ALLIANCE FOR HEALTH REFORM

Keeping Coverage Continuous: Smoothing the Path between Medicaid and the Exchange
Alliance for Health Reform
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ED HOWARD: My name is Ed Howard. I'm with the Alliance for Health Reform and I'm going to talk whether you listen or not. I want to welcome you to this program looking at how states can deal with shifts in eligibility for public insurance programs like Medicaid, same time subsidies for private insurance to the exchanges that are supposed to start operating in 2014. That welcome is extended on behalf of Senator Rockefeller, our board of directors. We appreciate your attendance and we look forward to your vigorous participation in the conversation.

When the exchanges start operating in 2014 and Medicaid eligibility both expands and gets a little more standardized from place to place, there are going to be millions of people who find themselves eligible either for public coverage in Medicaid or SCHIP perhaps or for subsidies for private coverage through the exchanges.

Since family incomes and circumstances change over time, huge numbers of people are going to find that their eligibility has changed or maybe been lost or maybe been lost and regained in a different program. In other words, it's going to be a very complicated situation. Those transitions could very well be quite jarring for the families affected and

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frankly could present some challenging administrative problems for the states who are trying to sort all this stuff out.

As states wrestle with how to structure their agencies in this reform era, we thought that it would be timely to examine exactly what kind of problems might be encountered with this so-called churning phenomenon and what policy tools might help to minimize the disruption and expense that otherwise we might incur.

Our partner and co-sponsor in this briefing, the Commonwealth Fund, has done a tremendous amount of work in looking at the transition between the current healthcare system and the one that is scheduled to be phased in over the next several years under the Affordable Care Act.

Joining me as co-moderator today is Sara Collins, the Fund's Vice President for affordable health insurance who also happens to be particularly expert in this area. We've asked Sara to give us a bit of context for this coverage continuity question, if you will, that our panel is going to address. Sara?

SARA COLLINS: Thank you Ed. I'm actually going to take a pretty high level look at this before we dig down into the details and provide just a really brief overview of where the federal and state governments are in their implementation of the Affordable Care Act. This shows you the timeline from

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implementation of the coverage provisions in the law, the insurance reforms, in particular many have gone into effect last year and some are being rolled out this year starting in 2014. Those are when the major provisions go into effect and like as Ed said, a substantial expansion in Medicaid eligibility and subsidized private coverage to the new state insurance exchanges.

The state insurance exchanges are really the centerpiece of the Affordable Care Act. They're new, regulated marketplaces for individuals and small employers can purchase health insurance. Much of it, which will be subsidized, and will provide ideally one-stop shopping for people looking for coverage in both Medicaid and subsidized private plans.

States are required to establish an individual and a small group exchange. They can actually merge the two if they want to. If they decline to establish an exchange or HHS determines by January of 2014 that they are not able to, HHS will work with states to help them set up an exchange.

Congressional budget estimates that about 34 million people will become newly covered in 2020. This is about an estimate at 16 million people will gain coverage through Medicaid, 18 million more will gain coverage through the exchange or employer plans.

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Medicaid, as Deborah Bacharach points out in a paper in your brief, when you include the over-65 population, it's going to be the largest insurance carrier in the country. It will insure 25-percent of the population. With shifts of people moving from an individual market and employer plans and also small groups buying coverage through the exchange for their employees, about 30 million people will be covered through the insurance exchanges.

HHS has been awarding grants to states to plan and establish their exchanges through planning grants issued last year and the new state, new establishment grants that states are in the process of applying for last year, level one or level two grants depending on how long and how far along they are in their process. Most states will need to pass legislation in order to establish their exchanges.

This map is based on the national conference of state legislators tracking database. Six states have signed legislation in place, dark blue states on the map, Massachusetts, in addition to Massachusetts, California, Maryland, Washington, West Virginia, and Utah. Several other states, the turquoise states have legislation that has passed, one or both Houses and many are ready for the Governor's signature.

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Governors in Vermont, Colorado, and Hawaii, for example, are ready to sign their legislation shortly. The New Mexico Governor vetoed legislation that had passed both Houses. Louisiana has notified HHS it will not be establishing an exchange. Governors in the light blue states have pursued or considering alternatives to establish an exchange such as issuing executive orders that will do so.

Many states, the purple states on this map, bills introduced have been stalled for several months and in states that are white, legislation, for the most part, have not been introduced or has actually failed. Six states in a consortium of New England states were awarded early innovator grants to develop exchange information, technology, infrastructure that can be adopted and tailored by other states. The IT systems must be interoperable and integrated with state Medicaid programs.

The focus of the panel today and one of the key issues that these and other states are going to be dealing with is how to create an enrollment process across Medicaid and subsidized private coverage that will allow people to easily enroll in the coverage that they’re eligible for and also maintain that coverage, as Ed mentioned, when their incomes change or when they move between jobs.

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People with incomes up to 133-percent of poverty will be eligible for Medicaid. Those with incomes up to 400-percent of poverty without employer-based coverage will be eligible for private coverage through the exchanges. Premium subsidies will be available on a sliding scale that cap their premium costs, people's premium costs from two-percent to nine-and-a-half-percent of their income. Subsidized coverage through the exchanges will be tied to the silver plan, which will cover about 70-percent, on average, of someone's medical expenses to offset those costs.

People with incomes under 250-percent of poverty will be eligible for sliding scale cost sharing tax credits. In addition, the out-of-pocket limits are reduced for families with incomes under 400-percent of poverty. One of the major goals of the Affordable Care Act clearly is to reach and maintain near universal coverage in each state. How well federal and state policy makers address issues that are going to be explored by the panel today will have an important role in how well we're able to achieve those goals. Thank you.

ED HOWARD: Great, thanks very much Sara. Just a couple of housekeeping announcements, you have packets that have the papers that Sara was referring to and a bunch of other stuff and a list, which is duplicated on our website, allhealth.org, so that you can click on things and get a much

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more extensive list of resources that might be helpful in answering your next level of questions.

There will be available, on Monday, a web cast of this briefing through the auspices of the Kaiser Family Foundation, thank you very much, on kff.org, a transcript, a few days later on our website at allhealth.org, and you'll find in those packets two things I want to call to your attention again, a green card on which you can write a question at the appropriate time and also come to one of the microphones and ask the question orally, and a blue evaluation form, which if you do not fill out, you will not be permitted to leave [Laughter]. We're working on that but we would appreciate your filling them out so we that we can improve these programs as we go along.

We got a great panel today to talk about some of the issues that Sara has alluded to and we're going to start with Pamela Farley Short. Pam is on the faculty at Penn State. She directs its Center for Healthcare and Policy Research. Her own research has to do with how people's insurance is connected to their income and their employment and their overall health.

You'll find a paper by Pam and her colleagues in your packets commissioned by the Commonwealth Fund that lays out the major possible pitfalls for people who're trying to maintain their coverage under the ACA as their life circumstances change. it was really that that triggered our thoughts about

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the possibility of doing a briefing that could build on the excellent work that is encompassed in that paper and in the presentation you're about to hear from Pam Farley Short. Pam thanks for being with us.

PAMELA FARLEY SHORT: Thank you Ed. Let me start by thanking the Commonwealth Fund for supporting our work on this topic. I also want to thank my collaborators Kathy Schwartz from Harvard, Namrata Uberoi who's a PhD student working with me, and Deborah Graif who's also at Penn State. So the reforms that will be implemented in 2014 pull together coverage from a variety of sources in order to offer universal access to affordable insurance and hopefully to get something close to universal coverage as well.

So at the center of these reforms are the individual health insurance exchanges that will offer premium credits for some enrollees, those specifically that lack access to employment-based insurance and who have incomes between 133-percent and 400-percent of the federal poverty line. There will also be small employer exchanges, which can be separate or combined with the individual exchange, the states get to decide that.

Medicaid, as Sara said, will be expanded so that everyone under 133-percent of the poverty line will be on Medicaid and don't be confused, I think today we will sometimes

refer say the people up to 138-percent of the poverty line will be on Medicaid and others of us are saying 133.

There is a five-percent income disregard so that effectively, which will not be counted, and so effectively Medicaid will go to 138-percent of the federal poverty line but started one of those stars, little complications. Then the children's health insurance program is extended to 2019 and in the background but actually also at the center of things, three out of five Americans will continue to be covered by employers.

The jumping off point for today's session is though the realization that in the scheme, changes in income, changes in employment and access to employment-based insurance could cause lots of people to gain or lose coverage from these different sources over a year. When your income changes and you go over the limit for Medicaid then what happens? Even family membership and who's in the family is going to matter because the federal poverty line is adjusted for family size and depends on family composition.

The tax credits will be administered through tax units that also depend on who's living together and filing taxes together. So this leaves us with a major challenge in implementing the reforms that basically comes down to trying to figure out how are we going to maintain the guiding principles of covering everyone, affordability, shared responsibility but

how to define that and maintain it when someone's ability to pay for insurance is changing. It gets more complicated.

This isn't just a theoretical possibility. Here are some data that we tabulated from the survey of income and program participation that shows from one year to the next and remember that the exchanges are going to sign people up in the fall for coverage in the coming year, and income taxes are filed basically on an annual basis.

So starting with the people who will qualify for Medicaid here who are below 133-percent of the poverty line, if you take that group and you look at the next year to see what income category they're in, it's only 76-percent of them, about three-quarters stay in that category below 133-percent of poverty. The other one out of four have moved up and would then, instead of being eligible for Medicaid, would most likely be getting premium credits in the exchanges.

What's even more important or significant is that the greatest volatility in incomes is in the group just above that, 133 to 200-percent of the federal poverty line. Those are the people who would be in the exchanges in one year but the next year, only about half of them would still be in that category where they're getting the biggest premium credits, most generous premium credits through the federal tax system.

The other people would have moved, some of them, 17-percent on the left in the red will move down to Medicaid and others will move up into less generous premium credits or even a very small percentage out of the exchange.

Even decisions about the small employer exchange, you're going to figure here because low-income workers are concentrated in small firms. So the lowest income group is the longest bar at the bottom of my slide and it declines as you go up the income distribution. So coordinating Medicaid with premium credits to buy insurance in the exchange is going to be critical. First off, many new enrollees in either of those programs are going to be coming from the other program. It adds another large federal bureaucracy, the internal revenue service, to what's already a rather complicated partnership of involving in Medicaid with the federal state enrolls there.

We have a history of, we know that it takes special efforts to get high participation rates in Medicaid and CHIP. So it's not just enough to offer people eligibility. You have to work hard at getting them into these programs and keeping them in the programs. The tax credits are going to be based on annual income but Medicaid eligibility is based on income over a shorter time period and the law says at the time of application but not just here to point out the problems, we

actually have a number of policy solutions in this policy brief that was released by the Commonwealth Fund yesterday.

Our suggestions come at an admittedly high level and Deborah and Don are going to fill in some of the details beneath but one of those suggestions is just to be very clear that the eligibility and navigation systems that are going to help people get into the exchanges and find their place in the right, see what they qualify for, those systems really need to be designed to help people cope not just with getting in the door but with changes in their eligibility.

So we use these words about a single point of entry, a portal at all, kind of this image of coming in but really we need to put a lot of emphasis on the handoffs and think of this as helping people move from one program to another. The exchanges and people who are helping folks with their eligibility are going to be able to answer the questions that individuals are going to have about what if my income goes up next year? What if I get a job or what if I lose my job, what if scenarios, to help them figure out what they want to do and what really is essentially still a voluntary system because people have the option of paying the penalty and going without insurance.

Another possibility is for states to consider their option of creating a safe basic health plan that would bring

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everyone under 200-percent of the poverty line, basically under the state's umbrella, and that would help to coordinate between Medicaid and the income group that's just above Medicaid. It would also be possible to extend Medicaid and CHIP eligibility through the next open season to the end of the year.

So instead of moving people in and out of those programs, since everyone's going to choose their plan every fall, through transitional Medicaid assistance and 12-month continuous eligibility and some other options that are really already part of those programs, it would be possible to leave people where they are and not go to all this trouble for them and states and the exchanges to move them around.

We also suggest that this may be a reason to combine the individual and the small employer exchanges because, after all, if those are unified then when people leave a small employer and would have to get coverage on their own, they wouldn't have to move to a different exchange and perhaps a different set of plans. That would be more seamless.

Finally that even if we leave the exchanges separate or we have Medicaid and CHIP and exchanges, one of the things that states can do is to think carefully about the plans that they're contracting with so that people would have access to the same plans whether or not they're being covered through

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Medicaid or through the exchanges or even if not the same plans, at least the same provider networks.

So in our mind, none of these suggestions that I've put on the table here would require new federal legislation. Simplifying will not only benefit people whose lives are influx or going through these changes but are also going to reduce administrative costs. To us, it seems like the most promising way to simplify are actually to unify these programs. I think that's a theme that you may hear more this afternoon and to let people stay put. The easiest way to smooth transitions and avoid gaps is to not have transitions. Thanks.

ED HOWARD: Just to clarify, some of the others you mentioned explicitly about the combining of the individual and the small group market exchanges is something the states have the power to do at their discretion.

PAMELA FARLEY SHORT: Yes, that's right.

ED HOWARD: Okay, great. Thank you. thanks very much. Next we're going to turn to Deborah Bachrach who's currently special counsel to the law fir Manatt, Phelps, & Phillips and before coming to Manatt, she had directed New York's Medicaid program for several years. She has a rich background of work on health policy and financing issues having advised a whole range of groups including the new Medicaid and CHIP Payment and Access Commission, MACPAC.

Deborah's also written quite a useful document that you'll find in your kits, the Roadmap for States Looking to Structure Medicaid's Role in the New Exchanges and we're very pleased that she could join us today. Deborah?

DEBORAH BACHRACH: Thank you. The slide that I usually start with that's missing from this presentation but I'm going to take the liberty of telling you this and it is really the premise of how we achieve continuity of coverage in the exchange is Medicaid is health insurance. We have to keep reminding ourselves that it's changed dramatically since the 60s and it's now health insurance. We're looking at and Pam said it, I wrote it down, coordinating Medicaid with premium coverage will be critical and I couldn't agree more.

This workflow starts with the individuals coming into the exchange who don't know whether they're eligible for a subsidy or not because they have no clue whether they are at two-percent of the federal poverty level or 200-percent of the federal poverty level.

Donald talked more about that front end in the eligibility determination and redetermination but what I want to jus focus your attention on here is once an individual has been told they're eligible for a subsidy, now that could be a full subsidy under Medicaid, close to full subsidy if a state

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chooses to do a basic health plan, or a more partial subsidy through a qualified health plan.

At that point, they know their subsidy level and they will choose a plan. I particularly want to look at this through states that are now operating their Medicaid managed care plans and increasingly you will find states doing this through Medicaid managed care plans so that once your subsidy option is determined or your subsidy level is determined, you will move into choosing a plan among the plans that offer the product for which you're eligible.

Now looking at it from the point of view the individual in the exchange, the Affordable Care Act defines state health subsidy programs and it really plays into my point, if you will, very proud, that Medicaid is coverage in the continuum of coverage.

So there are four state health subsidy options, Medicaid and as Pam said, I use the below 139 because I build in the five-percent, CHIP, which starts at 139 and goes up to a state ceiling, which can be as high as 400-percent, the basic health program, which is an option for 139 to 200-percent, and then qualified health plans offering subsidized coverage up to 400-percent, and then qualified health plans without a subsidy for those above 400-percent.

Now the goal is to achieve continuity of coverage among these options in the exchange. From my point of view, what's the goal? Why do we care about this? Well the first, and this is the topic for today, it's about facilitating transitions as income switches but I think it bears mentioning that integrating coverage or continuity coverage is equally vital to states and increasingly, states are focusing on this because it leverages their buying power, which enables states to influence not only price but to drive payment and delivery system reform. This is very much on states' minds.

So in the next slides, we go through some of the ways that we can achieve integration and continuity. The issue that this slide depicts is will the plans in the exchange offer all products. In other words, if you start from the bottom and work up, will we have a qualified health plan that's also offering a basic health program, assuming the state takes that option, and is also offering a Medicaid managed care product.

There's obvious desirabilities to our approach because individuals will then be able to move and stay within the same plan but there are Medicaid managed care plans that are very good at providing care to vulnerable populations who may not be positioned to be a QHP and there may be QHPs that have no interest in contracting with the state's Medicaid agency.

So then there's the middle option, which is some choose to, and what states are thinking about is what levers do I have to a minimum, encourage Medicaid plans to move into the QHP space and for QHPs to move into the Medicaid space because at a minimum, all states would like to at least see some overlap in coverage.

This will raise another really tricky issue for states is provider networks because as much as we would like individuals to stay within the same plan, as their income changes, we want them to be able to maintain the same primary care physician and for those with chronic illness, specialty physicians.

So will the provider network look the same in your Medicaid managed care product and your QHP product? Experience suggests not always and too, even when they do, how will payment rates affect this because I can see some of you nodding, Medicaid managed care plans traditionally track to fee-for-service rates, which tend to be lower all of which are sort of being thought about now by states as they roll out the exchange and think about where Medicaid fits in.

The next three slides really speak to the extent you don't have complete uniformity of plans. I think in most states, you will not have complete uniformity of plans. We can align the plans through our requirements, our quality

requirements, our network requirements, and our marketing requirements.

Here's where I think a lot of this notion of are you going to be a passive or an active exchange is really overstated because the ACA makes it clear that there's certain requirements that a QHP must meet. Medicaid managed care plans have an awful lot of requirements they now meet. I mean in New York, we had strict quality, access, network requirements.

So what we're trying to depict in these three slides is the degree to which the state will want to align their requirements for quality, for network, for access, for marketing, and for reporting across all of the plans participating in the exchange and when I say that, I mean including your Medicaid managed care and basic health plans. So this one looks at the certification requirements building off of what's in the ACA for QHPs.

This is our quality strategies and this goes back to my point about leveraging your plans in the exchange to drive quality and then on reporting requirements so that we are aligning our insurance products in the exchange regardless of the income and the subsidy eligibility of the individual.

Benefit options, this is tricky and if I had more time, I'd have three or four slides following this but the QHP must offer an essential benefit package and that's in your first row

and that we're waiting for HHS to put more detail to that. But whatever it is states must provide a minimum benchmark to newly eligibles, so that's all childless adults and depending on your state, some parents up to 138 or 133-percent of the federal poverty level.

The minimum benchmark that must be offered to the newly eligible is column two and when states offer that benchmark; they receive an enhanced FMAP starting at 100-percent. The maximum benchmark could marry your standard Medicaid subject to approval by HHS.

States are making decisions on this now or thinking about this now and part of what's driving it is how do I maximize my ability to get enhanced FMAP? How do I align benefits so I don't have cliffs? There an awful lot of questions here about aligning your standard Medicaid, which will apply to your children, some parents, your newly eligibles along with your QHP or benchmark.

The last piece that I want to talk about is how to use a basic health plan. Increasingly we're getting states asking about this. The first level of interest came from states that were covering parents with incomes above 133-percent of the federal poverty level. That's what you're seeing in New York where we cover parents up to 150-percent.

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So is this an option where we can create a bridge between our lowest income individuals and our slightly more moderate income individuals? The way the federal law reads is it's available for the 139 to 200 group. It can include legal immigrants who are not eligible for Medicaid because they've been here for less than five years. The federal government will provide 95-percent of the subsidies it would otherwise have made available for these individuals as well as additional dollars to reflect the out-of-pocket offset.

The question for HHS was whether that's 95-percent or 100-percent but it is the sense that the states can purchase a more comprehensive benefit package and offer it at lower cost sharing by going into the market and by doing so making it more affordable for this still relatively low income group, align it with the Medicaid product, and transition more smoothly over to the QHP.

When I went back because I can't tell you how many questions I'm getting about this now and I read the statute, what I was struck by was the number of requirements regarding the quality levers to be built into BHPs, which really again suggests that the ACA sets us up to think about quality and deliver system reform across our health plans and from Medicaid through BHP and through QHP.

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I think for me that's the point that I would want to leave you with, which is this is our opportunity to once and for all yank Medicaid out of the sort of welfare/poverty program mode, move it into becoming what I call a mission-driven fiscally-disciplined health insurance program and align it with BHPs and the QHPs to ensure continuity of coverage and to maximize our leverage in the delivery system. Thank you.

ED HOWARD: Thank you Deborah. Let me just ask you one other quick clarifying question, if a state does choose to put in place a basic health plan that still will be a product ultimately provided by a private insurance company, is that right or the state is going to—

PAMELA FARLEY SHORT: Well the wording of the statute as it sets up a clear preference for a health plan to offer it. So the question then will be will it be offered by your Medicaid managed care plans? Will it be offered by QHPs or both?

ED HOWARD: Great, thank you. Well you've heard a couple of experts describing the problems and the potential solutions. Now you're going to hear from somebody who's had to wrestle with this in real life. Our final speaker's Don Gregory is the Medicaid Director in the Louisiana Department of Health. He's a native Louisianan.

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He's been in the department for many years. For nine years in fact, he chaired the CMS Technical Advisory Group on Fraud and Abuse Control. In the last decade, Don's overseen some dramatic improvement in how Louisiana's Medicaid and CHIP programs enroll and retain eligible folks and now he's grappling with how he'll coordinate with the exchange in Louisiana, which is likely amazingly to be run by CMS and not a Louisiana entity. So looking forward to hearing how you're juggling the various variables that you're coming across in this transition period. Don thanks for being with us.

DON GREGORY: Thanks Ed. I appreciate it. It's a pleasure to be here this afternoon and I'm going to assume that you can read faster than I talk and so I'm going to let you read these slides behind me and I'm not going to try to read them to you. There's some bullet points here that I want to tell you about that are important. I'm going to tell you very quickly about a 12-year journey that we've been on to solve churn within our Medicaid and CHIP program.

I'm also going to talk about children because that's mostly who we cover in our Medicaid program and our CHIP program in our state. I'm also going to talk about how we evolved from the very typical welfare eligibility process into something that's very, very different. We think that new model of eligibility determination for us has implications for our

work with the exchange not only in our state but are lessons there that can be used across other states as well.

This is kind of the lay of the land, nothing on this slide that anyone, anyone would be proud of. This is kind of where we were in 1998 when CHIP was introduced and we got all excited about the opportunities that came with CHIP. We did lots of outreach. We partnered with new community partners that we had never worked with before to do outreach and enrollment. We thought we were off running on something new and great in our state.

We discovered fairly quickly that we weren't quite as good at doing this as we might be. We were losing at redetermination once CHIP had been in place for a year. We were losing more kids at re-enrollment than we were enrolling through the front door. So we were actually having net losses in eligibility because of churn.

It would be great if these kids all suddenly became members of families that were doing so much better and that therefore didn't need the coverage that we were offering. That's not the case. These kids were still eligible for the most part. They simply couldn't or their parents wouldn't navigate our eligibility process to keep them enrolled in our system.

We set out to redesign and get away from this very paper-bound, face-to-face interview eligibility process and to adopt processes that would allow us to reduce, if not eliminate, churn within our program. Some of the things that we started doing was we started looking very closely for information that was in other computer systems that we could use that we didn't have to rely on the parents of these children to provide information to us.

We adopted some very simple technology that would help us achieve better outcomes in our enrollment process. We looked to see if we were doing some things that we'd internally called administratively stupid. I mean we did them because we've always done them that way but did it really serve any purpose?

We've really adopted something that we're particularly proud of, in our express lane eligibility, we have one computer system talking to another computer system to determine renewals and we're doing about 7,500 renewals a month, which no person touches. One computer system's touching another computer system and we're generating those as automatically and we have somebody that's kind of watching over this IT system to make sure that they keep talking to each other but there is no eligibility involvement in it whatsoever, which we really are proud of.

A big thing for us was the key point on this slide is that we started looking hard to see what else was out there instead of relying on, asking over and over again for people to provide us some information that we either already had ourselves or that some partner agency had in their system already. We started looking to see what we could bleed from other systems that were available to us that would help us.

In particular, I really like the information in food stamp cases. Food stamp cases are very granular in detail, a $3 change in income makes a dollar different in benefits. It's a very slow, laborious process to determining eligibility for food stamps, quite costly process.

Every food stamp director I ever met was obsessed with their rates because they get penalized if they have varied error rates in the food stamp program. So if there's great granular detail in the food stamp case wouldn't particularly want to be tied, from a Medicaid or CHIP perspective, closely with that process because I can go really fast and therefore fairly cheap in my eligibility processes because I don't have to be that precise.

It's only important for me when it gets close to a tipping point between Medicaid and CHIP or between CHIP and ineligibility that I'd really be careful. So therefore I don't need as much information to determine eligibility as the food

stamp folks do but food stamp information is great and I'd love to get my hands on it when I can.

One of the things that we adopted was really low tech. We simply started using the darn telephone. We started picking up the phone and calling people. We found out they like it. They don't like getting letters in the mail from us reminding them they're supposed to do something, fill out a form and mail it back.

So we started say, we would send them a notice to say call us when it's convenient and they would call and my eligibility workers will tell you to a person that they get better information out of a brief telephone interview than they get on a signed renewal form. So we simply adopted Graham Bell's great invention and had used it extensively in our eligibility process, again for these reasons.

It's key, it was a key component and this was not expensive technology. Somebody didn't have to come build me a $10 million computer system. I mean almost everybody that you know has a cell phone. Find somebody that doesn't. So phone contact works extremely well. I'll throw this slide up here so that you will see, visually, what I've been talking about. Twelve years ago, all of this, all of this would've been paper.

We would've mailed somebody an application form or a renewal form. We would've set up an interview for them. We'd

have them come in and sit in a waiting room. We would've interviewed them about this. We don't do that anymore. We don't do face-to-face interviews.

We rarely do any paperwork at all. It's less than five-percent of our work now and declining. You will see a small bit of web work here now. Some states do more work on the web than we do and we think that's going to grow. I think paper process in eligibility will pretty soon be almost a dinosaur.

It will be the rare, rare exception. Most of what we do in the way of renewals, we could either find it at another system, we could get it over the telephone or we can simply, the administrative piece of it is, we started looking at our processes and this is what I was talking about being administratively stupid, we realized that about a third of our eligibility cases never closed. These people were in situations where they simply, their situation just doesn't change. Is the children living with the grandparents? The grandparents' income doesn't count.

It's somebody that has social security income; it's not going to change much, a little bit, maybe January 1st each year. Those people are extremely stable. So why do I need an eligibility worker to contact them and do a renewal? So what we simply start doing is we send them a notice saying this is

what we have on file in our system about you. You call us and tell us if this changed. It's amazing, they will call. So we simply send them an annual renewal showing what we have on file and they will call our hotline and tell us if something's changed, works really, really well.

To show you an example of what this means, this was actual renewals for children in our program from last August. We renewed over 45,000 kids, almost 46,000. We closed only 327 kids because we couldn't find them. We couldn't get a form from their parent, or for some reason.

Now we closed other kids that were no longer eligible but for procedural reasons, we only closed 300 kids. Under our old process, we would've closed over 10,000 of these 45,000 kids. It's not because they weren't eligible. They simply couldn't jump through the hoops that we had out there to redetermine their eligibility.

For you budget folks out there, you will probably like this slide, I certainly do, as a manager, like this slide. Adopting these processes actually our clients like them but they actually save us money. We have computed very precisely that we save over $10 billion a year by adopting these renewal processes that I've described to you rather than doing a paper renewal process.

It costs us about 50-percent more to do a new application than it does to do a renewal. So for every person that we can keep in the program and do some kind of renewal on, we've saved money. For the administrative renewals at the bottom, we have 939,000 cases in our system. We were able to administratively review about 288,000 of those. I would need about another 160 eligibility workers employed in my system to be able to do those if I was still doing a manual process.

We have embraced technology in a big way and this has really helped us get where we are today but technology in and of itself doesn't solve your solution things. One of the things that we did do was adopt an electronic case record back 2004, it was fully deployed.

It has done a remarkable thing for us. It freed us up to do some of the business changes that I've been describing to you and if electronic health records does for the healthcare industry what electronic eligibility records have done for us, it will be worth every penny Congress spent on it. We pursued a paperless records for lots of reasons, lost records, really burdensome.

I used to have to work hard at the employee eligibility staff where the work was and I don't do that anymore. I simply move the work to wherever the staff are. All of the applications that are taken in the Baton Rouge area in my state

are actually processed in the small office out of central Louisiana. No one would know that outside of my office because I can simply moved the work very easily to wherever I have staff to handle it.

These are actually file records. Once we converted to our electronic file record, these were waiting to be destroyed, couldn't resist taking a photo of this. I don't spend money on file room anymore, used to spend anywhere $15,$18, $20 a square foot for file rooms. I don't need them. So I don't spend rental money on file rooms. I don't have the reason anymore. This is what enrollment has happened, as ours, look like in my state for the——I think I missed one, yes let me go back to this one.

I would like to tell you that I was really smart and that I built this electronic case record thinking that some day there might be a disaster and I would need it but it never occurred to me [Laughter] that there would be but I tell you I lost four offices in New Orleans stuff through Katrina.

I had over 35,000 of my recipients scatter to the winds, had 185 eligibility staff scattered to the winds but I only lost about 300 applications that had been received in the mail that day and had yet to be scanned into our system. Nothing else was lost of importance out of that process, a huge, a huge plus to have an electronic record.

This is the case load record; I'm going to move quickly, I'm out of time. These are the case worker, I mean enrollment records for the last 10 years and this is not going to change under national healthcare reform. If anything, it's probably going to accelerate a bit and even go up. This is the delta between the staff, the eligibility staff that I have and the workload.

The system should be under tremendous stress. We should be having problems keeping up with the work and we should be having problems with the quality in our system but we're not, at least not yet. I don't know how long we can keep this up but so far the processing times are good and the quality is very good and it's because of these investments, because we have reinvented our eligibility model. If we had not, we would be drowning.

As much as I've talked about technology, I want to tell you very quickly that the case workers are more important than anything else. I have a little bit over 500 eligibility workers. They have, on average, about 17 years of experience each. They're really, really good in what I try to use them for I need them for and not to use them doing busy work.

So I keep them involved in things that are really important around those tipping points that I talked about. We spent a lot of time since we mostly insure children talking to

our eligibility staff about parental apathy. I wish the world was as full of perfect parents but it is not. We have to realize that sometimes that we need to go the extra mile when at parent who should be doing these things does not for whatever reason. So it's part of our internal marketing especially when it comes to children.

Just so that if you're concerned that all these changes have resulted in us throwing the baby out with the bath water, I used to work program integrity for a long time, so I'm always very conscious of program integrity issues and we have a very, very good error rate. I'll take this one to the bank any day. I've started this slide of where we were 12 years ago and at the end, I kind of want to take you where you are today.

We still have challenges. We still have a very poor state. We still have dismal outcomes in our healthcare delivery system but we have done remarkable things to get at least the children in our state insured. We're some of the best in the country now at doing that. So we've come a long way in a dozen years.

I think there are lessons through this, things that we have learned over the last 12 years that will certainly help us deal with federal exchanges that I'll be dealing with and certainly help us be ready for national healthcare reform when it comes. It is a puzzle. It isn't just one thing.

It's just not technology. It's not just redefining your business process. It is a bunch of things and it's a puzzle. You need all these pieces to make it work. I know I'm out of time but thank you very much. I appreciate it [Applause].

ED HOWARD: Great, thank you Don. Now you get a chance to ask the questions that have been burning in your head for the last hour and 10 minutes. There are, as I mentioned microphones on either side and you can infer from Ebby holding up the green card that if you hand her that card, it will end up, up here, the other staff the same way. If you do come to the microphone, we do ask that you keep the question as brief as can so we get more time for more questions and that you identify yourself. There you go. Why don't you go ahead?

ROB NELB: Okay, thank you. My name is Rob Nelb. My question was, I was hoping the panel could talk a little bit about some of the coverage coordination challenges for children particularly children in CHIP whose parents will be in the exchange and I guess one of the recommendations was encouraging states to take up the basic health program for those under 200-percent of the federal poverty level and I was wondering about the coordination challenges there as well between basic health program and CHIP.

ED HOWARD: Go ahead Deborah?

DEBORAH BACHRACH: Well that's the question, I mean that it's for children and for adults and I think one is to the extent we have plans that are offering all products that, of course, makes it easier. So I mean I think that is really a goal that every state has, which is to have at least one option where a family can be in one plan so that right there children are in CHIP and plan X and the parents are in QHP with a level of subsidy in the same plan. Then when an income changes or if CHIP is eliminated then the child either moves into the QHP or the BHP.

I do want to say I think one of the challenges with the BHP is if we don't do it right, we're going to have more points at which families and individuals might lose coverage instead of once going from Medicaid to QHP or go from Medicaid to BHP possibly lose coverage, go from BHP to QHP. So I think BHP is a tremendous opportunity if done right.

MALE SPEAKER: Yes, thank you to all of you present today. My question is directed at Mr. Gregory. Just one of the things you mentioned was about 500 eligibility workers and about 17 years' average experience, where a lot of states are maybe in a similar position, lots of people have been doing it the same way they've always been doing it and obviously you've done some really great things, congratulations.

Can you just give me a little more detail on exactly how you've increased the ability of case load per worker and kind of what's your length of time for the application process and that sort of thing. Thank you.

DON GREGORY: Be glad to. It certainly wasn't easy. It never is to make major cultural changes within a bureaucracy especially when you change something that's been in place 40 years or more. We actually were the benefactor of the Robert Woods Johnson Foundation grant that we used to deploy a Toyota-style continuous process improvement. We brought in some facilitators that help us do that and we have employed a full-time person that's their sole job is for continuous process improvement and working with our staff.

It's a bottom-up. At first, our staff didn't really believe that they could have a voice in the way that we do things but, over time, we convinced them some of the very best ideas come from frontline workers and frontline supervisors. Once we had some early adapters that would try something new and found ways to work, we did a lot of small-scale testing where we weren't scared to fail and we had lots of small failures along the way but it was basically a long process.

It was not easy. There were some people that moved to retirement rather than adjust to the new processes but they saw the benefit. They were the ones that came up with the ideas,

for the most part, of things that we were doing. So it's kind of been that cultural approach.

ED HOWARD: Yes, go ahead Stan.

STAN DORAN: Yes, Stan Doran from the Urban Institute. First I want to congratulate the Alliance and Commonwealth for a phenomenal panel, just really an extraordinary group of presenters. So thank you for doing this for all of us. I have a question about the notion of Medicaid plans in the exchange because that has a huge amount of appeal but I am worried about the issue of provider reimbursement, which Deborah pointed out and the concern is largely because of Medicaid provider reimbursement rates far below private levels. If you control for risk and you look at a working population, private insurance is about 30-percent more expensive than Medicaid. So here's the concern.

Suppose you have a Medicaid plan in the exchange and it's paying its providers Medicaid rates. Suppose that plan winds up being the second lowest cost silver plan, which is the reference premium. Well the amount that everybody pays in the exchange, is your subsidy recipient is based on part on income but also it's based on the difference between the reference premium, that second-lowest cost premium, that's a silver plan and whatever plan I enroll in.

So if Medicaid comes in and not withstanding more comprehensive benefits, offers a product that's much cheaper than private insurance, my fear is that people in the exchange up to 400-percent FPL, will find it extremely expensive to enroll in standard insurance. Maybe that's okay but I think it's something that concerns me.

DEBORAH BACHRACH: This is the second time this issue's been posed to me. I really have to dig into this more Stan so we have to have a longer discussion but I don't think that it's likely that, let me skip back, when I talk about Medicaid and the exchange, I don't necessarily think that the Medicaid plan is a QHP.

You can have a QHP that is offering a Medicaid product but I don't believe that Medicaid product will become your second-lowest silver plan. I think that's what we have to look at so that we avoid the problem that you're talking about because I understand the risk of it but what we have to do is figure out how to address it because the answer can't be, and I think you'll agree with me, what we don't put Medicaid into the exchange.

STAN DORAN: Right but that too has a problem to the Medicaid agency because for that to achieve continuity, the Medicaid product offered to the QHP has to be a Medicaid contracting plan, which the state pays for and if it's the same

provider network with high payment rates that means the state Medicaid agency is going to be on the hook paying 30-percent more than it does or a huge percent more than that—

DEBORAH BACHRACH: Well I think that's the issue we have to grapple with because again, I think we agree on the goal. The goal makes sense and it may be that it places some, don't kill me Don, upward pressure on Medicaid rates. Maybe it brings down some of the, if I can, overpayment by the commercial plans and it begins to shake out but I think it's the discussion we have to have in order to bring Medicaid into the coverage world.

DON GREGORY: Stan, I'll add, from a Medicaid perspective that Medicaid is not always the most robust payer for sure. I can get away with that when I have a fairly small market share because the Blue Crosses and the Humanas of the world make up for what I fail to pay my private hospitals. I'm paying them about 70-percent of their costs currently in my state. I don't know that I'll be able to continue to do that once national healthcare reform's fully up and we recognize that now. So this is going to make Medicaid a better payer for services than it's historically been.

PAMELA FARLEY SHORT: It's an excellent point and I think it also points to the importance of keeping close eye on quality measures and measures of the quality of the network an

the size of the network especially if we're paying less. I mean if we can get away with paying at Medicaid rates and get the same network as you get with commercial payers that would be nirvana but that's probably not likely.

ED HOWARD: Robbie go ahead.

ROBBIE WHITLOCK: Robbie Whitlock with Senator Grassley, Medicaid staffer emeritus I think. During the '09 debate, there was a floor chart that I thought was particularly insightful that really got in the question of did the Affordable Care Act create a wall effectively between Medicaid and the commercial market, the above 133/138 market and ultimately is it going to be a bifurcated system?

This panel and this whole presentation certainly talks about the way to break those down but the folks who really can best speak to this, with due respect to the panel, not meant to insult you all in any way, but the folks that most speak to this are the insurers and CMS. AHIP in 2009, before the Baucus roundtables back then, which seems like a million years ago, testified that their commercial plans, their non-Medicaid market plans did not want to cover individuals in Medicaid.

So the folks that you can lay out that an AHIP commercial plan could ease the transition, bridge the wall, since we're working in metaphors here, between the Medicaid individuals and the commercial market and solve a lot of the

problems we're talking about here because functionally that would, again break down the wall and someone stays in the same coverage, same doctors, and all it is, is a payer and it's all behind the curtain. Black box, they don't know what happens, just the payer changes but that presumes that those plans will participate.

The second half, you have the Medicaid payers and I think it's pretty obvious, the ACAPs of the world, Meg Murray are you here before I insult you, Meg Murray, okay she'd be perfectly happy having a monopoly in the state up to 200-percent. She also has the advantaged position of being nonprofit, which she has over for-profits.

So they would be an advantaged position to do that but one of the interesting things on the BHPs and their development is whether or not the providers in the state are going to get wise to what could happen here and use their lobbying ability state to state to try to tamp down BHPs because BHPs necessarily to work, are going to have to work on payment rates similar to what are done in the Medicaid managed care market.

Then the other side of the equation, of course, is CMS. CMS has to create in a regulatory environment where any of this will work because they can't effectively, and I would argue and Cindy's reinterpretation in 1937 to cover transportation, absolutely makes it difficult for a commercial AHIP plan to

want to play in the sub-133 space and that they can do the same in choosing to try to morph basic health plan to benchmark plan.

So again, respectfully you guys are a good panel but the people who actually decide this are going to be the plans to participate and CMS and whether or not they're going to create an environment that allows it, very curious to your reaction Deborah since you're not—

DEBORAH BACHRACH: Well you made a lot of points. So let's start with commercial plans do not want to participate in Medicaid. Now there're lots of reasons why commercial plans may not want to participate in Medicaid and I think we have to piece them apart. I'll give you one example, which is that the states are not always a good partner and if we're going to be running Medicaid, my terms, mission-driven, fiscally-disciplined health insurer, I have to be a good partner. So we need consistency. We need transparency and we need accountability. So the state has to be a better partner.

Two, when you look at the numbers, because there will be so many more Medicaid beneficiaries in this country by 2019, 14, pick your date, you are seeing commercial plans looking at this business opportunity much more than I ever expected across the board. In fact a lot of the pure-payer plans are getting

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very nervous because more commercial plans are looking at Medicaid.

On the BHP point, some of the modeling that we're involved with is we're assuming provider rates that are 120-percent of Medicaid so that it actually genuinely a bridge if Medicaid's 100, we're looking at BHP at 120 and let's say commercial, 130, whatever the numbers are. So I think it may be a way to become the bridge.

It may deal with what Stan talked about, which is we can start to bring the provider networks more in line. So I do think that we can effectuate this. We can have those discussions with the providers, the commercial plans, and the pure Medicaid plans, and again I think we have to. We're having the same conversations with CMS, how do you create the regulatory framework that enables that.

ED HOWARD: Didn't I read last week that Blue Cross of Florida was entering the Medicaid market for the first time statewide? I don't know, is that a harbiture of something that's going to be happening more often?

DEBORAH BACHRACH: I also think the more we talk about Medicaid and the exchange and continuity of coverage across plans that too will peak the interest of the commercial market more.

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FRANK MITCHKAE: Hi, my name is Frank Mitchkae with McKenna, Long, and Aldridge and I had a question slightly variant from what we've been discussing but I think it has to do with churn. Do you anticipate that the shop exchanges will be screening employees who enroll for Medicaid and their children for CHIP and if so, how do you think that'll affect both the churn issue and the sustainability of the shop exchange pool?

ED HOWARD: Would whoever answers also start by explaining what a shop exchange is?

PAMELA FARLEY SHORT: Those are the small employer exchanges.

DEBORAH BACHRACH: I don't know the answer to this. I was hoping somebody here would jump up and answer it. So I think I'm going to duck the question because I don't know enough about shop exchanges to give a smart answer but I think it's a good question.

PAMELA FARLEY SHORT: We haven't seen the systems yet or all the rules but certainly the concept is that there will be a one place in the state that everybody can go to figure out what they have coming to them and to my way of thinking that wouldn't make sense if it excluded the shop exchanges.

KEN FEINGOLD: Ken Feingold, HHS/ASPE. I wanted to ask Don Gregory to explain his Governor's rationale for not

establishing a state level exchange and I wanted to hear what the rest of the panel thought about, whether it's a good thing or a bad thing, for other states to make the same decision that they're going to let the federal government do it.

DON GREGORY: Oh not an authorized spokesperson for our Governor. I'm actually not an appointed official by our Governor, so I wouldn't presume to speak for him.

ED HOWARD: Don, nobody will know [Laughter]. This is completely off the record. The web cast doesn't mean a thing [Laughter].

DON GREGORY: From a Medicaid Director perspective, I'll tell you this. I was rather agnostic about it. It didn't really matter to me much whether I dealt with a state exchange or a federal exchange. It's still going to be pretty much the same process for me, the same grids that I need to cover. At least I know early who my partner's going to be and I certainly will be engaging CMS on the dialogue on how we're going to make that work but it was interesting, I think at least in the press releases that I read about the decision, it was the unknown that was driving it. There were so many unknown factors was the rationale that they gave for their decision.

DEBORAH BACHRACH: I would just add to what Don said and he alluded to is that all of the requirements in the ACA and all of the guidance that has come out of CCAIO and CMS have

been absolutely clear that the integration of the eligibility systems is required regardless of whether it's a federal exchange or a state exchange. It's a requirement that's imposed on state Medicaid, so it has to happen. I think it may be more awkward if your partner is in Washington and also you're bringing the federal exchange into your insurance market because has obvious implications.

ED HOWARD: Let me just add to that, a few weeks ago, Joel Ario, from CCAIO, who has something to do with the way exchanges are going to end up at the federal level, made the point that in states where the state either chose not to operate or HHS found them inadequate to operate. In both cases that defaults to the feds that HHS intended not to make it a one-size-fits-all operation that they would work very closely with each individual state to try to tailor that exchange to the needs of the rest of the operation.

ED HOWARD: You want to identify yourself young lady?

Female Speaker: I'm a health policy journalist. You've talked a lot about we've come in the last 12 years and gains you made. Can you talk a little bit more in detail about what you do have to do to your Medicaid staff to get ready for January 2014?

DON GREGORY: I know that advocates are deeply concerned about outreach and enrollment. We're very good at

that. So that doesn't keep me up at night. I think, matter of fact, I kind of know where that population we're going to be bringing in is getting their healthcare now. They're getting it through free care clinics in our state that we're very familiar with. They are also getting it from FQHCs.

So we know where that population is getting their care now and so I'm not so worried about reaching them and getting them enrolled in my system. I'm a lot more worried about what kind of network we'll have available of providers to treat them than I am about getting them enrolled.

It'll be more of the same. We certainly learned lessons. We certainly can't use a paperbound process. We know that even at our best intent, we're going to have people in blended families that will be bridging these programs. We're going to have people in the exchange and they're going to have maybe stepchildren in CHIP and their children in Medicaid, I don't know. It's going to be a blended world. So we're going to have to recognize that we're going to have to go the extra mile to help those families that are in multiple situations and multiple plans.

ED HOWARD: Yes go ahead?

JILL WEXLER: Jill Wexler with *Managed Healthcare Executive Magazine*. I believe in the 1099 legislation that was passed a few months ago that individuals who get subsidies and

then earn more money in the following year now will have to pay that money back. I'm wondering how you see that adding to the complexity or the attractiveness of these systems.

ED HOWARD: Let me just add that the complexity of that, one of the points that was made in our discussion of ACOs last week was the need for timely data. It seems to me that's another instance where we're going to need very timely data and if you got an open season in the fall and a tax filing deadline the following spring referring to the previous year, you got some problems. Pam, you want to start us on that?

PAMELA FARLEY SHORT: Yes, you're absolutely right. As it was originally passed, the Affordable Care Act did require people to pay back some small amount of the premium credits that were advanced to them in the exchanges if their incomes turned out to be higher then anticipated. The starting point for that is really that the premium credits will be calculated in advance at this fall open season so that people know, at least have that much information about what the government is going to kick in through the premium credits and therefore what they might have to pay if they sign up for insurance in the exchanges.

Since not everybody has that kind of cash flow sitting around, the credits will be made available in advance rather than saying okay, you sign up, pay for it, and we'll pay you

back at the end of the year when you file your taxes but ultimately the premium credits that people receive will depend on the income that they earn during the coverage year, which will not be known until they get to the end of the year and they're filing their taxes. So where people's incomes do increase appreciably, they could end up having to settle up with the IRS at the end of the year.

I have some, to be honest, I have some real concerns about having, expecting people to pay back a lot and expecting people to make decisions about buying insurance when they don't know what it's going to cost them. I mean my feeling is that this is ultimately a voluntary system and that, that payback will have a chilling effect and keep people from signing up for an insurance. There are some things that could be, and there's certainly the administrative cost of getting that money back.

It's not clear to me that it wouldn't be better even to reduce the, if you could, in a budget-neutral way, kind of figure out what you're going to get back and the payback or some part of it. If you even made the subsidies a little less generous but certain upfront, that might actually do better in terms of getting people to sign up and they would certainly be much happier not getting to the end of the year and doing their taxes and saying oh gee I owe a couple thousand dollars. These

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are not families that mostly are going to have a spare couple of thousand dollars laying around.

DEBORAH BACHRACH: The flipside too, people whose incomes' actually drop get more subsidy. So there's that.

PAMELA FARLEY SHORT: Well that's true, they get more subsidy but if they were way off or noticeably off, the fact that they weren't going to get that much subsidy might prevent them from signing up for a plan in the first place and then there wouldn't be anything to subsidize if you don't get them in.

I did some simulations of this in an article that's referenced among the materials and it actually turns out that not requiring people to pay back the subsidy is a good way to encourage participation in the voluntary system because you're talking about people who have more income than they expected and if they don't have to pay it back, they've got the subsidies and they're the people who are most likely to use that extra income in keeping with a little more generous subsidies to sign up.

ED HOWARD: Pam, we had a question on a card that's related to this. You had mentioned that states could choose to extend coverage for Medicaid to the end of the year to help align the time periods and the question is what authority or flexibility do the states have to do that and let me just add

to that, the question of whether or not states have any flexibility or power to deal with the exchange subsidy problem that you just outlined in a similar way?

PAMELA FARLEY SHORT: Well the exchange subsidies are federal through the tax system. So the states don't have direct say over that. There is a program called Transitional Medical Assistance that allows people who lose their Medicaid eligibility because of an increase in earnings to stay on the program for a while.

I mean one of the things we haven't really said is that when people go to work or they earn more and you penalize them for that by taking away their health insurance, it can have a chilling effect in terms of whether or not they are going to earn that money, maybe even a bigger effect on whether or not they report earning that money. So that's a general concern and one that's already been acknowledged in the transitional medical assistance.

Then as well, there are some options for 12 months of continuous coverage that have been built into some of these programs and it's sort of in that same spirit that, so I think there is the flexibility without through decisions that CMS would make or existing authority for states to keep people on.

There was mention of walls dividing people from Medicaid from commercial insurance but I want people to also

have in mind that this is a hugely dynamic process that we live with right now. Something like a couple million people every month are uninsured and get coverage and another couple million people lose their coverage. People move in and out of Medicaid all the time.

That doesn't happen and many people who are uninsured are uninsured for relatively short periods, I think about half of them for six months or so. So there's a lot of turnover, a lot of churning that occurs within this one year window that the ACA has in mind. Part of our challenge here, where we really can make a difference, is to keep some of that from occurring and let people stay in place for longer periods of time up to a year. That would be a real improvement to be able to stay in place for the rest of the year let alone move on eventually from Medicaid to a commercial plan.

CARL PULZER: Thanks Ed. Carl Pulzer, American Healthcare Association and just a note, when policy makers are thinking about policies like continuous eligibility to help promote continuity of coverage and care and reduce churning, just to think about, this goes beyond the exchange because Medicaid's going to intersect with private health insurance in a much greater way all across the market not just in the exchange but in every workplace in America as folks are now eligible among the low-wage workers.

So employers have an incentive to educate employees about Medicaid. What happens in the same way in the workplace when wages go up or family income changes, family composition changes, the same issues arise about continuity. So when we think about just a question, I guess, in the form of an answer whatever, when we think about these policies, they need to be thought about maybe across the whole market with the exchange as a very important part of that, just your response. Thank you.

DON GREGORY: I think that's not commonly known that a large number of the people that are currently Medicaid-eligible also have private insurance and Medicaid often is a second payer for those services. I know that one of the things in my state, there are probably 230-plus thousand individuals that are Medicaid-eligible and also have private insurance and all that Medicaid pays is the co-pay and reduce for those individuals. We want them to keep that private insurance.

So we have a very vigorous program where it's cost-effective for us to do, we will pay their insurance premiums so that they can keep that private coverage because it's cheaper for Medicaid to do so.

DEBORAH BACHRACH: I mean I agree. I think that again that the theme is consistency across programs and so that Medicaid has to interface with the employer coverage is

absolutely right and then we have to think about the individual who turns 65 may remain eligible for Medicaid and becomes a dual eligible just the way they're getting commercial coverage or employer coverage and they become 65 and Medicare comes into the picture. So this is both the opportunity and the challenge that we face right now and we have to think beyond the walls of the exchange even as we bring Medicaid, in my terms, into the exchange.

SARA COLLINS: I also think that I'm clear how many employers are actually going to come into the exchange and buy their employees coverage. I mean the states have the option to expand exchanges to employers with more than 100 employees starting in 2016. I think there's a big question mark about I think employers are eyeing this as a market shaper potentially.

So we may have a case where we have a lot more employers bring in their employees into the exchange and that raises a lot of questions again for these transitions that Pam points out in her paper, allowing merging those exchanges, merging the two exchanges, the individual and the small and the business exchanges so that people, when they change their job and but it on their own, can actually still buy within the same marketplace, the same exchange without having to move to a different exchange.

So I think that the employer piece of this is really kind of a wild card in how that pie chart that I showed where people are gaining their coverage, how much of that employer coverage is actually going to be purchased through the exchanges.

JIM KAUFMAN: Hello, Jim Kaufman with the National Association of Children's Hospitals. Deborah, you made a comment about the modeling that you're doing is basing Medicaid at 120-percent to look at access. Well right now Medicaid pays, on average, about 30-percent less than Medicare. So even at 120-percent, if I'm doing my math correctly, it's still going to be 15-percent below Medicare for the exact same services.

Don, you made a comment about how Medicaid is going to be a growing market share, do you think states are going to have to deal with their Medicaid reimbursement rates to actually ensure access to care as the market grows or as they're adding more Medicaid beneficiaries to the program in the same direction, have to go in the opposite direction to deal with their budgetary pressures?

DON GREGORY: No, I actually think the former. I think when we have a larger market share, we're going to have to do a better job at being a payer for services than we do today because quite frankly, Medicaid, and no one likes to say it out

loud but Medicaid's been a cost shifter. Medicaid's been underpaid and other insurers have picked up that underpayment over time and not only in my state but every state that I'm aware of. As Medicaid becomes a bigger part of the market, it simply is not going to be able to do that.

DEBORAH BACHRACH: I agree with what Don said and I would add to that, I think Medicaid has to be a smarter payer as well so that we know and you know that in pediatrics, obstetrics, and mental health, we are a major payer and how we pay dictates access much more than how we pay for cardiac surgery. So we have to be cognizant of that. We have to know where we need access and where we can't do across the board increases or decreases and two, payment methods can be as important, and this is another one of my favorite themes, as much as payment levels, it's how we pay.

We still have states that are paying based on institution-specific cost basis, or paying per diems, or paying off of base years that date back to the 1980s. So I think Medicaid ahs to be a smarter payer and includes payment levels, payment methods, then we have to move into and then we can move into some of the more innovative payment policies that we see emerging now from CMMI.

ED HOWARD: Sara and I have about 650 green cards with questions. So I urge you to go to a microphone and if you want

to be absolutely certain that your question gets asked. In the meantime, Sara, if you want to pick one out, I've got one that I've been dying to read. It's a hypothetical situation. A man and a woman have three children but do not live together.

She has the children. He is obligated to support them but cannot claim them. She is in poverty with $22,000 a year in income. He is out of poverty at $10,000 a year in income. How will he buy insurance? How will he pay the penalty? How will he eat [Laughter]? Any suggestions for this gentleman?

DON GREGORY: We would, in an eligibility process, particularly looking at the wife and the kids and we're not so concerned about how he eats, we would be looking at [Laughter] the income that's available to him in determining their healthcare coverage if he's not contributing, not doing what he's obligated to do. We certainly wouldn't hold the children and the spouse accountable for that.

ED HOWARD: There are affordability provisions in the ACA that, are there not Sara that allow you to avoid the impact of the mandate?

SARA COLLINS: That's right. So at $10,000 income, I'm trying to understand, he would be eligible for Medicaid under the law and I'm not understanding the family composition implications because I don't know the eligibility, how that will work out. If she were to apply too with $22,000, she is

also eligible for Medicaid under the law. So both of those have no premium obligation, very little cost sharing obligation, so they're moving into a world that they're much more protected than they are today. Eating will be much more possible under [Laughter] 2014.

DEBORAH BACHRACH: On $10,000 in income.

SARA COLLINS: Yes, right.

ED HOWARD: As we get to these last few minutes of Q&A, I would urge you to both listen to the answers and fill out the blue evaluation forms as you listen. Sara, do you have any card questions that are right at the top of the list there?

SARA COLLINS: There's a question about the premium credit provisions in the law so that the credit, do the credits cover the entire premium? What does it mean when it covers two to nine-and-a-half-percent of income? What does that mean in terms of share of the premium that people are actually responsible for paying for?

PAMELA FARLEY SHORT: Well the share that people are responsible for goes up as income goes up. So it's graduated with income. So that's the first point. I'm kind of forgetting what the rest of the question was.

SARA COLLINS: So essentially the income caps people's premiums. The premium caps cap people's premium contributions as share of their income. So that will break out into a

certain percent of the income, for certain share of the premium and that goes up as their income goes up. The Commonwealth Fund has done some analyses of these and the share is really quite high at lower income levels and it predictably goes down at higher income levels.

An important provision too in the law and it's not gotten a lot of attention is how these are adjusted over time. So my understanding originally, at least under one of the bills early on was that people's premium obligations would be fixed in their first year. So your cap would fix it in your first year and then as premiums grew over time, the share of the premium would actually remain the same. So you might end up paying more as the share of your income, over time, as the premium growth rates are adjusted but I think that's somewhat of a complicated issue.

ED HOWARD: This one is originally targeted to Deborah. What information do states need to make decisions about the basic health program? when can we expect to know which states will choose to run a BHP and do you know if CMS has issued guidance on that subject?

DEBORAH BACHRACH: CMS has not issued guidance yet and there an awful lot of questions because they start with 95-percent of what, because you get 95-percent of the subsidies that otherwise would have gone to these individuals. So we

have to figure out what's the 95-percent of what. We need to know if the offset for cost sharing is at 100-percent or 95-percent. None of that is clear.

Then we have to model whether there is enough dollars available in order to provide a benefit package that is at least enough to make any sense, it has to be richer than what the individual would have access to through the exchange. Then the question will be what plans, what provider networks? So there's some amount of information that needs to be, we need to hear from CMS on.

Another one, and Stan brings this up in his paper, so I'll give him credit for the first one to alert me to this, I got your attention, was how do we do risk sharing? Can we use the same risk sharing between BHP and QHPs, which would mitigate the loss of individuals from our exchange or QHP population. So that's an open question for CMS but states are starting to do the modeling even with the open questions with respect to CMS at this point.

DON GREGORY: Now I would like to add, on the Medicaid side, they have this new eligibility process for families and children where it's MAGI, modified adjusted gross income, and CMS has yet to define that. We do know that our current eligibility systems will not do that whatever it is.

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We've taken a guess that it's in our S1040 line 37 and we've done a gap analysis between our current eligibility processes and what that looks like and we're working with that assumption but if CMS doesn't fairly soon make some kind of definition of what MAGI is, where the states are going to be in deep trouble. I've got an issue and RFP this summer to revamp my eligibility system to do MAGI and, as I said here, I don't know what that is.

ED HOWARD: Could somebody just spend a minute or so explaining why that got put into the law and what impact it has on the current state operations in Medicaid in figuring income eligibility?

DON GREGORY: I think it was to provide a uniformed standard for income across the states because every state has been free to kind of adopt its own processes. It causes a complication for us, at least, in our early analysis inasmuch as if we're guessing correctly that MAGI's a 1040 line 37. We've done the analysis and we know there are some children that would be disadvantaged by that income process that are currently eligible but will not qualify under MAGI.

Well there's a maintenance of effort standard under ACA, which means that we may have to run a double eligibility process for any kid that doesn't qualify for under MAGI to run them through our current processes to make sure that they're

not disadvantaged under the new rules. So that really makes it more complicated to build an eligibility system that will do all of this.

DEBORAH BACHRACH: Yes. I think we're expecting CMS guidance on this by the end of June is what I understand not that I have any special information. I think coming back to the reason for MAGI, which is part of an effort, at least as I understand it, to simplify the process for individuals to secure an eligibility determination and to enroll in Medicaid and consistently, that I'm cautiously optimistic that the regulations and defining MAGI and defining this shadow system will actually eliminate the need for shadowed system so we can use things like proxy because the overarching message of the ACA, as I read it, is that we want to streamline the eligibility enrollment process so individuals who are eligible for coverage can get on coverage and keep that coverage.

PAMELA FARLEY SHORT: I believe it was, in part, to help facilitate the coordination of Medicaid eligibility with eligibility for the premium credits, which will be in the framework of the federal tax system. So the numbers all work out. Under 133-percent, you're on Medicaid. Then you switch over to premium credits but if you're not defining income with a consistent yardstick, you can have gaps and overlaps and that's not something that anybody wants.

ED HOWARD: Question about something that has been raised earlier. Can you speak to the issues associated with Medicaid eligibility being based on point-in-time income versus the subsidies being based on annual income over the course of the year in which they were received? How do you make that work?

PAMELA FARLEY SHORT: Well I think this is one of the other things that CMS is going to have to speak to but the legislation has a specific provision that says there's nothing here related to modified adjusted gross income, means that states can't continue to evaluate Medicaid eligibility based on income at time of application but exactly what that's going to mean, I don't think we know yet but that will be critical.

Again, it's this idea, you can imagine people moving along a yardstick that's measuring their income and, at some point, you pass a line and you move from one program to the other. It's not going to work if we have two different yardsticks and one's in meters and is in the metric system and one's in the old English system. We got to have a consistent way of measuring.

ED HOWARD: We got a question here that looks like an appropriate panel ending question [Laughter]. If there was one thing you'd like to see CMS include in the regulation on exchange and Medicaid eligibility to keep coverage continuous,

what would it be? I can ask another question to give you time to think about that question.

DON GREGORY: I can tell you one of the things that has certainly benefited us in our processes is we adopted early on the 12 months' continuous eligibility. We also adopted a rolling renewal. Whenever we have an opportunity to have interaction with a family for whatever reason, if they call up to report a change of address, somebody moved in, somebody moved out, we'll take that opportunity to ask a few quick questions and renew their eligibility and extend it for another 12 months.

So both that 12 months' continuous eligibility and rolling renewals whenever we have an opportunity for contact have been critical in reducing churn and keeping people on our rolls for an extended period of times.

A point that I didn't make in my presentation is so critical about churn is if you don't have 12 months of continuous eligibility, you can't do HEDIS measures. So you don't even know how good the quality is with the healthcare that you're delivering to the people in your eligibility system because it can't be measured. So you've got to have at least 12 months of continuous eligibility to even know if you're improving the health outcomes.

ED HOWARD: Let me just clarify, Don, you have the power to do that now and other states could do it without CMS having to do anything additional right or not?

DEBORAH BACHRACH: Yes, yes for children, for adults it's a little bit more complicated. It took us a long time to get CMS approval to do 12-month continuous for adults but you can do it very easily for children. So I agree with everything Don said and then I would come back to this issue of point-in-time versus annual calculation of, 12-month calculation of income eligibility that needs to be resolved consistent across Medicaid and exchange subsidies with an eye towards the payback issue that Pam spoke to but if you put all of that together, we're moving towards a system where individuals can get on and stay on without fear of losing coverage or out of fear of an unaffordable payback.

PAMELA FARLEY SHORT: Yes, I think the vision that I'm pushing is one where most people would be able to sign up for insurance in the fall or sign up for insurance and know they're going to have it for the next year and that they would get help paying for that through these various mechanisms also in a way that would be as predictable as possible and frankly, to the extent we can afford it, I think it needs to be as generous as possible.

This is going to be a voluntary system. If we don't want to hit people with a club, if they don't get coverage and we want most people to be covered then we have to make it as easy as possible for them to sign up. We have to give them as much help paying for it as we can afford.

SARA COLLINS: I agree with what everyone on the panel and I also hope that on the recruitment issue that CMS pays very close attention to Pam's issue brief on all the ways that we can actually improve this and make it easy for people to keep their coverage even when their income changes. Also I think a point that Deborah makes that I hadn't fully grasped was the ACA requires eligibility coordination across the different kinds of premium subsidies in Medicaid enrollment but not so much on the enrollment side.

So I guess I'd like to see an emphasis not only on coordinating the eligibility but making sure that the enrollment, people choose plans within the exchange regardless of whether they're eligible for Medicaid or for private subsidized coverage.

ED HOWARD: Okay, there's the agenda. We can come back to it in a few months and see if CMS paid any attention to us. Thanks to you for—

PAMELA FARLEY SHORT: Send them the video link.

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ED HOWARD: There you go and to reiterate what Pam was referring to, you can watch the web cast of this on Monday at kff.org and relive every wonderful moment including pictures of you filling out the evaluation forms [Laughter], which if you haven't done yet, we'd appreciate you doing.

Thanks to our colleagues at the Commonwealth Fund, most specifically Sara, for helping shape this, putting the paper in Pam Short's capable hands to get the information in front of us. Thank you for sticking with what can have been a pretty technical discussion of insurance markets and eligibility rules. I'd like to ask you to help me thank the panel for answering those tough questions [Applause].

[END RECORDING]

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