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Medicaid as a Platform for Broader Health Reform: Supporting the High-Need and Low-Income Populations
Kaiser Family Foundation
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DIANE ROWLAND: —using Medicaid as a platform for healthcare reform. And I am very pleased that we can have this briefing this morning and present to you some of the findings that have been developed through our work with the Urban Institute through the Kaiser Commission on Medicaid and the Uninsured.

And what we wanted to start with today was just to remind you a little bit about the platform that Medicaid serves, and then we are going to turn to John Holahan from the Urban Institute to present some of the findings on what the options are and the cost implications of those options for expanding coverage for the low income population through Medicaid.

We've also got with us a very distinguished set of discussants to shed some light on the implications of these findings, as

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well as the current debate over the future of the low income population within healthcare reform; Karen Ignagni, President and CEO of America's Health Insurance Plans needs no introduction to any group, nor does Sheila Burke from the Kennedy School of Government and former Hill staffer on the Senate side, and Alan Weil, now with the National Academy for State Health Policy, a former Medicaid director, among other past responsibilities. And both Sheila and Alan serve as members of our Kaiser Commission on Medicaid and the Uninsured.

What I'd like to talk to you about as we begin in this discussion is really the platform Medicaid now serves in its role for low income populations, and to just briefly remind us that it provides coverage to a wide range of populations that have very diverse healthcare needs.

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We are most familiar with the numbers in Medicaid who are low income families, children and some of their parents, especially pregnant women, children who need routine, as well as specialized care, and families that have affordable coverage through the Medicaid program with very low cost sharing and comprehensive benefits that really meet the needs of a very low income population.

But Medicaid also plays a very central role to people with disabilities, covering some 8 million Americans with disabilities who are low income that include autistic children, those with cerebral palsy, individuals with HIV/aids, those who need extensive services and are really often individuals that need not only medical care, but many of the rehabilitation and support services and long term care services that Medicaid can provide.

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And, finally, as the trustees report comes out today and talks about the dire circumstances of Medicare I always like to remind people that Medicare wouldn't work very well for some of its lowest income beneficiaries without Medicaid as a strong supplement to the Medicare program filling in on their cost sharing, helping to provide additional benefits, especially nursing home care and also helping to cover the part B premium which may be quite an issue as we go forward this year without a COLA increase in social security. But these are the roles that Medicaid plays for the low income individuals that it now serves.

But it also plays a substantial role in terms of its share of the healthcare system. It's a major component for spending on healthcare. I've pointed out the role it plays for Medicare. It also, I think, helps some of the private insurance plans to be relieved of the

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responsibility for some of the very lowest income people with severe disabilities that would increase the premium payments in a market if they were in that pool.

It is a major source of coverage for community health centers and many of our public health facilities and safety net clinics and part of our public health infrastructure. Many talk about expanding coverage to the low income population through community health centers, yet one of the sources of their payment that they rely on the most is their contributions from participation in the Medicaid program.

And also given that that low income population lives in areas that are often medically underserved, it's particularly important to have this range of safety net facilities that can help provide those services in those areas.

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We need not be reminded that coverage matters, that's why we are in this health reform discussion together, that those who have no insurance don't use the healthcare system in the same way as those with private coverage or those with Medicaid coverage and, in fact, coverage matters and we see that both Medicaid and the private insurance options provide much broader coverage and much better access than those who are uninsured.

But we also know that one of the challenges we face as we go forward in the health reform debate is that those who are uninsured are, unfortunately, predominantly low income. And in this slide you see the share of the population, two-thirds of the uninsured are under 200-percent of poverty, about $40,000 for a family of four, and a substantial share are actually under the poverty level itself.

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And one of the challenges in dealing with this population is that the eligibility and participation are not always as good as they can be, so one of the challenges is how do we boost and improve enrollment. And you see that there are children here who are eligible but not enrolled, and we see that among parents, though, and especially among childless adults. Many of them are actually not eligible, so it's less of a problem of participation and more of a problem of eligibility. And that is, of course, what's on the table with the changes being proposed under healthcare reform.

And these changes relate to the fact that today income eligibility for pregnant women and children is substantially higher than that for the elderly and the individuals with disability, tied mostly to the SSI work level. Working parents and jobless parents have even lower levels set and

determined by the states that vary widely across the country.

And childless adults are ineligible for federal matching funds under Medicaid except when states have been able to obtain a waiver. So they constitute actually our largest group of the uninsured, low income population are childless adults with their ineligibility for public coverage today.

What I think is also important to note is that as we look at the low income population, we're not looking at a really healthy population. We're looking at a population with a lot of mental disability, physical disability, and a combination of 40-percent of the poor, uninsured, low income adults report either a physical or a mental condition, and 34-percent of the near-poor.

So we really need to also be cognizant as we look at the coverage options for this

population that they are, because they are uninsured, not utilizing services at the level they should be and they are likely to be needing a lot of care once they come into the system and, therefore, are going to be higher cost than some of the healthier uninsured that may come in at higher income levels.

And just to restate the kinds of complex populations and service that Medicaid provides, we can understand why the program has such an extensive coverage network that it provides for those who it serves, given the range of illnesses that are covered. And especially important is its coverage of those with mental illness and intellectual disabilities where both mental health benefits and acute care benefits are necessary.

And as we have moved forward with Medicaid, there has been a challenge of getting providers to participate in the program under the

fee-for-service system, many of the states have moved quite aggressively to managed care and to case management so that for their low income populations, especially, they are trying to develop both a network and a way of providing services, and you see here that the penetration varies across the country, but is substantial in almost every state.

And, finally, as we enter the debate today of what to do and how to provide coverage for the low income population and look at some of the options that John is going to put on the table, I think it's always important to remember that when we do go to the public, there is a lot of myths about what the public thinks about the Medicaid program, and here you see that there is substantial support among the public in the polling that we do for expanding Medicaid, and CHIP is one of the options for broader coverage.

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So, with that framework, I'm going to turn to John to talk to you a little bit about what the coverage and cost implications are of some of the options on the table. John?

JOHN HOLAHAN: Okay, so the work we did was designed to estimate the coverage and cost impacts of expanding Medicaid. Let me start by just saying a word or two about my co-author, Bowen Garrett has really led and done an extraordinary job in developing the new microsimulation model that we have now for looking at health policy changes, and Allison Cook, Irene Headen, and Aaron Lucas put in tons of hours to make sure that this project, as well as some others, are getting done on time.

So what did we do? The idea here is to look at the cost and coverage impacts, and we looked at several different kinds of policies and what effects they would have for children and

parents, and non-parents. We looked at different assumptions about participation rates, that is the likelihood that uninsured people would take up coverage, and people with current coverage, either employer coverage or non-group coverage, might drop that coverage.

Essentially we assumed in the base case that people would behave as they do today, participate at about the rates of around 60-percent or so. The second assumption is that participation rates would go up to 90-percent, which is pretty close to full coverage, particularly since we really could not deal with the number of undocumented's that are there.

So this is pretty much equivalent to the coverage and cost impacts you would see if you adopted a policy that excluded undocumented residents. We looked at the effect of options by region, and then we looked at the impact of

increasing Medicaid provider payment rates to Medicare levels.

A word about the simulation model, the idea here is to capture the responses of business and individuals to policy changes and in this context how do individuals and families respond to new eligibility options. How many take up voluntarily, what do people do about dropping the current employer coverage and non-group coverage that they have. And those responses come out of the model, but they are calibrated to be consistent with the published economic literature that has tried to measure these things.

We spent a lot of time going into details on incorporating state level Medicaid and CHIP eligibility rules so that we know the current eligibility levels so that when we change them we can measure the effects. We adjust for the

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Medicaid under count in the current CPS, which is a complicated topic that I will not go into.

We then project out to 2009 because you may have noticed that we are in a pretty deep economic downturn, and you can't use the 45 million uninsured anymore, unfortunately, because of the impact of unemployment on coverage. And our estimates are that unemployment rates, or the number of uninsured in 2009, by the time the data is released in a year or so, will look more like 49, our estimate is 49.1 million, so that is our base.

The spending numbers are in 2009 dollars. The options that we looked at were to expand coverage to 250-percent of poverty for children to 100-percent for adults and then we said, well, what if we only extend coverage to adults to 100-percent of poverty, so that is 1A.

Two is going to 300-percent for children and 150-percent for adults; 2A is a drop in the expansion for children and expanding coverage of adults to 150-percent of the poverty. There actually is some pretty significant implications of doing that and I'll talk about that in a minute.

Then we go to results; first, this coverage and if you look at the left hand side, assume current participation rates and expansion of kids to 250 and to adults to 100, we pick up 9.7 million people; 2.1 would drop private coverage and reducing uninsured by 7.6.

If you go to the higher participation rates, you end up increasing the coverage in Medicaid by 22.4 million and reducing the uninsured by 16.8, you get a very large effect because these higher participation rates not only apply to the new eligible's, but all those who are

currently eligible, but uninsured, which would bring everybody up to these levels, so think of it as a mandate that everybody has to get covered. And then look across at option two, the same with the higher participation rates, pick up another 6.8 million people and reduce the number of uninsured by about 4.1 million.

This slide compares changing the way we treat children, either covering them up to 250 and setting a uniform standard versus just leaving policy in place today. And it assumes that states don't cut back and essentially build upon where they are, but that they don't reduce coverage.

So what you see is that there is not a lot of difference, that you pick up another 9 million individuals, almost all, or literally all, are children, not surprisingly. And it's not more than that because, first of all, there's a lot of new coverage for children, even built into the

21.5 because of picking up the eligible but uninsured kids. But it doesn't go further than that because some of these states are already at reasonably high levels, particularly the more populous and higher income states, so that is the main reason there.

There is a big difference between these policies that I think is important is that if we have income related subsidies above the Medicaid eligibility levels, there is no guarantee that states will stay where they are in terms of coverage because Medicaid coverage above mandatory levels is optional as is CHIP. And if states are to bear a big burden for increasing coverage to adults, they may respond in the way they treat the current optional population. We have not assumed that, but it's an important implication of this.

The next slide shows, not surprisingly, and Diane already mentioned this, that so many of

the uninsured are childless adults so the expansion to 250 and 100, as with the broader expansion, it picks up non-parents. I mean, the biggest impact is on non-parents, it clearly picks up kids and parents as well, but the biggest impact with the new Medicaid and the reduction of the uninsured is on non-parents.

Figure six looks at the cost, so we estimate under the first option, the 250 and 100, that it would cost Medicaid 62.9, or cost the government 62.9 billion, but they are offsetting savings that are important. Business because, I already mentioned, some people will drop private coverage to come in, some businesses would save 8.7 in premiums, and a good chunk of this is among small businesses.

There are savings to individuals who are paying out-of-pocket for the employee share, are buying non-group coverage or have out-of-pocket

expenses. These would all go down if these people are in Medicaid and we estimate that that goes down by 19.6 billion. We also estimate that the amount of uncompensated care in the system would fall by 17.5 billion.

So the net cost of the system, which is a real measure of the true economic impact, is 17.2 billion. If you go to option two, the costs go up to 81.8, you get a little bit more in offsets. The net cost is 19 billion, which is what is shown in the box there at the bottom.

Let's look in figure seven at the difference between option one and option 1A, with 1A being the one that didn't expand coverage for children, and what you can see is the Medicaid costs are slightly higher. But what's interesting is that the system costs are a little bit lower, and what's happening here is that when you go to 250 for kids, a lot of the people who are getting

picked up, there is a pretty high rate of substitution of private coverage, or dropping of private coverage, to come into the public program.

People are essentially dropping reasonably expensive small group, or non-group policies to come into Medicaid, and Medicaid ends up so that the savings to businesses are actually greater, and individuals, greater in option one than in 1A, so the overall system costs don't increase as much in 1A.

Figure eight looks at the impacts by region and this should not be surprising, but it is I think very important that the biggest impacts by far are going to be in the south, to some degree in the west. And this is places where Medicaid coverage is not as generous now and there are a lot more uninsured people, and the problem here is that these states are least able to afford, to expand coverage, so it really does set

up a problem of how do you deal with that, and I will come back and talk about that in a second.

The next issue is the one of Medicaid rates. It is often said that you can't expand Medicaid coverage to any significant degree without increasing payment rates because they are too low, so we figured, okay, we certainly agree with that, and so we tried to estimate what that would be, and these are the impacts that are shown here.

And what we did was to estimate how much, or use published data, that is, on what it would cost to increase Medicaid rates to Medicare for hospitals, and the American Hospital Associate data tells us that it would mean an increase in payments to hospitals of 5-percent. Steve Zuckerman, who is actually here today, just published an article in *Health Affairs* that showed that it would take a 40-percent increase in

Medicaid rates for doctors to get them to Medicare levels.

We assume that other providers, like dentists and podiatrists and so forth, would also require a 40-percent increase, and put those together, we figured out how much spending on hospitals and clinics versus physicians and other practitioners so we could get a sort of weighted average, and it comes out to about close to 15-percent overall that rates would have to go up. So that is what's reflected in these two bars and the increase in costs that would come about if you increased Medicaid rates to those levels.

But there is another thing that's hidden down there, and you may not be able to see it in the footnote that's very important. If you increase Medicaid rates, it’s not going to be just on the new enrollees, it has to be on everybody. So we estimated what it would cost to increase

payment rates for all services used by non-dual eligible's, thinking that dual eligible's rates are more or less set by Medicare, and Medicaid just fills in the difference. So that would add another 20.5 billion, so increasing rates to Medicare levels is costly, but the main reason its costly is because of what you have to do to the base.

So let me just sum up; clearly the potential is there for broad Medicaid expansions to have very large effects on the number of uninsured. There is as lot bigger effect if participation rates are high, either through very aggressive and very successful outreach efforts, or through a mandate, it more likely is the latter.

You still are going to see some shift from private to public coverage, and the more the higher of the income distribution you set the

expansion. And it will cost significantly more if we increase Medicaid rates to Medicare levels to improve access. So all those things, I think, are the key things that come out of this, but I want to say a word in closing about sort of the issue of how this gets paid for.

As I said, these are fairly big increases in costs to states and a lot of that will be in states that are the poorer states in the country. So one way to do it is just simply say we are going to pay 100-percent of the costs of the new enrollees.

The problem with that, even though it's obviously very well targeted, it's highly inequitable. If you've already done a lot, you get nothing, and if you haven't done it, you are going to get 100-percent of the cost paid for. So it's hard to see how that goes forward despite its advantage of being targeted.

So I think, again, you have to look at options that are not so well targeted, but sort of relieve states of the cost that they now bear, and there are a number of ways to do that. One is to increase matching rates on acute care services, or long term care services, or all services. It turns out that if you really want to get as much money into these lower income states as possible, it's better to do it on acute care services because there's a much bigger difference across the county in spending on long term care.

Then we could shift costs that states now bear for their share of Medicare premiums and cost sharing, shift it all, have the federal government take over all of those costs; that has been called for many times. It could eliminate the drug claw back payment the state are now making, eliminate the two year waiting period for Medicare so that people are off of Medicaid and onto Medicare much

more quickly. And all of those would probably be enough to at least be budget neutral at the federal level.

Another way to do it is simply shift all of the costs of dual eligible's to the federal government and that has, I think, enormous advantages from a policy point of view to allow better coordination of that care. It's probably more money than you need for one thing, but it's also the biggest beneficiaries of that would be the states that have spent the most on the dual eligible's.

They tend to be the states, like in the northeast, that would have the least incremental costs of expanding coverage up to the poverty line. So there are a lot of ways to do this and we are going to release a report soon here that will have the national estimates of doing that and

I will say that it's hard to do the state level estimates.

I think it is not that difficult to make this budget neutral at the federal level, but to make it budget neutral for every state, but the expansions and the offsets are very hard, it would require a huge amount of federal dollars, so I think the question is if you're going to have to put up some money, but get a huge federal match and the economic benefits that would come to the states from that, it seems to me that's a reasonably good deal and we ought to be able to work something out and states should be happy. Not that they will be, but I think we can figure out a way that they should be. So I will stop with that.

DIANE ROWLAND: Thank you, John. So, clearly, John always gives us a lot of numbers to contemplate and a lot of implications from those

numbers. I think one of the take away messages here is that it's not just eligibility levels, but it's also participation rates that matter in getting people who are eligible to enroll.

And we come to concepts like an individual mandate that could also be applied to the low income population, or ways to improve outreach and enrollment in the program as we've seen through the CHIP program experience and through Medicaid as a participant in the expansion of coverage of children.

Also, looking at the fact that it's not the children that are the focus here of the uninsured coverage, but it really is the low income adult, both the parents of those children and the childless adults and some of the policy implications of treating parents different from childless adults as we have historically.

It may also be continued in the future. And, finally, I think the financing issues always stay with us, and so with a few opening comments, I am going to turn first to Karen Ignagni to share her perspectives, and then to Alan and Sheila.

Karen Ignagni: Thank you, Diane. Good morning, everyone. It's a pleasure to be here and, John, congratulations, a very, very provocative and important study, and congratulations to the Kaiser family for making all that possible.

I wanted to begin by letting everyone know where we stand on the Medicaid program and its role in healthcare reform. We, about three years ago at AHIP, our board issues a proposal to get everybody covered. We are strongly supportive of that goal and we want to accomplish it this year. As part of that work three years ago, Medicaid,

the program, we viewed that as a very important part.

The safety net, we thought, needed to be repaired, so we came to a policy recommendation that we maintain today and we are delighted to see these data because I think it moves us yet another step closer. The concept of imbedding in reform, doing away with and upending of the categorical restrictions and requirements, those are outdated, nobody understands them, they vary from state to state, creating significant inequities across the population, in our view.

We ought to have an income standard very plainly set out and clearly set out in Medicaid. We recommended 100-percent. Everybody under 100-percent needs to be eligible for Medicaid. We have to shore up the safety net, and it's been an important policy position for us, we will maintain

that throughout the discussions on healthcare reform.

We have eight issues. I am a list maker; seven issues, actually. And as I was preparing for this last night, I made my list of issues that I think are very complimentary to the matters that John put on the table and that I know Alan and Sheila will undoubtedly talk about as well.

Number one is dispensing with categories, so we have an income test for Medicaid. And it's clear, it's transparent, it's equitable across the country. There shouldn't be an inherent advantage of living in one state versus the other, and that's what we have today in Medicaid.

Number two; Diane, in her opening comments, quite appropriately talked about the need to expand outreach. We have been working with Ron Pollack and Families USA on this concept of one-stop shopping. Some of that is embedded

now in CHIP legislation, we need to do a better job of making sure we are capturing everyone who is eligible and, particularly, if the country sets the simple income eligibility standard.

Third, we are strongly looking at the concept of a permanent counter cyclical ability in Medicaid so that as we look at the economic downturn this year, members of congress have to scurry around state governor's and others. Advocates had to come to Washington to demonstrate what we already inherently know, that in times of downturn states are hurting, their budgets are under more stress because we have higher unemployment.

So if we are going to consider repairing the Medicaid safety net, this whole concept of a counter cyclical ability built into the program with certain conditions ought to be raised, in our view.

Fourth, and this will probably ignite many, many people who are here and watching. We have to relook at the federal match because if you look at states on the very sides of the country, there are a certain number of very wealthy individuals who are skewing the formula, so it means that their share is proportionately lower than other states.

It's time to take another look, in our view, at whether that formula continues, that was set out so many years ago, continues to be relevant for today's population because if you look at the wide variation in matching rates and you look at indigenous issues that are peculiar to certain states, there is not a lot of rationality associated with some of the lower matches in certain states. So we think that needs to be looked at.

Fifth, we need to look at ways to improve long term care and care for the disabled, in particular. We need to look at the duals, there needs to be a much broader, better strategy for the duals. Our health plans have found that there are very significant results in coordinating care for dual populations. We need to end the idea that we are going to be thinking about the long term care and disabled population in a waiver situation for community based care.

That makes no sense to us given the developments in the delivery system. We think that everyone should have a care plan and they should be directed to the care that's appropriate for them. So we've been working very closely with ADAPT, we agree with their comments, we agree with their advocacy that we have to do a far better job of getting folks to the right care at the right time.

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The sixth issue is that there is an inherent problem for plans that are managing care in Medicaid. We don't have the benefit of the state rebate, the rebate that the states get. And the problem here is that there is an incentive now built into the program for states to carve out drugs because when they use managed care, they depend on managed care to provide better care, more coordinated care.

They don't get the financial advantages of that. That also should end in our view because we know that job one is coordinating not only the care services, but the prescription drugs, so we can do the best we can for individuals and get them the right care.

The final thing, which Diane and John also talked about, is the issue of payment adequacy. And John talked about that, you saw numbers which are very important, we think, for this discussion.

But we're not going to accomplish this goal of safety net repair if we don't look at how physicians and hospitals and providers are being paid under Medicaid.

And we have to have that conversation, we think, straight up. There is a principle that's built into Medicaid, which is actuarial soundness, which is a requirement that the funding be actuarially sound. We find very little of that across the country, and we've worked very hard with advocacy organizations to try to address these issues, but that principle needs to be taken far more seriously.

Because we are not accomplishing a goal of repairing the safety net unless we really are attacking the payment side so we can guarantee that the best providers will be available for people with disabilities, people who need long term care, and women and children. So that's

where we are, Diane, on healthcare reform. We think Medicaid is an important part of that.

DIANE ROWLAND: Thank you, Karen. Alan?

ALAN WEIL: Thank you, Diane, and thanks to the Kaiser Family Foundation for keeping the attention on this critical issue, and John and colleagues for doing this important analytic work. I get to work with states all the time and then have to say at the beginning of my remarks that I do not speak on their behalf, so here are a few observations based on my work with them.

The first is that as we look at creating a national floor of coverage through Medicaid eligibility, this is going to be disruptive. And, as John notes, it's going to be the implications are variable across states around the country. Let's just say that there is a lot in health reform that is likely to be disruptive.

And on the disruption scale, this is probably only moderate, and so we should not be deterred from doing this important work by the problem that John raised at the end, which is that it's very difficult to hold states harmless against all changes that might occur as a result of changes in eligibility.

The variations in coverage are largely a result of historic choices related to welfare, historic choices related to the granting and application for waivers, and it is time if we are going to have any sort of a national commitment to health insurance coverage to have a solid platform on which that coverage is based. I would note, however, that the issues here are not just about the financing.

They are also about state capacity, about administrative systems, ability to handle this number of people, their enrollment in health plans

if that is where they are getting services, simply processing applications, those kinds of rather banal activities are actually quite complex. And, indeed, the participation rates, which are so central to the cost estimates, are heavily determined by state policy choices with respect to the ease or complexity of the application process.

And so while I know it was somewhat tongue in cheek to say that states should want this, whether they want it or not, I think states' enthusiasm with respect to increasing the floor of coverage, will have an effect on the fervor with which they pursue finding and enrolling these newly eligible populations. So we need to keep the state interests in mind if we want to achieve the goal of coverage.

Second, there is a great deal of interest in improving the relationship between Medicaid coverage and the private coverage that people

hopefully will obtain as they move up the income scale. This is a very important transition because we know that the income of low income families is quite volatile.

We have a general hope that employers will pick up and retain their share of the cost and of coverage, and so the transition between public coverage and private coverage is very important.

Unfortunately, behind that very reasonable goal lurk a number of policy choices and options that could fundamentally impede our goals of simplicity, as Karen suggested, and other goals for health reform, and I would draw your attention to two of them.

The first is the notion that we are going to offer all of these newly eligible folks coverage through some new connector exchange market, whatever you want to call it, and then we are going to wraparound a traditional commercial

package with all the additional benefits that Medicaid provides.

State experience with benefit wrap-arounds is not particularly good. It's one thing to wrap maybe a transportation benefit around a comprehensive medical package. That's not a medical service and it's not traditionally part of a commercial package.

But when you start thinking about things like EPSDT, when you start thinking about things like case management or more in-depth therapies that someone might need that would be capped in a commercial product, this adds a level of not only administrative complexity, but really barriers to access to services that this vulnerable population requires.

And so although it sort of rolls off the tongue, we'll get the base benefit over here, wrap it over there, on the scale that's being discussed

as we move up the income scale for Medicaid eligibility, the potential for having benefits available on paper, but no in practice becomes quite substantial.

Similarly, there's an interest in premium assistance, something most states do in their Medicaid program. We want people to have an opportunity for private coverage, employer based coverage to retain that coverage. But, again, the complexities of administering and assuring benefits within premium assistance should not be under estimated. Take the simple point of simplicity of enrollment. We want a simple eligibility threshold of 100-percent.

But when you do premium assistance, you have to ask people who is your employer, what health plan do you have, what are the cost sharing provisions, what are the benefit exclusions, how is it paid for, and how do we flow dollars between

the employer, the employee, and the health plan, and some wraparound benefit to make sure that you get a comprehensive package. This delays the determination of eligibility and undermines the simplicity that we are striving for.

So, again, it's not as if we shouldn't have these programs, but as we move up the income scale and we're thinking about potentially having millions and millions of Americans with wrapped benefits and premium assistance and that's what we call a Medicaid expansion, I think we're really undermining what Medicaid expansion could accomplish.

This is not to say, of course, that what we want to do is take folks and just throw them in a connector with a commercial product. Medicaid is a lot more than just commercial insurance with zero or low cost sharing. It has a set of

consumer protections and benefit enhancements that really go beyond what traditional products offer.

And so we need to not just think of this as insurance plus, it is a different product for a vulnerable population and we need to respect the needs of that population or else we're simply saying we're expanding coverage without expanding access.

The final point I would make has to do with rates. We do often talk about the need to increase rates and, of course, states facing tough budget times tend to scale back rates as a way to prevent the worst, what they view as a worse option, which is rolling back eligibility.

And we talk about rates largely as an access issue and a cost issue, and there is no question it has implications for those. But it seems to me we ought to think about bringing Medicaid rates up to something more like Medicare

rates as an opportunity for the kind of delivery system improvement that everyone is talking about as necessary and a part of health reform.

If you look around the country at the innovations often driven by states to pursue medical homes, to pursue an emphasis on primary care, these are all payer efforts. And, in fact, the one payer who often is not at the table is Medicare, but Medicaid usually is, and in the private plans many of them are. It's all payer efforts that drive changes in behavior of providers because providers want to practice one kind of medicine.

They want to have one consistent set of incentives coming from the various payment strains. An increase in Medicaid payments and an integration of Medicaid payment into all payer efforts to drive delivery system reform is an opportunity for the kinds of changes in the

increased efficiency in the healthcare system that we have now with health reform. And if we leave Medicaid payment in a separate category and do it separately, we lose that tremendous opportunity.

Medicare has had some interesting leadership around payment reform, but they treat experimentation, they take the concept of experimentation very literally. They want to have a box in which they make their changes and they measure the effects of those changes. That's a very important source of data, but it is not an effective way to change the overall healthcare system. And we need Medicaid's participation in those.

So I would just close by saying something along the lines of what Karen did at the end of her remarks. We tend to think about and talk about these Medicaid expansions, but we are largely focusing on families and kids; 43-percent

of Medicaid expenditures are associated with people with disabilities, a similar percent of Medicaid expenditures are associated with the dual eligibles.

Of course, there is some overlap between those two numbers, but only some overlap. If we are serious about Medicaid playing a positive role into the future, we need to not only get it right with respect to these income thresholds, but we need to be improving the delivery of care throughout the populations that Medicaid serves.

So I think it's terrific that we, as a nation, are having a discussion, a serious discussion, about creating a solid platform of coverage that people can rely upon no matter where they live. And I think it's great that the notion that that should take place has become really a mainstream view and is considered almost as a given by those who are pursuing reform.

But I do think how we do this may be just as important as that we do it, and so as we move forward to the next level of the discussion about health reform and about Medicaid reform, we need to keep an eye on what it really means to the populations we are serving as we move this threshold and create a national floor so that we don't just create that floor, but we create a floor that really provides people with the benefits that they need.

DIANE ROWLAND: Thank you, Alan. Sheila?

SHEILA BURKE: Thank you, Diane. My thanks, as well, to the Foundation for keeping this issue alive for all of us and for the work of the Commission. As Commissioners, Alan and I have had the benefit of seeing the kind of background and work that the staff has done to provide this information. So I am grateful for the opportunity

to be here with a group of really distinguished colleagues.

As I was thinking about this topic and preparing to talk with all of you today, it brought to mind an article, and I tried to find the article in my files, that was done some years ago, and the title was *The Little Engine that Could*. And it was a story about the history of Medicaid and the role that Medicaid has played.

And it brought to mind some of the original views of Medicaid and some of the challenges that it has faced, as well as its history in terms of sort of a, one hesitates to say, sort of the bastard child of the discussions of the 60's, sort of came along late but has played an extraordinary role over the years in caring for a very remarkably challenging population.

It's interesting to me in today's debate that the discussions we're having today and the ones that are taking place on the Hill are those not about whether Medicaid ought to continue, but whether and what role it should play in the context of healthcare reform going forward. So it is clear that it will play a role, that is quite evident from the materials that we've seen, and the discussion is about the framework and really the dimensions of that role going forward.

I think Alan has laid out for you a terrific list of challenges that we have to confront in dealing with this question and ones that I think ought to influence the way we think about the changes going forward.

As evidence in the materials that the Finance Committee put forward only yesterday, there are clearly a mixture of views as to what the role of Medicaid should be, whether it is in

fact an organization that is going to be called upon increasingly to play a different kind of role going forward.

No one questions the role of the program historically for the most vulnerable populations, the disabled, the aged, the very low income, the benefits of the program as originally designed, and as they have changed over time, address the very unique needs of that population, and Alan has done a terrific job of noting that it is not a simple thing to simply wraparound or simply redesign what it is that Medicaid has done for these unique populations.

And, as Diane pointed out, the results benefit a number of other players in the system. They clearly benefit the insurance companies in a sense because, essentially, this population is one that the traditional insurance model would not have taken care of.

It clearly benefits the Medicare program in terms of dealing with a unique set of populations in helping to essentially manage that population and the kinds of things that it provides. The successes of the program, I think, are known, as are their challenges and the challenges that it confronts, and as Alan clearly pointed out.

But as Congress approaches this and, again, as we saw the Finance Committee's document yesterday, it's really a question of whether to build or buy, to use Medicaid as the base upon which we build additional coverage, or essentially buy private coverage through the exchanges or whatever these new organizations are going to be, for this population.

So an issue, I think, and Diane has asked me to talk a little bit about how Congress approaches this question, are really questions of

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

cost. We've seen in John's work a tremendous opportunity to look at what the exposure would be or the cost would be that would be incurred by both the states, potentially, and the fed government were we to use Medicaid.

And this question of cost to who will be critical, that is whether it is a federal cost that is borne on the federal government and relieves the states of certain costs, but Alan has also done a nice job of helping us understand how that nets out in terms of the system, and that is sometimes something that we forget.

Whether or not to break up targeted populations; we have seen in Karen's suggestion that simply establishing an income level rather than the category requirements that we built the program on is one option to essentially build that base.

But that raises a series of questions that, along with everything else, is not a simple question to ask. Whether or not some stay in Medicaid, what it is you expect of the states or of the program in terms of a maintenance of effort, an issue that certainly comes to the forefront each time we talk about Medicaid, and Medicaid as a potential expansion.

Whether some of the new enrollees are based on the current model, essentially the populations that we have traditionally served, some of which John has given us in terms of the models of essentially increasing the federal poverty line, or whether you expand it to populations not traditionally covered, at least as a requirement. Singles and childless couples are the obviously population, and ones that are certainly the most exposed today in terms of

either falling into the individual insurance market, or simply falling out of the system.

And then there is this issue of the extraordinary variation among the states. Again, as Alan has suggested, simply suggesting we all move to one level ignores the realities of the enormous variation in states and how the states would respond to such a suggestion. It raises a series of questions about the size of government.

There will be a lot of discuss about whether or not using Medicaid as a platform for a certain population will dramatically increase the presence of the government, or move us towards a single payer system. That will be one of the concerns that are raised, and they are not unlike some of the concerns we have heard around the CHIP reauthorization about whether those same issues need to be brought to bear in terms of this is a part of a long term solution.

What the push-back from the states will be, as Alan suggested, there are states that have been very responsible over the years, who have essentially covered vulnerable populations that have not been within the categorical requirements, and whether or not in doing anything, we relieve them of some of that burden or whether we simply add to that by bringing everybody else up, but not essentially dealing with the commitments they have made.

There are questions about capacity. Again, the suggestion that we can simply change the income level and the state are capable and prepared to deal with an influx of new populations, how long that transition might take, the complexity of moving to a simple system, a simple enrollment system, is not at all simple and clearly one of the things that has to be asked.

Again, states would be happy for a buy-out, whether a buy-out essentially of the new populations, but also some of their existing populations. The traditional suggestion of a trade-off of essentially moving the dual eligible's entirely to the federal government, or whether or not you essentially, in terms of looking at those populations, pick up certain activities; long term care, for example, or acute care services, whether you trade that off.

So the relationship between the federal government and the states around this program is a very complicated one. I was quite interested in Karen's list that one of the things that she suggested is we sort of go down these possible solutions, is to relook at the match and the formula that's used for a match.

I remember vividly some years ago an extraordinarily unpleasant exchange that took

place on the Senate floor between me and a member of the United States Senate from a southern state that will go unnamed about the matching formula and whether that state was disadvantaged as compared to some of its colleagues.

So the suggestion that we ought to relook at the match makes perfect sense, but the politics of that and what is considered essentially available as a resource in the state is not at all a simple question to deal with.

And there is this fundamental question of the private and public sector roles. Karen suggests that we, for example, move up to 100-percent and require everyone remove the categorical eligibility, certainly something that people have talked about, certainly something that makes sense in a variety of ways.

But it begs the question about whether or not the insurance industry in its current

structure is prepared to take on everyone else above 100-percent and whether that is the right venue for those populations. Certainly the very low income or a population that the insurance company acknowledges, they are perhaps not best prepared to deal with.

For a variety of reasons, the linkage to the workplace, the needs and services that have to be provided, but again is it that everybody above 100-percent can suddenly move into that system with acknowledging all the questions that, in fact, Alan has raised about whether that is the right venue, whether the right services, whether the wraparounds essentially solve the problems that are confronted by these populations.

One of the other things I think that the Congress will certainly consider looking at, and you see again in the finance Committee materials, John gave a tremendous overview of what the cost

implications are of using Medicaid as a base. What we don't know is the comparison, that is, what is it that it will cost the government to essentially purchase coverage for these same populations above 100-percent so that if essentially you use Medicaid as a base up to 100-percent, but then essentially assume you are going to buy-in everybody into an exchange environment, what are the cost implications?

Are they likely to be less expensive in a subsidy to a private insurance for that same coverage assuming that you have to do a wraparound for certain populations? So, again, I think one of the things the Congress will look at is what the cost implications are of these options.

And also this question of access that has been raised both by Karen appropriately, as well as by Diane and by Alan in looking at the system as we know it today. There is no question that

there are a unique set of services and providers that deal with this population.

They are community health centers, they are relatively non-traditional, one might imagine, and so the question is how does one acknowledge that system in either buying them into a private sector model that perhaps has less experience in dealing with safety net hospitals, in dealing with community health centers, in dealing with the locations where many of these populations are currently serviced, and whether or not that fact is also a question, and that is how one gets one into the system.

There is no question that there have been issues with respect to Medicaid over the years. The number of physicians, for example, willing to accept Medicaid patients is something that has troubled us for many years. But, again, there are a unique set of providers who have in fact taken

on this population and service them quite well and whether we can assume that that same population of providers will be dealt with and acknowledged in the same way in a model that essentially is built upon a private sector, rather than the sort of public sector model.

So, again, I think the question is not whether Medicaid will play a role, it will be the dimensions of that role and I think what you've seen in both Alan's comments and some of the suggestions that Karen has made, there are a fair number of questions that the Congress will have to deal with in trying to balance out both the needs and desires of the states, the enormous variation around the country, and therefore the variation in the populations that have to be served.

We certainly look to Massachusetts, for example, as one of the places that has begun to take on this issue and quite successfully in terms

of the number of uninsured that have been dealt with, but one has to acknowledge that Massachusetts was a very different place than you experience in the rest of the country. They had fewer individuals who were uninsured; they had a system that was quite different in terms of the resources that were available and the role of the non-profit insurance industry and the provider community.

So, again, we ought to look at that example, we ought to look at some of the issues that some of the other states have raised in moving forward, but recognize that Medicaid will play a role, it will be a platform. The question is how big a platform, it's a question of what the balance will be between the traditional public service programs, as well as the private sector, and how best to match those two resources.

DIANE ROWLAND: Okay, thank you. Well, obviously we have done a lot to demonstrate that Medicaid is a complex program for a complex population, but also the tip of the iceberg of the complexity in the system-wide healthcare reform that we are now contemplating as a nation, and some of the issues we have raised here around Medicaid kind of pale in insignificance when judged against some of the broader issues about how to use structure and exchange, who do you put into it, and how do you set as the rules for that exchange.

We welcome, though, your questions. I'm sure that we have inspired at least a few provocative questions from the audience. If you would raise your hand and we will bring a mike to you, and please identify yourself and if you want to pose a question to one of the panelists, state so, but state your name as well. Thank you.

VICKI GOTTLICH: Hi, Vicky Gottlich, Center for Medicare Advocacy. Thank you all for your comments and, John, for your report. Many of you talked about the costs to the federal government and the states, but I'm interested if anyone has done any analysis of costs to individuals who are currently in the Medicaid program.

We know when Medicare part D went into effect, even with the low income subsidy, there were some Medicaid individuals who are now paying way more out-of-pocket because they had been in states where Medicaid had picked up cost sharing. And so my concern is that if we move to a floor, if we move to some additional models, we might have some current Medicaid enrollees and beneficiaries who end up with fewer services or being required to pay more out-of-pocket and I

wonder if anybody has done any looking at those kind of issues.

JOHN HOLAHAN: We didn't directly, but I mean I think what this study shows is there are enormous numbers of people whose payments out-of-pocket for insurance or services is going to go down by a huge amount. I think the case in which somebody could be worse off is that if states do drop back in part to be able to afford their share of the newly mandated coverage, whether they cut back on some optional populations, those populations could be in a situation of having to pay more.

They would, under a comprehensive reform, go into exchange and then it depends on what protections lower income people have within those exchanges were benefits were available, so of course my guess is it would not be as generous as

what you see in Medicaid, so there will be some change there, I think.

DIANE ROWLAND: Karen?

KAREN IGNAGNI: Vicki, I think you raised a very, very important point and I was struck with the very incisive analysis that Sheila did about the politics of all of this. But one of the issues that I think provides some instruction, and Sheila you indicated this as well, although Massachusetts is different than other states, yes, for all the reasons you suggested.

I do think they have it right in thinking about if you took Medicaid up to 100-percent leaving aside all the complex issues that everyone has talked about in terms of financing that, where the states are now and how we get them all to a certain point and over what period of time. Then I think there is another group of people, 100 to 100 and fill in the X, that would need the kind of

cost sharing protection, out-of-pocket caps and so on and so forth.

And I thought Massachusetts has actually provided a framework, not necessarily as the perfect way to do it, but a framework to think about the complexity of this. So safety net in terms of Medicaid, what's its responsibility, and then as you start thinking about benefits packages, we clearly have to be sensitive to the people under a certain income level in terms of their ability to finance out-of-pocket kinds of requirements in any kind of essential benefit package.

So I think you've raised a very important issue, and I'm certain based on conversations with both the Finance Committee, the Health Committee, and over on the House side, that people are thinking about this.

DIANE ROWLAND: And Alan?

ALAN WEIL: So I think that's right, but I also think that we run some real risks in thinking that a gross income measure is the only test of the need for financial protection because it's really the relationship between income and health status, the need for health services that determines the exposure of a family. And a lot of the complexity in Medicaid eligibility is not tied to the income side, although there's plenty of complexity there.

But it's tied to the health status, the tremendous variability in the population served by Medicaid, the desire to target benefits to people who really need them, and that can include people whose incomes are in three or four hundred percent of poverty who have a seriously disabled child and all of the gradations in between, and so I think the risk here is that we say, well, the poorest we know they need protection, but once you're above a

certain point, you're okay as long as you don't have high levels of cost sharing.

It just keeps getting more complicated than that. And without replicating all of the complexity we have now, I think there are ways we can move to a simpler standard, but it can't just be income.

DIANE ROWLAND: And Vicki, I just would say that while it's easy to model how to change from where we are today, it's hard to model what's going to happen under a system that hasn't been defined yet. So I think you raise a very good research question that we should keep in mind, but we need some more details on the other side of the equation to do it. Next question.

MEG MURRAY: Hi, I'm Meg Murray from the Association for Community Affiliated Plans. And I had a question for John about your assumptions about the role Medicaid managed care plans would

play in the expansion, Diane pointed out that 60-percent of the people are in some type of managed care, although that includes PCCM and actually for CHIP it's even higher.

It's about 75-percent, and so I was curious in your model, what percentage of people or expenditures do you assume would be in Medicaid managed care, and what assumptions do you assume that they would save over the current fee for service system?

JOHN HOLAHAN: We don't make any assumptions about how many people would be in managed care. Essentially the assumption is that Medicaid spending would be, as it is today, adjusted for health status. And so to the extent you're bringing in a healthier population, it's going to be less expensive and by and large that happens. So it is the same configuration of managed care versus fee-for-service that you see

in existence today, is essentially what's to assume.

MEG MURRAY: Okay, thanks.

BOB ROSENBLATT: Bob Rosenblatt. I'm writing about this for the new Kaiser Health news service. A couple of questions – John said that it would require a huge amount of federal dollars to hold the states harmless. I'd like to know how much that would be and then also, to have Alan and Sheila discuss the politics of this.

I talked to Carol Steckel who runs Medicaid in Alabama and who's the head of the Medicaid Association this year. And she said she is very nervous about this. She can barely keep her program even with the stimulus money she's got. When it runs out in 2010, she doesn't know what she's going to do.

And she said to cover all adults, childless adults, it would cost her $80 million.

She has no idea, she says, where the money would come from unless it all comes from the feds. So how much would the feds have to kick in? How would the states do this and would it require something like perhaps a new tax on insurance companies to help pay for all of this?

JOHN HOLAHAN: I think the way you think about that is we put out different estimates, depending on the coverage expansion. But the broader ones got up around 80 billion and I think the one is to 250 and the 60 million range, billion range. And then if you raised Medicaid rates, say on top of that, 61 or 2, you get in the low 70s.

SHEILA BURKE: Per year.

JOHN HOLAHAN: Per year, right. Not a 10-year. So roughly 60-percent of that would be federal. And so that gets you, what, 40 some. And then the balance would be borne by states. If

the federal government was going to pick up that cost either through restructuring matching rates or shifting some responsibilities to the federal government, that would mean essentially the federal government's picking up all of that 70 billion and leaving the marginal cost to states at zero.

One of the things that I said was that to be budget neutral at the overall would mean some states will be winners and some states they're still going to have to put in some money. The winners being that they would spend less than they're actually spending today.

So the question is, do you let people be losers or are there one-time payments to them so that nobody's a loser? That just increases the federal cost even more. If you do such a huge number of kind of matching rate changes and shifts and so forth that nobody's a loser, you're going

to create some huge winners. And the federal cost is going to be well above that 70 billion. It's a tricky thing.

My own feeling is that if the states that haven't done much have to put in some money, it's not the worst thing in the world because they're going to get a huge match on that. There are states that would probably get a three to one match or so. But that's the economics of it. The politics are obviously quite different. We have to see. These are complicated calculations.

DIANE ROWLAND: Alan?

ALAN WEIL: Well let's just say this is not a good year to be talking to states about an increased outlay for much of anything. And I think the overwhelming majority of states would have the same answer. You know, we're struggling to hold onto what we have. The thought of taking on a new burden is impossible.

I'm not sure substantively there's a lot that can be added to John's answer. It's exactly right. If you froze the Medicaid program, you can calculate the number of federal dollars it would take to buy the coverage for all the people you want to cover. But if you don't do that, because there are states that would have some bad feelings about a whole bunch of dollars flowing to other states when they've been paying this cost on their own, you have to come up with any of a range and it's probably a collection of policy changes that assist those states. And once you do that, the numbers just start growing and there's no easy way to answer it.

There might be some offsetting benefit for states that have already done more. If you have a subsidy structure above Medicaid that's income related and you have states that are already putting some of their own dollars into coverage at

that next level of income, those states might actually receive some money back because the federal government would be paying the subsidy instead of the state. Unfortunately, I don't think there's a lot of money there, but at least it moves in the direction of helping those states that have already moved ahead.

So sitting next to Karen, I don't think I should say anything about the possibility of an insurance tax. I think the real question that John poses correctly is, at some point if the nation as a whole is making a commitment to universal coverage and the federal government and federal taxpayers are putting out a lot of their money to make this happen, is there a point at which you can say to states, you have a role to play in this in financing it beyond the role that you're playing now. And as I say, I don't think today you get a lot of states standing up.

But if you went back a couple of years, you'd find many states that are trying to solve this problem. And feeling like if they had a fixed amount of outlay that they had to contribute to a solution to this problem, it might be less than what they were imagining they were going to have to pay a couple of years ago when they thought they had the resources to do this.

And I think the certainty into the future would be important. But as I said at the beginning, it's organizations like the Governor's Association, the Conference State Legislatures that speak for the political aspects of this and I certainly wouldn't try to do that.

SHEILA BURKE: I mean I think I agree with everything that Alan has suggested. The history in the Senate and the House, but the Senate particularly, is such that making these kinds of changes certainly tries to avoid a loser. And we

used to literally go through charts where we showed exactly what the result was of a change in the match rate and who won and who lost and what the adjustments were going to be to those who were potentially losers. So the instinct is to essentially create a level playing field among the states.

And one of the complexities of this issue is the enormous variation and the fact that there are states who've essentially chosen to expand where others have not. And there is in fact this history of real opposition to essentially bailing out those who have been failed to be responsible as compared to those that have not.

The other question I think that is quite interesting – I would go back to one of John's earliest comments, which certainly struck fear in my heart – and that is what they believe to be the new estimates for the uninsured at the end of this

year if in fact we're looking at going to 49 million, as John suggested.

One of the challenges the states will have to do with is simply the existing system. And essentially it's not only new populations, but essentially those that are currently eligible in the current environment. And one of Karen's points, which is this question of a counter cyclical adjustment to the states that acknowledges what has occurred is certainly something I think the states would look at quite favorably, even on their existing population.

So I think we have both the question of essentially the increase to the base. That is some kind of adjustment for new populations. But also the challenges the states are going to be facing in simply dealing with those that are currently eligible. Whether they in fact are reaching out to try and pick up some of those

people, I think will also complicate these questions.

And then finally I think, again, as you look at what has been put on the table, this question of transition is quite a serious one. The exchanges arguably would not be available, even in the best of circumstances if you assume that they are going to be looked to to pick up some of these populations. And there's got to be some expectations that the states can try and help deal with some of that issue in the short term because they have the systems in place, because Medicaid is up and running, because they have the administrative capacity.

So the states have also got to be wondering, are we going to hit, even in the short term, some of these populations that maybe over long-term would be purchased into a private sector model, but certainly short term are going to be

dealt with. So I think the states are going to be leery of promises now and we'll pay you back later. And they're certainly going to be leery of certain states essentially benefitting more than others.

KAREN IGNAGNI: I think Sheila and Alan did a great job answering, Bob, your question about the financial horizon, the politics, etcetera. So I'm not going to repeat what they said. I'll go directly to your question about the health plans.

I think surtax has made politicians feel great because they don't have to bear the rage from voters of enacting additional taxes. The fact is surtaxes are passed on. And so, it's one of the least progressive ways to do it. We have to finance health reform. We ought to do it in the most progressive and effective way possible.

And I think that may involve some surtaxes linked to products that are fueling the obesity problem, which is running through all the healthcare stakeholders. And then we're left with how else do you raise the funding? And I think we need to really look at the most effective ways to raise revenue on earned as well as unearned income.

And surtaxes, unfortunately, are exclusively on earned income, not unearned. And I think that that's going to leave us far short of our goals. So that would be my answer. I think that we can definitely – we should, we have to have a discussion. And I think the Senate Finance Committee is having it today about how do we best and most effectively finance health reform? And I think that there are a number of proposals that need to be on the table and seriously considered.

ANNA SUMMERS: Hi. Anna Summers with the Hilltop Institute at University of Maryland, Baltimore County. I am hoping you all can talk me down, if you will. The discussion around the increased or adjusted federal matching rate seems to be centering along this higher income bracket where there's a lot of variability across states. You've already pointed out a lot of the problems and equities associated with that given the differences in baseline commitments across states.

I haven't heard this idea floated, and I'm wondering if you can talk about maybe the significant disadvantages of this, is to reverse that allocation and look at an adjustment to the lowest income brackets. So for instance, providing 100-percent federal subsidy for that income level under 30-percent of poverty, let's say. That's a group that every state covers. It's a group that has higher participation levels

across states compared to other income brackets. And therefore, there's more sort of embedded equity across states.

And when I think about it – I haven't thought about it a lot – but when I think about it, the factors that would determine variation in states, these are factors that are outside of state's control. They're percentage of chronically unemployed. They're a percentage of disabled, for instance. And then there seem to be some advantages to looking at it this way because there's probably also a lot of overlap with the dual population, the elderly and other groups, whether there's some interesting in shifting cost to the feds. Can you think of some, perhaps, significant disadvantages of taking this approach?

ALAN WEIL: I mean this is a fairly straightforward average cost versus marginal cost problem. The states' total outlays are based on

the total amount of expenditures minus whatever they get back from the federal government. When we're trying to motivate states to change their behavior, you want to lower the marginal cost of that change. So in CHIP, even though it's a higher income population, we gave a higher match rate to give states a stronger incentive to take the next step.

So the question I think appropriately posed is do you need the marginal cost incentive anymore in a universal system? If we really get the whole way there, then the marginal decisions of states at the higher income levels probably aren't as important because there's a federal safety net or a federal program.

And so all that matters is the table at the end of the day that Sheila referred to, which looks at states winning and losing. And if you shift where you're getting your match from and

what population that's associated with, but in the end, it's the right amount of money, then states sign on the bottom line. And if it isn't, they walk away.

To me that's really the question is, if we're moving into a system that's sufficiently coherent and complete that we're not worried about trying to keep the marginal incentives at the edge for state behavior, then I think flipping it makes perfect sense. It sends the right message about the value of the population. It probably, as you say, automatically responds to some of the problems we have in the current system. But it then reduces the incentive for the marginal shift at the upper edge and that's something I think we'd worry about giving up unless we knew that there were protections at that level.

DIANE ROWLAND: Okay. Next question.

JOAN ALKER: Hi. Joan Alker with the Georgetown Center for Children and Families. And I wanted to pick up on the comments you made Alan, which I thought were excellent about some of the challenges in integrating public and private coverage as we move to some kind of expansion using Medicaid as a base. And also Sheila, I thought you made some excellent points about some of the politics around those issues.

For the population I think you see some discussion in the finance committee options of using, for example, premium assistance, which I think Alan, you outlined some of the operational challenges. But I wanted to also stress, I think the point you made Sheila, about the cost comparison. Because states have been trying to do this and I think particularly for the expansion population, we're talking about the very lowest income adults, there's not a lot of their there.

So it would be unfortunate to end up with a situation where states had to go down a path that wasn't very productive. And so I think it's just going to be important to keep in mind what we know that there hasn't been a lot of cost savings there. It's been pretty complicated as we move forward.

And then I had a question for John. I haven't heard any discussion of this and I don't know if you were able to look at this in your model, but I think it's accurate to say that a lot of low income adults, the very lowest income adults, are actually veterans. And I don't know if there's been any estimates of cost savings to the VA to the extent that they're getting some healthcare, they're getting it through the VA in some cases. I don't know if anybody's look at that issue.

JOHN HOLAHAN: We didn't. And it's an interesting point and maybe that's something that we should try to see if there's a way to take a look at it. It is. It's a really interesting idea.

DIANE ROWLAND: Other questions? We have one in the back.

STACY SANDERS: Hi. Stacy Sanders from Wider Opportunities for Women. I'm curious about long-term care because so much of Medicaid cost to the states are in the long-term care programs. Is there a role for long-term care reform either through rebalancing to home care alternatives or other options to create more cost savings in terms of the Medicaid costs?

SHEILA BURKE: Thank you for asking that question. I think long-term care is sort of the silent part of this entire discussion and I think there has been little in the way of attention

given to the opportunities and also the challenges that are faced in terms of the states' roles and the financing of long-term care, as well as how long-term care is currently delivered.

And so, I think the answer to your question is no, I don't think, at least I'm not aware of a current discussion about trying to deal with the broader questions of long-term care, changing the nature of the service, the location of the service, the method of financing it, the right balance between public and private sector, since most of the costs are currently borne out of people's pockets – about 50-percent nationwide. But it is an enormous problem and one that I worry isn't going to be addressed. And it's certainly one we've successfully avoided for years. But Karen and Alan may know of conversations occurring. I certainly don't.

DIANE ROWLAND: Karen?

KAREN IGNAGNI: Actually Senator Kennedy through the Help Committee has put together two group of work horses. And one deals with long-term care. And it has virtually every – on the long-term care side, virtually every group representing the disabled population, seniors, advocates, health plans, just a range of different folks trying to work through this policy question that you posed, which is how do we integrate efforts and to the extent we're moving down one path in healthcare reform. How can we think about synergistically lining up what's done in long-term care?

So there's a proposal that Senator Kennedy has there. There's a great deal of discussion going on about how best to do this, as Sheila indicated. And one of the things that I think is emerging from that, that I'm very encouraged about – I was going to use the word excited and really

that's a better word, excited about is I think in healthcare reform, at a minimum, what we're going to end up with is a real focus on the duals. What do we do with the duals? How do we improve their care? How do we better coordinate? What are the barriers to doing that?

And then the point you raised about should we continue to treat long-term care in a demonstration-like manner, that makes no — on community care side — that makes no sense in today's delivery system. That's a decision that reflected the predominant way of delivering long-term care when Medicaid was passed, was of course through nursing homes. And now it's home and community-based care. That's what advocates want. That's what the population wants. At the same time, we need, obviously, nursing home care to be integrated with that.

So getting this right is very, very important, not only from the perspective of providing the highest quality of care, but embedded in John's numbers is some assumptions about how do we improve value? How do we get the biggest bang for the investment? And I think that this is a very important conversation.

So I'm glad you raised it as well. And I'm very excited about the conversations that are going on. And I do think at a minimum, there will be certain things done. And even there are a number of individuals who have strong commitment to doing even more and I think that's a very productive dialogue at present.

Then the question is how do you pay for it all? How do you line it all up? And those of course are going to be issues that the finance committee is focusing on today. But a great deal

of the debate will turn on those questions and how we answer them.

ALAN WEIL: Let me just quickly add that I think we need to be thoughtful about the language on this issue because long-term care is a service. And when we say we should do something about long-term care, we're saying there's a lot of unmet need and the first question is how are we going to pay for it?

But the people who need long-term care services are people who also generally need acute care services. And when we start talking, although the duals – it's an awkward term – at least we're now talking about a category of people. And when we talk about improving the efficiency of service delivery for people who have acute and chronic needs and chronic and long-term needs, and a continuum of services that are not well met by the current financing and delivery

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system, we have an opportunity I think to discuss this issue in a way that is not just about, we're already taking on a trillion dollars, how can we possibly pay for more services?

So Karen, I hope you're right that this really is an opportunity. I think the tendency has been we're already taking on so much, we can't possibly do this. But if we can focus on maybe, not all of the populations that require long-term care services, but some of them and particularly the ones paid for by public programs and think about how do we improve services, I think that really is an opportunity we have now that's unique.

DIANE ROWLAND: Well I clearly think today we've managed to go through all the responsibilities that Medicaid now picks up for the low income population and come full circle to really talk about the complex population it serves

with acute and long-term care needs at the end, which I think is why, as we move forward in healthcare reform, clearly stabilizing the base of the Medicaid program for the populations it now serves, thinking about how to build on that in the most effective way to cover some of the additional populations that are low income and many with special health needs as well is the question of the day.

And I hope that the finance committee is moving forward to figure out how to pay for all of this. Because I think it is a critical need and we have to also think about how these things get phased in and the transition issues that were raised here today. Or that maybe we start at one place and we move toward another as we get experience and as we understand the implications.

Because at the end of the day, I think what we all have to remember is when we're talking

about the lowest income population, we're talking about a population that's a substantial share of individuals with really significant and complex health needs who are very fragile. And we need to try and assure that in moving forward, we do no harm as well as provide coverage for the American population.

So I thank you all for coming today. We'll continue to try and answer questions like Vicky's, of what are the implications of some of the options being put on the table. But at least today I think we started a discussion about Medicaid and its role and the possible framework it can provide for healthcare reform.

[END RECORDING]

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