State Medicaid Expansion: The Third Way
The Commonwealth Fund
Alliance for Health Reform
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ED HOWARD: I thank you all for coming, there are – as you are seeing people being directed to – some seats up front. If you are still looking.

I want to welcome you on behalf of Senator Rockefeller, Senator Blunt, Board of Directors of the Alliance to today's program on how a handful of states are expanding coverage using federal Medicaid dollars to purchase private insurance for low income residents. Just a few words of context, the Supreme Court decided in 2012 that the Medicaid expansion in the Affordable Care Act couldn't be forced onto states. That each state could decide whether or not to expand coverage under the Medicaid program and about half the states have moved forward with expansion, other states have decided against expansion now, but some states are pursuing an all together different path. The third way in the briefing title and the in the hashtag, if you are going to tweet about this event. They are enrolling target low income population from the Affordable Care Act and private insurance using federal Medicaid dollars and to do that, they need federal approval in the form of a Medicaid waiver. Three states already have their waivers in hand and are operating their new programs. And today, we are going to take a look at the experiences of two of those states and a broader look at what some other states are proposing to do. We will also look at the balance between, on the one hand, exposing these same low income people to say, additional premiums or cost sharing and on the other, additional – I'm sorry, additional premiums and coverage as a condition of getting it. And on the other hand, not getting coverage at all.

So, we are pleased to have as a partner today the Commonwealth Fund, a century old philanthropy, established to promote the common wheel or the common good. And we are doubly pleased to have as the co-moderator, Sara Collins, who is Vice President for the fund's healthcare coverage and access program and someone with a very extensive knowledge of state efforts to expand coverage. Sara, welcome back to the moderator's chair and we look forward to having you help frame the issues for us today.

SARA COLLINS: Thank you Ed and also, on behalf of the Commonwealth Fund, I want to thank the Alliance and also extend a warm welcome to the panelists today and the audience. The Affordable Care Act expands health insurance. So the law expands coverage through two major sources, first private plans sold through the new health insurance marketplaces that are running in all 50 states for people and providing subsides for people with incomes up to 400% of poverty or about 94,000 for a family of four. And second and this is the focus of the discussion today, a major expansion and eligibility for the Medicaid program up to – for people with incomes up to 138% of poverty or about 33,000 for a family of four. The federal government is providing 100% financing to states that expand their Medicaid programs, that phases through 2016 – that phase is down to 90% by 2020. The law, as Ed mentioned, the law originally required all states to expand their Medicaid programs, the Supreme Court decision basically turned that into an option and as you can see from this map, this has had significant consequences in what is happening on the Affordable Care Act's Medicaid expansion, only 22 states and the District of Columbia so far have decided to expand their Medicaid programs under allowable federal rules. Three additional states have HHS approval to try alternative approaches to expanding their programs and two states are seeking approval to do the

same. But about 23 states have not decided to move forward on their expansions. Because of the way the law was drafted, people with incomes in states that aren't expanding their Medicaid programs, who earned 100% of poverty or more, are eligible for the subsidies through the marketplaces. But people with incomes under 100% of poverty are not eligible and this was because Congress basically assumed that everyone in that income range would have access to Medicaid. Consequently an estimated five million currently uninsured people in states across the country that aren't expanding their programs, don't have access to any of the new coverage options under the law and states are leaving a considerable amount of federal dollars on the table by not expanding their programs.

Today, we are going to focus, as Ed mentioned, on five states that face political barriers to expanding their Medicaid programs and were able to find a way forward through alternative approaches through – very different from what is laid out in the Affordable Care Act. In order to pursue an alternative, states have to get permission from HHS, but they also have to agree to increase eligibility up to 138% of poverty. They can't do a partial expansion. HHS has used it's authority under section 1115 of the Social Security Act to grant permission to states who want to do this. Section 1115 allows demonstrations that advance the objectives of the Medicaid program. The secretary has broad authority to approve these demonstrations, but is required to determine that a demonstration meets Medicaid objectives, provides additional oversight, including an evaluation and she has to ensure that there is public input into to the process and ensure that it doesn't cost more than it otherwise would have under a traditional expansion. So far, HHS has granted 1115 waivers for three states, Arkansas, Iowa and Michigan and we are going to hear the details on Arkansas and Michigan from Joe Thompson and Steve Fitton today. Pennsylvania's waiver application is under review, New Hampshire is in the process of applying. These states are all taking very different approaches, but with the exception of Michigan, most states are using what is referred to as mandatory premium assistance, where states use Medicaid funds to pay premiums for their beneficiaries and private plans offered through the marketplaces. States have also generally sought permission from HHS to charge premiums and add some cost sharing. Some states have also sought permission to reduce traditional Medicaid benefits and some states have added wellness incentives. There are some pros and cons to these alternatives and we are going to talk a lot about this today. Among the pros, first and foremost, these alternatives are allowing states to break through political barriers that they have faced and expand their Medicaid programs. Depending on the approach and I'm really referring to the private – to the premium assistance approaches – these approaches have the potential to reduce churn when people's incomes change. So in other words, people don't have to switch between Medicaid plans and marketplace plans when their income increases above 138% of poverty or falls below 138% of poverty. Sara Rosenbaum and Ben Summers have estimated that 28 million people might have that kind of fluctuation in a given year. It also has the potential to increase the size of the marketplace. Risk pools, this is obviously a very big advantage to small states like Arkansas and New Hampshire. Has the potential to reduce administrative costs to federal and state governments. Among the cons, premiums that are added to these may lower people's participation below what it might otherwise be in a traditional expansion and out of pocket costs and fewer benefits might reduce access to care. So stop there and turn this back over to Ed.

ED HOWARD: Okay, thanks very much, Sara. Good context setting. Let me do a little housekeeping, if I can, before we turn to our speakers. In your packets, there is a wealth of good information including a blog post from Sara and some of her colleagues at the Commonwealth Fund that is excellent in laying out some of the differences and similarities among the states that are trying to pursue this path. There are copies of the presentations of each of the speakers. If we had them at the time we put the papers together. There are biographical sketches that give you more information than we will have to time to give them credit for in the briefing itself. There will be a video recording of this briefing available in a couple of days. A transcript a few days later. Both available at our website at the Alliance. Allhealth.org. And the speaker's slides, the rest of the material that are in the kits that the folks in the room are looking at are also posted on that website. At the appropriate time, if you want to ask a question of one of the panelists, there is a green card in your packet that you can use to write the question. There are microphones in the room that you can use to ask the question yourself. Then there is a blue evaluation sheet in your kits that we would ask you to fill out before the end of the briefing so that we can help make them even better as we go on.

One word to those of you who may be watching on C-SPAN right now, the materials that the folks in the room have in their kits on paper, if you have access to a computer right now, you can take a look at on our website – allhealth.org and there is – you can click on the briefing icon for today and get access to all of those materials.

I did mention that there is a Twitter hashtag that you can use if you are so inclined. #Medicaid3rdway – three being a numeral and not a word. So feel free to do that if it is your want.

Let me start the presentations by turning to Dr. Joe Thompson and we will give him the clicker so that his slides will align. Dr. Thompson is the Surgeon General of the State of Arkansas and Director of the Arkansas Center for Health Improvement. His list of achievements both at the national and state levels is both long and impressive and highlighted by initiatives to combat childhood obesity and the health threat of tobacco use. Now, back in Arkansas, he has worked with a Democratic governor and a Republican legislature and was a leader in developing this creative alternative to Medicaid expansion that Sara was alluding to, under the Affordable Care Act. That alternative is now being carried out and Dr. Thompson is here to tell us how it's going. Joe?

JOE THOMPSON: Thank you, thanks for being here today. First of all, if you are wondering who your state Surgeon General is, you probably don't have one. There are only three states, actually Michigan, Florida and Arkansas that have utilized that aspect. Both for former Republican Governor Mike Huckabee and now Democratic Governor Mike Beebe, they have asked me to serve as the lead Cabinet level strategic advisor. I don't run the Health Department, I don't run the Medicaid program, I just call it like I see it and we end up where we are.

So I look forward to sharing with you what has been an interesting past few years as we have dealt with some of the opportunities or challenges that have come from Washington. Let me do a little bit of environmental assessment. Arkansas, as you may note, is in that more reddish tier of states, maybe purplish – along the southern aspects of our nation. We have a Democratic Governor. We have, for the first time two years ago since reconstruction elected a majority Republican House and Senate. We have a low income level. We have a high uninsurance level – 25% of 19-64 year olds were uninsured with some counties having more than 35% uninsured. Our healthcare system was fragmented predating the Affordable Care Act and candidly we were in a fairly significant sense of crisis. I say all of this to say, our healthcare system was in jeopardy prior to the Affordable Care Act. I describe the Affordable Care Act as a "disruptive act", disruption is neither good nor bad, it's what you do with it that depends on whether you have a good outcome or a bad outcome. So I look forward to sharing with you down the path. Our expansion of health insurance coverage actually was not our initial foray. Our system was in trouble and we had actually previously started to really ramp up our adoption of health information technology. For the first time we had put a workforce strategic plan in place. We had actually worked in a multi-payer public and private effort to change the way we pay. More for value based outcomes so that we have our public and private payers – our two largest commercial carriers, Medicaid, Medicare in a limited way, our self-insured state employees, public school employees, even some of our self-insured private sector, Wal-Mart Corporate as well as some of our other large self-insured companies had joined us in trying to change the way we paid. So we had dealt with, to a certain extent, the cost issue, when along came the challenge of whether the state was going to expand health insurance coverage or not.

This is a patchwork quilt that we have used locally to describe where Arkansas was. Income on the vertical axis, age across the X axis. Virtually everyone with Medicare, when they hit 65, if you had a high enough paying job, you got private insurance from your place of employment. We had differentially invested in our children's health insurance program through AR Kids A and B, so that we had over 60% of the kids on the Medicaid program. But if you were an adult and not disabled in our state, we had the leanest Medicaid program in the United States, tied with Alabama. If you had no children and were not disabled, you were never eligible. If you had children, you had to make less than 17% of the poverty level and have less than $2,000 to $3,000 in assets. So we were very lean. Of our 3 million citizens, we estimated that there were about 550,000 that lacked health insurance coverage and this was a direct contribution to the fragility of our health care system, the threat to our providers and the poor health of our citizens.

So going forward, we had a political challenge. Not only do we have a new majority Republic House and Senate, but in our state, we have to get 75% of the House and Senate to vote each and every year to spend either a federal dollar or a state dollar. And along came the opportunity for a solution, but significant political resistance, as you are well aware of, both within the state and nationally. We came up with an alternative to Medicaid expansion, commonly called The Private Option. Effectively, Medicaid since it's inception in 1965, has had two or three mechanisms to pay for care. Traditional fee for service payments from the state directly to providers, which was what Arkansas'

primary care case management program continued to utilize. Other states had turned to outsource Medicaid managed care where they would put their clients up and ask managed care companies to bid for a Medicaid managed care book of business. A third, which was infrequently utilized but which was legally available, was premium assistance. Where if an individual worked for an employer, that the benefit was at least as good as the Medicaid benefit and from a cost perspective it was advantageous for the state on behalf of the state and the federal government to purchase private health insurance. It could use premium assistance to buy private health insurance coverage. The challenge was, before the Affordable Care Act, employer based health insurance was all over the map in what it covered and all over the map in what it cost, so it was prohibitive for any Medicaid program to effectively use that in a broad base. But with the establishment of the new health insurance exchanges, with the establishment of the new Essential Health benefit, with the standardization of the price structure, we ended up exploring the use of premium assistance to buy individual private plans on the new health insurance marketplace. We identified the qualified high value silver policies as those that were most in alignment with the requirements for Medicaid. And it has the Essential Health benefits with private provider payments. So not only did we get the Medicaid benefit covered, but instead of the differential with Medicaid payments too frequently being below the commercial rates, we were buying private health insurance that paid commercial rates.

Now, I'm giving you the nuts and the bolts. The political process was a little messier. We ended up having a big debate between the Democrats and the Republicans over whether to expand Medicaid which took us from the floor up to 138% was the right policy because between 100-138%, if we expanded Medicaid, we took away the right of an individual to use their tax credit and buy private health insurance coverage. So this was the threat between, do we take away somebody's option to buy private health insurance coverage with a tax credit or do we end up with upside down policy where we are offering federal support for higher income individuals and not using funds for our Medicaid program? Our solution, using premium assistance in the private market garnered enough support, all the Democratic support in a majority of the Republican support in both House and Senate to actually reach that 75% bar and put the private option in place. It's funded via the Affordable Care Act. This is using the Medicaid funds and the Affordable Care Act with preexisting options for premium assistance in the Medicaid program to buy private coverage. A majority of the newly insured are placed with private carriers. This is not a Medicaid managed care, we are placing them in the same plans that somebody making $90,000 a year is receiving care through. Medically frail individuals, those that have wrap around service needs or might otherwise be better served or retained in the traditional Medicaid program. Some of our existing Medicaid beneficiaries that had less than a full benefit package, for example, those on family planning or those with breast and cervical cancer coverage only are better served and will be transitioned into the full benefit package of the commercial sector. And as I mentioned, it required a waiver of select federal Medicaid requirements. Our waiver requirements actually were not a waiver to use the private option. It actually was three-fold. One is, we had to get a waiver to not require 24 hour access to drugs. The commercial standard is 72. We had to get a waiver to require people, if they wanted coverage, to go into the private sector and not stay in the traditional Medicaid program.

And we had to get a waiver to be able to pay provider rates in the commercial marketplace as opposed to the traditional Medicaid lower payment reimbursement rate.

So those were our waivers and again, each and every year we have got to get bipartisan support with 75% approval in the midst of the political discourse, which is anything other than constructive. This is where we are going. Our plan is – the 550,000 individuals we think in the grey scale at the top, they will get a sliding scale tax credit, increasingly supportive, down to 138% of the poverty level. In the new red zone, we are going to have tiers there where individuals have cost sharing above 100% and in the future, below 100% so that they also have some engagement in the financial well being of their plan and responsibility for their service delivery.

One of the issues that we had is we have a relatively non-competitive insurance market and was this a mechanism that we could improve the competition of our insurance market? These are the seven divisions of our state into the insurance markets. The large numbers are the number of carriers in each of the markets. We had at least two carriers in every market. Four carriers in some. And as a comparison, Mississippi across the river from us, who chose not to expand Medicaid or actively participate, had 36 counties that no insurance carriers offered at all on the insurance exchange. So we think we have achieved the competitive aspects. We have our providers reporting significant reductions and uncompensated care in the first three months of this year compared to the first three months a year ago. And probably most importantly are some of the personal stories coming through whereby individuals are either addressing life threatening illnesses that they knew they had or are getting new diagnosis that they did not know that they had because they had not covered their care before.

Some of the pent up demand we saw initially was not as people provided in critical access problems in the primary care area. We actually saw most of the pent up demand in prescriptions that had been previously written but never filled. And so in the first week of January, people who knew they had a condition had seen the doctor in one way or another, gotten the prescription suddenly had a financial barrier lifted and they started actively taking part in their care going forward.

This is where we are, we are a state-federal exchange. The red bar here are the individuals that have come across from the Healthcare.gov site – 44,000 folks. The blue entry point is our state portal. We have 155,000 folks that come through there. You remember, each of these groups has about a 250,000 denominator, so we are about two thirds of the way on the Medicaid side, we are less than one fifth of the way on the private health insurance exchange, we have kept 16,000 out as medically frail. We have put 121,000 in so that we have 166,000 of the 550,000 people covered now in the marketplace.

Required to have a significant waiver evaluation for major efforts. Do we achieve better access in healthcare compared to what we would have done, had we had a traditional Medicaid expansion? 74 out of 75 counties are medically underserved areas who I think with the commercial approach we probably will succeed in that. Will we get better care

and outcomes? Importantly, the third one, will we have continuity of coverage? So as people go to reenroll and/or their income fluctuates, we have them in the same plan that they can stay in with the same doctor. All we are doing is flipping who is paying the switch. It's the exact same plan, the exact same coverage, the exact same provider network. And of course, importantly, in the next two and a half years, we will have to assess whether it was cost effective to actually utilize the commercial sector as a delivery system point.

So with that, let me close. Look forward to questions. I don't know that my contact information is in your list, but it's there on the bottom should you have questions after today. Thank you for having me.

ED HOWARD: Terrific, thank you very much, Joe. We are going to turn next to Steve Fitton. Steve has directed Michigan's Medicaid and CH programs for more than five years now and he headed the policy and financing activity for those programs before that. He's a career civil servant operating, I guess, in a completely non-political environment. After all, it's only 15 billion out of 50 billion dollar state budgets so it's hardly noticeable, right? Steve has a story to tell about how Michigan is extending coverage to hundreds of thousands of lower income residents through its Healthy Michigan program and we are glad you came to share it with us. Steve?

STEVE FITTON: Thank you, Ed. I wondered how he was going to introduce a career bureaucrat. That was very kind. In any case, I am pleased to be here to share with you some of the high points of the process to pass and implement the Healthy Michigan legislation.

The Michigan political environment, our legislature, both House and Senate is Republican at this point and was during the passage of the legislation and the governor is a Republican governor. Snyder. So where we started was to make the case that the Michigan Medicaid program is – was and is effective and that the fundamentals are sound and in a lot of ways we are near the front of the line in terms of how Medicaid programs operate. And this is really to counter what was the commonly held notion and what is a commonly held notion in some segments, that the Medicaid program is broken and all you are doing is putting more people into a broken system and it's a false promise because it's a card and you can't get services. And so we really set out to get the story straight in terms of Michigan and the fact that we had data to counter those concerns. And in fact, we can show that we have access and quality in the program. Well, as you can imagine, the conversation isn't exactly a linear conversation, so there was lots of attention to other states and what was going on nationally and what might Michigan do differently as we were making the case that at least we were starting from a good place. And so, we would get comments like, why don't you do what Florida is doing and privatize the program? So we would say, well actually we did that in 1997, so 17 years ago we privatized the Michigan Medicaid program, in case you weren't paying attention, and that has been done. So we don't have that place to go. So we started to have a conversation about where we were and where we fit nationally on some of these dimensions in terms of program design and structure. And we are able to point to a

number of features in terms of where the programs stacked up nationally. We have six of our 13 HMOs are in the top 20 Medicaid HMOs nationally, according to NCQA. We have metrics that show we do provide access to care, just in terms of visit rates because we have the data and we are able to show that we are affective from a financial standpoint. So we shared this slide with them that showed that there had been an increase in health insurance premiums on the private side, commercial side of 127% over this 12 year period while the Medicaid program had gone up 31% and Medicare, I think, during the same time period, went up 94% to show that we hadn't been able to be effective in terms of holding the cost of care down and it was largely due to our managed care strategy, but it was also due to the fact that we had volume purpose programs for eye glasses. We started in the '80s. We started a multi-state purchasing consortium with Vermont, but has now grown to ten states and the District of Columbia to hold pharmacy purchasing costs down. So we are able to point, I think, to a solid track record.

We also had data on quality, so this shows the percentage of women who get a prenatal visit in the first trimester or within 42 days of enrollment in the program. So both clinical and access and quality measures and we had them in great volume and I won't bore you with them.

So the path to legislative enactment really starts with the fact, well it was a lengthy process. We started with the budget presentation from the Governor in late January, early February and ended up actually having this last till the end of August and the legislation wasn't even signed until early September, but you start with the fact that we need to give credit to the Governor. The Governor was all in on this, he was fully committed, he went around the state doing Town Halls, he was convinced to the economic argument and obviously you can't ignore the impact of the really deep recession in Michigan over the last decade, far earlier than other states have experienced. And so that is partly what is in play here, but I think the Governor also was moved by the various stories he heard of people who were uninsured and the impact it had on their lives. And so he was a strong advocate as was my boss, the Community Health Director, Jim Havenman. So – and I think as we engage with legislatures, there was intense interest on the key parties in terms of understanding and improving the program. We got pretty good buy-in for the discussion and ultimately we were able to get the bill passed at the end of the August or so.

The political and policy issues. Essentially there is a lot to talk about and there was a lot to talk about and so because healthcare is such a large part of the economy, a lot of it did have to do with financing and economics. Uncompensated care costs have been growing rather dramatically in the state and our rate of employer financed insurance had dropped from the high 70%, which was very good, at the beginning of the last decade, to somewhere around low 60's. So lost between 15% and 20% of employer financed insurance. So people were losing coverage, uncompensated care was growing, a lot of interest on the part of business in terms of the Small Business Association and the Chamber and so a lot of focus and some focus specifically in the legislation, uncompensated care, the impact on uncompensated care and then the impact that that would have on private health insurance premiums. And so there is a lot of focus on the

economic aspects, I think it's fair to say. We also emphasized the fact that it's not a static situation. If you don't do this, the world will not stay the same. The needles have been moving and they will keep moving as the costs go up and you can see as private commercial insurance had gone up 127% in cost, employers are being priced out of the market. I think a lot of people understood that both from being exposed to it and then just looking at the data. And so we got traction there. And then there was a lot of health policy to talk about and it's a pretty transformative time, so we have the largest demonstration for patient centered medical homes in the country. A big emphasis on that and trying to transform the health system in the way it operates and so – and how to engage consumers and other topics. Anyway, a range of topics that were on the policy side that there was deep engagement.

So the themes of Health Michigan are really – there are quite a number of them and the legislation is quite long and it touches a whole bunch of fronts if you will. Certainly there was reinforcement of the managed care approach that we have had in place in Michigan since 1997, which included in 1997; mandatory enrollment of the disabled population which I think was very early among the various states in terms of doing that. Put there is also a look at incentives beyond just the health savings account notion or health savings account like notion as well as co-pays, but alignment of incentives so that beneficiaries, providers and health plans were all pushing in the same direction. There is a heavy consumer engagement piece in this, both in terms of finances and skin in the game, but also in terms of healthy behaviors and really trying to find ways in which we can make the population of Michigan healthier. We have a high obesity rate in Michigan. We don't do very well on some many broad measures and we are really looking for ways to move the needle there. And we are actually doing a dual eligibles demo, so we had an MOU signed recently and there was reinforcement of that. So reinforcement of the managed care approach and then a whole bunch of measures of accountability, a lot of reports that are required. I accused the legislatures of wanting to beef up the bureaucracy.

In any case, the health plan incentives, which had been limited to .19% of total premium previously on the Medicaid side, that was the biggest we could make the incentive pool. This legislation moves at the .75% so a much bigger pool of incentives and the notion that financial incentives are important across the system. Health plans, providers, beneficiaries.

The consumer engagement piece does get attention and rightfully so. And this is the place where we did need a waiver from the federal government. There are required contributions or premiums, if you like, of 2% of income, but only for those who are over 100% of the federal poverty level. There are co-pays that would apply – will apply to the entire population and we do want to engage the consumer by showing what the care costs and think that is a useful endeavor and so we will be sending out quarterly statements showing what those services are and what the dollars are that are tied to them.

But there is also a heavy piece in terms of healthy behaviors. We are requiring a health risk assessment – or, not requiring it, but it's going to be heavily incentivized on both the provider and on the beneficiary side in terms of getting people to go through that process

to being informed, encouraged to do healthy behaviors and then being rewarded for engaging in those healthy behaviors. And I think I have to say, there is an awful lot to learn here. We look at this as a learning process because if you look at the experience on the commercial side, you see nobody has quite figured out how to manage this effectively. There is a lot going on in the commercial sector, but it looks like there is a lot to learn yet and a lot of tweaking in terms of the models that are being used.

So the implementation itself, we didn't get immediate effect in the legislation and in fact, the legislation passed the Senate 20 to 18 and there weren't enough senators to get the two thirds majority to get immediate effect, so we ended up implementing on April 1st. We did a lot of preparation in terms of the IT systems to make sure eligibility was going to work and we really weren't willing to pull the trigger even on the April 1 eligibility date until we had the testing done and had that accomplished. But you do find out in government that most of these jobs, no matter where you find yourself on the ideological spectrum, are about execution. You have to execute effectively in order for the programs to work and it really does affect how people perceive the programs. And so we had a lot of focus on that. We have done very well, frankly. We have had the system in maybe a third to a half of the cases be able to determine eligibility with no human hands, no human intervention. It's all done electronically and 15 seconds after they complete the electronic application, they get a message back that you are approved for Healthy Michigan. So you are eligible instantly and it's really been a big plus for folks in terms of the reaction. Affirmative reaction on the part of the beneficiaries that are applying.

And I think the last thing that I want to say is that there is tremendous potential for improvement in areas that we are really just starting to understand. So we know that there are a lot of individuals in the corrections system that have behavioral health issues. We know that – we are confident that at least some of that can be addressed and we can reduce the number of persons in our corrections system. And so there is areas to focus on there, there is certainly areas to focus on in terms of high utilizers and healthy behaviors, so we have a lot that we are digging into, a lot to learn, but a lot to really engage in and what I think is very worth – is going to be a very worthwhile endeavor. So thank you.

ED HOWARD: Thanks very much, Steve. Finally, we are going to hear from Alan Weil. He is Director of the National Academy for State Health Policy, or NASHP. He has been that for – what? Almost a decade. For those of you who don't know, NASHP, it is a non-partisan, non-profit research and policy organization dedicated to excellence in state health policy and practice. How is that? In a prior life, Alan directed the Colorado Department of Healthcare and Policy and Financing. He was health policy advisor to the Colorado Governor, Roy Romer, he's one of the most thoughtful policy analysts around, a quality you are going to be able to see more clearly perhaps very soon, by reading the Journal of Health Affairs where he is about to take over as Editor in Chief. And today we have asked Alan to give us a broader view, the possible expansion choices that states have faced and in some cases are still facing when looking at the Medicaid expansion opportunities. Alan?

ALAN WEIL: Thank you Ed and the Commonwealth Fund for putting this event on. I titled my segment, "What does it take to get to Yes" because I think the overarching theme here is that you want to have to do this to make it happen and you are hearing – you have heard examples of two states that are doing so. And what is the Yes that you need? It is a waiver, a section 1115 waiver under the Social Security Act and I always start with the original text to understand what this environment is about. And to remind you that a waiver is available in the case of any experimental pilot or demonstration project, which in the judgment of the secretary is likely to assist in promoting the objectives of titles – various titles, including Title 19. Focus for a moment on experimental pilot or demonstration. This is not plenary waiver authority, it is – it has to be tied to a learning opportunity. There is that word "judgment" of the Secretary that states sometimes bristle at. It's not the judgment of the Governor or the State Legislature, it is the Governor of the Secretary and it does need to be tied to promoting the objectives of the law. Despite the changes in the enforcement opportunities for states after the Supreme Court's ruling on the Affordable Care Act, the Medicaid expansion still resides in the Federal Medicaid Statute and so it's pretty clearly the objective of Title 19 to have everyone with incomes below 133% of poverty covered. And then the question is, how do you go about doing it?

I remind you that there are a lot of meetings about this third way or whatever we want to call it, but it is worth remembering that the vast majority of states that have expanded Medicaid have done so the old-fashioned way, which for a state administrator it is called the state plan amendment. You just tell the federal government you are going to do it and it happens. And so the question I think for today is why might a waiver, which is a lot harder to get, be an appropriate mechanism from a state and federal perspective to effectuate a Medicaid expansion. And again, I want to remind you, the state has to request it and the federal government has to approve it, so both parties to the deal have to believe that a waiver is more appropriate here than a garden variety Medicaid expansion. And tying back to the language of experiment pilot or demonstration, there has to be some kind of learning going on. We have to be finding something out that we didn't know before. I would loosely place it in four categories of learning. There is overlap among these, but I think given the way the program operates, it's a decent starting place. A lot of times we don't know how carriers or a health care provider is going to react to a certain change - the shape of the market and the shape of the delivery system. We are certainly very interested in knowing how people's access to care utilization of care changes based on program parameters. There is a good deal of interest in engaging the Medicaid enrollees and we want to know how they will respond to certain circumstances.

And of course, I put it last, but it's really often first, which is, will any of this save us any money? So what I'm going to do in just a few minutes is try to pull out examples of these four kinds of questions which animate the approaches that states are taking to use a waiver method instead of a standard plan amendment.

If we start with carriers and providers, we are very interested in what the states you have heard from are experimenting with and others are interested in, is trying to understand if you consolidate the Medicaid and the exchange insurance markets, what the effects will

be. Traditionally, these have been very separate markets. You have had Medicaid plans, you have had commercial plans. With the exchange, even without a Third Way Medicaid expansion, with the exchange, we have already started to see in states some of the plans on the exchange depending on the state are traditional commercial carriers, some of them are traditional Medicaid carriers, this boundary is beginning to blur. Why have these markets been separate? Well, partly they operate under very different rules and partly the commercial plans in particular have always felt that there were a lot of benefits in Medicaid that they didn't know how to administer and so it was sort of a special area of expertise to be able to operate in the Medicaid world. Well, with the Essential Health Benefits redefining the Medicaid package in the Medicaid expansion and with the exchange putting a – changing the structure of the entire market, there are a lot of questions now about whether or not, if you bring these two markets together, who will participate, on what terms will they participate? How eager will they be to participate? As Joe described, will you get new entrance into the market relative to the world you have been in? I should say these are very interesting questions; they are also very dependent on what the market looked like before you did a Medicaid expansion. And so figuring out a research question here is very dependent on knowing where you started.

What about the area of access in utilization? It is commonly expressed that there is a concern about access to providers for people on Medicaid and Steve's comments about the data notwithstanding, it's still a broadly held view that Medicaid doesn't provide as good access as other sources. So as Joe has described in Arkansas and other states are certainly interested in the question, if you have the same provider network in Medicaid in the exchange, will access and utilization change? Will they improve? And I think it is again, a commonly held view that more access to the commercial market will improve access and utilization for people on Medicaid, but I should say that we don't actually know that. We know that many Medicaid providers have invested a lot in culturally competent care, geographically available care; linkages to social services that people might need that commercial carriers historically have not. And so the question of whether bringing everyone into the same network will improve access and utilization, it is a great question to ask. But this is why we have to ask it, because we actually don't know the answer. We may think we know the answer, but we don't.

Similarly, traditionally, there has been a big gap between what commercial careers provide in benefits and what Medicaid provides. Now that has been greatly narrowed with the essential benefits package but we still have these so-called "wrap around" benefits and the question here is whether you can really make wrap around benefits work. We don't have a lot of good experience on that front. So if you are going to bring these markets together, you have to wonder whether or not people will get the care that they are entitled to if its not delivered through their major plan.

And there certainly has been some efforts on the parts of states to exclude certain benefits from the Medicaid package. CMS has been less open to that, but it's just the opposite side of the wrap question of whether or not excluding certain benefits has an effect on people's ability to get care. Many questions about Medicaid enrollee's responses to incentives and changes in the delivery system, some of these have already been

mentioned by our speakers. How will Medicaid enrollees respond to having a choice of plan within the exchange? Not all of the states that are trying this so called private option are extending that choice to the enrollee. But some are. So can people navigate choice in the exchange? How will that differ from navigating across plans in Medicaid? A good deal of discussion already about financial incentives for wellness. CMS has never been particularly interested in taking benefits away from people. We don't need a lot of research on whether or not utilization goes down when you eliminate benefits or increase cost sharing. We know that. The question then is, can we encourage people to do something different through some of these wellness approaches? I think a common thread across states that are pursuing this alternative method, is that they want to try out different ways to engage the patients but not just through garden variety, higher cost sharing.

Speaking of cost sharing, it is not lost on states that there is a misalignment in the cost sharing provisions between Medicaid and the exchange for people between 100 and 138% of poverty in – traditionally in Medicaid you couldn't extend cost sharing, but the exchanges, the statute is written with premiums down to 100% of poverty. So there is a lot of interest in what happens with cost sharing in that income range and I think we will learn about that from these states.

And finally, it's not often discussed, but most of these – actually, I believe all of the states are excluding some people from their demonstrations based on some sort of a health screen. How effective will those be? If we take those people out of the risk pool for the mainstream exchange plans, will we achieve the same as we thought we were going to save? I don't think we know the answers to these questions yet, but it would be good to find them out and to find out what kind of health screen really works.

And of course there is the question of saving money. A big plus, as described earlier, is the possibility of less churn, but less churn only happens if people actually do move seamlessly across different sources of coverage and it's not at all obvious that just because the same plans are offered on the exchange and in Medicaid, that people will actually move from Medicaid to the exchange or vice versa when their income changes. So we need to actually find out whether there is less churn and if does yield benefits. Is this more effective at providing stability than some state's bridge plans or a basic health program? We don't know yet. Similarly, there is a big hope that when you put everyone in the same network, that we reduce cost shifting. That we cover more people and that the prices for private coverage will go down. Economists aren't so sure. People who run hospitals and health plans are sure. Here is our chance to find out.

And finally, again, a lot of interest in these behavioral incentives associated with financing. So these are the kinds of questions you have to – if a state is interested in going forward, not with the standard state plan amendment, these questions in the form of some kind of a demonstration or pilot, need to be built in. Otherwise you are not really doing what Section 1115 calls for. So I would just conclude by noting that I like the catchy title of the Third Way, but we should be aware that there isn't just one third way. Each of these states and the others that are having this discussion have a third, fourth,

fifth, sixth and seventh way and that the differences which are often at the level of detail, are in many instances profound, but the advantage of having those differences is from a research pilot and demonstration perspective, we will learn a lot more, which is what Section 1115 is all about.

ED HOWARD: Thank you very much, Alan. Good framing of the broader issues as well. Now we get a chance for you to join the conversation. As I mentioned, there are microphones you can use to ask your question verbally. If you do that, I appreciate your being as brief as you can and as questioning as you can. Identify yourself as to your organizational affiliation if any and I would invite our panelists, who might want to question each other, to offer similar questions and certain Sara, join in as well speak and if you have a question to be written down, hold the green card up and someone will bring it forward. There is a gentleman at the microphone.

AUDIENCE MEMBER: Thanks Ed. Mike Miller, I'm a former orthopedic surgeon and now a health policy wonk for 25 years. I wanted to ask Steve about his last slide. The one that says, questions. And I'm wondering what kind of – for Steve and Joe, what kind of questions do you hope to be able to have answered in the next six to nine months that maybe you will be able to know the answers for about the operations or making your waivers work that are more operational rather than the kind of questions that Alan asked in his slides, which relate to the effectiveness of meeting the waivers, demonstration pilot characteristics. So things that are maybe keeping you up at night and you are hoping to know how to do better or hope they work out or figure out as you go forward. Does that make sense?

JOE THOMPSON: So I will start. We affectionately call those – that list, which is not a short list of issues, our transition to market issues. We are marrying two different approaches that are philosophically and operationally very different. The insurance world where you have no coverage until you pay your premium and the Medicaid world where you have coverage immediately upon eligibility. The insurance world where you have had different levels of cost sharing and a variation of management efforts. The Medicaid world that had a fairly regulated approach from the federal government. So I would actually say our biggest challenge and it continues, we are managing through it. We Meet every Monday afternoon – obviously not today, for a couple of hours between the leadership of our insurance department and the exchange and the leadership of our human services department in the Medicaid to go down the list of 20-25 different operational issues, as we marry two federal agencies – [unintelligible] and the Center for Medicaid program and two state agencies, the insurance department and the Medicaid program. It's a four way relationship and you can only imagine the complications of the different rules, regulations and philosophical orientation for each of those four perspectives.

STEVE FITTON: I think for us, there are a couple areas of focus. One has to do with the engagement with the consumer. So maybe number one is, can we figure out a way that they can pay their required contributions and co-pays and will they? And so first we have to set up a structure and we have talked to Wal-Mart and Meyer, which is a big chain in Michigan, to see if we could actually create the process for them to take in cash, for

instance, and credit to the account without charging us a huge transaction fee. So we are trying to figure out whether we can make those mechanics work and then to see how folks with respond. On the health behavior side, just to see if individuals will complete the health risk appraisal or assessment and then that is two sided – it also has to do with primary care providers that we need to engage with and the early returns are that they are being completed at a rate we didn't foresee possible, even in the first five or six weeks. So we are kind of amazed that that seems to be actually going well in terms of early returns. And then lastly, I think we will start to see some data on uncompensated care and what the impact is, particularly on the hospital sector. I don't think we will know much about private insurance premiums in six to nine months, but I think we will start to see some data on uncompensated care and see what the impact is there and that is obviously very interesting to us.

AUDIENCE MEMBER: Okay, I'm Dr. Caroline Poplin, I'm a primary care physician. My question is about the premiums in the insurance. My understanding from what you said is that you are going to use Medicaid money to pay the premiums for private insurance with some co-pays or something. Or a small contribution. Do you negotiate with the insurance companies about the premiums? I would imagine that CMS will only give you so much money per capita for private insurance premiums. And obviously people below 140% of the poverty line aren't going to be able to contribute very much.

JOE THOMPSON: So this is one of the open questions. The insurance exchanges are newly formed this year. The premium price point for the new essential health benefit had never been experienced before. So the carriers came in with price points on premium this year for a product that had never been sold in the marketplace. Obviously over time we will introduce cost competition for the Medicaid dollar. So first year in, the price point competition is really largely guarded by the medical [unintelligible] requirement in the individual marketplace. Over time, as a large state purchaser, we will likely introduce some price competition so that we will buy the second lowest plan, plus a percent of premium, which is the same strategy that the federal health insurance exchange will use for what is applied to the tax credit.

AUDIENCE MEMBER: Right, but what if there isn't much price competition or what if all the prices turn out to be higher than what CMS will give you for Medicaid? They are not going to pay more for a Medicaid patient in Arkansas or Michigan than they pay for a Medicaid patient in New York.

JOE THOMPSON: Well, they currently do pay dramatically different prices for Medicaid patients between different states. Our demonstration waiver is to actually test whether the purchase of the private premium is worth the increased access and outcomes and continuity of care that we anticipate. So that is the pilot project, to use Alan's demonstration perspective and they are allowing us to have a differential payment to test that pilot.

ED HOWARD: There is actually – I would like to follow that up just to clarify for those of us who don't immerse ourselves in Medicaid every day, Alan noted that there is

always a high interest in trying to explore potential savings in moving to this kind of a system. And yet, Medicaid rates – though they vary obviously a great deal from state to state, are generally perceived to be well below commercial rates. So how, by moving from a Medicaid program to a commercial program, can you expect to save money? Alan?

ALAN WEIL: I don't know why you are asking me. Well, what you spend is price times volume and one answer is that you might imagine that with better access to care, particularly access to things like care that better manages chronic conditions or diverts people from high end institutional services, that you would bring the cost down. The original move of Medicaid from fee for service into managed care, where states were required to show five – minimum 5% savings, relative to fee for service was based exactly on that premise that you would drive down high cost volume and certainly the – I think the data have been hard to find because in many instances they are proprietary, but if you talk to those who run the Medicaid managed care plans, they will tell that they jack up the rates on the front end on primary care to try to reduce that utilization and that is their winning formula. So that is one answer. The other answer is, maybe it won't. Or one might ask, if the solution to our problems is paying higher rates, do you need a model like this to solve that problem? So the answer is, we don't really know, but there certainly is a hypothesis out there that is worth testing. But it is a hypothesis that extends well beyond the private option expansion.

JOE THOMPSON: If I could just add, our Medicaid rates we believe would have had to been substantially increased to actually gain the access that newly covered lives would have because of – Ed, as you suggested. The other piece that we have already seen is that we anticipate that by reducing dramatically the number of the uninsured, that we will eliminate some of the cost shift that is going on within the private sector and although I think it was premature, one of our larger carriers actually introduced a 10% reduction on specialty rates across the board as we implemented essentially an offload of the uncompensated care. That didn't stick because we didn't have people already covered. But I think there will be potential deflationary pressure across the market as we eliminate some of the cost shifts on the uncompensated care on the private market.

ED HOWARD: Steve, any experience in the month and a week that you have been in the business?

STEVE FITTON: Well, actually, reflect more on the conversation we had in Michigan and that was, as we engaged with the legislature and we had a lot of parties to this discussion, but the question of – you know, the 100% threshold was very important. It was important in Arkansas and I think it is important in a lot of the states that are sort of in the middle. And the fact that the private insurance option was viewed as preferential from a philosophical standpoint. But what we ended up talking about was, what is the total cost to government, whether it's federal or state. And we were able to make the case effectively enough in Michigan that we were below the private market and in fact, more effective than the private market and therefore that the government would spend less if we did indeed have Medicaid and Healthy Michigan going up to 138% of poverty. And

we are going to be held to that in terms of looking at what is the total cost and how might that have played against what the exchange prices are. And in fact, we have already had to do a preliminary analysis that shows that we are below where the exchange is. But we essentially did what we did because the assumption is that it's cheaper to government to run it through the Medicaid system.

ED HOWARD: Yes sir.

AUDIENCE MEMBER: Hi, my name is Seth Gold, I'm with the Men's Health Network and I have a question for Mr. Thompson. In regards to assessments that you do in Arkansas for newly enrolled Medicaid patients, we were wondering if you have some form of programs like Michigan has with the Healthy Benefits, kind of trying to assess what chronic diseases patients might have, just so that you catch them early and want to see if there is something that you guys are actively doing to insure that.

JOE THOMPSON: Sure, great question. Many of our carriers are actually either already implementing or are in the process of developing essentially early screening mechanisms to try to get case management and support on these newly insured individuals. If you have had no experience before, there is no record of what your issue is, so there is an obvious benefit to the carrier to better manage those costs. The other reflection on your question that I would say is, there is discussion around our independence accounts which are not dissimilar to Steve's health savings accounts approach that I think in the out years there will be expectations for healthy behavior requirements, other contributions in certain ways that increase the individual's first awareness. I don't know that many of these people have the awareness of what the contributing factors are to the illness and over time, fiscal accountability for those issues.

AUDIENCE MEMBER: Joan Alcrue with Georgetown University and I had a Michigan question. We found your authorizing legislation super complicated to understand so I was wondering if you could talk a little bit more about your health accounts, which I think are really the unique feature and in particular, I know you are going to be looking at sort six month periods of utilization for beneficiaries and then revising their cost sharing based on some of their practices. So I know you haven't fully gotten there yet, but can you tell us a little bit more about where you are on implementation and how that is going to work?

STEVE FITTON: Sure, the part of the legislation that is referred to here has to do with the fact that we wanted to take the co-pay responsibility off of the provider. It was alleged that that's just a fee reduction to the provider because of the difficulty in collecting co-pays. And so the legislation calls for accumulating experience over a six month period and then spreading the co-pay obligation out to be collected in the next six months where its pro- rated across the different months. And so we are working hard to operationalize that, I don't know how happy the staff are that that is the structure we have adopted because it gets tricky in terms of what happens if people go off the program in various ways and are you going to continue to pursue them, because you are really collecting after the fact. So we are wrestling with a lot of those logistical challenges and – but we are working toward it and essentially trying to set up apparatus to make those

collections after the fact and they will be spread out in an even way, so we think it might be more affordable and it does reduce the burden on the provider. So that will be one of the interesting things to see how well we can make that work.

AUDIENCE MEMBER: Hi, I'm Sue Ladasina with the Blue Cross/Blue Shield Association. I would like to ask our panelists to look ahead in the future a little bit – in Arkansas, when do you anticipate the exchange will move – transition to a fully state based exchange? Would it be in time for the 2015 annual enrollment to begin? And in Michigan, when do you anticipate the state would have the legal authority to move to first, more of a partnership exchange and then eventually to a state based exchange?

JOE THOMPSON: So we had the political experience of not wanting to have to have anything, so we were a federal exchange. And then the feds said, well, we don't really want it, so now we are a state federal partnership exchange. I actually don't think we could have done our private option if the state had not had control over the plan management function to be able to marry the Medicaid program and the private marketplace. In some of the legislation surrounding the private option legislation was the establishment of an independent health marketplace board that I think likely will advocate to move from a federal/state partnership to a state only exchange, probably not before calendar year 2016. I think the timing is too tight to get to calendar year 2015.

STEVE FITTON: The exchange isn't exactly my wheelhouse, but I guess what I would say is this – both the House and the Senate at different times chose not to act in an affirmative way on either a state based exchange or a partnership exchange and at this point, I don't know what the political will would be. I know that there is some regrets in some corners that we didn't move forward with that, but it's sort of an open question and I'm not really sure what the future will hold. But I don't see anything in the short term that is going to move to a state based exchange.

ED HOWARD: I think we had one more person who was in line before this gentleman was in line.

AUDIENCE MEMBER: Thank you. I had kind of a two prong question. My name is Katie Allen, I come from Congressman Burgess's office. So my first question is about enrollment, the risk pool. I know particularly in the private option in Arkansas, and this is sort of specific to the demographics of Arkansas, but the vast majority of enrollees are in the Medicaid population. You also have a pretty significant portion of your enrollment coming from your high risk pool. So how is this effecting overall risk and rates and then the second portion is – the private option seems to be removing a lot of the cost controls, inherent and traditional Medicaid programs. So how is this kind of [unintelligible] to increase cost in state and federal budgets.

JOE THOMPSON: So excellent question. Let me just set up the answer to the first. If you remember on my slides, roughly there were about 200,000 – 250,000 that could be newly eligible for Medicaid and about the same amount that could be newly eligible for the tax credits. We are about 160,000 into the Medicaid and we are only about 45,000

into the tax credits. You allude to two previous high risk pools, one that the state had run, one that the Affordable Care Act established that were terminated and those individuals are probably in the 44,000 in contributing to some adverse risk selection of our tax credits. We also had our legislature prohibit any state agency from doing outreach or enrollment into the Affordable Care Act, so we are not – our uptake is not great on an exchange, however our Medicaid eligibles that we are buying private coverage for are drawing down the risk pool so that Arkansas' risk pool is on average ten years younger than every other state's risk pool. The only risk pool that has an exchange that is younger than ours is yours here in the District of Columbia because all of your young people are in that risk pool. But we are buying down by ten years, our younger poor people into the risk pool, so we actually have an advantageous risk pool compared to almost every other state. Now, with respect to the cost controls, I think that is part of our demonstration. We were a – still a fee for service primary care case management state. We had lots of administrative efforts to have cost controls, including lower payment rates. The question is going to be, can we get improved care, access and outcomes for a marginal cost of using the commercial sector? And what I think we are already starting to hear from some of our commercial sectors that original actuarial projection may have been a little high because of perceived adverse risk and they may end up bringing that in at a lower rate in future years that will help both the states obligation and over time, because of the tax credits that the federal government is paying into the risk pool, potentially the federal obligation also.

SARA COLLINS: So Joe, I just want to follow-up too on the administrative cost. A question came in on how the administrative cost is going to be affected by doing the private option.

JOE THOMPSON: I would say that our legislature was very interested that we did not grow state government because the private option. So almost all of the administrative costs are transferred over in the premium price point that we are paying for the carrier. So the administrative costs are in the premium price. I can't say that there is not administrative effort that is being extended, but in terms of no new state employees, no new administrative costs, we are buying the premium assistance and the administration of the plan, the production of the cards, the appeals process, the formulary management, all of that effort is transitioned over to the commercial carriers as part of their commercial obligation. It is ruled by commercial rules, the appeals process is the commercial appeals process. So all of that now factors under the insurance department's authority and oversight.

ED HOWARD: Alan?

ALAN WEIL: I just want to comment on the part of the question about cost control, which I would actually transform slightly into cost and quality oversight. And note that we have two decades of experience in Medicaid managed care with state and federal oversight of health plans and the how to do that has evolved. The exchanges of course, there is some potential – there is some standards in the Affordable Care Act and then there is a lot of potential even the most ambitious state trying to create a market and get a

bunch of plans coming in has been fairly timid about exercising that control. I think it is an open question whether or not the quality and cost contracting standards in the exchange will evolve more toward Medicaid. Probably not as far as Medicaid has, but it's also I think notable that you take a state like Arkansas without that 20 year history and actually you are not really giving up a lot because you didn't have that 20 year infrastructure. Where as if you take a state like Michigan where you have been building that over years, which plays out very differently. So just to say that this notion of sort Medicaid cost control exchange market, there is a starting point that is about right on average but actually it very quickly gets a lot more complicated than that

AUDIENCE MEMBER: Tate [name], Senator Prior's office and I just want to say thank you to Dr. Thompson for the work him and others in state government have done. 250,000 people are eligible for the program. We have over 150,000 that have signed up thus far. It's proven to be wildly popular in the state despite a lot of restrictions placed on informing people and being able to market the plans. And one question I wanted to ask is, when I first heard about how the private option would work, I was a little bit skeptical because when the Affordable Care Act was being developed in Congress, there was effort to try to minimize churn and have a more uniform marketplace. But the Congressional budget office projected that for 2020, the plans and marketplace, the QHP's, would be 50% more expensive than what they thought traditional Medicaid plans would cost. I think one of the things we learned in Arkansas is you get more granular in dealing from one state to another state. There is a lot of difference in what the risk pool is for the Medicaid expansion program and also with what the costs are for a Medicaid program. My question is: the states that have not expanded Medicaid at this point, as they evaluate this as an option, what are some of the criteria that would make the third option attractive for a state versus a state that may have challenges trying to make it work? Thank you.

STEVE FITTON: You know, you really end up with a conversation about what the state of healthcare is in your state. And there is, as I talked about in my presentation, there are multiple economic aspects to talk about in terms of the impact on the state. How does it affect uncompensated care? How does it affect private insurance premiums and trying to get keep that under control and affordable for employers and for individuals. But also the public health situation. Where are you in terms of obesity rates and diabetes and smoking and a number of these areas that are really important to the health of the state and to the health of individuals? And so I think just needing to engage in that process in the state and looking at the benefits of coverage – and I think there are benefits of coverage and I think it's a pretty – in a lot of ways, a pretty clear cut case. I mean, it doesn't answer the question of, is the federal government going to renege – or you can get in some fairly basic issues that need to be worked through. But I just want to throw out one example of a comment or a question that we got as we were implementing Healthy Michigan and an individual wrote in and said, I have a friend who just signed up for the Healthy Michigan program and I'm wondering if you cover cataract surgery. And they said, the reason I'm asking is I have been trying to get someone to pay for his cataract surgery and the optometrist told us if you have the surgery, he would have normal vision. And he's lost his job and he hasn't been able to drive and this would enable this person to get back and be a contributing member of society and obviously improve their life. So I think as we

hear those stories, I mean, there are compelling stories and our governor was really great about getting around the state and hearing some of those stories. And it's not true to the entire population, but I think those stories do illustrate there is a segment of the population that hasn't been getting services. Has been reluctant to incur the costs, they haven't found a way to finance this. And their life will improve and they will be able to be more contributing members of society. And that, I think, is part of the argument as well.

JOE THOMPSON: I would just add, if you are in a state that has already substantially expanded above 138%, you are going to be bringing it down probably and this doesn't offer you a new option. If you are in a state that has an effective management function like Alan alluded to, that your Medicaid managed care is working well, then probably that is an expansion strategy that if you can navigate the politics, makes more sense. Conversely, if you have a Medicaid managed care system that is not working well or you, like us, had not invested in much of a managed strategy over the last decades, this is a new and different approach in an individual exchange that depending on how assertive the exchange is managed, offers a real opportunity to lead [unintelligible]. I do think operationally, it requires your Medicaid director and wherever that authority lives and your insurance commissioner and wherever that authority is, to work together in a way that they have never worked together before.

ALAN WEIL: I started by reminding you all that the vast majority of states that have done the expansion did it just through a state plan amendment. So you have to sort of – this conversation only begins in a state where that is not a viable approach for political reasons. In my goings around the country, I would say the defining message that I hear from those who are looking for another way to do this is a sense that Medicaid and certainly it's part of the broader politics of the Affordable Care Act, that Medicaid is a one size fits all program that the federal government, after the court opinion, the federal government was not open to states doing partial expansions. They were not open to limited benefits. And that it is sort of a take it or leave it. And they want to shape this program in a way that fits with their values and with their – the structure of their market and with the resources that they have, acknowledging that they will pick up a share of the cost in a couple of years. And that a lot of this is just about a sense that they want to construct something that fits them, not something that was written and defined in Washington. Now, converting that into a viable waiver proposal that meets the needs and the criteria that I described at the very beginning is quite hard, but fundamentally, I think the conversation begins when a state says they want to do the expansion, they don't feel that the Medicaid program as it currently exists is one that they want to expand further, and they are willing to be creative, as these states have been in trying to figure out a structure that would be – that would meet the federal government's requirements and would enable them to feel good about it if it were ultimately approved.

JOE THOMPSON: It may be that you don't want to do the expansion, but you have a problem you must solve. That would be more our situation.

AUDIENCE MEMBER: Hi, Jeff Levine, blogger, former CNN medical correspondent. Steve, I wanted to pick up on something you said earlier, that since Healthy Michigan has come into being, there is a greater demand for prescription drugs. So is there out there an unanticipated or unfulfillable demand for service that is going to put additional pressure on your systems? Individual state systems 1115 that are a little leaner than federal Medicaid?

STEVE FITTON: I'm sorry, I'm not fully understanding the question. So the concern is about really high demand for prescription drugs?

AUDIENCE MEMBER: Or anything. In other words, if there is a lot of consumer demand for service, that you don't have the surge capacity to fulfill.

STEVE FITTON: Well, there is certainly – the concern in our state was more focused on primary care capacity. There was a survey done by an organization The Center for Health Research and – or Research and Health Transformation. Or Health Research and Transformation. I think I'm screwing up their acronym. Anyway, CHART, we call it. It's affiliated with the University of Michigan. They did a survey of primary care providers and found an overwhelmingly positive response to the ability to take on newly insured patients that would be Healthy Michigan patients. And there also is data that we have that our health plans have in terms of the number of providers that have paneled and their ratios are very low in terms of primary care provider to benefit number of beneficiaries, albeit that that is sort of absent the information of how many other insured populations they are taking care of. But all the data that we saw was very encouraging in terms of the capacity of the system to absorb the population. Now, we are only like five and a half weeks into this, or something. But initially we were paying bills on the second day. Individuals were taking their card and they were going to the FQHC because the Primary Care Association was involved in outreach and helping them to enroll in Healthy Michigan and so there were referrals, but people were getting to physicians and to this point, we have not heard of big lines. There is a better way to say that. But any rate, in terms of individuals that are having problems with accessing primary care or big waiting times. You know, I don't think we have enough information at this point to really know because most of the health plan enrollments won't actually be effective until June 1 for this initial population. And it's certainly a lot of people in a short amount of time in a state like Michigan. We have a population of about 10 million and a Medicaid population of 1.8 something million, traditionally. Now we are talking about already having 220,000 individuals and probably going to hit 300,000 here in the next month or so, we hope, or month and a half. Although that is being somewhat optimistic. In any case, that is a lot of people. I don't quite know how it would go, but all of the information we have been able to collect and evaluate would suggest that the capacity is there. I think there could be surge issues, but in terms of primary care and pharmacy, we think we are alright at this point.

JOE THOMPSON: If I could just add, we have similar concerns. One of the issues around our payment transformation effort is trying to move our primary care workforce to really think more about team based care so that you are scaling the appropriate level of

service to the appropriate need. And we think that is a benefit. Anecdotally, again, it's early, but our surge happened on the pharmacy side where people had previously seen a provider, had a prescription, but hadn't had a financial mechanism to pay for the prescriptions. In January there were people getting care that they had previously been diagnosed with, but were not successfully affecting that care of. We also potentially have an educational effort for folks who historically had only used the Emergency Room because they didn't have access to a primary care home. And so there is going to be some migration of folks' usual source of care as they better learn how to utilize the healthcare system.

SARA COLLINS: A question on the benefits package in the Arkansas plan and also in Michigan. In Arkansas, what dental benefits are included in the private option plan? And someone else asked about wrap around benefits, so maybe both of you can explain some of the differences in the private option benefit package and compared to traditional Medicaid.

ED HOWARD: And somebody might explain what a wrap around benefit is.

JOE THOMPSON: So starting with a definition, which since we don't have Medicaid managed care, I will probably get it wrong. But essentially, Medicaid has guaranteed benefits that if a plan doesn't offer; the state is still obligated to provide an access point for. In our private option, those wrap around benefits really include three major areas. Non emergency transportation – let me back up. So we are buying the essential health benefit on the marketplace, which our state used the second largest small group market, which did not include vision or dental as a covered benefit. The wrap around benefits that we have to make sure people have are non emergency medical transportation, largely long term care services and EPSDT benefits for 19 and 20 year olds. The EPSDT obligation goes up through 20 years of age. So if we have an individual that is likely to need those benefits, we are trying to retain them in the traditional Medicaid program so that we can give them those benefits or to extract them if they didn't make it into the commercial program when they need those benefits. We are trying to avoid as much as we can, the coordination of benefits between a commercial plan and a state obligation that wraps around. Now, Sara asked and one of our transition to market issues, a couple of the plans actually put dental and vision benefits in that Socio approved even though they weren't a part of the Essential Health Benefit program and the state is now paying for it. This actually makes our price point be above what the federal agreement is. This is one of these marriage issues. We are moving to eliminate those supplemental benefits, if you will, in year two, which will bring the price point back down into alignment. If I were king for a day, I might try to add them to all the benefits, but the rules that we were established with requires us to go with what the state chose as an Essential Health Benefit.

STEVE FITTON: I think it's important to remember that the Medicaid enabling legislation was passed in 1965 and it hasn't changed much. And so the list of mandatory versus optional benefits would surprise you, I think. It surprises me when I look at it and I have looked at it for 40 years now. What surprises me is that it hasn't changed. So

pharmacy is optional even though no state in their right mind would make pharmacy optional. And then you have things like non emergency transportation. But as it relates to the Healthy Michigan program, one benefit design change that we made, I think that might have been significant as any is the fact that we included dental in the managed care package previously. And for the traditional program, it's been carved out and we pay very low fees and we do have access challenges. And so it kind of – and we have a mixed bag. We do completely different things for kids and we actually have a very good program for kids in the vast majority of the parts of the state called Healthy Kids Dental, where we partner with Delta Dental. But anyway, by rolling the dental benefit in, we think that we are going to require that there be an adequate network and an organized system of care and in fact if you have to pay actuarially sound rates, it's a different financing structure as well. So we think that was an important change and a good one.

AUDIENCE MEMBER: Hi, I'm Caroline Kramer, I am from Consumers Union and one of the questions that I have is, you mentioned – especially Alan, that a lot of the questions that we have right now about these different approaches to Medicaid, we still don't know the answers. So whether our cost will go down, how access and utilization will be affected. A lot of those things we just still don't know. I was wondering if you could talk a little bit about efforts that are underway to study those things and find out whether they are state government based or whether there are partnerships with universities. I know that things are sort of [unintelligible] and are starting to come out more about for example, in Oregon, Medicaid experiment. So just efforts like that, that are underway. What is emerging? What can we kind of expect?

ALAN WEIL: I'm not going to give you a very satisfactory answer. Part of every Section 1115 waiver is an evaluation component. It's hard to summarize, because there are dozens and dozens of them and they cover a lot of different ground. There are people in the audience here who I'm looking at who follow them more closely than I do and then there are two people here who are living through it, particularly around the questions that their waivers raise. But there is an evaluation component to every Section 1115 waiver and I believe – I can't remember if it was in this session or just a side conversation before, I mean, given the high level of interest in this model, there is I believe a higher level of interest in the federal government in making sure that those evaluation plans will answer some of these key questions. Because there are others – the thinking has been that there are other states lining up interested in these approaches. And so we really do need to have the answers. But I'm not sure how else to generalize about what the nature of those evaluations is.

JOE THOMPSON: Just to be explicit, the first amendment to our waiver was our federally approved evaluation plan. An interim report is due at the end of the second year. A final report is due at conclusion of the waiver. There are, to my knowledge, two or three other evaluations ongoing. I'm not sure what the timeline on those reports coming up, but there is a fair degree of interest on whether this is successful or not.

SARA COLLINS: Just to go on to the next question, all of these alternative state Medicaid programs appearing to have something in common, which is a move towards

managed risk sharing capitation and away from fee from services. Is this critical to the access of the alternative state Medicaid expansion efforts?

STEVE FITTON: Well, we think it is. We moved away from fee for service in 1997 and it gives you a predictable cost and it also gives you some certainty in terms of provider networks and the organization and delivery of services. And where we are looking and we have a procurement for our managed care program coming up in about a year and a half, we will be looking to try to affect the financing relationships between the plans and the providers to try to move further away from fee for service rather than just having them become a fee for service system in their own way. But to try to make sure that we are moving toward value purchasing all the way through our system. So we are there.

JOE THOMPSON: I would echo – prior to the Affordable Care Act, we had started our Arkansas Payment Improvement Initiative – the payment transformation effort that I mentioned, to move explicitly away from a fee for service reimbursement system. Not to a capitated system, but to a value based outcomes system. Maybe on the path to capitation, but we may never get there. The private option actually – that was a voluntary effort with our two largest commercial carriers – Medicare, Medicaid and self-insured companies. The private option legislation requires that all carriers on the exchange now participate in that payment improvement effort as an explicit statement that we don't believe the fee for service reimbursement mechanism is the right approach to the get the value we want out of the system or the outcomes that consumers want from the system.

ALAN WEIL: The vast majority of low income people without any sort of disability in Medicaid are already in a managed care arrangement. So for most states that would consider this kind of private option, it's not so much a shift from one way of thinking to another as that they have already embraced the model of risk sharing and that as they considered an expansion, this is the path they would naturally take.

ED HOWARD: Let me just say, we are moving into the last few minutes of our session here and I would deeply appreciate your pulling out the blue evaluation forms and starting to fill them out as we go through these last few minutes. I am particularly directing that request to those of you on Congressional staff who are here because Senator Rockefeller would say, they are - not to dismiss anyone else, but that they are our most import target and the most direct policy opinion leaders that we try to reach. So I would appreciate if you would fill that in. Sara, you have got only about 115 more green cards.

SARA COLLINS: So here is another related to the last question, but what is the level of direction and oversight from CMS with regard to patients, providers and health plans? And I guess I would just add to this question – some approaches have healthy behavior incentives – Michigan has a healthy behavior incentive, Iowa does too and Pennsylvania is also proposing a set of healthy behavior incentives that are actually tied to having premiums waived in subsequent years. And there is – if you read through the waivers, the waiver applications and the approval from CMS, there is a considerable amount of

oversight and attention to those incentives and how they will be evaluated. So I thought maybe we could discuss that, the oversight, within the context of those provisions.

JOE THOMPSON: Our experience has been fairly intense level of engagement and navigation with the CMS officials. I wouldn't say there is that much direction, but they clearly have concrete boundaries that they want to protect in terms of the basic benefit offered through Medicaid, the basic protections afforded to individuals and the income gradient that they recognize at lower levels. Individuals cannot participate in the same way as someone that has more affluent set of assets. Having said that, I think the bigger issue on many of these new additions are operationally. How are you going to make it work? I mean, that is where – it's not necessarily oversight or intrusion, it's how you will make that healthy behavior assessment actually have meaning and how are you going to reach the individuals? I mean, we are having a hard time with some of our individuals, finding them to give them their insurance card. I mean, we have hundreds that are homeless. These are not small operational issues. So building the bells and whistles, at least in the early years, we can have a dialogue and a discussion about the goals and objectives of the program. But I think many of our issues are, lets make sure we can operationally – back to Steve's earliest thing – we have to be successful on implementation or else this is really an at-risk program and the more challenges you lay on top of in early years, the more likelihood you are going to have an implementation failure.

STEVE FITTON: It's always good to follow Joe, because then I can just sort of piggy back on the comments. You know, I think it's fair to say that states almost always would like more freedom than what the federal government will afford us and it's also true that the health plans that we oversee want more freedom than we give them. I mean, it's sort of a natural law of some kind. And I think it's fair to say that our experiences that we have a very ambitious agenda in terms of the legislation. And it's about financial contributions and having skin in the game. It's about healthy behaviors, it's about accountability, and it's about alignment of incentives. It's about a whole bunch of things trying to affect the public health that really move the Medicaid program to the next level. And I think there are certain places where the federal government does have – they have values that they are concerned about in terms of protections and so forth. And so there is sometimes discussion on those, but I think they have been quite flexible and open, frankly, in terms of the program that we have and the legislation that we have in terms of getting from here to there on the implementation.

ALAN WEIL: I would just state, what is maybe obvious, but is I think often not referred to in a conversation like this. The private option is a Medicaid expansion. It's not a different program. And that means that people who enroll in a plan through a private option are Medicaid enrollees and that means that all of the constraints and conditions that the state or the federal government would put around the terms of that are present unless they are relieved due to a waiver. So contracting with plans through an exchange is not qualitatively different than contracting with plans directly, which is what state Medicaid agencies do all the time. The issue is that the exchange plan relationship is still – it's brand new and so we don't know much about it. We don't know where it's going to

settle out. So I do think – one of the earlier questions was sort of – I talked about one kind of thing and the others were all operational. I do think much of this is operational. The boundaries are fairly clear. The question is operationally, can you make it work? And if you do make it work, do you get the benefits that you thought you were going to get? But in terms of what the flexibility is for the state, it's not really that different from any other Section 1115 waiver and the legal entitlement to the enrollee is no different from the legal entitlement to anyone else on Medicaid.

ED HOWARD: On last question?

SARA COLLINS: One final question. Just looking forward to states moving forward on their exchanges or their marketplaces. Do you think the interstate exchange markets – so states partnering with other states to create broader insurance markets, is an option for states in terms of lowering costs and moving forward?

ED HOWARD: Any appetite for that in Arkansas or anywhere else?

ALAN WEIL: At some level, I think an interstate exchange is an opportunity for reducing administrative costs. We have obviously seen the administrative costs associated to bringing up all of these different exchanges. The barriers to doing so, and my organization has put together a paper on this, because one state requested an analysis of doing a multi state exchange, are well known to those who work in this field and they have a lot to do with the fact that insurance is regulated at the state level and there is relationship there that would have to be unraveled and redesigned if you worked across state lines in that area. I don't think there is any reason to think that the plan issues change if you have an interstate exchange. I think it's primarily about administrative infrastructure.

JOE THOMPSON: The one thing that is present are the multi state plans, which is not quite an interstate exchange, but it is the potential to increase some competition across plans. I cannot imagine an interstate exchange either helping facilitate or not being a real challenge to a state that is doing the Third Way expansion. I don't want the 36 counties in Mississippi. I want to keep my 75 and try to get them as covered as possible, because that is within the degrees of political, operational and policy flexibility that I have.

ED HOWARD: Okay, well this has been, at least for me, an enlightening conversation and keep in mind the title of Alan's presentation, "What does it take to get to yes?" We are going to be watching this as it develops over the – not just the next weeks, but the next couple of years. And we will see if people are moving to "yes" and what the barriers are to trying to get them there. We are going to continue this conversation on Friday in a slightly different way, with our colleagues at the Commonwealth Fund, by looking at – and there were some references to them today – the federally qualified health centers. The FQHC's. We are going to take a look at how well prepared they are for new enrollment, new rules, new opportunities and we'll see if we can't try to find another way around toward helping states get closer to "yes" at least in the capacity part.

I want to thank our friends and colleagues – Sara Collins and her colleagues at the Commonwealth Fund for their work on this topic and in this briefing. Thank you for both sitting through a pretty dense and fact rich set of presentations and discussion and ask you to help me thank the panel for explaining most of those difficult situations in a very erudite and understandable way.
[applause]