Alliance Supreme Court
Alliance for Health Reform
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ED HOWARD: My name's Ed Howard, I'm with the Alliance for Health Reform. I want to thank you for joining us for this discussion of approaches to covering the unfolding health reform story through the elections, through the new congress and presidential term, possible rollout of major parts of the Patient Protection and Affordable Care Act. A few statutes have been the center of such contention as this one and it continues two plus years after its enactment, but few laws also are more likely to have a bigger impact on healthcare. Regardless of what happens in November, this law has already set in motion or accelerated the motion of trends that are very unlikely to stop, whether it's delivery system and payment changes, accountable care organizations all over the country, wellness, prevention programs, the list is very long, even without the coverage and finance changes contained in the law.

Today, we've recruited quite a roster of resources to make story suggestions, answer your subsequent questions as well and you'll meet them in a second. Our partner in today's program is the Robert Wood Johnson Foundation, America's largest philanthropy that is dedicated to improving people's health and healthcare. We are pleased to have as a co-moderator, Dr. John Lumpkin, who's the Senior Vice President of the foundation and Director of its healthcare group, Johnson

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Emergency, physician by profession, and directed the Illinois Department of Health for twelve years before coming to RWJ, John, thanks for being with us.

JOHN LUMPKIN, MD, MPH: Thank you.

ED HOWARD: And you can either make some remarks or not, depending on how you [laughter]—

JOHN LUMPKIN, MD, MPH: [Interposing] Okay, good. Well, I actually had some plans.

ED HOWARD: You can see we had this sketched out very closely.

JOHN LUMPKIN, MD, MPH: Very closely, so I'd like to welcome and thank all of you. Thanks, Ed. This is really a very important event. Today's panel will help give a better perspective on health reform after the Supreme Court decision. While there is a lot of discussion about some of the most controversial pieces of the law, I'd like to talk a little bit about what we're seeing based upon our work as a foundation with States across the country. Our foundation has had a long history in supporting efforts to expand and enhance health insurance coverage. We've worked for forty years to improve access to safe, affordable, high quality healthcare, and in many ways, the Affordable Care Act brings us closer to achieving that mission. The Foundation will continue to commit resources to help States, non-profit organizations, and

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communities in the private sector to fully realize the potential of the law, but right now, all the attention is focused on the States and what we're doing to implement key provisions of the Affordable Care Act including establishing insurance exchanges and opting in or opting out of Medicaid expansions.

Many States have already made a lot of progress in implementing the various provisions under the Affordable Care Act. We had 14 States at the beginning of this week. Kentucky just announced that they were going to do an exchange, that brings it to 15, and the District of Columbia enacted either legislation or executive order to establish an exchange. Many others have taken other steps to set them on the path of creating an exchange.

About a year ago, the Foundation selected 10 States to participate in what we call the State Health Reform Assistance Network or the State Network, and we chose States that are diverse in terms of geography, demography, politics so that each of the States that are part of this 10 can serves as models for the rest of the country. Over the past year, we've worked with State agencies and helped them receive intensive, integrated technical assistance in implementing the Affordable Care Act, and this ranges from planning and data analysis, to giving them help in assessing the IT infrastructure, and

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evaluating the other systems that need to be transformed. When it comes to establishing the exchanges, States are working pretty hard, and there are many questions for them to think through such as where will the exchange be housed and how will it integrate with Medicaid, how will it interact and manage plans to participate, how to coordinate eligibility between the expanded Medicaid and the exchanges. The ruling by the Supreme Court last month allows the nation to move forward with health reform. Regardless of the issues and the politics of this, when fully implemented, the ACA will significantly expand the number of people with health coverage and introduce strategies to improve healthcare quality.

The Supreme Court has ruled, and in many ways the action really begins. I think we can safely assume that more activity from the States is going to be on the immediate horizon and it's going to have some impact. So we're very pleased to be a sponsor for today's discussion and like you, I'm interested and anxious to hear from the panelists, so let's get right on.

ED HOWARD: Thank you, John. Let me squeeze in a brief commercial before we move to the program. First, you haven't met the Alliance's Communication Director, Bill Erwin. You ought to. Bill is responsible for the production of our source book for reporters, both in print and online. He's in charge

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of our find-an-expert service; there's a flyer about it in your materials and you ought to take advantage of it if you haven't already.

Let me get right to our panel members. I'm going to introduce them in pairs if that's all right with folks. You'll find full biographical information in your materials so I apologize for the verbal version that I'll give them.

First, we're going to hear from Alan Weil and Michael Cannon. Alan is the Executive Director of the National Academy for State Health Policy where he advises States on best practice techniques for arranging policy initiatives. Michael directs health policies he studies at the Cato Institute. He's been particularly active in discussing the Reform Law in national media and in the States. Let me just ask for a few brief introductory remarks from each of you outlining an issue or two that you think reporters should be following between now and November, or are following and shouldn't be following, or any other aspect of the ACA that you think ought to be raised in a forum like this. Let's start with Alan.

ALAN WEIL: Thank you, Ed, and thank you, John and the Robert Wood Johnson Foundation for this event. We're happy to be a part of the State Network project that you described.

Before the Supreme Court's decision, I think most people knew that States were responsible for insurance

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exchanges. Now, after the decision, they also understand there's a Medicaid component to the law, but there are still many aspects, particularly around private insurance regulation and health care market organization that are under-attended to so, having been told to keep to five minutes, I'm going to lob out very quickly five quick topics that I will summarize as follows.

First of all, State-level debates tend to be more about real people than they are about ideology. I don't want to overstate it but I think it's generally more true than in Washington. One of the things that I think is more critical and probably gets less attention than it needs is all of the individual people in different ways who are being affected by the law and will continue to be affected. There's been a lot of attention to those under 26 who can be covered on their parents' plan, a little less attention, which I think is surprising, to the high-risk pool roll out, the effects of eliminating annual and lifetime caps on coverage, but also, just so that you don't think that all effects on people about the law are uniformly positive, in 2014, certainly healthy young adults will see their premiums go up and you might want to help them tell that story. There are some new taxes that go into effect; I'm not referring here to the mandate, and people who pay them might have some feelings about those. My guess is

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that the ability of State and Federal governments to provide excellent customer service is not going to be uniform around the country and there might be people who want to talk about the service they received. Are there affordability exemptions in the law from the mandate? There are many individual-level stories that I think are crying out to be told, and will be over a period of years. We were asked not to just focus on the immediate story.

Second of all, States were always interested in how they compare to their neighbors. If you look at the ACA as crafted, the expectation was that interstate variation would go down. After all, Medicaid eligibility was going to become uniform and then tax credit eligibility would be uniform above that. We're now in an environment where that may prove false. States can make very different choices about Medicaid which could actually exacerbate differences and if Michael is right, although I think he is not, that you can't get subsidies in a Federal exchange, then that would also be highly variable across a States. I think that it's very compelling over the years to help States not just describe what's going on but to see how the availability of services, the prospects for businesses and individuals differs across States.

Third, States are very interested in how people experience care. Unfortunately in my experience, most of the

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organization of care news is covered in the business page. It's about the hospital mergers, creation of ACOs and that's treated as a business story.

I just have a little vignette: my oldest daughter was sick a couple of weeks ago and we live in Virginia but we were up in Maine. It took me an entire day after her pediatrician here in Virginia in, I might add, one of the wealthiest zip codes in the country, could actually get her records up to Maine so that she could be seen in one of the poorest States, certainly the poorest and oldest New England State in the country, where she was seen by a nurse practitioner who had an electronic medical record and who e-prescribed the medicines she needed. So much of the healthcare discussion has been so abstracted from how people actually interact with care and all of these changes, if we treat them as business stories and finance stories, seem not to have any bearing on individual people, and I think that is something you all could really help.

Fourth, States are working on many different visions for the delivery of care, Medicaid-managed care, integration of behavioral and physical health, patients in their medical home, payment reform, integration of public health and population health services with personal health care services, these are the real story of State Health Policy and they're not just an

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ACA story. Some of those efforts are supported by, some of them are impeded by, but they're a parallel story and by lumping everything healthcare now into being about Obama care, pro or con, I think we're also doing a disservice to people actually understanding the changes that they are experiencing in the healthcare system.

Finally, and Ed, I didn't know you were going to say it, but I am glad you did, my fifth is the stories that don't really help very much. It's no surprise that there is a political campaign going on, on both sides of this issue and so many of the stories are really not stories that have any effect on real people. They're theoretical and they're based on, I would argue often, very questionable claims. I'm up in Maine and the governor is saying that the maintenance of efforts in Medicaid provisions are invalid. Where does that come from? Maybe from Michael, and you're going to hear a little bit about Michael's theory on Federal tax credits and I think that's a great one-day story. It's great that some analyst has figured out a way to read the law but until this actually has some bearing on people, unless you're political and you have to be in the five-minute news cycle, I don't think this helps. I would just close with this vignette. Within twenty-four hours of the release of the Supreme Court's decision, I counted 15 reporters who asked me the exact same question: How many States

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are not going to take up the Medicaid option? I just want to say that any story written within twenty-fours of the decision that tries to answer that question is only going to be a political story. It's going to be a talking point story. Fortunately in the last few weeks, we see analysis, costs and benefits, State budget, Federal budget, and there's some context and I just think that shortening the news cycle forces the stories into a political mold which, has its place, but I think for the average reader, if you can stretch that out a little bit more, these are much more robust stories. I think concepts and conflicts like MOE and tax credits are great, but they really do need to be stretched out in the context and not viewed as part of the daily cycle.

ED HOWARD: Great. Thank you, Alan. Have you been spreading stories like that, Michael?

MICHAEL CANNON: No. I want to thank the Alliance and the Robert Wood Johnson Foundation for the opportunity to speak to each of you and to throw out a couple of story ideas that focus really one or two main ones. First of all, really just themes. I agree with Alan that there are individual level stories that are not being told surrounding mostly the healthcare law. The ones that aren't being told are stories of the dislocation that comes from this law. If you recall, and maybe not all of you will, there is a study conducted of the

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child-only health insurance markets in all fifty States. If you'll remember, the law imposes its pre-existing provisions on the child-only market on September 23rd, 2010, six months after the law was signed. This study found that those markets collapsed under those government price controls immediately in 17 States and insurance left those markets in another 18 States. The people who broke that were actually Republican staffers at the Senate Health Education, Labor and Pensions Committee. That's the sort of stuff that I wish we didn't have to rely on the Senate Health Education, Labor and Pensions Committee to be researching. Those stories affect people. There are kids who can't get health insurance as a result of that law.

The Robert Wood Johnson Foundation financed a study estimating how many people would lose their current health insurance coverage as a result just so the minimum medical loss ratio requirement in this law. That study estimated that maybe as many as 150,000 sick people, and that's just people with high-cost conditions, would lose their existing coverage and have nowhere to go as a result of that one provision of this law, and that didn't even include California so the number might even be higher. I've been looking and I see very few stories, and that might meant that those people aren't out there. It could mean that. I know that some people are losing

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coverage due to this law but I don't see a lot of effort going into finding them.

Another theme is I think the track record of the government in trying to promote changes that the healthcare law tries to put in place. This isn't the first time that government has tried to improve the quality of care, reduce the cost of care through really central planning. They've tried comparative effectiveness research before and it always fails every time they try it. They've tried lots and lots of Medicare pilot programs. They've always failed every time and I think one story that is not being told is: why is that? And it's generally because anything the government does to improve the quality of care reduces cost threatens the revenues of some low-quality or high-cost provider and they lobby to kill that. I think that's a story that needs to be told more often.

But the two main story ideas that I wanted to talk to you about, and there are things in the packet pertaining to each, one has to do with the Independent Payment Advisory Board. A colleague who was actually the lead attorney on the lead lawsuit challenging that board's constitutionality, and I, found an aspect of this that we subsequently learned that some people do about but no one ever reported. We haven't found this reported in the news anywhere which is, under the law as written unless Congress repeals that board through the very

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restricted process that's available in 2017, then that board can go on writing laws and Congress can never touch them after 2020. I know it's absurd but that's what the law says and so that's something that deserves a little attention.

But the number one thing I want to talk to you about is an issue that has been gaining some attention this week. It is surrounding the question of whether the law authorizes tax credits and cost-sharing subsidies, and even the employer mandate in States that fail to create a health insurance exchange, and the IRS's effort never to offer those tax credits and the rest through Federal fallback exchanges. I'll just mention three quick points about this and if you have any more questions, we can certainly talk about it. I think the three most important things to remember are: Number one, the language of the statute is clear. The language explicitly repeatedly restricts those tax credits to exchanges "established by a State under Section 1311." Number two, that language does reflect congressional intent. The Chairman of the Senate Finance Committee who wrote the bill that first included that language and eventually became law said that those tax credits are restricted to State money exchanges. They are conditional upon the State's creating their own exchange. So you've got clear language, you've got congressional intent, and the third thing to remember about this issue is that the House passed

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that bill, the bill passed the Senate, and made minimal changes to it through the reconciliation process knowing that there were imperfections in this bill. They knew that there were imperfections and they passed it anyway. Right there, that's game, set, and match. It shows that there's a lot more to be said about this, a lot of questions that are being raised. I think those three factors just positively show that actually those tax credits are thought as non-authorized through Federal exchanges and it suggests that with the IRS rule offering those tax credits Federal exchanges is doing and the precedent that its setting, is very dangerous one because it's not just tax credits that that rule creates without congressional authorization, those tax credits trigger further government payments to private insurance companies, taxes on employers that Congress did not authorize, debts and spending that Congress did not authorize. I think that story deserves more attention. Also because if my and co-author's read of the law is correct, that means that the law is even more unstable and more likely to collapse than people think right now.

ED HOWARD: All right. Thanks very much, Michael. Now, we're going to turn to two seasoned healthcare journalists on my immediate right, John Reichard who is the editor of CQ's HealthBeat, a web-based news service with all the best stuff on health policy which I wish I could afford. He also edited

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Medicine and Health in another area which I rely on as the source for what was hot in health policy when I was on the hill. And then we'll hear from Marilyn Weber Serafini, who has been covering D.C. long enough that if you ask her how do you think the health reform today turn out, she'll ask you which one? [laughter] She's done really great work for the National Journal, started their healthcare expert blog and is now their Robert Towner Senior Fellow at the Kaiser Health News. Let's start with John.

JOHN REICHARD: Thank you, Ed, and for the invitation to join today's panel. I have to admit that when I got your invitation, I had mixed feelings. On the one hand, it's certainly an honor. I've never covered an Alliance even without coming away with either a story that day, a story idea for later, or a good contact. We take the Alliance as a given, but what if it wasn't here? Who else gives you the best sources and balance, too? Speaking of balance, I'm not going to be able to call you by your proper name. At CQ, the word 'reform' is verboten because it implies something positive and we're supposed to be neutral so thank you, Alliance, for health overhaul.[laughter]

ED HOWARD: I have a ground rule suggestion here, and that is in the interest of simplicity, let's stipulate that one can refer to this law as the PPACA, as the ACA, as the

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Affordable Care Act, or just the Reform Law, without being docked points for political correctness or incorrectness. Just use the name of the acronym of your choice. Okay, go ahead.

JOHN REICHARD: As I said, mixed feelings because having written hundreds of stories on the Health Law, I thought, great, here I am scratching for something my competitor don't have. If I am to be credible on the panel, I have got to get up, give up whatever I do to come up with. Well, that was Mr. Ed speaking, as he so often does, with the Health Law, there's no end to possible stories, particularly now that the court has ruled. I'm sure from your questions today, I'll come away with many more stories that I'll ever give up and maybe from your answers, too. I see a number of colleagues in the audience who knows much or more about the Health Law than I do. I'm going to talk a few minutes about exchanges and then two minutes about how the Health Law aims to fuel changes and payment to spur less wasteful treatment.

So what are the key developments to watch for on exchanges the rest of the year? The most obvious one is the election. If Mitt Romney wins and if the Republicans can get the 50 votes in the Senate or maybe just close to 50 votes, the Health Law could easily be a goner. I don't think that everything would go but instead of having exchanges in fifty

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States or a Federal fallback exchange, we might have only a few hang on for a while. The history of exchanges shows that they don't last long if they aren't mandatory, or they aren't a place where people could get subsidies to buy insurance. But Federal officials and many State officials aren't going to wait to see how the elections turned out. They'll be busy trying to create exchanges because they have very little time to finish them. Under the Health Law, open enrolment in the exchanges is supposed to start a little over a year from now in October 1st. Look for HHS to dangle technical assistance and grant money in front of States in the coming weeks to get them to create their own exchanges. HHS is sponsoring one regional meeting in July 31st as a listening session to hear State concerns, and three more in August. Mid-August is the deadline for the first of ten more opportunities States have to apply for grant money. States can get the money as late as the end of the first year of operations or December 31st, 2012, even if they have done nothing until then to create their own exchanges. The big date to watch out for this fall other than the election is November 16th, which exchange insiders call the Declaration Day. That's the day States have to tell HHS whether they plan to run their own exchange, do an exchange in partnership with HHS where the State does some functions and Federal officials, other functions, or say they will do nothing. If they do that or

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they don't respond by November 16th, that's the declaration that they will do nothing and the so-called Federally-facilitated exchange will step in.

The next big date after that is January 1st. The HHS at that point will certify States either as approved to open their own exchanges for 2014, as conditionally approved if they fulfill certain requirements in 2013 as a partnership exchange or as a place where the Feds will run the exchange. I often concluded on the exchanges by throwing some numbers at you. The industry and other analysts expect 15 or so States to open their own exchanges on time. Thirty-four States have received establishment grants totaling $850 million. 10 or so other States have applied for that money. At California, officials see zero chance of State funding for the California exchange if the Health Law is repealed next year. Shifting the payment, arguably, this is one of the underreported aspects of the Health Law. Later this year, some 3,000 hospitals will see the start of the value-based purchasing program under the law. In theory, this could create some real benefits for the consumer. Let's say I'm a hospital patient and the nurse ignores my call button or is cavalier about bringing me pain medication, or my doctor doesn't really explain what's wrong with me or answer my questions, or my room is messy and so noisy I can't ever sleep, or to take some other examples, I'm admitted to the hospital

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with a heart attack and I didn't get a clot dissolved within thirty minutes or angioplasty within ninety minutes, under the value-based purchasing program, hospitals are supposed to be paid less as a result of, or more if they do a good job in those areas. In a few weeks, some 3,000 hospitals will be notified how Medicare will drop or increase their payments based on how they did on these measures. Sixty days later, Medicare tells them what the final adjustment will be. Payments themselves will rise and fall starting in January.

Value-based purchasing also calls for hospitals to be paid more or less based on how efficient they are. This is supposed to start this fall but has been put off until at least 2014. The way this works is that Medicare calculates how much it spends per beneficiary at a hospital on average, taking into account the period that starts a few days before admission and the thirty days after discharge. The per-beneficiary average is then compared to the average per beneficiary for all hospitals. Hospitals get paid more or less depending on how they do against the overall industry average. I'll wrap up by mentioning a couple of other payment approaches the law pushes forward but on a test basis, global budgets in patient-centered medical homes. Their idea of a global budget is to set a spending target ahead of time for a group of providers for the continuum of care they give Medicare patients. Beat the target

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while meeting quality standards and you get more. Miss it and you get paid less. That's how the pioneer ACOs and Medicare are paid, and it's the approach of lose or taking through their alternative quality contracts in Massachusetts for commercial enrollees. The contracts are supposed to be part of the way Massachusetts controls it spending on its historic overhaul law. In the interest of time, I'll stop there but we can talk more about these concepts during Q and A.

ED HOWARD: Great. Thank you, John. Marilyn?

MARILYN WEBER SERAFINI: Great. Thanks, Ed. You know, this wasn't how I intended to start and I really have a few subjects that I'm going to hit briefly, in hopes of leaving plenty of time to talk about what you want to talk about but Alan's number five, the stories that don't matter, just a word about that. I think plenty of what-if stories don't matter but I think a lot of them do matter if they're done the right way. Right now, just about every story that is being written in Washington about healthcare is a what-if story because everything is at play. We've got the elections coming up. Everything is going to be a what-if story but I think what Alan was saying about getting the real people involved, how does this affect the real people, how does this affect the stakeholders, that is an important story to tell if it's done right and you can get deep enough with the real people involved

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and that has an important role in actually potentially shaping the debate in some of the decisions that are made, informing people so that they can know where they can want to stand and where they want to be on these issues.

One of the three issues that I'm going to hit briefly is Medicaid and of course, we can just spend this whole session talking about Medicaid. You can't cover healthcare without covering Medicaid right now. It was the big surprise. So what have we been writing about? We're some of those people who were calling Alan and asking him how many States are going to not go with the Medicaid expansion. I'm sure everybody in this room has asked that question. There's just stories you have to cover. You have to write about who's in, who's out, who's maybe. If we can take a step back and try to think about how we can move that story forward or write it a bit differently, then we start to come up with questions about, well, okay, the Governor is saying this. Is the Governor the only person making that decision? So let's get into the States. Let's look at the partisan differences between the Governor and the State legislatures, who's going to be making these decisions, how is it going to be made, and let's look at the stakeholders because the politicians are not going to be making the decisions in isolation. One of our reporters at Kaiser Health News just wrote a story about the pressure in Texas that the

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stakeholders there are putting on the politicians to go ahead with the Medicaid expansion. There's a lot of pressure from these guys. Just look at the hospitals. They cut a deal in the Health Reform Law where they said, okay, we will take these cuts but you have to give us the insured people. So now, they're looking at a situation where, in some States, if they don't go ahead with the Medicaid expansion, of course then, they're looking at fewer insured people and they're worried about their DSH money, the disproportionate share money that they currently get for uncompensated care. Now in all fairness, that is tied to a certain extent to how many uninsured people there are in their district. They're not going to lose all of that money but this is a big deal to the hospitals and to the other stakeholders, the individuals. There's a lot to be done in the States with getting at the stakeholders and being able to put a real face on what this means for them. There's also a big money issue. There's a lot of this rhetoric. This going to save State's money, it's going to cost State's money, it's going to save the Federal government money, it's going to cost the Federal government money, and we're hearing a lot of rhetoric on this. I ran a story, I think it was last week, about the Federal government and whether the Federal government would actually save money or whether it would cost them money if the State actually backed

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out of Medicaid. This is something that the CBO is going to score pretty soon. It's something that just about every organization in Washington that crunches numbers are looking at this and they're coming up with very different conclusions. The folks mostly on the right side are saying that it's actually going to cost the Federal government more money if the State doesn't go ahead with Medicaid. There are some other people who crunch the numbers and they say, no, it's just the opposite. The Federal government's going to save money. My point is only that there is a lot of rhetoric and the more that we can do to get in there and to try to just pick out a piece of it and put a real face on it, even going forward with some of our own calculations, I think is very helpful.

Okay, so we're all doing Medicaid. We've been spending so much time focusing on Medicaid that we've seen a lot less reporting about the budget deal which is quickly coming to a head. January 1st, of there is not a budget deal then we're going to see automatic cuts. Is it possible that we're going to see a budget deal before January 1st? I think regardless of who wins big in November, it's looking unlikely that this is going to happen, so where does that leave us? It leaves us with automatic cuts on January 1st, potentially, and then very likely, we're still going to see the politicians in Washington going for some kind of a deal after that. Just because we go

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with the automatic cuts doesn't mean the discussion is over. So what does that mean for healthcare? Medicaid is essentially held harmless. Medicare can only be cut by 2-percent. Where does that leave the rest of the healthcare programs? It sets up a healthcare program versus healthcare program scenario. Does that mean that the CDC, which already had some big cuts in the not-too-distant past, will be cut 9-percent? That's not a statistic I'm giving you hypothetically. Some people are calculating that some of these healthcare programs could be cut as much as 9-percent. For an agency like CDC who is out there and the pressure's on to deal with food-borne illnesses, to deal with prevention, what is that going to mean if there are actually 9-percent cuts in a year? It wouldn't be every year but it could 9-percent in any given year.

Then there's also the healthcare program versus other programs. If you look at the Appropriations Committees, it's not just the Healthcare Subcommittee; it's the Healthcare, Labor, Education so that raises big questions. How much ability will a committee be able have to decide where the cuts are going to come from? If the pressure's on for Education, then will the hit be greater to Healthcare? Also and this doesn't have anything to do with Healthcare versus Labor and Education, programs that people around Washington are saying they're concerned about, Ryan White, Aids funding, I think it

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will be great to focus more on some of these programs to talk about what the real impact could be. This is going to be a race and some of these healthcare interests are in a better position than others to do deal with this. For instance, NIH does a very good job and the research institutions do a great job of making their voices heard in Washington to keep the money flowing. That's why I brought up AIDS a little but because some groups are not quite as good at really being able to ensure that they're going to get the real big money. I think we're going to really look at this group versus group battle going on.

All right, the last issue that I'm going to hit here is the IPAB, the Medicare Board, and this has already been discussed a little bit. 2013, that's actually when this gets started. Nothing can happen until 2015, but as early as 2013 is when we're actually going to start seeing this board if it is appointed, and if it appointed before then, we'll actually start working and looking at where we are in terms of meeting the targets. The trigger of the IPAB is CPI in early years, a formula that involves CPI and then it moves to Gross Domestic Product plus 1-percent. Now, President Obama last year changed that target, not officially, but he started talking in the budget negotiations about considering GDP plus half a percent. After that, Paul Ryan who in his budget deal from the previous

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year had also said GDP plus 1-percent then said, "Well, if the President can say GDP plus half a percent, I can say GDP plus half a percent." So then he started talking about that, as well. So I think we're going to have to start looking at the IPAB sooner rather than later, and in the context of what's going to happen in the budget deal and something that we're not really going to talk a lot about here at least in the intro, is what happens with the efforts on entitlement changes, Paul Ryan's other ideas to reduce the cost of entitlement programs? This is really hard to talk about because no one knows what the elections are going to turn up, but what I can say is that every time I talk to any healthcare stakeholder around Washington, they're saying we're meeting privately. We're talking about how we're going to handle this, what is our position going to be, how are we going to approach this when it comes, and they're starting to put together all the various scenarios. Before the Supreme Court made its ruling, we had half a dozen stories ready to go. None of them worked exactly, but that's a lot of what these stakeholders are doing, the hospitals, the insurers, all these groups. They're getting together and they are starting to talk about this. They're doing to privately. They're not coming out with these big ideas yet but if you start to talk to them, they will tell you what they're thinking, how they're moving, and I think there's

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some early work to be done on that. Whether it leads to stories now or whether it leads to stories later, I think it's worth starting to talk to those stakeholders. I'll stop there.

ED HOWARD: Okay, I know it's going to be hard to get you to speak up and ask your questions here a reticent group but try to overcome those inhibitions and if you would, do we have a handheld microphone? If you will hold your hand up, someone will hand it to you and you can address your question to anyone on the panel. John, let me formally invite you to be part of this, either as a questioner or an answerer. Let's start here. If you'd identify yourself, we'd appreciate it.

MAUREEN GROPPE: Maureen Groppe with Gannett, question is for Alan. In trying to cover the decision that the States are going to be making in whether to do the Medicaid expansion, two questions on how to do that, one on the DSH payments. I was trying to figure out how much the State might, say it covers like little lose and DSH payments and I'm told that that determination will be made later by HHS. When will that be made? What will it be based on and can you look at what the State is getting in DSH payments now to give some kind of sense of how much money is at stake for the hospitals. And then secondly on the point about talking to hospitals and other stakeholders in the State about what they're doing to try to convince the legislature and the Governor to go along with

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this, is that happening now or is the intense lobbying not going to happen until, for example, the legislature convenes next year? In general, what's the timeline for when they're going to have to be making these decisions?

ALAN WEIL: On this issue, I have no knowledge on when HHS will offer additional guidance. The statute is, as I recall, fairly broad in terms of giving some factors that HHS is supposed to consider in how it allocates the DSH cuts, but it's not a formula that you can read now and know how it plays out. Obviously, one of the questions States are asking is since the number of uninsured is one of the factors, the choice of whether or not to do the Medicaid expansion is going to have a significant effect on the number of uninsured and so they may actually get less of a cut. That said, I think you can pretty easily start with where the State is now and have a sense of how much is at stake, but I don't know that you can do a lot more detail than that.

You're talking about lobbying about whether or not to do the Medicaid expansion so here's all we know. HHS has made very clear that unlike November 16, there is no declaration day for the Medicaid expansion. Like any other State-planned amendment, you would submit it and it would go through review, it would be approved, and there's some lead time, although it's not much. I think in States that know what they're going to do

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and have sort of tipped their hand, they're done. I do think that we see the battle playing out in some States. Marilyn described some of the discussion going on in Texas in terms pushback. I can't exactly say when the lobbying will occur, will start, will end. I think what we do know is what the provider interest tend not to really get partisan before an election because they're hedging their bets and they need to be able to work with whoever wins. So I think they're going to have these sort of high-level talking points, like a lot of money is at stake, but they wouldn't sort of say you're right, you're wrong in the middle of a campaign. That's more likely to wait until after that. It also means they'll be more clear on what the future of the law is going to be. There's no question from a planning perspective, people would like this to be answered sooner rather than later because there are some very important practical implications about building your eligibility systems where delay here is problematic but my guess is that the interest they want to see it happen would be they could live with it happening in September of 2013 as long as it happens. So they'll pick whatever they think is the best time they're going to be most likely successful.

JIM GUTMAN: I'm Jim Gutman of Health Reform Week, a question for Alan again because you brought up the subject, Maine and the maintenance of effort and the Governor's argument

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on that. We're a subscription newsletter with a largely industry audience so they're not looking for us to evaluate how good or bad the argument of the Governor is but how many other States are apt to do something like this or say they're going to do something like this and what's likely to happen as a result. That's my question for you. How many other States might make that argument to cut their current Medicaid spending and claim the Supreme Court ruling makes that a valid choice?

ALAN WEIL: Well, I did a call with certain officials, sort of mid-level folks, on a number of topics and I was struck by how many came back to this MOE question so I'm going to answer a little bit in a follow-up to Marilyn's reaction and to mine, and then I'm sure others will have things to say about this.

First, I just want to be clear. I wrote a piece with Horatio Puck [misspelled? 00:46:44] who was then the Chair of the National Guard Association shortly after the law was enacted. There are many reasons why States might not want to implement an insurance exchange and we said that and there are reasons States might not want do a Medicaid expansion. I'm not saying they should or shouldn't do it. That's never been my perspective. What I do think is important as reporters and the intermediaries between the people who are doing the talking and people trying to understand what's going on, is that resistance

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to State implementation of the law has been a conscious political strategy adopted by opponents of the law and so sowing the seeds of uncertainty plays into this notion of, well, why would we want to do this in the first place? We don't know what the future is. And that has substantive consequences. I'm not saying these aren't stories to be written because I believe they are. I just think that they need to be placed in the context of the political environment that generates them as much as the substantive issues that are at play, and I'm certainly not suggesting they shouldn't be reported because they are very important which leads me to try to answer your question directly. I don't think this is a close call about whether maintenance of effort.

As I'm sitting here, you all have them too, I see that CRS just released something that also concludes that maintenance of effort and other provisions in Medicaid are still in force so I don't think this is a close call, but we know that States listen closely to each other and I think what we should expect is that many States that are concerned about MOE will be listening carefully to see how the Secretary responds. The Secretary sort or preemptively responded a week or so ago with her letter saying all other provisions are in force and now we're going to see what the formal response is to the State. You may recall this happened with Arizona. When

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Arizona pulled back a year plus or minus ago, there was a big story that the Secretary was backing away from maintenance of effort. It turned out that that's not true. What the Secretary was doing was saying there are provisions of the law because Arizona was operating under a waiver that they are not bound by any Federal law to renew their waiver. So again, this is sort of the internal State politics news cycle which is, I think, one State goes out front and a lot of people are going to be watching, and if it looks like the door is open, a whole bunch of others will run through it. But do I think a lot of others will actually follow closely behind and force the issue? I think now that there's a test case, they're likely to want to say at least the early responses before they take it on. They may rhetorically offer their support but substantively, it's hard to imagine them moving right behind Maine.

MALE SPEAKER: Michael Cannon, you've talked to a lot of States about what they ought and ought not to do to implement this law?

MICHAEL CANNON: Not very much about Medicaid, though, or at least my conversations with States about Medicaid have gone like this. Before the Supreme Court ruling and before I told them they should not implement an exchange, I said you shouldn't expand your Medicaid program and they all just sort of laughed at me because that meant losing 12-percent of their

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budgets, but I was arguing for it when it wasn't cool. Now, however, I don't even have to make that case to States anymore because on Medicaid, they can't afford the programs that they've got and so a lot of them are not looking to expand it. If it weren't such a good deal for them, would Congress have had to mandate it?

On the maintenance of effort question and whether that still stands, I think I believe the CRS and I agree with Alan. My read of that language, and it wasn't touched by the Supreme Court's opinion; however, the Supreme Court didn't really draw a bright line between what is coercive and what is not coercive. It said the line is somewhere well shy of what Congress actually did which was tie old Medicaid funding to the creation of a new program, that Medicaid funding is more than 10-percent of State budgets, etcetera. It remains to be seen exactly what other sort of conditions will invalidate as unconstitutionally coercive. It doesn't seem that the Medicaid maintenance of effort provisions will be found as unconstitutionally coercive by this court. Then again, you had 7 votes for what the Supreme Court did this time around. You don't need 7 votes. You might lose 2 and still get a ruling something like finding the maintenance of effort provision unconstitutional. Between maintenance of provision and the Medicaid mandate, what the court did strike down, is this

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requirement that's in the law that says the maintenance of effort provision will be lifted as soon as the State establishes the health insurance exchange under Section 1311. It's actually somewhere in between those two, and there you do have conditioning funding either on State's maintaining effort or creating a new program which the Supreme Court is saying verboten, or conditioning old Medicaid money on new program is verboten. I haven't spoken to anyone in Maine about this but it maybe that that State or some State just wants to see exactly what they can get 5 votes for on the Supreme Court, what's the most that the Supreme Court is going to strike down as unconstitutional.

ALAN WEIL: Can I player lawyer for two minutes? I promise that I won't do this too often. It is true that we don't know the boundaries of what the courts will find coercive. The language was very vague. It is also true that the Supreme Court has issued its ruling on NFIB versus Sibelius, and they have stated with finality what their view is on the Affordable Care Act. They have stated with finality that MOE is still intact. If Congress were to do a different MOE next year, if they were to do an incentive on welfare, if they were to do anything starting tomorrow, I think it's totally appropriate to ask the question, where would the court draw the line? I don't think we know where the line is, but

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NFIB versus Sibelius has been decided and it has decided in the final voice of the court what falls on which side of that line, so I don't actually think there's anything in the ACA that you can ask this question about although I think it raises a huge number of questions about all kinds of other things.

MICHAEL CANNON: I don't know that anyone cares but I'm not sure I agree with that because I don't think they consider each of these questions separately, they look at the big Medicaid issue.

ED HOWARD: Other questions? Yes, right down at the other end.

JEFF YOUNG: I'm Jeff Young with the Huffington Post. I'm going to phrase my question really broadly because I don't want to lead anybody in a particular direction. When you look ahead in the next year in change before these exchanges and everything are supposed to be online, considering the Federal government's role, the State government's role, the health insurance industry providers, and patients, what do you see as the most potential weak spots, that is to say the things most at risk of failure, that would lead to the promises that this law makes to the American people, not being fulfilled?

JOHN REICHARD: I can answer. I was sort of struck this week by Karen Agnani's presentation at Healthy First briefing where she talked about the different factors in the

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Health law that would combine to drive up premium costs for the young, age rating bands, essential health benefit provisions, a couple of others, and I really think a big question quickly for the States that are really opening up the exchanges is going to be okay, this is coming up pretty quickly. What are the rates going to look like? If you open up an exchange, you're like a shopkeeper opening up your business and people coming in. You want them to like your merchandise and I think there's an undertone of real concern about that and how will that be dealt with.

MARILYN WEBER SERAFINI: Just one point, I think we're starting to hear more and more talk from people that the way around the budget problem is to delay the Healthcare Law a year. If we see that kind of delay, I think that could have a lot of implications.

JEFF YOUNG: And does the fact that the money that is on the table, that could be used to help in the budget situation goes to fund things that haven't started yet so they don't have quite a strong a constituency as existing programs at NIH and some of the others that we've talked about have any appeal?

MICHAEL CANNON: To answer your question, Jeff, if there are no tax credits and cost-changing subsidies in Federal exchanges and you have a lot of States not creating exchanges,

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then what you're going to have is a situation where all of the other regulations, the community rating price controls, the individual mandate, all these things operate within a State, but you don't have the tax credits and subsidies there to shift the cost of those regulations, from insurance purchasers and insurance companies onto tax payers. If those tax credits and subsidies weren't there, that doesn't increase the cost of insurance because those tax credits and subsidies just shift the cost to taxpayers. It would expose to those two groups, health insurance consumers and health insurance companies, the full cost of those regulations, and the carriers are not just going to sit there and let that happen. They're going to lobby their first preference, I'm sure, would be for more subsidies. By all means, give us money through Federal exchanges. But they're not going to sit there and let that happen. I imagine you would see a lobbying effort like we might have seen, like they were gearing up to launch if the Supreme Court had struck done the individual mandate. You probably saw their Facebook page and them doing other things to get out the idea you can't just have these community rating price controls without the other stuff to subsidize us or else we'll go out of business. If those two things happen, if there are lots of Federal exchanges, lots of States don't create them and there are no tax credits and Federal exchanges, I think that is the number

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one thing that is going to, you could say, destabilize the law but also make it apparent that it's going to fall short of its promises.

ALAN WEIL: I'll offer three, two of which I think are quite consistent with where Michael has been today. The first is he, very appropriately, mentioned the dislocation that's already occurred. I think for most people, the law will have surprisingly small consequence and that's sort of frustrating watching this politics play out, but there are a lot of people who fall in the category of pay more-get more who have sort of inadequate or thin benefits now and will be essentially forced to buy a product that has more value but also has higher cost. I think that's a complicated dynamic because you're paying more so you're mad, but you're getting more so you should be happy, and how people perceive that if they just focus on the pay-more side which is likely, I think that's a real challenging area.

The second is eligibility systems. We do a lot of work in this area. You can already file your story for January 1st, 2014 about all the people who tried to sign up for their new benefits and can't get them. You could write it. The good news is you already did it for the Medicare Part D. Prescription Drugs, so it's the same story, and it will pass and you should plan on that.

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The third is, and not surprisingly I would characterize it a little differently, Michael, but I think it's ultimately the same issue. At bottom, this law puts tremendous control at the State level to spend Federal tax dollars. So the Medicaid expansion is paid for by the government and the tax credit subsidies, the size of which depend on how the State operates its exchange and the bids it gets from the carriers, those subsidies are paid for by the Federal taxpayer. I think in this budget environment, the likelihood that despite all of the Secretary's pronunciations that she wants to be flexible, and I believe those were genuine, at the end of the day, someone is going to be looking at the Federal budget and say, wait a minute, we can't give all this authority to this other level of government to spend our money and that clash, I don't know how it plays out, but I don't think it will be pretty.

MICHAEL CANNON: Let me just add one other comment to that, and that is that the healthcare in this country is approaching 20-percent of the economy and we have a tremendous amount of uncertainty about what 2014 is going to look like. If that economy bets wrong on what the realities of 2014 will be, the ability to deliver services in an efficient way to actually meet the demand at that particular time will be in jeopardy.

ED HOWARD: There's a question there. Yeah, go ahead.

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FEMALE REPORTER: Yes, thank you so much. For my question, I was just wondering if some States would refuse to adopt the ruling on Medicaid, I was just wondering as to whether those people in certain States that would not therefore be helped by Medicaid, and if Medicaid is their only source of healthcare, would there be a likelihood that a certain part of these specific groups would move to other States that may accept the Medicaid, the Federal mandate? I'm especially referring precisely to the immigrant or more or less the newcomers into this country who are probably less able to have access to healthcare.

MICHAEL CANNON: That's a concern that States have about the Medicaid programs and all their mean sensitive programs is, if they're too comprehensive, they become a welfare magnet. People come to the State to take advantage of it so that's a concern that States have right now. In the wake of NIFB verses Sibelius is if we expand our Medicaid program up to 138-percent of the Federal poverty level and our neighbors do not, do all of those people move to our State and increase our tax burden, increase the burden of our programs? That's a real concern.

ALAN WEIL: And a couple of things. I mean one is since you amended it in the end by focusing on immigrants, of course, legal immigrants are barred from Medicaid for five

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years so that particular group won't be moving for Medicaid benefits. There is a long literature on welfare, less so, to my knowledge, on healthcare. About twenty years ago, if you asked welfare researchers, do people move for welfare benefits, they would tell you mostly no. And then about a decade ago if you asked, they would say, well, there's starting to be a little evidence of that so I think we're not quite sure. I would just note that there are already huge variations today in eligibility standards for these programs. If to the extent that this is a problem, and I completely agree with Michael, it comes up in every State conversation I've ever had. But to the extent it's a problem, it's not as if it didn't exist and now it will. I think that just the texture of it will change, but these potential large gaps of one State up to 138 and one 17-percent, that's a pretty big gap.

MICHAEL CANNON: A parallel issue with regards to health insurance exchanges, I'm sure you're all familiar with how the employer mandate works under the Health Care law. Employers get hit with penalties if and only if one of their employees receives a health insurance tax credit through an exchange Now, if the argument that my co-author and I are making is correct, that the statute does not authorize those tax credits in Federal exchange, then a State that establishes its own exchange, that State's employers will be penalized

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under the employer mandate. But if a neighboring State does not establish an exchange then there will be no tax credits to trigger those penalties against those employers and the employer mandate will not operate there. So this is another concern that comes up at the State level. What if we create an exchange and we have this $2,000 per worker tax imposed on our employers but our neighbors do not? What is going to happen to the climate for jobs in our State? Are employers going to move next door? Or are we not going to be able to attract employers that way that we had before? These sorts of Federalism issues come up with regards to exchanges, as well.

ALAN WEIL: I think it's also important to recognize when we say the Medicaid population that we actually understand who we're talking about. In Medicaid expansion, roughly about 80-percent of the individuals who will be accessed to Medicaid will be childless adults and who are working, so these individuals will be forced with the choice in this economic environment of high unemployment, do I give up my job to move to another State versus staying? So I think the dynamics in this particular environment are really hard to assess.

ED HOWARD: I don't want to ask a question that I don't know the answer to but we have some experience with a parallel situation in Massachusetts. For the last three or four years,

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has there been any evidence of either movement or lack of movement, because of the mandate there?

MICHAEL CANNON: A colleague of mine, Ern Yellowitz at the University of Kentucky, who's student and co-author with Jonathan Gruber, he and I did a study of Massachusetts a couple of years ago that we need to update where we found evidence consistent with fewer young people moving to Massachusetts after 2006, after they imposed a very similar law in their State. It was correlation, not causation, we can't prove but it's consistent with the theory that because that law increases the cost for health insurance for young and healthy people, really because they imposed the mandate, that caused fewer people to relocate to the State.

ED HOWARD: Further questions? Comments from any of our panelists that are over here? Well, an interesting group of topics. I hope you profit both from the rich discussion and from the materials that we've put in your packets. It took a long time, somebody pointed out to me this morning, for every State to get onto the Medicaid bandwagon when it was enacted in 1965 and I think Arizona didn't come on until 1982. So we may have a continuing storyline for you for as long as you want to be reporters. Thank you for being here. Thanks to the panelists for their contributions and we'll look forward to

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reading what you have to say, listening to it, and watching it.

Thank you. [Applause]

[END RECORDING]

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