



**Health Insurance Exchanges: Can States and the Federal
Government Meet the Deadline?
Alliance for Health Reform
July 27, 2012**

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ED HOWARD: Good morning. I'm Ed Howard with the Alliance for Health Reform, and on behalf of Senator Rockefeller and our Board of Directors, I want to welcome you to a program that looks at one of the key components in the machinery laid out in health reform law that is health insurance exchanges. Now these are places where the idea is to offer consumers and small businesses a transparent market where they're going to be able to shop around among affordable coverage options, and it'll be a place where the exchange can help determine the individual's eligibility for various subsidies that are available under the law. They're scheduled to be operational and in time to start covering people in January of 2014. There are a lot of moving parts that have to be put in place for that to happen.

Now it's been almost two and a half years since the law was enacted, but a lot of states have been reluctant to invest a whole lot of time and resources into establishing these exchanges, given the continuing controversy of the law's merit even if it's constitutionality. As you'll hear, there's a lot of work to be done if consumers are going to be able to use these marketplaces to choose the insurance that's right for them. Now we're hoping to gauge that progress this morning, the progress that both Federal and State governments are making on

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setting up these exchanges and we're going to look at the major challenges facing everybody involved in both setting them up and operating the exchanges.

We're pleased to have as a partner today the Commonwealth Fund, which has done and commissioned a lot of analytical work on exchanges as an important component of a high-performance health system. I want you to not in your packets a brand new paper by Sara Rosenbaum and her colleagues that Commonwealth commissioned on the first generation of state exchange laws that's a good example. We're more pleased to have as the co-moderator and active participant in today's discussion, Sara Collins, an economist by training and the Vice President for Affordable Health Insurance at the Fund. Sara?

SARA COLLINS: Thank you, Ed, and thank you to the panelists for joining us today. As Ed mentions, the state exchanges are really new private insurance marketplaces. They are the centerpiece, truly, of the Affordable Care Act's coverage provisions. They'll be the central place where people will go for health insurance if they don't have an offer of affordable coverage through a job. People will gain access to an array of insurance options, private plans, Medicaid, the Children's Health insurance Program. States may establish their own exchanges or HHS will play a more active role in the states setting up exchanges.

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In order to establish exchanges, states have to give themselves the legal authority to do so, so on this map, which is now an interactive tool on the Commonwealth Funds website, 14 states and the District of Columbia, in darker blue on the map, either have signed legislation in place or Executive Orders by their governors that have established exchanges. The lighter blue states on the map are a mixture of states with histories of legislation over the past two years that has been introduced or passed, or active initiatives by their governors. The 8 states in white have decided not to establish exchanges.

As Ed mentioned, in your packet, there's a new Commonwealth brief by Sara Rosenbaum and her colleagues that compare the provisions of the state exchange laws. As of right now, the key finding of the research is that while much of the details are yet to be worked out by the exchanges themselves, really all of them have been created as public accountable entities with policy and market-shaping power.

Many states that don't have legislation in place have Federal grants to design their exchanges. About 34 states and the District of Columbia have received about \$830 million in grants. In 2014 when both the Federal and State exchanges are operational, people without an offer of employer coverage or public insurance coverage will have a choice of private, so-called Qualified Health Plans sold through the exchanges that

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will offer a comprehensive set of benefits also known as the Essential Health Benefit Package.

People with incomes between 100 and 400-percent of poverty, that's about 23,000 to 92,000 for a family of four, are eligible for tax credits that will cap their premium costs as a share of their incomes. In the wake of the Supreme Court decision, the Congressional Budget Office estimates that about 29 to 30 million people will become newly covered under the law by 2020. This is about 3 million fewer than CBO estimated in its prior estimates in March, about 11 million people will be newly covered through Medicaid. This is down from 17 million in their prior estimate, about 25 million people are estimated to be covered through the exchanges. This is about 3 million more than were estimated to be covered previously before the Supreme Court decision.

So what's behind the change in the estimates? The Supreme Court decision, as everyone knows, changed the Medicaid expansion in the law such that states are permitted but are not required to expand their Medicaid programs to adults earning up to 133-percent of the poverty level. The decision, however, leaves intact the substantial Federal financing for the expansion, 100-percent in the first three years, and phasing down to 90-percent by 2020.

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In states that participate in the expansion, people earning between 100 and 133-percent of poverty are eligible for Medicaid. The people in states that don't expand would be eligible for the premium tax credits within that income range. Those plans are more expensive to enrollees and so the CBO estimates there will be a lower take up than there would be in the Medicaid expansion as a result.

Under law, people with incomes under 100-percent of poverty are not generally eligible for the tax credits. It was assumed that nearly everyone in that income range would be covered through the Medicaid expansion. Nationally, nearly half of adults, about 15 million people, with incomes under 100-percent of poverty are uninsured. The numbers are even higher in some states that have indicated they won't move forward, about 1.9 million people uninsured in that income range in Texas, for example.

In arriving at this latest estimate, CBO makes assumptions about incentives facing states in deciding whether participate and the numbers of people newly-eligible who might face delays in gaining coverage, but there is a huge amount of uncertainty, clearly, about what the final outcome will be.

The panel today is going to take up some of the key implementation issues for the exchanges, particularly in the wake of the Supreme Court decision. Given that open enrolment

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begins in October 2013, what are the next steps for State and Federal governments to meet that deadline, and what are the implications of the decision, particularly with regards to coverage of lower income families? What are Federal and State policy options if state participation in the Medicaid expansion is delayed? With that, I'll turn this back over to Ed.

ED HOWARD: Good, thank you, Sara. Just a couple of quick logistical items. In your packets, there's a lot of good background information including biographical information of all of our speakers. There are copies of the PowerPoint presentations that we had on hand in time to reproduce, and we'll have Krista Drobac's presentation on our website, allhealth.org, as soon as we get back. Everything is listed on a one-page materials sheet that has a lot of background material that we didn't kill trees to put into your hands in hard copy but are nonetheless useful in this discussion. There's a webcast available on Monday through the good offices of the Kaiser Family Foundation on their website kff.org or the Alliance's. We'll have a transcript on our website in about a week. We invite you to use the green question cards at the appropriate time in the program, and there's a blue evaluation form that we would desperately like you to fill out and give us some feedback and suggestions on not only how to make the programs better but what to do programs on. We can use your

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input on that very important question. Let's get to the program without further delay.

We've got a great panel for you. We're going to start with Tim Jost. Professor Jost teaches health law, among other things, at Washington and Lee University Law School. In fact, he wrote the most prominent case book used in teaching health law across the country. He's a consumer representative on the National Association of Insurance Commissioners. He's a veteran of a number of Commonwealth Alliance panels and we're very glad to welcome you back. Tim?

TIMOTHY JOST: Thank you very much. When Affordable Care Act was passed 28 months ago, many wondered why its most important reforms were delayed for almost four months. Today, a little over a year before the exchanges will start signing up their first enrollees, it seems that 2014 is coming far too soon. HHS, the IRS, and the Labor Department have released hundreds of pages of regulations and guidance since March of 2010 when the ACA was signed into law. Most were issued on time and implemented without serious problems although the pace of implementation has slowed, at least recently.

On January 1st, 2012, most of the remaining ACA reforms are supposed to go into effect. First, an American Health Benefits Exchange must be in place in every state, including the shop, small business exchange. Second, the ACA underwriting

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reforms, which I think Brian will talk more about, must be in effect. Third, the risk adjustment, reinsurance, and risk quarter programs must be up and running. Fourth, the individual and employer responsibility programs must be in place. Fifth, premium tax credits and cost sharing reduction payments must be available to assist middle-income Americans purchase self insurance. Finally, Medicaid must be expanded to all individuals above age 65 with incomes below 138-percent of the poverty level in those states that choose to participate.

Most important among these reforms are the exchanges, the gateway to all the other reforms. The ACA asks the states to establish exchanges but allows also the possibility of Federal exchanges for states that do not decide to proceed with establishing their own exchanges, and in particular in states that are determined on January 1st, 2013 to be unlikely to have an exchange in place by January 1st, 2014.

The final rule, however, on exchanges sets forth a somewhat more complicate framework. First, it recognizes pure state exchanges, although even these state exchanges concede certain functions to the Federal government. Second, there are partnership exchanges in which a state agrees to carry out plan management, consumer assistance functions or both, and leaves other functions to the Federal government. Finally, there are Federally-facilitated exchangers, but even in these, states can

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take on certain functions. States must notify HHS by November 16th of this year, eight business days after the election, which of these options they prefer to pursue, but the exchange rules recognize even further flexibility. State exchanges can be conditionally approved in 2013 if they are likely but not certain to be operational by 2014. A state that begins with Federally-facilitated exchange can transition to a full State exchange over a 12-month period or vice versa. Exchange establishment funding will continue to be available till the end of 2014 for lagging states and can be spent for up to three years thereafter.

While 2014 is the target date for the reforms, in fact, the exchanges must be underway well before that day. They must open for enrolment October of 2013. They must therefore have certified, qualified health plans before that date. In turn, insurers must have designed and priced their exchange plans and filed forms and rates with state regulators before QHP certification. If you work backwards from October of 2014, you get almost to the present. Obviously, states and insurers need a lot more information very soon, and here I suggest that you look at the grey handout rather than trying to read the slides, because there's a lot of information here which you won't absorb now but hopefully can use later.

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HHS has issued final rules on the individual and shop exchanges, Qualified Health Plans and Qualified Employers, the 3R programs, Medicaid eligibility under the ACA, and as of last week, on data collection to support Essential Health Benefits and recognition of QHP Accreditation Programs.

The IRS has issued final rules on premium tax credits although those rules contain significant gaps. For those of you who don't know, every time a new rule comes out or guidance, I blog about it on the Health Affairs blog, so if you don't want to read a hundred-pager or three hundred-page regulation, that will give you a quicker intro.

HHS has also issued guidance on a number of topics including the Federal exchange, Essential Health Benefits, Actuarial Value in exchange and Medicaid IT systems as well as Frequently Asked Questions on a variety of subjects, a draft blueprint for state and partnership exchanges. HHS has also provided additional guidance to the states as it is negotiated establishment grants. On some issues such as the Essential Health Benefits, guidance will not suffice and further regulatory action is necessary. On other topics such as the Federally-facilitated exchange, HHS has no legal obligation to proceed through regulation and they simply proceed through guidance.

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A number of 2014 requirements of the ACA are from my reading of the statutes so executing, no rule is necessary to implement them. These, among others, include the prohibition on annual limits post-2014, the pre-existing condition exclusion ban, guaranteed renewability, and the prohibition against discrimination based on health status. For other 2014 reforms, however, rules will be needed that are not yet issued, including requirements for quality reporting by plans, the limits on rating factors that can be considered in the individual and small group market, guaranteed availability, the basic health plan, individual/employer responsibility provisions, and I'm trusting Mike's going to give us an update on all of these later on in the program.

The agencies have already signaled their intent to delay full implementation of some of these provisions such as the exchange quality provisions a bit longer, and we may, perhaps, have a little bit breathing space left yet before some of these provisions, like the individual/employer responsibility provisions need to be in place. On the other hand, some issues such as risk pooling or underwriting requirements, we need decisions very soon. Making major policy decisions in the highly charged political atmosphere that will exist between now and the election will be difficult but some decisions simply cannot wait if we're going to get to the

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January 1st, 2014 date. States that have not yet taken executive or legislative action to establish an exchange have probably missed the boat for creating a state exchange. Time will also be tight for creating partnership exchanges. I would expect at this point, that we will end up with a Federally-facilitated exchange initially in most states. On the other hand, if President Obama is re-elected, I expect that Federally-facilitated exchanges will be up and running, and capable of fulfilling basic exchange functions. I also expect that most states will transition to a state exchange with partnership status being a potential way station.

There will certainly be glitches along the way as there are in the implementation of most major changes in the public and private sector. I remain hopeful that in the near future, the promises of extending health insurance coverage to millions of middle-income Americans will in fact be fulfilled.

ED HOWARD: Thank you, Tim. Next, we're going to turn to Brian Webb who's also been our guest before. He's the Manager of Health Policy and Legislation for the National Association of Insurance Commissioners. Brian's also served as the health policy advisor to former House Ways and Means Committee Chairman Bill Thomas, and in senior positions at what's now the Federation of American Hospitals and the BlueCross BlueShield

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Association, wide background. We're very pleased to welcome you back to the program. Brian?

BRIAN WEBB: Thank you very much. Before I get too far along here, one of the questions we always get is the why question. Why do we have to have these exchanges up and running by 2014? Can't we just put that off a year or so? Can't we just string it out a while? And the problem is the rest of the law. We have to remember the exchange is not operating in a vacuum here. The reality is the individual mandate, we have been told, is constitutional. It will go into effect. That will start January 1st, 2014. People have to have coverage, have to have qualified coverage, in order to meet that mandate.

Well, to help those, especially lower-income persons under 400-percent of poverty, there are subsidies available, but in the individual market, the only way to get the subsidy is to purchase where? Through the exchange. You have to have an exchange up and running, selling products prior to January 1st, 2014. They've suggested October 2013. Selling qualified products so people can have those products in their hands as of January 1st, 2014 so they can then meet the requirements of the law. There isn't really a lot of wiggle room here unless somebody wants to go back and change the law. Do I have hands [laughter]? I know there's some but unless they can do that, people are going to get caught in a bind, so we need these

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exchanges up and running, and frankly, if the states don't do it, the Feds will have to. That is not an option that a lot of people want. We love the Federal government. Right? [Laughter] They do a fantastic job, but this is a task that would be massive for the Federal government, so just speaking for the National Association of Insurance Commissioners, we hope the states will play a major role in getting these things up and running, and making sure that everybody gets the protections.

Now, there's a lot of work to do. You can't see this but it's on your paper. We've gone through many things, but you see that 2014, exchanges isn't the only thing going to happen. You have to keep that in mind. The states are going to have to do a lot of work to try and get ready for 2014, and it's not exchanges. In fact, much of it has to do with the market reforms. I know that exchanges are the big, beautiful building out there that everybody want to point to and say, isn't that wonderful, and it's going to change everything. The reality is the thing that will change insurance for most people are the market reforms, especially in the individual market. For the first time in most states, people will be able to get coverage even if they have a pre-existing condition. They can get coverage immediately. They will not be rated based on their health status. They will not be able to be put into a small little book of business but will have to be shared across the

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entire book of business. These are major reforms that will impact rates and will impact access to coverage in every state. These are important reforms and we have to get ready for these, not just in the exchange but outside the exchange, as well.

The reality is, of the states do not get ready for this, then they lose the ability to regulate. We must understand we have some states who will sit there and say, well, I'm not doing anything. Well, they may get their wish and not be able to anything in their marketplaces. There's language in the legislation that says nothing in this title should be construed to preempt any state law that does not prevent the application of the business title. What that means is if you have a state law that prevents the application of the Federal law, then it is thereby preempted. If you, as a state, sits there and say, well, I'm not going to do guaranteed issue in my individual market. I'm not going to do the rating reform. I'm going to approve plans that don't have these untold benefit package. I'm going to approve plans that have annual limits. I'm going to improve plans that have lifetime limits. The reality is your laws in your state will be preempted and it will be up to the Federal government, my cash personally, will have to come in and approve all rates and reforms in your state. Basically, the state will be relegated to the position

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they had with Medicare Advantage, where they do licensing and solvency, and that's it.

Whose choice is that? That is the state choice. That's the reality, that's why states have to start getting ready. You have many options. Again, that's the whole marketplace. We have to start getting ready for Essential Health Benefits. Now the Federal government has said, we will allow the state to choose the Essential Health Benefits from a list of possible options. I know you've heard this many times. The three largest small groups, three largest Federal employee plans, three largest state employee plans, the largest HMO. You choose. Now, we need the final reg, Mike. Propose regs, anything, but states should be working on that. We know what the first quarter of this year looked like and we have until September 30th, 2012 for a state to choose what that benchmark plan is that people had to sell inside and outside the exchange. Now that's become a soft deadline, but I'll tell you, the insurance companies are very nervous about this being a soft deadline because they need to know what the products are that they're going to have to sell. We need to know what these products are. States have an opportunity to step in and be part of that process of choosing that benchmark, what has to be offered?

We also have to start being prepared to do this concept of actuarial value. We don't do this a lot, if any. We have to

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be able to look at these plans and see if the cost sharing structure that they have for those essential benefits meet these bronze, silver, gold, platinum, catastrophic limits, so states have to be prepared to do that. Again, if the State government doesn't do it, it'll be up to the Federal government to do it. If the states are approving plans that don't meet those standards, then the Feds will have to step in, so states have to be prepared for that.

They also have a choice whether they want to run the reinsurance program. That's a three-year program. Billions of dollars nationwide are going to be shifted from the individual small group, large group, self-insured marketplace down into the individual market. The state has to choose, do I want to be part and be making the decisions about who in the individual market gets that windfall or appropriate amount of money, depending on how you look at it. Who's going to decide? If the state doesn't do it, the Feds will.

Risk corridors. If the state and only if the state is doing the state exchange, then the state can choose to do the risk adjustment. Otherwise, we're going to be using the Federal Risk Adjustment Program. Risk corridors, that's a Federal program. We don't like to talk about it. We think it's kind of interesting [laughter].

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Now when we come to exchanges, states do have options, and we appreciate this. I have to say, as states, we're always pushing for state flexibility, state flexibility, state flexibility. We're getting that through these regulations, and we got this in this law. States have the choices here. Now there are minimum standards but states have a lot of flexibility.

A state can say I want a Federally-facilitated exchange. I don't want to do this. What that means is that the Federal government is choosing how it runs. Now initially, they've said, we'll let everybody in. Any qualified health plans, they can come in and they can sell. There's no guarantee in the future that's the way it's going to be. We don't know the future Federal facilitation exchange is going to do, how it's going to operate, how it's going to choose people. They've said we're going to use State Network Adequacy Rules; we're going to use State Marketing Rules generally. Again, if they're running it though, they still have the opportunity to make those decisions, so that is a question. Do you as a state want the Federal government making those decisions and running a Federally-facilitated exchange? Now the state can still do the Medicaid eligibility, but you're basically giving the rest over to the Federal government.

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Now I would warn if the state says I want to do Federally-facilitated exchange, we are hopeful that states at least will help the Feds, telling them who's licensed, who's solvent, who's a Qualified Health Plan and has actually approving plans that can be sold on the exchange. We have to have the coordination. They recognize that, we recognize that.

We can do a step up, though, and do partnership where the State government is actually for the Federally-facilitated exchange deciding who the Qualified Health Plans are. They're certifying them. They're saying we're going to look at their rates, we're going to look at their forms, we're going to make sure they have all the benefits, we're going to do that and then tell the Federal government that these are approved. We're going to check the network adequacy, we're going to check the marketing, we're going to do all of that. That's an option where the state is a good, solid partner with the Federal government, and therefore has more say in how these plans are regulated.

Finally, a state, of course, can do a state exchange where they have total control about how these things run as long as they meet the minimum standards in the Federal law.

Now what I didn't put on in here is the states also at the same time they're deciding how the exchange is going to work, they have to decide how the outside market's going to

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work. States have to be very careful here. For example, individual market guaranteed issue. In the exchange, it will have an open enrolment period, certain times during the year where everybody can go in and purchase guaranteed issue through the exchange. What if the outside market doesn't have an open enrolment period? What's going to happen to the outside market? Who's going to sell out there where they can get everybody sick whenever they come whereas the exchange has only a small window in which to purchase that? States have to think about that. Even if your state says, I'm not doing a Federally-facilitated exchange, I'm not doing it, I'm not doing the exchange, I'm not doing anything, you'd better look at your outside market to make sure the rules of the exchange don't severely injure your outside market, and make sure you're getting all that taken care of.

Deadlines. We have until November 16th, 2012 to get our application in, basically to say how we are going to do this. We're going to be a partner. We're going to do a state exchange. If you're silent, Feds better get to work. In January 2013, the HHS will certify the state exchanges as well as the partnerships. This is how we're going to move forward for the year to get ready for October 2013 where the initial open enrolment period. I'll tell you between January and October, that is going to be a very busy time for states as we sit there

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and try to get all these plans certified, up, ready to go. Then January 2014, coverage is effective. Funds are available. Tim already talked about that.

Just very briefly, our Medicaid options. They've added this. The Supreme Court said yes, more options on Medicaid. You don't have to do the expansion, but as was already discussed, if you do that and don't do the expansion of 133-percent, you're going to have a gap. You're going to have some people under 100-percent of poverty who don't have coverage. States have to deal with that and figure out how they're going to do want. States, do you want to expand under the ACA, go up to 133-percent? Do you want to not expand? Do you want to expand your old program? Do you want to cover them that way? Other options may be available but we're going to need some guidance from CMS on that. If you have any questions at all, there's a couple of other people you can call on there other than me [laughter].

ED HOWARD: Excellent. Thanks so much, Brian. We can move the flicker [misspelled?] along. Thanks very much.

Next up is Krista Drobac from the National Governor's Association where she directs the health division of NGA's set up for best practices. Krista's also a Hill veteran on the Senate side and has held senior positions both within HHS and

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at the Illinois State Department of Health Care and Family Services. Welcome back to Krista.

Krista Drobac: Thank you. My apologies that my slides did not make it in the packet. They will be available later. I hope that I don't have to rush through this but they did put the big red clock right in front of me, and I'm standing between you and Mike [laughter].

This is actually a very timely discussion because NGA just had its Annual Meeting two weeks ago with our governors and last Thursday and Friday, we had 40 states in town for a discussion about post-Supreme Court decision-making. A lot of what I'm going to say is going to reflect what we've heard in the last few weeks. There's also a summary of our meeting with these 40 states on our website, so that goes into a little bit more detail.

The states are in very different places as you know. There are some that are going to expand Medicaid and are already well on their way to a state-based exchange. There are other states that have declared that they will not be expanding Medicaid and that are most likely to have a Federal exchange. There's a whole group of states that are in the middle that have a lot of considerations, and the considerations are very similar. They're considering whether to expand Medicaid. They have to decide whether they'll have a state-based partnership

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or a Federally-facilitated exchange. They're looking at the implications of the elections in November. They're also looking at the pressure to reduce the Federal budget deficit and how that is going to impact state spending so that can't be underestimated.

I know we're here mostly to talk about exchanges but in light of the Supreme Court decision, states are really focusing a lot on Medicaid as well as the exchange, so I wanted to go through some of the things that states are considering as they look at whether or not to expand Medicaid. Obviously, there are a lot of questions which Mike is well aware of, that in thinking about whether you expand, a lot of states are wondering, well, could we just go up to a hundred, so that people between 100 and 133-percent of poverty have access to the exchange. If we just go to 100, there would be no gap.

Can we expand over time? What happens to our DSH Funding if we do only do a partial expansion? Can we get the 100-percent match rate if just went up to 100? What happens to the Children's Expansion and the Mandatory Expansion to Foster Kids up to age twenty-six? There's some debate whether that is included in the Supreme Court decision, or whether we're sort of part of the old program.

The last question, I think, which is a really, really important one is if we do expand up to 133-percent poverty, can

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we go back down later? So if we run into significant budget challenges in the state, we're at the 90-percent match rate, we can't come up with the 10-percent state match, can we go back down? The statute reads that all individuals up to 133-percent, so it's very difficult to figure out what might happen there given the way the statute reads.

So right now, states are trying to estimate the impact on the state budget of going up to 133, and I know this may not sound like a lot when you're in the Federal government, it sounds like boy, we're being really generous, 90-percent is a lot, but states are cutting Medicaid right now because they can't carry the budget implications now. They're very carefully considering what it really means to have an additional group of people on Medicaid and the state paying 10-percent.

I think a lot of state officials right now are trying to figure out what are the right assumptions in estimating the impact on Medicaid. There's a lot of numbers floating around out there so they want to make sure they get it right. They are trying to figure out, for example, how many people can we expect that are already eligible and not enrolled that may be enrolled because those people are not going to get the 100-percent match. What's the budget impact of that? What are the costs of our current state-only programs? So there's a lot of mental health programs that are paid for by state-only dollars.

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On compensated care pools, the state high-risk pool, all of those things are paid for with state dollars that, if those people become eligible for Medicaid, they could actually reduce the cost to the state so it's something to think about. What might our savings be if we did the Medicaid expansion?

Then, of course, there's what are the implications of the DHS payment reductions? Now the Secretary in the statute has authority to come up with a fair formula, but the problem is there's going to be less money. Either way you look at it, there's going to be less dollars for uncompensated care through DSH.

What's going to be the provider reaction to that? Obviously if you don't do the expansion, you're still going to have uncompensated care and people going to the hospitals, and if those hospitals get less DSH funds, what is their reaction going to be?

What is the cost to the state and the counties, and actually individually, privately insured people if there continues to be uninsured people that go to the hospital as they do today?

What are the administrative costs to the state to have new people on Medicaid, and then if you look at the expansion population and the characteristics of the expansion population, are they going to be more expensive than current? How much

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might we expect these folks to cost? There's definitely a disproportionate number of people in the expansion population that have mental illness and behavioral health challenges. For some states, that makes the decision clear. That means we must keep them on Medicaid because the Medicaid benefit package for mental illness is very good and rich, and if you have them in the exchange, well, the benefit packages for behavioral health aren't as great. It also factors in whether you need to keep community mental health dollars in your state budget.

Finally, the states that have done Medicaid expansion already have found that the people are definitely more costly than the current parents but their less costly than disabled enrollees, so they're somewhere in the middle. Also, you're looking at a new kind of churn. We all talk about churn a lot. What happens if they go between Medicaid and the exchange, and the continuity of care, et cetera? Well, now you've got people going between insurance and no insurance, and so they've got, obviously, very different networks of care.

On the exchange, you've got states trying to work through all those Medicaid issues and now they're also working through all their exchange issues. In deciding whether to go for a Federal partnership or state-based exchange states are thinking, well, could we start a partnership and maybe move to state-based exchange? In the partnership model, what's the

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sustainability model? How do we pay for it? If we're going to do consumer assistance and plan management, how do we pay for the additional administrative cost on an ongoing basis? Because the Federal government may have a user fee in the exchange, but the state has to consider whether they would have a user fee. They're trying to figure out the costs of what a partnership actually means.

They're also wondering what's the state level of effort. Somebody's got to change their programming language so that the two programs can talk to each other as they build an interface between Medicaid and exchange. What's the level of effort in doing that?

What does the memorandum of understanding with the Federal government look like? Obviously, many states can apply for grants to cover a lot of these administrative costs upfront. It's just the sustainability in the long term.

Many states, as you may know, have advanced planning documents so they've actually used the 90/10 match opportunity in Medicaid to build eligibility systems and in doing that, they have agreed to build an interface between the state exchange and the Medicaid programs. There's a lot of work to do on that interface.

Finally, do you make your Medicaid eligibility determinations or do you accept the assessment from the Federal

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exchange or do you have Medicaid folks in your own departments making those eligibility determinations? Obviously, that impacts administrative costs.

Market question. If you drive people between 100 and 133-percent into the exchange to shift the cost more to the Federal side of the ledger, how do you do that? Can you pay for their premiums, because obviously there aren't premiums in Medicaid like there are in the private market and a lot of people may not pay those premiums at that income level, so could the states pay their premium? Or could providers pay it, for example? So how do you make the impact on low-income people less so they may choose the exchange? What happens to the marketplace if those folks go into the exchange? As I mentioned before, disproportionate share of behavioral health needs and what about their benefit package in the private market?

Then of course, as Brian already talked about, what are the effects of the market reforms on insurance premiums, and whether people would take up the exchange at that income level. Obviously, everybody is well aware of the impact of the election. States have to declare ten days after the election what their decision is, whether they'll have a partnership, state, or Federal exchange so there has to be some groundwork laid because in the blueprint for the exchange, states have to complete 42 activities to be a state exchange and 19 activities

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to be a partnership exchange. If you're going attest that you're going to get some of that done, obviously some of that work has to start now, and considering what you might do. That does make it politically a little bit difficult as you're waiting for the election.

Finally, I just want to mention the Federal budget. Everybody is worried about the state budget but many, many governors are worrying about the debate going on here in Washington about deficit reduction. If Medicaid becomes part of a deficit reduction deal, what does that mean for the Federal match rate for states? It obviously goes into the consideration. If we go up to 133, what happens if you decide we don't get 90-percent match anymore, that we go back to our regular rough math or some kind of blended rate, and then we've got all these new people on our rolls. We can't afford them and we can't go down in eligibility. The Federal budget is just a big factor for many governors in considering whether or not to expand Medicaid.

ED HOWARD: Terrific. Thank you, Krista. Now, we turn to Mike Hash, who's the Acting Director of the Center for Consumer Information and Health Insurance Oversight within HHS. At the same time, he's also the actual Director of the HHS Office of Health Reform. He's a veteran of the White House Office in Health Reform and also of the Respected Health Policy

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Alternatives firm here in DC. He's a long time senior staff member of the House Energy and Commerce Committee and at one point, the Acting Director of what is now CMS. Michael Hash thanks for being with us, and I should say because we had to shift the timer around, Mike is going to have leaved long before the Q and A is over. We appreciate you're carving out as much time as you could.

MICHAEL HASH: Thanks, Ed. I'm delighted to be here and to join with the Alliance and my colleagues here in the dais to talk to all of you about what we're doing at CCIIO to implement the Affordable Care Act.

As everyone in this room knows, we now know that the Supreme Court has found the Affordable Care Act to be fully constitutional and that decision ensures that all hardworking middle class families will get the healthcare security that the law was designed to provide. From our perspective at HHS and more particularly at CCIIO, it simply means that we continue moving ahead with full steam to implement the law.

Today, I want to talk to you briefly about where we are and the progress that we are seeing in the establishment of the health insurance marketplaces, the affordable insurance exchanges. I think several people on the panel have already said, at least at HHS, our strong preference, our premise, in fact, is that we want each state to establish its own exchange

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because the state-based exchange provides states with the most amount of flexibility and involvement in running these new marketplaces. At the same time, we know that some states will need additional time and assistance before being able to run their own exchanges, or they may choose to work in partnership with us, as has been pointed out, in the context of a Federally-facilitated exchange.

We've seen what we think is really good progress around the country with the establishment of state-based exchanges, the process of building them, and we expect to see more now that the Supreme Court has provided a clear and final decision. I think, again many of you may know in this room, 34 states and the District of Columbia have received approximately \$850 million in exchange establishment Level 1, Level 2 grants, or Cooperative Agreements, as we call them. Those funds, of course, are designed to provide the resources that are necessary to build the exchanges.

A few weeks ago, we announced additional opportunities for states to apply for exchange establishment grants through the end really, of calendar year 2014. These funds are clearly available for states to use beyond 2014, as they have to continue to work on their exchanges. We believe this will insure that states have the support and the time necessary to

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build the best exchanges that meet the needs of their residents.

We also announced that these establishment grant funds are available to fully fund exchange-related activities during the startup year of an exchange. We are expecting to award additional sets of grants in the middle of August and we'll offer further opportunities to apply for these grants in each subsequent quarter between now and the end of calendar 2014.

This past May, as again you know, we published the Exchange Application or at least what we refer to as The Blueprint that states are going to use in order to receive approval for their state-based exchanges. We are in the process of getting comments on that blueprint. We'll be finalizing it later this summer. Our exchange blueprint is structured around; of course, the functions and activities that states need to perform in order to be certified as a state-based exchange or a state partnership within a Federally-facilitated exchange. The blueprint is, I think Krista just mentioned in her remarks, is due generally 30 days before the beginning of a calendar year, but in the case of the first year of 2014, we're asking for states to complete the blueprint by November the 16th. Other states that are still on their way to be a full state-based exchange can apply in subsequent years.

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Now here's the latest data that we have assembled about the progress about the states. First, as of the 24th of July, a few days ago, 13 states have sent a declaration letter expressing their intent to establish a state-based exchange. As I think I mentioned earlier, we now have 35 states, including the District of Columbia who have already received establishment grant funding and obviously, we're expecting there will be more as we move through that funding opportunity cycle.

19 states have already established the authority that's necessary to operate an exchange, whether that be state legislation or an Executive Order, 17 states have hired or are in the process of hiring an executive director or its equivalent to actually manage the operations of a state-based exchange.

With respect to the critical function of building the information technology infrastructure, about 42 states have completed an information technology, a so-called gap analysis, to see what they need to do. 22 of our states have, in fact, issued a request for proposals from vendors and contractors in order to start building the systems that are necessary to support the exchange functions.

Let me say a couple of words about the Federally-facilitated exchange. As I've said at the outset, our strong

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preference is for states to establish a state-based exchange, giving them the maximum amount of flexibility to tailor their exchanges to the needs of their own marketplaces. However, we realize that not all states will be ready to establish these exchanges by 2014 so we're on track to set up the Federally-facilitated exchange in those states that aren't certified as of January 2013. Federally-facilitated exchange is on track, on time, to go live October 2013, which I think many of you know is the beginning of the first open season associated with both the individual and small group markets.

Like states building their own exchanges, we're covering the major operational areas, the functions that the law requires exchanges to perform, plan management, the eligibility and enrolment functions, the determination of advanced premium tax credits and cost-sharing reductions, the financial management responsibilities that exchanges have for the flow of funds such as the payments, of course, to the issuers of Qualified Health Plans. Our Federally-facilitated exchange is being built in a very collaborative manner with the states. We're using industry standards for the exchange of data which is so critical for a seamless consumer experience which we're all striving to achieve.

The first round of testing with the states and the insurance carriers, some of who will be using the Federally-

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facilitated exchange, is currently underway. The Federally-facilitated exchanges are being built so that it's easily accessible and scalable so that we will be able to meet the need in any number of states who require an FFE or a partnership model with the FFE.

We're also building what we refer to as the Federal Data Services Hub. That's on track with a contract awarded earlier this year to establish that. You may know the Data Services Hub is going to be a single place where the FFE and every state-based exchange can use to securely validate the information supplied by applicants with the relevant Federal agency partners that are called upon to help with that task.

Soon we are going to really the Federally-facilitated exchange implementation schedule to states so that they can align their own work with the schedule of our work on the FFE. Of course, we're going to release additional guidance about how we are implementing the FFE and the partnership arrangement with respect to plan management services and consumer assistance programs.

I think you can see, at least from our vantage point, we certainly believe that we're making significant progress on the actual build, both of state-exchanges, partnership arrangement under Federally-facilitated exchange, and the Federally-facilitated exchange itself. The design of all of

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this is moving forward on pace, and we are doing everything that we can to make sure that we're ready for 2014.

We're pleased, as I've said at the outset, by the progress that we see and with our colleagues in the states, with our colleagues within the insurance industry, and all of the stakeholders who are helping us create these new marketplaces where consumers can access quality, affordable healthcare coverage. We want to assure everyone that we're going to be ready and we believe our state partners will be ready to make the promise of the Affordable Care Act a reality for all Americans. Thank you for having me here and I'd be delighted to participate with my colleagues with some questions that you may have. Thanks, Ed.

ED HOWARD: Thank you, Mike. That's terrific. As Mike said, we've got questions that you have that we'd like to put to the panel, and perhaps an early emphasis on Mr. Hash because of his early departure. There are green cards in your packets. You can write the question, hold them up, and they'll be brought forward. There are microphones that you can use to voice your question, in which case I would ask that you identify yourself and keep the question as short as you can so we can get to as many as we can.

I should have said this earlier, but we are summarizing today's briefing live on Twitter using the hashtag

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faahrexchanges. Since you're here, feel free to share your thoughts and favorite moments from the briefing. As Zack Thompson has told me to say, we'll retweet the best of them which will likely make you rich and famous [laughter]. We have someone at the microphone and let's start with that.

BERNADETTE FERNANDEZ: Bernadette Fernandez, Congressional Research Service, my question specifically is for Brian but actually before I get to that, there's a couple of things I wanted to add. You mentioned that maybe one of the motivations to get the exchange up and running is all about market reforms. There's also a few other things that you might want to remember. There's the termination of the pre-existing condition in high-risk pools that were established so we can go back to what was in the states before, but a third of the states don't have those high-risk pools.

There's the termination of the health coverage tax credit, where some of those individuals might get access to tax credit in exchanges. There's a lot of moving pieces. Just a final reminder that there's that provision in the law that basically said members and their personal staff have to get coverage that's established under the law [laughter], so self preservation, that might be a motivation.

ED HOWARD: This means you.

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BERNADETTE FERNANDEZ: [Laughter] Yes. The question to Brian is about the Reinsurance Program and the Risk Adjustment Program. At the risk of getting wonky really fast, there's some concern that the language isn't really clear about who establishes those programs and who essentially is the Oversight authority if a state decides not to establish an exchange and it becomes a Federally-facilitated exchange? I just might be spending too much time around lawyers, but there is some, it's not necessarily disagreement, we're just kind of unsure about the language so I'm curious to hear your read on the provisions and kind of what you see applying in a Federal exchange situation.

BRIAN WEBB: The way we're reading is under a Federally-facilitated exchange, it would be the Federal government that would do the Risk Adjustment Program, and they have established some early constructs of how they're going to do it, but we're expecting this fall to have some more details exactly how they plan to operate a Risk Adjustment Program. It'd be their responsibility. Now, whether they would contract with somebody or something like that, I don't know but it would be their responsibility in a Federally-facilitated exchange or a partnership exchange, which is an FFP.

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But in a state-based exchange, it would be the option of the state to, within the requirements of the law, do the Risk Adjustment Program kind of the way they want to do it.

On reinsurance, we see it as they've given the state the option to operate that and gave them some options about who, what kind of entities in the state could do it, but if they don't do it, then we see the Federal government having to do it. That's our reading.

ED HOWARD: Okay. Sara?

SARA COLLINS: I'm just reading a couple of questions for Mike Hash before he leaves. With enrolment beginning October 2013, can we expect guidance on benefits before that deadline or does HHS believe that the bulletin provides enough certainty to move forward?

MIKE HASH: Yes. We are obviously planning to issue and go through the rule making process for establishing Essential Health Benefits. I think, again, we have already issued a bulletin last December which we laid out our intentions with respect to how we would define with the states the Essential Health Benefits package. We have also put out some questions and answer to fully flesh out some of those issues that came up in the context of the bulletin from last December. We got a lot of comments on that bulletin and we are using those comments as

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the bases for putting together the Essential Health Benefit proposed rule which we expect to have out shortly.

SARA COLLINS: Another question for Mike, when will the details for the Federal exchange be released?

MIKE HASH: The Federally-facilitated exchange. We put out, and many of you will know, we put out a guidance document in May in which we described the Federally-facilitated exchange and our intentions. We realized that not every operational detail was included in that guidance and so we are in the process of formulating additional guidance for later this summer, related to the Federally-facilitated exchange.

BRIAN WEBB: Can I ask a question?

ED HOWARD: Please go ahead, Brian.

BRIAN WEBB: No [laughter]. While I've got you here, I'm just curious. All that stuff that's coming out later on the Federally-facilitated exchange, will that include kind of a cost estimate. I'm getting that from a lot of states. They want to know how much the Federally-facilitated exchange so they can kind of compare it to how much it would cost for them to operate it. I'm just curious with that and kind of how you expect to fund it going to be in there?

MIKE HASH: I think the funding issue is really a budgetary issue and I'm not sure that will be in the guidance itself, but it's certainly something that we have in the

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President's and budget and is a part of our planning for the future but the guidance that we are preparing now to elaborate on the May guidance is more detail about the operational aspects of the Federally-facilitated exchange.

ED HOWARD: Krista?

KRISTA DROBAC: I just want to add something, and correct me if I'm wrong here, but the Federal government can only assess the user fees inside the exchange, whereas the state has the option to do a more broad-based user fee or tax. In the Federal exchange, it could be higher cost per user for the operations of the exchange. I just want to mention that.

ED HOWARD: Do we have any notion of how much money we're talking about, either on a per population basis or overall? In either the Federally-facilitated exchange or the state-based exchanges?

MALE SPEAKER: No.

KRISTA DROBAC: So it depends, too, on the size of the population that you expect to be in the exchange if you're going to use user fees but I've heard some smaller states use numbers between \$5 and \$8, but then larger states using smaller numbers. It totally depends. If you look at Utah, that could be smaller, as well

MIKE HASH: [Interposing] I completely agree with Krista on this, in that it varies wildly depending on the size

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and scope of the exchange operations. We clearly are going to be working closely with the states. Our expectation and desire is to leverage the resources that already exist and the capacity that Brian's colleagues across the country and departments of insurance already have in place to perform a number of the functions of certifying and reviewing Qualified Health Plans. Clearly, we're thinking some of the resources related to the activities of reviewing Qualified Health Plans; we can leverage the existing resources in states where they already have capacities to perform these kinds of functions.

BRIAN WEBB: But we will charge you [laughter].

ED HOWARD: There's a factual question that's been raised, and it'd a certain level of confusion of you don't know what folks are talking about. The statute says the Medicaid expansion covers people up to 133-percent of our poverty line. Several of our speakers have referred to 138-percent of the poverty line. Would somebody please explain the difference?

BRIAN WEBB: There's a five percentage point disregard of income that's built into the statutes, so you just have to add that on to the 133-percent and you get to 138-percent.

ED HOWARD: And this is part of the standardized income calculation that is also new to Medicaid?

BRIAN WEBB: Right.

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ED HOWARD: Very good. Here's one that has not been raised before so far as I can tell, can employees of a large employer agree on a collective bargaining agreement to enroll as a group or as individuals in a particular plan sold on an exchange? Why is that important?

BRIAN WEBB: Well, I would say if the state decides to expand to allow large groups to come into the exchange, then that could certainly be an option for them to agree to basically purchase on the exchange rather than have them self-insured or other product outside the exchange. There is a decision that needs to be made by the state.

ED HOWARD: Yes, Brian's right. There is a provision in the statute that defines this employer size for the small group market as up to a hundred employees, and state may actually choose early on to limit it to fifty employees or less. Later, I think in 2017, states can make a decision about whether they want to enlarge the eligibility of larger employers above a hundred to actually come into the shop exchange and shop for what would provide coverage for their workers and families.

BRIAN WEBB: There's been a lot of discussion about whether employers will drop health insurance and expect that their employees will go into the exchange. Of course if an employer does that, then they face the penalty of their employees get health insurance through the exchange, but of

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course they would also lose the tax benefits there are now which are quite substantial, as well as all of the other labor market reasons why employees offer health insurance. Unless you have very low-wage employees, it just doesn't make economic sense for employers to do that but we'll see what they do do.

TOM BRADY: Hi, I'm Tom Brady with ASURA Health Technologies. We're a technology firm and this question is directed at Mike Hash. Earlier this year in February, you released a bulletin, CCIIO released a bulletin related to actuarial value and cost sharing. I'm just curious when you talked about regulations being released soon related to the exchanges and the Federally-facilitated exchange, if that's going to include cost sharing details?

MIKE HASH: It will. It will include details around the actuarial value determination for Qualified Health Plans as well as the methodology for providing eligible individuals cost-sharing reductions that are provided for in the act, as well.

TOM BRADY: Will that include the reimbursement mechanisms for the health plans?

MIKE HASH: Yes, it will.

TOM BRADY: Okay. Thank you.

ED HOWARD: Mike, I hate to keep putting you on the hot seat. We'll have you go out in a blaze of glory then

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[laughter]. Can you comment on whether the Federal government will subsidize states that expand coverage but up to less than 133-percent of poverty?

MIKE HASH: Actually, I can't comment on that because I'm actually here representing CCIIO but my colleagues in the Medicaid part of CMS, I'm sure, will be happy to talk with you about that, but my purview doesn't extend to the Medicaid program. [Laughter]

KRISTA DROBAC: NGA has a letter on our website that we've sent to the Secretary asking a very similar question so we're all anxiously awaiting guidance on that.

ED HOWARD: Sara?

SARA COLLINS: I think we may pass it through to Mike?

FREDERICK ASASI: Sure. Well first, terrific panel. Thank you, guys. The discussion is super helpful. My name is Frederick Asasi. I'm working with the Advisory Board. We work with about 3,100 hospitals and health systems in the country. After the Supreme Court ruling, tons and tons of interest from our members about the relative exchanges and the Medicaid expansion. To Krista's comments, we've got lots of providers who are very anxious to find out if their state's going to, in fact, expand Medicaid, if they're going to have a donut hole in coverage. For a certain population, that's super important. A question to you which is, anecdotally throughout the country,

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as we've been talking to many hospitals and health systems, they're reporting that the planning community, the insurance community, and their states, when they're discussing with them exchange products, the starting premise is that the payment rates for private coverage in the exchange must be set at Medicaid payment levels, and I was wondering if you guys could comment on that. It seems like that's not a very accurate reading of the statute, and also, to the extent possible, really comment if you could provide some guidance. I think the provider community could really benefit from that.

MIKE HASH: My quick answer to that is I'm not aware of anything in the Affordable Care Act that imposes requirements on issuers of health insurance or Qualified Health Plans and the providers that will actually deliver the benefits. That's a matter between the health plan and the providers. I don't believe there are provisions in the Affordable Care Act that actually speak to that.

KRISTA DROBAC: And further, I think you should check the CBO assumptions, too, because I think they assumed a higher rate in the commercial market.

FREDERICK ASASI: Yes, I pointed that out to people.
Great plan, Krista. [Laughter]

MIKE HASH: Okay, I'm sorry. I have to leave.

ED HOWARD: Thanks, Mike.

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MIKE HASH: Thank you very much.

RODNEY: Can I ask one very last quick question, Mike?

[Laughter]

ED HOWARD: Right now, because he's going to be gone, though.

RODNEY: Rodney with the American Optometric Association and a lot of you have asked about specific regulations that you're anxious to see you guys come out with. Mr. Jost earlier talked about some of the sections of the law he thinks are self-executing, and then you won't need to do regulations. Can they teach us and provide any guidance on which section of the law that they're not going to do regulations on so that we're not waiting for them, asking for them anymore?

MIKE HASH: I think my answer to that question is I don't have a list of what's in, what's out. I think clearly we want to address all of the aspects of the Affordable Care Act, either as necessary through rule-making or through guidance of one kind or another. To the extent that there are areas or aspects of the law that are not clear to you or anyone else, we should talk about this because we want to make it as simple and easy as possible for people to get answers to those kinds of questions. We're definitely receptive to sitting down and

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talking about any questions you have about how we're going to apply the various provisions of the law.

RODNEY: Okay, thanks very much.

MIKE HASH: Thank you all. [Laughter]

TIMOTHY JOST: If I could respond quickly to the question about self-executing provisions. As to some of those provisions are already there, then rules proposed or guidance issued, so I didn't mean by that to imply that there would be no guidance or rules on those. However, there has been some discussion about what happens if we have a regime change at the end of the year, and I just wanted to make the point that until and unless the statute is repealed, some provisions of the law will go into effect regardless of who is running the administration, including final rules that have already been issued. I think we'll have a very interesting situation if that happens.

ED HOWARD: And Tim, there's a question here that kind of builds on that same premise. How will Federal exchanges be implemented if Congress fails to appropriate adequate funds for the purpose?

TIMOTHY JOST: I'm sorry; Mike just left [laughter]. That's an interesting question. There's a lot of money within CMS and I assume maybe some of that can slosh around, and of

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course there's already some money that has been appropriated but that will be an interesting question.

ED HOWARD: Krista?

KRISTA DROBAC: So in the appropriations question, I just want to distinguish between the administrative cost and the cost to actually build the Federal exchange because the cost to build the Federal exchange are actually appropriated in the Affordable Care Act. Until January 1st, 2015, there's a lot of essentially unlimited amount of money that can be put into building the exchange. The appropriations comes into play in the administrative side for funding staff at CMS, so I just want to make that distinction.

ED HOWARD: A question for Brian Webb, can you elaborate on what states are doing with respect to regulating outside the exchange market, a lot of activity or not much at all? You mentioned open enrolment, are there other major areas of concern?

BRIAN WEBB: There are a lot of areas of concern and right now, the NEAC is developing model laws, model regulations. We've done white papers addressing issues such as adverse selection, trying to basically educate people on that relationship between inside and outside, what states need to do for the entire marketplace, regardless of whether it's an exchange or not. We hope to have by the end of the year; the

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model laws that states would need to adopt early next year to put into place all the 2014 market reforms. Including that will be some guidance on some other items they may want to do in their marketplaces in order to avoid adverse selection and things like that. That's been the place where we typically develop those proposals and those will be developed by the end of the year.

SARA COLLINS: I'll just add to that, too. On your materials list, there's a paper by Kevin Lucio, and colleagues at Georgetown where they looked at the implementation by states of the early market reform, so 2010 reforms such as bans on recessions, bans on lifetime benefit limits, and the striking finding of the report is that nearly all states had moved forward to implement those rules into their own state laws or issuing regulations or sub-regulatory guidance, and I guess my question for Brian, too, is that given that sort of significant compliance and action by states across the country, what that says about the 2014 reform, so states are going to move assertively forward in the next 18 months or so on those?

BRIAN WEBB: We certainly hope so because there is that kind of hammer out there that if the state doesn't do something, either legislatively or regulatory or just in practice, to enforce those reforms, then the Federal government will have to and there is not a department of insurance in

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America that would want to say, no, we don't want to regulate this. We did have nine from California. I worked for Governor Wilson at the time that HIPAA came down and California was one of the two states along with Missouri that said, we're not doing HIPAA. CMS, or at the time HCFA, of San Francisco had to enforce HIPAA in California, but that was such a small area, such a small item compared to what we're doing now that taking to the commissioners, they don't want a situation where they're not in control of their marketplaces and what they're doing, on review, is kind of pushed aside so we think they'll get there.

ED HOWARD: There's a question here, actually, several questions in this topic and fortunately, we have anticipated it by putting materials related to this question in your packets. Some legal scholars are making the argument that the ACA does not provide for subsidies in a Federally-facilitated exchange, as opposed to a state-run exchange. Would anyone on the panel like to comment on this argument, and if you assume that the Courts were to agree with that argument, are there any workarounds that you can think of?

TIMOTHY JOST: I would like to respond to that argument. Ethics responded to that argument at length on the Health Affairs blog, and my comments are included in the materials. The problem here is that at several points in the statute, language was picked up from the Senate Finance

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Committee Bill in the final Senate bill that talks about premium tax credits being available to enrollees in plans through exchanges established by the states under Section 1311.

That language is also used in other places. For example, in Medicaid Maintenance of effort provision also applies until exchanges are established by this, so you have to take the bitter with the sweet on that one. The argument is being made by some people that that means that premium tax credits cannot be made available through the Federal exchanges which are established under Section 1321.

If you first look at the legislative history of the bill, you can see that the Congress never intended that the Federal exchanges would operate any differently than the state exchanges. If you look at the language of Section 1321 itself, it's clear that a Federal exchange effectively becomes a state exchange in states that elect not to establish a state exchange and has all the power and authority of a state exchange.

Also, the Healthcare and Education Reconciliation Act which amended the Affordable Care Act after the act was adopted and signed, explicitly refers to premium tax credits being provided through the Federal exchange.

So the language of the law could have been drafted better. As we all know, nobody intended this bill to become the final law. It just happened that way because of the

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Massachusetts Senate election. If you look at the legislative history, if you look at the structure of the act, if you look at fact of the language of the statute and certainly, if you look at the Reconciliation Act, it is clear that premium tax credits can be provided through Federal as well as state exchanges.

The other question, however, is what happens when somebody decides to sue and challenge that? The only plaintiffs that I can see out there that have standing to challenge would be employers who would have to pay penalties because their employees received tax credits through Federal exchanges. The statute explicitly refers to the exaction that is placed on employers if they don't offer health insurance or adequate or affordable insurance and their employees go into the exchange. That's explicitly referred to as a tax, and all of us remember from the Supreme Court case that one of the big questions there was the tax anti-injunction act and whether that applied. It clearly would apply under the Supreme Court's reasoning to this provision which means that it would be 2015 probably, before any employer would be able to even get into the court to challenge premium tax credits being issued through Federal exchanges.

I think it's clear to me that, and this by the way was also the position of the CBO took in its report last week, that

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premium tax credits would be available through both the state and Federal exchanges and that's the position it's always taken. As one of my colleagues has said, Congress people may not pay much attention to what other people are saying on the floor but they do pay attention to what the CBO says. I think when you put all of that together, the argument is overwhelming that premium tax credits will and be available legally through the Federally-facilitated exchanges.

ED HOWARD: Tim, if we can take advantage of your professorial expertise on one related question. There has been an assertion that because the Supreme Court has now labeled the penalties as taxes, that the law is unconstitutional because it didn't originate in the House, and the House by constitutional edict, is required to be the originator of all tax legislation. How's that grab you?

TIMOTHY JOST: My recollection is that the bill did originate in the House and that the Senate language was substituted into a House Bill, but I could be wrong on that. That's my recollection and in any event, I don't think the Supreme Court wants to do this all over again. [Laughter] They made it clear that what they thought on this legislation.

There are of course other questions out there, like whether the IPAB is constitutional or whether the ban on Medicare payments to a physician and hospitals is

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constitutional. There's some other issues bubbling around, contraception, but on the basic question of the constitutionality of the statute, I think we've heard the final word from the Supreme Court.

ED HOWARD: Sara?

SARA COLLINS: This is a question about the differences in the shop exchange or the small business exchanges and individual exchanges in each state will operate two different exchanges? They can merge those into one. This question, can you speak about the differences in administration and enrollment when it comes to the shop exchanges compared to the state run and the Federally-facilitated individual exchanges?

BRIAN WEBB: Well, there are significant differences in how people will be accessing coverage in the shop exchange because obviously in the individual, you're coming as an individual or a family. You're accessing coverage for yourself.

In the shop exchange, there's going to be some options available. Where you have an employer involved, the employer can come to this shop exchange and say, "Well, I'm going to allow all my employees to choose from a particular level of coverage. Everybody can choose from the Silver coverage or the Bronze coverage," or something of that effect, and then let them all choose.

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We believe that most states also will allow employers to come in and just choose a plan and all their employees would get that plan as an option to them. Also obviously, there's not the individual subsidies available. Instead, there are tax credits available to the employers that are limited in time and amount, but there are those available, rather than the individual.

So it's really a different dynamic coming in. You're administering. You're not looking at each individual's income and coming in and trying to determine whether eligible for Medicaid, whether they're eligible for subsidies. You are instead, looking at them as a group, coming in and how does that employer want to access coverage through that exchange and let people make their choices?

So it will be administrated differently although, I don't know of any states who are out there creating two different boards, one for shop and one for individual, not getting two different vendors. All that backroom stuff will probably be the same people.

But as you access, it will look differently and they will ask you different questions. It will be different administratively on how you get coverage and sign up, and maybe even different options in what carriers you have available and coverage options, too, as they are now.

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SARA COLLINS: Now just a follow-up. The key questions that states are facing, the states are looking at are establishing their exchanges is whether to merge their individuals and small group markets, most deciding just to wait and see and study the issue and wonder what—

BRIAN WEBB: [Interposing] People looked at Massachusetts and Massachusetts did that. They combined their individual and small group market. People have to remember they had already done a tremendous amount of reform in their individual market. That wasn't a big shock to that system.

In most states, just the fact that we're putting all these new reforms in the individual market will be a tremendous shock. Trying to combine that with this kind of unknown group of people, how healthy they are? They have no idea. How effective the individual mandate is? We have no idea. How effective subsidies? We have no idea. Saying to the small group market, we're not going to bring this whole group in, together with you. Most states are not going to that. They'll let that play out and then maybe in the future, we don't know, they may make the same decision as Massachusetts, they may not.

ED HOWARD: This question here observes that Tim Jost had said that states that haven't yet taken executive or legislative action to create an exchange have probably missed the boat, and this person would like to set the over-under at

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19 fully state-run exchanges and ask what the panelists think about that. Would you take the over-under?

BRIAN WEBB: Over.

ED HOWARD: More than 19 will have them. Krista, what do you think? [Laughter] You don't have to admit to-

KRISTA DROBAC: [Interposing] I'm not a betting woman, sorry [laughter].

BRIAN WEBB: I think we're going to see a lot of different approaches taken. If we're counting partnership exchanges, then probably over. If we're looking at strict state-run exchanges with no Federal involvement, maybe under. It remains to be seen.

But if states waits until a lot of states, the legislature is out of session and if the Executive doesn't have the authority to do it by itself, you're not going to be able to vote in the Spring of 2013 to establish an exchange and have one up and running.

SARA COLLINS: To add to that, I also think, too, as states are running their exchanges and they've got them underway, whether that will have an encouraging effect on other states to jump in when it becomes more clear how this can run, what the different options for states are.

Again in your packet, you will see just the bare outlines of what states have established, their exchanges are

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doing right now, and it's striking the amount of discretion that they have allotted to their exchanges to make key decisions about how they're going to run in the next few years.

ED HOWARD: There were, at one point, a number of states talking about collaborating with each other and sharing some of the common functions in a way that would be able to realize some economies of scale. Are those continuing? Are they growing? Have they withered? Is there any result that might be helpful there?

KRISTA DROBAC: Yes, those discussions are still happening for sure. There's a lot of interest in whether one state could conduct the backroom operations of another state's exchange.

ED HOWARD: Okay.

TIMOTHY JOST: There was an early innovator grant for a group of New England states working on technology together, so there may be different ways in which states can work together.

CARL POSER: Carl Poser, American Healthcare Association. My question goes to consumers, like a year from now and they're thinking about going to the exchange, resources for counseling and education. They're going to have to be making complex decisions about potential individual penalties if they're uninsured, the affordability of their employer-based coverage, the affordability of exchange coverage, or if they're

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eligible for Medicaid. A lot of these folks, especially in the part of the market most effected where it intersects with employer-based coverage, where there's low-aged workers. They're not very literate with their health benefits. Do we have resources for that? There seems to be a large need for that.

BRIAN WEBB: Yes, one of the objectives very soon here, will be to start developing the educational program for navigators, for agents and brokers, which especially with small business, most of them uses agents and brokers as their primary educator because they need to know what they need to tell people. They need to know about the new Medicaid rules because they're run into a lot more of those. They're going to need to know the subsidies. They'll need to know kind of the exchange versus outside the exchange, what options are available. We'll need to know frankly, why are rates going up or down based on the rating rule changes.

So we are in that process. We have a meeting in Atlanta coming up where we're going to start that process of developing educational materials for them, for consumers, for also even the consumer of people within the departments so they can be well educated as we can.

As we say with Massachusetts, it takes a lot of effort and frankly, a lot of resources to get people the knowledge

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they need to make the right and good choices. It's a point well taken and people are working very hard on that.

SARA COLLINS: I'll just follow up with a question maybe to Tim, just elaborate on the exchanges are envisioned as a central place where people will go to and find out about their range of insurance options available to them, whether tax credits, whether Medicaid, whether the Children's Health Insurance Program. The question is and it acts to the key implementation issue is whether the state exchanges will be able to assess eligibility for both the premium tax credits and eligibility to the Medicaid program, and how that process moves forward in a seamless fashion so that people are immediately enrolled in the affordability programs they're eligible for. Tim has written them a little bit about the rule on this from HHS and there's some questions about whether the exchanges can enroll people who are eligible for the Medicaid program.

TIMOTHY JOST: Well, the way in which the rule is written, the exchange will either, at the state's option be allowed to enroll people or they'll be able to do an assessment and then refer the individual to the state which will then do the enrollment.

I think the presumption is that since the eligibility is going to be based in states that decide to expand on percentage of Federal poverty level and that's relationship to

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modified adjusted gross income, that this is going to be a fairly straightforward determination. If the exchange determines eligibility, that should pretty much decide it.

But this is going to be a very different way of doing business than Medicaid programs in many states have been accustomed to. It is going to be a new experience for everybody trying to do this hand-off. The hope really is that you will be able to do real-time determinations of eligibility for the premium tax credits for Medicaid. People will be able to go onto the web or go into wherever a navigator is located, and a half hour later come out and enrolled in an insurance plan with their eligibility determined.

Whether that will take place all the time? Probably not, there will be some complicated questions some time, but that's the goal. That's the hope and that's where we really need to get.

ED HOWARD: I've heard John Kingsdale talk about the patient-friendly experience, that consumer-friendly experience that they were working to establish in the Massachusetts connector, which is, I guess, the only fairly elaborate exchange operating, as opposed to just an informational function in Utah. I wonder if that would give you some optimism about the ability to provide that information in a useful way in a lot of other states.

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BRIAN WEBB: Yes [laughter]. This is going to be—

ED HOWARD: [Interposing] I guess that came out a rather rhetorical question, I'm sorry.

BRIAN WEBB: Okay, because there you don't have all of the—The exchange will have more functionality than the Massachusetts exchange does, but it is very impressive. I saw John McDona in a meeting like this a few months ago, go through the whole enrollment process while the clock was running for the hypothetical person. Hopefully, that is the way that it's going to work a lot of the time.

SARA COLLINS: I guess a takeaway, too, from Massachusetts is their coordination early on, with MassHealth the Medicaid that pillars health insurance programs. It was a great deal of interaction, coordination with that in terms of how to enroll people based on experience of MassHealth in that state.

BRIAN WEBB: One thing, by the way, that I haven't heard too much about recently, but starting in September, health plans and employers are going to start issuing the summary of benefits and coverage, that HHS issued a rule on earlier this year based on work that the NEAC did. I think that's going to lay some very important ground work for the exchanges because for the first time, anybody who applies for, enrolls in, is shopping for an insurance plan will be able to

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get a four-page, although they interpreted that to me in double-sided, so an up to eight-page summary of all of the important features of the plan that will be exactly comparable plan to plan. You're going to have something that works like the nutrition labels on food cans, mileage labels, efficiency labels on appliances. Consumers will be able to intelligently shop for health insurance. There've been surveys that show people would rather go to the dentist and have a tooth pulled than shop for health insurance. In any event, it's going to make it a much more consumer-friendly experience and that's going to happen a year before the exchange is open. We're going to start something of a glide path into the exchange experience.

JAMES WILLIAMS: First of all, thanks for putting this together. My name is James Williams and I do some work with Rocky Mountain Health Plans, and this is a question for Bryan and this around non-discrimination and protections in the exchanges.

HHS put some pretty landmark guidance and rulings coming out around protections on sexual orientation and gender identity in the individual group exchanges, and I wonder how the exchange, particularly from a state insurance commissioner perspective, is planning on handling any complaints or

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courageousness from insurers who actually aren't following those protections within their plans?

BRIAN WEBB: It's not something we've discussed thus far. We can certainly do that. I mean generally, the case is any kind of complaint that would be a violation of State or Federal Law, they would take it very seriously. They would talk to the company if there's a pattern of it. They would take action against them. They would have authority under their license to fine them, etc., so a lot of things they can do to a company that's violating those laws. I'm sure all the departments will take that very seriously.

JAMES WILLIAMS: And do you see that as a question for the Insurance Commissioner or the Office of Civil Rights? Do you see where that lies from a jurisdictional perspective?

BRIAN WEBB: Well, it would be the Department of Insurance under the contract and making sure they're complying with all the rules and regulations, obviously that folds over into a actual civil rights issue. You can get your AGEs and all those involved as well, and that often happens.

JAMES WILLIAMS: Thanks.

ED HOWARD: I've got a question that was actually raised in a newsletter that a couple of days ago, asking what the panelists thoughts are about the possibility of low-income people relocating to states that do expand Medicaid from states

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that don't, and the economic impact on the respective states?
Krista?

KRISTA DROBAC: The best thing you could you do is take a look at states that have already expanded Medicaid and the impact that that has had. I know in Illinois where I came from, we have a program that covers all kids, and I know one of the worries was that sick kids were going to come to Illinois. I haven't looked at it recently so I can't tell you the verdict, but I would definitely look at the experience of existing states that have expanded Medicaid.

ED HOWARD: Sara?

SARA COLLINS: It's another question on mobility. What about portability of insurance through the exchanges? What happens if someone with coverage through an exchange crosses state lines, does that mean they need to re-enroll in that state's exchange or can they maintain their coverage?

BRIAN WEBB: Health insurance is different than a lot of insurance because it is so tied into your networks and coverage where you are at. Yes, if I moved across state lines, I'm in Kansas City and I moved across state lines from Kansas to Missouri, probably not. Pride covered if you go from DC to Virginia or something like that, but if I'm moving from Wyoming to Connecticut, I would probably change my insurance or else I'm going to be paying all out of network costs.

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There's ability to do that where you get a special enrollment to go in and change your coverage and choose coverage. The important thing here is all guaranteed issue and even with the open enrollment, there's special enrollments so people can make the choices necessary so when we have those gaps in coverage that they have now, all too often.

ED HOWARD: We've got just a few minutes left, and I would ask you to pull out the evaluation form and fill it out while we are finishing. There is someone at the microphone. Thank you, Sara.

LOIS THET: Good morning. I'm Lois Thet [misspelled?] from Majority Women of Businesses. An article came up in the paper about a child being cast out of school, in fact suspended, because he was on diabetes and he had to get a certain shot or whatever, and the person that was supposed to do it was out that day. Will this insurance cover a situation where we can put more the nurses back to some of our public schools here in DC, or is it up to the council? I guess it will be.

TIMOTHY JOST: There is funding in the bill for school-based health care programs, and that unfortunately, is a part of the legislation that I have not been following very closely. I don't know if anyone else here has been. I mean certainly, people with diabetes are going to be among the very big

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beneficiaries of the bill because they are people who often find a hard time finding affordable health insurance in the individual market at this point.

But how it would address that particular problem, I don't know off the top of my head, but there is provision in the bill for school-based clinics and I thought I saw some rules on that, sometime back.

ED HOWARD: I expect that's one part of the acts that was not fully appropriated in the act itself, in the subject annual appropriations but I could be wrong.

I've got a question here that's originally to be asked of Mike Cash, but actually comments about the premise of the question are just as aptly directed to our panelists here. The original question was, what is HHS's plan for the Federally-assisted exchanges, if states resist any cooperation with HHS on any functions? And the question is, how likely is that in any state? And we have folks with good relationships with lots and good intelligence about what a whole lot of different states are planning. Anybody planning the stonewall? Krista?

KRISTA DROBAC: I'll just give you the facts. There is a provision in the statute that essentially requires some cooperation, but the penalty for not cooperating is your existing Federal match, which could be argued now that is coercive.

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So there is also a provision in the advanced planning documents that at least 45 states have entered with HHS around the 90/10 match for their new eligibility systems of Medicaid that does state that there needs to be cooperation between the Medicaid program and whatever exchange is in your state, whether its State or Federal. That's in an agreement between the State and the Federal government related to that 90-10 money. I don't know that an enforcement strategy has been outlined, but that provision is out there.

BRIAN WEBB: Certainly if a state decides to stonewall and say, we're not going to help the Federally-facilitated exchange at all. We're not going to give them any information. That leaves them no alternative except to basically ask the companies to self-certify that their licensed, show something. Show something from the department that says that they're solvent, and then to have Federally-facilitated exchange reviewing their forms, reviewing their rates, and making sure.

That just puts the company in a tremendous bind. It's going to take a lot more time to get things up and running. You have a situation where the Federal government will say, well we think that rate's okay, it meets the standards. The state may say, no, it doesn't. We're to going to allow it to be sold in our state. I mean this could cause real problems that there's no communication, no consistency, and all it's going to do is

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harm the companies, increase cost and it's going to hurt consumers too. They're going to be confused about what's available or not available. People understand that ramification, that result, so hopefully we won't have any of that. We'll just sit there and completely stonewall.

FEMALE SPEAKER: Yes, I have a question about undocumented immigrants, and some of the states that have thus far said that they're not going to participate in the Medicaid expansion, what effect that's going to have on some of the teaching hospitals that are really dependent on the DSH payments and maintaining a high ranking, getting really good residents, all of that, if those governors are getting any pressure that you know of, to go ahead and participate in the expansion.

ED HOWARD: Pressure? Governor? [Laughter]

TIMOTHY JOST: Every hospital association in the country, which includes I believe, almost every hospital in the country submitted in an AMICAS [misspelled?] brief in the Supreme Court in support of the Medicaid expansion, and I think they all understand that they're going to be in a very tight situation if the Medicare cuts go through, particularly the cuts of the DSH payments and their state decides not to participate in Medicaid.

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Medicaid doesn't pay all that well, but it's better to have something than nothing. I expect the governors are hearing from their hospitals.

Specifically with respect undocumenteds, however, the bill of course has nothing in it for them.

FEMALE SPEAKER: Right.

ED HOWARD: I know I have seen one estimate that the remaining uninsured population, if the ACA is fully implemented, would include maybe 25-percent undocumented. There are a lot of people who will not be covered who are not undocumented immigrants. If that estimate was right and we certainly have heard from the public hospitals and programs and we've done about the potential implications of phasing down of DSH payments. One estimate is that Texas already receives about a billion dollars a year in those payments, and with a 50 or 60-percent reduction over time, that's going to certainly have an impact on a lot of those hospitals.

FEMALE SPEAKER: Thank you so much.

ED HOWARD: I didn't mean to take the last words, Sara [laughter], but we are just about the end of our time. Thank you for hanging in there. I will remind you there will be a webcast available on the Kaiser Family Foundation website on Monday. If you turn on Cspan over the weekend, you might see a rerun of the live coverage of the briefing that we had today.

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I'd like to take this opportunity to thank the Commonwealth Fund for its co-sponsorship and support and contribution of Sara Collins to the area addition of the panel, and I ask you to help me thank the panel for a really useful discussion.

[Applause]

[END RECORDING]

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