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Webinar for Journalists on Medicaid and the Affordable Care Act: The Impact of State Decisions
Kaiser Family Foundation
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PENNY DUCKHAM: Welcome everybody to this third in a series from the Kaiser Media Fellowship Program exclusively for journalists looking at reporting issues on the Affordable Care Act. As you just heard, I'm Penny Duckham. I'm the Executive Director of the Kaiser Media Fellowships program, and if you're interested in looking at the previous webinars and in a little while if you need to look at this one online, everything will be posted on our web site together with the slides and we will have ample time for Q&A either through email or through calling in at the end of the presentation from my two colleagues. I would really encourage you to get your questions in there. It would help if you could say which state you're from so we can try to tailor the responses most helpfully to you.

With that I'm going to get started. My two colleagues today are Robin Rudowitz and Rachel Garfield, Associate Directors for the Foundation Kaiser Commission on Medicaid and the uninsured. Robin is going to get started with the presentation.

Thank you, Robin.

ROBIN RUDOWITZ: Thank you, Penny and everyone for joining the webinar. As Penny said, Rachel and I will provide a brief overview of Medicaid and the ACA, and then we along with some other colleagues in the room here will be able to answer questions.

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Let’s start with the big picture and how Medicaid fits into the ACA. The ACA was designed to make health care coverage more available, more reliable, and more affordable. With the goal of making coverage more available and connecting the uninsured to coverage options, the law establishes new pathways for coverage in two main ways. First, through an expansion of Medicaid for low income individuals and second through tax credits for moderate income individuals to purchase coverage in newly established marketplaces or exchanges.

The new options for coverage do not change how the majority of people get coverage, which is through their employer. The ACA also includes requirements for individuals to purchase health care coverage or pay a penalty, and another number of reforms that underpin how health insurance markets can operate.

As enacted, starting January 1st 2014, the ACA would expand the Medicaid coverage umbrella to nearly all adults with incomes at or below 138-percent of the federal poverty level. This is just under $16,000 annually for an individual.

Before the ACA, to be eligible for Medicaid individuals had to meet both income and categorical eligibility requirements. Medicaid has traditionally provided broad coverage for children and pregnant women, but coverage for parents have been much more limited and adults without dependent children or childless adults were generally excluded

from coverage regardless of how low their income was, so the ACA Medicaid expansion really would significantly increase eligibility for adults.

In addition to establishing new coverage options the ACA includes a range of provisions to streamline enrollment processes to make it easier to obtain coverage. These provisions are applicable to all states. The vision under the ACA is to have integrated and technology-drive enrollment processes for Medicaid and marketplace coverage. These changes required completely new systems to apply for marketplace coverage and major upgrades to Medicaid enrollment systems. As you all know, the marketplace opened for enrollment on October 1st, and while it is clear that there is more work that needs to be done to realize these streamlines processes envisioned under the law, it is worth pointing out that a number of states with state-based marketplaces are successfully enrolling people in coverage, and particularly relevant to today's topic, states like Washington and Minnesota that break out their enrollment across programs are showing significant increasing in Medicaid coverage.

Also for Medicaid, a number of states are implementing other automated enrollment processes with great success. For example, four states, Arkansas, Illinois, Oregon, and West Virginia are enrolling large numbers of individuals through Medicaid if they're receiving benefits from the Supplemental

Nutrition Assistance Program, or SNAP, and New Jersey just received approval to move ahead with this option. This option makes it easy for enrollees to get covered and it is very efficient for state governments to process the enrollments.

For states, the Medicaid expansion has a number coverage and fiscal implications. In total, Medicaid enrollment could increase by an estimated 21 million people by 2022. This number reflects increased participation, or take-up, of some people who are currently eligible for coverage and not enrolled, including children, as well as estimates of new enrollees if all states were to move forward with the Medicaid expansion. Expansions in Medicaid coverage would reduce the number of uninsured, and importantly, increased coverage would mean better access to health care services.

The Medicaid expansion also has a number of fiscal implications for states. Under the law, the federal government would pay 100-percent of the costs of those made newly eligible for Medicaid from 2014 through 2016. The federal share would be phased down to 90-percent in 2020 and beyond. While states may face relatively small costs associated with new coverage after 2016, states could also see savings tied to the Medicaid expansion from reductions in state spending for things like uncompensated care and spending for programs that serve uninsured residents such as mental health services.

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In addition, some states anticipate broader economic benefits such as increased revenues and jobs from the Medicaid expansion and the increase in federal funds. Accounting for multiple factors, many states anticipate net fiscal benefit from the Medicaid expansion. In addition, providers, such as hospitals, are also likely to see increased revenue tied to Medicaid coverage.

On June 28, 2012, the Supreme Court ruling limited the ability of the Secretary of HHS to enforce the Medicaid expansion requirement which effectively made the Medicaid expansion an option in states. Currently, there are 26 states including D.C. that are moving forward with the Medicaid expansion and 25 that are not moving forward at this time. Ohio was the most recent state to decide to move forward earlier this week. This picture has been evolving over time and CMS has told states that there is no deadline to decide about participation in Medicaid expansion, so we will continue to monitor this activity.

Also, we wanted to point out that this current picture is strikingly similar to take-up when Medicaid was enacted in 1965. At that time, 26 states were initially participating in the Medicaid expansion and five years later by 1970, 49 states were participating.

We know from our recently released annual Medicaid budget survey that total enrollment and spending growth in

Medicaid is expected to grow faster in 2014 compared to 2013 due to the implementation of the ACA. Across all states, those moving forward and those not moving forward, one of the drivers of increased enrollment growth is due to this increased participation for those who are currently eligible but not enrolled due to outreach and education efforts. This coverage will increase spending and will be matched at the state's regular Medicaid match rate.

However, there is a differential across states moving forward and those not moving forward. As you can see in the second set of bars here states moving forward with the expansion are expecting to see higher enrollment growth which is tied to enrollment of those newly eligible for coverage and higher total spending which is a result of significant increases in federal funds to support the expansion.

RACHEL GARFIELD: This is Rachel. I'm going to pick up where Robin left off. The changes in enrollment and spending that Robin just discussed are reflecting the expansion of eligibility under the law. As Robin mentioned, effective January 2014, the ACA establishes a new minimum Medicaid eligibility level of 138-percent of poverty for non-disabled adults who were not previously eligible for the program. The expansion would significantly increase eligibility in states that implement the expansion. Though many states moving forward with the Medicaid expansion already offer coverage for

parents up to poverty, adults without dependent children are generally ineligible under pre-ACA rules as you see in the left panel of this figure. In these states, the expansion extends Medicaid eligibility to all parents and other adults up to the new Medicaid limit.

However, Medicaid eligibility in states not moving forward with the ACA Medicaid expansion is very limited. As you see in the right panel of the figure, as of January 2014, the median eligibility level for parents in states not moving forward will be just 47-percent of the poverty level with is about $9,400 a year for a family of three. Of the states not moving forward with the expansion, only Wisconsin will provide full Medicaid coverage to adults without dependent children in 2014.

Limited Medicaid eligibility in states not extending Medicaid will leave many poor adults without a coverage option. This situation arises because, as Robin discussed, the ACA was designed to provide a continuum of coverage options to people across the income spectrum. For people at the lowest end of that spectrum there is a current Medicaid program represented by the red section of the umbrella in this figure, which Robin mentioned had many holes in eligibility for adults, so the expansion was intended to fill in these holes and to be the main vehicle for covering low income individuals.

The extension also provides links between the current program and new private coverage options available through the marketplaces which were envisioned as the vehicle for people with moderate incomes, and you can see that in the blue section of the umbrella here. People with moderate incomes are eligible for premium tax subsidies to help them purchase this coverage. Because the ACA envisioned people below poverty receiving Medicaid, it does not provide for premium tax credit for the lowest income and as a result individuals below poverty are not eligible for these tax credits even if their state does not extend Medicaid.

The result is that in states that do not expand their programs, individuals with incomes below poverty but above Medicaid eligibility levels will fall into a coverage gap of earning too much to qualify for Medicaid but not enough to qualify for tax credit and you can see that in the white section of this umbrella.

Nationally, nearly 5 million poor uninsured adults will fall into this coverage gap meaning their income is above Medicaid eligibility but below poverty. These individuals would have been newly eligible for Medicaid if their state had chosen to expand. More than a fifth of people who are in the coverage gap live in Texas which has both a very large uninsured population and limited Medicaid eligibility. Another 16-percent live in Florida, 8-percent in Georgia, 7 in North

Carolina, and 6 in Pennsylvania. These shares largely reflect the population sizes of the states with larger states accounting for a greater share of people.

When you look at just within each state, what this figure shows is that people in the coverage gap account for the vast majority of poor uninsured adults in states not moving forward with the expansion. Nationally, 86-percent of poor uninsured adults in states not expanding Medicaid are ineligible for Medicaid. This share varies across states reflecting both variation in Medicaid eligibility and in the income distribution of the uninsured. The share of poor uninsured adults in the gap ranges from high of 91-percent in Idaho, North Carolina, and Texas to 67-percent in Alaska and 74-percent in Tennessee. Notably, there are no uninsured adults in the coverage gap in Wisconsin because, as I mentioned earlier, the state will provide Medicaid eligibility to adults up to poverty level in 2014. However, in most states not moving forward with the expansion, the vast majority will remain ineligible. Most of these people are likely to remain uninsured as they have very limited coverage options available to them.

To wrap up, we just wanted to leave you with some key questions that people will be asking over the next several months as the ACA/Medicaid expansion unfolds, so these are

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things that we thought would be interesting both to your readers and are going to be of interest to many policy makers.

The first is how the status of the decision regarding the expansion is going to change. As Robin mentioned, there's no deadline for states to expand their programs and states are continuing to make decisions, and just this week Ohio moved from the not-moving-forward to the moving-forward category, so that is something to keep an eye on in the next weeks and months.

The second question is how will new enrollment systems work and how will systems be coordinated across health programs. The rollout of the marketplaces has been rocky and technical issues affecting people's ability to shop and enroll will undoubtedly continue to be of interest to many. Given that the systems are coordinated with Medicaid, there will be a lot of attention to how the marketplace rollout in past affects Medicaid coverage as well as how well Medicaid systems are working in starting in January of 2014.

Next key questions are how the ACA will effect Medicaid enrollment and the uninsured, so this is going to be focusing on the issue of the pickup of the coverage options, and a lot of people want nearly immediate numbers on how many people are enrolling and what the impact on the uninsured is going to be, so there will be a lot of interest in trying to get that information as quickly as possible.

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The bigger question that people have is what impact does this coverage have on access to health care and ultimately health outcomes. This is going to be something that is going to take a little bit longer to measure simply because these things take a while to show up, but it is something that our organization as well as other organizations are going to be paying close attention to.

There are also questions about how Medicaid will impact state revenues and fiscal conditions. As Robin discussed, we have some preliminary data on what states think will happen but we will continue to measure that.

The final couple of questions here are what's going to happen to people who fall into this coverage gap. Are they going to be able to access health care that they need? They are likely to face significant barriers to care and many of them are likely to continue to rely on the safety net, and by the safety net we mean mostly community clinics and public hospitals which are already stretched in trying to care for underserved populations. There will be a lot of attention to how well that system's able to hold up in the coming years.

With that, I think we'll move back to Penny and move to the Q&A.

PENNY DUCKHAM: Thank you very much. I think the operator, if you could just remind everyone how to call in or send in your questions by email, and that's up on the screen

now, but maybe the operator could just run through that one more time.

OPERATOR: Absolutely, ladies and gentlemen, if you would like to register for a phone question please press the 1 followed by the 4 on your telephone. You'll hear a three-tone prompt to acknowledge your request. If your question's been answered and you'd like to withdraw your registration please press the 1 followed by a 3.

If you'd like to ask a chat question, please use the chat feature located at the lower left corner of your screen.

One moment please for the next question.

Our first phone question comes on the line of Rus Zimmer [misspelled?] with the BN Network [misspelled?] of central Ohio. Please proceed with your question.

MALE SPEAKER 1: Thanks. Thanks for taking my question. As you mentioned, Ohio this week elected to go forward with the expansion. It sounds to me like their plan for communicating with potential enrollees under the new guidelines just kind of involves leaving that up to like the managed care organizations and community clinics and places that folks who are uninsured currently who might qualify for Medicaid might intersect with the health care system.

I'm wondering if that is an efficient way to communicate with those folks and if that is the route that other states have taken.

PENNY DUCKHAM: Rachel or Robin, could you pick that up please?

ROBIN RUDOWITZ: Sure. We actually have in the room some of our colleagues, and our colleague Samantha Artiga who has been focusing on the outreach and enrollment effects, so I'm going to turn to her to chime in on that one as she has more expertise than I do.

SAMANTHA ARTIGA: This is Samantha. I'm not familiar with what you're referencing specific in Ohio related to their guidelines and their approach, but I would say what we're seeing in other states is a wide range of different outreach and enrollment strategies. I would note that in establishing the marketplaces, many of those have tied into the outreach and enrollment campaigns and the establishment of new consumer assistant resources including the Navigator programs that are designed to reach out to eligible individuals and help them enroll in coverage, and included in all those efforts tied to the marketplaces will be connecting people to the Medicaid programs. Those are designed to connect people to all insurance affordability programs created under the Affordable Care Act so that would include Medicaid, and in fact where states are breaking out separate enrollment data we are seeing that many of the folks coming into the marketplaces are actually connecting to Medicaid coverage and being enrolled in Medicaid.

Outside of that, states are in varied places with what they're doing in terms of outreach and enrollment specific to their Medicaid population. Some states have much more established outreach resources and collaborations with community-based organizations to reach out to that population and are building on that experience to reach out to the newly eligible. Others don't have as much experience or practice in that and are in varied places to what extent they're conducting outreach separate from their marketplaces.

I hope that helps.

MALE SPEAKER 1: Thank you.

PENNY DUCKHAM: Thank you very much, Samantha.

Now we're going to take a question online from Matt [inaudible] who says there are no deadlines for expanding Medicaid but does the Supreme Court decision also give the state an option to back out of Medicaid down the road?

ROBIN RUDOWITZ: This is Robin, and that is correct. CMS has said that there's no deadline for states to come in and participate in the Medicaid expansion and states that are participating are able to stop participating in the expansion going forward.

PENNY DUCKHAM: Another question. This from North Carolina, Mark [inaudible]. In a speech at the Heritage Foundation, North Carolina Governor Pat McCrory said the state could be forced to expand Medicaid in 2014 despite turning down

expansion this year. Is there anything in the ACA that would force states to expand?

ROBIN RUDOWITZ: There's nothing in the ACA that would force states to expand or take up the expansion. The expansion is a requirement and it's really a result of the Supreme Court decision that states now effectively have the option to participate or not in the expansion.

PENNY DUCKHAM: This is, perhaps, a related question from Steve Johnson in Nebraska. How does expansion create economic benefit for the states? Nebraska has not expanded Medicaid.

ROBIN RUDOWITZ: This is Robin again. There's been a lot of research over the years about the economic multiplier effect that Medicaid has in state economies because when a state spends money on Medicaid they receive matching dollars from the federal government. This is really magnified under the ACA because the federal dollars are so significant with the federal government paying 100-percent of the cost of those who are newly eligible, so there's a significant increase in federal dollars coming into states and that really ripples through state economies both in the health care sector and beyond creating revenues and jobs. So many states have explicitly factors these broader economic benefits into their state estimates of the net effects of the Medicaid expansion.

PENNY DUCKHAM: This is from Jim [inaudible]. Do you have any idea ofhow many states not expanding Medicaid this year are considering expansion in subsequent years and what are the pros and cons of delaying expansion?

ROBIN RUDOWITZ: This is Robin. There are a few states that I think we will be continuing to watch very closely. New Hampshire is one of them. The commission that was looking at the Medicaid expansion said that the state should go forward with the expansion and the governor has now called a special session for November, so we'll be watching what happens in New Hampshire as well as Pennsylvania where the governor had come out with a proposal related to coverage. I think we'll be watching those states closely.

PENNY DUCKHAM: This is a question from [interposing].

ROBIN RUDOWITZ: I'm sorry Penny. I forgot the second part of the questions which are the pros and cons of delays, and that's an important question, I think, because the benefit of coming into the Medicaid expansion quickly is that states benefit from the three years of the 100-percent federal matching funds for those who are newly eligible for the federal government, so states that don't come in for a year or two years miss out on a portion of that 100-percent federal financing because that is set in the law.

PENNY DUCKHAM: Another question from Joe Paduda How will the reduction in federal payments to hospitals for

uncompensated care be affected in the states that don't go forward with the Medicaid expansion?

ROBIN RUDOWITZ: This is Robin. I believe that the caller is referring to the reductions in the disproportionate share hospital payments. These are payments that are for hospitals that serve a disproportionate number of uninsured and Medicaid patients. In the law, there are reductions in the DSH payments that are scheduled to take place. They get increasingly bigger over the years as there was anticipation that there would be more coverage, so the federal allotments are specified in the law and the department of HHS was to come up with a methodology on how to distribute those reductions across the states HHS has come up with a formula based on the law that does not explicitly account for right now whether a state is moving forward with Medicaid expansion or not. They will need to revisit that allocation/distribution in 2016.

PENNY DUCKHAM: Now we're going to take a call-in question please.

OPERATOR: Our next phone question comes in line with Debbie Rubin with the CBS Evening News in New York. Please proceed with your question.

FEMALE SPEAKER 1: Hi, I just had a question about the general—if there have been measures taken to understand, for people who are enrolling in these new plans across the board,

can we see people's plans, the coverage plans costs increasing or decreasing?

RACHEL GARFIELD: For what we're talking about today which is people who are enrolling in Medicaid coverage, the vast majority of people who are going to be gaining Medicaid coverage are currently uninsured, so they will be newly acquiring health insurance coverage. The Medicaid coverage is designed for people with limited incomes and so there are no premiums generally for people to have that coverage and cost sharing in the Medicaid program is limited to what are called nominal levels, so really again reflecting the low incomes of the people that that program covers.

I'm not sure if that gets at what you were getting at in terms of what would happen to people's costs under the plan, but for Medicaid their out-of-pocket costs will be quite minimal.

FEMALE SPEAKER 1: Right, okay, thank you.

PENNY DUCKHAM: Another caller on line from the operator please.

OPERATOR: Our next phone question comes on the line from John Kennedy with the Palm Post in Florida. Please proceed with your question.

MALE SPEAKER 2: Yes, hello. Can you hear me.

PENNY DUCKHAM: Hello?

MALE SPEAKER 2: Hello, can you hear me?

I'm sorry. I wondered if you have any thoughts on if the centers for Medicaid and Medicare sources are looking at considering states that are not looking to enact a full Medicaid expansion but trying to come up with some kind of plan of their own. Florida, for example, is very resistant to the idea of extending coverage to uninsured adults without children or disabilities. As the Affordable Care Act continues to have some complications, do you think CMS may be a little bit more willing to deal in coming months?

ROBIN RUDOWITZ: This is Robin. We, obviously, cannot anticipate what CMS will do but they have put out a number of regulations and other guidance to states about what states can do moving forward. One of them was that states cannot do a partial expansion and be eligible for the enhanced matching rate that's available under the ACA, but they have also put out some other guidance about waivers and other ways that states may look at doing the Medicaid expansion, like Arkansas, for example, has been approved an 1115 Medicaid Waiver Demonstration program to look at using premium assistance as a way to do their Medicaid expansion.

That's probably the best we can do on that question.

PENNY DUCKHAM: Carla Johnson is picking up on an earlier slide of yours, Robin, about the changes across all states in the enrollment system for Medicaid, so her question

is was the funding for major upgrades to Medicaid enrollment systems appropriated under the ACA or was it separate funding?

ROBIN RUDOWITZ: That's a good question. For Medicaid, the funding for the enrollment system was provided through the Medicaid program. Medicaid, through administrative matching funds, already provides assistance to states in upgrading eligibility systems. They were able to provide enhanced matching funds, so 90-percent matching funds for states to upgrade or replace their eligibility systems for a limited amount of time, and most states, if not every state, had taken advantage of that additional federal financing to improve and upgrade their Medicaid and eligibility systems and that's across states that are moving forward as well as states that are not moving forward with the expansion.

PENNY DUCKHAM: Chrisinda Conder going back in the way to the question that John was raising from Florida. Is Ohio taking the Arkansas approach to Medicaid expansion using federal funds dedicated for Medicaid expansion to instead purchase private health insurance for more than 200,000 of its low income residents, or is it going the route that is outlined in the ACA?

RACHEL GARFIELD: This is Rachel. As far as we can tell, based on the information that's available, and again this is somewhat of a late-breaking thing, Ohio is planning to go with a traditional approach to its expansion.

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One thing I'll note in the question is it's important to note that in most states people who are covered under Medicaid are actually going to be enrolled in private plans and they're going to be enrolled in the Medicaid Managed Care Plan, and so that's just something to bear in mind in thinking about how people are actually going to get services once they're covered in insurance that's financed by Medicaid.

In direct response to your question, as far as we know, the Ohio approach is not mirroring what's going on in Arkansas.

PENNY DUCKHAM: Richard Marr has a question for you, Rachel. You said that people under 100-percent of the poverty level are not eligible for tax subsidies and he asked what about those between 100-percent and 138-percent?

RACHEL GARFIELD: That's a great question. In fact, these people in states that don't expand would be potentially eligible for tax credit for their premiums in a marketplace coverage. There are a couple of other stipulations about who is eligible for those premiums. They, for example, can't have what's considered another affordable offer of coverage, but there is a small share of people who would have been covered by Medicaid who may, instead be able to purchase coverage in the marketplaces.

When we look at the numbers of how many people actually fall into that group, it's not that many people. It's just under 3 million people in those non-expansion states. The vast

majority in those non-expansion states are being left out even with that provision that some of them could go into the marketplace.

PENNY DUCKHAM: Steve Jordan asks do you have an estimate of the people in the coverage gap per thousand population. He's trying to get an estimate of how many there might be in Nebraska or one of the other smaller states not shown in your pie chart.

RACHEL GARFIELD: I don't have that particular estimate in front of me. However, in the slide that is pulled from and referenced at the end of the slides in the webinar, we do have state-by-state estimates of the number in the gap, and so we can get those figures to you.

For Nebraska, we estimate that about 33,000 people are falling into that gap, and again if you go to the report it's in table two there. You can see state-by-state estimates for each of the states.

PENNY DUCKHAM: Here's a question from Minnesota. Logan Mortison]. What are the options available for individuals in non-expansion states who will fall into the coverage gap in 2014?

RACHEL GARFIELD: This is Rachel again. Unfortunately, for people who are in this situation they're going to have very limited options for affordable coverage. By definition, people who are in the coverage gap are living on very limited incomes,

they’re living below the poverty level, and at that income being able to afford coverage on their own is very unlikely. When we look at what the premiums are likely to be either in the current market or the marketplaces, they account for a very substantial share of income for people.

We also know that most people who are in this situation, even if they’re working, don’t have an offer of employer coverage. Many of them may be working part-time; many of them may be seasonal workers, so unfortunately the vast majority of them are most likely to remain uninsured.

PENNY DUCKHAM: [Inaudible] has a question. For those people who have not enrolled by March 2014, what are the options to enroll at a later time?

ROBIN RUDOWITZ: The deadline for the open enrollment period is related to people who are applying for coverage in the marketplace. For Medicaid there is no open enrollment period. Individuals can apply at any time for Medicaid coverage.

PENNY DUCKHAM: That’s a helpful clarification then.

Marissa Toriary says in the CMS Medicaid language, it says the expansion will cover those up to 133-percent of poverty, but you have been saying 138-percent. Which is it and why is your percent different from CMS’s or did CMS change things?

RACHEL GARFIELD: This is Rachel. No, nothing changed. You are correct. The law says 133. It also allows for a 5-percentage point income disregard, so the effective level is 138 and we tend to use that in our work because we're frequently trying to look at who's going to be captured under the effective eligibility level, which again is the 138.

PENNY DUCKHAM: Jeff Kelly asks whether the Kaiser Foundation is tracking state and federal efforts to integrate Medicaid enrollment into the online marketplaces and asks whether technical problems with the exchanges will delay or undermine the expansion of Medicaid.

ROBIN RUDOWITZ: This is Robin. We are trying to follow what's happening with enrollment both through state-based marketplaces as well as the FFM, and as everyone is looking and waiting for enrollment numbers, we will continue as well. There are better numbers coming out from some of the state-based marketplaces, and those are capturing who is enrolling and applying to the marketplaces at this state, and again some states are also breaking that out into whose applying or getting Medicaid coverage differential for marketplace coverage.

[Interposing]

ROBIN RUDOWITZ: I just wanted add one thing, Penny, that folks can still access the Medicaid eligibility and application side of things in this state. For example, in a

state that may be relying on the federal marketplace where there have been known problems, folks would still have the option for applying for Medicaid through the traditional Medicaid application route and I think we are continuing to see enrollments that come through that avenue.

PENNY DUCKHAM: Thank you, and now we're going to take two questions please from the operator.

OPERATOR: Absolutely. Our next phone question comes on line, Viji Sundaram with the New America Media in California. Please proceed with your question.

FEMALE SPEAKER 2: Thank you for taking my question, but Robin just answered it. Somebody else asked a question about whether states that delay participation in Medicaid expansion, would the enrollment period not apply to them, and she said it doesn't apply so my question was answered.

PENNY DUCKHAM: Another question please from the operator.

OPERATOR: Our next phone question comes from the line from Maria Zamudio with the Chicago Reporter Magazine in Illinois. Please proceed with your question.

FEMALE SPEAKER 3: Hi, thanks for taking my question.

I wanted to talk to you guys about this coverage gap that you mentioned for the folks who fall between the 100-percent and 138-percent poverty line, so we're really talking about low-wage workers, are we not?

RACHEL GARFIELD: This is Rachel, just to clarify, the people in the coverage gap are people who are above the state Medicaid eligibility level, which is about 47-percent of poverty but below the poverty line.

The people who are between the poverty line and 138 in non-expansion states may be able to get subsidized coverage through the marketplace, so the people in the gap are living below poverty

In response to your question about their characteristics, many of them are working. They tend to be working in part-time jobs and in, obviously, very low-wage jobs because they have low income.

FEMALE SPEAKER 3: I'm sorry, just a followup question. For those folks who fall into this coverage gap, what options will they have?

RACHEL GARFIELD: Under the ACA, unfortunately they're going to have very limited options for coverage and so they're likely to remain uninsured, and so that's why we thought it was important to highlight who is falling between the cracks in these coverage extensions as a result of what's happening in the way that the law is being implemented in some states. Because the law originally envisioned all of these people being covered by Medicaid, it did not make provisions for sort of a backup source of coverage in the event that that didn't happen, and so that is why they're falling into this gap.

FEMALE SPEAKER 3: Thank you.

PENNY DUCKHAM: I'll take a question from Mary Nehan [misspelled?] who I think must be in Kentucky. She says what is the impact of the federal technical issues on Medicaid enrollees at the state level? For example, could getting care through Medicaid for Kentuckians be delayed or hampered by federal struggles.

JENNIFER TOLBERT: Hi, this is Jennifer Tolbert I'm going to jump in and respond to this question.

Actually, specific to Kentucky because Kentucky is a state-based marketplace, they have developed their own integrated enrollment system and their own web site, so people applying for coverage, whether for Medicaid or for qualified health plan coverage through the marketplace will go through the Kentucky web site, not through the federal healthcare.gov web site, and the Kentucky web site is actually working quite well and they've reported fairly robust enrollment to date including those people who are eligible for coverage through qualified health plans in the market place as well as those who've been determined newly eligible for Medicaid.

Kentucky, again, because it's a state-based marketplace, has a lot more control and the web site there seems to be working.

In states that are relying on the federal marketplace, so healthcare.gov, as the mechanism through which people apply

for coverage, there are obvious problems there. The web site is currently not working as well as was hoped, and people applying for coverage, again, the healthcare.gov and HHS is collecting all those applications and anyone that is determined potentially eligible for Medicaid will be sent to the states. That process has been slowed down, or hampered, by the problems with healthcare.gov.

Importantly, in states where they are relying on the federal marketplace, if the state is expanding Medicaid people can still apply through the traditional Medicaid system in the state whether it be online or be paper application in this state.

PENNY DUCKHAM: We'll take another question from the operator please.

OPERATOR: Our next question comes on the line of Deidre Baker with the Quad City Times in Iowa. Please proceed with your question.

FEMALE SPEAKER 4: Yes, I was just asking. Iowa is like Arkansas. We've got this hybrid going on because of the politics here. I don't know if you can add anything. Iowa thinks they're going to sign up about 150,000 people. I don't know if you have any insight beyond that.

ROBIN RUDOWITZ: I think we'll be continuing to watch what happens in Iowa, as it sounds like you will too, but Iowa has a proposal that requires another Medicaid 1115 Waiver

approval from CMS and that waiver is still pending at CMS, so there are many provisions that we'll have to see what's approved out of that waiver.

FEMALE SPEAKER 4: Yes, knew that too. Thanks guys, bye.

PENNY DUCKHAM: [Inaudible] asks, traditionally mental health has been a current optional benefit under Medicaid. Will the expansion combined with a new mental health federal parity law effectively mean that mental health becomes covered under Medicaid in every state, even states that haven't covered it before?

RACHEL GARFIELD: This is Rachel. I'll chime in on that one. The way that mental health has been treated traditionally in the Medicaid program, it's not technically an optional benefit. In fact, there is no mental health coverage category under Medicaid law.

However, states do cover mental health services under other service categories such as provider services, inpatient hospital services. There has been a gap in Medicaid services in mental health which is specifically institutional services for people of a certain age and that is because those services are traditionally covered by states.

That said, there is, at the same time that we're rolling out the Affordable Care Act, this relatively new federal parity law which specifies that plans that cover mental

health have to do so at parity with physical health, so that means that they have to have the same cost sharing requirements, they have to have similar network requirements, and under the law everyone who's gaining new coverage has to gain coverage that does include mental health and also substance use disorder services, so people who are gaining new coverage will receive coverage for mental health services and they will receive that coverage at parity.

PENNY DUCKHAM: We have another caller on line. Thank you from the operator. Operator? Alright, well we'll take that in a minute I guess.

Here is a question from Maureen Gross [misspelled?]. Is there concern that states that expand Medicaid will face a strain on doctors as many more people try to get care? Alternatively, I've also heard concerns that if a state doesn't expand Medicaid and is next to states that do those states msy attract doctors away from the non-expansion states leaving it with a doctor shortage.

Any thoughts on this?

JULIA PARADISE: Hi, this is JuliA Paradise speaking. The issue you raised of physician shortages is an important issue systemwide, not specifically a Medicaid issue. I'm not sure I'm aware of evidence that indicates that expansion decision would bear on and change physician behavior with respect to where they locate.

I want to mention there are provisions in the law that increase Medicaid payment rates to Medicare levels for primary care physicians for a couple of years. That's providing better support for physicians who are participating in Medicaid already, and also inducing increased participation by physicians who may be not participating at present or to a more limited extent.

PENNY DUCKHAM: Can we try again, operator, to take the call please?

OPERATOR: Absolutely, and our next question comes on line with Steven Johnson with the Modern Healthcare Magazine in Illinois. Please proceed with your question.

MALE SPEAKER 3: Yes, hello. Thank you for taking my question.

I was just wondering, my question had to do with enrollment, and I was wondering how you explain the fact that you've seen in a number of states, especially those who are expanding their Medicaid programs, you've seen the numbers of those who are enrolling into Medicaid outpacing that of those who are enrolling to qualified health plans. If those numbers continue, if we see past the enrollment process where they'll be more people enrolled in Medicaid than qualified health plans, what do you think will be the overall implications? Do you see that being the—unfortunately I don't know of the

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[inaudible] of a Medicaid-for-all type of system that might be in place?

RACHEL GARFIELD: This is Rachel. I think it might be a little bit premature to come to a judgment about how people are gaining coverage under the law particularly because a lot of the numbers that are being released about people's enrollment through the marketplace coverage actually haven't been released yet because in many cases many people are not considered enrolled in that coverage until they pay the first month's premium which is not yet do. I don't think we actually have great numbers to make that assessment yet.

When we look at the potential pool of people who are eligible for coverage we see that actually there's probably about equal numbers of people who are going to get covered through the two main routes in the ACA, but that is something that we'll have to take a little bit of a wait-and-see approach on and look at how people are actually enrolling and what the numbers look like.

MALE SPEAKER 3: Thank you.

OPERATOR: Our next [interposing].

PENNY DUCKHAM: Is there another one?

OPERATOR: Yes, we have one more phone question, a followup question from the line of Viji Sundaram with the New America Media in California. Please proceed with your question.

FEMALE SPEAKER 2: Yes, thank you so much for taking my call again.

Rachel, did you say that under current Medicaid policy there is no provision at all for mental health coverage?

RACHEL GARFIELD: No, and in fact if that's how it was interpreted, I apologize. In fact, current Medicaid programs are a very important provider of mental health services in the United States and all states do provide some mental health services under their laws. There are some limits on those services in some states, but Medicaid is actually, after state and local governments, the largest source of financing for behavioral health services in the United States.

FEMALE SPEAKER 2: Thank you.

PENNY DUCKHAM: We're going to take a question from Judith Talsmith [misspelled?]. Could you elaborate on what specific drug coverage is available for Medicaid patients and is there a specific drug formulary in each state and who creates that formulary?

ROBIN RUDOWITZ: This is Robin. Each state creates their formulary and preferred drug list and states have pretty sophisticated policies around what's covered in Medicaid for pharmacies.

PENNY DUCKHAM: I think this is coming towards one of the last questions here from Kristine Crane.If a non-expansion state decides to expand would all the uninsured in those states

potentially have some form of coverage? In other words, would Medicaid expansion theoretically take care of all uninsured people who are not able to purchase their own insurance or would anyone be left behind?

RACHEL GARFIELD: This is Rachel. In those states, if those states were to expand their Medicaid programs, there certainly would be a substantially bigger decrease in the uninsured in those states, but one thing that is important to bear in mind is that in all states there are going to continue to be people who are uninsured even after the law is fully implemented. These are going to be people who are ineligible for coverage perhaps because of their immigration status, there are going to be people simply opt to pay the penalty rather than enroll in new coverage, or there are going to be people who are exempt from that penalty and perhaps are unaware of coverage options or who had difficulty enrolling.

One of the things that's very important to keep in mind as the law is unfolding is how is outreach working, are people aware of their coverage options, do they understand their coverage options, and we we're going to continue to shine a light on who's being left out and who's falling between the gaps for various reasons.

PENNY DUCKHAM: We have a question from Jeff Tully [misspelled]. Could the ACA basic health program help fill the Medicaid gap in states that are boycotting the expansion?

JENNIFER TOLBERT: Hi, this is Jennifer Tolbert again. Unfortunately no, the basic health plan won't help fill in the gap in coverage in states that aren't expanding Medicaid and that's because the basic health plan was designed where the marketplace is on top of the Medicaid expansion, so the only people who'd be eligible for basic health plan coverage is, in a state that chose that option, would be those with incomes between 138-percent of poverty and 200-percent of poverty. The idea of the basic health plan was to promote sort of continuity of coverage between Medicaid and the Medicaid expansion and the coverage through the marketplace by providing perhaps more affordable coverage for that population of people with incomes between 138 and 200, then they would find, even with the subsidies in the marketplace. Unfortunately, again, it's not a mechanism that would help fill in this coverage gap.

PENNY DUCKHAM: We're going to need to wrap this session up now. As you can see, there are all sorts of ways you could followup with questions if you feel we didn't answer them fully or you have followup questions.] Note the contact emails on the last slide.

Thank you very much for this conversation and I'm sure we will be coming back to it again in the not-too-distant future and we will, of course, have future sessions. If you have suggestions about topics we should try to address in these

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webinars, again these are exclusively for you, journalists, so please let us know, and thank you again.

[END RECORDING]

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