ALLIANCE FOR HEALTH REFORM

Getting the Most Bang for Our Post-Health Reform Buck: Enrolling and Retaining Everyone Who's Eligible
Alliance for Health Reform
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ED HOWARD: Why don't we get started? I want to welcome you. My name's Ed Howard with the Alliance for Health Reform. I welcome you to this program on how to make sure that millions of Americans who will be made eligible for coverage under these reform proposals being discussed actually sign up and get that coverage and the care that it provides access to.

Extend that welcome on behalf of Senator Rockefeller, Senator Collins, our board of directors. As we said in the announcement for today's program, providing the subsidies to increase access in programs like Medicaid and the Children's Health Insurance Program actually accomplishes very little if subsidies go unused.

Now we know from our experience with the Medicare savings programs and with CHIP and the health coverage tax credit that there are often a lot of big gaps between the number of individuals who are ineligible and the number who are actually participating.

We also know that there are examples of creative and efficient mechanisms already working in a bunch of places to streamline the way we determine and redetermine the individuals who are eligible and actually enroll them once we determine they're eligible. Those examples occur in blues states, in red

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states, in purple states. We have a few examples for you today from across that political spectrum.

Our partner in this examination is the Pharmaceutical Research and Manufacturers Association, PhRMA, who not only are supporting today's briefing but they also provided support for the analytical paper by Stan Dorn that provides the foundation for the discussion. I want to thank Greg Gierer and his colleagues at PhRMA for really pushing us to cover this subject, which has gotten little enough attention in the course of the debate.

A few logistical items that those of you who are regulars will recognize. There will be a web cast of this briefing available sometime tomorrow probably on kff.org thanks to our friends at the Kaiser Family Foundation.

They'll also have copies of the materials, electronically, that you have in your packets. Those will be available on our website at allhealth.org and a few days later, we'll have a transcript on our website that you can use to take a more efficient look at the words of wisdom that you'll be hearing later.

At the appropriate time, you can ask questions of our panel. There are microphones that you can use on the floor. There are green cards that you can write your question on and we'll look forward to that part of the conversation in which

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you join. Following the presentations and the Q&A, we'd like you to fill out that blue evaluation form that you'll find in your packets to help us improve these briefings as we go.

By the way, that evaluation form contains a question on your preferences for paper versus electronic versions of background material. If you have not answered that question previously, please do so today. We're trying to get a sense of what practice to follow that best meets your needs and tries to respond to environmental needs as well.

Now let's get to the program. We have just a terrific group of individuals today. They're nationally respected analysts and people working on the ground that have been working on access through improving eligibility and enrollment procedures for years. We're going to give you a chance to get into the dialogue with them following the brief presentations.

We're going to start with Stan Dorn. He's the senior research associate at the Urban Institute. Stan has 20-plus years of experience working on low-income health care and insurance issues including, less than three weeks ago, an appearance on an Alliance panel discussing coverage for children.

He's also, as I mentioned, the author of the paper on enrollment and eligibility methods that provides a jumping off point for today's discussion. We've asked him to sort of

preach from that text this afternoon. Stan, if you would? Thanks for being with us.

STAN DORN: Thanks so much for having me Ed. Is the mic on?

ED HOWARD: It is indeed.

STAN DORN: Okay, excellent. So will national health reform legislation actually succeed in enrolling most of the uninsured into coverage? That's the question that Ed posed. After we've had a chance to discuss the importance of enrollment, examples of other programs that have succeeded enrolling the uninsured and possible lessons for national health reform, I hope you'll agree with me that if Congress and the administration want national health reform to reach the bulk of America's uninsured, it will be critically important to pay careful attention to the nitty gritty details of how eligibility is defined and how enrollment and retention are handled.

Before I discuss any of that though, I would like to once again thank PhRMA for funding our work on this topic. It's been very helpful and we're most appreciative.

So to begin with, if Congress provides subsidies for the uninsured and makes available comprehensive coverage and perhaps even adds an individual mandate, can we be assured that all the people who are eligible for subsidies, eligible for

health coverage well come forward and will apply. Well maybe but maybe not. Maybe if we built it, they will come or maybe they won't come. A lot depends on the details.

So as Ed mentioned, one example of a program where they did not come is the Medicare Savings Program. This is a set of benefits that helps poor, near-poor seniors pay Medicare out-of-pocket costs. More than a decade after the legislation passed, a third or fewer of eligible seniors had signed up to participate in this program.

The Children's Health Insurance Program, phenomenally successful, by and large, by five years after the law passed, only 60-percent of eligible kids were enrolled despite heroic efforts to educate the community and streamline the enrollment process.

As a third example, health coverage tax credits for laid off workers, certain early retirees wound up covering only a small fraction of the number that was anticipated when the legislation made its way through Congress in 2002. So there are plenty of examples where a failure to pay careful attention to these little details like eligibility and enrollment and retention has severe consequences in terms of failing to reach most of the target audience.

Now the good news is we have plenty of examples of programs that have succeeded. I'll give you a couple. One is

Medicare Part D low-income subsidies. Now all of the programs I've mentioned to you share a common characteristic.

They all rely on a consumer coming forward, filling out an application, and finishing through the process of enrollment. That's not true with Medicare low-income subsidies for Part D. If last year I got Medicaid in my state and the data match shows this then this year I automatically qualify for low-income subsidies without having to fill out a form.

Now if the match doesn't show that I'm eligible, I can come forward and fill out a form but it's a fallback. It's not an initial requirement. As a result, less than six months after this program first became available, 74-percent of eligible seniors were enrolled, most of whom were found eligible by data matches without any need to file a piece of paper.

Second example, in some ways more striking, Medicare Part B, as I think most of you know is part of the Medicare Modernization Act, premiums in Medicare Part B were made to be means tested but in determining my current subsidy, we look not at current proof of income, we look at what my federal income tax records show from two years in the past.

If this year's income has gone up, that will indeed affect my subsidy eligibility in a future year. If my income

has gone down and I need more help, I can come forward and apply for assistance and receive it right now.

So as a result, every single one of the tens of millions of Part B beneficiaries received an interim income determination on the corresponding subsidy level without having to complete an application form, a truly remarkable accomplishment. I would note that income tax data's used for a number of other programs as well who serve people who are not seniors.

The third example, Massachusetts, you can see Paul Revere riding his horse across the lawn to announce the uninsured are coming, the uninsured are coming. They did come in large numbers. Within two years of the state passing its 2006 legislation, only 2.6-percent of state residents were uninsured, the lowest number ever recorded in an American state.

Now more than half of these new enrollees received subsidized coverage either through Medicaid or the state's new ComCare program. I'm sure you all have heard about Massachusetts. Raise your hands if you've heard about Massachusetts. Alright a very informed crowd. Most people think Massachusetts' individual mandate, and that indeed was an important factor but not a sufficient explanation because most of the subsidized enrollees were exempt from the individual

mandate or did not have it enforced against them. So how do we explain it?

Well we came out with a report a few weeks ago, there will be a link on the Alliance website, that looked at Massachusetts and how they reached so many low-income people. Here's what we found. There was a massive public relations campaign that was critically important but there was indeed a driven eligibility.

About a year and a half after the program began. About one out of four newly covered residents in the state had qualified for ComCare using data already in the state's possession through its free care pool program for compensating hospitals and clinics for uncompensated care. With these folks, the state just said we're converting you automatically into ComCare. They didn't have to fill out an application.

In addition, when people did have to fill out applications, more than half the time they were not completed by the consumers themselves. Rather, they were completed by community organizations or health care providers on the consumers' behalf. So as a result, most eligible low-income residents in Massachusetts were enrolled into subsidized coverage without having to fill out a piece of paper. Sound familiar?

Now a little bit more about how they did this. E Pluribus Unum, we know that on the coins. Here's a civics question and a Latin question. What does that mean, e pluribus Unum? Anybody know? Out of many one, Ed's right on this, as on everything, he's right. Out of many one, that's what Massachusetts did.

The state has four different subsidy programs run by four different agencies but they all use one application form and it's processed by a statewide office within the Medicaid program that uses computer-driven logic rather than traditional case worker discretion. So the upshot is you fill out your form.

Wherever you send it, you send it and then you find out the program for which you qualify. You don't have to run from agency to agency until you find the right program. The state established a virtual gateway and cyberspace not in St. Louis and what they did is they said if you're a trained, certified staff of a community-based organization or provider, you can complete an application form on behalf of the consumer.

The state said hey providers, you know what, you're not getting paid a dime for a patient unless that patient completes the application form. That means no dish money, no nothing. Well you can guess hospitals, community health centers worked really hard to make sure people fill out those application

forms. The state gives small grants to community-based organizations to help consumers to fill out these forms and that's particularly important in immigrant communities and certain other underserved communities.

So the result is not only in the state. Did they rapidly achieve an incredibly high take up of coverage and a remarkable reduction in uninsurance? There were many fewer errors when eligibility was determined based on data and when forms were completed by trained application assistors. Ineligibility was determined much more efficiently.

It cost a lot less money to determine whether somebody was eligible or not. Now the GAO has looked at this issue more broadly not just in terms of health coverage but means tested programs in general and what they found is that if you use data-driven eligibility and matching between different programs, you can reach more people.

You can prevent errors. You can detect and thwart abuse of the program and you can increase efficiency. You can cut red tape by sparing families the need to file redundant applications filled with information they've already given the government all at the same time.

So how can we do this with national health reform? What are some lessons? Well lesson number one, you won't be surprised to hear this point is to use data whenever possible

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to establish eligibility for subsidized coverage rather than to force consumers to complete paperwork. Now you may note that the United States, as a whole, does not have a free care pool program comparable to Massachusetts but we do have an income tax system.

In the report that we're releasing today, we find that more than six out of seven uninsured, 86-percent file federal income tax forms. So if we can use income tax data to determine eligibility, we will have an enormous impact on reaching and enrolling the uninsured. Now the good news is the Senate bill comes really close to doing it.

You can just touch it. They use tax data to define eligibility for all subsidies including Medicaid and CHIP and there are important provisions that establish data matching systems and say that data should be used to establish, to modify, and to renew eligibility whenever possible but the Senate bill is not quite there.

Most important, there's a provision which says if you want subsidies in the exchange, you have to fill out an application form and it's kind of interesting because you fill out the application form then they match the data with the tax records and they say whether you filled it out properly or not. Well my goodness, why go through all that?

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If you're going to do the data matching anyway, just do the data matching to establish the eligibility and have the consumer confirm it or deny it. Why force that person to fill out a piece of paperwork giving the government the information it already has? Why force public officials to spend valuable dollars processing that needless paperwork? The House bill has farther to go. Income tax information determines eligibility for subsidies in the exchange but not for traditional Medicaid. There's some other issues as well. That's the first lesson, use data.

Lesson two is exploit the power of unity. Use a single application form in a single, integrated eligibility determination system for all subsidies. The Senate bill does this already. The House is coming close. They're heading in the right direction. They're not quite there.

The third lesson is use community organizations and providers to fill out paperwork for consumers when it's necessary. Neither bill provides significant funding for community-based organizations, which as you can see, it's a very sad thing. Neither bill gives providers new and powerful incentives to fill out forms for consumers, which is also sad.

So in sum, if you want to cover the uninsured, you have to pay attention to these nitty gritty issues. The pending

legislation makes important steps in this direction but further steps are needed.

ED HOWARD: Alright, thank you. Thanks Stan. Now we turn to Tricia Brooks. She's a senior fellow at Georgetown's Center for Children and Families and a research professor at the Health Policy Institute there. She was the Children's Health Insurance Program Director in New Hampshire for, according to her biographical sketch, longer than there's been a CHIP program. New Hampshire's enrollment and retention performance in CHIP has been among the country's best. Hence, a combination of analysis and practical experience and we're really pleased to have you with us Tricia to do both.

TRICIA BROOKS: Thank you Ed and I want to thank the Alliance and PhRMA for putting on this forum. I think it's a really important topic as we move forward in health reform. I'm going to focus a little more on the lessons that we have learned from Medicaid and CHIP.

The good news is that since this data that was released earlier this fall with the 2008 data on the insurance status of children indicates that we have dropped to the lowest percentage of uninsured kids in more than two decades since we began collecting these data. That is largely due to the success of Medicaid and CHIP because we know that this is a

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marketplace where children have been losing coverage in the employer-based insurance world.

The bad news is that out of the eight million kids that are still uninsured, five million of them are already eligible for Medicaid and CHIP. We also know that as many as 40-percent of those kids that are uninsured and it varies tremendously from state to state, were actually enrolled previously and are still eligible. So we have two challenges. One is certainly getting newly eligible kids enrolled but also there's a hole in the bottom of the bucket that we need to plug.

I'm not going to spend a lot of time on retention because we certainly have the queen of retention here with Ruth Kennedy and the job that they've done in Louisiana. So let's look at the lessons that we've learned from Medicaid and CHIP.

First of all, we've been able to identify a number of barriers and if we're really serious about enrolling all of the eligible kids and I think this certainly will apply to the exchanges and subsidies in health care reform, we have to identify those barriers and we have to remove them. So Stan's already talked a lot about paperwork.

We definitely impose too much paperwork on families that's not necessary, that doesn't do anything to strengthen the validity of the eligibility decision. It's excess

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paperwork and its costly to states. It results in children who are eligible not getting enrolled in the program.

We also don't do a great job of communicating in particular, communicating who's eligible. Many people have heard of their Medicaid and CHIP programs. They didn't think they were eligible. They didn't think they were eligible because they owned a home. They didn't think they were eligible because they had a job but we haven't really done a good job of making sure that people understand who is eligible.

Then for those who actually began the application process but are unable to complete it, we don't do a good job of communicating what's necessary for them to get enrolled. I think that's, hence, what you hear from Stan about a data-driven system where you're using existing data available to the state to identify these eligibility elements to make sure that we get kids enrolled.

There's also the issue of CHIP and that it's not necessarily affordable. CHIP is a program that we are able to charge premiums in and when those aren't affordable to families or the payment options are not flexible then families have a difficult time getting in and staying in. We also have some residual stigma associated with these programs.

They're much less about the product. If people tell you that families don't want Medicaid and CHIP, you can tell

them unequivocally we know that that is wrong. Families do want this coverage but what they don't want is the hassle that they get in the system of trying to get in and stay in. We also have cultural issues.

Those cultural issues are not isolated to people who have racial or ethnic diversity. It's isolated in rural areas. We used to encounter this in New Hampshire where we would talk with people who would say I don't have insurance. My parents don't have insurance. Why do my kids need it? Then lastly, we have outdated and inflexible technology that we're trying to run these programs on.

The other difficulty that we have is in coordinating these programs. That is lining up the policies, the requirements, the procedures. Often Medicaid and CHIP are operated out of two different agencies and that causes coordination issues. We have those systems being run out of separate computer systems. That also causes issues. Then when you try to move kids in between these programs, that results in incomplete and unsuccessful handoffs.

So it's not really rocket science what we need to do if we know what the barriers are. We need to harness technology and, as Stan pointed out, that's going to enhance productivity and accuracy. Then we need to engineer the business policies so that they're efficient, that the consumer are client-

focused, that they're performance-based and I'm going to come back to that in a minute, and that they are seamless to families.

So as Stan pointed out, Massachusetts has four different programs being run out of a virtual gateway. People don't need to know which program they're eligible for. They just need to apply and get enrolled.

So even though it's not rocket science, there are challenges that we face. Certainly, there's always resistance to change. I think a huge issue is the political will and state resources and Stan Rosenstein will talk more about that. Also technology cost, we do reimburse the states with federal funds, 90-percent for our claims payment systems but only 50/50 match on eligibility systems. So many of those are more than outdated.

States dramatically lack capacity in the ability to collect and analyze data and act on that data to improve how their programs work. There's a ton of effort that's required to really map out your processes.

If you want to re-engineer those business processes to be fully functional, you've got to take the time to understand how things are being done now to find the bottlenecks so that you can remove those and make the system function better but

that takes a lot of time and effort and states don't necessarily have those resources.

The last thing is that as we look forward into health care reform, we're going to add an exchange. We're going to add subsidies that are based on tax code and that's only going to add to the complexity of our coordination efforts. So what are our effective strategies moving forward?

Well first of all, we absolutely have to maximize the use of technology. It's a broad gamut of what technology will do from providing program information, providing new self-service options for families to screen, apply, renew, manage their accounts online. We need to centralize as much as possible these coverage programs.

We need to use those data matching that Stan talked about, use express lane eligibility, which is coordinating with other public programs that have already gathered the information that we need to determine eligibility. Lastly, and not least by any stretch of the imagination is getting better data so that we can make informed decisions about our programs.

We really have to make the system simple and consistent for families. Again, that's how do you apply, what are the requirements? Income, in particular, is a big issue. We need to make sure that there's consistency in our health care reform with Medicaid and CHIP. For example, you might have in CHIP a

20-percent income disregard but in Medicaid, you've got a $90 disregard for every working parent and you could deduct childcare. We need to align those kinds of decisions on our eligibility requirements.

We've got to work on our materials, our forms, our letters, all forms of communications to make them as simple and understandable as possible. We have to remember that one size does not fit all. We have to offer multiple ways for families to enter the system, either it's mail, web, on the phone, in-person, we need to offer all of those venues and to make sure that there's consistent information in process and it goes across those.

Lastly, as Stan pointed out, there are some good things in health care reform that talk about screen and enroll. We have to make sure that that happens every step of the way. Stan also focused on this and that is supporting community-based application assistance. It helps to overcome that stigma and those cultural and language barriers and community-based application assistance provides a full breadth of services from outreach to helping people apply, to helping them stay enrolled, to helping them understand what benefits they have.

Lastly, the community-based application assistors are really important in terms of giving feedback on what's working and what's not working and ideas about how to fix those

problems. We have to make sure that premiums are affordable. We have to understand that it's not just premiums. It's cost sharing. Premiums impact enrollment whereas cost sharing or co-payments impact access to services. We have to balance that.

I'm having come from New Hampshire and it being a high cost of living state, I've always been frustrated by basing eligibility on federal poverty levels because quite frankly, what 200-percent of poverty buys in Texas costs 300-percent of poverty in New Hampshire. So what looks affordable in one state may not be affordable in another state. I wish we could find a way to deal with that.

We have to provide options for families to make premium payments through various mechanisms not just send a check in the mail and also recognize that they need grace periods and there are times when things happen in their lives that create a financial crisis and they need help with making those premiums or getting rescued.

We also need to focus on outcomes. We have to have clear program goals. If we are serious about enrolling all eligibles then we need to make that a stated goal. We have to collect the data.

We have to show how well we're doing and that when we make program modifications that they actually make a

difference, that they result in improvements and if they don't result in improvements, let's document that too and make sure that people know that that's not the right thing to do to move the ball forward. These data need to be reported publicly to enhance accountability and transparency. There are very few states that report good data on their Medicaid and CHIP programs.

So in closing, I think health care reform gives us yet another opportunity to issue the welcome mat for families. This happened when CHIP came along for the first time doing the outreach and marketing Medicaid became something that was acceptable.

It really enthused the coverage of kids. CHIPRA has the ability to do the same thing with the reauthorization of CHIP but we need to make sure that as we go forward with health care reform that we coordinate the system and take care to make sure that it really does work in a seamless way for families and individuals.

ED HOWARD: Great. Thank you very much Tricia. Before we go on, could I just ask you to explain a little bit, you used a phrase that Stan alluded to without explaining, that is screen and enroll. It's a term of art I know and some of us may not be as familiar with it as others. Could you kind of clarify what that means in operational terms?

TRICIA BROOKS: Well it came about certainly in the CHIP and Medicaid world that when CHIP came along, there was a requirement in the law that says that you must first screen eligibility for Medicaid and if the child is eligible for Medicaid, they must be enrolled in Medicaid and that same concept is being applied in health care reform that wherever someone may try to apply for whatever program they're applying for, hopefully they're applying for health coverage and they don't have to decide whether they're eligible for Medicaid or CHIP or a subsidy but that wherever they present, wherever they try to get into the system that at that point, their eligibility is screened for every program that's available to them and that they actually result in enrollment.

The enrollment piece is a huge piece of it. We do a good job of screening and then we do these manual referrals between programs and paperwork gets lost and the system never comes up with an actual enrollment. That's where the data is really important for understanding what happens behind the scenes to make sure that enrollment is successful.

ED HOWARD: Good. Thank you. Now let's turn to Ruth Kennedy on my right. Ruth directs the eligibility division for Louisiana's Medicaid and CHIP programs. The Louisiana CHIP program is LACHIP and Ruth is also the LACHIP Director. In fact, she is a member of the Eligibility Policy Group for an

RWJ project, Robert Wood Johnson Foundation project covering kids and families when I first got to know about her great record in Louisiana. Now she's in demand to explain how other states can learn from Louisiana's successful enrollment and retention policies as Tricia mentioned. Ruth thanks for being with us.

RUTH KENNEDY: Thank you Ed. Thanks to everyone for the opportunity to share, from the perspective of a state government, our experiences in the last 10 years. I'm most often asked to talk about our eligibility improvements and simplifications and retention when it comes to children but I want to make the point upfront that all of the policies and practices we have implemented over our entire Medicaid program for our Medicare savings programs as well as for even our long-term care for parents as well as children. So these simplifications, this streamlining that I'm talking about and our results are applicable for our whole Medicaid program.

The subtitle for today's briefing I found especially intriguing to enrolling and retaining everyone who is eligible for Medicaid. Ten years ago if you had asked me was that possible, I would have said I don't know. I mean wishful thinking maybe but I can say unequivocally now that I believe that it is possible and that we have in our crosshairs being there in Louisiana within the next two or three years for our

eligible population but I have to be blunt and tell you that in order to do it, you have to make transformational changes in eligibility policies. Eligibility policies vary from state to state and there is great variation in those policies.

A quick overview of what I'm going to be talking about, I'll do a historic look at Medicaid eligibility in Louisiana. I'm frequently asked how have you been able to do this? So I've done some reflecting and so we'll take a flashback and see some of the things that are in place that have been the pre-requisite for what we've done.

The policy options that are available to states and they are just that, they're options, they're not mandates that can help enroll and retain everyone who is eligible for the program. The impact that the implementation of those policy options and changes in eligibility practices has had in Louisiana both on our enrollment and on the accuracy of our cases and finally some lessons learned from CHIP and general observations.

Medicaid eligibility in Louisiana during the 90s, now this is not a typo. In 1992, we eliminated the asset test for children and pregnant women in Louisiana. We eliminated face-to-face renewals and started making widespread use of community-based organizations to do application assistance and help people complete the application process. Now there was

another thing that happened in 1992 that was the catalyst for these three things.

Medicaid eligibility was separated from the AFBC and food stamp agency. I have been around a lot of time and we still refer to it as the split but because we were no longer so administratably linked to the food stamp eligibility determination, we were able to make some progressive changes. In 1998 when we implemented the program, this was another important decision was CHIP was implemented in Louisiana as a Medicaid expansion.

So what did that mean? A rising tide lifts all boats? So it was impossible for us to make improvements for CHIP without those changes being applicable for our Medicaid children as well. This is an important policy option that I think is frequently overlooked and that is 12 months continuous eligibility.

Twelve months continuous eligibility is very different from 12 month renewals. Twelve months continuous eligibility means that any changes in income are disregarded until the next annual renewal. So that policy makes a lot of the simplifications that we have put in place possible.

The last time I saw only 18 states currently have 12 months continuous eligibility for both their Medicaid and CHIP programs. We began then and we continue to do very aggressive

outreach for our Medicaid eligibility case workers, supervisors, and managers and that has been a factor in changing the eligibility culture in Louisiana I believe.

So still we had a problem even though we had made all of those improvements, until we discovered and identified the hole in the bucket and that was those children who were losing coverage at renewal and began addressing that is we were, at best, treading water.

It just felt like a hamster on a wheel but in about 2000-2001, we began giving our undivided attention to improving renewal outcomes. We started using data, as Stan and Tricia have talked about, using data from other systems, in this case the food stamp agency from which we had administratably separated but still very much work in tandem with, use that data.

I say Alexander Graham Bell's great invention, the telephone, is when we didn't get a form back just to call. Our case workers would call and say hey we haven't gotten that form back made a big difference in the number of people that we were able to keep in the program.

In 2003, we made the decision that we would no longer require a signed form in order to do the annual review of eligibility. Do we review eligibility? Yes but it doesn't require a signed form. We found better ways to do it. We

began allowing enrolling our off-cycle renewals. This has been a continuum. We continually look for ways to improve the renewal process. Now we have identified using data. We identified very low risk cases for ineligibility.

For example, the Medicare savings programs, our data shows that those individuals are very unlikely to get an increase in income or assets that would make them ineligible. So we do what we call an administrative renewal. It's a more passive process. Here's a little pie chart. This is based on children but it's going to be about this for all of our programs. It shows that in September, only two out of 100 enrollees who were due for renewal submitted a signed renewal form in conjunction with their renewal.

About 40-percent, we did an ex parte renewal use and information in the food stamp system. About 38-percent got administrative passive process, 17-percent phone, we're just getting into the web-based renewals and that's another area but you can transform eligibility and do renewals a way other than having families sign forms and send out papers.

So I know what you're thinking because I've heard it for 10 years. What about the error rate? Are these people really eligible? Now we don't allow so-called self-declaration. We verify income. We just don't require the family to produce documents and go on a scavenger hunt looking

for documents. We use alternative sources. We made good use of data to drive our eligibility decisions.

So our perm error rate, which was established and HHS issued a press release the week before last, in Louisiana for Louisiana's Medicaid program, 1.54-percent, which is 25-percent of the national error rate, so I think that validates that these kinds of simplifications do not increase the error rate. So there are policy changes that you can make that can help that as well.

We love the new express lane eligibility that is an option in CHIPRA and we actually have a state plan amendment that's pending at CMS and we're going to use data in the food stamp system or the SNAP system, as it's now called, to identify and enroll children in the program. We're poised right now to do automatic enrollment starting in January assuming that we get our state plan amendment approved.

So the verdict on eligibility simplification in Louisiana, first let me say that simplification isn't simple. It is a very complex process and it particularly changes to systems. They require money and they require knowledge and resources to make that happen but it does work and we see continually see robust increases in our enrollment. It's not about just seeing our numbers go up but also the number of uninsured go down.

Ten years ago, almost one in three low-income children in Louisiana was uninsured. Our most recent survey that LSU did for us, state-specific household survey, we had five-percent of uninsured. So it makes a difference.

We have been able to virtually eliminate paperwork related closures. When we first were able to get a baseline, we were close at about 22-percent of our children at renewal because of not getting paperwork in. Last month, it was less than one-half of one-percent. So I mean I'm saying that's virtually all children and adults who are eligible that were able to retain that renewal.

Administrative savings, conservatively, we estimate that if we were to require signed renewal forms again like we did circa 2000, is we would be looking at, conservatively, another $20 million in administrative costs. One of the things that has to accompany this kind of change is a change in the culture of eligibility and we've seen that.

So that's from Louisiana, some general observations from my 10 years in the trenches is building on that field of dreams idea that we've learned is if we build it, they may come but not necessarily. Some actual experience that we've seen challenges the classic economic theory that says that people will always do what's in their economic best interests. We

know, for the last 10 years, that that is not the case, that people do not have limitless ability to process information.

Increasingly, I'm beginning to question whether with welfare reform, is Medicaid and TANF or AFDC where deletes statutorily but there still seems to perhaps be in some places and administratively between food stamps and Medicaid so that Medicaid applicants and enrollees are held to a higher standard. Be careful what you ask for.

We've asked for express lane eligibility and we got it but there is a price tag attached with that because it works and we expect that we're going to enroll thousands of additional children. That is going to have a price tag attached. As long as states must put up even a part of the cost of coverage with health reform, even that five-percent that we're seeing right now, that's going to be an issue is that the cost that states have is going to be an inherent tension.

ED HOWARD: Great. Alright, some lessons from the trenches. Now we go to another coast and learn some different lessons. We're going to hear from Stan Rosenstein. He's Senior Advisor of the respected firm, Health Management Associates. He works out of Sacramento, which of course is a fitting base of operations since he was the Director or the

Deputy Director at the California Medicaid Program, MediCal, for about 13 years.

He oversaw some notable successes in that time including in areas of enrollment and eligibility process improvement. He has a close understanding of some of the massive problems that states like California are facing in the current economic situation. So we're very pleased to have you with us Stan.

STAN ROSENSTEIN: Good afternoon and thanks for having me. Thanks to the sponsors. Thank you all for attending. I spent most of my career working at how to simplify eligibility. I'm very proud of the things I've done and I agree with people have said. These are great ideas but I've been asked to come here, in part, to put a flavor on what's happening in the states and kind of the gut level reality check of what does this mean for states who are a fundamental part of this.

If you met one state, you met one state and how they operate. Every state operates its CHIP and Medicaid programs differently. They all differ on approaches and the approaches change very dramatically based upon how the state budget changes, well the governors change, etc. So it's a dynamic process but you really can watch how the process is changed with the budget.

The complexity of enrollment is really a function of four major issues. One is the desire of the state to reach the population and enroll them. You may say it's surprising that some states may not desire to do that. That's the reality. A big issue is the ability of states to fund the enrollment. States have to balance their budgets and, as you get better and better at enrolling people, it costs money. States have the ability to pay for it and if they can't pay for it, they can't do it.

So often, some of the red tape you see is a function of controlling costs. There's no question about it. You can see states simplifying when they have money and making it more complex when they don't. There's concern about fraud and abuse and it doesn't take very many bad examples to really set this one off. I can't understate what it's like when you get a call and say Mike Wallace is going to do a review of fraud of your program and 60 Minutes is coming out. Your life is very, very different.

Then the last thing that really complicates the process is litigation and often litigation to make people eligible complicates things. When you look at Medicaid and CHIP, you got to look at it and make sure you understand *it's* patchwork of programs, good and bad with every patchwork, you've added, you've increased enrollment, cover new people.

So income levels vary based on children's age, whether the parents, different levels for seniors, people with disabilities, working disabled programs. Some programs like California have breast and cervical cancer programs, every one of these programs had different income levels. So it's a very stair step charge, you have seen them, very, very complicated income. There's not one income makes you Medicaid-eligible.

There are many Medicaid eligibility tests. For parents, for most states, asset tests, 1931b program has what's called a deprivation test of whether the parents even get eligible, they have to pass this test. States vary and Medicaid varies how you define household. California's got an enormously complicated process created by a lawsuit and what I've seen over time is the way Medicaid defines household pretty much follows family law. It's very, very different than other programs define household. Food stamps, very different.

Medicaid, at least in California, we do everything we can to make a family eligible and then you get to questions of families that have stepchildren, working children, all of those income counts in some cases for some family members but it don't count for others. So it's very, very complicated.

The reason I talk about the complication is one of the concepts in health care reform that needs to be addressed and understood is enrollment versus funding. Health care reform,

it looks like, we'll provide an enhanced federal matching rate for newly eligible populations. We'll provide temporary matching rates for currently eligible population but, at some point, ending and it appears as though it may require maintenance of effort by states in terms of eligibility levels and processes.

The contradiction here is I went through all these complicated processes, asset tests, deprivation tests, well how do you determine who is newly eligible in a world of simplification that's income-driven? How does the state claim the federal funds for a family, for parents who would fail the deprivation test or fail the asset test but have income below the Medicaid tests? This is all going to have to be sorted out.

I know in California, when we went to the CHIP program, we like Louisiana, did the asset waiver as part of our CHIP expansion. We were entitled to an enhanced federal match. It was quite a battle to be able to work out a simple process to get an enhanced federal match. So I just want to leave it there that if states are required to determine who would have been eligible to Medicaid pre-health care reform, it's going to be a complicated process just to sort out the funding.

ED HOWARD: Stan can I interrupt you just to clarify something before it gets too far in my mind? I remember

something that you just talked about is something Stan mentioned in a conversation we had preparing for this discussion. You talk about the deprivation test and Stan mentioned the deprivation standard for parents. I remember you characterized that as the biggest single barrier for getting parents into the program. I don't have a clue what the deprivation test is.

STAN ROSENSTEIN: Okay, the deprivation test, it is the largest barrier for parents for two-family parents to get enrolled at least in California MediCal. I won't speak for other states. It's a legacy of the old welfare days but it's still in federal Medicaid and it basically says that for you to be qualified for Medicaid as a parent, your child has to be deprived. That means that child has to be either have a single parent or a parent who is disabled or if you have two parents, the primary principle wage earner has to be unemployed or underemployed.

So I'm sorry it's very complicated but this is the first test California does and it's 1931B, this family program. This is a test that more people fail and it used to be the old 100-hour rule who follow welfare but basically says if you're working long hours or making low-income but even if you're below the Medicaid income standard, you won't qualify.

So the example we always use is either cab drivers or farm workers that work long hours for low-income. They don't qualify. They can't get eligible. They ever get to the income test, they could pass the income test and it's still there. Most states, I think a lot of states, California did some of that is defined it so it's such a high level everybody passes but a lot of states haven't.

The question is when you define who's newly eligible for federal funding level, people who fail that test are newly eligible. The asset test is a better example too.

ED HOWARD: Thank you.

STAN ROSENSTEIN: Okay. I just want to make the point, I think hopefully everybody knows is that Medicaid is under enormous stress right now. We loom with a high unemployment rate that is not reduced yet and states are at least two to three years or more before revenues are returned where they were at. So we are under crisis at the state level.

We did a survey of states and we only found one state that now is not under physical crisis at this point. The bottom line is that states are going to continue to struggle with their financial crisis and this is going to make it very, very difficult to implement health care reforms. States are a fundamental part of it. What states have to look at is what is

the effect of health care reform on their current budget obligations.

A good example is when the CHIP program came in, one of the great things about CHIP was it expanded Medicaid enrollment very dramatically. As people focused on CHIP, actually I think we brought in more people in Medicaid than we brought in the CHIP because of the CHIP expansion. That brings a cost to the states. I hate to talk fiscally but the states have to look at this and say can we afford to meet our obligations with the need to balance budgets and very, very declined revenue.

So states are now, almost every state, reducing provider rates and program benefits. They can't reduce Medicaid eligibility now because of the Recovery Act prohibitions. They can reduce CHIP eligibility now and some are looking at that. Some have and California was one of them. States are looking at, some point, the enhanced federal matching rate dropping.

There's pent-up demand in Medicaid and other state programs. So states are very, very concerned about what's going to happen if the FMAP drops or when it drops and what does that do to Medicaid eligibility. So there's a number of challenges. What will we expect the effect of Medicaid expansion, which would be very, very large in health care reform to our Medicaid networks and Medicaid provider rates.

Will there be a need for states to increase their rates for specialty care?

Congress provides funding to increase primary care but not for specialty care. So would that need to happen? Without help, it's pretty clear that states will not be able to continue to afford to manage their Medicaid programs in their current level especially in an environment where health care reform, without a doubt, will bring and expand Medicaid for existing populations.

That's part of the whole intent is to get people who are not eligible or not enrolled but who are eligible to get enrolled and that's going to come at an obligation to the states that they're going to have to fund a part of. How does the eligibility work get done with the federal claiming rules? I mean can we simplify and yet know who would have been federally matchable, what FMAP level?

What happens if the simplification causes some people who are Medicaid-eligible not to be Medicaid-eligible anymore? Family units have used a tax form for example. Is it okay that a step-parent is on the tax form, wouldn't count in Medicaid to that child's income, is it okay now to accept that step-parent's child income for certainly the child's eligibility, you have to sort it out to make sure the child only consists of their immediate family level. Does the continuous whole

patchwork of programs make sense or should we get rid of some of these patchwork programs?

In conclusion then, most states do want to simplify their programs. It's a question of whether states can pay for it or not and whether the federal government and the states can sort out these claiming arrangements.

ED HOWARD: Terrific. Thank you Stan. Now you get a chance to join into the conversation. As I mentioned, there are microphones that you can use to ask your questions orally. There are green cards that you can write a question on. If you'll hold it up, they'll bring it forward. If you write it, they will bring it forward.

Let me take advantage of the microphone and your business in writing the questions to get us started. I want to start with Stan Dorn who mentioned in his presentation of the need to drive this process with data and particularly tax data was prominent, more prominent in your presentation. How do you minimize the privacy problems that we are often very concerned with when we're talking about income tax information?

STAN DORN: Well if I were king, what I would do is say on your federal income tax form, you can number one, on your health reform legislation with an individual mandate, it makes sense to say you have to indicate who in your household is uninsured at the time you're completing the form.

Then I would say give the taxpayer the option to check a box that says please use this data on my form and any other information you have about me to determine the eligibility of this uninsured person for subsidies. If the taxpayer doesn't want to convey that data, fine. They can come in. They can fill out a form. They can really go to town but let's give the taxpayer the option to disclose the confidential information. That's how I would do it.

Now what I would note is on the application forms for public benefits for Medicaid, for CHIP, and presumably for subsidies in the exchange, you have to waive your confidentiality for purposes of verification. So in fact, even if you wind up filling out, I mean under the Senate Finance Bill, I have to fill out an application form saying what was on my tax form and that gets verified with IRS to make sure that that was on my tax form.

So in other words, there's a considerable amount of disclosure of information that's happening anyway. What I'm suggesting is let's do it in a way that's a lot more efficient.

ED HOWARD: Okay. You mentioned express lane eligibility, I guess Ruth, you were talking about how well it was working in Louisiana. I wonder whether that is an experience based on your conversations with other folks who are working in this area, that kind of, I guess where are we? You

submitted an application for a waiver and are awaiting approval. Are there states that have done it and have results? How big of a deal is this? Anybody?

TRICIA BROOKS: Well we're still waiting on guidance from CMS on express lane eligibility. I think the important thing is that CHIPRA sort of smoothed the way to say it's okay to do this but there's going to be an evaluation to make sure that after the fact, it made a lot of sense but it sort of deals with some of the issues of the confidentiality of the data and how it's going to work.

Of course, as we all know, the statutes themselves don't give the kind of richness of detail that you need to operationalize something like express lane eligibility. Quite frankly, states are interested and I think that there's sort of this balancing act going on of is CMS going to tell states how to do it or is CMS instead interested in states trying different things and coming back and talking about what those experiences are to figure out whether this is really as good an idea as it seems like.

I won't speak too much for Ruth but when Ruth talks about express lane in Louisiana, they're talking about it on the renewal side. So they've already got a family who's enrolled who, at some point, actively wanted to get enrolled. On the renewal side of things, it's easier to deal with some of

those issues of do you have consent or do you not have consent. So I think express lane is a promising practice.

Particularly you see New Jersey, Maryland, and Stan knows a lot about this, Iowa doing some tests with state income tax. They are learning many lessons along the way but it's not yet a proven strategy that is the panacea that some people think that it may be.

ED HOWARD: Stan?

STAN ROSENSTEIN: I think at this stage, [inaudible] express lane, the changes were tremendously fixing some of the problems in express lane that, at least in our survey what we've seen so far, is most states are just waiting to see not what CMS is going to do as much as what their fiscal situation's going to be like. They're having very, very large case load growths there and they're just trying to manage their budgets right now.

RUTH KENNEDY: In Louisiana, we have been using our ex parte eligibility process. We have to crosswalk the income from the food stamp eligibility system into a Medicaid budget. Well under express lane eligibility, we will no longer have to do that crosswalk. The fact that the child or the adult or that senior is eligible for food stamps is, in fact it's only applicable in CHIPRA to children.

I think that's a consideration that needs to be put out there. What about the Medicare savings programs? What about seniors? What about parents as we look ahead to post-health reform. It's not the silver bullet but it's one tool that we need to have multiple ways and multiple tools available to states to be able to piece together this puzzle and find the sweet spot.

ED HOWARD: Ruth, a couple of things occurred to me as you were talking. One is, and I apologize for keeping asking clarification questions, but distinguish ex parte for us from, I don't know, third party review or automatic renewal or online processing.

RUTH KENNEDY: I'm not an attorney but I looked it up on Google a long time ago in 2000, and ex parte is a legal term that means an action by one party and in our case, that party is our Medicaid and CHIP eligibility agency without the participation of the other party. It means we go out and we do the leg work to find the information, to find the verification. So that is the ex parte process in Louisiana that, more than anything, was responsible for us getting our retention rates where they are today.

ED HOWARD: Second half of the question. Do you see any contradiction in using, as you were talking about, say food

stamp eligibility and minimizing the stigma effect that you characterized as persisting this long after the split?

RUTH KENNEDY: No. I think it is, for our population who is already receiving food stamps, we use that food stamp information, that food stamp data to keep them from having to provide it again but for that population who is not receiving food stamps, there's a different process for them. For example, we also look at state tax records, quarterly tax records.

Could you use that information for determining food stamp eligibility? No, because it's stale but because Medicaid and CHIP eligibility is very different from food stamp eligibility, you can have a more relaxed verification standard. So I think it's actually the best of both worlds Ed.

ED HOWARD: Okay. Is stigma, a problem in New Hampshire Tricia?

TRICIA BROOKS: I think, over time, stigma has been reduced particularly in the Children's Health Insurance Programs, when CHIP came along and we started talking about it as children's health insurance and many of the CHIP programs were delivering their benefits through contracts, managed care plans and began to look more like what you and I have with our employer-based coverage.

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I think that CHIP ushered in a lot of new practices that helped to remove that stigma from Medicaid. Certainly the split from TANA was a big, important part of trying to get it away from looking like it was part of the welfare system.

It's even changing with food stamps. You may have seen an article in *The New York Times* over the weekend that was talking about how even the stigma with food stamps is going away in this economy because so many people need the benefit.

ED HOWARD: Okay. Here's a question that actually let me direct initially anyway to Stan Rosenstein. Should states pay outreach workers or community organizations to find and enroll kids into Medicaid and SCHIP and I guess in the new programs, into any of these new avenues of coverage and as far as the past record, does this strategy work? I know in California, you have some experience with that.

STAN ROSENSTEIN: Yes. We've got quite a bit experience in paying outreach workers. When we started our CHIP program, we started off with grants and paying $50 enrolled application. Both were incredibly successful. We rolled out an electronic application and it worked. The problem is, over the budget years, I hate to be a broken record I apologize, all of that funding's now been cut.

It is gone but yes they should fund it and it works tremendously. I would add we've got to figure out ways to pay

for performance because you really want to pay for a completed, enrolled application.

ED HOWARD: It is not just the cost of the application. It's the cost of the coverage that results from the outreach.

STAN ROSENSTEIN: Yes but the problem was that we were rolling back everything else. People said how can you fund outreach. I also point out we paid for not as high an amount for retention because I think as Ruth said very well, you've got to fix the leak in the bucket or all the outreach in the world doesn't do any good if you can't keep people in. So we pay for both.

ED HOWARD: Go ahead Ruth.

RUTH KENNEDY: I would say as we have continually streamlined and simplified eligibility, we have freed up eligibility case workers and managers and supervisors to spend more time doing community outreach. There's that aspect but at the same time, it has allowed us these simplifications with, Louisiana is, of course, not immune to the budget situation.

We have a hiring freeze right now and in our eligibility division, we have lost 15-percent of our eligibility employees in the last 18 months, so without continuing to improve performance and do outreach with our eligibility workers.

ED HOWARD: Here's a question I'm not quite sure I understand but let me read it and maybe the person who wrote it can clarify if I mangle it. Are there lessons applicable from Medicaid/Medicare enrollment to individual commercial mandated insurance and what has been the Massachusetts experience? That's the literal reading of the question that I'm not sure that I quite understand the point. Any panelist who does would be—

STAN DORN: Well I don't know whether I understand the question, I never let ignorance prevent me from opining so I'll answer it anyway. In Massachusetts, people enroll into private coverage above the Medicaid eligibility level but it's often subsidized through the ComCare program. As I mentioned, the states use data that it previously had on hand to determine eligibility.

The state has had this comprehensive system through which providers have very powerful incentives to help people fill out application forms and community-based organizations have grants to help people fill out those forms. As a result, most of the people who qualify for subsidies have been able to enroll without filling out paperwork. Now that goes up for the subsidized coverage.

In terms of people who are, and the way it works is you fill out just one form. It goes in and you're told what you're

eligible and what you're not eligible for. Suppose you're not eligible for anything?

In Massachusetts, they say okay, now you can enroll in our affordable Commonwealth Choices program, which is available for people with incomes too high for subsidies. It could work much the same way in national reform where you have one, and in fact the Senate bill says this, one application form, you fill it out.

Whether you send it to the Medicaid agency, the CHIP agency, or the exchange, your eligibility for all those programs is determined and you're told here's what you're eligible for. If you're not eligible for any subsidies at all then they'd say you know what, you can enroll in any plan in the exchange. Here's your choices. So I think there are really important lessons to apply.

Now the interesting thing in Massachusetts is they had automatic enrollment of people only when they were not charged subpremiums at all. So once you reached the income level where you had to pay premiums, they said you have to enroll but we're not going to do that for you. You have to at least pick a plan and sign up and it actually lost some people at that stage.

So a question worth thinking about in the national context is do you want, under some circumstances, the default

of the enrollment even when premiums are being paid. Lots of tricky questions around that one. So I won't opine about that.

ED HOWARD: Very good. Here's a very straightforward question. Can you imagine schools or Kindergartens playing a role in the enrollment process? Maybe you don't have to imagine. Maybe it's happening somewhere. Anyone?

TRICIA BROOKS: Well I think if we enrolled every kid that was in school and every child that was born in the hospital, we could really take care of this problem of kids. Schools play a significant role in New Hampshire. When we started our CHIP program, they were, for a number of years, the biggest referral source to the program. I think the primary issue with schools is that they also lack the resources to do much more than disseminate information and refer families.

So I think if we were to invest in the schools and provide them with the staff that they need to actually help families get enrolled that we would go a lot further in terms of using the schools as a great source for getting kids enrolled.

STAN DORN: Yes, I think all of that is right but I would even take it a step farther. I would love to see a situation where you don't need to have school staff help you enroll, where when you send your child to school and you fill out that form that says here's what Johnnie's allergies are, I

give you permission to treat Suzie if she falls on the playground and breaks her arm, etc. you'd say now does your child have insurance, yes/no?

If not, do you authorize disclosure of your income tax information and any other personal information to agencies X, Y, and Z for purposes of determining your child's eligibility for your low-cost health insurance. Check yes, check no. Now if you want to do that, you need to say what your social security number is, social security numbers for everybody in the family.

That's what I would do if I were king and working with the schools but you all need to know that the data infrastructure in schools isn't necessarily so grand and that piece of paper that you fill out may wind up being on a shelf someplace. So you need to think about how does that data get actually entered into a computer, transferred over to the relevant federal authorities and so forth.

So that's a promising area but it's going to take a lot more work than one might think. You need to, don't underestimate the issue that Trish pointed out about schools have a lot on their plates now. They are suffering economic hard times as well. Even if you offer them Medicaid dollars for their outreach staff, a lot of people will say well you know, we've got to educate these kids. We've got No Child Left

Behind. We've got all kinds of pressures, not such an easy nut to crack.

TRICIA BROOKS: But you know, there's some interesting samples. Chicago actually started to target their title stand, Title I funds, Title V funds to, based on kids' enrollment in Medicaid and CHIP. So there's some ways to provide incentives to the schools but I think, as what's been pointed out here and I think Stan Rosenstein mentioned it most, this looks so simple on the surface. We try to tell families if you earn less than $54,000 a year, a family of four, you're eligible for Medicaid or CHIP. Just come sign up.

It is so complex under the surface. We lack the technology and the resources to really do it effectively. That's where we have to invest. If we are serious and I think that's a big if, if we're serious about covering all eligibles, we've got to invest the resources to make the system work.

STAN ROSENSTEIN: I would also add schools are incredibly valuable but it's time to really, there's a need to foster and improve relationships between the federal government, the states, and the schools. It wasn't too long ago that CMS was seeking to eliminate all administrative funding for schools. It is incredibly difficult to fund schools for either admin or for services.

Hopefully it's a new day and things can get better because the schools, actually the schools it [inaudible] schools, schools want to help. They want to do things. They need help, financial assistance and Medicaid can pay for it but we need greater flexibility in federal rules.

ED HOWARD: So that's not a statutory question?

STAN ROSENSTEIN: That's administratively. Things are better. I mean the regs have died that would eliminate administrative claiming but school funding's a landmine in Medicaid.

ED HOWARD: Questioner wants to know what gaming strategies might states use to try to obtain higher federal match rate for new Medicaid beneficiaries who might be old beneficiaries and of course, the other half of that, how can the federal government effectively monitor this?

TRICIA BROOKS: That's a question for you.

STAN ROSENSTEIN: We would never game the federal government [laughter].

TRICIA BROOKS: Never happen right?

STAN ROSENSTEIN: Well that's an enormous issue. I don't know if it's really gaming but think about we've got a 55-year old severely ill person who today, to get on Medicaid, has to become disabled, has to be determined disabled. Now

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same income level, they're Medicaid-eligible without the disability test, states do disability tests.

So are they ever going to do those tests anymore? That's one option, one thing that may happen and it may go the other direction too. I mean there's a whole world of work is going to be needed to be done on this issue.

STAN DORN: Yes I think there is a federal policy remedy but before I say what I think it is, I just want to underscore the severity of the issue. Stan talked about it in his very low key way during his presentation but people need to understand if Uncle Sam says you get enhanced federal match only for newly eligible people, that means if somebody could have qualified under state law as it existed back then back in 2009, why then you don't get that enhanced match. Everybody follow that?

So what that means is if I'm a 53-year old guy and I now qualify, well would I have been eligible as a person with disabilities? My health isn't so good but was I disabled? So does that mean everybody aged 53 is going to have to go through the full SSI disability determination process, all the forms, go to the doctor, etc.? Do you remember all the stuff about deprivation?

The beauty of eliminating the income test is now we don't have to worry about deprivation for eligibility but when

the state wants to claim that enhanced match, do they have to go through and prove that there was deprivation and therefore I would have been ineligible? Everybody following what the issue is?

So if you have to go through, it's complicated, but it's hugely important, if you have to go through every single enrolled Medicaid person and run them through the old Medicaid application process before you can claim enhanced federal match, you've accomplished zippo in terms of, and to use the technical health policy term, in terms of simplifying the enrollment process, so how do we do this?

Well what I would think about is sampling. How do we determine Medicaid error rates right now? We say don't do it in the front end. Do it in the back end. Take a statistically valid sample of your cases and for those small number of people, really investigate the heck out of them and see how many got coverage in error. Let's do that with claiming enhanced federal match as well.

Let's not require every single applicant to go through the 2009 Medicaid application form. After people are enrolled, sample them, see which portion would have been ineligible under prior law and use that to determine your claims for enhanced federal match. That way you avoid gaming. So you're protecting program integrity. You're building on an existing

administrative system that's already been used in terms of Medicaid eligibility errors and you're avoiding burdening the enrollment process with all these bits of information that are irrelevant to eligibility. So that's my recommended remedy for this really important policy problem that Stan has pointed out that I have never seen discussed anywhere else. So you guys are really lucky to be here and hear about it from Stan [laughter].

ED HOWARD: Yes, you want to identify yourself and let me just say that for others of you who will be going to the microphones as briefly as you can state your question, the better it is for our panelists to be able to address it adequately. Yes, go ahead?

BOB GRISS: Bob Griss with the Institute of Social Medicine and Community Health. Stan's comment about looking for a simplification solution for this problem and coming out with the sampling strategy is what is prompting this comment. It seems to me that there's no benefit to society, well to any segment of it, to deprive medically necessary services from people on the basis of any of the eligibility criteria that are being talked about here.

So I don't understand why there is such a focus on rationing health care to the poor differently than the rest of the population. Wouldn't all of these problems go away if

there was a right to health care for everyone and that all the resources that you are creatively figuring out how to use to ration care to the low-income people without hurting too many of them too often in too conspicuous a way could be eliminated by requiring, not creating policy options but requiring eligibility for health care on the basis of medical need.

That is how other countries do it. I don't hear any context for the discussion that you are leading us into about how to ration care without doing too much harm.

ED HOWARD: If I could sort of paraphrase what Bob has said, in the words of someone who identifies themselves as a career federal employee, if the goal is inclusion, isn't a single payer not-for-profit, privately delivered health care system clearly preferable?

TRICIA BROOKS: Well these are all very interesting ways to look at the issue. When we started the health care conversation or the reform conversation, it was pretty clear that at least the decision makers weren't willing to throw out the employer-based system.

There are only three countries in the whole world that rely on an employer-based health coverage system, Malaysia and South Africa and the United States but for whatever reason, that's what we are stuck with and people aren't willing to throw that out and start all over again but I used to tell

people in New Hampshire who were disgruntled at an ineligibility decision that if I made the rules, there wouldn't be any. Unfortunately, there are a lot of people who like to make a lot of rules and enforce them.

STAN DORN: If you had a single payer system where there were no premium payments and no out-of-pocket co-payments then that would work well for low-income people as well as for others but that's not what folks are discussing right now. I mean we have a chance in this country to see tens of millions of low-income people who don't have health coverage today receive health coverage. That would be a tremendous step forward. It wouldn't be as big a step as one could envision but we're having a hard enough time even taking that step.

So all these complications, as Ruth said, her motto can well be emblazoned as the title of this session, simplification ain't simple but if we're going to be stocked with this incremental world, we have to be willing to wrestle with these complexities and make it work as well as we possibly can for low-income people. I think that's where we are.

I mean are we going to throw up our hands and say to the tens of millions of low-income people with chronic illness no, no sorry you just have to wait another generation before you're going to get health coverage because what we're moving

to isn't as good as what we would like? That's not something I'm willing to say.

ED HOWARD: Here's a question for Stan Rosenstein following up on something you mentioned in your original presentation. Which states are reducing CHIP eligibility and how does that balance with the number of states holding on and increasing eligibility?

STAN ROSENSTEIN: Well I can't name every state that's reducing CHIP eligibility. I'll just speak about California. Without a Hail Mary at the last minute, we were prepared to take 500,000 children off of our CHIP program and right now what we're seeing is almost every state has got eligibility very high and every state has got budget problems.

The vulnerability that CHIP has is that it's not protected by the stimulus money whereas Medicaid eligibility is. That's why California didn't reduce eligibility levels. It just basically said we're going to limit our budget and not enroll children who are otherwise eligible because it's not an entitlement in California. I don't know if there's other states besides California.

ED HOWARD: By the way, let me just clarify once again. The reason you say it's protected by the stimulus money is there's maintenance of effort requirement in Medicaid?

STAN ROSENSTEIN: Right. Medicaid got the FMAP. Medicaid was prohibited from reducing eligibility levels, enrollment processes. CHIP didn't get the increased FMAP and didn't get those protections, unfortunately made it vulnerable.

TRICIA BROOKS: There's a synopsis of a report that the center did, in your packet, called *Weathering the Storm,* actually 23 states made either increases to eligibility in CHIP or implemented simplifications in the way they manage their programs. Only three states, and California was one of them, took backwards steps. So we were pretty impressed with the fact that states have held steady on their commitment to children but that's really consistent with the will of the American people.

Survey after survey even year after year, you end up with, in the high 80s, low 90s-percent of Americans who say we should cover all children even if it increases my tax burden although I do know that there are several states that have already proposed cuts, say this is going to be an even worst budget cycle. We know that departments that manage their Medicaid and CHIP programs have been asked to come up with cut lists for their governors.

The Governor of Iowa just recently turned down passing on some simplifications that they had put into state law back last July. The Department in Washington State has proposed

cutting eligibility from 300 to 205-percent. I think you're going to see more of this but I am reasonably confident that, we particularly in an election year, that we're going to see states holding on the children's health insurance programs because they're just way too popular I hope, cross my fingers.

ED HOWARD: Here's a question in the let's you and him fight category. It seems to me Stan and Tricia, and I'm not sure which Stan so whoever really wants to disagree can chime in, Stan and Tricia disagreed about whether using the tax code to dictate subsidy eligibility is a good idea. Is that disagreement as perceived really true and if so, is there a way to reconcile those concerns?

TRICIA BROOKS: Okay, so I'll jump in here first. At least I think I know where the question was going. I think, first of all, there are two issues. One is using the tax code in express lane eligibility. The other's using tax code for subsidies in health reform. I'm happy for us to use the tax code. I just want us to use it for all the programs. I don't want to have one standard in Medicaid, a different one in CHIP, and a third one in health reform.

So if we're going to use the tax code, let's use it across the board and let's keep the definitions of household size, whose income counts, where the source of that income comes from, let's make it consistent among all the programs.

Now before you make a comment, I'll go to the express lane eligibility. My concern with what's going on with the test in state implementations of using the tax code to find and enroll kids through express lane is that we have proven through eligibility process improvement collaboratives, retention collaboratives that Robert Wood Johnson Foundation has sponsored that small-scale testing is really the most effective way to figure out if an idea's a good idea, sort of work the kinks out of the system and then when you find success to spread that success.

We launched very big initiatives in the states, they're using the tax code. For example, the state of Maryland, I think it was Maryland, when they asked the question on the income tax about whether you have health coverage, it wasn't specific to children. It was worded in a way that you didn't necessarily give an accurate response.

So when we make those kinds of mistakes, it would appear that we have something that doesn't work but if we would implement those kinds of initiatives on the small-scale, figure out what works, what doesn't work, and then spread them and let them be successful, it would be highly more efficient and effective.

In Iowa, when they did their income tax code, the tax department, whatever their name is, sent a letter to the

Governor and said we identified tens of thousands of families who said their children were uninsured. They don't even know whether they're already enrolled in Medicaid and CHIP.

They went through an outreach process and they enrolled 400 kids and they said it costs them $58,000. My numbers are not accurate but you get the picture that what happens with these big tests is that you haven't worked the kinks out of the system and you come back with something that doesn't look like a tremendous success.

So I would suggest just going at it from a different perspective. That is making sure that you do it on a smaller scale and figure out how to make it work. It's a promising practice.

STAN DORN: Yes. Well I'm sorry to disappoint the questioner but I agree with Tricia. Number one, using the same income methodology for all the subsidy programs makes a lot of sense and that's what the Senate bill, by and large, does not entirely. If you want to preserve existing Medicaid eligibility or CHIP eligibility. However, you need to recognize as Stan R. pointed out that you're going to cause some people to lose that eligibility.

So one option you have if you want is to say first we see whether you're eligible based on the tax data and if not,

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you can come forward and show that you would have been eligible under the old systems of Medicaid eligibility.

So you could do that if you want first thought. Second is I totally agree with Tricia about the desirability of small-scaled implementation, tests that work the bugs out. We shouldn't be under any illusions that that's going to be enough to solve the problem though.

I mean in Maryland, Howard County did it first and then they took it statewide and they kind of screwed up but one huge issue facing Congress is how much administrative discretion are you going to leave HHS? I have to say I'm very worried that to the extent, lots and lots of details get specified, Congress may find that they have locked HHS into a weird little corner with totally unforeseen problems. I mean I'll give you an example.

With the health coverage tax credit program and I've obsessed over that program for years and years and years, they had this weird problem that emerged that said that where in order to apply for the credit, you had to already be enrolled in health insurance paying the full premium. Now that seems like a bizarre thing to do right?

The reason why is because the definition of credit eligibility in the statute said somebody's eligible for the credit if they're enrolled in coverage. Well my friends, we

have the same definition of subsidy eligibility in the exchange under the legislation.

So my counsel, if there's any folks from Congress here, give as much discretion as you feel you can, HHS, in working out these little nitty gritty details because I guarantee the world's going to be a heck of a lot more complicated when implementation time rolls around than anybody in Congress is currently imaging. One piece of that flexibility is the ability to do slow step-by-step testing of innovative strategies.

ED HOWARD: We have time for just a couple more questions. I'd ask you to pull your blue evaluation forms out and fill them out as you listen to this last couple of exchanges. We have a couple of questions on a sort of nuts and bolts level. Maybe Ruth can start off. Are there enough, were there enough accessible, local field offices for walk-in options in your state or most states for people who really need that? How do you assure adequate training for your outreach staffs?

RUTH KENNEDY: Well in Louisiana, we have about 40 Parrish or county eligibility offices but augmenting that, we have about 500 community-based application centers where a person can go and get assistance. That would be community-based organizations. Some are provider-based. So there is, I

think we have the opportunity is there and it's very important for those, not only of course our case workers, our eligibility case workers in those 40 offices are trained.

Nut we have a very, it's been in place almost 18 years now, that training for those, we call them application assistors. So that is a couple of days training that before they can do that assistance. So that's very much a process in place, the training because misinformation is worst than no information at all. So it's very important that people get the right information.

TRICIA BROOKS: Well I'll just kind of quickly comment on that. In New Hampshire, we had a very robust training program for community-based application assistors but it's an ongoing effort. It's not a one-shot deal and we implemented that in various ways.

We had field coordinators who did initial briefings with folks and then we had semi-annual trainings and you just have to make a commitment to keep going to make it happen but I would suggest to you that there's an internal training problem in our eligibility offices as well.

When I talk about consistency, you could go from eligibility office to eligibility office and find that case workers do things differently. So training is a really

important, key in health care reform to make sure people get it right and are consistent in how they apply the rules.

ED HOWARD: How many states do what Ruth was talking about, which is centralizing sort of the decision making of eligibility so that you can smooth out some of the inconsistencies from office to office?

TRICIA BROOKS: The states that rely on county-based eligibility systems certainly have some challenges in terms of ensuring that kind of consistently. I don't have a count. Stan?

STAN DORN: It's a huge issue. It's a critically important issue and not much work has been done on it. There was a paper by the United Hospital Fund of New York that talked about the county eligibility system of New York and some of its nightmarish problems and Stan has had to deal with it in California. I'm sure he can regal you indefinitely with horror stories.

My impression is that most states do not have a county-based eligibility system but that the minority that do is a significant minority and it includes a lot of the largest states like New York and California and New Jersey but it's a huge problem.

ED HOWARD: The last question I have is actually a combination several questions and it raises the same issue for

a couple of sides. Starting from Stan Dorn's comments on which features are in or out of the various reform proposals, the question is kind of a combination of an elaboration of what Stan was talking about.

What's in there that we really ought to be interested in hanging on to and what's not in there that we ought to be making some noise about the value of adding at this stage? What are the barriers? What are the tools that we need to have or should have to do something about smoothing some of the problems that we've been talking about? Stan Dorn?

STAN DORN: I'll take a crack at it. I think critically important to hang on to is the Senate bill's use of a common income methodology for ineligibility discrimination method for all subsidy programs that I think it'd be important to build on that and eliminate the requirement in the Senate bill that everybody has to fill out an application even if the government already has all the information in hand needed to determine ineligibility. It's essential to make sure that people could say please determine my eligibility. I authorize you to look at all my data. So that's one important piece.

Another important piece is dealing much more effective way with changes in income levels over time. Low-income household income fluctuates greatly and all of the bills try to capture real time income information and it's just a set-up for

a nightmare. Let me give you a couple of examples of the forms that the nightmare can take.

The House bill says that you have to report all the changes in income. You know what's going to happen? People won't do it. There will be an audit and they'll find huge number of rates of errors because both the House and Senate bills say we're going to precisely allot your premium subsidy to your income. It's going to be a percentage of income. So if my income is $100 higher, my subsidy should be $2.33 lower.

So that means when they do this audit and all kinds of people haven't reported that they've gotten three extra hours in the restaurant last week, we're going to find that 90-percent of the people are going to have these errors and it's just going to be a disaster. That's just one particular form the disaster's going to take.

Another form the disaster will take is that people will change incomes and they'll report it and suddenly in February, you go from Medicaid to the exchange and you have to change health plans and suddenly you'll have to spend 63 times more for your premiums and then in July when they cut back on your hours, you go back into Medicaid. These are going to be silly things.

So the best approach would be to do what we've talked about in Louisiana is to provide a continuous eligibility

period where at the beginning of that period, it's 12 months in Louisiana, it could be a shorter period of time, you say based on all the information we have right now, this is your subsidy level.

It's in place until 12 months from now, six months from now. The problem with that is it raises your subsidy costs because that means people, three months from now who have higher incomes, are going to have the same subsidy that they had in the past. So that's why all the bills try to provide some form of real time income determination but it's just a disaster waiting to happen.

So I think a much better push, if you don't want go to the full 12 months route, at least you can do things like six months continuous eligibility or when somebody files their federal income tax form, let that automatically renew eligibility or when quarterly wage reports become available, have that automatically change eligibility but it's a really serious problem.

TRICIA BROOKS: Well I think 12-month continuous eligibility is absolutely critical moving forward. I have to say I've been specializing more on CHIPRA and health reform and waiting until we have a final bill to figure out what it really means for children and families but we have to do more about collection analysis of data and making those data publicly

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available and being transparent in how well we're doing in our programs. CHIPRA started to get at that a little bit. I'm not sure how well health reform deals with it but it ought to be part of the package.

STAN ROSENSTEIN: I think it's critical that at least CMS really has the flexibility to do something to sort out the funding versus the eligibility process so that states can simplify and make sure, I like Stan's idea, doing a sample but it'll be critical that CMS will have the authority to do that otherwise you could just see it coming when they say case by case determination.

RUTH KENNEDY: I think that is important to pay attention to administrative funding, the match rate for administrative funding. Perhaps the reason that Medicaid lags is that the match in Medicaid for admin is 50/50 whereas states get the same match rates, the enhanced matched rate for administrative costs in their CHIP program that they get for payments for services.

So are there ways through match that you could incentivize those kinds of practices that you want to see. I think CHIPRA begins to do that but we need to look further into that, is for example the systems. These costs, the simplification is very expensive. When states are having to

pay 50-percent of those costs rather than 90-percent, it's going to enforce their decisions.

ED HOWARD: Okay. Well that is about as good a way to summarize the discussion as I can imagine. You know, there are very few areas of bipartisan agreement these days about health care but we seem to have agreement on the proposition that if you're eligible, we want to actually get you covered and get you the care. I think that makes this discussion about as important as anything that we're talking about these days here.

The other point I think that's important is that if we do pass a reform package, the practices that we've been hearing about today are going to be needed to fulfill the promise of that legislation.

If reform doesn't pass then enrolling and retaining these now eligible people, the millions and millions of not just kids but adults as well may hold the biggest potential for broadening access to care that we have in the next couple of years.

So I want to thank the staff of the Alliance for putting together a great briefing, thank our friends from PhRMA for supporting both Stan Dorn's research and the briefing itself. Thank the panel,

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I'll ask you to help me, for a thoughtful and nuanced and very practical discussion of the issues that are involved in this particular aspect of reform [applause].

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