a health – provides health insurance to their employees, they have a lot of bureaucracy that has to get put in place to be able to manage those plans to be able to make decisions about which plans to offer how much to charge the employees and so forth. What the law requires of states if they choose to create a state exchange is to do that work. That's the part that's the hard work because there's actually quite a bit of complicated legislation, regulation, and procedures that have to be set up in a state exchange.

So that's, going back, that's the most aggressive in terms of most laborious for states. Now a lot of states have made a very rational decision saying that we can't afford to put together that level of bureaucracy. And that's certainly an understandable question. But the Feds have actually allowed for two other ways of handling this, and one is more sort of involved with the states, and that is what's called a state partnership. This is where, in fact, the state would operate certain parts of the – I call them the health benefits office for the state. And then the Feds would actually do a lot of the leg work in terms of the management of the plan itself and the processing of payments and so forth.

The states actually have other specific things that they would need to do if you opted to do a state partnership exchange. The other way is simply to operate what's called a federally facilitated exchange. This is the default option if the states don't have an approved plan with DHHS by January 1st of 2013. What this simply means is the Feds will, through their bureaucracy, which they are setting up, create an exchange for the state of whatever – wherever you happen to be.

Now this allows for – the basic decision here is, on one end, states have the greatest involvement in the ability to shape what they do with their health insurance exchange. California has been held up as a model in that. New York seems to be heading on track to do that. But the nice thing about this particular place is because you can do a lot more. You can follow the minimal letter of the law, but you could also use it to shape a whole variety of other health needs, particularly for around individuals who are vulnerable populations.

Typically the idea is that states would be in a better position to coordinate things like Medicaid, other kinds of health services that may be offered through other kinds of funding mechanisms as well as health insurance exchange. So it really operates the whole system. And so there's a lot of strength to doing that, the problem is there's also a lot of responsibility and bureaucracy that has to go on that. And

a lot of states feel very unprepared to be able to do that because there's quite a few technical issues involved in these. On the other end again is the federally facilitated exchange and the major difference here is how much involvement the states actually have in terms of being able to shape what happens in the states.

If you go with the The federally facilitated exchange – I'm pressing the wrong button. The federally facilitated exchange, the feds will make a lot of the decisions about what the health plans look like, what's included, the qualified health plans we made from Washington, not from your own state capitol. And that has caused some people some concern because it may not be able to tailor. And that was one of the great wisdoms because if you remember back to when this was being debated in the Congress, the House version of the bill was actually the do it all at the federal level. And a lot of states lobbied, including our own governor, rightly so, I think, that in order to be able to tailor it for the needs of our state, because not all states are the same. They have different health needs, that states should have more of a role here. And so the law actually created this option, but it seems – it's right in my mind. I'm kind of surprised by how many states are choosing to let the federal government take it over for them.

So now just to give you a sense of this, and this is actually right out of the Center for Consumer Information Insurance Oversight. This is the new federal agency that is overseeing this establishment of all these exchanges. What's important here is you look at – I didn't put the Xs in here because it gets a very long table. It's a three-page table which you have in your handout. But this is if you wanted to look at it like this, it's the to-do list if you're going to create a state health insurance exchange. And all these have lots of subheadings, but there are Xs all up and down the state health insurance exchange because there's quite a long list of to-dos. To make a plan that is going to be accepted by DHHS, you have to be able to do all of these things and you have to demonstrate that in time for the January 1, 2013 deadline. So time is of the essence if your state is one of those that hasn't started this conversation.

The partnership model, and the federally facilitated exchange actually only have things to do down in here. So it's a little bit of an easier task for states to actually accomplish. And I think states are – they're all over the map. This is very important, which is why actually I highly recommend you contact one of the consultants of which there are now many that are helping the states think through these issues because they're quite complicated, but most importantly, there are different levels of involvement of the states.

But I think the great – the strength of the, again, the state insurance exchange is you will have the greatest opportunity to influence the overall shape of your healthcare system and as opposed to opting for the federally facilitated exchange.

Now so in one of the key decisions, which you're going to be discussing in your small groups, is whether or not you're going to, it falls under one of these categories, about the type of purchaser arrangement that you can do. There is kind of, again, a big model or wide range of models. Most health policy experts focus on Massachusetts as the example of a active purchaser. And what does that mean? It means in fact that in – it's sort of like a lot of businesses have done over the last few years, reduce the number of policies that they offer to their employees because the fewer the policies you have, the more directive you can be as an employer or as a state government, in terms of what's included and what's not included. You can also change the – how much cost is being incurred by the individual consumers. You can also be a lot more directive in terms of the kinds of specific benefits. You can expand the portfolio benefits. If you're more of an open purchaser, which is more what you call the Utah model, where in fact the states or employers will say, we'll take anybody who meets our minimum threshold. You're going to get a lot more variety of the kinds of the plans that are in the plans that are available to folks in the exchanges. And this is an important distinction because you're going to have more control over the future of your system in an active purchaser arrangement than you would in open, but you'll also embrace the involvement of more smaller insurers and so forth that are able to compete in an open market model. So that's an important decision that I know you're going to be talking about in your small groups.

The other major decision is in fact around the essential health benefit package, and here the train has already left and the door may be closed, but I think actually since quote, unquote, a soft deadline, you still may have some opportunities to influence. And this is where a lot of the politics and the economic interests are coming at you. I have no doubt because I know our legislators are getting bombarded with emails about whether chiropractic or massage therapy should be part of the essential health benefits.

Okay, now I'm not making a judgment about massage therapy or chiropractic services, but the law actually says these are the only ten things you have. Now like Congress, they often don't give us enough specifics. And so what's happening is they go back and forth between the Feds and the states about these essential health benefits and the goal needs to be to try and figure out what should we

include in this package. The bottom line is, the more you put in this package, the more expensive it's going to be, and that's the simple sort of way of thinking about that.

So one of the questions that legislatures need to grapple with is the more expansive, the more stuff we put in, the more expensive it's going to be both for the individual consumer and also for the state government. Now the question here is this is also where you have the greatest tools to actually shape the epidemiology, that is the distribution of disease, in your individual states. If you have particular health problems that you know are particularly prominent in your populations, you should be very concerned about what's included in here because you want to make sure the services that you know affect those particular situations are included in your essential health benefit package. This is why it's important for you to get involved in the conversation here.

Now the default has been the DHHS has already done the math and studied the insurance markets in every single state and has identified a set of benchmark plans. They've identified one of the three largest small group plans. They've identified the three largest state employee health plans, the three largest federal employee health plans, and the largest HMO. They've compared those benefit packages against this list of required services and have actually recommended for each state a plan, okay. Now this was for information, but I know it frustrated a lot of state bureaucrats because they again thought it was the federal government telling them what to do. In fact, what they were trying to do is provide some technical assistance to help the decision-making process. That doesn't mean you have to follow that, it simply means that's the minimum standard that meets the letter of the law. And this is, in fact, one of the questions that you will probably want to grapple with.

Issues around women's health that I know have been very political come to play here, whether what is included in that list of covered services is part of what's becoming a political issue. But I think one of the questions you as legislators could do is ask yourself, what do I know about what's going on in my state? What do we really need? And make sure that those needs are addressed in the essential health benefit plans. The nice thing about this, like all health insurance, you're going to have opportunities each year to change and update our plans, but here's where state legislators could have a lot of influence. And again, if you don't know already, please check with your state department of insurance– and that's one of the other chaos issues around this, is each state seems to have slightly different point people who's leading this effort. So if you don't know who that person is, this is the question to ask them. What did you send to the Feds about your essential benefit package? Because

that deadline was last Monday. So all states, except Indiana. Indiana said we're not – we're going to wait. That was their response on October 1st, which I think is interesting.

Now one choice is not part of your small group but is an essential question that you should be asking, which I know the states are struggling with across the country, is whether or not to expand Medicaid. You may have been paying attention in June when the Supreme Court made a ruling on the Affordable Care Act, and the good thing was, depending on your political persuasion, upheld the law. The complicating question is it actually talked a lot specifically about the Medicaid provision, and this is an important gap that was created by the Supreme Court decision. And this is one why it's become now a really important issue for state agencies.

This is where states are, and you'll see a lot of balancing – symbols of balance thinking about it and where they're leaning with the red states leaning towards not expanding Medicaid, the darker blue definitely either made a decision or thinking about leaning towards expanding Medicaid. Now as if that weren't complicated enough, let me explain just a theory about the Affordable Care Act and how we were supposed to get to universal coverage, because this is important for everybody to keep in mind. If you look at here, we use the FPL because that's the language of the law, but in fact the red areas represent here, and you may not be able to see this, where traditional Medicaid falls in terms of coverage. And it's based on categories of children through the CHIP (Children's Health Insurance Program) program, but pregnant women, parents, and seniors with disabilities are covered by Medicaid as we know it. The idea behind the Affordable Care Act was to try and tackle the group between 400 and 200% of the poverty (FPL).

We know based on analyses that have occurred over the many years that that's where most of the high rates of uninsureds come from. These are what you might think of as the working poor. There are a lot of individuals who work for large businesses that offer minimum wage or just above minimum wage jobs that don't provide health benefits. So these are working individuals that can't afford health insurance. So the theory behind the Affordable Care Act was to try and use the exchanges to provide opportunities both to help them and small businesses to get coverage for their employees, and that this would be then subsidized at some level based on income to make sure that it was affordable. And so there are some formulas in the law which I won't dwell into as much you're interested I could talk a little more about that.

There's also – and so subsidized healthcare was how we're going to fill in the gap. The other piece was they were using this 133% of the poverty line as of demarcate and sort of said, Medicaid would then cover everybody up to 133%. So by the exchanges, we take care of the problem in the middle because we also know that about 99% of the people who are 400% or better of the poverty line have jobs that actually provide health insurance. So we don't usually need to worry too much about the people at that high income level. It's the bottom where we need to be worried the most, and that was the idea here was use Medicaid to fill in the gaps on Medicaid.

Now there's also this notion of a basic health plan, but I'll come back to that in just a second. Now post-SCOTUS, the abbreviation for the Supreme Court of the United States, this has created a new gap, okay. That means that states are now allowed to opt in or opt out of the Medicaid expansion. If they choose to opt out, there will be a bunch of people in the black box here who are not covered by anything. They will also not meet eligibility requirements for the exchanges depending on the laws, but mostly by income, they won't be able to afford the required contributions that are going to be implied in most of the exchange models that are being developed.

Now there was an option under the law to create a basic health plan. The idea was to fill in the gap between 133 and 200% of the poverty line, which really, for some of the health insurance body can be very expensive. And people are still trying to sort this out, but this is a way for states to voluntarily expand the impact of Medicaid and there's a lot of debate right now about whether or not doing a basic health plan in addition to expanding Medicaid might be a better way of making sure that the needs of those less fortunate at our society are met.

So the big things you should be worried about, and this is why this is a state issue, is if your state chooses not to participate in the expansion of Medicaid, you will create a structural gap of people estimated to be somewhere between six and about 12 million people across the United States who will be uninsured over and above the plan, which we already knew wasn't going to reach universal health coverage. So this decision is probably the next most critical one. There's no stated deadline when states have to make this decision. And the reason this is also important is because if you take this exchange model seriously, whether you do a state exchange or a partnership exchange, I would not divorce the conversation about what you're going to do about Medicaid from about what you're going to do on the exchange. All the economic analyses are very clear. The more the states coordinate the benefits between what's going on in Medicaid and what's going on in the health insurance exchanges, the more

effective their solution will be to reaching full coverage and providing better care and access to care for their citizens.

Which leads me to my last slide, which focuses on what is going to be a major challenge for your state governments? And that is the coordination of benefits between if you opt for a federally facilitated exchange, it'll be more difficult because again, as I just said, the more you coordinate what's going on in the Medicaid with what's going on in the exchange, the more – the less administrative costs you will have as a state. But one of the big headaches would be is if you let the federal government do it, you're going to have to figure out how to seamlessly coordinate your state Medicaid office with the federal government. And I know some states struggle with that just internally with the state. But the reality is the eligibility process for getting into the federal exchange will require the IRS and the Social Security Administration to verify all sorts of things around income, but then they will also then be telling the states, oh, this person actually is eligible for Medicaid. So there's going to be a lot of back and forth between the states.

So to sum up, it doesn't matter which direction you go, the role of the state is going to be very important in making health reform work. The key questions becomes is how much influence does your state want to have on reshaping your healthcare system? Some states, mostly the blue states in the map down there, are very interested in using this as an opportunity to reshape their healthcare systems. And not surprisingly, California and some of those states that have the highest numbers of uninsured and also some of the highest healthcare costs in the United States, are going at this very aggressively. Other states, Texas, are taking a hardcore political stance on this and saying, we don't want to do this. And one has to ask the question, what's the next move in this kick the can game? What happens when a lot of states choose not to expand Medicaid or choose not to adopt the exchange? I'm not sure what the solution will be or how the federal administration is going to respond, but I can tell you what's been kind of interesting for me is as a policy wonk is watch this process and everybody sort of waits for the next major Supreme Court decision or now are waiting for the election as if it's going to derail that.

And this is the part that I want you to sort of understand. This is a nonpartisan statement. The system, the train, is already moving and it's driving at least 55 because all you have to do is walk about six blocks from here and take a look at any of the new health system buildings that have been built just in the downtown area. And I happen to go to Mardi Gras every year because I love Louisiana, and I actually watched and I drove through every state and I saw the university health system doing exactly the same state in every state we passed through on the drive. Every state's doing the exact same thing,

and this is a health system that is changing itself without any involvement of government. This is why, in fact, states could have a huge role in helping and working in partnership with the state health systems to really fundamentally achieve the long-term goals of health reform.

And I caution you because this is the first of several conversations we're going to be having over the next two decades. The analogy I use is we are on the Titanic. We see the iceberg and we're going to try and turn the Titanic. Again, remember, the healthcare system is 20% of our economy. That means that we're going to try to turn the Titanic, but it's going to be a very slow process. And so after we deal with this issue of access, there are going to be many more other complicated issues around delivery system reforms, trying to deal with other progressive public health initiatives, trying to sort of focus on how do we improve and maximize the population health. So now I believe you're going to be going into your work groups and talking about some choices states have to make.

SENATOR USIE RICHARDS: Well, one second Dr. Wright. We are going to take at least two or three questions before they go to the work group. Anyone with any question for Dr. Wright? Come on down, Representative Flaggs.

REPRESENTATIVE GEORGE FLAGGS(MS): First of all, thanks for the presentation, and I'm George Flaggs from Mississippi. And I would predict that all the states will be in within the next three years anyway because of the economic impact and because of as we go through the healthcare affordable and the expanding Medicaid, there as a provision that nobody knows about now is that if you opt out, you don't know what's going to happen till your disproportional share credits is given to the hospital, which most rural hospitals, certainly in Mississippi, but most hospitals utilize this as a – to offset their costs for underinsured undercompensated care, healthcare, and it's going to drive the utilization of emergency room costs up so high, you're not going to be able to afford it. You cannot have as many people that is in that gap not being insured. So I would suggest, I would think that it's political now, but after the election, most reasonable governors in states going to come to their realization that it's an economic impact.

DR. ERIC WRIGHT: I would have to agree with you. I think actually whether or not it's – I'm not sure about the reasonable governors, but I think the reality is that over a couple years, the nice thing again is states could change their mind a year from now or two years from now if they're working in active partnership with the federal government to address those kinds of issues. But again, it sort of speaks to the importance of thinking in a more holistic way, which I know is uncomfortable because we have

tended to approach healthcare in terms of these silos. But coordinating what's going on in Medicaid with what's going on in the private health insurance market is really important to it to avoid exactly that problem. But I bet you if the state doesn't do it, you're exactly right, a year from now they're going to be drowning in emergency room costs and they're not going to know how to pay for it. And it's going to force them to the table.

REPRESENTATIVE JOE GIBBONS (FL): Good afternoon, Joe Gibbons from the state of Florida. We're in a really bad situation. We have completely refused to deal with the exchanges. We had a Medicaid expansion program that was an absolute failure, and we've been fighting the legislature back and forth as to whether or not to expand it. So here we are coming up on these deadlines, the Medicaid expansion failed, we haven't done anything with the exchange, and the light at the end of the tunnel to me is just simply another train. And, politically, instead of dealing with the Titanic heading for the iceberg, we're rearranging the chairs on the deck on the Titanic rather than dealing with the problem. So in your mind, as we're getting ready to come up on the legislative session in the spring, where should I focus in order to be most effective because right now we're heading backwards and the world is heading forward?

DR. ERIC WRIGHT: Well, I would actually – I'm not going to try and sort of comment on the political process, but I think once we get passed the election, I think it will start to sort of clear some of the conversation a little bit. I do think that what will probably end up happening is that many of the state legislatures will be given a second opportunity. So far the language has been these are soft deadlines. I think the problem is that the law does say we have to start something in January '14. So it may be in Florida or other states that choose to wait that you couldn't take it up in the next legislative session and but then you're going to be really thinking about fiscal year 2015, which might mean the Feds in the interim would operate a federally facilited exchange, which might not be such a bad thing because what it does is begin sort of just to help the system recalibrate.

Because what we're talking about is a really a huge shift in the equilibrium of our healthcare system. The providers have to get used to this new process. The consumers have to figure out what it means to have better access and to have some new constraints put on their behaviors. So I think what you can – there are going to be other opportunities for mid-course corrections, but I have a funny feeling that the states that don't – haven't already taken action may be forced into a federal exchange. We may get to the end of that process and actually decide that the federal exchange model, the House version of the original bill, might actually have been a better strategy for the nation as a whole with

some state partnership involvement in terms of the benefit process. So it's a wait and see game. This has been the most fascinating life career-changing experience in my life. It keeps me up at night.

SENATOR USIE RICHARDS: Thank you, Dr. Wright. This is the last question before we have the breakout.

SENATOR JEAN BREAUX (IN): Thank you, my name is Jean Breaux. I'm with the state of Indiana. And most likely we will have a probably a federally facilitated exchange. But you alluded to something about a basic health plan in conjunction with that. Can you talk a little bit about that? And my second question is, if we do not choose to expand Medicaid in the state, does our Medicaid program stay as is or do we offer the same programs under the Medicaid program today that we would be required to do if we expanded Medicaid? I guess I'm just asking, does our Medicaid program stay the same if we choose not to expand it?

DR. ERIC WRIGHT: I wish I could be absolute in telling you and giving you an answer, I'm not sure how the Feds are going to respond, because I have a hunch that it's going to depend on how the other states react, how they're going to handle. The Supreme Court says that we should – the state should not be penalized in their existing Medicaid program if they choose not to expand. One option we have in Indiana is the basic health plan, which actually would take – provide better coverage up to 200% of the poverty. In my mind actually the be the Healthy Indiana plan, might be adopted to become our basic health plan. And the idea would be is it would be – it's a bridge between Medicaid because it's designed for people who are not eligible for Medicaid but who also can't probably afford the full premiums in the exchange. But here's a case where in fact the – Jonathan Gruber who's the sort of the mind behind most of this model has kind of done a couple papers now where he's actually suggested, you may not want to do the basic health plan which is essentially an expansion of Medicaid to a higher level, unless you do that in close coordination with your state health insurance exchange and Medicaid, because what might happen is you create these dramatic increases in consumer cost shifting. Because the benefits in the exchange have to follow the gold, silver, bronze, and platinum, which are basically different levels of cost sharing with the individual. So taking somebody who's 200% of the poverty, or 190% of the poverty, they may not be able to afford and follow through on the cost sharing agreements in the health insurance exchange. So what Jonathan Gruber's been cautioning everybody is don't create such a huge difference between the basic health plan and the health insurance exchange that you create people who are falling in and out of the system or what he calls churning, which creates other economic inefficiencies in the system.

The goal should be to have a seamless integration of all these different health plans so that we make sure that everybody has coverage, and continuous coverage, because that's how the system can save more money, administratively.

AUDIENCE MEMBER: So the basic plan is a state option?

DR. ERIC WRIGHT: It's a state option. States have to choose that. I think most of them are sort of presenting it as we got to decide about Medicaid before we decide about the basic health plan. Thank you.