Children's Health Coverage: A Primer

Alliance for Health Reform and Kaiser Commission on Medicaid and the Uninsured

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ED HOWARD, J.D.: I want to thank you for being here and welcome you to the briefing that will be held on the way children in America have their healthcare needs met. I extend that welcome on behalf of Senator Rockefeller, Senator Collins, and the rest of our leadership. Our partner in today's program is the Kaiser Commission on Medicaid and the Uninsured, which is a project of the Kaiser Family Foundation, one of the most respected policy voices in reform, debate, and discussions not only on kids but in many areas of health policy. You'll be hearing from Diane Rowland from the Foundation and the Commission in just a moment.

This town loves kids. It's not just that politicians like to kiss babies, they really love kids. They love to provide healthcare coverage for kids and we have erected a fairly elaborate, some would say confusing, checkerboard of public programs to try to get coverage to as many kids as possible in this country especially those with low incomes.

If you care enough to be in the room today, you know that Congress is smack in the middle of a major debate over coverage for kids, the SCHIP programs, State Children's Health Insurance Program, which was first enacted back in 1997, is due to expire in less than two months unless it's reauthorized. I think it's safe to say that neither Democrats nor Republicans

in Congress, nor the administration is going to allow that to happen.

But we're not here to debate the merits of one SCHIP proposal versus another or the House version versus the Senate version or even to talk exclusively about SCHIP, today's program is a primer to give you a grasp on how kids get coverage now not just through SCHIP but particularly through Medicaid and don't forget private insurance.

In fact, most kids have private coverage, something we often lose sight of in the heated debate over government programs. Now there are a lot of new staff members in Congress, a lot of new members of Congress, people who are new to the Hill or new to the issue, I understand how those portfolios shift. So today, our goal is to equip you with the basics of kids' coverage patterns, public and private, and the sources that you can use to seek out more information.

This briefing is also being made available through the good offices of Kaisernetwork.org to Senate and House offices around the country via a live webcast. If there are staffers here today who want to make sure that your district or state staff tunes in just hold up your hand and somebody in the staff will tell you how you can get the information folks need to connect with this webcast in time to get some good use out of it. We'll even forgive you a brief cell phone call in the middle of the meeting to make that connection if you want.

This is the first of several primers that will be holding in cooperation with the Kaiser Family Foundation and the Commission. The others are on Medicaid, which is on the 16th, a week from Friday, I'm sorry, it is the 13th. Yes, it is the 13th but it's not unlucky. You can come. Don't worry. Then on health reform issues generally, on March 2nd, and Medicare on March 16th. So pass those dates along to your state and district staffers if you will.

A few logistical notes, by tomorrow morning you can view an archived webcast, if you want, of this session on Kaisernetwork.org and in a few days. You'll be able to look at a transcript of today's discussion and all of the materials that you have in your kits in your hands at both Kaisernetwork.org and allhealth.org, which is our website.

Let me say to the folks who are tuned in to the live webcast that you can view all of the materials that people in the room have in their kits by going to the allhealth.org website and looking through those materials including the PowerPoint presentations that folks are going to be using this morning. You'll have a chance to email your questions and we'll get to that when we get to the Q&A part of this program.

Let me just reiterate that because it is a primer, there is no question too simple or for that matter, given the level of sophistication of our panelists, no question too complicated but don't be afraid, if you don't understand a

question or if you don't understand the answer, remember it's Ground Hog Day, you can do things over and over again until we get it right.

I will ask you to keep your questions, at that point, as brief as you could make them and remember, this is a fact-based question. It's not what's the best policy necessarily but what's the current policy. So with that in mind, I'd ask you to turn, unless you're calling your district office, turn your cell phone off and let's get started.

As I noted, our partner today is the Kaiser Commission on Medicaid and the Uninsured and we're going to start with Diane Rowland, who's the Executive Director of the Foundation and the Director of the Commission. One of the most respected health policy analysts in the country by the way; she has a special interest and expertise in vulnerable populations like kids. She's doing double duty today because we'll have her as our leadoff speaker to give us the overall background for the discussion to come and then we'll have her as co-moderator of that discussion. So Diane, thanks for being with us and thanks for lending your support to this briefing.

DIANE ROWLAND, Sc.D.: Thank you Ed and thank you all for coming today to the primer on Healthcare Coverage for Children. As Ed said, children have been one of the major focuses of health reform efforts and efforts to broaden coverage over the last decades. My job is to sort of set a

framework for you of how children are covered today and some of the issues involved in the structure of the Medicaid and SCHIP programs as they provide coverage to children but I think it's instructive to begin by looking at sort of where children get their coverage today.

About half of America's children are covered through their parents through employer-sponsored health insurance coverage. That is an area where, of course, coverage has been declining in recent years but still half of the children in America depend on that as a source.

Another four-percent get their coverage through private insurance policies that their parents purchase, either parents that are self-employed or go into the individual market but today, 29-percent of America's children get their coverage through Medicaid, through the State Children's Health Insurance Program, and other public programs. So obviously public programs play a very important role in filling in the gap in employer-based coverage for America's children. Yet 11-percent of our children remain uninsured, which is the challenge before us as we look at legislation such as the SCHIP renewal. How do we reach and insure more of America's children?

I think that it's instructive to remember that the Medicaid program has been around for a long time providing health insurance coverage to low-income children and today, covers 29½ million children up from 28 in 2005. When SCHIP was

enacted in 1997, it was intended to provide coverage for those above the income eligibility levels for Medicaid, so low-income children but children whose families' income was not low enough to qualify them for their state's Medicaid program.

So today, it covers about 6.7 million children. In 2005, it was 6.1 but I think it's worth noting the difference in the size of the population of children covered through Medicaid and through SCHIP, which is why, when we talk about children's coverage, we talk about the two programs together.

Now we also talk about these programs and care about them because they are the way in which children access the healthcare services that they may need and what you see here is the striking difference between children who are uninsured and those with either private or public insurance in terms of their access to care, the availability of the usual source of care, the lack of postponing care due to costs so that we know that it's not just that we cover children but when you give them health insurance coverage, that health insurance matters in terms of how they and their families access healthcare services and especially some of the services that are beyond what the scope of a normal health insurance policy may be such as dental care, which can be extremely important for children.

There are major differences in not just the size and the number of children covered between Medicaid and SCHIP but in the framework of those programs. Medicaid is a much broader

program than SCHIP taking care of a much broader part of our population including both health and long-term care services for the elderly, people with disability, for some of the parents of children but in terms of its structure for children, it is a program where the states have required minimums, income levels that they must cover all children under poverty, are eligible for the Medicaid program. Younger children and pregnant women are eligible and covered in all states at somewhat higher levels.

States then have the option to go above that level to cover more individuals at higher income levels if they so desire but they must provide for the federal minimums in terms of coverage. It is a program that is an entitlement to both beneficiaries and to states are guaranteed a federal matching rate, which varies by the per capita income of the state but is no less than 50-percent federal, 50-percent state to be able to pay for the medical benefits that they provide to eligible individuals.

No state is allowed to put in an enrollment cap or to somehow freeze eligibility. The nature of the entitlement is that all children who meet the eligibility criteria, that's income and their age, must be covered by the program unless the state changes the eligibility rules but they cannot, in the middle, decide that they are spending too much money and then put on an enrollment cap.

The matching rate is open-ended. This federal government agrees to match all appropriate expenditures of the state and the scope of coverage is broad with very limited cost sharing due to the low-income nature of the program and also because there's an option to provide wrap-around services and early periodic screening and diagnostic care so that the children get whatever services are needed.

When you looked at the SCHIP program, you see that it is intended to serve a somewhat higher income population than the Medicaid program. That was still low-income. States, under this program, have what we call a capped entitlement. They have an allotment of funds. They must match the services that are provided with the federal dollars but the matching rate is more generous than under the Medicaid program but there is a cap on the availability of federal funds.

Because of that, states are allowed to put in enrollment caps if their spending is accelerating too rapidly and they would use up their allotment and they are allowed to have a much different benefit package that is shaped a little more like the benchmark plan of a private health insurance plan. So significant differences between the two programs though both aimed at covering children especially low-income children.

When we look at the eligibility threshold, it's important that beyond these minimums to recognize that many

states have built upon their SCHIP program and upon their Medicaid program to cover individuals at higher income levels especially children where the coverage at 200-percent poverty is the median and yet they leave behind, because of the lower eligibility levels in Medicaid, many of the parents of these children, which has some implications for the ability of whole families to get their care.

As this slide shows you, states have aggressively implemented coverage for children. As Ed said, children are popular. Children are well liked as a constituency to provide broader coverage too and we know it's an investment to getting them better education in getting them better healthcare throughout their lives. You see here the majority of states have at least gone to 200-percent of poverty and many beyond that in terms of their eligibility levels for children recognizing the difficulties of affording private health insurance coverage and the lack of availability in the workplace for many moderate-income families of an employer-sponsored coverage.

We know that some of the children that are actually eligible for these programs have not been participating. It is a strategy that has been tried to do more outreach, to do better simplification to make it easier for families to sign up that when we go as a worker and get employer-sponsored coverage offered, it's part of signing up at the workplace as we start

our job but for a family looking to cover their children under a public program, it means a separate application process.

The easier and the more availability that process makes it, the more likely there are to be children enrolled. So the real challenge that we see as we move forward in implementing both Medicaid and SCHIP is that there are 14-percent of children who are uninsured below 200-percent of poverty.

As I've shown you, many of those should be living in states where they are eligible to participate in the programs but not enrolled. So the real challenge is to how do we simplify the enrollment process? How do you do better outreach? How do you bring these children into coverage rather through Medicaid or through SCHIP? We know that as children are being reached through the SCHIP program, we are also finding children who are eligible for Medicaid and enrolling them.

So the two programs together have been stepping up to the plate to try and fill that gap in coverage of children but more needs to be done to try and better the outreach programs and to get the participation and enrollment up. That's what my colleagues on the panel today are going to fill you in on and discuss. Thank you very much.

ED HOWARD, J.D.: Thank you Diane. You got us off to a good start and on time. That's right. We're going to turn now to a couple of folks whose exposure to both SCHIP and Medicaid is not theoretical. They deal with this stuff every day and

they come up with ways to make it work better. We're very pleased to have them with us today. We're going to start with Terri Shaw. Terri is the Deputy Director of the Children's Partnership, serves on its executive team. The Children's Partnership, those of you who don't know, is a non-partisan child advocacy organization. The main office is in Santa Monica, California, an office here in Washington, D.C.

Terri's based in California. She also has experience as a health policy analyst right here in town. She's worked for the Ways and Means Committee on the House side. She's worked for the Department of Health and Human Services. Back in California, she's been with the California Managed Healthcare Improvement Taskforce among other groups. So Terri, if we could solve California's problems with kids' coverage, we could solve them in the country. So tell us how it's working out there.

TERRI SHAW: Great. Thank you Ed and thanks Diane. Thank you both for hosting us today, bringing everybody together. Thank you all for being here. As Ed mentioned, I am with the Children's Partnership and I think it's worth explaining just a little bit more about what the Children's Partnership does to give you some context for my remarks.

We are a national non-profit, non-partisan advocacy organization and we focus primarily on getting uninsured kids covered and also on the ways that information technology, information communications technology can benefit the lives of

children. We are a national organization. We do a lot of work in California at really trying to get kids there covered. So most of my comments today are going to be focused on the experience in California and our efforts in California but we are, as I said, also looking at the ways that technology can benefit kids.

There are a lot of really promising uses of health information technology to both reach uninsured kids and get them enrolled as well as to actually improve access to care and the quality of care that they receive. So I'll touch on those issues just a tad as well.

So let's see, get my technology in order here. So I do want to talk about the importance of Medicaid and SCHIP. In California, the California versions of those are Medi-Cal and Healthy Families. California has chosen to implement its SCHIP program as a separate program as opposed to a Medicaid expansion. Different states handle that differently but in California, that's how we've chosen to do it.

I'll talk a little bit about the challenges that we have to enrollment and retention and some of the solutions that are out there for addressing those challenges and then touch real briefly on some of the policy implications on some bills that are before you all right now, both the SCHIP reauthorization package, of course, but also the economic

recovery package has a lot of really important implications for coverage for children.

So as Diane has already covered very well, Medicaid and SCHIP together cover 35 million children approximately with millions more who are eligible for coverage. So the evidence shows that upwards of half of the uninsured kids that we still have are eligible for these programs. So in California, the numbers can be a little bit boggling. In California, there are approximately three million children who are covered by California's Medi-Cal program and just under 900,000 children who are covered on our Healthy Families program, our version of SCHIP.

So together that's about four million children who are covered in California through these programs. It's an incredibly source of coverage for children in California, although as is true with the rest of the nation, the majority of kids in California are covered through private coverage but this is an incredibly important source of coverage.

We've now gotten to the point and again as sort of indicative of the rest of the country as well, I think consistent with the picture in the rest of the country, we've made a lot of gains in covering kids, a lot of progress in California and largely due to the public programs. We are now in California, according to the most recent data that we have

available, we have approximately 94-percent of kids in the state are covered.

It's only about six or seven-percent of the kids still remain uninsured but in California, that means nearly 700,000 children that are without health insurance in the state. About 56-percent of those, so again over half of those kids, are currently eligible for either Medi-Cal or Healthy Families.

So a lot of the work that we have to do in getting kids covered is really just doing a better job of reaching the kids who are currently eligible and getting them enrolled. So we'll talk more about that in just a second but I also want to just note that, as I said, four million kids approximately in California, do have coverage through Medi-Cal or Healthy Families and that makes a tremendous difference as Diane's slides showed.

It makes a tremendous difference in terms of access, outcomes, quality of care that these kids receive that their results are on par with what happens in private coverage and much better than what would happen if these kids were uninsured. So they really make a tremendous difference. That makes a difference in terms of their school performance and attendance as well.

There have been studies on California's Healthy Families program showing that there are reductions in missed days of schools and improvements in terms of paying attention

in school and performing well in school so that the coverage really makes a huge difference in terms of how the kids do and of course, that in turn has impacts for the state. Of course we all know about the fiscal impacts that these federal dollars for these programs are a huge source of revenue for states that really are crucial to supporting these programs.

They also have direct and indirect economic impacts. First of all, as those dollars flow in and combined with the state dollars, those are dollars right into our communities to provide reimbursement for services for your local pharmacy, hospital, clinic, etc. but there are also indirect economic impacts as children do get better preventive care and they have more access to care and their outcomes improve, that of course improves their health over their life course helping to improve their long-term productivity and their contribution to the economy over the long run. So there are a lot of really extensive impacts of these programs that are important to keep in mind.

As I said, there is a continuing concern about actually reaching eligible but uninsured kids. The reason for this is I think, in some ways, it's quite simple. As Karen Politz [misspelled?] is fond of pointing out, it's easier to lose health coverage than it is to get it. That's particularly true in these programs that it is incredibly difficult and challenging for families to be able to get their kids enrolled

in coverage and to keep their kids enrolled. It's much easier for them to lose the coverage or to not have it in the first place. That's even assuming that they know about the programs, know how to apply.

So there are real challenges there. Some of that is rooted in some really good policy goals that, as we're really focused on these programs, we want to make sure that we carefully target the assistance to those kids who are most in need and that we want to avoid crowd-out, the substitution of public dollars and/or public coverage for what would otherwise be provided through the private sector.

We, of course, want to ensure that there's good program integrity that there is no fraud or waste, or abuse that's going on and that we're keeping these programs as efficient as we can. All good policy goals but they have tremendous impacts, practical impacts. What we see as a result of all of those sorts of concerns, unintended consequences include incredibly complex rules.

So in California, as I mentioned, we have a separate Healthy Families program. Just looking at income eligibility, California covers all kids up to 250-percent of poverty who are federally qualified as well as legal immigrant children. How we cover them is highly dependent on age and income. So for infants, they're up to 200-percent, they're in Medi-Cal. Above that, they're in Healthy Families.

For kids between the ages of one and five, up to 133-percent of poverty, they're in Medi-Cal. Above that, they're in Healthy Families. For kids who are six to 18, at 100-percent of poverty you get the transition from Medi-Cal to Healthy Families. Just trying to describe that is complex enough for families to understand that and be able to navigate that is really quite a challenge.

As a result, we get all kinds of gaps in coverage. Some of this is by design. So for example, to address crowd-out, there can be waiting periods. In California, you can't have had employer coverage in the three months prior to coming on to Healthy Families, which can lead to gaps in coverage.

There are also gaps in coverage that occur as kids transition from one program to the other, that handoff can sometimes lead to kids dropping out of the bottom and becoming uninsured. There are all sorts of burdensome requirements on families in terms of all the documentation that needs to be provided.

An example of this is there's a lot of good evidence out there about the citizen documentation requirements that were included in the Deficit Reduction Act in 2005, which were intended to ensure that we have only eligible kids on and not have ineligible kids on but the result is really burdensome documentation requirements that have resulted in very high administrative costs, a lot of inefficiencies, and a lot of

kids who appear to actually be eligible not actually being able to enroll because of some paperwork requirements.

All of this leads up to a bias against enrollment, which also occurs because of, for example, some hesitation on the part of states to take advantage of some opportunities that do exist in federal law to minimize some of these complexities and burdens but they may be hesitant to actually take up those options for fear that down the line when they are being audited, for example, it will turn out that things didn't work out as planned and so for fear of facing those sorts of repercussions down the line, there can be a bias against enrollment in the first place.

I'm already exceeding my time. So I'm just going to, real quickly, touch on that there really are some great ways that we can use technology and other tools to be able to reach some of these eligible but uninsured kids. It's not on the slide but one key example that I want to give to you, as some of the state experience from California, we have, in California in addition to Medi-Cal and Healthy Families.

Because those programs still do have gaps in coverage for kids and because they go to 250-percent of poverty only, we also have in about 30 counties around the state, local children's initiatives. So local efforts to fill in those gaps, cover those gaps, and make sure that all kids really do have a

place to go for coverage. So it's very different than the targeted approach that many programs take.

The experiences there is fascinating that for example, in Santa Clara County, the first one that did this, that's where San Jose is for those who aren't familiar with California, they implemented this Healthy Kids program and they found that they had a very broad outreach strategy that basically took the position of bring your kid and we'll find coverage for you. They worked very closely with the state programs as well.

What they found is for every kid that they were able to enroll in their local program, they enrolled two kids who were eligible for the state Medi-cal or Healthy Families programs. So really counter to the notion of really targeting our outreach or targeting our efforts, they took a very broad approach and the result was they reached a lot of really hard to reach kids. So I think there's a lot of important lessons to be learned there as one example of how we can get around some of these issues, these persistent problems with coverage.

Maybe when we get to the discussion, we can talk more about some specific ways that technology can be used to really access data that is already available to determine whether or not children are eligible for coverage, to be able to verify data that they provide, to make sure that they are in fact

eligible, and to really reach them in programs that they're already covered in.

For example, in California we have an express lane program that takes the school lunch application, adds just a couple questions to it and treats that as a Medi-Cal application because what we realize is that about 56-percent of uninsured kids are actually already enrolled in school lunch. So if you can find kids in these other programs, use the information from the other programs to establish their eligibility for Medi-Cal, it can be a really powerful means for reaching those hard to reach kids. A lot of that can be facilitated with information technology.

There are also some really great examples and rather than belabor them, I'll just point out that in your packets, first of all there's a lot of great information in the packets. I highly recommend looking at all the information that's in there, a really tremendous set of materials that are there but among the things that are there is a report that my colleague, Beth Morrow, wrote and we worked with the Kaiser Commission on that highlights a lot of different ways that states are using technology to help improve access and quality and other measures for kids in Medicaid and SCHIP. So take a look at that for some more of those examples.

Just to quickly note, there are some real potential changes afoot with the legislation that's currently being

considered on SCHIP and then on the economic recovery package. In the SCHIP package, not only does it of course address the basic coverage and financing provisions of SCHIP and reauthorize all of those good things.

It also includes some new opportunities for really looking at this issue of how do we streamline eligibility and enrollment and retention. How do we really get those hard to reach kids and keep them enrolled? It has not only some new options that states can use for that but also some bonus payments that are available to states when they adopt these opportunities and those results and higher enrollment of kids. So there's some real strong incentives there to get past some of these barriers to coverage that we've seen and do some really good innovative work.

There are also some provisions in there for some improved quality measures and health information technology that I think again states can tap into those to really get at some of these thorny issues that we've been discussing.

Then I also just did want to make sure that everybody was aware that there are implications in the economic recovery package for children's coverage as well. Most obviously, there is discussion of including some enhanced federal match rates for Medicaid in those packages, which really has at least two impacts for states.

One is the increase in federal revenue at a time when states are facing tremendous budget challenges. It's really important and that's important not just for the basic budget issues but also because the FMAP provisions require states to maintain eligibility as a condition of that enhanced federal funding.

So in California this year, we're facing a state budget deficit of $40 billion. That is an amount equivalent to our entire state budget for our entire Medi-Cal program. It's a huge, huge budget hole. Having the federal matching dollars there will make a tremendous difference in terms of keeping that program available for kids. The state has already started, had been looking at ways to cut back on spending by including things for kids' coverage.

So moving the wrong direction of what we've been talking about including having semi-annual reviews, basically making families have to re-sign up for coverage more frequently than they do now, which is estimated to impact about 250,000 kids over time. So really some huge impacts that hopefully can be undone due to the effects of the economic recovery package. Just to note, there's also some money in there for health information technology, which I think states can use to great advantage and maybe we could talk about that more in the question and answer. I'm sorry to take so much time but thank you.

ED HOWARD, J.D.: Thank you Terri. Now we're going to turn to Ruth Kennedy. She directs the Louisiana Children's Health Insurance program, which has the delightful name of LaCHIP as well as the state's LaCHIP and Medicaid Eligibility Division. Now she served as a member of the National Eligibility Policy Group for the Covering Kids and Families program, which is a project I was lucky enough to have been part of as well.

Ruth began her career as a Parrish, that is to say county in the rest of the country, eligibility caseworker and she's a graduate of Southeastern Louisiana University. I know that on her first slide, she has a former alliance panelist picture that would be Bobby Jindal, the Governor of Louisiana. So we know you're in good shape coming up here to pick up in your Governor's stead. Ruth, thanks for being with us.

RUTH KENNEDY: Thank you. Good afternoon. As someone who's been on the front lines for the last 10 years, the last decade, working to improve enrollment in children's health coverage, this is an exciting time here for us and I appreciate the Alliance for Health Reform and the Kaiser Family Foundation for giving me the opportunity to share with you the lessons we've learned in the trenches in Louisiana during the last 10 years.

A quick overview of what I'm going to discuss. First is the importance that we know to be in focusing equally on

Medicaid as well as CHIP. You can have a Rolls Royce SCHIP program but if you ignore Medicaid, it's not going to be good for children.

Administrative simplification, the adoption of those, the kinds of strategies that are incentivized in the SCHIP bill, they go a long way toward insuring the eligible children are going to actually benefit from the Medicaid and CHIP programs.

I want to talk about the critical role of retaining eligible children once they're enrolled and getting to our goal. You know, in the last now 11½ years since the first SCHIP bill was passed, things have changed. The good thing is that the legislation has, in both the Senate and the House, they've responded to those changing needs.

Finally I'll share with you why I believe that enrolling virtually all eligible children in Medicaid and CHIP is an achievable goal.

A little bit of context in Louisiana, in a single word you could say that health coverage in 1998 for children was abysmal. We had and still have one of the highest rates of child poverty in America with health rankings for every factor at or near the bottom, absolute minimum levels for our children's health coverage in our Medicaid program back then. Like most states, we had a really onerous application process, verification requirements.

Just as an example, not only did you have to have eight check stubs in order to get your child signed up, they had to be eight consecutive check stubs and not surprisingly, Louisiana had, at that time, the nation's third highest percentage of uninsured children with about one out of every three children in the state being without health coverage of any kind.

I'm a firm believer, based on our experience, in the saying when it comes to public health coverage that a rising tide lifts all boats. It's proven true for us. Since, in Louisiana unlike California, we have a Medicaid expansion CHIP program. That's one of the models that is allowable and now we have, we're a combination state, but we couldn't distance ourselves from our Medicaid program. So we had to fix the Medicaid program. In retrospect, CHIP has proven to be this really great catalyst for streamlining and simplifying children's enrollment in Medicaid.

Right now, we have about 662,000 children enrolled in public coverage in Louisiana and more than 80-percent, 81-percent of those children are in the Medicaid program. right no about, we have enrolled in the last 10 years, about 126,000 children in SCHIP during that same time, we've increased enrollment by about 230,000 in our Medicaid program.

Last, you get the idea that that's just happened in the early years. In the last seven months, our increase in

enrollment is 78-percent of the increased enrollment has been in Medicaid for those lowest income families rather than our CHIP program. That's even with us expanding the CHIP income limit to 250-percent of poverty. The reality is that in Louisiana as in the rest of the country, a large number of the remaining uninsured children live in poverty even deep poverty.

In Louisiana, we know that the highest percentage of uninsured children are actually in households with income between 50-percent of the poverty level and 100-percent of the poverty level. So that's why administrative simplification strategies, the kinds that are incentivized in the CHIP legislation matter because of the literacy issues that families face.

Priorities are very much, I found, being driven by Maslow's hierarchy of needs. On most days, health coverage and the hassle factor that enrolling one's child for public coverage can represent, isn't at the top of a parent's to do today list.

We say, in Louisiana, we like to say that enrollment is simple but that is relative. Is it simple compared to 1998? Yes. Is it simple? Not really. The population moves very frequently. There's a lot of address changes and this makes a great challenge once children are enrolled to retain them in the program.

So the bottom line, administrative simplification is so important to enrolling the most vulnerable, the lowest income children. In Louisiana, we've been able to achieve a balance and we've demonstrated to ourselves that eligibility and enrollment can be radically simplified without compromising the integrity of our eligibility decisions.

Streamlining the process has meant acceleration of enrollment into the program and their access to healthcare. It was not unusual, 10 years ago, for an application to languish two months from the time the family requested assistance until approval. Now we have, for all of our applications, including those that we need to get follow-up verification on, their average processing time is eight calendar days. Now as someone who's been working in the area of eligibility for 28 years, I'm very proud of that.

Here's a newsflash is that streamlining eligibility for families, streamlines it for case workers, and for the administration as well. It means that administrative cost savings are possible and states really can do more with less. Advances in technology that were not there 11 years ago have opened a lot of doors that didn't exist like express lane eligibility.

Of all the strategies to reduce the number of uninsured children, to me, none has been more important in Louisiana than fixing the renewal problem. In Louisiana, we've been giving

this our undivided attention since November of 1999 when, in a single month, we had a net loss of 6,600 children because we were enrolling them hand over fist, new children coming in but we lost them out the back door because of the renewal issue.

We have been able to develop a process through which we're able to complete a review of eligibility of about 99-percent kids due for renewal each month. So if anyone tells you that the renewal issue is an intractable problem, it's not. Why is this important? Because when we finally got a baseline to see how we were measuring up in 2001 on this, is we were losing 22-percent rather than about one-percent of children.

What is the difference? That would have been about 9,800 kids that fell off the program rather than 393. So that means over 9,000 children who would have ended up in an emergency room would have needed to apply, become uninsured again, just that vicious cycle of churning that people talk about.

In 2007, the Louisiana legislature unanimously approved expansion of CHIP to 300-percent of poverty. It was actually the first state in the South to do so. Then we encountered an unexpected roadblock that was the SCHIP reauthorization philosophical debate, the CMS letter that they sent to states with new conditions for expanding the eligibility to children beyond 250-percent of poverty.

One of those was that 95-percent of children already be enrolled below 200-percent but that was not the deal killer for us. The deal killer was the five-year employer-sponsored insurance trend in the state. There was no way that we could meet that condition. So we expanded our eligibility to 250-percent of poverty.

The reason that we were so anxious to expand the eligibility limit was the recognition that we had come to that the 200-percent income limit was creating, for us, a new hole in the bucket. For years, we had referred to renewal, losing children at renewal as the hole in the bucket but this was the new hole in the bucket.

Families with modest increases in their income, the income putting them just over that 200-percent limit, I think it was an unintended consequence of the increase in the minimum wage especially for families with two working parents. So what we saw was children were moving from years of being on CHIP or Medicaid to being uninsured. So that was the hole in the bucket.

We know that of the 1,800 children that we have enrolled from moderate income families in Louisiana since last June, is that 85-percent of them were enrolled for either Medicaid or CHIP in the previous 36-months and none of them voluntarily dropped employer-sponsored insurance in the last 12 months. So these are not children who are dropping private

coverage to come on to public coverage. So for that reason, we believe that increasing the income limits is essential to maintain the gains.

In conclusion, I can tell you that in Louisiana in the last 10 years, we have more than doubled the number of children with public coverage from 315,000 to 654,000 and our Louisiana household insurance survey, it's a large survey, 10,000 household survey in 2007, the results were that the percentage of uninsured children in Louisiana is now 5.4-percent. We have witnessed a radical change in the culture of eligibility in our state. Public and legislative support for children's coverage is very high.

Now SCHIP reauthorization contains some additional resources and tools to help us get to where we want to go. so we really can see the light at the end of the tunnel I would say and it's not an oncoming train.

ED HOWARD, J.D.: That's terrific. Thank you Ruth. I think the Children's Partnership, with its emphasis on the use of technology in this process would be really pleased with your slides the way they activated and moved and kept your attention.

Let me just go back remind those of you who are watching the webcast here on Monday afternoon, if you're watching it in an archived form, you can ignore the next 30

seconds that you can go to the Alliance website and get information on how to submit a question to our panelists.

It will tell you if you're unable to juggle back and forth that the easiest way to do it is to send an email to nancypeavy, all one word, at allhealth.org. We'll get it in front of our panelists as quickly as we can. As I say, all of this is laid out on our website, allhealth.org, and you can participate actively in this discussion.

We would ask you here in the room to fill out those green cards. You don't even have to put an email address on them, or go to one of the microphones that are strategically positioned around the room and identify yourself and ask the question in as brief a way as possible. We want to get as much chance for everyone to get their question as we possibly can.

Let me just start off by asking our panelists to talk a little bit about what has happened in the last few months. Ruth has talked about the increase in enrollment and Terri talked about the importance of the stimulus legislation aimed at doing something about the impact of the slowdown but what have you seen, if anything, in your areas in the way of increased demand on your programs and availability of resources as a result of the economic conditions that we're now experiencing. Terri, do you want to start?

TERRI SHAW: Sure. Well, in the last few months, the economic downturn of course has had at least a two-fold effect.

One is that there is an increased demand for these programs as families are losing access to or losing the ability to afford employer-sponsored coverage for their kids. As their incomes are affected, there is more demand and we are seeing an increase in enrollment in the programs.

The other impact on the economic downturn is the impact on state revenues. So at the same time that we're experiencing this increased demand for the programs, the state is experiencing a decreased ability to be able to support those programs, find the state dollars to support those programs. So that's why California has looked at ways to curtail program costs including, as I mentioned, the reverting from what had been 12-month continuous eligibility with just one annual renewal.

They're now looking to implement or had been looking to implement semi-annual reviews. So twice a year now you'd have to do this. The impacts of that are huge in terms of kids losing coverage. It's also undeniably, as Ruth was getting at, going to increase state costs for administrative costs. there have been studies that have been done in California that show that the effects of churning of kids coming on to coverage, losing coverage, and then coming back on to coverage as most of them do within the next three months or so, the costs of reprocessing that eligibility in California have been estimated at, on the order of $40 million a year. That's huge.

So the effect, basically, has been increased demand, decreased capacity, and according to that then cuts in different ways that really will have the impact of decreasing the number of kids who are covered. With the economic recovery packaged, as I mentioned, that increases the likelihood for a variety of reasons that the state will not have those eligibility limits and will be able to support kids' coverage.

ED HOWARD, J.D.: Thank you. Ruth?

RUTH KENNEDY: Two things Ed. One is in the first six months of 2008, we had begun to see a shift into where the increase in enrollment each month was much more on the SCHIP side, those was higher income families. Then, as I previously alluded to in the last seven months, that has just totally flipped to where the great majority of the increase is in Medicaid because of reductions in income or loss of income from families.

Like most states, Louisiana, I was looking at budget cuts and it actually had to implement some mid-year budget cuts. One of the things that Governor Jindal did was he directed the Department of Health and Hospitals to make sure that there was no cut in eligibility for children and made it very clear that we have not cut back on outreach for children even with all of the circumstances we're in is that it's still a very important goal in Louisiana.

ED HOWARD, J.D.: Terrific. Diane, you have some questions?

DIANE ROWLAND, Sc.D.: Ruth, we have a clarification someone would like. You said in the CMS August 17th letter there was a requirement for five-year ESI trend for kids in the state. They want to know what was that and how did it affect Louisiana.

ED HOWARD, J.D.: And what's ESI.

RUTH KENNEDY: My understanding, ESI, the acronym for Employer-Sponsored Insurance, one of the requirements in the letter that didn't get as much attention as the 95-percent coverage requirement, is that the employer-sponsored insurance for children could not have decreased by more than two-percentage points in the past five years. That was the condition over which our Medicaid program, our CHIP program really had no control. That is what I'm alluding to.

DIANE ROWLAND, Sc.D.: And then you also had a hurricane somewhere in the middle of that.

RUTH KENNEDY: Well actually in the short-term after Katrina, we there was an increase in employer-sponsored insurance and when we looked back for a couple of years, from 2005 to 2007, there was an increase but when we looked back for the five years is it had decreased by much more than two-percent.

DIANE ROWLAND, Sc.D.: One question here is to discuss the benefits or challenges with having separate SCHIP and Medicaid programs. Is it better to have an expanded Medicaid program or to have the dual programs and maybe Terri could start and then Ruth can comment since you both come from states with different models.

TERRI SHAW: Well having only experienced one, it's hard to know which is better but there definitely are some challenges that have occurred for families as a result of having the two programs. The most noticeable one being that because we have two programs, that means as children get older or their family income changes slightly, they move from one program to the other.

The state has, at times, had difficulty making that transition happen smoothly for kids. There's a handoff but not a hand to catch. So the kids just become uninsured or the applications get bounced back and forth from one program to the other where each one is saying that they're eligible for the other program, all sorts of challenges that occur and the bottom line being that kids wind up not in coverage even though they are eligible for something.

So we've worked, the state has now adopted presumptive eligibility between the two programs so that now the kids are presumed eligible for the other program and are enrolled until

the final determination is made one way or the other and then things get worked out.

So the families aren't suffering as a result of these discontinuities between the two programs but that has been a challenge.

RUTH KENNEDY: There are advantages and disadvantages to both of the models but in retrospect, the Medicaid expansion was the right thing for Louisiana. It's very unlikely that we would have seen the improvements in the Medicaid eligibility enrollment process as quickly were it not a package deal as I previously alluded to.

One of the things that, with the Medicaid expansion is it's a seamless process for families is they move between the two with a simple change of the code because when we do renewals each month, it's about 20-percent of our children who are enrolled in CHIP who are due for renewal, we move them to Medicaid because of reduction in income or loss in income and about six-percent of children who are in Medicaid, we move them to CHIP because of an increase in income so that no one is lost, no one falls between the cracks in that Medicaid expansion system.

I know that in the last 10 years, the states have worked very hard to better coordinate between the two programs. As I said, our expansion program for moderate income families higher than 200-percent of poverty, is a separate state program

that the benefits package is slightly different, the delivery system is different. So I mean there are a lot of things that a state has to look at to make that decision.

DIANE ROWLAND, Sc.D.: This question relates to whether there are any plans for measuring or assuring quality of care for the Medicaid and SCHIP children and how can technology be used in regards to monitoring quality and improving quality.

TERRI SHAW: So certainly in California, the state does monitor quality for both the Medi-Cal and the Healthy Families populations. HEDIS measures, among others, are used. There are some challenges in that, lots of different challenges, but including that, as is the case for all plans, there are challenges with, for example, having the quality of data and the volume of data that would be necessary or at least desirable to be able to get really rigorous quality data including for sub-populations.

So for example, it's not just, so sometimes you'll see the quality measures for the Medi-Cal program as a whole or for the Healthy Families program as a whole. They tell you some interesting things but if you were to be able to look below those numbers, to look at some issues around geographic disparities, racial and ethnic disparities, etc., I suspect you'd get a much different sense of what quality is like in the programs but the data are simply not there or not in an easily accessible enough manner to be able to make those kinds of

rigorous quality measures happen in the way that we'd like to see.

So having information technology in place that captures better information in a more timely fashion and enables that information to be used for this kind of quality measurement is really crucial and is definitely among the things that potentially could be pursued with the authority in both the SCHIP package and in the economic recovery package if those make it through.

RUTH KENNEDY: For us, enrolling children, increasing enrollment even if we get to 100-percent of all the eligible children enrolled, that's not our end game. Our end game is actually improving health outcomes and monitoring quality is a very important aspect of that. So one of the most exciting things for me in the SCHIP legislation is that that is addressed, for example, I believe there's language that by January 1st of 2010, there will be additional quality measures for children's coverage.

We too, the HEDIS measures that we're measuring like well child visits, appropriate use on treatment of asthma. We are seeing improvement each year and closely monitoring that. So very much quality is the goal here. The ultimate goal is quality and improved health outcomes for children.

ED HOWARD, J.D.: Thank you Ruth. Before we take the next question, let me just remind you, as I neglected to remind

you before, there is in your packet a blue evaluation form, which we would very much appreciate your taking the time to share your content with us. I don't know where that sentence is going. It doesn't parse very well but fill out the form please. How's that? Diane?

DIANE ROWLAND, Sc.D.: Thank you. Terri, this question asks how California provides care to undocumented children. Could you just clarify that?

TERRI SHAW: Sure. So currently, Medi-Cal and Healthy Families do provide coverage for legal immigrant children including those who've been here for less than five years. So the SCHIP provision that would lift that ban for kids in their first five years would serve to basically provide federal support for what is now being supported with state only dollars.

In terms of for undocumented children, there are no state programs that are available for them. It is among the coverage expansions that we are trying to achieve and actually has been supported. Coverage for all kids regardless of immigration status up to 300-percent of poverty, so expanding Medi-Cal and Healthy Families to cover all of those kids, is a policy that has been supported very broadly by the public in California as well as among policy makers.

So for example, those policies were included as core elements of larger health reform packages that were supported

by Governor Schwarzenegger and by leaders in the California assembly back in 2007. Unfortunately, those health reforms didn't go through but had they been able to go through, they would have provided coverage for all kids.

So that's very important and meanwhile, at the local level as I mentioned, there are a lot of, about 30 counties, we have 58 counties in California, about 30 of them are providing local coverage initiatives that generally do include coverage for children regardless of immigration status. As I said, having those programs in place has had a tremendous impact not only in covering and supporting the cost of services for those kids but has a tremendous impact in increasing enrollment among eligible but uninsured kids in the Medi-Cal and Healthy Families programs.

So it has a sentinel effect not just for coverage for those kids at the local level but for really reaching those hard to reach kids through the state programs as well.

ED HOWARD, J.D.: Diane? Diane could I just follow up for a second with Terri? For those folks who are listening in Congressional districts and states other than the ones in the room, and other than California, where do those county programs get their money? Presumably there's no federal money involved.

TERRI SHAW: Right. So those local programs are funded by a variety of means but generally they're supported by local communities, by employers in the community, corporations'

funding. Some of the foundations around the state have been really crucial in providing support for those programs. So that's been really important but it is, one of the challenges that we're facing now is that those programs are not sustainable because they are funded through these cobble together sources.

They're not sustainable over the long run and yet they're having a tremendous benefit for kids at the local level and for service provision at the local level, supporting the providers in the community as well. So that's part of the reason why moving towards this state solution is so important because it will make it possible for all those kids who do have coverage now to retain coverage, which otherwise they'll probably lose.

I also want to note that it may be more true in California than in other states but there are a lot of families in California who have mixed immigration status within the same family. So having programs that don't account for that is also another barrier to coverage because it's very difficult for a family to come in and be able to say okay, I'll get coverage for one of my children but what do I do about my other kids.

If there aren't programs available to serve all of those kids that can be a very difficult situation for a family to face. So because of that mixed immigration status, it's one of the reasons why it's so important to have these continuous

coverage programs that don't create those kinds of barriers for families.

DIANE ROWLAND, Sc.D.: Well and clearly it's important to remind people that while parents may be legal immigrants, children born in the United States are born as American citizens so that this is one of the other issues that may discourage parents from coming in to enroll their children who are entitled to the coverage even within that five-year period.

The next question we have, I might direct to Ruth but it's what assurances does the tax payer have that Medicaid relief will actually go to funding Medicaid and SCHIP programs and not fill the general revenue hole if this FMAP increase is included, the increase in the matching rate as part of the economic stimulus plan. You might just explain how matching funds work.

RUTH KENNEDY: The matching funds, Medicaid and CHIP are a federal state partnership and with the state putting up a percentage and the federal government matching that, the federal government paying a larger share for most states than the state pays. One of the things in the versions of the stimulus package I've seen is that there would be a condition, is that eligibility could not be reduced as a condition for getting the FMAP relief from states.

DIANE ROWLAND, Sc.D.: The FMAP is cued off of, you submit for the services provided and so it is directly related

and I believe the provision in the legislation says things like disproportionate share, hospital payments are not subject to the FMAP increase.

RUTH KENNEDY: That's correct.

DIANE ROWLAND, Sc.D.: This question relates to the concept of automatic enrollment at birth and unenrollment only with proof of other coverage. The questioner wonders whether enrollment at birth through 18 years would ensure coverage to all children with no issues of renewals, gaps, administrative costs. Is this better use of federal state funds? Is this an idea that ought to be considered?

RUTH KENNEDY: Are we talking about automatic enrollment of all children even if they're going to get private health insurance?

DIANE ROWLAND, Sc.D.: I think we're talking about moving to a single payer system. I think the problem here that our programs today are geared toward having eligibility based on income and so that income determination has become a huge part of establishing who's eligible for this program. How you do that documentation is the subject of some of the simplification discussions we've had.

ED HOWARD, J.D.: And here on one of the multiple question cards is actually something that is a useful follow-up to that discussion and that is if you can't move to a single payer system or you don't think that's a good thing to do, how

do you best target the half that both of you mentioned of uninsured kids who are already eligible for either Medicaid or SCHIP? How do you go after them and get them enrolled? That'll be an even bigger group if the SCHIP reauthorization goes through and there will be additional children eligible for that.

DIANE ROWLAND, Sc.D.: Right.

ED HOWARD, J.D.: Terri?

TERRI SHAW: So regardless of what program you may be enrolling children into, however that question's answered today, it's primarily Medicaid and SCHIP on the public program side. The point, I think, of all of our comments today have been really geared towards that process has to be as simple as possible.

There are a lot of things that we can do, particularly given technology, to find those kids and get them enrolled through automated processes, for example, that make it really incredibly simple for the family. So be given that approximately 70-percent of kids who are uninsured now are actually already enrolled in public programs of some support, Women, Infants, Children, WIC, food stamps, school lunch, what have you and given that, those programs already hold information about the families, information that could be used to make a determination about eligibility for Medicaid or CHIP.

So given that, there's a huge untapped resource there to be able to just make this process as simple as possible. It's beyond just looking at the health programs to looking at some of the other public programs that these kids are using.

So there are lots of different ways that you could use the information that we already have, tap into that to make it easier to get these kids covered.

RUTH KENNEDY: Three things I would say. One is outreach, it is critical that at both the state level and the national level, is that aggressive outreach continue. Another is when we saw the different strategies and simplifications in one of Diane's slides, almost all states had eliminated the face-to-face interview. Almost all states had eliminated the asset test but I believe there were fewer than 20 that had 12 months continuous eligibility.

That is one of the simplifications that Louisiana has had since we implemented our program in 1998. I think it's very important, the 12 months continuous eligibility for children in both Medicaid and CHIP and then lastly, I would say that particularly for the most vulnerable, lower income children, any time they touch the social and healthcare system, whether it be through food stamps, through the school lunch program, through the WIC program, that opportunity not be left there that we could also enroll them in Medicaid or CHIP as well. You

just can't let them get away, let that opportunity slip away. So there needs to be coordination at that level.

TERRI SHAW: There are some states that are engaging in that particular effort. If a family comes in to renew its eligibility for any of those programs, that information is shared with the other programs and then used to restart their eligibility term, if you will, in the other programs. So if you come in and you recertify on food stamps, that information is used then to redetermine your eligibility for Medicaid and then you have that next 12 months is taken care of for Medicaid as well. So there are ways to be able to tie those things together.

ED HOWARD, J.D.: We started this discussion with the idea of enrolling kids at birth no matter what their income status but given the fact that there is this contact with a number of income-related programs, is there any state either doing or thinking of doing a process that would automatically enroll, re-enroll or re-extend the eligibility in SCHIP or Medicaid on the basis of the information that was submitted for some other program?

TERRI SHAW: I believe Washington State is already doing that. I believe it's Washington State that's already doing that but then I think there are many other states that are looking at, so there's using information that's provided to other programs. Then there's also using the actual determination made

of another program instead of having to recalculate all of that information in Medicaid.

That is among the things that the SCHIP bill makes clear that states can do is be able to use determinations made by other programs like food stamps to serve as determinations for Medicaid and CHIP, which will have a big impact.

RUTH KENNEDY: Louisiana actually has state law that was passed in 2007 that authorizes us to use income determinations from other programs to determine eligibility for Medicaid and CHIP. The law says contingent on approval by Congress. So as soon as that, if that happens, that will open a lot of doors for us to be able to use those other income determinations because eligibility is such a mish mash in terms of whose income is counted but this would make it so much simpler and the coordination would be there that we could do things that we currently can't do.

DIANE ROWLAND, Sc.D.: One of the key issues that becomes a controversy is called crowd-out and at what point does public coverage begin to erode availability in use of private health insurance coverage that's provided through the workplace. This question sort of asks what are the appropriate provisions that should be considered to examine the impact of CHIP on issues such as the effect on private health insurance coverage or what can you do in structuring your program to help to minimize that impact?

RUTH KENNEDY: Well it certainly not our intent in Louisiana when we expanded eligibility beyond 200-percent of poverty to transition people from private health coverage to public coverage. That wouldn't do anything to further reduce the number of uninsured children in the state. So we knew that we had to have some kind of deterrent to prevent crowd-out and we do have a waiting period so that some states have waiting periods.

Some have reduced the waiting period or eliminated the waiting period but for us, at this point in time, we think it's important to have that deterrent but at the same time, we believe that it's important that there be exceptions to the waiting period that good cause conditions exist. For example, one of our conditions that is an exception is if the cost of the employer-sponsored insurance has increased to beyond 10-percent of the families' income and we actually have some cases in which that has happened for those 1,800 children.

ED HOWARD, J.D.: And the waiting period, just to be clear, is sort of a look back for a period during which people aren't eligible if they had access to employer-sponsored coverage in that time or actually had coverage.

RUTH KENNEDY: For us in Louisiana, they were enrolled. They cannot have been enrolled and voluntarily dropped private insurance without good cause. If they do that then we have

currently a 12-month waiting period. So we have had applications that we have denied because of that requirement.

ED HOWARD, J.D.: And there are some very good background materials on the issue of crowd-out in your packets. I would comment them to you.

DIANE ROWLAND, Sc.D.: This question relates to the services provided for those who become eligible for the SCHIP programs specifically asking whether preventive services such as mental health services, nutrition classes, and regular checkups are included in the SCHIP benefit package.

Then following up, do the children and the families take advantage of these or is coverage under SCHIP really mostly a source for when children become ill and need access to medical care?

RUTH KENNEDY: The Medicaid benefit package and for our CHIP program, the CHIP children, about 124,000 children who are in our Medicaid expansion CHIP program, it's a very comprehensive benefit package, all medically necessary services, in fact, because of the EPSDT, the Early Periodic Screening, Diagnosis, and Treatment program. So yes, they do have very comprehensive benefits.

In regard to utilization of the benefits, we see that the benefits are being utilized and to monitor that utilization, that's why the quality focus is so important so that we can make sure that children are getting at least one

well child visit depending on their age, the period DCT [misspelled?] schedule. So yes, right now in Louisiana for our CHIP program with 126,000 children, we're on target to spend in federal dollars, $188.7 million this federal fiscal year. So utilization is happening for more than emergency care.

DIANE ROWLAND, Sc.D.: This question is directed to you as well. In your beginning remarks, you said you were hoping to focus equally on SCHIP and Medicaid and I think you've demonstrated that in the answers to your questions but the questioner wants to know if you were referring there to funding, to time, to outreach, or how you are balancing those two program.

RUTH KENNEDY: Well as I've indicated previously, for us it's a package deal but I think though, what we're seeing is that I see in the CHIP reauthorization bills is they focus on Medicaid children as well. So for the first 10 years, the CHIP legislation itself, there was no Congressional focus through that legislation on increasing enrollment of children in Medicaid but just the outreach is there.

The reality, I think, that states faced was that like it or not, is that enrollment increase in their Medicaid program, as a result of CHIP outreach, CHIP simplification, CHIP focus because of something called the screen and enrollment requirement, which means that if a child is eligible

for Medicaid, they must be enrolled in Medicaid, is the parent can't say just send me straight to the CHIP program.

So we see in the CHIP bills is performance bonuses for increasing enrollment in Medicaid for those states who have seen huge spikes in enrollment in Medicaid as a result of the CHIP program. So that's what I was alluding to.

ED HOWARD, J.D.: Well we have a little bit of time remaining but we've run out of cards. There's not a big line at the microphones and we have used up all of the questions that have been emailed to us. So we're going to give you time off for good behavior and remind you that we will be continuing this series of primer briefings on February 13th with a program on Medicaid specifically and then later, on March 2nd and 16th with health reform and Medicare.

I want to thank, once again, the Kaiser Commission for its participation in shaping and support of this briefing. Thank you for sticking around to learn all that you need to learn and ask you to join me in thanking our panel for a really great explication of a couple of very difficult programs [applause]. Please take a moment to fill out the evaluation form before you go.

[END RECORDING]