



**Trends in Health Insurance Coverage in the U.S.: The Impact of
the Economy
Alliance for Health Reform
December 6, 2010**

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ED HOWARD: -I'm Ed Howard with the Alliance for Health Reform. Thank you for coming. I want to welcome you on behalf of Senator Rockefeller and Senator Collins and our board of directors to this program to examine how trends in health insurance coverage in America are being affected by the larger economy and what the new health reform law might have to say about that.

While reform was being debated last year and early this year, both sides noted that the number of uninsured Americans was high and needed attention. They didn't agree on what to do about it, no big surprise but there was a pretty clear consensus on the need to bring down the number of uninsured.

Then in September, the Census Bureau told us that the number of uninsured had actually grown by more than 10 percent in one year from 45 million in 2008 to 50 million in 2009. In short, while Congress and the President were working on ways to bring down the number without coverage, millions more lost coverage. It could have been worse as you're going to hear today.

You're going to hear also that the worst recession since the 1930s has had a substantial impact on health coverage for ordinary Americans and that the slow growth economy we're now experiencing is going to have an impact in the future, and

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in 2014 when the major coverage expansions are scheduled under the Affordable Care Act, we're going to hear from some important state officials who have to cope now with consequences of the economic slow down.

We're pleased to have as our partner in today's program the Kaiser Family Foundation's Commission on Medicaid and the Uninsured, one of the best sources of information, if you haven't identified that yet, on coverage trends and Medicaid, and other public programs.

Representing the Commission is its director, Diane Rowland who also happens to be the Foundation's Executive Vice President and also the Chair of the newly created MACPAC, the Medicaid and CHIP Payment and Access Commission that was created by the ACA. So Diane thank you for being here.

DIANE ROWLAND: Thank you Ed and thank you all for coming. Once again, we're here to talk about Americans without health insurance coverage, who they are, why their numbers have been growing, and what some of the implications of that have been for the public coverage that often helps to fill in the gap when individuals lose their employer-based coverage or more significantly when their income declines to levels where they would qualify for public programs.

Indeed this has been a long and hard recession on many of the folks that we will talking about in terms of their

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ability to gain health insurance coverage, retain it for themselves and their families, and especially on some of the states that have had to face both declining revenues as well as increased enrollment in the Medicaid and CHIP programs due to the recession.

Some help from the federal government through the FMAP extension that increased the federal share of funding for the Medicaid program but that's going to end in July and our state commentators may well comment on some of the implications of that since what these numbers are going to show us is that even though we talk about health reform, we have not solved yet the problem of the uninsured or the way in which recessions impact people's health insurance coverage.

So I'm delighted today that we're able to focus on the people and the concern of why they are lacking health insurance and what some of the changes that health reform will bring about could do to change these trends but I think it is a sobering time to remember that as we debate exchanges and all the other pieces of health care reform, we have to also fundamentally remember that there are 50 million Americans who, in 2009, were without insurance, potentially more in 2010.

We really need to make sure addressing their coverage is a part of what we do. So I'm pleased that we've got this session but I'm not very pleased that the number of uninsured

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continues to grow but I think it is a time to deal with it.

Thank you.

ED HOWARD: Thanks Diane. A couple of quick housekeeping points, in your packets you're going to find a lot of material that is relevant to discussion and a list of other material that's not in your packets but is relevant. You can find those on our website at allhealth.org. Probably some time tomorrow, you'll be able to view a web cast of this briefing thanks to the Kaiser Family Foundation at KFF.org.

A few days after that, there'll be a transcript on our website of the briefing itself. At the appropriate time, you can use these microphones that are here to ask questions. There are also green question cards that you can fill out and hold up and we'll bring them forward. If you would remember, in the back of your mind, to fill out the blue evaluation form to help us improve these programs as we go along, it would be much appreciated.

So let's get to the program. We got some very, very good panelists with us today. We're going to hear from them and then you get a chance to be part of the conversation. Leading off is John Holahan who's the Director of the Health Policy Research Center at the Urban Institute.

John's one of the most knowledgeable experts in America on Medicaid and state health policy. He's been writing,

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recently, on cost containment and how states will likely be affected by the ACA. He's the author, which is most immediately relevant, of a new paper entitled at least in this iteration, *The 2007-09 Recession and Health Insurance Coverage*. It is appearing today as a web-first paper in *Health Affairs* and thanks to Susan Dentzer for allowing us to reproduce it. She asks that we not make this the publishing debut of the paper.

If you want to make more than personal use out of it, go to their website or have some contact with *Health Affairs* if you would and you would help our relations with *Health Affairs* and your ability to have *Health Affairs* papers in our packets in the future. John, thank you for being here. Thanks for your paper.

JOHN HOLAHAN: Thanks Ed. So I'm going to go through what I did in this paper and essentially provide some data on what happened to the economy over the last decade between 2000 and 2009 and then what happened to health insurance coverage and suggest the linkages between the two and then focus a lot on the last two years when the recession has been very deep and known, as many of you know, as the great recession.

So this is the data on unemployment rates over the decade. You go back to 2000, the official dates of that recession were 2001-2001 but as you can see, the economy stayed

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weak for the next couple of years. Unemployment rates were high, state revenues continued to decline. Incomes continued to decline in real terms. So that recession, more or less, ended in about 2003-2004.

After that, there was a clear economic recovery. There was income growth, declining unemployment rates. Recovery was not real strong but nonetheless it was clearly a very positive period until 2007 and then everything broke loose and unemployment rates increased from 4.6 to 9.3, and recently the other day announced at 9.8.

This data shows what happens to real personal incomes. The top is real median household incomes then real per capita incomes. They decline in the early period. That is the earlier recession, then grows a bit and then decline again by about four-percent or so. Two things are to note, there is that the peak in 2007, incomes did not return to the peak of 2000.

So there was still some decline even though we had some recovery. Over the entire period, at the very end, there's a decline in real incomes of about five-percent and it really doesn't matter whether you look at real median household or real per capita income. So overall, we as a nation got poorer.

Another way to look at that is to look at the net change in population growth. What net change means is that

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people are being born, they die. People move in and out of the country and they move up and down the income ladder.

So what this captures is what are those net flows look like. What you see is that the middle income group fell a bit from 74.6 to 72.3 over the 10-year period. The upper income group increased a little bit. You could go further out to 400-percent above poverty and probably see growth but by and large above 400-percent of poverty; both groups pretty much stayed the same.

What's really striking is the number of people below 200-percent of poverty and how much that changed. That group grew by about 25-percent. So the net change in the population growth over this period was really among low-income people.

ED HOWARD: John, excuse me, are those numbers in millions of people? Is that what that is?

JOHN HOLAHAN: Millions of people.

ED HOWARD: Okay, thank you.

JOHN HOLAHAN: Right, right. Okay, this is what happened to coverage of adults over each of these three periods, so 2000-2004 you see a fairly sharp drop-off in employer coverage, some increase in Medicaid and state coverage. Medicaid is not anywhere near as important for adults as it is for children. Because of the sharp drop in employer coverage, uninsured rate went up to 19.5-percent.

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I think in your packet that's going to say 18.1-percent. Are you able to correct that today but the end of the day, there was an increase of 5.6 million in that previous recession in the number of uninsured. Between 2004 and 2007, the economy improved but the rate of employer-sponsored insurance continued to decline.

Medicaid offset some of that and the uninsured rate blipped up a little bit because of that and because of the population growth, you got another 1.5 million uninsured in a period of some economic growth. Between 2007 and 2009, we saw another sharp drop in employer coverage some of that offset by increases in Medicaid and state coverage but the uninsured rate jumped by almost three percentage points and another 5.6 million uninsured.

So the driver here is what's happened to employer-sponsored insurance. There's a lot of reasons for that. Premiums were growing faster than wages making it less likely particularly for smaller firms to offer coverage, less likely that people are taking up that coverage but it's more than that.

There's been a shift in the way we work from industries that have had high rates of employer-sponsored insurance to those that are low, think manufacturing moving to services, a shift from higher to lower paying jobs and many of those jobs

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coming without health insurance, population migration, moving to the northeast and Midwest to the south and west where rates of employer-sponsored insurance are well below those in the northeast and the Midwest and uninsured rates are higher.

A lot of these losses in employer coverage are among lower wage workers and the data you saw before, we have more of them. So they're experiencing a likelihood, an increased likelihood of not having coverage but there's also a lot more people in those income groups. Among children, you see an interesting contrast.

The changes in employer-sponsored insurance are pretty much the same but the Medicaid and state coverage jump a lot because of the expansion of Medicaid and CHIP going all the way back to the 1990s. So Medicaid increased from 16.7-percent of the child population to 28.3-percent over the period the uninsured rate fell and the number of uninsured children declined. So essentially Medicaid and state expansion offset the drop in employer coverage and led to a decline in the number of uninsured children.

This chart shows some of that same data in a slightly different way. It looks at percentage point changes and the trick here is that the percentage point changes below the line have to be matched by percentage point changes above the line.

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So if employer-sponsored insurance falls by 4.1-
percentage point there as it does for adults. I'll point out
that a percentage point is a lot of people like 4.1-percentage
points is 5.6 million losing employer-sponsored insurance.

Medicaid increased by 1.3 percentage points but the
percentage of people without health insurance increased by 2.7-
percent. The overall population down at the bottom increased
by 2.6 million. So there's a higher likelihood of being
uninsured, coupled with population growth, led to that increase
of 5.6 million in just two years in adults without health
insurance.

The picture for children is very different. They had a
larger drop in employer coverage but a very large increase in
the likelihood of getting coverage through Medicaid or CHIP and
because of that, there was a small drop in the likelihood of
being uninsured.

So this meant that the number of uninsured children
fell by 600,000. So at the same time, you're seeing this large
increase in uninsured adults, we're seeing a drop in the
coverage of children all tied back to the Medicaid and CHIP
expansions that allowed those losing employer coverage to be
picked up.

The next slide focuses on low-income adults and
children because that's really where all the action is. It's

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affecting those who are already low-income but it's also affecting those who became low-income, which turns out to be a lot of people.

So among low-income people, there's a drop in the rate of employer-sponsored insurance by four-percentage points. Some increased in Medicaid and CHIP and an increase in the uninsured rate of three-percent. So that increase likelihood of being uninsured of three-percent coupled with the large growth in that low-income population of 7.8 million meant that 5.1 million became uninsured, so that's 5.1 out of the 5.6.

Among kids, the big expansion of Medicaid and CHIP offset, way more than offset the drop in employer coverage so that there was a big decline in the uninsured rate. The number of uninsured children would have fallen by even more had it not been so many more children became low-income. So you got to couple what's happening in these insurance markets with what's happening to the income dynamics affected by the economy.

This looks at the changes in health insurance coverage by work status. What's interesting here, to me, these are all people in a household or a family with two full-time workers or one full-time worker, part-time worker, no worker is that the drops in the likelihood of having employer-sponsored insurance fall but not by a lot.

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Medicaid and CHIP pick up some of that and the uninsured rates are basically pretty flat. So if you're working, you're pretty okay. I mean it didn't really affect you but if you look down at the bottom, you can see that we are losing lots of people out of these two groups, the number of people living in households with two full-time workers fell by 4.7 million, one full-time workers by 4.3. Where did they go? They went into just a part-time worker or no worker.

So while the number of uninsured people, if you were still working didn't really change, you can see that more people became part-time workers or no workers with the likelihood of having employer coverage to begin with is not great. What the chart also shows is that it declined for those people so that the likelihood of having ESI dropped off quite a bit.

Some of those people got Medicaid and CHIP but there was a large increase in the uninsured rate among both part-time workers and no workers. So that meant that if you add those together, 5.5 million at the bottom, of the increase in the uninsured was among those households in those two categories on the right. So why is there a drop in the ESI among no workers? It's COBRA and it's getting coverage outside the household just in case anyone's curious.

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The next chart looks a little bit by region. Every region's been affected by this economy with the biggest increases in the uninsured rate have by and large been in the Midwest and the west. That shows up in the drops in employer coverage, which are well over four-percent. In the Midwest, some of that is picked up by Medicaid and CHIP but the uninsured rate went up by two percentage points. I think in many ways the Midwest was the hardest hit by this in terms of health insurance coverage.

The number of people uninsured in the Midwest increased by 18-percent. It was about 10-percent in all the other regions but in the south and the west, they started from lower rates of employer-sponsored insurance and much higher uninsured rates.

So any real effect on them is starting from a much bigger base and results in pretty big increases in the number of people uninsured. So it's 3.1 out of the 5 million increase in the uninsured is in the south and the west even though the declines are not quite as great.

So a few other things before I close, about 60-percent of the increase in the number of uninsured was among Whites. This is in line with their share of the population but it's not in line with their share of the uninsured population. It was disproportionately large.

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If you look at the data on what happens to income transitions over this period, Whites turned out to be affected more than others starting from a higher base but fell off quite a bit. So the impact of them on the likelihood of becoming uninsured was really quite significant.

About 80-percent of the increase is among Native citizens, non-citizens that we hear so much about, only a small share of this growth. They are about eight-percent of the uninsured population and they're only about four-percent of this growth in part because there was some out migration among non-citizens. That population became smaller.

The next point, about half of the increase in uninsured adults was among young adults but for the first time in this decade, there was a drop off in or an increase in the uninsured rate among older adults. They had been able to maintain employment and maintain coverage throughout this decade but not in the last two years. I think much of this is related to job loss but it's sort of an ominous, ominous thing given their poor health and younger population groups.

So to close, what I think this data shows is that there's a longstanding secular decline in employer-sponsored insurance related to a whole bunch of reasons, faster growth in premiums relative to wages and how that affects employers' decisions to offer coverage but it's also related to how, where

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people are working, much less in manufacturing, more likely in services, construction, agriculture, and so forth, declines in incomes, more low-income people, many in jobs that are less likely to offer health insurance.

All of this is exacerbated by economic downturns and we've had two of them in this decade. There is a slow increase in public coverage among adults, much greater expansions for kids. So they did so much better in all of the uninsured. The increase in the uninsured is concentrated among adults.

We all know that the growing uninsured place great strains on families and health care institutions and I'll point out that this is likely to continue as a growing problem up until 2014. At that point, health reform, assuming it gets implemented, will end the link between the ESI and the uninsured by expanding Medicaid and expanding tax credits.

So the options that are there now for kids and why they did so much better will then be there for adults. So while the number of uninsured will fall because of health reform, the other thing that we'll see is this susceptibility of being uninsured to the economic cycle, the business cycle. That should change as well. So that's a somewhat positive note to close on.

ED HOWARD: Thanks John. Excellent table setting for this discussion. Next we're really pleased to welcome back

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Sherry Glied this time in her new position as the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services.

Prior to assuming those duties, Sherry chaired the Department of Health Policy and Management at Columbia's Mailman School of Public Health. She's an economist, one of the most respected health economics' analysts in the United States and very pleased to have you back.

SHERRY GLIED: Thank you. Thank you very much and thank you for that warm welcome. I really appreciate it. I'm very glad to be here finally. I'm going to reiterate a lot of John's themes and tie them in a little bit to how we're looking at changes in health coverage and where the Affordable Care Act fits in. So if you wanted to kind of diagnose the problems that John described over the last decade, there is a limited number of factors that you probably quickly glom on to, to explain it.

First of all, health care costs had been rising relative to family incomes. Second the cost of obtaining coverage are particularly challenging for people who work in small firms and for people who have to get coverage in the non-group market. Third, the small firm and non-group markets function very poorly.

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They're very subject to risk selection by insurers and adverse selection by insured people. So people's risks status plays a particularly important part in those markets. That makes them function more weakly than the large employer market. Finally I think as John pointed out, our system currently has a very limited ability to smooth economic changes, to smooth fluctuations in the economy in terms of where people get their coverage. Let me just walk through those points a little bit.

So this is actually an old picture. It's only a projection after about 2006 although you would see exactly the same thing going on. What this shows is that if you wanted to look overall at what happens to coverage in the United States, the number one predictor is what health care costs are relative to personal incomes because some people are simply priced out of this market as costs go up.

So people are priced out of the market actually in two ways because the cost of health care goes up or because their incomes fall and in this recession, we see both of those things happening, both the cost of coverage being very expensive and the decline in personal incomes, both of those things contributing to a decline in employer-sponsored coverage. Some people and some employers are priced out of the market.

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You can see that this problem of employers particularly being priced out of the market is particularly acute in the small firm market.

So if you look at where the declines in employer-sponsored insurance come from, what you'd find is that when you're looking at the large firm market, it's people who can't afford to pay the employee's share of premiums and don't take up coverage that is offered to them by their employer but when you look at the small firm market, many people don't even have the opportunity to decide whether they can afford that coverage because their employer is not offering coverage at all. That rate of coverage offering has fallen by 10-percent just over the past decade. So in the small firm market, you're really seeing a decline not only in take-up but also in offer.

We've been doing some new analysis at ASPE looking at the non-group market. The non-group market is particularly important for several reasons. I think most significantly as John pointed out, we have changing patterns of employment in the United States. We're really excited about some new sectors of employment, people starting out on their own, small firms, so on. The individual market is very important for people who don't have an attachment to a large employer.

Unfortunately, the closer you look at the data the worse this market looks. It's really been declining pretty

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precipitously over the past decade. There's been about almost a 30-percent decline in the share of people who are able to get coverage in this market over the last 10 years.

We only have data up through 2007 here. So as the economy has gotten even worse, we anticipate that the non-group number has fallen even further. That would be consistent with the numbers that John has in his paper.

So this market is particularly challenging. This is also interesting because this has been a decade in which, to some extent, policy has bolstered the non-group market. Federal policy, tax policy has actually worked in favor of the non-group market but despite that effort, I think there's really been a very substantial decline in the market.

That decline is even more striking when you look at different population groups and you can see that the people who have really lost out in the non-group market are sort of prime age working adults, ages 35 to 54. If you think of the group that might be using this coverage because they don't work for an employer that offers insurance that market is really not functioning well at all.

In fact, the non-group market seems to work best for people who are using it only as transitional coverage going from one thing to another from college to job or adults moving on to Medicare.

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Indeed if you look at how long people hold coverage in the non-group market, what you see is that the vast majority of them hold coverage not for a terribly long time. Relatively few people holding coverage in the non-group market for two years or more.

This is in contrast to the employer market where these fractions are much higher. So if you think about self-employed people and so on, again this is a pretty small share of this market in terms of people who are able to really hold on to coverage for a long period of time.

Another piece of evidence about the functioning of this market has to do with how you can get coverage in it and if you think about a market that's really transitional like this, people moving in and out, it's really important that they be able to move in and out easily but that simply is not the case in the market.

If you look at the number of people who can't get coverage because they have a pre-existing condition or they're denied coverage for one reason or another, you can see that those numbers are pretty substantial. Even if you look at fairly healthy groups of people, 19 to 34-year olds, 11-percent of them report that they were actually denied coverage in the non-group market. When you get up to people in their 50s, that

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number is over a quarter of them. So the non-group market just is not functioning very well.

Then this is the slide that John showed you actually stretched out a little bit further looking at changes in the unemployment rate over time. You can see that that bottom end, you see almost a 5.5-percentage point increase in the annual unemployment rate.

As John pointed out, if we break it out by ages, those increases are highest, and this is always the case every recession, for teens and young adults. So if you look at the red bar, those are young adults, 20 to 24 and they've had a very particularly sharp increase in the unemployment rate.

Now in that context, if you look at the programs that we have to sort of offset the effect of economic recession, the main program that we have in place now for that is Medicaid. Medicaid and SCHIP really only work for kids.

So if you look at this picture of how many people are covered by Medicaid and SCHIP, you can see that picking up on the recession as John pointed out, those programs have been pretty effective in shielding children from the effect of the economic recession but they've had much less impact on smoothing the effect of the recession for adults. Really there's only about a 2-point pickup in the Medicaid rate among

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adults, among parents in this period even though the unemployment rate has picked up so much.

So putting all of those trends and analysis in context and thinking about the Affordable Care Act and where it goes, you can think of it as really even though I think most of the work has been done over the past decade trying to think about what this act might look like, it wasn't done in response particularly to this recession, we didn't.

Much of the work was done before anyone imagined such a catastrophic thing could happen but if you look at the design of the act, you can see in the provisions, both in the immediate provisions and in the long-term provisions, they really go after exactly these problems.

I think in terms of the immediate provisions, I don't know that we had thought about covering young adults up to age 26 as being countercyclical but if you think about where the unemployment effects are that really is the population that isn't able to get coverage because that's where the unemployment rate has really increased.

So it is quite possible that this is going to have a much bigger effect. We don't know yet because of the recession than it might have in better economic times where more of those 20-to-24-year-olds would be able to be getting coverage on their own. The pre-existing condition insurance plans, an

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opportunity to try and get around those high denial rates in the individual insurance market and small firm tax credits, again really focusing targeting efforts at the part of the market that has really had the most difficulty retaining coverage.

Then as John pointed out, I don't think that we can really lick these problems until we do a much more substantial and comprehensive reform in 2014 that's going to involve the exchanges and premium tax credits and cost sharing reductions and Medicaid expansions that I think should really get rid of this cyclical relationship between health insurance and employment, which doesn't really make a lot of sense from a policy perspective.

I just wanted to point out what we're going to do at ASPE working on this just to give you a little bit of a highlight of what to look forward to in the future. We are really focusing on developing the capacity to routinely track key indicators of how the Affordable Care Act is affecting the U.S. health care system and trying to develop an evaluation framework.

So we'll understand which parts of this are working really well and which parts need more attention as the act rolls out and particularly looking at variation among states thinking about where we're seeing best practices and where

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there might be more assistance that we could give. So let me leave it there.

ED HOWARD: Great. Thank you so much Sherry. You've heard some really excellent analytical looks. That's not the right word but you understand the mixed metaphor of this set of problems. We're going to now shift gears and take a little more empirical look at the way the problems you've heard described play out in real life as it were.

We're going to start that discussion with Janet Olszewski who has directed Michigan's Department of Community Health with its emphasis on protecting vulnerable and underserved populations for the better part of the last eight years. Now there's a rumor that the Michigan economy has been less than robust lately with state revenues to match. So Janet we're eager to hear how you're coping with the present and preparing for the future.

JANET OLSZEWSKI: Great. Thank you very much Ed. First, let me start with a little bit of a description of Michigan. We are a state of approximately 10 million people and that population has been relatively stable. We're in the upper Midwest and we tend to have net migration out but we've been relatively stable at about 10 million people.

In this past decade, which we've been hearing about in terms of uninsurance rates, the state of Michigan has lost

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between 800,000 and a million jobs over half of those in manufacturing in particular auto manufacturing. We went from an unemployment rate of 3.7-percent in 2000 to 13.6-percent in '09. We've been up above 14-percent in 2010. We are somewhat the canary in the coal mine. We've led the nation's unemployment rate for many, many quarters. I think we've actually been replaced now but nevertheless it's been a very substantial change.

So during this decade, I think what's important to understand about Michigan is we've become a very different state than we were before. Our rates of poverty have increased. Our rates of unemployment are higher. Our economic base is changing and we are attempting to transform our economy now. So this is not just a recession for us. The jobs we've lost aren't coming back. So that has an impact on revenues and I can talk about the challenges we face as we go forward.

Still with all of that, we still enjoy a higher percentage of our workers with employer-sponsored insurance coverage at approximately, it went down 10-percent but it's still higher than the nationwide average. We still enjoy lower rates of uninsured individuals than other states and in particular for children.

We have very low rates of uninsured children. During this time, this is what you see in terms of the Medicaid case

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load. Now the eligibility policies in 2003 at the beginning of this trend line were exactly the same as the eligibility policies at the end of this trend line. So this does not represent liberalization of Medicaid eligibility. This represents children in particular falling into poverty and their parents.

In our state, the Medicaid eligibility rates for children are at 200-percent of poverty. For parents, they are 60-percent of poverty. For childless adults under a waiver, we're at 35-percent of poverty. So we are not necessarily amongst the most generous states in terms of our eligibility.

So this is really for us the challenge and of course, revenues were going down at virtually the same type of trend line as those enrollment rates are going up. That's a challenge for states going up. Even though the Affordable Care Act may break the cycle of uninsurance and employment, it will not break the cycle of state revenues during unemployment, periods of high unemployment.

This gives you just a sense of who's on the program. As has been stated earlier, Medicaid does a good job with children. Over half of our enrollees are children. You can see adults represent a quarter of them. So we have many children on the program whose parents do not qualify. Then if you look at per capita, how have we been managing?

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We've been managing by making the program less expensive on a per capita basis. This includes total population not cost per Medicaid and rurally. We are in the lower third of states on a cost per capita population basis. We've been doing many things.

During this eight years that I've worked for Governor Granholm, we have not eliminated any eligibility categories or cut anybody off from Medicaid eligibility during these eight years while we've been resolving \$10 billion worth of revenue issues in that eight years. Federal stimulus dollars have helped very substantially. When those stimulus dollars end in July of next year, we'll have a \$700 million hole in the Medicaid program to fill but here is some of the measures we've used.

We've been a very heavy managed care state. We have most of the individuals who have full Medicaid coverage are enrolled in health plans. We're the first ones to start a multi-state drug purchasing pool. We've done bulk buying and volume purchasing of several other things.

We've done a great deal of nursing home transitions. We've been moving thousands of people out of nursing homes and into home and community-based care, which has saved us dollars and given improved quality of life to individuals. We've added family planning services under a waiver. We've done mental

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health managed care as well and we've certainly maximized our federal funding through waivers and pilot programs and use of approved provider tax revenues, etc. So we've tried and all the stimulus dollars and all the federal grants we can apply for.

When we look at health care reform, what this means for us is the gold bars on this chart are the people who'll gain coverage in Michigan. It will not be children. It will be adults. The largest group will be the childless adults. Right now we cover them under a very small waiver, approximately 62,000 individuals at 35-percent of poverty or below.

So this will be the largest group who gains coverage for us but parents and young adults will also gain coverage in this program. We estimate that it's about 400 to 450,000 people and again you can see about 275,000 of those will be the childless adults.

So this is what we're looking at in terms of the Medicaid expansion. Of course there are additional individuals who will be gaining coverage under the health insurance exchanges, etc. so that we are looking at that picture together.

We are starting our process of stakeholder engagement to design and answer the questions around are we going to operate a state exchange. If we operate a state exchange, how

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are we going to operate exchange? I think the challenge for us as we look at the Affordable Care Act is how do we stay alive and how do we keep our Medicaid program operating at the levels it is now until 2014 to be perfectly honest and what do we do beyond that as well?

Certainly federal money will cover the expansion populations but what about the base populations? We're struggling to stay even now in our state. Will the economy get substantially better and those enrollment numbers come down? That's the way to reduce costs in our program because certainly it's been, the budget buster has been the number of people enrolled.

I think as we move forward, our particular challenges and sort of the policy implications we're most worried about are provider rates in particular physician rates. The Affordable Care Act does contain language and funding to take primary care rates up for a limited period of time but the Medicaid program historically was built on being a safety net small portion of health insurance coverage.

We've always paid less than market rates physician services in particular but at this point in time, it represents 19-percent of the population in Michigan. By the time we're done with the Medicaid expansion, it'll be fully a quarter of the population. Providers can't survive on low rates when

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fully a quarter or more of their population is Medicaid and in the case of pediatrics, we already have practices where it's at least 40-percent and in some cases, 80 to 100-percent of their practice. The only providers who do well under that scenario are the federally-qualified health centers and other public clinics who can get cost-based reimbursement.

Another area that we're looking at very carefully is the dual eligibles. There is new language in the Affordable Care Act that will allow us, as states, to do more with dual eligibles. Historically anything we can do at the state level saves money for the federal government not for us.

So we need to look at this population together to give you some idea of sizing it for Michigan. The dual eligibles represent 200,000 of those 1.8 million beneficiaries. We spend about \$3.5 billion on them out of a \$10.5 billion program. We estimate that Medicare pays another three to \$3.5 billion. So that's \$6.5 to \$7 billion on 200,000 people. Clearly we need to get a handle on that population.

We also feel that we really need to have much better integrated behavioral health and primary care. We've had managed care on both ends but we find that, again, persons with developmental disabilities, substance abuse, mental health problems, they have many chronic disease issues. They

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certainly have access to care issues on the physical health side and moving that together is going to be very important.

The other issue that I think we're really concerned about is the whole issue of moving upstream, the social determinants of health, keeping a healthier population. We hear a great deal about that. We've certainly done a lot of work in that area but I have to tell you that as the health director, individual lifestyle change is only possible within a context of an environment that supports it.

The people I'm serving don't have access to grocery stores. They don't have access to safe places. The children don't have access to safe places to play. Without that, we're really not going to, long-term, change, bend this cost curve.

Then finally one interesting policy implication at the state level is right now hospitals in particular but nursing homes, hospitals, the health care sector is the largest employment sector in our state. We end up in this interesting conundrum of health care as economic development versus health care as a budget drain.

My department represents two-and-a-half-percent of the Michigan economy. If you reduce the funding that goes to Medicaid, etc. what is the impact on the economy? The studies we've seen in Michigan show that on average, every dollar you spend in Medicaid generates \$5 in economic activity. That's a

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discussion that generally doesn't take place but one that we think a lot about at the state level. So with that, I will close and just the slight picture of Michigan.

ED HOWARD: Thanks very much Janet. Our final speaker is Kim Belshe who's the Secretary of California's Health and Human Services Agency. She's been that for just about as long as Janet's been in office in Michigan. She was appointed by Governor Schwarzenegger, served under previous Governor Pete Wilson as well in various senior positions.

Her agency, and this echoes what Janet was just saying, has more employees and a bigger budget than a lot of small countries. If you just look at the numbers of the uninsured in California, the number of MediCal beneficiaries in California, those are pretty stunning numbers as well. So Kim thank you for coming and we're looking forward to hearing from you.

KIMBERLY BELSHE: Great, thank you very much Ed. Good afternoon, I guess it is, everyone. I'm happy to be here and my goal is really to try to translate some of the previous comments about trends in coverage to really a more, in a more on the ground way to share with you some of the challenges and opportunities we're seeing from a coverage and cost perspective in our state not just in the near-term but particularly in the context of implementation of federal health reform, which for

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purposes of shorthand, I'm going to probably refer to largely as ACA.

I start with the context because, as you heard from Janet, context really does matter. If you've seen one state, you've seen one state. To the extent that the responsibility for reform implementation rests with the state, it's going to be really important for policy makers both at the federal and state level to account for the diverging context.

I think our California context really underscores the significant state program and fiscal challenges associated with implementation of the ACA. It underscores the imperative for really thoughtful and strategic implementation by state policy makers and program administrators.

I think frankly it really underscores the high stakes associated with how state policy makers employ the tools that ACA gives states to modernize their Medicaid programs to create more competitive transparent marketplaces and most fundamentally, to improve the health status of the people of California in our case. So we start with a very large number of uninsured, 8 million people-plus. At any point in time, it's about 6 million.

This is a number that has grown considerably in the context of the national recession. It's a big number. It's a sobering number but it also calls out the promise of ACA in

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terms of the opportunity to extend coverage to millions of Californians.

Our estimates suggest that we will reach roughly 2 million additional people for our Medicaid program, which we refer to as MediCal as a part of the coverage expansions in the ACA that will reach roughly two to 3 million uninsured through subsidized coverage in our health benefit exchange. So that really underscores the important promise in terms of extending coverage and economic security to millions of low and lower-income California households.

Our Medicaid program is the foundation upon which both the expansion and the exchange will be built. Roughly 20-percent of our population is currently enrolled in Medicaid. This number has jumped dramatically over the course of the past couple years. It was just about 6.5 million about three or four years ago. Our program is a fairly broad program.

We cover people to about 100-percent of poverty in terms of working adults, about 125-percent of poverty for the disabled population but I would characterize our Medicaid program as a pretty fragile foundation because we are among the lowest cost programs in the country.

We all use different words to characterize our reimbursement rates. The word, some will say we are competitive. Others will say we are parsimonious. There are

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other far less appropriate words to share in a public setting [Laughter] but it's, in all seriousness, a very significant issue because as we contemplate 2 million more people coming in to our Medicaid program that will create a tremendous on demand for providers because we want to make sure that Medicaid card actually means something in terms of access to a provider network, appropriate services, and better health outcomes.

So we are anticipating, as a part of reform and the program expansion that we're going to see some pretty significant pressure on provider reimbursement. When we have done fiscal estimates of what reform means for California from a state budget perspective, we estimate in the out years with full implementation additional state costs that could be as high as \$3-4 billion a year.

The overwhelming majority of those costs are costs that we associate or estimate associated with increased provider reimbursement. Even with the proper and helpful acknowledgment within ACA of full federal funding of increased primary care rates for two years, our assumption is the state is going to have to continue that, number one, and number two, we're also going to have to increase other outpatient services to 80-percent of Medicare. So for us, we estimate the big costs are going to be on the provider rate side.

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Many have followed, perhaps, a little bit of our state budget trials and travails. Diane referred to our state context as strained. So I thought I should include that, \$25 billion is quite a strain and when Medicaid is the second largest general fund expenditure that deficit has significant implications for Medicaid but our context today is very different because we have the ACA Maintenance of Effort Requirement as it relates to eligibility.

We also have federal court decisions in recent years that have effectively precluded the state or are increasingly precluding the state from using other tools that are typically used such as reducing provider reimbursement rates or modifying benefits that we provide.

So notwithstanding the size of our Medicaid program, the growth of the Medicaid program, the breadth of our state fiscal challenges, Medicaid increasingly is going to be fairly limited in terms of what kind of reductions can be made because of federal law and because of federal court decisions.

Our budget problems are not short-term. They are enduring. So come 2014 and beyond, this will be a big issue for state policy makers. Like other states, we've got a big transition going on. These transitions matter. We've had a Governor who's been very invested in health reform.

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Hopefully our new Governor will similarly be invested but those changes, both at the senior political level as well as in the executive branch where we're seeing a lot of retirements, will have implications for how thoughtfully and how effectively states are able to move forward with implementation.

At the same time, as I say here, we're not starting from scratch. Our state has taken a keen interest in health reform. While Governor Schwarzenegger led an effort back in 2007 that wasn't successful to achieve near universal coverage in our state, it really established a very solid policy foundation upon which we've been able to build in terms of our planning and implementation efforts.

In terms of our actual preparation focus on priorities, Governor Schwarzenegger has been very clear even though he had real concerns with the federal law. Once it was enacted, he said the law is the law and we need to move forward with implementation responsibly and thoughtfully and successfully.

So our focus in 2010 has been on putting in place some of the key building blocks that are foundational for reforms' ultimate success. We've begun with those areas where there's an opportunity to extend coverage such as through creation of the state's pre-existing condition insurance. We've pursued insurance conformity including dependent coverage to age 26.

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Perhaps most importantly California is the first state that has established in the post-ACA environment, a health benefit exchange.

It really does reflect a recognition on the part of California policy makers of how critical this piece of reform is in terms of extending coverage to many of the working uninsured that we've been talking about earlier in the panel presentation. Importantly, policy makers in California noted the importance of giving the exchange some important tools to drive more value-based purchasing and broader reforms in our health insurance marketplaces.

We've also moved forward with implementation planning but let me say a few words about this last issue around our Medicaid waiver. The state invested significant time, over the course of the past year plus, negotiating with the Obama administration a new five-year waiver. It was recently approved last month.

It's \$10 billion over five years. We placed the kind of emphasis we did on the waiver renewal because we recognize that the Medicaid program really is the foundation upon which federal reform will be built. So Medicaid's success translates to federal reform success in a very real way.

Given the challenges our state is experiencing in terms of the size of our program, the significant growth in the

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program, the need to redesign and reorient the program, we invested in this waiver effort because we thought it would be critical to helping us prepare for and bridge to the reforms of 2014.

So under this waiver, California for example will be able to extend coverage to roughly 500,000 medically indigent adults who, come 2014, will be eligible for reform. We're being able to support some pretty innovative delivery system reforms that not only we believe will improve access and care coordination but also slow the rate of growth of spending in our MediCal program, which is going to be really critical from a budget perspective that we can't ignore and significant investments in our public hospital systems, which we really view as not only an essential provider today in a safety net context but a critical partner come 2014.

So investments to help position and strengthen their ability to compete in a 2014 world and near universal coverage and consumer choice.

In terms of some of the challenges and considerations that I'd call out, people don't like to talk about bureaucrats but I'll talk about bureaucrats. There's a significant train wreck looming very large in my mind in terms of the disconnect between what we are asking states to do, particularly state

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Medicaid programs, and state internal capacities and expertise to execute effectively.

So one of my real worries is ensuring that we have the capacity, the quality, the technical skills and abilities in Medicaid programs and exchange staff, etc. to meet on the significant expectations of them.

This idea of a culture of coverage, we talk a lot about the goal of coverage expansion and a lot of people say well it's all about the individual mandate. I would submit it's not so much about the individual mandate. It's really more about this broader community responsibility to create a norm where insurance is something that is valued, it's expected and it's accessible.

That's going to require government to act and employers and plans and providers but it's really changing community norms around what coverage is, its value, and its availability. Government has a very important role. Decisions government makes, for example, in terms of how it brands and positions the MediCal program, the rules and the processes by which people access eligibility and enroll in programs, all of that's going to influence the extent to which people value, understand, and access, and actually take advantage of the opportunities provided under the ACA. Eligibility enrollment is a really good example of that.

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ACA gives states some really unprecedented tools to modernize and streamline, and create much more seamless eligibility enrollment systems between Medicaid exchange and SCHIP. How states employ those tools is really going to make a difference in terms of creating or contributing to this idea of a culture of coverage and promoting enrollment in practice not just the concept but actual enrollment and maintenance of that insurance.

Provider capacity is going to be critical not just we need more primary care doctors. We all stipulate to that but we need to be looking closely at what do we know about the profile of those uninsured people we've been talking about previously who'll become newly enrolled in Medicaid and exchange coverage?

Are we aligning both the benefits that those populations will need as well as the proper provider profile and expertise? We know in our state, for example, very medically complicated population below 100-percent of poverty single adults, big concerns about adequacy of our behavioral health specialty providers as one example.

Serving those outside of the mandate, we talk a lot about near universal coverage. Near universal is not universal. In our state, we have over a million individuals who will remain outside the reach of the ACA because of their

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citizenship status so working through the implications of that in terms of those individuals, their ongoing health care needs that will not go away, and making sure that there's financing streams to support their usual sources of coverage.

The final point I'd make in terms of an important consideration for Medicaid and I do dwell upon Medicaid for a moment in my comments because we talk a lot about the exchanges. The exchanges are, as we say, the shiny new objects. They're exciting. They're neat. They're new. They provide an opportunity to really drive some pretty important changes in health care financing and delivery but again they're built upon the Medicaid programs. So we got to get Medicaid right if we want to be successful with health reform.

This final issue relates to the relationship between Medicaid and the exchange. Our policy makers gave our exchange board the authority to be what we call an active purchaser to set plan participation standards and then contract for the highest value plans for participants. How the exchange executes that active purchaser authority, how it aligns or combines its purchasing with the Medicaid program and our SCHIP program are going to be really very important.

So working through those dynamics and relationships from a purchaser perspective as well as from an enrollee perspective with an eye towards bringing the best value for

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those who enroll and maintaining continuity of coverage. As we know, those individuals will go through considerable transitions. It's going to be really important.

I would just close where I started, our state context, as Janet and I have indicated, are very challenging. Now we know, Ed, why California, Michigan were invited [Laughter] as the poster children for challenging context. Our unemployment rate has been persistently above 12 million. Janet and I were comparing notes last night which state has lost the most jobs. That is a bad competition [Laughter].

No one is a winner there but our challenge, our context is certainly challenging. The ACA is certainly not without flaws but it has opened an incredibly important policy window and states, by and large, are eager or at least willing to take advantage of that opportunity and with proper deployment of some of those critical tools, as it relates to Medicaid, as it relates to the exchange, I think we can make important improvements in the health status of the people of our state through improved coverage, through delivery system reform, through investments and prevention and wellness.

Going back to Diane's comments, that's why we do what we do. We do what we do to make a difference in the lives of the people in our states. At least, under Governor Schwarzenegger's leadership, we have viewed the ACA as

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providing just that opportunity to make a difference in the lives of the people in California. Thank you.

ED HOWARD: Thanks very much Kim. Time for you to get involved in this conversation. There are, as I said, microphones that you can use to ask questions. There are green cards in your kits that you can use on which to write questions.

While you're doing that, let me just follow up on something that both Janet and Kim were talking about in the notion that states are trying to use the ACA to deal with some of these problems. Something came across my desk a couple of days ago from a conservative commentator that was titled something like here are eight steps states can take to slow or impede the implementation of the ACA. I wonder, in your conversations with your colleagues, whether that kind of technical assistance is likely to get picked up in any significant way.

KIMBERLY BELSHE: I've been really struck in our meetings and there've been a lot of meetings. It's actually been a really useful effort supported by the administration, NGA, many of the foundations to bring together the Governor's leads who are advancing health reform.

I have really been struck since our very first meeting and throughout the balance of this year by the thoughtfulness,

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the responsibility, the professionalism, the sense of stewardship that my colleagues, our colleagues have brought to this really daunting task.

With very few exceptions to date, my colleagues whose bosses are part of litigation who take a different political view and policy view than Arnold Schwarzenegger, they're like the law is the law and so until such time as the quarter the Congress makes change, we are going to move forward thoughtfully and responsibly.

They will likely do it very differently than California has done it but generally the sensibility is we have a responsibility and until the law changes, until the courts take an action, we're going to take the steps necessary to at least modestly move the ball forward. Janet, do you have a different perspective on that?

JANET OLSZEWSKI: I agree Kim and what I would say is that even when I've seen people suggest that they're not going to implement say states cannot go after federal funding, etc, in reality those states still are moving forward with pieces of the Affordable Care Act. Again we're all going to implement it somewhat differently.

As soon as you get beyond the rhetoric and start talking about what's really in the law, there's a lot there to

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like for both parties to like. So I think states really are all about state control.

So for example, on the exchanges, I think that you'll see more states than not choose to operate exchanges again even if there is states are involved in litigation, until such time as the law changes, they would make a decision to maintain the activity at the state level because they believe that they know their state best and that the result will be a better one for their citizens.

ED HOWARD: Yes Bob?

BOB GRIST: Bob Grist with the Institute of Social Medicine and Community Health. My question has to do with the efficiency of delivery models. In Michigan, it was mentioned that the community health centers are getting costs plus reimbursement, which presumably is higher than the Medicaid health plans.

Does the state have any way to distinguish, to compare the efficiency of the delivery models of community health centers with Medicaid plans or with Medicaid as a payer for other Medicaid providers because it would seem that you would want to be focusing on using your resources in the most efficient way and if the community health centers are more efficient, what can you do to move the Medicaid providers in that direction?

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JANET OLSZEWSKI: Well I think in our state the answer is complex in that number one, our Medicaid health plans do contract with the federally qualified health centers, community health centers. So they are providers for our managed care population. I think that we see performance is a continuum and that there are some community health centers that are extraordinarily effective and efficient and others that are less so, same with private practice.

We, of course, are very involved in developing patient-centered medical homes and developing those community resources around primary care practices. Having started with pediatricians and pediatric practices earlier now, we are one of the eight states in the CMS multi-payer demo. So we have some evidence.

I will tell you the other challenge in state capacity is we don't have the capacity to continually do the evaluation to get the data points we need to understand as well as we should some of the aspects of our delivery system. We have to rely on outside researchers and grants to do that. We can't even pay for their researchers to do that in all cases but we see varied performance in all of them.

We do bonus payments. We do performance improvement with our providers and with our health plans. The health plans work extensively to try and get those practices and the

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community health centers to do the job that needs to be done for the population so we have constant quality improvement cycles within managed care as well as externally.

KIMBERLY BELSHE: Ed can I offer a comment? I think you're raising such an important point particularly in the context of FQHC's, which in our state, like in Michigan, are just absolutely essential providers of care. They are critical sources of services not only for the insured but the uninsured in particular particularly our undocumented immigrant population. You call out though one of the really important tensions that policy makers and program administrators are going to need to work through as it relates to FQHCs because on the one hand, yes they are essential providers of care.

They have this semi-protected right to cost-based reimbursement, yet at the same time when you look at trends more broadly, as you know, the payment trends are oriented increasingly towards outcome performance, value-based purchasing, evidence-based reimbursement. So it seems that there's an important tension that will need to be reconciled.

So when my FQHC colleagues come back and say how can you raise such a thing? We value and embrace our cost-based reimbursement and we're so efficient. I think it's going to be critical that they're able to demonstrate that efficiency.

Otherwise this kind of entitlement sense of cost-based

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reimbursement is really going to be increasingly at odds with the broader financing and delivery reforms that are increasingly focusing on outcomes.

CARL PULZER: Carl Pulzer, American Health Care Association. This is a question for the analytical side, when you see the trends in the uninsured, did you also study or do we have any data on the growth of suboptimal insurance, I don't know what the clinical term is the many med plans or the plans that either, they lack a catastrophic component or they don't meet the new rules for annual coverage limits because as you said, a lot of the workers are on these types of jobs like long-term care's a job, a lot of low-wage workers.

There's lots of folks covered with these plans. We saw the McDonald's situation, I think if you go to the Office of Insurance Oversight, more than a million workers are covered by plans that have gotten a waiver, many med plans, so just that type of insurance.

SHERRY GLIED: We've actually just looked at the number of people in plans with very high deductibles and that number has definitely been going up over time so that's kind of consistent with that story. Many med plans are not picked up very well in existing data sources. So we don't have a very good sense of those but there certainly is evidence that the

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generosity of coverage has been declining especially in the small firm and individual insurance markets.

DIANE ROWLAND: John, a question for you in terms of the Midwest. What are some of the reasons do you think that the Midwest has seen such a large percentage increase in the uninsured and is one of the contributors to that potentially the auto industry or are there other factors that you might tease out of the data?

JOHN HOLAHAN: Yes. We couldn't really tell whether it was the auto industry, it almost has to be to a great extent. If you look at the data on unemployment rates, the Midwest really has about the highest on average, the west pretty close behind. I think all the economic turmoil that the Midwest has been under really explains it, loss of jobs, moving to lower paying jobs and so forth, jobs without health insurance. I think it plays out in the Midwestern states and some of the western states and probably to a greater extent than it does elsewhere.

DIANE ROWLAND: Okay and Sherry is there a collaborative effort with the Office on Aging to address some of the issues of coverage for those over 55 and what components would be considered in your research agenda? Are you looking specifically at that and its implications potentially for Medicare?

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SHERRY GLIED: We are looking at coverage trends in all populations including the population 55 to 64. We don't have a specific initiative that's going on right now but we do work closely with the Office on Aging. So we will go back and try and see what we can do there.

DIANE ROWLAND: Okay and a question for Janet. Can you comment on the challenges of maintaining adequate provider networks under Medicaid managed care and how do you actually monitor the adequacy of the network and address any problems you encounter?

JANET OLSZEWSKI: We have two different approaches to managing the adequacy of provider networks. First in terms of licensure, we contract with licensed HMOs in the state and they have requirements from the insurance commissioner in terms of how they demonstrate adequacy of network.

I think one of the challenges we have, whether it's in managed care or not, we are beginning to see in the northern parts of our state absolute losses of providers. OBGYNs, for example, we've had a couple of hospitals in northern Michigan stop their OBGYN services.

So now we're going back to a situation I found in 1987 when I began working in the maternal and child health area where women are traveling two hours-plus for prenatal care. That's not because the health plans won't contract with

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anybody. There just isn't anybody left. We have retirements, people not coming into the area, etc.

So we start with an issue of who's out there. We have the requirements from the insurance side and that's kind of a front end analysis of the network assuring adequacy for size of population, etc. Then we have a regular monitoring approach through our Medicaid plan. We do this through consumer surveys.

We do it through analysis of encountered data. We do it through our own spot checks, etc. So we've got a variety of mechanisms we use to try and manage the network to assure the adequacy of the network but the challenges again are in places where we are seeing providers leave practice and other providers not come in.

DIANE ROWLAND: This next question requests what any of you have as experience and observation with the high-risk pools and how they've been playing out and what this economy may have done to their ability to be affordable and to take the place they're supposed to be taking.

KIMBERLY BELSHE: California's one of 27 states, I think it is, that stepped up to administer their own pre-existing condition insurance plan. We were the last state to get ours up and running in part because we need the

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legislation, which we were able to do this summer on a bipartisan basis, which was nice to see.

So even though we had a fairly late start-up, we didn't begin coverage until well into October, we've enrolled about 1,000 individuals. That is a pretty modest number of people but relative to other states, it's not bad in short order.

Our \$761 million in federal support will enable us to serve upwards of 23,000 individuals a month. So obviously we are well short of that. Why is it? It's providing access to more affordable, comprehensive coverage and more affordable is simply not affordable for many if not most of the people who have pre-existing medical conditions and who are finding themselves outside of the insurance market.

So there are issues around affordability. There's issues around awareness. So we are beginning to do more in partnership with agents and brokers and legislators and other community interests to get the word out but those are the two principle challenges we found, the affordability issue and the awareness issue.

JANET OLSZEWSKI: We too are operating an existing condition pool. This is the first time we're operating one at the state. We have historically not had a high-risk pool in Michigan. We have a non-profit Blue Cross plan in the state, which has served as our insurer of last resort.

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This particular plan, we've enrolled a couple of hundred people with the amount of money that has been allocated to us believe we could serve anywhere from three to 5,000 people. So the uptake has been really slow for the reasons Kim has suggested.

AYANNA NUJUMA: Hi, I'm Ayanna Nujuma with Lincoln McCleod, we are a communications firm here in D.C. I'd like to ask Janet and Sherry the question together. You indicated the lack of physicians in the state of Michigan and I know Sherry your area's not exactly the public health service but in your planning and research initiatives that you're developing, how do you envision the public health service adding value to what's going on in Michigan in terms of the low number of physicians in that area?

SHERRY GLIED: I don't want to give you a very specific answer because I don't exactly know what it's going to do with respect to Michigan but certainly expansions in the national health service corps, other efforts of the public health service to expand access to coverage are an important element of the Affordable Care Act and it's one of the things that we're actually tracking.

One of the things that we're planning to track is to look at access to services and what areas of the country are having difficulty getting access to services.

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AYANNA NUJUMA: Do you know if there are going to be any initiatives that are going to be available to medical students in terms of encouraging them to go into populations like Michigan to provide services?

SHERRY GLIED: I'm not 100-percent sure and I don't want to guess. So I could get back to you if you leave me your card.

AYANNA NUJUMA: No, I just wondered, it's got to be something that the government may be in the process.

SHERRY GLIED: So certainly we are looking at ways to get primary care doctors and other doctors into underserved areas but what exactly the initiatives are I just don't know off the top of my head.

AYANNA NUJUMA: Thank you very much.

JANET OLSZEWSKI: I would offer a couple of comments. One is it's about primary care physicians. We have more than enough radiologists thank you very much. Until we change the health care system to focus and pay for outcomes and what we need the system to do, this will not change. Medical students are not choosing primary care because they cannot. They can make a much better living in a specialty.

They also, lifestyle issues, so until we change the culture of practice and payment, we are not going to solve this

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problem no matter how many national health service scholars that the public health service puts up there.

AYANNA NUJUMA: Thank you very much.

BOB HALL: Hi, I'm Bob Hall with the American Academy of Pediatrics. Thank you so much for having this discussion today. First off for Dr. Holahan, the news actually looks really good for kids generally. It's very encouraging to see the numbers of children actually being enrolled, etc. and uninsurance decreasing but my question is, is that a result of us actually improving in terms of enrollment or is that a result of kids going into poverty at a higher rate?

Can that be teased out more effectively? The second question I'd have is for Ms. Olszewski and Ms. Belshe and there's a lot of kids in Michigan and California who are very lucky to have you in those positions because it sounds like things are just very, very impressive.

One other thing that the ACA included is funding finally and I hope this question isn't unfair because of Ms. Rowland's position here, one of the things that the ACA included is finally funding for the MACPAC, the Medicaid and CHIP Payment and Access Commission.

A lot of the times, we're looking backward at information that we then try to make policy going forward from but one of the things in that component on MACPAC is sort of an

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early warning system about coverage. I'm wondering what you think that might look like, some initial thoughts on how that might be effective for federal policy makers to be thinking about based on your state experience.

JOHN HOLAHAN: It has to be that it's expanding eligibility in efforts by states and others within states to expand enrollment because the decline in incomes is creating a larger pool that you've got to draw from. So if that pool wasn't expanding, we would have seen a much larger drop in the number of uninsured children than we did so that lowering of incomes is making the problem that you're starting with worst.

JANET OLSZEWSKI: As for the early warning system, I'm afraid I'm not familiar enough with the specific provisions and haven't given it enough thought to be able to answer that.

KIMBERLY BELSHE: Is this like a tracking of enrollment trends and patterns with an eye towards in the form of policy programs?

DIANE ROWLAND: The early warning system provision in the MACPAC charge is to look at both supply issues and general access issues and identify what measures should be put in place to look at a situation where either the provider payment rates are so low that access to a particular specialty or to services are limited, to what extent are providers like potentially children's hospitals, if they have significant share of

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Medicaid patients unable to break even because of the payment levels.

So it's really try and find indicators that would say we should be careful that whatever this policy change that's being put into place could adversely affect care. Some of it derives from issues like rather a 10-percent across the board payment cut, what impact would that have on access? Is that a trigger to sort of look at what's going on? That is the subject of what MACPAC is going to be looking at and working on for its March and June reports this year but especially over the next year.

LINDA HAUGHTON: I'm Linda Haughton and I'm a member of the local Black Nurses Association of greater Washington D.C. area. We had a discussion with the Robert Wood Johnson Foundation on December 2nd regarding who will provide the care. The advanced practice nurse is supposedly that particular link to help with the shortage of doctors and physicians although there is still some controversy in that area based on the physicians' point of view about scope of practice. So Janet in California, what do you all think about that issue for filling in the gap, the advanced nurse practice person to do the health care delivery and care?

JANET OLSZEWSKI: Well we certainly have advanced practice nurses now providing care to the population generally

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under the auspices of community health centers, university clinics, other things. We see few in private practice. Some of that has to do with our scope of practice laws.

We are, as a state, not as liberal as many others in terms of advanced practice nurses. So that's a challenge for us going forward. Although I am starting to see more and more practices use them but what we are also seeing is that those nurses follow physician specialists. They are moving into specialty care. They're not necessarily staying in primary care.

We're seeing more advanced practice nurses being used in the specialty setting and again that's payment and delivery system culture, style, etc. So we agree that there's an opportunity to use them. We've seen that not be as robust for all the same reasons that medical students aren't entering primary care but we also have a more limited scope of practice situation in Michigan and the environment to change it is toxic.

We've had numerous scope fights in the last eight years and recently had yet another battle royale not in front of the legislature but sort of working up to some legislation. So it will take a lot of political will to change that.

KIMBERLY BELSHE: When the state health reform leads get together, one of the fun things we all talk about is so

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what's the issue that keeps you awake at night. This is the life of a policy and program nerd. One I touched on in my comments in terms of states moving forward with more modernized, streamlined, seamless eligibility enrollment systems. If we don't get that piece right then all this talk about coverage, expansion, improved access, and improved outcomes is going to be for naught.

The second stay awake at night I would identify is around workforce and having the right number and types of health care workers to meet the needs of a growing covered population but beyond the numbers, it's also aligning the workforce with the changes we are increasingly seeing in the delivery system. So it's a workforce that's not just the numbers and the types. It's a workforce that's trained in the practice of more patient-centered, primary care-focused, team-oriented health care delivery.

Nurses are absolutely indispensable in that respect and yes we need to focus on the pipeline for primary care doctors and nurses and allied health professionals, etc. but we also need to be looking at scope of practice. We cannot train enough of the different types of providers that we need.

So it's looking at practice patterns in terms of practicing to the top of their license as well as modifying that practice. Janet used the word toxic, I would echo that as

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well. We tried in 2007 and state policy makers are going to have to try again to modify scope of practice to enable nurses, as one example, to extend their reach and to extend their practice.

We're also going to need to look at information technology and looking at telehealth and telemedicine as in critical tools to extend the reach of all types of medical providers. So we acknowledge the amazing role that nurses play. We don't have enough of them but it's not all about the nurses. We got to look at the stuff broadly.

KYLE CASWELL: Hi, my name's Kyle Caswell. I'm with the U.S. Census Bureau. I have a question about how the health status of the uninsured, we've seen a lot of data about what the uninsured look like in terms of family structure, demographic characteristics, the relatively young but do they have, for example, disproportionate amount of chronic conditions and how might that in turn affect the state or national capacity to serve these people's needs?

JOHN HOLAHAN: We didn't look at that in this study. I mean I think the uninsured are a very mixed group. I mean by and large they're healthy but there's lots that aren't and how that might be changing over time with regard to, because of the various factors that affect the changes in coverage over this last decade.

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I don't know that. If you look at, by age just for example, the fact that the 55 to 64-year-olds lost coverage when they seemed to be maintaining jobs that had coverage or maintaining non-group coverage up until this point, despite what was not a particularly strong economy even up until 2007 makes you think that there are some growing problems among people with health issues. So I wouldn't be surprised. It's probably a real oversight that we didn't look at that, I didn't but that's a good question.

I suspect that we would see worsening conditions among people with worst health status but having said that, that sliver of adults that gets into Medicaid is probably picking off the worst of that pool.

KIMBERLY BELSHE: In our state, we'll have about 1.8 million people who will come into the Medicaid program under the 2014 expansion. Between a half or two-thirds are single childless adults with incomes below 133-percent of poverty. The Center for Health Care Strategies and other studies suggest that the medical needs of that population are pretty significant, pretty complex.

We've had some experience through our existing waiver, which will now be expanded, which has extended coverage to about 100,000 thus far of these childless adults. We found a pretty significant need in terms of mental health services,

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substance abuse services, so that's my point of looking closely. States will need to look closely at the profile of the newly eligible population with an eye towards both benefit packages, what the benchmark looks like as well as proper provider capacity.

SHERRY GLIED: So Kaiser has done reviews of what the health status of the uninsured is and there's actually a lot of research out there on the question. In general, I think the finding is that they tend to be less healthy than the privately insured, especially those with employer-sponsored coverage but healthier than the population already on Medicaid.

That's partly because when people get really sick and spend a lot of money, some of them wind up on Medicaid. So some are in that category but I would also say it's a very diverse population and you do have a chunk who are very healthy and a chunk who have serious conditions and have not been treated and who could benefit enormously from the coverage expansion.

DIANE ROWLAND: We all wish we had more data from the census data on the health status [Laughter]. This last question that we've gotten really goes to the economists on the panel and it deals with sort of the difference between CBO estimates and the reality of implementation.

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The question here is really that are the CBO projections on the number of individuals receiving subsidies significantly low potentially are the numbers on Medicaid potentially low or high. I think we've heard much today about what influences the success and enrollment but can the economists comment on how well projects tend to mirror reality? I know John's done some work on different participation rates.

JOHN HOLAHAN: I tend to think that the CBO projects are on Medicaid take-up of probably a bit low and with the subsidy, the number of people coming in and getting subsidies, may be a bit high. So I think on balance, they probably are pretty close. The mix may be different. So I wouldn't say that we have big disagreements in terms of where they come out overall.

SHERRY GLIED: We've been reviewing some of the different estimates that are out there. No one's got a perfect crystal ball. I wish somebody did. It would make all of this much easier. Everyone's making estimates but they're actually all in a fairly tight ballpark. I guess the real question is the real issues have to do with the division of the population between Medicaid and the subsidies.

I think the CBO number is about as reasonable as anybody else's out there. I think that's what the best thing we have to go on right now. I think the real key number here

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to remember is that everybody's projections, CBO, everyone else you could think of, of what covering the uninsured will do to national health expenditures, that's the total amount of money we're spending, suggests that that number is a very small number, under five-percent.

So really what we're talking about is where the division of that money between states, the federal government, and individuals, it's not really, that total number is actually fairly well understood.

DIANE ROWLAND: One more question is where does the private sector fit into the structure under ACA? Is there anticipation that more private insurers will at least begin to implement Medicaid managed care, products, and what do you think that will do to access and to cost?

KIMBERLY BELSHE: Private sector specifically from a plan participation perspective?

DIANE ROWLAND: Yes I think, that's my assumption.

KIMBERLY BELSHE: Okay. California's very fortunate. Again going back to my opening comment, you've seen one state, you've seen one state. Our state actually has a fairly vibrant and robust set of health plans both public and private participating or providing coverage in our state and participating in our state Medicaid program.

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We have adopted, in Medicaid, an approach we call the two-plan model in which focus counties, people choose between a commercial plan like a HealthNet and Anthem and a locally developed kind of quasi-governmental plan.

We also have county-organized health systems where the entire county, seniors, people with disabilities, women and children, are all enrolled in a managed care plan. So it's very vibrant. We've got a lot of choice, a lot of activity.

We would expect that in the context of the health benefit exchange that we will see quite a bit of interest by our plan partners in being a choice that is offered though there's also a lot of concern in our plan community in California because our policy makers gave the exchange board the authority to competitively or selectively contract.

So that of course has health plans very interested in what plan participation standards will be established and what that means but my expectation is that the exchange will be successful as they're offering choice that individuals and employees of small firms value and individuals value choice.

They value quality, cost effective health care, and our health plans in California do a good job in the context of Medicaid and we would expect in the context of the new health benefit exchange.

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JANET OLSZEWSKI: In Michigan, we too have a pretty vibrant set of health plans we contract with for Medicaid. There are two large commercial insurers who've never participated in Medicaid and even before the Affordable Care Act was passed. I could sense some interest from them. As a matter of fact, this last bid process we went through both of them thought about it seriously.

One of them actually submitted a bid and wasn't selected. The other one chose not to bid because they felt that they didn't have the internal expertise at this moment to do that but when I talked about after the expansion, Medicaid covering 25-percent of the population that's not going unnoticed by anyone in the private sector.

So whether it is a health plan, whether it is a health system that has not done traditionally a great deal of Medicaid, they're all feeling like they need to get more knowledgeable and participate.

In our state, we did small market reform. We have not done individual market reform. So our private insurance markets in the individual and small market are somewhat skewed and in particular with the way we're structured. I think a lot of what happens in the exchange will also depend on whether we change some of the regulatory underpinnings of those markets.

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ED HOWARD: Well we've come to the end of our time and I think you'll agree that this has been a really rich discussion at a number of levels. I want to remind you that the web cast of this briefing will be available tomorrow on kff.org thanks to the Kaiser Family Foundation.

Thank you in advance for filling out your evaluation as you rise and walk toward the exit. Thanks to Barbara and Diane and their colleagues at the KCMU. They're going to help us keep a close eye on this bundle of issues; I'm sure, as they develop. Finally I ask you to help me thank our panelists for an incredibly good discussion of some very wide ranging issues [Applause].

[END RECORDING]

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