Implementing Health Care Reform in the States

Alliance for Health Reform, the Association of Healthcare Journalists and the Robert Wood Johnson Foundation

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ED HOWARD: Welcome, my name is Ed Howard I'm with the Alliance for Health Reform and for the next hour we're going to be discussing what states are doing and will be doing to prepare for the full-scale rollout of the National Health Reform Law, the Patient Protection and Affordable Care Act, which we're going to call the ACA or we won't get anything done.

Those of you watching this live are aware that we're holding the conversation literally in the middle of arguments before the Supreme Court over whether there's going to be an ACA at all. That is, if the Act is constitutional and we're going to be looking at that question between now and when the arguments are being held in June when the decision is likely to be announced.

At the center of the argument over constitutionality is the so-called Individual Mandate that is, the requirement that beginning in 2014 most Americans are going to have to demonstrate that they have health insurance that meets some minimum standards.

Now while the Supreme Court decides the overall fate of the law, states are for the most part continuing to prepare for the implementation of the law because they don't have much of a choice. If it survives judicial review they're hoping to be

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ready for that big day in January 2014 when a lot of the major provisions of the law kick in.

For example just last week Washington State's governor signed a law creating a state insurance exchange. The Maryland legislature passed a bill just yesterday doing the same. Now today with the help of some really important and expert analysts, we're going to look at what states across the country are doing to implement the Affordable Care Act.

And what some are not doing in the face of the uncertainty created both by the Court's review and efforts by Congressional republicans to narrow or repeal the law.

Joining the Alliance for Health Reform as sponsors of today's discussion are the Association of Healthcare Journalists and the Robert Wood Johnson Foundation. I'd like to thank them both for their support. I also would like to thank the Kaiser Family Foundation for allowing us the use of its video facility to do this webinar.

Let me briefly introduce our panelists for today. First Enrique Martinez-Vidal, he's the vice president for state policy and technical assistance at AcademyHealth. And he's Director of the technical assistance project State Coverage Initiatives, which is a Robert Wood Johnson Foundation national program.

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Next to him is Matt Salo who's the executive director of the National Association of Medicaid Directors. Matt's been dealing with Medicaid policy at the highest levels for almost 20 years.

And to my immediate right is Noam Levey who covers health policy for the Los Angeles Times Washington bureau, Noam previously was an investigative reporter for the San Jose California Mercury News.

Now our panelists are going to have some opening remarks then we'll open it up to your questions. If you have a question for the panel, you can email Zack Thompson, Z-A-C-K T-H-O-M-P-S-O-N all one word @allhealth.org or you can tweet to @allhealthreform, all one word. And we'll try to get your question asked for our panelists.

Now this webinar was originally planned as a service to reporters who weren't able to attend in-person briefings that were mounted by these same sponsors in a series of cities. That means we're going to give priority to questions from reporters and it means for reporters that when you submit your question you ought to identify yourself as a member of the media so that we can give you that preference.

And let's start now with Enrique Martinez-Vidal, Enrique?

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ENRIQUE MARTINEZ-VIDAL: Thanks Ed, first let me start with an upfront assertion which is probably why we're all here and that's states are the locusts of a lot of the ACA implementation and they need practical, actionable support to effectively implement the law. AcademyHealth and our work with state coverage initiatives and the new state reform, state network initiative is providing various levels of technical assistance to those states to do that.

We take broad lessons of research and experience in states and help other states apply that information to our unique situations. When we've been working with states we really have encouraged them to think about their own goals for improving the healthcare system. There's a lot of flexibility in the ACA as we know and to look at how the ACA can really help them achieve their own goals.

And those goals might be maximizing their residence health coverage and access to care, making the health insurance market function more like a traditional market, holding insurers accountable for providing high quality coverage at a reasonable cost, or reforming the healthcare delivery system.

We're not going to talk about all of those aspects but I think we're going to talk primarily about coverage aspects today. And the three areas in ACA that are really focused on coverage are; insurance or health benefit exchanges, insurance

exchanges they're sometimes called. The Medicaid Expansions that I know Matt's going to talk a lot about as well as insurance market reforms. And we'll probably only get into that maybe tangentially.

Those three areas are really interconnected at an unprecedented level. There's a lot of inter-agency coordination, cooperation that states have to figure out to implement the reforms and in fact we're hoping to release an issue brief shortly on inter-agency coordination and cooperation. It's such a big issue at the state level.

So I'll focus primarily on insurance exchanges. So I'd characterize the progress at the state level on exchanges by dividing them into thirds. It's not quite thirds and it's maybe a little bit simplistic but it really helps see a broad pattern. So about a third of them, maybe a little less have passed – two of them had legislation, had exchanges before the ACA so we knew that Utah and Massachusetts.

Another 11 have passed legislation post ACA to establish an exchange most of those – all of those states in fact have level one establishment grants to help them through that process. One of the states; Rhode Island, has established their exchange through an executive order, they have a level one and a level two grant at this point.

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There's about another third that are in the planning, researching, building their information technology infrastructure, policy making phase but they don't really have an exchange on the ground at this point. And then there's about another third that are taking a wait and see policy towards implementation.

So I'll focus most of my comments on the states in the first two tiers, those that have passed legislation and those that are really thinking about building an exchange. Those are the states we're working with closely on their forefront of exchange development. In those states you'll really see a combination of research and planning going on alongside policy decision making and operational implementation, it's all at the same time kind of a big mix of work.

So to talk about some substantive issues, so exchanges really have two major responsibilities; one is to determine consumer eligibility for qualified health plans. Those are the plans that will be available within commercial market. And also to determine eligibility for insurance affordability programs, that's the new term in the regulations. That's sort of an umbrella term for all the public programs; Medicaid, CHIP, the Basic Health Program if the state determines that it wants to develop that.

The second major responsibility is to really establish a transparent marketplace where consumers can shop, select among health plans based on price, benefits, cost sharing arrangements and quality information. So if you look at the work that the states are doing I'd really characterize those or categorize those into seven major areas. One is the whole, big sort of first process area of setting up an exchange. That's the legal authority, the governing structure, staffing, those memorandum of understandings, stake holder process, those sorts of things.

Then there's a lot of content areas. The eligibility determination that I mentioned as well, the enrollment of those folks into the program, there's a lot of plan management aspect to this. How do you work with a qualified health plan, certification, procurements? There's a lot of cross-company issues there with Medicaid and the insurance departments as well at the state level.

There's consumer assistance work that states have to do. That has to do with navigators you hear a lot about. How do you work with brokers, call centers, outreach and marketing, those sorts of things? Again there's a lot of cross-cutting coordination issues there.

Then there's the whole financial management of exchanges. Making sure there's a fraud abuse and waste program

in place, also how do you – an exchange is required to be self-sustaining after 2014, so states have to figure how to do that, that sort of financial management.

And then there's the whole area of setting up a shop exchange for small employers. Each of those areas include a huge number of policy decisions, operational choices, implementation details and we can talk more about those details under Q&A.

In addition, on top of all this there's an I.T. build going on in almost all the states to support much of that work. They're identifying, engaging with vendors to support the design and building of the I.T. system for eligibility and enrollment. That's no small feat in and of itself.

A couple of challenges and we can get into again, more detail. One, I would just the actual operationalization of the entire endeavor, it's huge, a lot of tight timelines to make it happen, waiting for regulations from the Federal Government to make sure that they're going down the right path. The I.T. build as I mentioned is huge, complicated, dependent on many factors that are still unclear including what a federal data hub might look like.

And then there's the whole timeline that's related to having products and premium information available on October 2013 for coverage to start on January 2014. That entails

establishing a central health benefit package; we might talk a little bit more about that. Then once that's established that has to go to carriers, they have to design their products, their proposed premium rates which then all have to go the insurance departments for them to approve. So all these states are doing all this work in real-time, some are slightly ahead of others in some areas but not others so there's a lot of sharing of information going on at this point.

ED HOWARD: Very good. Lots of activity there and you mentioned interface with Medicaid, let's interface with the Medicaid Director, Executive Director.

MATT SALO: Great, thanks Ed. Let me build a little bit on what Enrique was talking about, I think the most important part he said was that states really are the locusts here of a lot of the activity with the Affordable Care Act. And he talked a lot about the exchanges which are a big component of this, but it's Medicaid really that serves as the fundamental underpaying not only of the healthcare safety net in the country but of the Affordable Care Act as well.

And in fact if you look at the sort of the totality of what the Affordable Care Act spends, the majority of it is in financing the Medicaid Expansion. And just to you know, back up a little bit on Medicaid for people who aren't intimately familiar with it, it's a state federal program that covers more

than 60 million people today. And we spent more than $420 billion collectively state and federal on the program last year.

It's a program that's growing and part of the Affordable Care Act is essentially the largest expansion of the program it's history. According to CBO their estimates are that it will add an additional 17 million people onto the roles on top of its current projected growth rate. And so before I talk a little bit about what state's been doing with respect to Medicaid, I think it's important to put some of this in context because the Affordable Care Act is coming at a time when there's lots of other things happening.

Putting aside the political, putting aside the Supreme Court and what happens with the upcoming elections. The important context here is that states are struggling now and they have been struggling recently and they will be struggling in the future with how to balance the needs of Medicaid given the very serious struggles they're having with revenues.

And you know, states are really struggling you know, the lowest levels of revenue comparatively speaking since the Great Depression. And it's putting enormous pressure on states, on Medicaid directors, on the healthcare system now. And so states are in sort of the very difficult position of

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having to do two things. One of which is to prepare for a fundamental, transformational change of the program.

Not just with the size of the expansion but with the fundamental overhaul of eligibility. But do that in the context of trying to cut costs as much as possible in order just to survive the next couple of years in a very tight budget environment. So you're seeing states unfortunately having to struggle with a messaging problem of we are trying to improve healthcare but at the same spend less on it.

And so what I think you're seeing in a lot of states is independent of the Affordable Care Act, is an effort through Medicaid to try to change the nature of the healthcare system. And a recognition that Medicaid is expensive not because it is inefficient, it's in fact quite efficient and not because it's poorly managed. But Medicaid is expensive because A) the healthcare system is expensive, we spend 17-percent of our nation's GDP on healthcare.

But also because Medicaid's role is unique in that the populations that we cover, I kind of call it birth to earth. Medicaid covers 40-percent of the nation's births, a lot of whom for lower income populations are higher risk. Medicaid also funds the majority of long-term care in this country and a lot in between; the majority of mental health services, the

majority of HIV/AIDS treatments, the majority of disability care.

These treatments, these populations are expensive because quite frankly the rest of the healthcare system doesn't know how to deal with them or wants to avoid that risk as much as possible. We have embraced it and so what Medicaid directors are doing is trying to fundamentally change the nature of how we deliver care. Moving away from just allowing people or forcing people to try to navigate a very complex health system in a fee for service modality.

But, and also try to change the incentives, the financial incentives that are inherent in the system so that we're not paying people. We're not paying doctors; we're not paying hospitals on volume. That we are paying on quality. We are paying for better outcomes. And so they're doing this now independent quite frankly of the Affordable Care Act but it is important that they will be using some of the tools the Affordable Care Act lays forward. But quite frankly they have to do it because there's no way that states are going to be able to afford 17 million additional new people, unless they do something about turning the battleship of healthcare costs around.

So just to quickly sum up and get into some great Q&A afterwards, but so with the Affordable Care Act states are

really looking at this in terms of how it affects them in terms of Medicaid. The numbers of new people who are coming on, what that's going to do to the overall size of the program. And what it's going to mean in terms of access you know, we've got 60 million people on the program now. Reimbursement rates are lower than Medicare and generally Medicare is lower than the private sector generally.

How are we going to deal with access and providing appropriate services for all these new people? But then, and again Enrique alluded to this, is the systems, changing the systems. Medicaid eligibility is going to have to be fundamentally overhauled and this is going to require massive, massive changes of eligibility systems, claims systems, information systems, all of which are going to be very expensive, very time consuming and done on a very, very short window. So we've got a lot on our plate but we're up to the task.

ED HOWARD: Terrific, thank you Matt. And as I said the original design of this program was as a way of getting reporters whom we could not reach in these city visits that we had arranged over the last six months or so a chance to think about story ideas dealing with state implementation of the reform law. And to help us with that we've got one of the best reporters in Washington in the health beat; Noam Levey, Noam?

NOAM LEVEY: Thanks Ed. Well I wanted to try to talk a little bit about possibly some ways to think about writing about the two issues that Enrique and Matt raise. Both the incredible amount of changes in the insurance market that are going on at the state level and also what's going on with Medicaid. And these are both obviously complicated, they're arcane and they're also by their very nature, sort of speculative we don't know what's going to happen in the future. So a lot of the challenge I think of reporting about these things is to sort of look into the future and say it could be this, it could be that.

I would sort of divide the reporting task into a couple of different areas. The first I'll touch on very briefly and I think that's something Enrique talked about a little bit and Matt as well, is the political context for what's going on. All of you who are out there at the state level presumably know very well what the environment is like, it is amazing that in 50 states there literally are probably 50 different iterations of the implementation of this law.

With every possible combination of support, opposition, qualified support, outright revolt and you know you look at states like California, like Maryland, like Rhode Island that are going full speed ahead to implement both the insurance exchanges and the Medicaid Expansions. You look at other

states you know Florida, Texas, Kansas that are in open revolt not just those that are suing, you have some other states like Iowa I think where you have kind of a mixture where you may have sort of political opposition but quiet work to implement a lot of this law.

So I think there's some interesting stories to be done there. The more challenging ones obviously are trying to get at the policy side of this. And I think turning to insurance regulation first and exchanges, I think one thing that could be very useful to look at is to simply look at how well positioned your state is at the moment to assume this amazing amount of responsibility to actually regulate insurance at a very high level.

There are some states that have been doing the quite aggressively for a number of years but many have not. And one of the principal goals of the law as Enrique indicated was to empower states to take further control on their insurance markets. And an interesting place to look actually is the website that the Federal Government set up; Healthcare.gov, which has quite a wealth of information about premiums, the size of premiums in the small group in individual markets, what's going on with them.

And also essentially a report card on how well states are doing with federal HHS has gone in for better or worse

depending on your political point of view I suppose. And actually made a determination about which states are ready and which are not to do that. Some really rich opportunities to look at there.

On the Medicaid front I think again, to hit on a point that Matt made there have been enormous amounts of struggles over the last few years at the state level to hold Medicaid together under enormous budgetary pressures. And I think there's a lot of opportunity there I think to still look at where states have made cutbacks and what are the costs associated with that? It's always challenging to write about Medicaid frankly because it's hard to write about poor people, it's hard to interest readers in people that are not like that them a lot of the time.

And I think the important part about Medicaid beyond this sort of I think, human responsibility we may have to look out for our neighbors is that there's an opportunity cost for states in providing the safety net that's really taking a big toll. NASBA, which I think is the National Association of State Budget Officers is that right, does an interesting report every year which I would recommend to people on the share of state budgets that are devoted to various different categories of spending.

Not surprisingly Medicaid is sort of the tomato that ate the state budget. You look around the country and it's quite dramatic, the cost particularly higher education has taken a particularly big blow over the years. I think if you look at kind of what's going on in your state and kind of explore that a little bit further, there's a lot to look at.

Essential health benefits let me touch on very briefly. This is a requirement in the law as Enrique indicated; that each state come up with its own standard for what health insurance has to look like staring in 2014. And a decision that we didn't actually think that states would be making but the Federal Government last year handed that decision off to State Capitals and it creates sort of an interesting opportunity for reporting because every state sort of is going to have another process that we get to follow. But additionally, I think it provides an opportunity to look at what kinds of benefits every state has and what the benefits of those benefits are.

In other words, how much do they cost? How effective is it to require autism? If that's something that your state does. How important is that to people? So I think there's some interesting opportunities to do that.

I'm probably running out of time but let me finish with another line of reporting that I would recommend that people

look at. There is, I think it's been underscored today by the Supreme Court arguments that a real chance that the Affordable Care Act may not exist in its current form by the 2014 gets here. And I think there is a responsibility that reporters have around the country to look at sort of what the world looks like now and what the trajectory is if the Affordable Care Act doesn't stay in place. It is obviously quite speculative but there are major issues in healthcare that will keep healthcare reporters at least in business, if not the broader industry.

And you know, you can look at long-term care as one of them, huge challenges for how the healthcare system deals with that that won't be dealt with no matter what happens with Affordable Care Act they have to do that. And I think there's a responsibility that we have in the press also to press those who are opposed to Affordable Care Act to say okay what is the alternative, what are the ways to deal with these questions?

And I would commend to people in particular a report that doesn't get a lot of attention but it's an incredible resource from the Commonwealth Fund. Which is a state report card on state health systems and Commonwealth has done an amazing job of going out and looking at 50 or 60 different metrics of what healthcare looks like from a coverage point of view, from delivery system, from cost. And there's some really, really rich data sources in there that I think can be

used to sketch out kind of what the challenge is like and what happens if the law remains or even if it doesn't. And I would commend to people to go find that there's some good resources there.

ED HOWARD: Terrific Noam. Let me have an aside to my own folks here the whiz-bang technological fix we had to relay your questions to this very desk seems to have gone haywire so either we need to fix this or you need to hand me little scraps of paper in a reprise of an earlier version of this program from 25 years ago.

Let me just pick up with something that several of you alluded to and that was the diversity of the approaches that states are dealing with. And one particular one just has to do with the structure of how they're discharging the duties that they have to do under the act. What are some of the decisions states are making about where they put whatever it is they have to have? Who's making the decisions? And does it reflect sort of a workman-like approach to getting things done or are some of the politics that influence the 26 states to file suit against the act in the first place seeping into the implementation process?

MATT SALO: Do you want to take that from an Exchange perspective?

ENRIQUE MARTINEZ-VIDAL: Sure I'll start. So in

terms of the states that have established exchanges as I mentioned before that's been primarily through legislation only one state, Rhode Island through executive order that had some politics that was the reason behind that. But most of the time, and actually to be the ACA allows states to house so to speak their exchanges in three different places; either a non-profit organization, a free-standing independent agency within state government or as part of a state government agency.

Most states have really – there's not a lot of difference between all of those actually even the ones that have gone with the non-profit which I believe may only be one or two. It still has a lot of the state requirements that apply to it, a lot of oversight that legislatively created so the legislature can put whatever sort of oversight at once into those. Whether it's part of a state agency or a free-standing state agency there's not a lot of difference there, there's some accountability differences. Most of the time even when they're within state agencies what the legislature has done is try to allow a little bit more flexibility that's what we're seeing very operationally.

The procurement rules the personnel rules, that's where we're seeing exchanges to be given a little bit more flexibility, a little bit more nimbleness to really operate

in the commercial market than a typical state agency might have. The politics maybe a little bit been playing into but the requirements under ACA really don't offer that many options. And most states have really been going down having it being some sort of state agency.

ED HOWARD: If I can just follow up, now there are options for states who don't want to do this. They can all the Federal Government to operate the exchange.

ENRIQUE MARTINEZ-VIDAL: True, true.

ED HOWARD: Anybody doing that, and what's it look like?

ENRIQUE MARTINEZ-VIDAL: Well that's going to be a big question. So there's really - you could put a state based exchange at one end of the continuum, you could put a federally facilitated exchange at the end of the continuum. There's a big area in between of what's being called the partnership model where states will do part of it, the feds will do part of it. The feds have laid out five different areas where states or the feds can take precedent or you know, take responsibility.

Most states are actually thinking at this point they're going full force into the state based exchanges, or else they're just staying behind and saying we'll let the Federal Government do it. I think the big partnership area,

the partnership model is going to come into play based on what else I had said and that's the timing challenge and just being able to get this – even some of those states that really want to go a full blown state based exchange, may just run out of time to be able to do that and to be certified.

And they're going to have to figure out well maybe we can end up doing three-quarters of what we wanted to do but we're going to have to rely on the Federal Government to do a quarter of it at least for the first year, two years something like that. And there is the ability for the state to transform and to basically transfer federal operations onto itself later on down the road.

ED HOWARD: Very good, Matt how about the Medicaid side?

MATT SALO: Yes I'll just say you know a couple things to add to that. I mean the politics are interesting but the politics of being against the Affordable Care Act don't necessarily mean that people are against the concept of an exchange. I mean the concept of an insurance exchange is a fairly simply one at its core and a fairly popular one at its core. So you can have folks who don't like the law or perhaps don't like the way that the way the exchange is being envisioned by someone else but still like the concept of an exchange.

But there certainly are folks who don't see the vision of this, the vision of these exchanges as designed, working. And so like Louisiana has sort of come out and said no we're not going to run this you know, you want this, you the Federal Government you want this to work your way, you do it. And we think it's going to fail and when it fails, you fix it. But yes, people really are all over the map on this.

And then in terms of the Medicaid side with all of this, I think you know regardless of what people think about it from my members' perspective Medicaid expansion is the law of the land and people are moving forward with trying to come into compliance with it as best they can. Some people can hope, wish and pray that Supreme Court or November elections change things but if they don't then you're out of compliance and the consequences of that are pretty serious.

ED HOWARD: Noam, does that suggest any story ideas for you?

NOAM LEVEY: Well I think you know one thing I think; we're sometimes reluctant or hesitant about writing history too much since that's sort of not technically our job description once it's past about 24 hours. But I think there is an opportunity with what states are thinking to look at the experiences that states have had with both Medicaid and insurance regulations in the past. I mean, there's some –

I've been looking at some of the sort of state where there have been Medicaid exchanges and there have had to been scale backs or there have been attempts at insurance regulation that have not worked for one reason or another.

And I think you know to the extent that past is prologue, there is an opportunity to kind of look at what a state is doing and it's approach to handling it's healthcare. To look backwards and say well to what extend is that something that's a fair argument to make? And I'll give one example very quickly, I spent some time looking at Texas back when the governor there seemed like he might be a credible candidate. And you know one of the lines that he advanced, I don't mean to mess with Texas here but was you know Governor Perry said we don't need health reform in Texas; we're fine thank you very much.

Well you know if you looked at sort of how Texas did sort of managing its healthcare system, I mean the record was pretty pathetic frankly I mean across the board. And there are obviously challenges that Texas has that other states don't have but you know by most metrics it wasn't working terribly well and I think you know there are opportunities to do that in every state. Just sort of say well you know this is something that the state has shown it can do a good job at, these are some things that the state hasn't done such a

good job at. What does that say about the future?

MATT SALO: Although defining what is a good job or not becomes somewhat subjective.

NOAM LEVEY: Well maybe but I mean, I think if you look at things like rates of coverage, if you look at affordability of insurance coverage, if you look at sort of outcome measures on hospital readmissions for Medicaid patients within a state I mean I think there are certain metrics that you can use. Coupled with you know with reporting obviously that back that up.

ED HOWARD: By the way, one question that has come in asks you Noam, to repeat the name of the report that you mentioned that was so helpful in your remarks.

NOAM LEVEY: The Commonwealth, I think it's called the State Score Card by the Commonwealth Fund. And interestingly Commonwealth just very recently sort of doubled-down on their methodology and now they have a report card on community specific that actually looks at sort of metropolitan areas I think it is, within states. Really, really interesting stuff there.

ED HOWARD: Let me turn to one of the aspects that hasn't been mentioned yet except in the general term of insurance regulation and that is the whole notion of rate review. The statute as I understand it gives some more

federal attention to this and gives states some resources on the hand for reviewing individual rates that insurance companies offer. And on the other, establishes something called the medical loss ratio that has to do with how much money gets actually spent on care. How are those doing and how are they being covered in various place around the country?

ENRIQUE MARTINEZ-VIDAL: I can't answer about the covered part, maybe you can but I think that states were given a lot of money for rate reviews, lets' start with that. They were – it required a number of changes to their processes within their insurance agencies to do a better job of rate review, bring in more stake holder – you know a stake holder process, more transparency. A lot of that is underway as we speak; those grants are still in process.

The Federal Government also sort of rated whether a state was doing a good job in the individual market, in the small group market and I believe in the association market. And they came out with a score card so to speak, of where that state was. Whether it was doing an adequate job, not, if they were not doing an adequate job then there is additional federal oversight. The states that we are working with that did not meet the adequate criteria really want to improve. So we're providing technical assistance, they're

working with other states, they're working with a national association of insurance commissioners to try and figure out how they can do a better job so that they can take that back.

I think it's very important to states that they maintain oversight over their insurance markets, so that's a key piece.

Medical loss ratios, for the most part states put in some applications for waivers to the medical loss ratio requirement, some states were granted, other states were not. The waivers were requested under the premise that the requirement would destabilize their market. The Federal Government I think did a pretty good at analyzing whether they believed the changes would really destabilize the markets or not.

Some states they gave the full waiver to, some states they said we'll give you a partial waiver we'll let you come down a little bit, other states they said no really you're insurers are doing fine we don't have to worry about you. So I think that's been a good – if the insurer does not meet that medical loss ratio and they make more money than they're allowed to make so to speak or they don't spend as much money on claims, as much as they're supposed to they have to actually provide a rebate to consumers, to their policy holders.

So that has not happened yet but we're on the cusp of that so maybe that's an interesting reporting aspect.

MATT SALO: Yes I mean the regulation of the private insurance markets, it isn't really a Medicaid thing so I don't want to comment too much on that other than you know in my past lives it certainly was important from a state perspective, every state has an insurance commissioner, this is what they do. And to continue to invest that authority within the state as opposed to doing it at the federal level is pretty important policy decision.

ED HOWARD: One of the things that somebody has pointed out in recent days is that a lot of the states that are resisting the law on a policy level are those perhaps like Texas and Florida where if the law actually is implemented their residents are going to be the recipients of a lot more assistance than some of the states that have relatively low rates of people without insurance. And I wonder whether that translates into a different approach to putting this stuff together?

If you're preparing for a huge task as opposed to say Massachusetts when it implemented its reform law and had only seven or eight-percent of its population uninsured.

MATT SALO: Yes and I think it's a valid question. You know clearly some of the concern is political but as you

pointed out some of the concern is that you know, this will have much, much different impacts in some states as opposed to others. And it does get into actually a very legitimate public policy discussion of; is all insurance the same? Is private insurance equal to – equivalent to government funded, sponsored or provided insurance?

And you know I'm not here to say there is a right answer to that but I think clearly when you see some of the opposition to the large Medicaid expansion it's – yes, there's a lot of people in this state that will be getting new coverage but it's all Medicaid and what does that mean in the big picture? What does that mean from a market perspective and what does that mean from – because at the end the state's on the hook for a lot of these costs, what does that mean for the state's capacity to continue to pay for that out into the future?

And when you think about with the Medicaid expansion does, it essentially says everybody in the country who is at or below 138-percent of the federal poverty level and you can tease out what that means in terms of dollar amounts, is now automatically eligible for Medicaid. Now that means one thing in a state like Massachusetts that has a relatively high per capita income, it means a very, very different in other states with relatively low per capita incomes.

You know Mississippi, Louisiana, West Virginia what have you, where you're talking about a much, much larger percent of the overall state's population now eligible for the Medicaid program. And that does have a lot of dynamics that have to be layered on in addition to the question of are they getting insurance or not?

ED HOWARD: In that same vein are the states where that's the case starting to get static sort of in advance from some of the providers who are now going to have to take, pick a number 85 cents on the dollar, whatever it is and whoever pays the dollar for a much larger percentage of their caseload? Or are they so happy that a bunch of people who had no coverage are no going to be bringing in 85 cents on the dollar?

MATT SALO: It's a little of both but I think primarily the first. Part of the challenge with Medicaid is as I said earlier, we cover a lot people we cover 60 million people, we spend $420 billion a year. If Medicaid paid providers what Medicare pays providers let alone what Blue Cross/Blue Shield pays providers we wouldn't be spending $420 billion, we'd be spending $700 billion.

Part of the reason why we keep Medicaid the size that it is, is that reimbursement rates for literally every provider are lower than what is quite frankly the ideal.

That creates stress in the system that creates stress on providers who have to see a lot of Medicaid patients. So when we're saying on one hand yes, we're adding 17 million more people on top of the rates you were getting combined with the fact that state budget pressures are dropping – are increasing the pressure to drive rates lower.

It's going to be a real interesting challenge trying to figure this out. Now there is a piece of the Affordable Care Act that could potentially help, there's a provision that allows for Medicaid rates for primary care to get bumped up to what Medicare would pay and I think that will help. The interesting and bizarre challenge about this is that that provisions exists for two years and two years only and then it goes away.

And the real challenge is going to be when that goes away at the end of 2014, what happens then? Does Congress step in to extend it the way they do with the Medicaid doc fix or not? And are states completely holding the bag? We don't know.

NOAM LEVEY: I mean there have been some really interesting thing reported around the country about kind of how states have sort of tried to do this. California is you know – may not usually be mentioned in the same breath as West Virginia and Mississippi but when it comes to Medicaid I

mean, it is a state that pays incredibly low amounts and the state has made incredible cutbacks. There's been a lot of really good reporting out in California on that and I think there's probably opportunities elsewhere to do that.

Then I wonder, there's one other area that I think probably hasn't been reported that much but probably is pretty rich and that is sort of the attempt by states to use managed care in Medicaid as a tool for dealing with this that's still relatively new but there's sort of enough probably experience around the country to tell some interesting stories about what's worked and what hasn't.

MATT SALO: Yes, no I think it's a great idea for some great stories. Managed care is, actually it's quite prevalent in Medicaid now and if you look at the demographics probably about 70-percent of the Medicaid population of those 60 million are in some kind of managed care now. So they're already in some kind of entity either in external managed care organization or in some sort of more managed fee for service or primary care case management model.

However that 70-percent of the people who are covered in managed care now really only represent about 20-percent of Medicaid spending. And so what that means is that the people in Medicaid who aren't currently in managed care who are currently trying to figure things out for themselves in fee

for service, they represent all of the spending, and that's where states are going. And I was talking with some folks at HHS this morning and they said the trend here, the movement here is so fast that those numbers 70-percent of people covered now, 20-percent of the money, in 18 months it'll be 90-percent of people covered and at least 50-percent of the spending.

The train has left the station. States are moving towards more managed care and more managed care for long-term care and mental behavioral health and for the typically forgotten populations, the SSI populations, the aged, the blind, the disabled and they're doing it for two reasons. One is clearly budget; moving to managed care can drives cost lower. But they're also moving there because we have demonstrably shown in a number of different states that the move to managed care results in higher quality outcomes.

So we see it as a win-win and we see this as you know the real potential for improvement in the program.

ED HOWARD: Is there resistance from some of the patient advocate groups in the movement into the managed care [inaudible]?

MATT SALO: Anytime you change – anytime you change anything there is resistance. And again I said you know healthcare is 17-percent of the nation's GDP that's a lot of

people who have a lot invested in the status quo. Any type of change is scary. Yes, there is resistance there are lots of people who stand up and say managed care isn't good for me, carve me out. Or don't do anything to the system that I have.

Quite frankly though the more you actually engage some of these advocacy groups and these populations, you'll find that they will do better in a managed care environment than they're doing now. And increasingly we're finding that the status quo, not sustainable from a financial or a health outcomes perspective.

ENRIQUE MARTINEZ-VIDAL: Maybe if I can just add a little bit on top of that. Getting back to some of your original comments in your opening remarks about sort of the whole delivery system reform and payment reform could be another rich story. You know it's not just managed care in Medicaid that's happening but also sort of a whole movement towards care delivery redesign reform, payment reform, financial incentives that are in Medicaid as well out in the commercial market states trying to work with the multi payers to do all these across the board.

Medical homes, accountable care organizations all those sorts of things too again, getting back to the affordability issue, the quality issue. Oregon is way out in

the forefront of doing this sort of thing with their coordinated care organizations that they're creating. It's sort of a hybrid between and ACO and managed care organization and Medicaid that they hope to actually extend beyond into the commercial market through their exchange work. So those sorts of things are – there's a lot of interest and a lot of work going on around the country in those areas.

NOAM LEVEY: And there a lot of resources too for reporters I mean Robert Wood Johnson's Aligning Forcing for Quality is you know there are lots of interesting projects on that website. Premier which is obviously a commercial company that works with some of these partnerships they have some really interesting things going on around the country. Brookings, Dartmouth, yes Commonwealth Fund also pretty much any community in this country you can probably find at this point somebody who's doing something quite interesting on delivery system reform that's worth sort of exploring.

ENRIQUE MARTINEZ-VIDAL: But it does disrupt that status quo.

ED HOWARD: We had a Medicaid director a few ago at a program at which he was asked whether some of the advocates were nervous about the potential harm to vulnerable populations as they moved, particularly people who are

eligible for both Medicare and Medicaid so called duel-eligibles into a managed care situation. And you know how he was planning to reassure them and his answer was well we can't. So he had budget pressures that he had to deal and we was going to try to accommodate the concerns of the advocacy community as best as he could in that context.

And another question that has come in has to do with one of the features of this law that would be popular if it ever gets finally implemented which is banning the use of preexisting conditions in discriminating against people who are applying for insurance. And the question comes up in the context of what do we do between now and 2014? And the answer is that the Federal Government has set up system of high-risk pools available to each state, once again with the states running it if they want to and the feds if they don't.

And I guess there are two questions that are implied by what has come in. One is; what about the people who don't meet the criterion for having been uninsured for 6 months and therefore can't take advantage of the new program? And second what about the people, who would like to be in the program even though there are federal subsidies, can't afford it? I know that the projections of enrollment are a lot lower nationally than they had been expected, is there any chance that that's going to change in the next year and a

half?

MATT SALO: Doubtful I mean I think the high-risk pool issue it's relatively minor in terms of the grand scope of things that we're talking about here. Enrollment as you said, is really small you know part of it is that there wasn't a whole lot of money there, part of it is that well it just probably wasn't designed all that well. I mean the restrictions and the inability to combine this new high-risk pool at the federal level with high-risk pools that already existed in most states, you couldn't combine them in a way that made sense.

You know quite frankly by the time that Congress gets to a point where it can consider potential changes to this law, this'll be post 2012 elections at that point I think trying to focus a lot of energy on fixing this probably is not going to be their biggest priority.

NOAM LEVEY: Yes probably not I mean, from a reporting perspective I mean I suppose to the extent that we are writing stories now about whether the law is working or not working, the sort of data points are relatively limited at this point and you probably can pick one or another to make either case. But I mean I would say that you know, one of the challenges obviously that the Obama administration and other champions of the law have had is that it is sort of

touched people – relatively few people directly, I think there are actually less than 50 thousand people that have signed up for these preexisting pools around the county.

But you know if you're looking for stories at the local level that sort of tell kind this challenge that's certainly one of them. I'd say the other are the small business tax credits that were in the law that were envisioned again as a sort of spurly sweetener to help small businesses get their employees covered between now and 2014. There's been very low uptake, I think 200 and some odd thousand small businesses out of four million which they had were going to be interested in doing that.

So I mean that's another area I think what's sort of worth looking at.

ENRIQUE MARTINEZ-VIDAL: I think the affordability issue is just the crux of it all and that is what 2014 is designed to address. The Medicaid expansion for those up to 133-percent, 138-percent you know full coverage and then between – you know from there on up to 400-percent with having substantial subsidies both in terms of premium and cost sharing arrangements. That's really the bulk of addressing the affordability issue.

You know how they tried to address between now and then was really you know not that effective in my opinion. I

mean you know, somebody who in a particular state could look to see what their own particular state high-risk pool had, some of those state run, state based high-risk pools have income subsidies you know, low income subsidies to them, those sorts of things, but in terms of the federal one, minor.

ED HOWARD: Let me circle back, another question actually refers to something Enrique, that you laid out at the beginning in listing the kinds of things that exchange designers had to worry about. Particularly the role of brokers and navigators I think was the term you used and the challenge of getting an I.T. system that will work in that complex environment. I wonder if you could say a few more words about the kind of concerns that people have when they're trying to deal with the role of people like insurance brokers.

ENRIQUE MARTINEZ-VIDAL: Yes, this is a complex area because there's a lot of vested interests again here with the brokers working primarily in small group market in most states, some in individual market in other states. There's a lot of community workers out there who do the same sort of thing for the Medicaid program so there's really almost a matrix that you have to design.

I'm familiar with what Maryland has taken on and

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they've really created a program that parses out responsibilities for the navigators both for Medicaid and for – not both but all three; Medicaid, individual market, small group market, as well as what the roles for brokers are going to be in those areas.

Compensation issues come up, oversight issues, who's going to create the criteria? All those things come into play. I'd say advice that saw really work well in Maryland to really have a strong and robust stake holder process in developing your program, developing the criteria and where the responsibilities are going to parse and split. And really try to keep them apart from each other because once they start overlapping, that's where you start really getting some confusion about well who is paying who, who's doing what, those sorts of things.

But the stake holder process that Maryland undertook really brought the community folks, the advocates as well as the brokers and the insurance side of things together to try and figure out – it really was a very pragmatic progress to come up with a solution.

NOAM LEVEY: They are good sources, insurance brokers they really do because they see what's actually going on in the market.

ED HOWARD: Very good.

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MATT SALO: Actually I'd add in terms of – you mentioned the I.T. component, this is huge. I mean if people don't know what this new system is going to look like and what it's going to be required to do. You know just at the exchange level you know, the federal hub what does that mean? Well what's going to have to happen is an individual is going to go online or a kiosk or to an office, type in social security number and they're going be able to in real-time in theory, with just a little bit of information figure out – you know verify they are who they say they are.

Their income is what they say it is, they're here in this country legally, what are they eligible for? Get them enrolled in that and get the payment started. This is going to mean instantaneous real-time communication not just between the state Medicaid agency and HHS but with Department of Labor, IRS, Treasury and Homeland Security.

This has never existed before; this will have to be created. And then at the state level, being able to interface with this hub, being able to convert the Medicaid eligibility process into something brand new. That's quite frankly what most states are spending most of their time really worried about. Because if you've had any experience, and I hope you haven't, but if you've had any experience dealing with Medicaid I.T. vendors and procurement processes for building out

systems.

They're done 50 ways in 50 different states and the only commonality is they come in over budget and longer – and late. And this these are the same folks that states are going to – all 50 states are going to have to go out and bid to change their systems and do it in you know, in about a year. That's going to be kind of dicey.

ED HOWARD: Very good. Well time limits are tough things and in fact we are facing one right now with coming just about to the end of the time that we have for this conversation. I want to thank our friends at the Kaiser Family Foundation for allowing us the use of the facility and by the way you'll be able to see an archived copy of the webcast of this webinar on their website at kkf.org as well as on the Alliance's website which allhealth.org.

I want to thank once again, the Association for Healthcare Journalists for cooperating and helping us identify our fabulous journalists, panelists and promote the event as well. Thank the Robert Wood Johnson Foundation for its support and encouragement in putting the event together. And most of all I want to thank our panelists for an incredibly rich and I think edifying and times frightening picture of the state efforts to ratify and implement this legislation, assuming that it survives the Supreme Court challenge.

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We'll reconvene you folks here after we get a decision maybe even after the election in the fall which might have some impact on the way we put it together. Once again, thank you for joining us, thanks again to the panel.

ENRIQUE MARTINEZ-VIDAL: Thank you.

MATT SALO: Thank you.

NOAM LEVEY: Thank you.

ED HOWARD: Good day.

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