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Low-Income Adults: Can Medicaid Fill the Coverage Gap?
Alliance for Health Reform and AARP Public Policy Institute
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ED HOWARD: Good day. I'm Ed Howard with the Alliance for Health Reform and on behalf of Senator Rockefeller and Senator Collins, our congressional leadership and our board of directors I want to welcome you to this briefing on whether and how to use medicaid as a vehicle for covering low income uninsured adults in America.

Our partner in today's program is the Public Policy Institute of AARP and in the spirit of full disclosure, AARP's executive director, Bill Mavelli serves on the Alliance board so we know all about the PPI. We're very pleased to have Susan Reinhard from the Institute with us today.

Now everybody knows that Medicaid covers health care expenses for a lot of low income people. In fact, it covers more people than Medicare in the course of a year and if you count both the state and the federal money that's involved, it spends more than Medicare does in the course of a year.

But what a lot of people don't understand is that millions of low income uninsured people can't qualify for Medicaid at all, no matter how poor they are, because to qualify for Medicaid, one has to not only be eligible financially, that is meeting the income and asset limits that the program sets in each state.

One has also to fit into one or another of the boxes of eligibility, categories of people, you're over 65, you're under

19, you're the parents of somebody who's under 19, just to name a few, and there are more than I can recount for sure. There's a PPI paper in your materials, it's called "What Can Be Done" that sums up the goals of today's discussion and that is what are the policy options for extending coverage to low income Americans who now don't fit into any of those boxes? And what are the strengths and weaknesses of those options?

Before I introduce my co-moderator and the people on today's panel, let me just make a couple of logistical observations, you're going to be able to view a webcast of this briefing by tomorrow on Kaiser Network.org and a few days after that, there will be a transcript available of the briefing, not just on Kaiser network.org but also on the Alliance's website, allhealth.org along with electronic versions or links to all of the materials that you have in your packets today and we'll send you an e-mail to let you know when the transcript's available.

You will note there are both green question cards in your packets to use at the appropriate time and a blue evaluation form that we ask that you fill out to help try to improve these briefings as we go along. So if you would turn your pagers and cell phones off or at least to vibrate, let's try to get started.

Now, as I mentioned, Susan Reinhard is here from the PPI. Susan is a senior vice president at AARP. She directs

the public policy institute. She came to AARP from Rutgers where she was on the faculty and codirected the Rutgers Center on State Health Policy. She's a nationally recognized expert on Medicaid and long-term care and on nursing policy issues and Susan is going to be sharing moderator duties today. Terrific to have you here, Susan.

SUSAN REINHARD: It's a pleasure to be sitting next to Ed. I'm looking at our logo sitting there together, it looks pretty good. It looks pretty good because we've been in the process of developing today's forum for several months I guess and it always feels good to actually be here with you.

I want to acknowledge three of the members of the Public Policy Institute who are probably humbly sitting somewhere in the back who had a lot to do with this, Sarah Thomas, there she is, she is the director of the public policy institute health team, and Linda Flowers, there she is, who is really the direct, directing this project with Stan Dorn and has long been committed to issues of Medicaid and help for low income persons in her long career and Rick Doitch who is the director of our communications and outreach who has been terrific in helping us to change the focus on the public policy institute to do things like this, to sit with Ed and with all of you here to have this discussion.

We write lots of papers, the public policy institute has been around for 25 years or perhaps even more. We really

want to have the opportunity to stimulate more discussion of sound and creative policies for all as we age. I'm sure, if anyone has a T.V. have you seen those "Divided We Fail" commercials? We have a lot of those and they're very serious about trying to make sure we, all of us, insist that our policy makers really take up the issues of economic and health security for all of us as we age.

It is not about specific solutions in that movement. AARP has certainly had some specific ideas and they are contained in something we're releasing today, "Building a Sustainable Future: A Framework for Health Security" and there are a range of options here around issues that I think people who came to this meeting would be interested in because you have similar interests.

What brings us here today of course is what Ed has already suggested that we're here to be talking about. Ed and his staff have been tremendous as you all know because many of you come to these sessions for many years now. I think we were chatting earlier that he is blessed with an amazing set of colleagues that made it possible to be here today so we appreciate all of that.

So we are very interested in having this session today. You've already heard from Ed about what it is about. Stan Dorn has been working with us on this for what, about a year now, Stan?

STAN DORN: Maybe a year and a half.

SUSAN REINHARD: A year and a half so we've clearly given this a lot of thought. In December, we had something known as an innovation policy roundtable to start thinking about it and some of you were at that. I know Nina, for example, was part of that discussion so now the paper is finished and it's ready for prime time, I guess you would say, and I don't want to steal Stan's discussion of the various options that we are going to talk about so I'll just not go there, so you can talk about it.

But I did want to also mention another handout which I guess it isn't in your packet but it's at the back in the National Economy for State Health Policy, just also released today or this week, which is really quite fortuitous because it talks about how nearly half of the states currently are providing some programs in place for some low income populations and you know, although not all of them had everything we would like, it does show that something is possible, some states are doing more than others.

I'm a big fan of states as you've already heard, and so we want to make sure that you have the latest information on what's going on and the various ways they're preceding it. So Ed, let me turn it back to you so we can get going.

ED HOWARD: Great Susan. Let's start by bringing on stage the aforementioned Stan Dorn. He is a senior research

associate at the Urban Institute. He is obviously the author of the paper that serves as our jumping off point in today's discussion. He's been working on Medicaid and low income issues as an analyst and an advocate for more than 20 years. One of the world's foremost authorities on using tax credits to help finance health coverage and he's I'm pleased to say graced this podium a number of times. Stan?

STAN DORN: Thank you so much Ed for hosting today's gathering along with AARP and thank you, I'd like to thank AARP for supporting our work. A lot of people, well informed people, think that as messed up as the health care system is, at least the poor have Medicaid but in fact that's not the case as Ed just told you. It's not enough to be poor. You also have to fit into a federally defined eligibility category.

That means you have to be a child, a parent currently caring for a dependent child, or a pregnant woman. You can refer to this as the child centered half of Medicaid eligibility. You have to be elderly or someone with a severe and permanent disability. That's the other half of Medicaid eligibility, but if you don't fit into those categories, you can't as a general rule get Medicaid, no matter how poor you are, so who's left out?

Adults who don't have children and who are neither pregnant nor disabled, nor elderly, and people who once cared

for dependent children but whose children have flown the coup, those folks also cannot qualify for medicaid.

I'd like to discuss with you, I think most Americans would be shocked to hear what I just said, that Medicaid does not cover most of the poor. I can tell most of you are not shocked, you're among the cognoscente, but I'm going to focus on this surprising fact and discuss the nature and history of this federal exclusion some key facts about this group of people and then finally some federal policy options for helping people out.

The federal exclusion, as a general rule states cannot get federal matching funds for uninsured adults unless they fit into the specific eligibility categories that we were talking about. Now there's an exception, a state can get an 1115 waiver to cover these folks but there's a catch. Those waivers do not bring with them new federal funds. There's an administrative rule of budget neutrality which says that what Uncle Sam spends under a waiver may not exceed what the federal government would have spent under the status quo.

So not surprisingly, relatively few states have taken advantage of these waivers to provide comprehensive coverage to even all adults up to 100-percent of the federal poverty level. Some states as indicated in the wonderful report back in the back provide less than that, they're sort of pushing at the

limits but as a practical matter it's of relatively little use to states today.

Now where did this exclusion come from? Believe it or not, it came from Elizabethan England originally, with the Poor Law of 1601 holding localities responsible for relieving and supporting their indigent poor. That came to America in Colonial Times and remained in effect until 1935 when the Social Security Act established federally funded or federally matched programs of cash assistance to certain group support, families with dependent children, the elderly, the blind, and the disabled, leaving out the folks that we're talking about today who remain the providence of localities.

When Medicaid was created in 1965, almost as an afterthought to the creation of Medicare, policy makers said well, Yes let's provide health coverage to poor people who get federally funded or matched cash assistance, again leaving these folks out, and as Medicaid has gradually expanded over time, the expansions have taken place within these incremental categories, growing for example starting with families with dependent children, eventually reaching poor children, poor pregnant women whether or not they get cash aid, but never challenging the basic bifurcated structure of Medicaid eligibility which leaves out childless adults and empty nesters.

It's not clear how much thought federal policy makers gave to this exclusion. The basic judgement was rendered truly in 1935 in the context of cash assistance and the basic concept was if you're an able bodied adult, you ought to be able to go out and earn a living for yourself and the federal government maybe shouldn't be paying for it.

The question facing policy makers in this context is what about health coverage? Is it reasonable to say that if you're a poor person working minimum wage job, part-time for example, that you can provide health coverage for yourself? That's really the question and in guiding our thoughts about that question I think it's important to share a few key facts that we announce in this report.

One is that low income; non-categorical adults are by far the largest group of uninsured. They outnumber all uninsured children. They outnumber all uninsured parents, and if you focus on the poor uninsured in particular, it's every more striking, 55-percent of all the poor uninsured are non-categorical adults. So if you're serious about doing something about the uninsured and about those who lack the ability to provide for themselves, this is a group of people you need to take very seriously.

The largest group, not surprisingly, is comprised of low income, young adults, but a surprisingly large number are low income older adults, age 50 to 64 as you can see almost

four million are relatively lower, moderate income folks in this age category. As with most other uninsured, 80-percent work, 80-percent are U.S. citizens, even young adults who are healthy by and large thankfully experience significant barriers in accessing care when they lack coverage, barriers they do not encounter when they have insurance but perhaps the greatest consequences are experienced by older adults.

One peer reviewed study found that if all adults aged 50 to 64 received health coverage; their death rate from 1992 to 2000 would have fallen from almost 7-percent to less than 4-percent. Another peer reviewed study also controlling for multiple factors found that in this age group without insurance.

If you hold everything else constant and you take away insurance the risk of death goes up substantially, particularly among older adults who are low income, but among all different income quartiles and that as a result this study estimated that more than 13,000 people in this age group die every year who would be alive if they had health insurance, placing lack of insurance as the third leading cause of death among older adults, following only cancer and heart disease, so this is a serious problem we're talking about.

One of the options that you and your bosses have to solve this problem, well the assumption in the paper and the assumption in the rest of my remarks is that for the very

poorest uninsured, non-categorical adults, Medicaid is going to be the policy vehicle of preference. We can talk about this in Q&A if you like.

Now there's certainly other groups of non-categorical adults for whom it would be reasonable to think about other remedies, somewhat higher income adults might benefit from refundable, advanceable tax credits to help subsidize the purchase of private insurance. For example, and older uninsured, non-categorical adults with higher incomes might be able to take advantage of a Medicare buy-in option but for the very poorest uninsured, non-categorical adults, the assumption of the paper and of the rest of my remarks will be that Medicaid reform is the policy vehicle of choice.

So how can one adjust Medicaid to fill this enormous gap in the basic structure of the program's eligibility rules? Well one approach would say let's change the way we do 1115 waivers. Most boldly you could say let's eliminate the requirement of budget neutrality when it comes to expansions that cover the poor uninsured.

Now if that were to take place, it would become much more and affordable for states to cover these folks but 1115 waivers have inherent limitations. They're cumbersome for states and a lot of the key decisions take place behind closed doors, not in the light of day, and lots of people have raised

questions about what really motivates the decisions to grant or to deny waivers?

All kinds of serious problems with waivers and I have to express some skepticism that an office of management and budget in any administration, no matter the party, would go along with the wholesale elimination or great reduction in budget neutrality requirements that might be required to cover any but the oldest, non-categorical uninsured adults.

A second approach would say let's change Medicaid from a categorical program to an income based program. Let's say everybody under Income Level X gets coverage, everybody above Income Level X does not get Medicaid. Well, not only would that cover most of the low income adults who are uninsured that we're talking about today, it would allow enormous administrative efficiencies.

Today states have to decide well let's see, does John fit into this category, that category, the other category, as Ed suggested in his remarks imply there's more than 50 eligibility categories that states have to administer. If there were just one and the question was just income, it would certainly be a lot more efficient and money could be used for other things.

It also would be more equitable in a sense, it would no longer be the case that depending on your eligibility category you either get coverage or you don't at the same income. In

other words, today people with relatively high incomes in one category get coverage, those who are desperately poor in another do not, then inequity would disappear. Of course the big disadvantage of this approach is lots of folks who qualify for Medicaid today would lose coverage.

Who are these people? I'll give you just one or two examples. Nursing home residents, people who get pension payments and social security checks that nominally place them above income eligibility standards but almost every red cent they get goes to the nursing home and they still can't pay the nursing home bills. Medicaid steps in and pays the remainder.

I'll give you a second example. Pregnant women with incomes up to 185, 200-percent of poverty qualify for Medicaid in most states. If they didn't have coverage they would be less likely to get pre-natal care. Their children will be more likely to be born seriously sick, costing the tax payers huge amounts of money as well as creating serious harm in the lives of those children.

So there are quite a few groups above whatever the income eligibility threshold is, millions of people above 150-percent FPL in 2006, 11 million, who would lose coverage under this approach so there's trade-offs obviously under this approach.

A third approach as well has trade-offs. You could say let's create a new Medicaid eligibility category for low income

adults, adults with incomes below a certain level, we don't care whether you're pregnant or not, disabled or not, if you're adult and you're low income, you qualify for coverage.

That would help the folks we're talking about, at least the poorest among them. It would achieve some efficiency inequity gains, though fewer than under the second approach, but the big advantage relative to the second approach is it would not take coverage away from people who have it today.

Now regardless of which approach you take there's certain policy questions you need to grapple with. Is this an optional group that states can cover if they want to or is it a mandatory group that they must cover whether they'd like to or not? And what's the level of federal funding?

Today on average the federal government pays 57-percent of health care costs. If that standard level continues, then many states would not expand coverage because they don't want to pay the 43-percent or whatever their applicable percent is.

On the other hand, you may say well let's provide additional federal funds for states that step to the plate and cover all poor adults, if you do that you still have to grapple with lots of questions about how do you deliver the money? Is the money capped per state?

All kinds of important design questions, none of which I will talk about right this second, and then most important who are the people you're going to benefit? Is there an income

cap? Is there an asset test? Do you want to make that income cap rock solid so no state can go above it? What flexibilities do states have?

In short, this is a very significant group of the uninsured, the largest group there is, serious harm is experienced, there are federal policy remedies that are available to help these folks but if you want to go down these roads you have to grapple with some very serious and detailed questions. Thank you very much.

ED HOWARD: Great, nicely done.

STAN DORN: Thanks, Ed. [Applause]

ED HOWARD: And they said you couldn't get through 27 slides in 10 minutes. [Laughter] Thanks very much Stan. You've set the stage I think for a rich discussion here. We're going to continue that discussion by calling on Gary Ferguson who is a senior vice president of American Viewpoint, Incorporated, a firm whose political clients have included Newt Gingrich and Richard Lugar and Fred Thomas, Gary himself has done, designed and managed national survey tracking programs for both the republican congressional and senatorial campaign committees.

He's done a huge amount of research on health care issues, I know for a fact, and I'm pleased to say he, too, has graced our podium from time to time in the past. Gary, thank you very much for joining us today.

GARY FERGUSON: Thank you, Ed. Glad to be here and I appreciate the invitation from our sponsors today. I've been asked to provide some context on this issue from the public opinion polling perspective. Unfortunately this is the time of year when polsters are not usually allowed out of their offices to speak in public on paying of debt, [laughter] but fortunately the survey that I'm going to be talking mainly about today is something that was released publically in the year that we conducted for the Federation of American Hospitals.

So, the first thing that we have to keep in mind when talking about any kind of reforms to the health system is that Americans have a very positive view of their own health care coverage. This is a feeling thermometer question where we ask on a zero to 100 scale how you feel about certain institutions and groups of people and so forth, with 100 being very warmly favorable, your own health care coverage in 2008 was, well this survey was conducted in February, a score of 65.

So that kind of positive view we've seen consistently for years and it is one of those things where this kind of view is a major impediment to reform when you start talking about change that might affect people's own coverage.

People also have a relatively warm and favorable feeling toward poor people who don't have health insurance at 60, working people who don't have health care insurance at 59,

so those scores, the people are very sympathetic toward the uninsured and we'll see that in later slides. These scores are higher than any for the Medicaid program, the Medicare program, or social security.

We also have to keep in mind that health care is an economic security issue. It's very much a pocketbook issue for people. More than one in four Americans express concern about their ability to pay for health care benefits or that they might lose their benefits. Also there was a Kaiser Family Foundation Survey in August in which 24-percent said that paying for health care and health insurance is a serious problem for them personally.

Now we also know that cost is the most important factor in Americans' minds with regard to health reform. The cost of health care dominates all of their thinking, really. However, they also place a high priority on the uninsured. When we checked against providing health care coverage for the 47 million uninsured Americans versus other reforms like addressing medical malpractice reform, requiring Medicare prescription, drug price negotiation, entitlement reform, social security and Medicaid, Medicare, and allowing drug importation from Canada, you can see that by far providing health care for the uninsured is the most important of those types of priorities.

Now, what is the federal government's responsibility in all of this? Well, that's driven by partisanship and voter's perception and the role of government, their etiological orientation. We asked do you think it's the responsibility of the federal government to provide universal government run health care coverage for all Americans.

And we found 30-percent are in favor of that but when you look at the next group, the next block there, republicans are only a 40-percent, independence is 29, democratic is at 44, so quite a bit of difference, or should the federal government assist those Americans who can least afford health care coverage to purchase it?

About a third, 35-percent, in this case the numbers are more evenly divided across the partisan divide. Another third, 31-percent say it's not the federal government's responsibility to do any of those things and if you look at the partisan differences, republicans, 54-percent hold this view as compared to 32-percent of independents, and 11-percent of democrats.

We asked the question about the role of government, should government be doing more things to solve the problems of people in our society or is the government doing too much?

And you can see that among those at the far right hand side, those who say that government should do more, 41-percent think that we should have universal coverage, 38-percent that we should assist low income folks in purchasing health

insurance, 17-percent say it's not the federal government's responsibility. Among those who think that the federal government should do less, 52-percent say none of these things are the federal government's responsibility.

Nonetheless, we know that voters believe that reforms are necessary but to what extent? Most voters say that although there's some problems with our health system, there are some good things that we should keep, nevertheless major changes are needed, that's 56-percent of the population back in February. However, when it comes to the uninsured, the sentiment is really over whelming, 65-percent say that major changes are needed to our system in order to cover the uninsured.

We tested some specific elements of reform that get a mixed bag in terms of responses and again a lot of this is based on partisan differences. There is overwhelming support for things like association health plans, allowing small businesses and the self insured to purchase health insurance through any organization or association to increase their purchasing power, 87-percent favor this overall back in February and a net favor, which is favor minus oppose is up around 82-percent for republicans.

Offering tax benefits for those who purchase their own health insurance equal to the tax benefits offered to those with employer based coverage also has very strong support with

82-percent total favor and really insignificant differences across the partisan spectrum.

We also asked about expanding Medicaid, the government program providing health care coverage for poor Americans to cover more of those with lower incomes, 68-percent total favor, total opposed is 28-percent, this is where the differences start to come by partisanship.

There is a net favor among republicans of just 7-percent as compared to plus 36 independents and plus 76 for democrats so there are clearly some differences that have to be dealt with there. Requiring all employers to purchase coverage for their employees or pay into a government fund has 68-percent support overall, but again, huge differences by partisan groups.

Requiring all Americans to have health care coverage assist those who need help to purchase that coverage, 64-percent total favor. The bottom line is that only the first two things allowing small businesses and the self employed purchase health insurance through their organizations, or offering tax deductions similar to those that employers now have are the ones that have across the board appeal. The majority support though is found for expanding Medicaid.

Where it becomes more difficult from a policy perspective is when you start to lay out specific costs, impact on state budgets, and so forth. In general there is broad

support but when you start to add in cost factors, you'll probably see that support drop some more.

Okay in the interest of time we'll skip this one. Mainly, again if you look at voting issues right now, the top five issues are, this according to a Kaiser Family Foundation survey, again from August, the economy is the number one voting issue, 49-percent, Iraq's at 25, gas prices at 18, health care is at 16, number four in the list of top five, above terrorism at seven.

Now where the uninsured fall within that, I don't know, but this issue has been up and down for the past year but with economic concerns as they are, there's less emphasis on health care. I suspect that you'll see that move up but nevertheless Americans want action on the uninsured.

We found that 83-percent believe that immediate action is required and the next president and congress to address to address coverage for the uninsured, 55-percent say that's very important and 28-percent say it is somewhat important, 83-percent overall. So with that I'll turn it back to Ed.

ED HOWARD: Thanks very much, Gary, and with that I'll turn it over to Susan.

SUSAN REINHARD: And I'll catch the ball. [Laughter]
I am delighted to introduce Barbara Edwards who is here to speak from a state point of view, from a Medicaid director's point of view, many of you know Barbara. Her now official

title is principal with the Health Management Associates, a very esteemed organization that does a lot of work particularly in health care financing. I've known Barbara a number of years, many of you have as well.

She has 25 years of experience in health policy and financing in both private and public side, eight years as a Medicaid director in Ohio, did a fabulous job there, but more recently has filled in as the acting director I guess it is for the National Association of State Medicaid Directors and before that had been a vice chair I think of that association so she has remarkable experience to share with you on this topic.

Barbara?

BARBARA COULTER EDWARDS: Thank you. I'm happy to be here. The title of my presentation today is a cautionary view about the use of Medicaid to expand health care coverage to working adults or adults who aren't in the categories that you were hearing about this morning and it's cautionary because I'm actually a big fan of Medicaid so it's not an anti-view.

Clearly over time Medicaid has already played a critical and important role in covering the uninsured in this country. This is a picture of the growth in enrollment in Medicaid and enrollment in Medicaid has been driven not only by recessionary downturns where we get a lot of folks that come on to the program as their income drops, but also by very deliberate policy choices that we have made as a country at the

state and federal level to allow more people to be eligible for Medicaid.

And it has done a good job of covering those populations, as states have continued to look at Medicaid as very attractive vehicle for covering the uninsured, particularly as we begin to move into working adults being uninsured, in part because as Stan pointed out, Medicaid already covers a large number of low income people and in fact increasingly covers people of the poverty level as well, particularly children and people with disabilities.

It has existing networks, very low administrative overhead, it has existing relationships with private, commercial health plans through the managed care plans, and of course it brings the federal dollar to match the state dollars that are put on the table and that makes it particularly attractive.

We also have to look at Medicaid when we're looking at the uninsured because in fact particularly among children, a good number of the currently uninsured people in this country are already potentially eligible for this program.

This picture shows that among the uninsured children in the country, 41-percent are estimated to be under poverty and families below poverty, that means they would qualify for medicaid if they signed up for the program, and that another 28-percent of children are estimated to be between 100 and 200-

percent of poverty and in most states that means they would be eligible for the children's health insurance program, so Medicaid is an important vehicle as we look to the future.

However, at 34 governors I think the estimate is in 2007, made recommendations that would cover more uninsured people in their state. They had all sorts of reform agendas, expansions to medicaid or to the children's health insurance program were a core element in many of those proposals, but there's been this little problem.

The federal government has gotten very unfriendly about making those federal dollars available to support those expansion efforts so the money may not be there when states step up to the plate and want to look at these particular vehicles for covering more uninsured. For example, the administration vetoed the CHIP funding expansion that was enacted by congress.

The administration has become very aggressive at going after and restricting the ability of states to use intergovernmental transfers, provider taxes, some of the other vehicles that states have used to draw additional federal matches they've sought reforms in the program. And in fact, the administration has gotten very unfriendly to state proposals around reform that would make additional use of already available but not matched state and local dollars to draw down more federal funds. So the fact is states had big

plans. The administration has been largely unfriendly to those plans in recent months.

There is a second problem and I think this is a bigger problem and that is whether or not states can commit to covering large numbers of additional uninsured people when they are having so much trouble maintaining the commitments they have already made to medicaid.

We know that states have got economic problems and I think everyone in this room understands that states unlike the federal government do have to balance their budgets and they have to do it within the 12 month period of the budget. They don't get to wait a couple of years, average out over five, they've got to by the end of a fiscal year come into balance between their expenditures and the revenue.

Well, Medicaid is counter cyclical, so just when the economy is at its worst, and the state is least able to pay, the demand for the program is the greatest. We have more people coming onto the program. We know that in the last recession that several states in fact began to back away from some of the eligibility expansions that they already put in place.

Some states even for kids, certainly for adults, because they had to balance their budgets. That makes states not necessarily a very reliable partner in being a partner around expanding to cover the uninsured. We also know that

100-percent of states in fact turn to rate freezes for providers and even rate cuts for providers to help balance their budgets and we also know that to be able to put a lot more people into those existing networks is going to be very difficult if states don't address the problem of the reimbursement for providers.

So there is a real concern and then we look back into the current economy, we know states are once again having fiscal problems and states all across the country are once again wrestling with what they can do with their medicaid programs, how to bring those costs under control, not because Medicaid is unreasonably expensive but because the states' revenues just don't keep up.

When we look to the future of the existing Medicaid program, we know we're going to see more growth. We know that in part because the demographics say that particularly among the aged and people with disabilities, the demand for Medicaid coverage is going to continue to grow and this is the population that is driving 70-percent of the spending in the Medicaid program so if the aged population and people with disabilities is going to continue to grow as a population base, the spending is going to continue to be grown because these folks are very expensive.

And because I'm in D.C., I always have to say this, 40-percent of all spending in Medicaid is driven by people who are

insured by Medicare, and states have a very difficult time controlling those because Medicare is the primary payer and Medicaid rules govern.

So let's talk about long-term care, it is rare to see a proposal for health reform to cover the uninsured that really deals with the issue of long-term care. People are focused on finding access to acute and primary care, long-term care is also an issue, and it is also rare to see a long-term care proposal that deals comprehensively with people who are chronically ill.

The drive in most reforms is to figure out a way to offer a low cost insurance product. A low cost insurance product tends to not fully address the needs of people with chronic illness and in fact either because it doesn't provide all the benefits that people need or you end up in the death spiral of health reform which is that the sickest come the first and hang on the longest to a subsidized product, driving the cost up, causing more people who are healthier to bail out of that offer and you end up with this sort of self defeating spiral.

So that is a real challenge as you look to health reform that folks in fact seem to be presuming that Medicaid is going to continue to be the default plan for people with chronic and disabling conditions. So we have reformers that want to see Medicaid cover more populations of the uninsured

and still be there to cover the chronic care and the long-term care that's not covered anywhere else in our health care system. As a result, we've got to deal with the sustainability of the financing of Medicaid for states if we're going to see states be able to accomplish either of these goals, let alone both of them.

States have recommended some strategies to deal with some of these issues. There have been proposals that have been put on the table around fixing FMAP to help sustain states better during the down turns. The NGA has actually recommended a bigger reform that Medicare ought to become fully responsible for the Medicare population rather than having Medicaid wrap around it. Either way the nation needs a new baby boom reality financing strategy for long-term care.

For many states, covering the uninsured remains a priority. If a new administration makes more federal money available again to help states do this, I think we can be sure states are going to step up and try new strategies. The reality that sustaining Medicaid with its current commitments around long-term care is going to continue to compete with efforts to use Medicaid to expand to working uninsured populations and without larger Medicaid reforms on financing, state efforts will fall short of the goal.

I think that has led some to begin to ask this question which is, is it actually helpful for states to continue to

pursue strategies they may not be able to sustain or is this simply taking the pressure off congress to act?

ED HOWARD: Thanks very much Barbara. One thing, for those of us who are acronymically challenged, you've said FMAP and I wonder if you could explain that.

BARBARA COULTER EDWARDS: FMAP is the Federal Matching Funds that are made available by the federal government to reimburse states a portion that they spend on Medicaid.

ED HOWARD: Our last speaker today is Nina Owcharenko. She's a senior policy analyst for health care at the Heritage Foundation at their center for health policy studies, in fact. She's done a whole lot of analysis and writing on a range of health policy issues including Medicaid and the uninsured, state based health reform and prescription drugs. Nina also spent nearly a decade on the staffs of members of both the senate and the house so she's on familiar ground when she's up here. Nina, thanks for being with us.

NINA OWCHARENKO: Thanks for having me, today. I thought I would start off with some general observations about a great paper Stan did and talk about some specific challenges of the approaches he laid out, and then talk a little bit about long-term strategies which I think is really where we need to start thinking for over time.

First I think as the paper recognized and as Stan had already recognized, this was a very narrow slice of the

uninsured with a very narrow policy solution and options as it's surrendered around Medicaid expansions.

And I do think that it offered some interesting food for thought if we were to live in a world where we were just working in that population, but I think the real challenge will emerge when tackling the trade-offs between prioritizing populations and prioritizing interests.

For example whether to expand coverage to low income childless adults or whether to expand coverage to children in middle class families, I think that is something that policy makers will certainly have to debate and work through as they start thinking about moving forward on health care policy and what the competing priorities are.

I also have to say I noticed that one of the issues that was very highly rated on the survey were people who were concerned with the amount of taxes that they pay on one of the presentations for the survey. So I think we have to keep that in context of how much is the threshold that Americans would be willing to pay for certain types of reforms and I think that's a challenge across the board whether it's a Medicaid expansion or other types of health care reform.

Now getting to the specifics on the various policy approaches that were laid out in the paper, the first one regarding changing and reforming or eliminating the budget neutrality and the waiver process, I just have to reiterate

that I think maybe, you know, I don't come from OMB but maybe I should because it is a very concerning issue to think that states would in essence have a federal open ended checkbook to fund waivers that they may want to, when they don't want to meet a budget neutrality agreement.

You would in essence have states that were possibly able to leverage additional revenue at the state level to come for waivers to support program expansions and I think that leads some kind of equity issues to be resolved.

I will say, however, that I think an existing waiver process still is a viable option for some states as was noted in the paper, there are several states who have taken waivers to cover childless adults so I think that's one option that still remains on the table.

I would also say that states still can do things on their own. They can do a state only plan. If this becomes a priority for their state to address the needs of the childless adults in their state, they too can use existing state funding if they have it or if they deem it necessary to do a program on their own.

The second approach is a need based on income. I did think that the issue of concern of what do you do with the disabled population will be something that is a political challenge because you are looking at prioritizing people based on needs but what do you do about those people who really may

not have any other option. I think that's a significant challenge.

I thought that the National Academy for State Health Policies approach that Stan mentioned in his paper was an interesting approach. I think that my main concerns with that approach is that it shouldn't be an unlimited expansion amount, that there needs to be some sort of a firm cap on how far states can go up if they're leveraging federal dollars and if there should be a maximum amount that states can leverage from federal tax payers to go above and beyond if they so wish.

Finally on the third approach which is the catch all approach I called it, I do think that it gets us back to the more direct and open discussion on allowing states to expand their public programs to new population, but I think it leads directly to the funding issues that we would have to face in order to not only accommodate an expansion, but accommodate the existing program that is already troubled in my view.

So if I were to rank them, which is kind of what I did on the back of my envelope, I would say that possibly number two with the waiver, minus any changes to the budget neutrality being a number one choice.

Second would be based on a need based approach where we would have some sort of a firm cap and an eligibility cap for those above the income threshold and then my third and least favorite would obviously be the catch all, but I do just want

to stress again on the funding issue that we have to face, I mean Medicaid is part of our entitlement crisis.

I always get a little bit upset when many of my colleagues talk about from the conservative side about our entitlement issues and the first thing out of everyone's mouth is social security but very few do we talk about the Medicare crisis that we face or the Medicaid crisis.

And just to put into some fiscal dollar amounts so that people can kind of grab their heads around it, in 2007 Medicaid federal and state spending was projected to spend about \$338 billion. By 2017 that number is going to reach \$717 billion so and as it was already noted, states are struggling already, 22-percent of all state budgets go to the Medicaid program.

You've got to wonder if it's crowding out other state priorities, transportation, criminal justice, education, a lot of other issues that are of concern to people at the state level so I think that the fiscal crisis that the Medical program faces is going to be a challenge in moving forward.

Now, I know that we're supposed to focus still on kind of the narrow focus of adding adults, but I think that if we want to address any of these populations I think that the best way of going forward is looking at a fundamental reform of the health care system and really looking at how do all these pieces fit together?

Because my worry is that starting with simply a Medicaid expansion to meet the needs of the low income, childless adults, just continues to build on the patchwork system that we see today, which is Medicaid coming in and filling the gaps for those that the current health care system doesn't work for. And I think we need to make a review of what the health care system is today and say why is it not working for these Americans or for pre-retirees?

What is happening in the current health care system that is causing Medicaid to have to be the safety net for everyone, regardless of income? And I think two things I would just stress, one is tax incentives, which was already alluded to earlier as kind of outside of the realm of this paper but I think an important issue to consider.

If we can fix the tax treatment of health insurance that obviously has high bipartisan support, I think it goes a long way in moving the system into a better direction of individually owned health insurance. If we can get people to buy health insurance when they're young, even if they're low income, an 18 year old working at minimum wage, if we can encourage through tax incentives to help people buy private health insurance, they can keep it throughout their lives.

They don't have to worry that if they lose their job or they change jobs they lose their health insurance. That I

think is a fundamental problem in the current health care system that we need to overcome.

It also helps for those near retirees. If someone wants to retire early, they shouldn't have to worry that they don't have health insurance if they decide to leave the job at 55 or if they're displaced from their job at 55. And so I think by doing some fundamental tax relief, I think that moves us in the right direction, starts getting where we want the future of the health care system to go, which have people owning their own health insurance.

You know, it's always ironic when we talk about if you lose your job you don't lose your home owner's insurance, you don't lose your car insurance, but you lose the most valuable piece of insurance which is your health insurance and that's a major problem we face.

Then I think we can look at what is the role of the Medicaid program in that context? Should we start thinking of a restructuring of Medicaid, maybe as offering financial support to people at lower income levels? We use food stamps for low income families to help them buy food, we should be thinking the same in Medicaid for helping people buy private health insurance.

And I would end, too, to say that we then would look at Medicaid and see how can we design alternative strategies that are patient centered for those people who really have no other

options, we're talking about the disabled that I think Medicaid has proven to do a good job in serving that population and even in long-term care services, what kind of alternative strategies should the Medicaid program start looking at that are more patient focused?

And I think if we can move away from more of the patchwork approach that we have been seeing over time because we can't get consensus on a larger reform package, I think that we would be far better off if we look at the programs and the system as a whole rather than in segments. Thank you.

ED HOWARD: Thank you, Nina. Okay, we are now at the point where we would love to have you join this dialogue. Please, there are microphones to which you can repair. There are green question cards in your packets which you can fill out and hold up and someone will bring it up here.

And while we're waiting for those developments to eventuate, let me just give Stan a chance to comment at least on one aspect of some of the things that have been raised.

Susan was talked about the rates of reimbursement in the Medicaid program as a barrier to substantial expansion and I note for the record that Governor Schwarzenegger in his major reform plan found it necessary to include in that package a major increase in Medi-Cal reimbursement rates and I wonder how you would swear that with the recommendations, the options that you've laid out in your paper?

STAN DORN: Yes. That's a serious concern. Low Medicaid reimbursement rates mean that in many cases Medicaid beneficiaries can't access speciality care, can't access dental care, etc, the fundamental problem is how much money is the political system willing to commit to helping low income people access health care?

And if in hard times you're not willing to commit more than a certain number of dollars, then the low income person is going to suffer one way or the other. You're either going to suffer by low reimbursement rates in Medicaid but with low out of pocket cost sharing amounts or you're going to gain access to the kind of private insurance that Nina's talking about or this higher reimbursement rates to physicians but where on average in the non-group market according to AHIP, you have a \$1,700 individual deductible.

If you're a poor childless adult earning \$425 a month to cover all your expenses, a private health insurance plan with a \$1,700 deductible is not going to meet your needs and but on the other hand, Medicaid has limits on access to care. The research does show, however, that not withstanding those limits despite the real problems that exists with reimbursement rates, access to care is much, much better for Medicaid adults than for people without insurance, and health outcomes are better.

So, to paraphrase Rumsfeld you do health policy with the health care system you have, not with the health care system that you wish you had. I think a key question is how sweeping a reform are we talking about?

I mean if we had a broad sweeping reform that we're talking about it could deal with both the reimbursement rate issue, by mainstreaming low income people, and to the same types of health insurance reimbursement levels that serve others.

You could also deal with the issues that Barb was talking about in terms of counter cyclical adjustments to Medicaid or perhaps even the federal government assuming responsibilities that states currently shouldered. I think all of those are wonderful ideas.

The big question is in 2009, how sweeping is the reform that Congress is going to consider and what I would argue is whether it's big and sweeping or narrow and incremental, this is a group of people currently left out, nine million uninsured poor adults who can't be covered even though others who are like them are covered, I think it is something that Congress needs to tackle.

ED HOWARD: Yes, we have someone at the microphone, would you identify yourself please.

JOANN LAMPHERE: This was a terrific panel. My name is JoAnn Lamphere, I direct State Government Relations, Health and Long-Term Care Team for AARP, so thank you for this discussion.

It continues to astonish me after years and years of being health policy that this group of Americans remains outside the protections of our policy. If society feels a moral commitment to care for the poorest and most vulnerable, the fact that people blow poverty, it's less than 50-percent of people in poverty are actually covered by Medicaid, and we should really ponder as we get off on all our different tangents how we continue to allow this to be so.

It seems to me that Medicaid is the preferred option for reaching this group of people for many reasons. The population of low income adults is diverse and doesn't have a continuous attachment to the workforce. So trying to provide job based coverage or incentivizing that seems not very realistic.

The poor adults can't afford health insurance, private health insurance at any price. The tax code is probably unrealistic because many people who are low income don't earn wages and don't file their income taxes. It seems to me from a consumer point of view expanding Medicaid is a preferred option to because people in a family would have the same kind of health insurance rather than having some children who are a certain age not covered by Medicaid, other children in the same

family at a different age covered by SCHIP, the poor adults, mother and or father covered by something else. Think about running your own household, how impossible that is, in terms of assuring quality care for your family.

And then finally, I think it makes sense to build on the existing Medicaid program because there is an existing network providers set of expertise that could enable more quality health care for this very vulnerable group.

All of that said, I'm wondering whether you have insight into the political forces that maybe necessary or that might help to influence a new Congress that may take up this issue because I think it's very important.

ED HOWARD: Anyone want to grapple with either the premise, the preamble or the question? [Laughter] Stan, go ahead.

STAN DORN: I wanted to deal, not with the preamble or the premise, but just the question, the politics.

In terms of the public opinion research that Greg presented, there are two things that leap out at me that are just fascinating because I think a lot of folks on the Hill would like to take this issue on, but they think, well you know this is not kids, this is not a cuddly group of people and will the public really be supportive of expanding coverage.

What's fascinating to me is first of all, the feeling thermometer that the number two group, the second warmest group

outside my own personal health coverage is poor people who do not have health care themselves suggesting that there might be some public openness.

And the other thing that was fascinating to me is that the elements of reform that score extremely well expanding Medicaid to cover more poor Americans supported by 68-percent and as Greg pointed out, the support is less under Republicans than other. But even among Republicans supporters outnumber opponents by 7-percent, and among Independents there is a 36-percent gap.

So it seems to me these data, I mean it hasn't been a huge amount of research on it, I think there needs to be more, but these data suggest that the American people would be very receptive to proposals that say, you know what, let's have Medicaid do a better job of meeting it's most basic goal of covering people who are poor.

And let's say that if you're poor we don't care whether you're 18 or 19, if you are low income you get help. If you're a parent we don't care whether your youngest child is 18 or 19, you can get help based on your need. I think there would be great openness to that.

ED HOWARD: Gary.

GARY FERGUSON: It is true that there is as I said earlier there is a great deal of sympathy for the situation of the uninsured, and it is also true that we find that in generic

terms there is a great deal of support for expanding Medicaid. But as I also said it really does come down to the dollars and cents of the matter, whether it is from a tax perspective or and it usually is, or any kind of personal costs associated with increase costs of premiums and so forth.

But if you look at, anytime we add costs into a public policy question, the support immediately drops by about 10-percent, and when you get specific with numbers you can see a great impact by adding in. So what we always try to do when we are testing, specific proposals is get a cost estimate so that people can make a realistic evaluation of the situation.

And that's one of the big problems that the questioner really introduces is what is it going to cost when you start to talk about major expansions or when you start to look at the obstacles to reform and there are so many from a, not only from a political prospective, but people's satisfaction with their own health care. Their attachment to the employer based system and so forth, it becomes very complex and then you got competing proposals involved also.

But on the question of expanding coverage for the uninsured, a different way of looking at it, there was an *LA Times* poll in February that asked people would you like to seek a candidate for President propose covering nearly all the uninsured and spending more, covering some, but with less new spending and keep the system as it is right now.

Thirty-eight-percent said cover nearly all, spend more, 22-percent cover some, but less new spending and 28-percent said keep the system as it is now. So, when you start to introduce the money, you can see very sharp drops in support.

ED HOWARD: Yes, go ahead, Nina.

NINA OWCHARENKO: Just wanted to go back to say that I think that it would take a significant shift in gears because we spent the past three years debating an SCHIP reauthorization Bill that was going to expand coverage to children 300-percent of poverty potentially higher, and I think it's a shift in gears and shift in political will and dynamics to say that we're now going to maybe make this a priority versus that, and I think there is some tradeoffs that would have to happen.

ED HOWARD: Here's a question from a card that raises some important points it seems to me. Questioner wants to know whether we can say, or whether we have the knowledge to know, does Medicaid managed care really save money and improve access to care or is this a failed approach?

And Barbara you talked about that in your presentation. There is a fair amount of penetration of managed care administered by private firms in Medicaid. Is that not right?

BARBARA COULTER EDWARDS: Yes, actually it's a very significant number of percent. I think it's well over half of the folks on Medicaid are now in managed care plans. So it's basically the dominant way in which health care is being

delivered in most states there are some states that are almost completely outside of the system that keeps it from being further.

I don't know that I'd want to be the final expert on whether or not managed care is saving money for states in Medicaid. What I can say from my own experience as a Medicaid Director that we did see some savings from managed care. It was not often as significant as advertised, but it's also difficult because the more people you have in the system the less you've got something to compare it to outside the system. So after a while it's gets very difficult to make a comparison to the before and after.

I think what states tend to believe very strongly is they do see evidence that they can improve access to a network of providers and that it creates a vehicle for pursuing improved outcomes and better process for people. So we saw it as a definite improvement in the quality of services available to people, including things like 24 hour access to a hotline and other kinds of services that were not available in the fee for service system.

I think that the bigger challenge for all of us around the issue of whether it's in managed care or not. To me the question wasn't so much can you get an absolute cost savings. I think most faced it experienced some absolute cost savings. I thin the bigger challenge is whether or not the trend is any

different, and whether the trend is low enough for states to afford it.

And that may not be so much a damming of the managed care system as it is an acknowledgement that whatever you're doing you're still buying health coverage out of the commercial marketplace. You're still buying it from the same set of providers, you're still buying the same services that got the underline cost structures aren't any different than the commercial marketplace.

Medicaid's rate of growth is tended to be slower on a per person basis than the commercial market sees. That's pretty phenomenal when you're buying from the same set of providers. So I think Medicaid fee for service and managed care has done a pretty good job of holding costs down. The challenge has been that the cost growth is still greater than state revenues can sustain.

And I think that's one of the reasons it's sometimes challenging, states sometimes have a hard time understanding that the solution isn't just, give it to the private sector, the state's are already working with the private sector, they were always buying from the private sector. I think the issue is, what is it you have to do to bring the growth trend in health care down for all of us, and if we could that we could all afford more coverage. So it's a mix bag.

SUSAN REINHARD: We'll take one from the audience first.

CLARE FEINSON: Hi, my name is Clare Feinson. I'm from the D.C. Primary Care Association. We work with safety net clinics in D.C. to help strengthen them to provide more services. And this actually ties into your last comment very well that, Stan was talking about how we're talking about such a broad sweeping reform.

And I think that the broadness of the reform is more than even many people in this room understand. And here we're just talking about coverage. We're talking about everybody getting the means to pay for health care. But once they have to means to pay.

Suppose we reach that golden state where everybody can pay for health care, are there enough services for them? In D.C. our answer is definitely no. Most of D.C. is either a medically underserved area or health professional service area as designated by HERSA, and they aren't services, even for basic primary care. And once you get everybody on primary care.

Say we even get there, beyond that there's the question of specialty care, there's the question of behavioral health, there's the question of dental health, and I'm wondering if very many people here have considered how broad the reform is we need to really get health care for everyone in this country

so that everyone can be healthy, and how we're going to do that, how we're going to make the safety net clinics.

Are we going to give them enough Medicaid reimbursements so that they can actually function without having to go after grants or without having to cut their services, and how are we actually going to upgrade our system in a way that it really provides the health care that it's suppose to provide?

ED HOWARD: Very good question.

SUSAN REINHARD: I'll take a stab. [Laughter] Well a lot of discussion around health care costs you're see this in the press, you're seeing it by Peter Orszag, for example who has been presenting the data quite prolifically and assertively and really with great deal of clarity that we have a great deal of, I guess he would call it inefficiency in the system.

Your language, and perhaps mine as a nurse is we're doing a lot stuff, but I'm not sure we're doing the right stuff. So some people are getting almost no care, other people are getting way too much care, not even because they are absolutely demanding it, but because providers move in that direction and you know the story because you're nodding your head.

So, part of I think our challenge in reforming health care as you very well put it is not just the financing end although it is so critical, but the delivery end, and how can

we change demand in ways that are appropriate and match to what consumers, people really need and spread that out, it's not an easy thing to address.

I think we each having earlier work force, big issue, the "Institute of Medicine Report" around care for older adults, a very big issue. I also Director and the chief strategy is I think the term is for the Center to Champion Nursing in America which gets to this issue of how are we going to have enough nurses in the future, but you could say for physicians and social workers and many other people.

So, I think you're absolutely right in dealing with that and raising that question, I guess we haven't as a group, I don't think we have many solutions out there to see how we're going to change delivery. But I'm starting to hear a real reasoned evidence based push for us to do so.

ED HOWARD: Yes, go ahead.

MAURI RUFFMAN: Hi, my name is Mauri Ruffman.

[misspelled?] I'm from the American College of Nurse-Midwives, and I just wanted to speak from providers experience about this shifting from straight Medicaid to using MCO's for that.

I think that if it has saved money it's only because when they switch over they cover fewer services and are more difficult for our clients to access. When we switched from Medicaid to MCO's one thing that we found was that some of our services were not covered by some of the MCO's and it wasn't

uniform across the board, so that our clients would sometimes choose like the wrong one and not be able to come to us anymore or not have some of our services covered.

And it was really ironic because maybe you don't know this, but certified nurse-midwives can save between \$3,000 and \$10,000 per pregnant women because of lower C-section rates and less use of technology and yet, here we were getting even less reimbursement from these MCO's or some of them just didn't cover our birth center at all, and so -

ED HOWARD: And MCO's are managed care -

MAURI RUFFMAN: Managed Care Organizations that we're managing the Medicaid clients that we had. So, if they're saving money, I think that's just because the money isn't being spent because people can't access it.

ED HOWARD: Barbara, what about that, the states presumably have services that they cover. How does that square with this kind of a response?

BARBARA COULTER EDWARDS: Well, one thing I would point is there are 56 different Medicaid programs and how they manage their manage care plans varies across all those states in the District and the territories and all the rest of it. So it's sometimes hard to compare state to state.

The one thing that was an inevitable rule is that the providers would tell you how much they hated you until you switched to a different system and then you find out how much

they loved you, because you suddenly looked better than they new guys.

I think clearly there are challenges in any kind of delivery mechanism that you put in place and states have to work at assuring that the minimal benefits are available. I think we have deal with the health delivery system that where the providers, the pairs, the organizers.

Nobody's got perfect knowledge of what really works and what's effective and some organizations do a better job of it than others. So, sometimes not everybody makes a very good decision in how they put their networks together. States do try to pay attention to those issues and sometimes it works well and sometimes it doesn't.

SUSAN REINHARD: I'll just add to that that what you're talking about is network providers and being part of the network. Pennsylvania comes to my mind, some states that are looking at the scope of practice issues, which is partly what I think you raised around nursing and it could be other disciplines too. And I know that that state has been quite explicated saying, they want everybody to do as much they can legally do. And they are looking for efficiency for value and for access for people.

So, that you could also appeal to your state legislatures, governors or whatever to make the case outside of managed care.

ED HOWARD: Got a question submitted by one of you, observing that most of the uninsured, they site a number that I think is probably too high, are employed. What does the panel think in terms of employer participation in finding a solution to this issue?

Do we need to think solely in terms of Medicaid expansion, that is to say government financing or are there other options in which small business or other employers may play a role? And I would urge the panel as they consider the question to think in terms not only of A and B, but perhaps some blend of A and B.

BARBARA COULTER EDWARDS: I'll make just a comment, and that is that there are certainly are states now that are experimenting and perhaps have some very interesting strategies in place that are about partnering with small employers, particularly to make more health coverage available to people who are working with the small employer participation.

Those states, I'm thinking of Oklahoma in particular, but certainly not just Oklahoma have found it's very challenging to get small employer's to be willing to step up and make the commitment to help fund the cost of care even if it's heavily subsidized. Particularly if the employer has already made the decision to take down the benefit, it's very difficult to make the absolute commitment to come back in or to come in for the first time.

One of the things that Oklahoma learned was that's particularly difficult if the employer doesn't trust that the program they're buying into is actually going to be there. The employer is not going to participate in an experiment.

And so again this issue of whether or not whatever programs are made available, whether they're actually going to be there over the long haul is important for employer participation. The other thing is just an observation I'm curious, maybe Stan or others have comments on it. Clearly from the public polling, the continued commitment to employer and employer based coverage is something we hold dear in this country.

But I don't know that anybody can argue that makes our system very efficient or low costs because there is a lot of churning and inefficiency that takes place when you've got that much overhead that's got to be advantaged in the system and that many different policies that many different negotiations as to what the benefits are going to.

I'm not saying it's right or wrong, we clearly value it and it's going to have to be a part of how we move forward because politically you're not going to get there otherwise, but it is part of what I think makes the system inefficient.

ED HOWARD: Nina, then Stan and Gary.

NINA OWCHARENKO: Well I do think that pointing out that the largest segment of this population we were discussing today is young.

And when you think about young and you that they're low income, they're probably just starting out into the workforce, 18 years old, getting their first job. You're hope is that over time that person moves out of poverty. I mean our hope is not that everyone, or all these people stay in low income jobs, we want people to move up and out of low income jobs.

Similar to the welfare reform model where the idea is to help mainstream people out of the welfare program, I think the same thinking could be applied in the Medicaid program. And I do think that similar to what Barbara said, I think that the concern of building on the existing patchwork system, and that includes forcing businesses, small businesses which have high turnover rate.

If you get a job that's better paying next door, you're far more likely to take that higher paying job regardless of whose the employer, we have a mobility issue, and people tend to move in and out of jobs frequently, and especially in this age group.

And I think thinking about looking at how do we create continuity in care is far more important and thinking about how do we have people again, having health insurance that's not

tied to the place of work. Just like it's not tied to their car insurance or their homeowners insurance.

I think that's the proper role to start thinking for the future, and rethinking what the role of an employer is. Possibly it's facilitating people's participation in health insurance just like they do with retirement funds, but not being the sole source of the coverage for them.

ED HOWARD: Stan.

STAN DORN: I actually think that for some of the populations we're talking about now, poor adults without health insurance, the employer base system. I agree with Nina is not a very happy place for people to be. Think about the cost of health insurance right now. Say you're a low wage worker and you get \$20,000 a year in income.

Health insurance for the family is going to cost \$12,000, \$13,000, \$14,000, it means a huge chunk of your compensation package is going to be health insurance. Is it reasonable to expect that the employer is going to provide this huge chunk of compensation in the form of health coverage for these folks? I'm not sure, I'm not sure that that's a long-term sustainable method of providing coverage for the very poorest uninsured.

That said, where we to redesign the system on a blank slate right now, I'm not sure that any of us in this room would assign to an employer based coverage the role that it has

currently. Nevertheless, 60-percent of Americans get their coverage from employers today.

And as the public opinion research that Greg mentioned talked about, it's like your Congress person, right? You ask most Americans, how do you feel about Congress? Terrible, terrible, terrible, horrible, horrible. How do you feel about your member? Oh, I love my member, he's fabulous. How do you feel about health coverage, terrible major changes needed? How do you feel about your insurance?

I love it, I like it. People are a little more concerned about cost these days, but by and large the polling data show people think it's, I like the quality. I like the coverage I get. So what that means is, if you have a health reform plan that says I'm going to take your coverage away and give you something that's better, whether that better coverage is Medicare for all, or whether that better coverage is coverage in the non group market, either way people are going to get pretty darn nervous.

So what that means is as a practical matter if you want reforms you need to give people the ability to keep their current cover in place, and that means employer base coverage.

The other practical concern is, about just sort of the dollars and cents that a huge number of dollars that support health coverage today come from employers. And if we want to shift outside of an employer base system, and let employers

stop spending that money, well whose going to come up with the money to replace it, Uncle Sam.

Well, I'm sure you all don't need anybody to tell you that Uncle Sam has a pretty darn large federal budget deficit right now, and I don't know that a policy proposal that entailed the substantial loss of employer dollars and replacement by public dollars is going to have a huge amount of success.

One final observation, I would make along the lines of what Barb was saying in terms of administrative complexity. Rhode Island is another one of those states that's done work in trying to support low income people's ability to get coverage from the job site.

And they've actually done pretty well with it. And what they found was and it's very cumbersome administratively to work with the individual employer to figure out how you're going to channel the money and so forth. What they found was that for poor people it did not make sense for poor people, the cost savings involved in having the employer be the primary payer rather than Medicaid, were outweighed by the administrative costs. But for adults above the poverty level, it did achieve some net savings for Rhode Island.

Questions about how's the access to care, how good are the benefits are important questions. But even just from the standpoint of dollars and cents efficiency when it comes to

poor adults, the notion of saying let's support the employer based system I think has some pretty serious problems.

ED HOWARD: Gary.

GARY FERGUSON: There are obviously lots of angles that could be employed from the employer prospective, but there are some problems as well. And we saw that there's a lot of support for Association Health Plans and other kinds of purchasing pools.

But then, does that raise the question of what happens to state regulated high risk pools and so forth. We see that there is a lot of support for large employers being required to purchase insurance or to pay into a government fund to help with the uninsured. That has potential consequences for wage increases and the ability to sustain jobs and so forth.

Another issue that is new, relatively new as we move more toward expanded health IT, there are a lot of privacy concerns out there about the employer's role in all of this. Nevertheless, we fear the unknown we're wedded to our current system because we're concerned about skyrocketing premium costs. And if we're on our own, what happens?

ED HOWARD: I thought everybody wanted change.

[Laughter] That's rhetorical. Yes, go ahead.

MARY GILABERTE: Hi, I'm Mary Gilaberte from the National Alliance on Mental Illness, and we confront the exact problem that Barbara Edwards talked about which is we have a

Medicaid system where we get calls all the time. People can't access psychiatrist, they can't access any services that they need putting them into emergency rooms and jails.

At the same time we know that the expansion population you have been talking about, childless adults, a lot of them have serious mental illnesses and substance use disorders. So we want a coverage to cover those people too, but then we get asked, talk about costs. So I look at it and see all the costs people going into jails and emergency rooms.

I mean we get an enormous number of calls of people whose love one or themselves are in jails and prisons now because of their mental illness. And my question is has there been any looks systemically at the overall costs picture, not just the health care system, but the judicial system and the other systems out there that bare a lot of the costs of a failed health care system.

And I'm wondering, I haven't been able to find it, but you all are the experts. Are there some research out there on some of these programs in states that are covering more uninsured adults and sort of looking at the overall costs picture because that's what we're seeing, there's a lot of costs to other systems.

ED HOWARD: Including costs to the health care system as you say that emergency rooms.

STAN DORN: What a great question. I'm not aware of any research that deals with it. What a fabulous idea. Are there any funders in the room? [Laughter] Let's support some research.

BARBARA COULTER EDWARDS: It really is important, and in fact one of the questions that states have been very frustrated with also in that kind of area is that it's very difficult to get the federal policy to reflect a broader view of the efficiencies and costs savings that you might find if you did a better job of knitting together Medicare and Medicaid coverage for example, around those populations. It has been very difficult to get people to look bigger than the category that is in front of folks.

And I think particularly with mental health, I think they're a lot of folks who believe, and there's some evidence out there that there could be significant cost savings particularly on the physical health care side with better treatment for behavioral health rather than trying to hide from the behavioral health problem.

SUSAN REINHARD: I would just add that I was going to raise earlier but it fits with this question. You're looking for a macro societal look at social costs for these issues. We can't even get the budget neutrality requirement under the 1115 Waiver to include Medicare savings to the states, which seems like a not brain or to me, to the Feds right.

So let me flip that into question for these panelists I suppose, or for anyone out there whose working on the Hill. How hard would that be to get the 1115 Waiver requirements since that's your choice Nina, well let's stick at least to the 1115 Waiver. How hard would it be to get that component, to get the Medicare savings into the component?

STAN DORN: I think that's a great idea and there's a lot of research now that shows when you provide health coverage to near elderly adults, ages 50-64, you realize tangible savings in Medicare in year one, in year two. And it seems to me that unlike the notion of completely ending budget neutrality to say, let's take into account federal savings on the Medicare side it actually more closely adheres to the point of the budget neutrality requirement, which is.

Let's make sure that if we're going to expand coverage to one group, that overall the federal government's costs exposure does not go up. So I think it's a great idea.

ED HOWARD: And if Peter Orszag were on the panel, he would tell you folks who are advising your bosses on these things that you write the rules under which they make their estimates. So, think about that as you interact with CBO.

SUSAN REINHARD: It's evidence based, it's logical, it's even consistent within the legal framework that we have. It seems almost a mistake.

This is a question directed for Nina. How would providing tax incentives keep from losing employer's supportive health insurance that is, wouldn't employers rapidly relinquish their roles in helping to pay for health insurance if tax breaks were given to the individuals?

NINA OWCHARENKO: Well first, I will direct you to heritage.org where I actually wrote about this when President Bush put forth a proposal on reforming the tax treatment of health insurance.

I just want to point out two things. First of all, most of Americans today get their health insurance through the place of work. There is a relationship there that I think will continue over time. People find that their employer is the trusted place for health insurance.

I don't think that most large employers for example, overnight will completely throw away the health insurance. They also see it as a very competitive advantage over their competitors. If one think tank was offering me a new job and the Heritage Foundation said, but we don't offer health insurance, I think that I would probably look at the options I had differently.

So, I don't think that there would be a fundamental shift. There is still a reason why employers would want to participate in providing health insurance. I think that they

key that we get at when we talk about tax treatment is getting tax equity. And today there is not tax equity.

If I don't have health insurance offered through my place of work, if I'm a low income, young, working person who works for a small business who has three or four employees who doesn't offer health insurance, I get nothing through the tax code to help me buy health insurance. That is the inequity that I think must fundamentally be changed first and foremost in looking at long-term tax treatment reform.

SUSAN REINHARD: Question for Stan and Barbara and Nina. This is a statement, actually that healthy, is that healthy IN is one example of Medicaid dollars being used to help low income adults using Section 1115 Waiver and cigarette tax they had paid for this program which has had a very strong response from consumers. What about this direction for Medicaid? Stan.

STAN DORN: Have to say I don't know much about the Indiana program. Did some research for Kaiser looking at a bunch of other programs, Washington, Minnesota, Pennsylvania and others, to the extent states either using 1115 Waiver are using their own dollars want to cover these folks, that's great. You can really help people you can improve their access to care.

But I just worry about state's capacity to do that given budget neutrality restrictions under current law and

given the fiscal constraints that Barbara is talking about. I think what would make more sense is to say if you're a low income adult, you can qualify for federal matching funds without having to get a Waiver. Right now we do that with parents, why not do that with people were parents a year ago and now are parents of children who are 19 instead of 18.

But I do think that for it to be realistic the Feds can't simply say, we're going to provide funds at the normal rate, there needs to be a prospect of additional federal assistance, and I think we do need to address. Whether or not we do anything about childless adults, we also need to tackle this issue about helping Medicaid restructure so that in difficult economic times, states aren't compelled to make cuts precisely when families and local economies need help the most. I think there are ways one could try to do something about that. So, I'll just stop there.

SUSAN REINHARD: Anything to add?

BARBARA COULTER EDWARDS: I would just say it's a good example of the fact states are working very hard to find creative ways to try to deal with this issue and the challenge, and it took Indiana I think upwards of two years to get approval for the proposal so it's not an easy undertaking and wish them well on it because lot of folks are watching to see how well that works over time. It's still fairly new and it's not been through much of an economic cycle yet.

ED HOWARD: Barbara's got a couple more questions on cards as to why. I just want to take this opportunity to suggest while you are involved in these minutes of the Q&A that you fill out that blue evaluation form so that we'll get some sense of how to make the next programs even better than this one. Susan.

SUSAN REINHARD: This is, I have one last question for Barbara, and it really gets back to your Medicaid history chart showing nearly a doubling of beneficiaries for the 1990 to 2005, which was much higher trend than the 1980 to 1995.

So, the question gets about trends, states expanding coverage, increases in poverty, teen pregnancy is that it, the Age, Blind and Disabled. The feeling was that from this person can't be driving this increase probably a part of the increase, but most of the gross must be moms and kids.

So, I think the general question is could you please explain these trends?

BARBARA COULTER EDWARDS: Well sure, and in fact this was a really fascinating time. The beginning of that trigger involves a lot of the CHIP expansion. So it is deliberate policy expansion to cover more people, it was on purpose. There are also smaller, but still important trends around breast and cervical cancer coverage, around ticket to work, little populations, lots of money that can get added with bringing in a population sort of have heavy need.

So, part of that was deliberate policy growth. A lot of it was recession growth, mMoms and kids, parents and children. It certainly in my state it was almost all under poverty that you saw a huge growth during a long recession, and it was significant in terms of the numbers of folks who became eligible because they lost their job, they lost their second or full-time job became eligible, and that was significant. So in terms of raw numbers you're really seeing the impact of a long downturn in the economy.

What is important about the Age Blind Disabled growth however, during those years is, the ABD Growth doesn't tend to drive up and down as much with the economy. It's one direction, it's very steady and it's going to continue to go up. So what we saw during that period was a peak of enrollment for children and parents, in terms of rate of growth and then a dropping back down of the rate of growth as the economy began to recover.

For age or blind or disabled, it was just a steady upward trend, smaller numbers, but very steady, and remember they're driving 70-percent of the spending in the program. So for states the issue is yes, the economy makes a big difference and yes it makes a big difference in your spending.

When the economy drops you're spending goes up because you see moms and kids and parents come on. But what is driving the costs over time is that slow, steady, relentless growth in

the elderly and disabled population because that's where all the money is in the program.

SUSAN REINHARD: Thank you.

ED HOWARD: One last question that I have here. How much would an additional expansion of Medicaid's low reimbursement rates to new populations increase the cost shifting and raise the cost of private insurance premiums. And we sort of alluded to this before.

STAN DORN: Well it would actually reduce costs shifting because people who are currently uninsured would gain Medicaid, and although Medicaid reimbursement is short of costs it's bigger than zero, so there would be less cost shifting.

Fundamentally when you think what kind of coverage are these people going to get? There's no really happy answer. You could say, well we're going to provide. You have a couple different options. One is you can say we're going to provide private coverage, which means high reimbursement rates, but it also means really unaffordable out of pocket costs for these folks.

In the non group market, the average co-pay is \$28 per physician visit. Well, if you're making \$600, \$700 a month it's going to be a problem, and we know research shows that even according to one study in Minnesota for example, recently a \$1 to \$3 drug co-pay costs 52-percent of affected beneficiaries to go with that necessary medicine and 34-percent

of those folks wind up going to the hospital for emergency room care for inpatient care.

California found in the '70s, a \$1 physician visit co-pay caused a 17-percent spike in inpatient hospital utilization. So, if you go the private sector route, yes you'll have private higher reimbursement rates, but you have out of pocket costs that folks can't afford. And then you go the Medicaid route, and you have non existing out of pocket costs or you have nominal co-pays which means you have better access to care, but we save money on those folks by lowering reimbursement rates and that means it's often quite difficult to get psychiatric care as we heard earlier today, dental care, all kinds of things.

The third route you could take is to say well we're going to give you the best of both worlds. We're going to give you very low cost sharing and we're going to give you higher reimbursement rates and that would be great for those folks, but my goodness that cost a lot of money. So you make your choice and you pick your poison, and there's no happy answer there's just tough tradeoffs.

ED HOWARD: Yes, Bob.

BOB GRISS: Bob Griss with the Institute of Social Medicine and Community Health and a happier answer than we've been talking about.

We're all really talking about how to deal with the fragmented health care delivery system and there are advocates up there who are saying this is what we could do with the Medicaid program, these are the positives, these are the negatives and there are advocates up there saying, but we also have an employer sponsored health care system and this is what we can do with that and frankly, if it was not part of the employer sponsored system, but if everyone had their own individual coverage than these are the things we could be doing.

But in all of those approaches that have been discussed we're still talking about a fragmented health care delivery system and at least we're recognizing that there are inefficiencies in that system. And even today we were talking about external costs to other systems outside of the medical care system and unfortunately CBO doesn't take that into account but the rest of us know that it's real.

And so I want to put on the table an option that is not being discussed and that is, how to make health care delivery systems function more like systems at a geographical level. Whether it's a state level or a regional level or a county level or a community level, and I think that that's something Congress really needs to be thinking about because there are levers of accountability in health care.

We have licensing and quality assurance and accreditation and conditions of participation. We even had something called Certificate of Need, where states were responsible for figuring out what were the health care needs in the community and how well are those health care resources in the community addressing those needs. And we only talk about these kinds of issues in terms of pay for performance back within at the level of the provider you see, but not at the level of the community.

Clare Feinson raised this issue when she was talking about the D.C. system and how inefficient it is as a system. I think we need to be thinking about strategies for making delivery systems function as systems, then we can figure out who ought to be paying for it and how that can be done in an equitable way, but there are much better options than just working within whatever sector of the fragmented system you happen to have the most experience with.

ED HOWARD: Okay.

SUSAN REINHARD: Any response?

ED HOWARD: Start with Stan and Nina.

STAN DORN: I think that that sentiment is really well taken Bob, and in terms of an application of that I would think about the issue that Barbara flagged dual eligible. The current system is insane, it's insane. We have Medicare paying

for some services. We have Medicaid paying for other services. We have prescription drug plans paying for the other services.

Every payer has an incentive to shift costs to the other payer. Inefficiencies people find through the [inaudible] its nut. Why not say let's us have dual eligibles in a single integrated system of care with one entity having administrative responsibility and I think the way you put it is absolutely right on.

Let's make that integration in place and then let's talk about the dollars. I mean NGA as Barbara mentioned, let's have Uncle Sam take care of all the dual eligible costs, well that would be pretty darn expensive for the Feds. You don't have to go all that way though, you can separate the issue of financial responsibility from an administration and say, let's have integrated systems of care for dual eligibles, and let's then revisit the question of how much does Uncle Sam pay for it, how much do states pay for it.

Maybe we can shift the percentage a little bit and shift some of burdens away from states and make it more feasible for the states then to pay for the low income, uninsured adults who are outside the dual eligible system. But I think in general, you're notion of about saying let's do what we can to think about integrating systems of care really makes a huge amount of sense from the standpoint of cost savings,

improve quality, and so I think your point is really well taken
Bob.

ED HOWARD: Nina.

NINA OWCHARENKO: My point would just be that I think
that the number one, the key to that to solving the delivery
reform is consumers. Until we get consumers controlling the
funds that are in the health care system today, we will never
be able to get at true delivery reform that is based on what
consumers need, not government costs.

And I think that by encouraging consumerism in the
health care system we are able to have better pay for
performance, we will have health IT because consumers will
demand to have personal health records, not because they're
employer picked a plan that had one or not or the government
said we needed to have one or not.

ED HOWARD: Bob, quick comment.

BOB GRISS: Quick comment. If we had a system that was
driven by the reduction in health disparities, we would see
what really worked, what didn't work and we wouldn't have to be
asking people, how much extra do you want to pay, which plan
would you have wished you had purchased.

We would be driving a system rationally on the basis of
how effectively it can reduce disparities, and we would be able
to collect information on disparities by income, disparities by

race, disparities by other categories and we would really be able to have rational system. Other countries actually do it.

ED HOWARD: Okay. Susan you have any final comments?

SUSAN REINHARD: Just to thank the panelists, which I'm sure you're going to do as well, Ed. But also this very spirited discussion, I think it's very helpful to have ideas come forward as well as challenging questions, and I'd love to see the whole system reform, but I think this effort was to at least get a better understanding of who we mean when we say, uninsured adults, not just the numbers, but a better understanding of what's going on in their lives and to at least consider some policy options for how to improve their situation.

ED HOWARD: That's great. Thank you and thanks to PPINA or P [misspelled?] and to you and your staff for pushing us to do this program. Please join me in thanking the panel for what I think was a very thought provoking discussion.

[Applause]

Just two quick things. One is please do the blue forms before you go, and more importantly, well maybe not more importantly, but addition I think what we've seen today is the in addition to the points that Susan quite properly made, is the importance of making sure as you go through the discussion a broader reform packages over the course of the next 18 months.

You've got to figure out what if anything you want to do with Medicaid to make it work a whole lot better than it does now, both for the Feds and for the state government, and most importantly for the people who get the care from it.

Thanks again. [Applause]

SUSAN REINHARD: Thanks.

[END RECORDING]