ALLIANCE FOR HEALTH REFORM

Children's Health Coverage: Medicaid, CHIP, and Next Steps

Alliance for Health Reform
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ED HOWARD: My name's Ed Howard. I'm with the Alliance For Health Reform. As you can hear, the acoustics in this room are not the greatest, despite the beauty of the room innately, so we're going to ask our speakers and you, when you ask your questions at the microphones to speak slowly and distinctly. Stan I know that's a problem [laughter] at least the first part.

I want to welcome you on behalf of Senator Rockefeller, and Senator Collins, and our board of directors, to this program on how well the public and private sectors are working to get America's kids covered.

I want to thank you for braving the weather. I want to thank you for overcoming your triskaidekaphobia, and we're going to, I think, have a great program today.

Now we know Congress took a big step forward early this year with the reauthorization of the Children's Health Insurance Program, CHIP, accompanied with a major increase in funding and some other provisions that are designed to bolster enrollment.

We also know that despite erosion in employer-sponsored coverage, between 2007 and 2008, and despite shortfalls in most states budgets, the number of uninsured children was actually reduced in that period by something like three-quarters of a

million children. But 8 million remain uninsured in the US last year, and most of those kids are already eligible for either Medicaid or CHIP.

And we know that there are kids coverage improvements in the pending reform bills in both houses, which is why—all of those factors—that we thought this was an appropriate time to take stock of how well children are getting their health coverage these days. Our partner in this examination is the Robert Wood Johnson Foundation which has been helping improve children's coverage for many years as part of their mission to improve both health and healthcare in America.

Some of you may have been familiar with the Covering Kids Initiative, followed by the Covering Kids and Families Initiative. I think there's a piece in your packets from that project. And they help spur efforts around the country to sign up and retain eligible children for the available programs, and the foundation continues to support research and programs on this topic today. I don't think we have anyone here from the foundation do we?

Well thank you for your support and for helping us to frame this issue as well. The folks at the foundation have been very helpful.

Just a word about today's program, we have three terrific presenters for you, whom I'll introduce in a moment.

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You'll hear about the current state of Children's Coverage from Jocelyn Guyer; you'll get the scoop of what's happening on the ground from Nate Checketts; and you'll hear about the relevant parts of the pending reform legislation from Stan Dorn.

Now these are all knowledgeable, very smart people. They have very definite views on many issues affecting kid's coverage. But for purposes of their presentations we've asked them to concentrate on what's actually happening; or in the case of the pending bills, what's actually in them rather than making the case for one side or the other. That doesn't mean they don't have opinions on these topics.

We have a lot of time for questions and answers, some of that will surely surface during that period, but we wanted to get you started with a factual basis first.

A couple of logistical items that many of you are familiar with: Monday you can watch a webcast of this briefing on kff.org, a service of the Kaiser Family Foundation. You'll find there also copies of the materials in your packets, along with the same materials on our website allhealth.org.

A few days after that there will be a transcript available through our website, and besides a lot of background material that you see in your packets and you can find on those websites, you'll find biographical information more extensive than the intros I'll have time to give our speakers today.

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At the appropriate time we're going to ask you to fill out green question cards if you have a question, or come to one of the floor mics and speak your question. And at the end of the briefing, to fill out that blue evaluation form to help us make these programs even better for you.

By the way, let me make just one more observation before we get going. We're going to try, beginning next year something many of you have suggested in your evaluation comments, which is, don't give us so much paper. And we're going to rely on our website, on which we will post all the materials—the background materials that we now run off these copies of, and give you printed versions of the speaker presentations and the bios and some other limited materials, and we'll keep you posted about that so you don't get surprised.

Now the program; as I said, we have a terrific group of panelists, nationally respected analyst's, people working on the ground. They're going to give a brief presentation and then answer your questions. And we're going to start with Jocelyn Guyer.

Jocelyn is the co-executive director of the Center for Children and Families at the Georgetown Public Policy Institute. She's done a ton of thoughtful work on issues of coverage for low income and vulnerable populations, and she's

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done it in several respected, non-profit organizations around Washington, as well as here on the Hill. Today we've asked Jocelyn to give us sort of a snapshot of where America is in health coverage for children. Jocelyn, thanks for being with us.

JOCELYN GUYER: Good afternoon everyone, thank you so much Ed for having me, and to the Alliance for sponsoring what I think is an extraordinarily timely event on where we are with Children's Coverage, and what health reform might mean for children.

My job today is to give you a portrait of where we are with kids, and thankfully it's a very pleasant job. I think in recent years there's been a lot of bad news about healthcare costs rising; rising numbers of uninsured adults and what's been happening with Children's Coverage is really a bright spot in these recent trends, and we'll talk about why that is.

I think for a quick overview, it reflects a couple of different things. One is the very strong public support out there for covering children. It's a pretty basic instinct. Americans feel strongly that our children should have health coverage.

And then this Congress and other recent Congresses have really made a substantial commitment to supporting efforts to

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cover children, and that is paying off in very concrete ways that I'll talk through.

In terms of where we are, I think it's helpful to give a basic portrait of how children are covered right now. If you look at the 79 million children in the United States, the vast majority are covered by employer-based insurance. That continues to be a basic source of coverage for most of our children.

I think in today's presentation we're really going to be focusing in on the one-third of kids who are covered through the Medicaid, and Children's Health Insurance program, as well as the remaining 10-percent of children who are uninsured.

As Ed said, the vast majority of those uninsured children are already eligible for Medicaid or CHIP, which is why you'll probably hear us talk a lot about the importance of making sure there are family-friendly ways to sign kids up for coverage. And then some of them are children in immigrant families—legal immigrants who may be barred currently from securing healthcare, or who maybe is undocumented.

To put a little meat on the bones of the very good news that Ed eluded to, some of you probably saw earlier this year, when the census bureau came out with it's report on trends in the number of uninsured in the United States, they reported that we have reached the lowest uninsured rate in children in

over 20 years. Again, reflecting that extraordinary commitment that's been made in recent years to cover children. What this graph does is show you the percentages. You can see the declines over time, and then the dark blue line is what's happening with children, and you can see that drop from 11.3-percent uninsured rate, down to 10.3-percent last year.

It's really important to know that that progress was made even as more and more families were losing their jobs and job-based insurance. And even as you can see from the top line, the uninsured rate of adults was climbing.

In terms of why we have that good news stories, it is because states across the country with strong federal support have opted to expand coverage through Medicaid and CHIP to relatively high levels; at least relative to what's available to adults. As you can see, basically the dark states—the darkest—there's three states that are not yet at 200-percent of the poverty line, but we've got 48 states, including DC that covered kids up to 200-percent of the poverty line.

Then we're increasingly seeing states decide that children in even more moderate income families need help purchasing coverage. And so at this point, we're actually at 23 states that cover children above 250-percent of the poverty line. So it's almost half of all states really deciding that even moderate income families need some substantial help.

The other basic backdrop that I think is critical to have going into this discussion is that Medicaid and CHIP really work together, and that's why we've seen progress in covering kids. What this graph shows you is that if you look at the enrollment in these two programs, there's almost 30 million in the Medicaid program, and there's 7.8 million in the CHIP program.

These are numbers reflecting enrollment over the course of a year, and basically what that means is there are about four times as many children on Medicaid as in CHIP. So as critical as CHIP is, and I'm sure we'll talk a lot about it today, the other really critical piece for low income children in this country, is what happens to the Medicaid program.

To give you some basics on it, folks may already know this, but states and the federal government share a responsibility for financing care for children under Medicaid through a matching rate structure. It is a federal guarantee to coverage, and critically, from a child health perspective, Medicaid offers the EPSTT benefit.

That's a very important benefit that's designed to make sure children get all of the developmental assessments they need, all of the health screenings they need, and if those screenings identify issues, to assure that they receive treatment and any medically necessary services.

It's been very important for low income kids, and we'll probably talk more about EPSDT in the health reform context. There are federal minimums for which children must be covered in Medicaid, and nearly all states have expanded above those, and done optional expansions of children.

CHIP came along in the mid-90s and provided states with additional federal funding to even further expand coverage. It did that by basically picking up a greater share of the costs of covering children. As Ed said, it was renewed earlier this year when President Obama signed the Children's Health Insurance Program Reauthorization Act into law in February.

A couple key differences from the Medicaid Program, it's a capped program. There's a set amount of money available to each state. States can use it to expand the traditional Medicaid program, and if they do that, eligible children are guaranteed a spot. Or they can set up separate CHIP programs, and those programs can be capped if the state runs out of state or federal funding.

In terms of the reauthorization, it extended CHIP through September 30 of 2013, and provided significant new federal funding, and I think it's taken off the table the prospect that there's any state out there that will run out of federal CHIP funding. I think there is enough money for states to cover the children that they decide that they need to cover.

Major new initiatives to reach those already eligible, uninsured kids that we've been talking about is representing two-thirds of the uninsured population. Overall, that legislation was estimated to cover an additional 4.1 million uninsured children.

In terms of the heart of where states are in their coverage, as I talked about earlier, 48 states, including DC are already covering children to 200-percent of the federal poverty line or above. To take it one level down, we're also seeing that that is very strong coverage; there's very strong affordability protections provided to children through CHIP and Medicaid.

Just to give you a rough sense, and it depends on your income level, and it depends on your state, but in a median state, a family of three at 200-percent of the poverty line is expected to contribute about .65-percent of its income; that's less than 1-percent of its income to purchase coverage for their children.

Cost-sharing when children go into youth services also is quite nominal; typically $5 for an office visit if anything. If you look at it from a little bit more of a broad picture perspective, what that means in terms of the actuarial value of this coverage—and that's kind of a measure of what share of cost the program covers, of covered benefits for an average

population. That actuarial value is 100-percent for children in the Medicaid program, for picking up really all of the medically necessary care they may need, and 98-percent in a typical CHIP program.

The benefits available to children, in many cases, mirror what's in the Medicaid benefits package; 22 states use the Medicaid benefits package for their children in CHIP. The remainder may have a somewhat more circumscribed definition of what they'll cover. Typically CHIP programs are covering the full-range of pediatric services that most children will need. So including oral care, vision care, hearing care, really critical services for kids that sometimes, if not often, are left out of private coverage.

In CHIP, as I said, it's not an entitlement. If you're in a separate state program, states can and have set up waiting lists. It tends to be very rare. At this moment in time, for example, I don't think there's any state that has a waiting list that is actually keeping children out of coverage.

There was a scare earlier this year with the large fiscal crisis in California. They did shut down enrollment for a number of weeks and subsequently reopened in the face of a fair amount of political pressure, that it was an unacceptable time to turn children in low income working families away from insurance.

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Over this past year, since CHIP was authorized, we've seen a very robust response from states, and again that is in the context of the worst fiscal crisis we've seen in decades. So it speaks to the resonance that this issue has out there in the states.

What this chart shows you is that over the past year or so, or over the several months since CHIP reauthorization passed, every single state except for just a few has held on to their coverage for children, and 23 have actually moved forward. So they've either expanded eligibility or done additional outreach efforts.

The other important piece of why this happened, and we may talk about this further, is along with CHIP reauthorization, there was a very important fiscal stimulus package passed earlier this year that gave states additional Medicaid funding if they did not cut back their Medicaid eligibility. And see that's part of why there's been strong, steady, coverage.

To wrap it up, I think a few key points to pull out of this experience on where we are with kids. The first is that this is a very strong track record. We really are making extraordinary progress on children, and there certainly is more to be done.

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There's still uninsured kids, and I think increasingly the conversation also is turning to how do we make sure that coverage translate into access to high quality care. So certainly I'm not suggesting to you that we're finished by any means. But there is a strong base on which to build.

If you look at what has contributed to that success record, a few key features; the very strong affordability protections that we see in CHIP and Medicaid have allowed families to sign their children up for insurance at quite high rates. The focus on making sure kids get benefits aimed at their developmental needs has been a key feature of the success of these programs.

Finally, as I referenced earlier, making sure that families have relatively easy ways to sign up for insurance, has been part of why we've seen the progress on children's coverage.

ED HOWARD: Thanks very much Jocelyn. Next we turn to Nate Checketts, who directs the CHIP program at the Utah Department of Health. In that capacity he's actually grown enrollment to over 40,000 kids; he's restructured the programs benefits and premiums to match private benchmarks, and created the state's Premium Partnership Program based on having the public program help pay for private insurance.

Mr. Checketts is also an assistant Medicaid director, overseeing simple areas like home and community-based services--we didn't get a chance to talk about that—for frail and older people. Today he's going to give us a sense of what challenges and opportunities he and the CHIP program face in Utah. Nate, thanks for joining us.

NATE CHECKETTS: Thank you for the opportunity to come and talk. I thought it'd be important, since CHIP provides states with a lot of flexibility about how they operate their program, to give you a brief introduction about how we've operated our program in Utah.

We are a separate program, and we cover up to 200-percent of the federal poverty level, which is about $44,000 for a family of four. We have service and co-payments that are tied to private health insurance policies. So our benchmark is set to what a family would receive if they were in a large employer and receiving benefits through that employer.

We do charge quarterly premiums for most families, and those range from $30 a quarter to $75 a quarter per family. As mentioned, we have about 40,000 children enrolled, which is about 5-percent of the total number of children in our state. And that's been a significant increase for us over the last two years or so.

We were one of the states that did close our enrollment periodically based on available state funding, and in July of 2007, the legislature appropriated a significant increase for our CHIP program. And so we've been open for enrollment since then and have grown, in that period, from 25,000 children to 40,000 children over the last two years. So we've had some significant changes there.

One of the other options that we've utilized as a state is that we've operated a Premium Assistance Program, and what that program—it's called Utah's Premium Partnership for Health Insurance, and we help families purchase their employer-sponsored health insurance coverage. These children are the ones that would essentially be eligible for CHIP, and then they also have a plan available through their parent's employer at work, and they're opting out of CHIP and instead into this subsidy program, and receiving insurance through their parent's plan.

We pay up to $120 per child, that does include dental coverage, and if they don't get dental coverage through their work, they can get it through our traditional CHIP program. We also use Medicaid funds to help the parents. We pay up to $150 per month there. So a family of four could receive up to $540 per month to help them purchase their insurance if all members of the family qualified.

Right now we have about 500 children that are on that program; that's about 1-percent of our total chip enrollment. Again, this is an optional program, so in essence, 1-percent of our children are opting into this employer-sponsored option.

Utah is one of the states that is beginning an exchange program for health insurance, and that will actually be providing benefits starting this January, and so our subsidiary program will also be working with our exchange program.

Because our subsidy programs are only available to employer-sponsored coverage where employers pay 50-percent, we won't be able to subsidize all employers that are participating in the exchange, but those that meet that requirement, we will be able to subsidize those individuals.

We've also asked for federal approval to try to expand the Cobra coverage, which we hope we will be able to get maybe as early as this month, and we are still having outstanding requests with the federal government to also be able to subsidize individual policies or non-group/non-work policies.

Some of the things that have worked well in Utah, our CHIP program is closely coordinated with the Medicaid program. As mentioned, I'm actually the CHIP director and in the Medicaid program, wherein one state agency we have the same eligibility system; same workers, so when an application comes in, it actually is given to one person, and they determine CHIP

or Medicaid eligibility, it doesn't need to be handed off to someone else.

We also have had a variety of different outreach efforts over the last couple of years. One that we found surprisingly successful, we had heard from Arizona that they had done an enrollathon, sort of like the telethon concept, and we did that for a one-day thing, and it was amazing how much response we had in the state, our Medicaid and CHIP numbers shot through the roof that month.

It actually caught us by surprise. We've done a lot of other efforts that we put a lot of work into and didn't get the results we wanted, and this was sort of a side event that we did that actually was very successful for us.

We are one of the states that received the Maximizing Enrollment Grant from the Robert Wood Johnson Foundation, and they have eight states that they're working with that they are working to identify administrative and renewal barriers and help us work through those and see if we can find ways to ensure that eligible families stay on the program.

We also feel like one of the successes that we've had as providing this option to families, but whether they do direct coverage CHIP or do a Premium Assistance Program trough our UP Program.

Overall, nationwide some of the successes of CHIP is that there is a lot of state flexibility. As mentioned, you'll see everything from a direct Medicaid expansion, to something that looks a little bit more like Utah's program where it's more private insurance than premium assistance. Each state picks that environment based on their political needs and the needs of the children in their state.

In our state there's a very strong public perception, and its approval ratings are much higher than Medicaid's. We think some of the reasons for that is that in our state, CHIP has a much less of a stigma than Medicaid. It's seen as a product for working families that just don't have health insurance, so this is a way that they can get some assistance with that.

Also, because CHIP, in our state, pays better rates than Medicaid does to providers, the provider panel—especially for physicians and dentists—are much better in CHIP than they are in Medicaid.

With the Reauthorization Act, there were several important changes for states. As mentioned, they dramatically increased funding, and so states are no longer in a position where they might run out of funding for their CHIP Programs. They create performance bonuses for states if they enroll a significant number of new Medicaid children, and expanded

options for states to enroll through WIC programs or food stamps to coordinate those enrollment opportunities.

The CHIP Re-authorization Act also puts some new mandates on states and CHIP programs, especially the separate CHIP programs like ours, are struggling to incorporate Medicaid policies into our CHIP plans; some of those are managed care, howewer deal with the federally qualified health centers, mental health parody and new requirements on dental services.

A few items related to healthcare reform; the discussion of individual mandates is an important part of discussion in public programs. These programs already cover many—especially Medicaid—already cover many of these individuals, but families choose not to enroll. And as we talk about individual mandates, I think that will be a significant contributor as more families actually decide to enroll into these programs.

The required expansion of Medicaid is something that is cheap because often states are reimbursing Medicaid providers at low rates. That does come with a trade-off, and in our state that has been that there's often less access to services that families need. If Medicaid is dramatically expanded without reimbursement rates being increased, there will be a significant pressure on our provider community to continue seeing Medicaid clients at existing rates.

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Some of the proposals eliminate CHIP at different time frames; 2013 or 2019, and those would eliminate these options for states to develop unique programs and to operate them differently from state-to-state to meet their local needs.

There's also some discussions of a national exchange, and how that might work with state exchanges that are just beginning to get off the ground. In our state, as I mentioned, we're starting one that will begin offering benefits in January. Some of the discussion items regarding minimum benefits, subsidies, and employer participation requirements aer things that we're just beginning to grapple with, and try to find local solutions to those issues. I do have a concern that if there are national items identified related to this, that that may limit states ability to find their own solutions to these issues.

Several other items that have been important to states as they've looked at health reform, Medicaid eligibility is not uniform across all the different varieties of Medicaid. There are different income levels for children and parents, and different asset requirements and different determination of income requirements for all these different groups.

States would benefit from the option to have the opportunity to consolidate all of these under on rule, one

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regulation that would determine income and assets the same way for all families.

Also, as I mentioned earlier, we've benefitted from having the opportunity to move our CHIP children into a health insurance exchange, or under premium assistance. I believe it's important that states be able to continue that opportunity to have premium assistance options so that they can be able to find the best place for the families, and allow families to choose where they belong.

Lastly, most of the discussion has been around expanding Medicaid to these income groups, and to the new groups, especially the Adults Without Dependant Children. Another option that I think is important to be considered is that CHIP programs can also be expanded to cover these groups rather than Medicaid, and leave the more difficult cases of the elderly and the disabled and blind, with the Medicaid programs. Thank you.

ED HOWARD: Okay, very good. Thank you Nate, those of you who thought that the only existing exchange was in Massachusetts have some learning to do.

The rearranging of the deck chairs here is so that Stan Dorn can see his own handiwork as it unfolds. Stand is the Senior Research Associate at the Urban Institute. He's put in 20 years or more on low-income health care and insurance

issues, including a stint managing the DC office of the National Health Law program. He's the world's foremost authority on the Trade Act Tax Credits, and today we've asked him to lay out the main provisions in the House and Senate reform bills that affect coverage for children. Stan?

STAN DORN: Thanks very much Ed. I'm going to talk with you today about what the various pieces of legislation do in terms of Children's Health Coverage, and I'm going to discuss Medicaid, subsidies in the exchange, and then CHIP. And I'd like to thank the California Endowment for supporting our work on this topic.

But first I have two preliminary questions. One, as you've heard both from Jocelyn and from Ed, rightly, that the vast majority of uninsured kids are eligible for Medicaid and CHIP, but not enrolled. What do proposed bills do to help these kids? And on this critically important topic, I'm going to say nothing whatsoever. Please come back on December 1st when the Alliance for Health Reform will sponsor a briefing on the topic of enrollment, both for children and adults for national health reform.

Second question is, I don't have a lot of time here this afternoon, tempest fugets as you can see, and so I'm not going to be able to talk about all the pending bills. On the Senate's side I'm going to focus on the Finance Committee

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proposal rather than the health proposal, simply because finance has jurisdiction over Medicaid and CHIP.

So turning to Medicaid, both the House and the Senate proposals would establish a minimum eligibility threshold for children and adults. In the Senate Finance Committee it would be 133-percent of poverty; on the House side it would be 150-percent.

But the difference is actually greater than it might at first appear, because the House threshold is a net income threshold, whereas the Senate threshold is a gross income threshold. So it's not a trivial difference. Both Senate Finance and the House proposals would substantially increase federal matching rates for newly insured adults, the House proposal would also increase reimbursement rates for Medicaid for certain services.

Why would you want to raise the Medicaid eligibility threshold to a relatively high level? Well the Congressional Budget Office says that actually saves the federal government money. Not only that, families get additional help under Medicaid that they would not receive under the exchange. Premiums are significantly lower, which means more kids would get coverage. It also means more parents would be insured, rather than uninsured, and we know that that actually benefits children in many important ways.

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Also, out-of-pocket costs are substantially lower in Medicaid than in the exchange, which means that low-income families are much more likely to be able to use care, rather than to be deterred by cost from using care. On the other hand, one of the reasons why Medicaid is cheaper than coverage in the exchange is, as Nate mentioned, that Medicaid pays providers a heck of a lot less than private insurance, and as a result, there's a limited pool of providers, and therefore that poses an access barrier.

The other issue with Medicaid is of course it's very reliant on the states. Under reform legislation, state coverage costs may increase, that's a topic of some controversy, about which I will not have time, but what is not such a controversy, is that state administrative burdens would increase substantially. A much larger number of people would be applying to Medicaid programs for coverage.

The question facing federal policy makers is, how can federal policy address an understandable incentive that states may have to keep caseloads low, so that their coverage costs are also low. Further, what can federal policy do to help states cope with a remarkable increase in administrative responsibilities that will soon head their way if national reform legislation passes?

Let's talk about subsidies in the exchange. Both the House Bill and the Senate Finance Committee bill help low income people pay for premiums, but the House still provides much more assistance, so that among your poor folks, for example, the lowest income people you can see in the table, in the Senate Finance Committee Bill, insurance would cost 50-percent more than it would in the House bill.

Out of pocket costs? The subsidies are even more different. As you can see, in the lowest income groups, you would have to pay, on average, about three times as much, if you're a low-income household under the Senate Finance Committee Bill, when you seek care, as you would under the House bill.

So in concrete terms, how would this work out? Well suppose you're a single mom—I apologize for my sexism, it could have been single dad as well—you're a single parent and you've got two kids, and you're trying to make it on $2,700 a month pre-tax income.

Think about what that would mean in terms of housing, nutrition, clothing and the like. Under the Senate Finance Committee Bill, you'd have to pay about $150 a month for insurance—not so easy to find—a little bit easier to find that under the House bill, a little more than $100 a month.

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When you go to seek care under the House bill, you'd have to pay 7-percent of those costs yourself, in terms of co-insurance, etcetera; 20-percent under the Senate Finance Committee Bill.

So what this means is that more generous premium subsidies, as in the House bill, me and you have fewer people uninsured. More people can come forward and seek coverage.

Lower out-of-pocket costs, as in the House bill, means fewer low-income people will say, you know what, I just can't afford to go to the doctor. I know I have insurance, but my gosh, it's a $20 co-pay, I can't pay for it. I can't afford it.

On the other hand, if you make coverage more affordable for low-income families, the federal budget costs go up. So that's the trade off facing policy makers when it comes to the exchange.

Now let's talk about CHIP. The House bill would end CHIP after 2013. What would replace CHIP? If you're a child below 150-percent of the federal poverty level, you could go into Medicaid. If you're above 150-percent of the federal poverty level, the only subsidy that would be available to you is premium and cost sharing subsidies in the exchange.

Forthcoming analysis done by my Urban Institute colleagues, Jenny Kenny, Allison Cook—Jenny's over here with

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us, over here on the side, thanks to the Packard Foundation's Funding—suggests that about 40-percent of kids who today are in separate CHIP programs, would wind up going into Medicaid under the House bill, and the remainder could qualify for subsidies in the exchange.

The Senate Finance Committee Bill is quite different. That bill, as you can see in the picture, continues the CHIP Program through 2019, with a substantially increased rate of federal matching payments. In exchange for that greater, federal generosity, states are required to continue their current eligibility unless their federal allotments run out, in which case, the remaining kids can go into the exchange.

The Senate Finance Committee Bill does not provide full CHIP funding past 2013. CBO estimates that funding would drop from $14 billion a year to $6 billion a year starting in 2014, unless Congress comes forward and does something to change that.

So, why would somebody who loves children want to end the CHIP program? Well, it's because CHIP is less certain than some of the alternative; subsidies in the exchange area guaranteed under federal law. Medicaid has guarantees that would be established under federal law in the House bill, and in the Senate bill as well.

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So there would be less subsidy, but it would be guaranteed subsidy. And by contrast, we don't know whether a future Congress is going to reauthorize CHIP and put enough money in for the program to do its jobs. We also don't know whether states are going to begin cutting benefits, raising costs for families, putting children on waiting lists.

As Jocelyn mentioned, this has not been characteristic in the past, but there are worries that in the new political environment post reform, things could change, and rather than subject children to these risks, the advocates of eliminating CHIPS say let's put children into a guaranteed coverage program.

If the children going into the exchange are Medicaid, they can be enrolled in the same health plan as their parents, there will be fewer subsidy programs without CHIP, and therefore, there'd be more simplicity, less complexity, which has advantages, both in terms of administrative costs to families. And there would be higher payment rates in the exchange.

What are the advantages of keeping CHIP? Well, one, in the Senate Finance Committee, CBO said that Senator Rockefeller's amendment, which succeeded, which restored CHIP to the legislation, actually saved money. We don't know how

broadly this finding would apply in other context, but that one data point we have says it saved money in that case.

You've heard mentioned by Jocelyn and also by Nate, of some of the new options in CHIP record states to reach out and enroll eligible, but uninsured kids. If states know that CHIP is going to be around through at least 2019, they are likely to invest the time and effort needed to make these new tools work, and as you know because you've heard over and over again, the vast majority of uninsured kids are eligible for Medicaid and CHIP, but not yet enrolled; it's critically important for states to master these tools to actually enroll these kids. They will do that if CHIP's around through 2019; perhaps less likely to do so if it ends at 2013.

Fewer children will become uninsured if there's CHIP, why is that? Families, if CHIP's around may say, you know what? I can't afford $150, $200 to enroll everybody in the exchange, not withstanding the premium subsidies. If CHIP is around, I can pay $20 a month, $40 a month to get my kids covered. So there may be families who choose not to get family coverage, but they afford to get CHIP coverage; that will not be an option if CHIP goes away.

And finally, and in some ways most important, the out-of-pocket costs are much lower in CHIP than they are in either the Senate Finance Committee or the House Bill. As Jocelyn

mentioned, families have to pay an average of 2-percent of cost under CHIP compared to 7-percent in the House Bill for low income folks, and 20-percent in the Finance Committee Bill, which means that low income families will be much likely to take their kids to go get necessary care, because they're not going to be facing a huge cost to it in the CHIP program. Now obviously critical for Congress to think about is how to fill that financing gap from 2014 to 2019.

In sum, it's a good thing that in the health policy banquet facing Congress and national health reform; it's an a la carte menu. Congress can pick one item from the House bill, an item from the Health bill, and item from the Senate Finance Committee bills, and come up with a combination—a meal that does right by kids. The nice thing is, Congress is chef as well as customer.

So people can take the dishes that have emerged from the committee process and add a few raisins, take out a spice here and there, adapt the legislative proposals and improve them on the floor of the Senate and the Finance Committee. But it's not just a question of how good the items are on the menu, it's also a question of how much each menu item costs. So policy makers need to grapple not just with what's in the best interest of children, but other topics as well.

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Finally, don't forget about those nitty-gritty implementation issues. If you don't pay attention to what's happening in the health care reform kitchen, than there's no guarantee that dishes that finally emerge will prove nutritious and safe for children, which is after all, what we are all about in this room. Thank you very much.

ED HOWARD: Alright. Thank you very much Stan. Now I understand that there will be a reversion so that you won't be confused in thinking that the people behind their respective tent cards aren't really who they say they are. We now come to the point where you have a chance to ask questions. There's someone already prepared with a green card. Emulate this gentleman and also take advantage of the microphones to ask questions yourself.

Let me just start off by giving you a chance to do that and asking Nate, it is a not very well know fact that Utah has an exchange that, as you say, is already enrolling people and begins to pay benefits soon. I wonder if you could talk a little about that. There's a lot of interest in exchanges these days.

NATE CHECKETTS: Sure. Our state's starting with an almost a pilot of this idea. We opened the exchange for employers to enroll in August and allowed about 100 small

business employers to enroll and cap it at that level. We have three or four different health plans that have come in and are going to be offering health insurance products through the exchange. The latest count I heard, there were about 67 or so some odd different health plans that they were going to offer.

As I mentioned in my presentation, the families are now selecting benefits and they will begin their coverage periods January 1st. We hope to, in six months, be able to repeat an open enrollment, expand the new businesses, and continue this process over the next year or so as we sort of step into this process a bit tentatively but trying to make sure that we don't make mistakes as we go through them.

ED HOWARD: Thank you. A question for Stan Dorn. If CHIP is eliminated, the questioner asks, will kids insured in the exchange get coverage for EPSDT that is services as good as in CHIP and Medicaid.

STAN DORN: No children will not receive coverage of EPSDT services in the exchange. There will be actuarial value tests, which mean commercial-style insurance. There's a requirement of covering dental care and vision care but there's no assurance what the cost sharing levels will be. I should note that CHIP doesn't necessarily provide EPSDT services either. It's guaranteed for Medicaid.

As a practical matter, many if not most CHIP programs provide that full set of Medicaid benefits to CHIP kids but that's not required under federal law but I think there's no question about it if children go from CHIP into the exchange, even with subsidies, they will receive much less coverage than they do under today's CHIP program.

JOCELYN GUYER: As Dan highlighted, it really is the cost sharing issue. I think both the Senate and the House have put together benefit packages that have the key pediatric-specific services, the oral health, the vision, the dental, the hearing. So I think the primary issue there is not so much that the scope of services and the items that are covered are not what we see in CHIP programs but rather that the cost sharing is potentially significantly more than in CHIP programs.

ED HOWARD: Here's a very straightforward question. Does CHIP now provide payment for emergency care? How, if at all, will that change under these new proposals? Anybody want to take a crack at that?

NATE CHECKETTS: It does cover emergency care now. I haven't seen anything in the proposal. So I don't know if there are any changes.

STAN DORN: I mean if CHIP goes away, obviously CHIP won't cover emergency care, won't cover anything but the insurance in the exchange would cover emergency care surely.

ED HOWARD: Here's a question that's addressed to Jocelyn or Stan but it actually flows out of something that Nate mentioned in his presentation and that is, it's almost universally acknowledged, the questioner writes, that coverage does not equal access but no one's talking about increasing Medicaid reimbursement rates, which is what Nate was describing as a potential access barrier. Why is that and when does access get addressed?

I guess in the context, whether you want to keep this program versus another program, I know when California was discussing a reform plan, there was a substantial increase in Medicaid rates that was part of that proposal. What do you do, whether or not you have CHIP?

JOCELYN GUYER: I think we're going to commission you to have another briefing on this because there are actually a lot of provisions in both the House and the Senate that are designed to tackle the question of access to care. In the House, it's probably particularly notable that they're directly going at the concerns about the reimbursement rates for primary care and Medicaid. They would be requiring that reimbursement rates for primary care be equivalent to what Medicare now pays.

That would be a substantial increase. The cost of that would be largely federalized. There would be some state shares, sorry Nate, but relatively modest, about nine-percent.

Then there also are a number of provisions aimed at exploring the medical home model in Medicaid. So I think that there actually is a fairly strong recognition of the importance of looking beyond just the coverage.

NATE CHECKETTS: Just say two things. Government programs tend to struggle with reimbursement rates and getting them right. We can see with the Medicare physician reimbursement rates. Budget issues have driven a certain policy and expectation of what rates will be but the reality on the ground is almost always that Congress has to come back in and address those on a year to year basis because the expectations are wrong. That's true on local levels too. Our hospital reimbursement rates in the state for Medicaid are great.

Hospitals may not agree with that but overall, they're great but our physician and dental rates are not very good. It's just one thing cities struggle with when rates and policies are set through legislative and congressional processes.

ED HOWARD: Stan?

STAN DORN: One final comment, notwithstanding the access barriers that result from reimbursement rates. It's worth noting that the literature, that examines children's access to care in Medicaid, shows dramatically improved access relative to being uninsured. In fact, there's research that suggests that many cases low-income kids have better access to care in Medicaid than they do in private insurance.

The issue is on the one hand, lower provider payment rates mean fewer providers participate but on the other hand, lower out-of-pocket costs means families aren't deterred from seeking care by unaffordable expenses. So even with the worst case of the traditional Medicaid program, it's certainly been much better than being uninsured and arguably better than private insurance for many kids but one hopes that with the measures Jocelyn talked about and other things, we'll see a significant improvement in these access barriers in the low-income kids getting even better access to care than they have in the past.

ED HOWARD: I guess I should ask the follow-up question. I share office space with Rick Curtis from the Institute for Health Policy Solutions and he's always worried that substantially increasing the number of people, whether it's kids or adults, who are ineligible for Medicaid, participating in Medicaid, is going to shrink the availability

of access for the average Medicaid recipient because providers will be asked to take that lower reimbursement rate for a higher percentage of their business. Is there any way of testing that empirically or do you want to speculate about it analytically?

STAN DORN: Well providers, as bad as Medicaid reimbursement is, it's better than zero. So if people move out of the uninsured column and into the Medicaid problem, that's more revenue for providers not less. I may not be understanding Rick's concern.

ED HOWARD: The question is whether or not they would actually get seen, get an appointment.

STAN DORN: Right. It's a challenge, no question but we saw in Massachusetts where there was a substantial expansion in Medicaid and COMCARE, the non-Medicaid program there, which uses the same delivery system that in the very first year when enrollment dramatically increased, access to care substantially increased as well.

In the second year, there were more, we saw a little bit of decline relative to year two but it's going to be a problem. It's a problem currently. It's going to be a problem in the future but for low-income folks, it'll certainly be better than being uninsured.

ED HOWARD: Nate, you've had to wrestle with that.

NATE CHECKETTS: Yes, I would say in Utah as we look at these bills, it looks like our Medicaid population may as much as double depending on the different bills and how it's implemented. I don't think, given our discussions we've had with our provider community again focusing on doctors and dentists, I don't think that they would be able to handle that with the existing reimbursement rates. Some sort of change will have to be made.

And I guess my observation would be it's probably important to contextualize it. I think, in general if we add substantial numbers of people to coverage, whether it's through Medicaid or the exchange, there will be some capacity issues that we need to deal with across the board not just in the Medicaid program but more broadly because we would ideally be bringing potentially millions of people into coverage.

So I'm guessing it will be a concern but it's something that's probably important to think about across different kinds of programs and ways for delivering care.

NATE CHECKETTS: I think it's important to look at what Massachusetts experienced that as they increased coverage to such high levels that their physicians started having huge waiting periods to get in because there just wasn't that upfront capacity. The market will respond. I mean more doctors will come out but there's that short-term issue.

JOCELYN GUYER: Right, short-term issue.

ED HOWARD: Yes? Go ahead. As with all the questioners who come to the microphone, we would ask you to identify yourself and be as brief as you can.

GARY KRISTOFFERSON: Gary Kristofferson, long-time friend of Ed. I want to take one step more off this question because I think it's a right line. What I don't hear in sort of refining the question is if I were the children that are out there currently covered by CHIP, the question on that is going to be is if we're trying to improve the health of children and make sure they get to the resources they need to get to, which strategy is better and why in terms of either going to the private insurance route or keeping CHIP alive to cover that group. I haven't heard that tradeoff as a real tradeoff.

STAN DORN: Well this is where we get into the point of view section of today's program. I'm delighted that you had to ask that question because my job, during the presentation, was to appear as neutral and in balance as possible. I just think it's clear that the way CHIP is today, children are much better off. Low-income children are much better off receiving care in CHIP than they will be in the private insurance that's subsidized in the exchange. It's not even a close question.

NATE CHECKETTS: One thing that families will face in the exchange even with the subsidies is they will face

premiums. We've had extensive experience with that. We charge, as I mentioned, $25 a month or $75 a quarter for these families and if you look at that population, there's only one segment of our population that we charge that much, all other segments of our population, those that don't get charged premiums or those that get charged $10 a month, their enrollment numbers rocketing but that group, the one we charge $25 a month to, is flat. That's at $25 a month.

Some of these discussions are at three-percent or 4.5-percent of income. Unless there's a mandate, I don't think those low-income families will sign up for it and stay with it. It sounds like such a great bargain. If you pay for health insurance even through your work and you're paying hundreds of dollars a month, those numbers sound great but when those families come to that decision, time and time again, we're seeing in our state that they don't keep paying their premiums.

In essence, they come on when they need it is what we find out and then they stop paying for a while and then they come back when they have another need.

JOCELYN GUYER: I have a couple of different reactions to it. I mean one is I think it's important to look at the assumption that CHIP is purely public and exchanges are purely private. I mean CHIP, in practice, often is contracting with private insurance plans. In fact, I think the majority of CHIP

children are in private insurance. So to me in some respects, the issue is less public versus private because both are a mixture.

To me, I would go back to those affordability questions. At the end of the day, CHIP has been a great success. It would be very hard to give it up. That said, what matters at the end of the day is that children have access to affordable insurance. I think you can do that a couple of different ways.

You could continue CHIP, although I think you would really need to modernize it further for a national reform context and deal with the fact that it's actually not a guarantee for children of coverage.

Alternatively if you are looking at moving children into exchange plans, it's really important to make sure that you carry over those key ingredients of CHIP that have worked so well. That is the affordability protections from my perspective that also has been that the benefits have really been aimed at children's specific needs.

ED HOWARD: By the way, let me just take this opportunity to invite people who might have a different analytical look at that question to make their argument whether in the form of a question of a statement when you have the opportunity to address this audience. So you shouldn't feel at

all hesitant about coming forward with that idea. Here's someone who's not hesitant at all about coming forward. Go ahead.

JANUARY ANGELUS: Hi, my name is January Angelus [misspelled]. I'm with the Senate on Budget. Just a couple of comments to that issue. I note that you did say that in CHIP, you charge $25 a month for premiums and that's considerably lower. I just want to remind people that when we're talking about the premiums that people would pay in the exchange, that's for a family. So you're talking about coverage of parents and kids and not just the child. So it's not quite an apples to apples comparison. That's just something that I think people need to bear in mind.

Just one comment on a presentation that Stan had made earlier. When you talked about what people would spend under the House and the Finance bill, you had indicated that at certain income levels, the out-of-pocket costs that families would face would be something like seven-percent at 175-percent of the poverty level. I think what you're talking about here is the actuarial values.

I also just want to remind people that that's not necessarily the out-of-pocket costs that each individual family would face. It's sort of generally across this typical population, they would pay for seven-percent of the medical

costs but there is no benefit schedule. We don't know what the deductibles were going to be and what the co-insurance is going to be. So that's just something for people to keep in mind.

JOCELYN GUYER: I think those are important points to put it into a little bit of context. If you look at CHIP children, most of them do have parents with insurance but about 40-percent don't. So obviously the chance to have family-based coverage that includes the parents would be extraordinarily valuable directly to the parents but then also there is a large body of research that when you cover families as a unit, children also do better.

Their parents are healthier but the family, as a whole, has more financial stability and then there seems to be a little bit of parents are able to do a better job helping their kids access care. So that's certainly a critical point.

NATE CHECKETTS: I think, as you come to the family coverage issue, it is difficult for families as they have their family members potentially scattered across these different programs where one parent may receive insurance through work. Another one may be uninsured because they can't afford the spousal piece. One child, at least in our state, may be on Medicaid. Another child may be on CHIP. So I think it is important.

I think most people would agree that it is a good goal to try to get families on a single source of coverage. One way we try to do that in our state is through this premium assistance where all the family can buy into one family plan. That's not the only way to address it but it is one way that we've attempted to try to get at that goal of getting families coverage in one place so they're not scattered all over.

ED HOWARD: Nate, could you talk about what the premiums, what the expenses are for a family in making one choice or the other in that situation?

NATE CHECKETTS: Well the children, do you mean versus CHIP versus UP or are you just saying the scattered family?

ED HOWARD: Yes. No.

NATE CHECKETT: Okay. CHIP versus UP. If a child qualifies for CHIP, they would face our premiums, the $25 a month for a family and the cost sharing that we have in our plan, which is for that higher income group, is about a 20-pecent co-insurance in most cases.

They would face that versus if they went to their employer-sponsored plan, whatever premium they face at work, we would pay up to, as I mentioned before, for a family of four, about $540 towards that premium.

So we could pay all of the premium in some circumstances if they have a generous employer benefit. If

it's less generous, they may still face some premium. Then they would face whatever the cost sharing is at that employer's plan, which we found in our state, should generally be about the 20-percent co-insurance type plan.

So you pay 20-percent and the plan pays 80-percent. So those families are balancing that. In our case, one-percent of those families have an opportunity to have employer-sponsored insurance and they think that's the better option.

We think sometimes they're using that to cover when they purchase family coverage, they're getting individuals covered that maybe aren't eligible for direct assistance but a family covered plan covers all of their family.

STAN DORN: One appealing feature of the Utah policy is it lets the family make that choice. I worry a little bit if Congress eliminates CHIP then families won't be able to make the decision about what they care about most, putting families, putting parents and children in the same health plan or enjoying the lower premium and out-of-pocket costs for kids in the separate CHIP program.

I don't know if there's a way to have families have some sort of a choice but if Congress has to make that choice, it seems to me that from what we know in the literature, the advantages for kids accessing care, given low, out-of-pocket

costs, significantly outweighed the benefits of putting parents and kids in the same health plan.

JOCELYN GUYER: I guess I would add because I'm trying to think of this from a family perspective, I think it is already daunting to contemplate health reform and think about all the choices people might have and some of the complexity of navigating different ways into programs. I think if Congress does come out in a place where it continues CHIP and we also have Medicaid and we also have exchange plans, it is absolutely critical that we have simplified, unified enrollment procedures.

There were some important additions, I believe it was Senator Bingaman in the Senate Finance Committee, added an amendment saying that there should be a no wrong door enrollment process so that if you're not sure which of those three things you or your family members are eligible for, you can apply at Medicaid. You can apply to the CHIP program.

You can apply to the exchange and wherever you apply, that entity is responsible for getting you and your family members into the right program. They can't say oops, you picked the wrong one. Go apply somewhere else.

I think particularly, if we're looking at multiple routes into coverage with maybe some family members in

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different programs that that kind of concept will be critical to make reform work from a family perspective.

ED HOWARD: I should say that on December 1st, which is a week from Tuesday, we're going to take up the whole question of how you enroll some of the folks who are eligible and how you enroll and retain people who will be newly eligible if these reform bills pass in a program that we've actually recruited Stan Dorn to be part of at that point.

So be alert for the notice for that program. We've got a question actually for Mr. Dorn about the intricacies of the budget process. Is the CBO score lower in the Senate Finance Committee because those costs are already accounted for whereas eliminating CHIP, you have to rearrange the deck chairs and account for additional costs?

STAN DORN: Well I'll bet you there are folks in the room who know a heck of a lot more about what happened in the Senate Finance Committee than I do, so I will venture my best understanding and turn it over to people who may know more. My understanding is that CBO had to consider a couple of things.

One, what's the per capita cost to the federal government of a child being in CHIP versus being in the exchange and that CHIP coverage is cheaper than subsidized coverage in the exchange. Number two, what's the impact of fewer children having coverage with the exchange and the lower

level of subsidies there than in CHIP and balancing those factors as well as other issues that were in play in the Senate Finance Committee. That's why I say, in other contexts, we don't know.

I mean for example, Jocelyn talked about the notion of modernizing CHIP. I think that's something worth serious consideration on the Senate floor. Is there a way to take the CHIP program and provide a greater assurance for kids that coverage will be there and for states that federal dollars will be there? If so, that would mean that CBO would say that in 2014 through 2019, kids would instead of receiving subsidies in the exchange would receive subsidies in CHIP. Would CBO score that as a cost saver?

Would CBO score that as an increased cost on balance? I don't know the answer. We just have one data point, the Senate Finance Committee and they said it was cheaper to have kids in CHIP than the exchange.

ED HOWARD: Okay. Any CBO people like to comment on that? You're probably working on the Senate Finance Committee estimate as we speak instead of coming to our briefing. I don't know why. We got a question directed to Nate Checketts. The person said he's heard good things or she's heard good things about Utah's E-find program in automatic renewal

strategies. Can you explain what Utah is doing to retain eligible children?

NATE CHECKETTS: Sure. One thing that our state's been able to do is that we've coordinated the databases from a lot of different entities, vital records, and others where our eligibility workers can see all of those electronically. One barrier that we found for enrollment in CHIP and Medicaid is the documentation issue and having to provide copies of all these different sources of information from paycheck stubs and birth records and things like that.

E-find is how our state workers are able to go out and get most of that electronically. So that greatly reduces the need to go back to the clients and require this documentation. I think there's a second part of the question.

ED HOWARD: No, just they heard good things about the E-find and wanted to know what you were doing to retain people.

NATE CHECKETTS: Oh and I guess there was some comment about automatic enrollment.

ED HOWARD: Automatic renewal, yes.

NATE CHECKETTS: There's simplified renewal options. What we do in the CHIP program is for families that look like they're going to have stable income year over year, rather than requiring that they send us back information in order to stay enrolled, we send them a notification that says look, we know

who you are. We know generally what your income is supposed to be.

If you don't notify us, you need to tell us if something has changed but if it hasn't, we're just going to keep you on the program. We call that a simplified renewal program. That's been very successful for us. We found, in some cases, that's probably not the best program and we have some logic sort of behind that as far as families that have their own businesses generally don't work very well on that because small businesses, their incomes are up and down, things like that. We only offer that to certain families with more stable income.

ED HOWARD: Actually, this next question seems primarily directed to you too Nate although any of the panelists is free to address it. Can you discuss the implications of the economic stimulus legislation coming to a cliff in December 2010? We were talking a little about that before the program started.

NATE CHECKETTS: Sure. I'll just tell you Utah's experience. The stimulus funds provided enhanced match for Medicaid over a, I think it was a nine-quarter period. It does come to end in December of 2010. We were in our legislative session last year before that bill was passed and the discussions on the table were which Medicaid groups will stop

receiving Medicaid eligibility. How much do we reduce the elderly? How much do we stop the medically needy?

All of those groups were on the table, literally numbers there; this is how many people will lose coverage. This is how much the state will save if we do this. The stimulus bill passed and not only gave the states money but also prohibited the reduction of eligibility.

Now we're going in, starting in January, and we will be looking at our budget that is only part, half-year funded with the stimulus funds. Those items are back on the table again. I think this stimulus funding did prevent that from happening for nine quarters but I think states are still in very bad situation financially. I think the discussions will come back up this year.

ED HOWARD: Jocelyn?

JOCELYN GUYER: Just to pick up on that, my understanding is that as deep and as troubling as the downturn is for those of us that work on federal issues and federal budget issues, states are expected to really lag. So even once we start to see a recovery more here in Washington, state budgets for an additional year or two, sometimes three years in prior recessions are likely to be in extremely tough shape.

I think we could fully expect major cuts in Medicaid if there isn't some continuation of that fiscal relief. I know

that the House bill actually does continue that fiscal relief for an additional two quarters. So they're already eyeing that a little bit.

From a kids' health perspective, it's pretty clear to me that the success stories that we've had over the last year including that census finding that we're at the lowest level in 20 years, would be very much at risk if states were to begin cutting back on their Medicaid and CHIP coverage. I think there's no doubt that we would potentially see those good news stories turn into bad news stories.

NATE CHECKETTS: In some of the earlier discussions, there were comments made about the state share is only nine-percent or five-percent. No, no, it's a great discussion. It's a bargain. I mean that's a great thing for states but in this environment that sends panic through states because there is no money on the table and it's so short. Now granted, most of these provisions don't come in until 2013.

So we always think well it'll be better by then and it probably will be but there is that tradeoff. I mean it's a great deal for states. CHIP shows that when you provide states a great deal of the enhanced match rate they went out and did massive enrollment efforts to get children enrolled in CHIP.

So I think states will take advantage of it but right now, when there's no state funds, even one dollar more just sounds like so much.

STAN DORN: I think Nate's point alludes to a more fundamental structural problem with the Medicaid program, which is that when times get bad, states are forced to make cuts because states have legal requirements to balance budgets. Case loads go up, revenues go down.

During the last two recessions or soon thereafter, Congress has stepped in and provided fiscal relief to states, which has made a huge difference but there was a concept put out in the Finance Committee white paper that I thought was really well taken, which is to look at restructuring Medicaid to provide automatic countercyclical relief so that when state conditions decline, federal help is forthcoming. When state conditions improve, federal help retracts.

Not only would that help states, it would mean that federal dollars, which are in short supply or often in short supply, given the federal budget deficit that we're looking at, would be much more closely targeted to need so that rather than an across the board allocation to states, whether they need more, whether they need less, only the states that need it would get resources.

Once conditions improve in a state, the stimulus would retract. So as Nate points out, 2013, God willing, we'll be out of this recession. States will be fine. They won't mind but from time to time, we're going to have these economic downturns and rather than react in the same panicked way every single time, is there a way we can rethink how we structure the underlying program.

NATE CHECKETTS: I think the state-specific option is a great option for states because they go into recessions and out of recessions at different pace. I mean Michigan's been in a lot longer than the rest of the states. I believe it's North Dakota, I forget who I was talking to the other day, still hasn't hit them yet and they're receiving stimulus funds. So they're doing great. I mean I would guess [laughter]. They probably have a different story but it sounds like they'd probably be doing great, so to have a state-specific one would be ideal.

The other situation that we've created, we've now gone two recessions where this federal government has come in and provided stimulus funds for Medicaid when recessions have come. So states are beginning to act as if those funds may always come. There needs to be a decision about whether that's really going to happen or if not, states need to change their behaviors. There have been discussions in our state before

these stimulus funds were coming about doing some sort of reserve pool or level funding over the years.

So money would be put in during good years and it would be there available in bad years but when the stimulus continue to come during bad years, it sort of undercuts that concept of needing to have Medicaid rainy day fund.

STAN DORN: Right. If Congress were to change this in a structural way, I was mentioning the Finance Committee white paper, that issue of moral hazard could be addressed. Congress could say if you want to access the countercyclical federal boost, you need to be responsible. You need to have a rainy day fund. You need to meet various standards of sound fiscal management. That way, states would know that they really have to have their house in order if they want to be able to tap into these resources in good times.

ED HOWARD: They need to make sure that Senator Collins and Senator Rockefeller continue in office because they were instrumental in putting the things together in both cases.

STAN DORN: Right and ARRA did contain for the first time flexible funding where it wasn't just every state gets the same FMAP boost. A chunk of the money said if you're a state in particularly difficult circumstances, you get additional resources. If we're addressing it on a structural ongoing basis that can really be the gist of what we do.

ED HOWARD: We've got a question addressed to either Jocelyn or Stan initially. Are there any provisions in the bill to protect children with special health care needs? The bills, I guess, are the reform bills.

JOCELYN GUYER: I think, in some respects, one of the very best protections for low-income special needs children is the Medicaid PSDT benefit. I mean that really is the benefit that if you have a special health care need will assure that you get coverage of all medically necessary services. So that is really at the heart of what low-income children need.

I think there's a separate question, of course, about if you're not low enough income to qualify for Medicaid, what is there for you? The benefit package that they're looking at, I think in both bills, has some of what would be needed including durable medical equipment, which often can be an important service for children with special health care needs but it's probably worth continuing to look at those to make sure that they work more generally.

There also are some provisions aimed at family counseling centers for families with special needs children and other items in there that I think have an eye on those issues but Stan, I don't know if you know of others.

STAN DORN: Well the other thing to think about is the out-of-pocket costs. If you have a child who has special

health care needs, that means you use a lot more services than the average child who, thankfully, is healthy. So if you're exposed to higher cost sharing, out-of-pocket cost sharing in the exchange that becomes quite a burden for the family. On this topic, I would recommend folks taking a look at what First Focus did. They did a report.

They commissioned an actuarial firm to look at what the out-of-pocket costs would be under CHIP programs today and under proposed reforms. They looked specifically at the issue special needs kids and the difference in costs between today's CHIP program and subsidies in the exchange is staggering.

ED HOWARD: We can commit, can't we Allison, to getting that report and posting it on our website with the other materials that we have from First Focus. We've got a question that harkens back to, I'm sorry, yes? Go right ahead.

JUDY SOLOMON: Hi, Judy Solomon from the Center on Budget and Policy Priorities. Hi. I actually wanted to hark back to something that Stan said that I think kind of got left without the significance really playing out.

That was the point on 40-percent of kids that are now in CHIP going into Medicaid under the House bill, I assume that analysis was, and just kind of play out what that really means particularly given the last question on kids with special needs

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because you've really got, these would be the lowest income children that are now in CHIP.

I think in Mr. Checkett's state, it would be actually a lot of your CHIP kids from older kids from 100 to 150 and your younger kids who are now a little fewer of them but a lot of kids moving from CHIP into Medicaid. I think what you said was in CHIP, in your CHIP program, they're getting a sort of more of an employer-sponsored plan, which I think would be similar to what the exchange would provide but the vast majority of those kids would be going into Medicaid where they would not pay any premiums at all.

They would likely not have any cost sharing at all except very limited basis. They would have EPSDT. So I just thought that it was a very, very important point that shouldn't be left behind particularly because I think if you look at what we've written about the bills, our main concern is with affordability are at the lower end of the set scale and the need to make it affordable. I think as we weigh this, it's really important to think that through.

NATE CHECKETTS: Yes, just talking for Utah, I think our numbers may be closer to 70 to 75-percent of our children will move from CHIP to Medicaid. That's, in part, because we have an asset test still for children ages six to 18. So we have children in our CHIP program that are at 50-percent of

federal poverty level but have assets and so they're on our CHIP program.

They do receive the employer-sponsored benefit but they have all of the cost sharing protections that are in there for those lowest income children. So no premiums, $3 co-pays for services, free preventative care. So they still get a great package. We still have families at those levels that as we're going through the eligibility, the determination process, sometimes those families end up on Medicaid and some other families, for slightly different reasons, end up on CHIP.

We still have families that come back to us and ask please can I move off of Medicaid onto CHIP, that's where I want to be, again mostly because of access issues but the way federal law is structured right now, if they qualify for Medicaid, they must be on Medicaid. There's no choice there.

ED HOWARD: Nate, you had alluded to the kind of situation people face when they are trying to figure out whether to buy family coverage through the UP program or insure the kids through Medicaid or CHIP. Questioner asks whether if health care reform includes an individual mandate, will that affect CHIP coverage as parents look for coverage for themselves. Will they move to family coverage and how certain are we that one or the other is going to be more attractive?

NATE CHECKETTS: As we've discussed in our state trying to get all kids covered, every time we come to that discussion, we get to a point where there needs to be either some reward or some penalty for not having health insurance without that, it doesn't seem like we'll ever get to a point where most people are covered.

So from what I've seen in the bills and I'll ask the others here to correct me but I believe there has been some discussion of individual, I guess, penalties if you fail to have coverage. So that may provide enough impetus to have families sign up. Again, there will be that question of is it enough given our experience that families have problems paying premiums on a regular basis.

ED HOWARD: Jocelyn?

JOCELYN GUYER: Certainly both bills do envision some potential penalties for people that don't sign up for coverage with exceptions that it's simply still not affordable to you. So there is some acknowledgement that even with the subsidy structure, some people may still continue to have problems purchasing insurance.

I think on this point, it's actually a really interesting point to look at Massachusetts because Massachusetts had a mandate as part of its health reform. It only applied to adults. It did not apply to the children. It

had relatively modest penalties. There were not major penalties associated with not purchasing coverage but somehow putting out the expectation that everyone is supposed to have health insurance had a very positive effect.

They sometimes call it the culture of coverage in Massachusetts. So they have the very lowest uninsured rate in the country close to, on kids even though kids are actually not subject to a mandate. It seems to be because they've been caught up as their families have gone out to buy insurance for the adults as the state has made it really clear that the expectation is everyone should have health insurance.

STAN DORN: It's actually, it's that but it's also a lot of other things too. We just came out with a report two days ago on the RWJ website called "The Secrets of Massachusetts Success." Massachusetts covers 97-percent of its' state residents. The mandate is one piece of it but there are all kinds of other stuff going on that I certainly didn't know before we made a visit to Boston earlier this summer.

About a quarter of newly insured individuals in Massachusetts were enrolled based on data the state had without having to fill our application forms. As Jocelyn mentioned, with respect to the Bingaman amendment, Massachusetts has a dozen subsidy programs, way more complex than what anybody's envisioning for health reform, Medicaid, a program for

immigrant kids, a subsidy program for hospitals and health centers, the COMCARE program and that's not a problem for families because they have one application form and one agency that determines eligibility for all the programs. So for the family, you don't have to worry. You just fill out the form. You send it in.

Massachusetts had grants to community-based organizations to fill out applications for people online. They said to hospitals and health centers unless you get your patient to fill out an application form and send it in, you're not going to get any reimbursement from us for uncompensated care.

So as a result, not only did about a quarter of the newly insured folks not have to fill out application forms, more than half of all the application forms that came in were completed by CBOs, community-based organizations and providers and not by consumers themselves. So yes indeed the mandate mattered as did subsidies far more generous than what's been discussed either in the Finance Committee bill or in the House bill but these other administrative factors that we're going to be talking about on December 1st were really enormously consequential. So check out the report. It's on the RWJ website.

ED HOWARD: Yes Bob?

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BOB GRIST: Bob Grist with the Institute of Social Medicine and Community Health. Except for this last comment, most of the conversation has been focused on health insurance strategies and yet in Utah, we often hear about Intermountain Health as an integrated health care delivery system. Are there advantages to children in getting health care through integrated health care delivery? What strategies is the state using to try to spread those advantages?

ED HOWARD: Good question.

NATE CHECKETTS: Yes, we benefit from having Intermountain as a major player in our market. In our CHIP environment, we have in essence, two options for families. One is what ends up being an Intermountain option and the other option being the non-Intermountain option. We have that just because there are different hospital networks in the state and physician networks.

So some families prefer to be in one or the other depending on where their physician is or where their hospital or preference is. So we do benefit from being able to access that network. We do think, as the national studies have shown, that there are advantages to having the integrated system.

In our state, we have a unique political system, we can't push people into that system because there are the non-systems, the non-Intermountain system that still has a lot of

political clout and wants to make sure that they have access to their facilities and their physician panels.

We are looking to apply for the CHIP reauthorization quality grant, which will study some of these issues a little bit more and also be able to help us look to see if there's things that we're learning in Medicaid that we might be able to apply outside of the Intermountain system and to other states in our region.

BOB GRIST: When you say the networks are determined, the physician and hospital networks sort of determine themselves through the market place, what could the state do to influence the way those networks are actually formed? Are there any strategies that the state could use to influence the shape of the networks that hospitals have with providers in their community?

NATE CHECKETTS: From our experience, that's been extremely difficult politically. There is this natural alliance of Intermountain where they started as an integrated system having a hospital and physicians and clinics. So they've been able to retain that but we're moving that with other providers, there's been a lot of resistance. We're trying to do that. One of our discussions that we have back and forth, is there any willing provider in the open network

discussions. Those are bills that are run almost every year in our legislature and occasionally get a lot of traction.

They haven't passed yet but those, in essence, would blow up the network concept and allow people to go wherever they want. They still get a lot of traction even given the performance of the different players in our system.

ED HOWARD: We have time for another question, yes?

KIRSTEN BERONIO: Hi, I'm Kirsten Beronio with Mental Health America. In my looking at comparing, is it better to move kids into the exchange or keep them in CHIP, one aspect that's important to us is that in all the health reform bills, mental health and substance abuse services are included in the essential benefit package. In the CHIP program, in separate CHIP programs anyway, mental health is not on the list much less substance abuse on the list of services that have to be covered.

I think all states do cover mental health but when you're doing this analysis, I think it goes to Jocelyn's point about making sure that we do ensure there are guarantees of coverage in the CHIP program.

NATE CHECKETTS: The mental health parity is something that states are facing right now. The CHIP reauthorization bill required parity on the mental health side. That poses some challenges for separate programs because that came a year

earlier than it's coming into the private market. So we're often benchmarked on private plans. They haven't moved yet to parity, at least in our state, and I think it's true of many other states.

KIRSTEN BERONIO: Not come out but they are supposed to be compliant as of this coming year as well.

NATE CHECKETTS: Yes, this coming year they are supposed to be but our law started in July of '09. So it has been challenging for separate CHIP programs to come into parity ahead of the private insurance that are supposed to be benchmarked too.

ED HOWARD: You had similar difficulties with the requirement of coverage for dental services or did that work more smoothly?

NATE CHECKETTS: I think the biggest issue on the dental services has actually been how the law was structured and to regulate the guidance that's been coming out from CMS on that. I think most states covered dental services just to differing degrees. It's really been more of how that's been implemented rather than the fact that there was a dental requirement.

ED HOWARD: Okay. We have time for just a couple more questions. I have a couple more questions on cards. I'm going to ask you to pull out your blue evaluation form and start

filling them out as we finish here. I'm particularly interested if you have an opinion about reducing the amount of paper versus having something in hand some of us old folks like. We'd like to particularly have your opinion on that.

This question is about legal immigrant children in states that haven't lifted the five-year bar to CHIP or Medicaid. They still face barriers to coverage. How would health reform affect them? How could they benefit from removal of that waiting period?

STAN DORN: I think those kids go into the exchange. They would experience much greater access to care and their families would experience fewer affordability barriers to enrollment if that five-year waiting period were eliminated for Medicaid and for CHIP.

JOCELYN GUYER: I just want to say I think it's a really critical question because if you look at who the uninsured children are in the United States, legal immigrant children, children whose families have played by the rules and are here lawfully are still a major piece of the kids who are missing out on coverage.

The one thing I would say about them going into the subsidized exchange plans, I think that's obviously a major step forward compared to not having any insurance but if they're very low income, those subsidies are really structured

for families who are near poor, kind of 133 to further up the income scale.

So I do think there may still be some serious access issues for legal immigrant children and very low-income families where even the premiums that are available to you if you're in the subsidy just don't quite match what their financial circumstances are.

STAN DORN: Repealing the five-year bar for Medicaid and CHIP, I wonder how CBO would score that given that Medicaid is, generally speaking, cheaper than subsidies for the exchange. It might be something that would save money rather than cost money.

ED HOWARD: But just to clarify the current versions of these bills do not do away with the five-year bar, is that right?

STAN DORN: In the exchange, they do. If you're a newly arrived legal immigrant in the United States and you're income eligible, you can get subsidies in the exchange. So that means that kids who would qualify for Medicaid or CHIP but for their recent arrival in the U.S., instead of getting Medicaid or CHIP, will get coverage in the exchange, which means higher costs and fewer benefits for the family and potential greater costs for the federal government.

ED HOWARD: That's what I thought. You touched on this before Nate, the question addresses directly the question of how you are coordinating eligibility determinations for those who are eligible for subsidies that are the UP program, which I think you should have called UP high, by the way, since it was health insurance and enrolling through the exchange.

Do you foresee additional complications? Should Medicaid eligibles be permitted to enroll through the exchange? Also do you think individuals will be confused by having 67 plans to choose from through the exchange compared to Massachusetts, which offers nine?

NATE CHECKETTS: On the simplified application, right now we do Medicaid and CHIP and all on one application. So you apply for any one of those programs, you use one application. You can get in through those doors. When we go to the exchange because we don't have a guaranteed issue on our state, there's a lot of different questions that the health insurers want to know that we don't want to know. They want to know about your history. They want to know your medical history and a variety of other things.

So in essence, we found that we're asking two different types of questions. On the Medicaid form, we want to know your income, very, very important and your family status. On the health insurance documents, they want to know your medical

history. Now with guaranteed issue that would help remove some of those questions that the insurers would need to ask.

We are working towards trying to get a single application where if you applied at the exchange, you would also be considered for Medicaid and CHIP but right now, one of the biggest barriers that would be a very long application. People that are at high income levels would need to answer the income and family questions that we have for Medicaid and families that were just applying for Medicaid would have to answer the insurance questions. So we're trying to balance simplicity versus completeness there.

The 67-option issue, we will see how that goes. It may be that nine options is the better way to go. Right now we're using the model of the website's ehealthinsurance.com where you go and you type in who you are and it brings up all the policies that are available to you. I don't know what the sorting features are but it's something, at least on e-health insurance, I believe it's your deductibles.

You can sort by deductibles or you could sort by premium rates and things like that. So you sort of sift through those. That does envision an online model where you can probably facilitate that rather than probably 67 options, on a page of paper is probably harder to work through.

ED HOWARD: Okay. I have one final question here. Do CHIP enrollees have better health outcomes and does CHIP reduce inappropriate use of emergency rooms beyond anecdotal evidence? Anyone?

NATE CHECKETTS: I would say over the uninsured yes and yes. I think that's been documented. I don't know if there have been a lot of comparisons between CHIP and Medicaid or CHIP and other insurance.

JOCELYN GUYER: Yes. I think there is some good, solid research out there and again, I get to be cheerful, it's good news. CHIP really has worked in terms of producing better health outcomes. There's some particularly strong research around children with asthma avoiding preventable hospitalizations. So I think there's a solid basis for that since it really has been working well for children.

ED HOWARD: My impression is though that emergency room visits are primarily by people who have insurance. Is that a correct impression or am I treading into the analyst's domain here?

STAN DORN: I think there are a lot of emergency visits by people who have insurance, the majority, I think that's right. My sense of the research is it shows that if you have CHIP or Medicaid, you're much more likely to have a usual source of care than if you're uninsured, which means that you

can keep going back to the same doctor or clinic for services rather than having to resort to the emergency room but your point is right Ed.

I mean the issue of managing emergency room costs is much more multifaceted than simply reducing uninsurance. It's about going back to the question that Bob raised. It's about how do we structure our health care delivery system? Are there options available where you can get urgent services where you can schedule an appointment the next day so you don't need to go into the emergency room tonight to get care rather than sit around and wait a week before you can get into your doctor's offices? There are lots of hospitals that are experimenting with models for diversion and alternative sources.

So I think it's an important issue but we absolutely cannot delude ourselves into thinking that all we have to do is take care of the problem of the uninsured and emergency room overutilization issue will go away. It won't. We need to take other steps to deal with that.

NATE CHECKETTS: In our Medicaid, we have a federal grant to look at this. We have sort of a three strikes program where the first time you come in and have an inappropriate ER use for something that wasn't emergent, you get a notification from us. It's a phone call the first time, a letter the second time, and if there's a third time then we actually put the

Medicaid client on what we call a restriction program, which identifies this is your physician. You have to go see your physician. This is your pharmacy and you have to go to this pharmacy.

Our initial numbers were only, we have six months worth of data so we're still working into it but our initial numbers are showing that that is providing us cost savings to do that.

ED HOWARD: Interesting. Very good. Well it has been an extremely interesting afternoon for me anyway. I've learned a lot from these folks already to my left and right. Let me just do a little commercial. Next Friday, we have a program that's going to look specifically at affordability questions that we've talked a lot about in the context of children.

As I mentioned, on December 1st, we're going to go back and look at some of the eligibility determinations and the administrative barriers and the strategies that people are using in different parts of the country to make sure that people who should be on these programs, who Congress wanted on these programs actually get some benefit from these programs.

I want to thank Kaiser Family Foundation for doing the webcast and posting the materials on their website and a special thanks, of course, to the Robert Wood Johnson Foundation, Maureen Cozine and David Colby and their colleagues, the staff at the Alliance for doing a great job in

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making sure this came off and ask you to join me in thanking our panelists for an enlightening discussion [applause].

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