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STATE OF UNCERTAINTY: IMPLEMENTATION OF PPACA'S EXCHANGES AND MEDICAID EXPANSION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

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STATE OF UNCERTAINTY: IMPLEMENTATION OF PPACA'S EXCHANGES AND MEDICAID EXPANSION

THURSDAY, DECEMBER 13, 2012

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:05 a.m., in room 2123 of the Rayburn House Office Building, Hon. Michael Burgess (vice chairman of the subcommittee) presiding.

Members present: Representatives Burgess, Shimkus, Murphy, Blackburn, Gingrey, Latta, Lance, Cassidy, Guthrie, Griffith, Pallone, Dingell, Engel, Capps, Schakowsky, Baldwin, Matheson, DeGette, Christensen, Sarbanes, and Waxman (ex officio).

Staff present: Gary Andres, Staff Director; Matt Bravo, Professional Staff Member; Howard Cohen, Chief Health Counsel; Nancy Dunlap, Health Fellow; Paul Edattel, Professional Staff Member, Health; Julie Goon, Health Policy Advisor; Sean Hayes, Counsel, Oversight and Investigations; Robert Horne, Professional Staff Member, Health; Ryan Long, Chief Counsel, Health; Carly McWilliams, Legislative Clerk; Monica Popp, Professional Staff Member, Health; Andrew Powaleny, Deputy Press Secretary; Chris Sarley, Policy Coordinator, Environment and Economy; Heidi Stirrup, Health Policy Coordinator; Phil Barnett, Democratic Staff Director; Alli Corr, Democratic Policy Analyst; Ruth Katz, Democratic Chief Public Health Counsel; Purvee Kempf, Democratic Senior Counsel; Elizabeth Letter, Democratic Assistant Press Secretary; Karen Nelson, Democratic Deputy Committee Staff Director for Health; Anne Morris Reid, Democratic Professional Staff Member; and Matt Siegler, Democratic Counsel.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. I call the hearing to order, "The State of Uncertainty: The Implementation of the Patient Protection and Affordable Care Act's Exchanges and Medicaid Expansion." This hearing is under the jurisdiction of the Energy and Commerce Committee.

I do want to observe as we start, the chairman of the subcommittee, Mr. Pitts, is ill today and we all of course wish and pray for his speedy recovery, and I hope that is well underway and we look forward to his return here to join us in the Congress next week.

In the meantime, it has been 1,000 days since President Obama signed the Affordable Care Act into law. The Obama administration has not provided critical information to Members of Congress, to the States, or to the health plans that they need to begin implementing the health care law's exchanges. We know Medicaid expansion is going to happen but we don't know what it is going to look like. We know insurance market reforms are occurring but we are not sure about what is going to be expected of the plans themselves.

The President's law intends that the exchanges will be ready to begin enrollment by October 1st of next year. In less than 10 months the administration asserts they will have a fully functioning, technologically advanced system by which Americans will be able to enroll in an exchange. The administration has yet to explain how it will share information between the three different Federal agencies that are involved in determining eligibility for the exchange: Treasury, DHS and Health and Human Services. And further, the administration has yet to explain how it will distribute the income subsidies, the cash to the beneficiaries to allow them to purchase coverage in the exchange, or how a State will be able to afford the administrative costs to deal with eligibility changes.

While the administration has the ability to push back the dates of implementation for Federal provisions, the States and the plans that are required to meet statutory standards do not have that flexibility. It was not until last week that the administration released the proposed rules regarding the State health insurance exchanges and the essential health benefits. However, the latest proposed rules and the other 13,000 pages of rules that the administration has released on the Affordable Care Act fail to address the questions that the States and the policymakers have asked since the law was signed.

Medicaid accounts for a quarter of most State budgets. Governors cannot be expected to plan for major changes and have legislative authority to prepare unless the administration makes clear the basic ground rules. Many State legislatures only meet for a limited time each year, or in the case of my State, they only meet every other year, and that time will be quickly evaporated while they are awaiting instruction on these rules.

There is a lot to be sorted out between now and the end of the year in Congress in general but in this issue in particular. The uncertain regulatory environment and the overall lack of response from the Department of Health and Human Services is not encouraging to States or to health plans to move forward in cooperation with the agency. And let us be honest: time is running out and the future of our health care system, indeed, the future of the health of America's patients becomes more uncertain every day.

It is my hope that this hearing will bring light to the questions that the States and Congress have been asking of the administration for the past 2–1/2 years and provide the States with an opportunity to provide their perspective as they attempt to plan for the unknown effects of the Patient Protection and Affordable Care Act.

[The prepared statement of Mr. Burgess follows:]

Opening Statement of the Honorable Michael C. Burgess, M.D.
Subcommittee on Health
Hearing on "State of Uncertainty: Implementation of PPACA's Exchanges and Medicaid Expansion"
December 13, 2012

(As Prepared for Delivery)

It has been nearly 1,000 days since President Obama signed the Affordable Care Act into law. However, the Obama administration has still not provided critical information to Congress, the states, or the health plans that they need to begin implementing the health care law's exchanges, Medicaid expansion, or insurance market reforms.

The president's law intends that the exchanges will be ready to begin enrollment by September 30 of next year. In less than ten months the administration states they will have a fully-functioning, technologically-advanced system by which Americans will be able to enroll in an exchange. The administration has yet to explain how it will share information between three different federal agencies involved in determining eligibility for the exchange, how it will distribute the income subsidies to beneficiaries to purchase coverage in the exchange, or how a state will be able to afford the administrative costs to deal with eligibility changes.

While the administration has the ability to push back dates of implementation for federal provisions, states and the plans that are required to meet statutory standards do not have that luxury.

Medicaid accounts for a quarter of most state budgets. Governors cannot be expected to plan for major changes and have legislative authority to prepare unless the administration makes clear the basic ground rules.

There is a lot to be sorted out between now and the end of the year. The uncertain regulatory environment and the overall lack of response from HHS are not encouraging states or plans to move forward in cooperation with HHS. The time is running out. Meanwhile, the future of our health care system only becomes more uncertain.

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Mr. BURGESS. At this point I would like to yield the balance of the time to the Member from Louisiana, Dr. Cassidy.

OPENING STATEMENT OF HON. BILL CASSIDY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA

Mr. CASSIDY. Thank you, Dr. Burgess.

First, I would like to thank Mr. Greenstein from my own State for being here and all the other panelists, and I will tell you, I have multiple concerns about how this is being implemented but I will say it is principally today about how this is going to affect the average American family. There is a McKinsey quarterly report from February 2011 that suggests about 30 percent of employers will definitely or probably put their employees in the exchange. Now, when I speak to brokers, they tell me most people opt for the bronze level, which has a 60 percent actuarial value. Then I pull up this from ASBE, which is a government agency which I can't recall the acronym for, in which it shows that roughly 98 percent of these workers have actuarial values of 80 percent or more. We have got a law inducing that we put people into an exchange in which the actuarial value of their policy will decrease from 80 percent to 60 percent. I am not quite sure how this serves the average American family. And just to put this in perspective, we know that actuarial value has a $2,000 to $4,000 deductible and an out-of-pocket of $6,350 before it is completely paid for. Now, if we are trading 80 percent for 60 percent, I don't see the value for the American worker, and I would love to discuss today how all this was determined.

I yield back. Thank you.

Mr. BURGESS. The gentleman yields back his time. The Chair now recognizes the ranking member of the subcommittee, Mr. Pallone of New Jersey, 5 minutes for your opening statement, sir.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Doctor, or I guess I should say Chairman Burgess. Thank you. You like doctor better? Polls better? OK.

Let me start out by saying that I am beginning to learn the Republican playbook on the Affordable Care Act. First they spent a year and a half holding repeal votes, and when that didn't work, they advocated that the Supreme Court would most certainly reverse the law, and of course, that didn't happen, and finally they crossed their fingers and hoped that the President would lose the election, and when all else failed, their next move now is to delay implementation under the guise of lack of information.

I want to stress that the President won the election. Implementation is going to move forward and the landmark health care law will continue to have a positive effect on millions of people's lives, and I just hope that I will be here one day when the Republicans finally realize that we did the right thing, the world is not coming to an end, and in fact, the Nation will be better because of the Affordable Care Act.

Now, I wanted to clear some things up for the record. One of the critical goals of the Affordable Care Act was to improve access to

health care for millions of uninsured and underinsured Americans because a healthy nation is a successful nation, and it simply is immoral to allow our fellow Americans to suffer because they can't access health insurance. A key feature to accomplish that was expanded Medicaid to help cover millions of low-income Americans, and when the Supreme Court allowed States to choose whether or not to accept the Medicaid expansion provision, Republican governors became nothing but openly hostile. But there is no question that accepting the Medicaid expansion is a good deal for States because it is a boon to the States' uninsured and its taxpayers. Today we are going to hear from both Maryland and Arkansas, two very different States, about their own cost-benefit analysis that proved this point with dramatic facts and figures.

Another critical piece of the ACA is the creation of health insurance exchanges, which beginning in 2014 will provide a stronger marketplace that provides coverage options for millions of Americans, and plenty of States have forged ahead with implementation of their State-based or partnership exchanges. Now, those States that have not are simply using HHS's regulation as an easy excuse. In fact, yesterday experts consulting with States on exchange development insisted that there is enough information and time to build an exchange. Meanwhile, as we will hear today from the director of CCIIO, the administration has been steadily working with States, providing flexibility, guidance and resources.

Now, a lot more work needs to be done, and I recognize that challenges do exist, but implementation of the Affordable Care Act puts this Nation on a path to better health, and we must not allow States to continue to play politics, which is what some are doing. I expect a lively discussion today, so I appreciate the witnesses' participation.

I did want to yield initially to the gentleman from Michigan, Chairman Dingell.

OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. DINGELL. I thank my good friend, and I commend you, Mr. Chairman, for holding this hearing today.

In my entire career, I have fought to secure the affordable, quality health care our citizens deserve and need. The passage of the Affordable Care Act by the House and Senate, ratification by the President and subsequent upholding of the law by the Supreme Court brought to fruition a dream that began with my father long before me.

The health insurance exchanges and Medicaid expansion are two fundamental provisions of ACA that will achieve our goal of providing affordable health care of high quality to every American. Through the exchange, patients and small businesses will be able to easily opt for a health plan that best suits their needs, and the Medicaid expansion will provide millions of uninsured Americans will access to our Nation's world-class health care system which heretofore has lacked the means of paying for it. Therefore, it is critical that we get them right, and I hope that this hearing will enable us to do so.

Mr. BURGESS. The gentleman yields back. The Chair now recognizes the gentleman from Georgia, Dr. Gingrey, for the purpose of an opening statement.

OPENING STATEMENT OF HON. PHIL GINGREY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. GINGREY. Mr. Chairman, I thank you.

What the distinguished Member from Michigan didn't say was that the Obamacare bill will cost $1.7 trillion and result in increased costs of health care, and it does not bring it down. So I find it remarkable, frankly, that 33 months after the passage of this bill, PPACA, a hearing like this is even necessary. We have States including my own of Georgia still looking for direction from HHS on provisions that come into effect within the next year. This type of uncertainty makes it impossible for such States to successfully budget for the future. What is more, State officials are left with no good options as HHS imposes arbitrary deadlines on them in regard to creation of the exchanges. That is why our State of Georgia, our Governor Deal, who served on this committee and indeed was chairman of this Health Subcommittee, has rejected the idea of the State of Georgia setting up its own exchange because the restrictions or handcuffs that are put on the States by HHS just almost make it prohibitive. And the same thing in regard to Medicaid expansion. Our State has taken the option, and again, I think Governor Deal is correct in doing this, in not expanding Medicaid because of the bottom-line cost to the State over an extended period of time.

Unfortunately, this hearing today is very much needed. I hope that we are able to find some real answers from CMS which allow States to indeed plan for the future.

And with that, Mr. Chairman, if there is anyone on our side that would like to have time yielded, I will be happy to do that. Otherwise I will yield the balance back.

Mr. BURGESS. Seeing none, the gentleman yields back. The Chair recognizes the ranking member of the full committee, the Honorable Mr. Waxman of California, for purposes of an opening statement.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you, Mr. Chairman.

In March of 2010, after decades of trying, Congress finally passed landmark legislation that extends access to affordable, quality health insurance to all Americans, and since then, the law has already provided remarkable benefits for American families. It has allowed over 6 million young adults to stay on their parents' insurance. It has extended a lifeline in the form of the preexisting coverage insurance plan to over 90,000 people. It has lowered prescription drug costs for 5.5 million seniors and people with disabilities. It has given 86 million people in the private market and in Medicare access to preventive health benefits at no cost. And it has eliminated lifetime insurance company limits on coverage for 105

million individuals. That is an outstanding beginning. And now we stand on the threshold of full implementation.

Despite the law's many benefits, it has faced united opposition from the Republican Party since the day it was passed. There have been over 30 votes to repeal this law. There have been numerous court challenges to the law. There are States that have steadfastly refused to move forward to assure smooth and effective implementation.

Yet none of these efforts have been successful. The House votes proved to be partisan political posturing. And the Supreme Court declared the law constitutional. Let us be clear: the Affordable Care Act is the law of the land. We should all be united in seeing that its implementation works.

As we will hear today, HHS and CMS have done their job. They have provided a constant stream of assistance and information to those taking steps to make this law their own.

For Some States, no information will ever be enough. And that is the tragedy of politicizing a law that will benefit so many Americans.

But other States are acting responsibly. Two of those States are here today. And there are many others. Just this week, for example, Nevada's Republican Governor announced that Nevada will move forward with the Medicaid expansion. The Republican Governor of Idaho said the State will set up a State-based exchange.

I welcome and look forward to hearing from all of our witnesses. I am particularly interested in testimony from Dr. Sharfstein from Maryland and Mr. Allison from Arkansas on what they have been able to accomplish with regard to the ACA expansions. And I would also like to thank Mr. Cohen and Ms. Mann for their work, the work they have already done and the work we expect from them in the future.

The Affordable Care Act is a solid law that will improve our Nation's health and health system for decades to come. Let us move forward and work together to implement it efficiently and effectively. Why do we have to have this political fight over and over again? We have a law that is doing good already. It is going to do so much more if we make it work effectively, and it is time to stop the fighting about it and work together.

I would like to now yield the rest of my time to Representative Baldwin from Wisconsin.

OPENING STATEMENT OF HON. TAMMY BALDWIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Ms. BALDWIN. Thank you, Mr. Waxman, and thank you to our chairman and Ranking Member Pallone as well as all of my colleagues on this subcommittee. I want to appreciate your dedication to health care issues, and it has been an honor serving with you in the House of Representatives.

On the topic before us today, the Affordable Care Act is the law of the land, and it is now time for all of us to come together and put politics aside and make American's new health law work for the American people. And that includes expanding health care coverage through Medicaid to those who need it most, and that in-

cludes creating health insurance exchanges that will provide individuals and small businesses with quality, affordable insurance options. If we all do our part, access to affordable health care will be within reach for all Americans and small businesses, strengthening their economic security.

To that end, I am pleased to be in the same room today with leaders who are integral to implementing the Affordable Care Act. Our esteemed witnesses from HHS and State officials are making decisions that impact the lives of citizens, citizens who deserve to have us put progress ahead of politics, and I ask that in our discussions today, we keep those Americans in mind.

I look forward to your testimony, and thank you for being here, and yield back.

Mr. BURGESS. An observation from a Member of this side of the dais is, you are already starting to sound like a Senator and you filibustered a little long, but notice the Chair was very preferential and let you go. I hope the courtesy will be reciprocated when you are in the august higher house. The gentlelady's time is expired.

I do want to welcome our witnesses here today and make the observation that there will be a vote on the floor at some point. We generally allow 5 minutes for an opening statement, generally try to be pretty flexible with that. This morning I am going to ask if you would try to stay within the confines of that time so that when votes come, we perhaps could have gotten through the entire panel. We have a single panel today but it is a large one but it is a very distinguished one.

Our first witness will be Mr. Gary Cohen, who is the Director for the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services, United States Department of Health and Human Services. We are also joined this morning by Ms. Cindy Mann, who is the Deputy Administrator and Director for the Center for Medicaid and CHIP Services within the Centers for Medicare and Medicaid Services. I am very grateful to acknowledge the presence of Mr. Dennis Smith, who is the Secretary of Department of Health Services, State of Wisconsin. We are also joined this morning by Mr. Greenstein, Secretary, Department of Health and Hospitals for the State of Louisiana. Mr. Gary Alexander, who is the Secretary of the Department of Public Welfare, the Commonwealth of Pennsylvania, Dr. Joshua Sharfstein, the Office of Secretary, very familiar to this committee from his time at the FDA, now works at the Department of Health and Mental Hygiene in the State of Maryland. We are also very fortunate to have Dr. Andrew Allison, the Director of the Division of Medical Services in the Department of Human Services for the State of Arkansas.

Mr. Cohen, sir, we will begin with you, 5 minutes for your opening statement, sir.

STATEMENTS OF GARY COHEN, DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES; CYNTHIA MANN, DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR MEDICAID AND CHIP SERVICES, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES; DENNIS G. SMITH, SECRETARY, DEPARTMENT OF HEALTH SERVICES, STATE OF WISCONSIN; BRUCE D. GREENSTEIN, SECRETARY, DEPARTMENT OF HEALTH AND HOSPITALS, STATE OF LOUISIANA; GARY D. ALEXANDER, SECRETARY, DEPARTMENT OF PUBLIC WELFARE, COMMONWEALTH OF PENNSYLVANIA; JOSHUA M. SHARFSTEIN, SECRETARY, DEPARTMENT OF HEALTH AND MENTAL HYGIENE, STATE OF MARYLAND; AND ANDREW ALLISON, DIRECTOR, DIVISION OF MEDICAL SERVICES, DEPARTMENT OF HEALTH SERVICES, STATE OF ARKANSAS

STATEMENT OF GARY COHEN

Mr. COHEN. Thank you, Chairman Burgess, Ranking Member Pallone and the members of the Health Subcommittee for having me here today to speak about implementation of the Affordable Insurance Exchanges.

I have the privilege of serving as Director of the Center for Consumer Information and Insurance Oversight in the Centers for Medicare and Medicaid Services. I oversee Federal implementation of the exchanges as well as many of the provisions of the Affordable Care Act that are working to ensure more Americans have access to affordable, quality health insurance.

I am confident that States and the Federal Government will be ready in 10 months when consumers in all States can begin to apply for quality, private health insurance through the Affordable Insurance Exchanges. Whether a State chooses to run its own exchange, partners with CMS or defers to the federal government to operate an exchange, consumers and small employers in every State and the District of Columbia will be able to shop for, select and enroll in high-quality, affordable health insurance beginning on October 1, 2013.

This is a groundbreaking time for health care in our country. Many families will have health insurance for the first time, and many people who lost their insurance when they changed jobs or became sick will again have the security of knowing that their health care needs will be met.

I know States are ready because they have the information and resources they need to decide whether to establish their own exchange or whether they need the federal government, at least at first, to take on some of the responsibilities of operating the exchange in their State. States that want to move forward are moving forward. For example, on Monday we announced that six States have already made enough progress in setting up their own exchanges that we have conditionally approved their plans.

While there is more work to do before open enrollment in October, these six States, including Maryland, which one of my fellow

panelists is representing, have shown that they are on track to meet all exchange deadlines.

We are pleased that many States are taking leadership roles and implemented exchanges in their States. That is what the Affordable Care Act envisioned: States taking the lead. We will make more announcements about State progress in the weeks and months to come. We hope every State will take an active role in operating its exchange.

Since the enactment of the Affordable Care Act, we have been working hard with States to prepare for the day when exchanges will be open for business. We began issuing guidance for the States about the exchanges over 2 years ago in November of 2010. Since then, we have released regulations, guidance and fact sheets including a final establishment rule and the essential health benefits proposed rule as well as detailed IT information about the specific processes for implementing exchanges. My office has been in contact with States every day in order to provide technical assistance and answer questions. We have held hundreds of hours of webinars, teleconferences and meetings at which thousands of State workers have participated. And States are helping each other as well, sharing many tools and documents with other States to help each other get the job done.

In addition to guidance and hands-on assistance, we have been working to ensure that States have the resources they need starting with Exchange Planning Grants and progressing on to Establishment Grants. States that were eager to move forward to establish an exchange could qualify for an Early Innovator Grant as early as October 2010 and the general funding for exchange implementation has been available since January of 2011.

To date, 34 States and the District of Columbia have received about $2.1 billion in grants to fund their process and building their exchanges. These grants are available through 2014 to help States build exchanges or fund first-year start-up activities. In addition, States that choose to partner with the federal government to build their exchange may receive these grants to establish State functions that are performed in support of the federally facilitated exchange.

Many States including the six we conditionally approved earlier this week are moving forward, and we are working to support them. At the same time, we are working with States that want to partner with us by taking on some of the key responsibilities of operating an exchange, and we will be ready to operate a federally facilitated exchange in States that choose not to pursue a State-based or partnership exchange at this time. If a State elects to have a federally facilitated exchange at first, it is not a permanent choice. States may choose to operate a partnership exchange or State-based exchange in 2015 or beyond.

Now, in operating the federally facilitated exchange, it is our goal to preserve the traditional State role as insurance regulator and not to duplicate State regulatory activity while also providing help for consumers based on where they live who have questions while selecting or enrolling in a health plan in their State's exchange.

We have made significant progress in developing the IT systems needed for the federally facilitated exchange including systems for

determination of eligibility for tax credits, enrollment in health plans and operation of the reinsurance, risk adjustment and risk corridor programs, which will help keep coverage affordable. We are now beginning to test these services so we can ensure they will be up and running in 10 months.

Since the federally facilitated exchange will need to interact with State Medicaid and CHIP agencies, we have been working with States on the technical details of those interactions and have held webinars with all States on these issues. States that defer to a federally facilitated exchange will not have to pay for Federal operating costs, and those States can apply for Federal funding for any State functions that they perform in support of the federally facilitated exchange.

This hard work, both in CMS and in the States, is beginning to pay off. As I said, six States have already demonstrated their readiness to stand up and operate exchanges. My office stands ready to aid any other States who would also like to move forward in establishing exchanges to offer affordable, accessible, quality private health insurance for their citizens.

Thank you.

[The prepared statement of Mr. Cohen follows Ms. Mann's testimony.]

Mr. BURGESS. Thank you. The gentleman's time is expired.

Ms. Mann, you are recognized for 5 minutes for the purposes of an opening statement.

STATEMENT OF CYNTHIA MANN

Ms. MANN. Thank you, Chairman Burgess, Ranking Member Pallone and members of the subcommittee, for the opportunity to testify today.

For Medicaid, the implementation of the Affordable Care Act is occurring in the context of an existing program that is undergoing rapid change. Change is being driven by the broader transformation in the private health care marketplace by States that are focused on changing the way that care is delivered and paid for and by Federal action, both legislative action and administrative action. We at CMS have a clear focus on helping State Medicaid programs improve care delivery and reduce cost through those improvements. There is no one-size-fits-all model. Medicaid's flexibility and the fact that it is run by 56 different jurisdictions assure that innovation is unfolding in different ways across the country.

With this backdrop, let me turn to the initiatives that are underway to promote timely implementation of the Affordable Care Act and the Medicaid provisions in that Act. People are often surprised to learn that Medicaid does not already cover all low-income people. Its coverage of children and pregnant women is robust, and most of its spending is devoted to care provided to the elderly and people with disabilities but millions of low-income parents are not eligible for Medicaid, and before the new law, other adults weren't eligible at any income level except through a waiver. The Affordable Care Act filled this gap and helps to establish a simplified, coordinated system of coverage. It does so by establishing one application, one set of eligibility rules that will apply to the Medicaid program, to the Children's Health Insurance Program and to sub-

sidies available on the exchange in the form of the premium tax credit, and by having a coordinated system for determining eligibility. Consumers will be able to apply, be found eligible for the appropriate program and enroll in a health plan without delay, but as we all know, much work is needed to implement these changes, and for States to be successful, they do need guidance and support from CMS. We have been working aggressively to provide that guidance and support.

In April of 2011, we released a final rule that increased the support we provide for the development and operation of State Medicaid eligibility systems. Forty-eight States and the District of Columbia have received approval for that funding. In March 2012, we issued a final regulation covering all of the major new income rules effective in the Medicaid and CHIP program that will be effective in 2014, and we did that regulation at the same time that my colleagues in CCIIO issued their income rules so that States would have the full array of rules available at the same time as they moved forward to implement. This fall we released comments for the elements of the new application and we are continuing to consult with States and others as we finalize that application. We have issued guidance on the data services hub and ways in which State Medicaid and CHIP programs will interface with the hub as well as with the federally facilitated exchange as applicable in a given State. And last month, we issued guidance on the flexibility States have to construct their Medicaid benefit package that will be available to newly eligible adults.

In addition to this guidance, we have been creating and sharing tools that help States move forward. We have shared, for example, a verification plan with States so that they can help construct their verification rules in the way that they design them to be consistent with our overall regulations. We have sent to each State the net income standards and disregards that will be applicable in their States and that will need to be converted to the new rules.

Throughout the years, we have had a particular focus on helping States accelerate their system builds to save time and resources. Through various venues, we are making our development products available to States and facilitated States sharing their system artifacts with each other, with CMS making direct links depending upon a State's design objective and the vendors that they are using. Complementing these efforts, we have conducted more than 20 webinars with States on 2014 implementation and established a State operational technical assistance team for each State, which consists of a multidisciplinary team of CMS experts on systems, eligibility, benefits and outreach, so each State has one-stop shopping in terms of answering the questions that they individually and uniquely have. Since this summer, we have conducted 200 calls with States.

It is important to say that the guidance and tools we have made available, and will continue to make available, have been created with substantial assistance from States themselves. We have numerous State work groups and learning collaboratives on a wide variety of topics. The vast majority of States, though not every State, has participated in one or more of these work groups. We think States have gotten the value from these work groups. We

know we have, and we appreciate their assistance and contribution.

The Supreme Court's decision did not alter the importance of any of this work. The decision left intact the provisions of the law other than the penalty provision relating to the new adult coverage. What the Court did was to make the decision to take up the Medicaid coverage expansion for low-income adults voluntary with each State. States are considering this important question. Soon after the Court's decision, Secretary Sebelius wrote to the governors to say there was no deadline for when a State had to make the decision and that the Court's ruling left fully intact the very significant Federal financial support available for that expansion. In a second letter, we confirmed to States that not only did they have the decision to decide when to come in and if to come in, but if they did decide to adopt the expansion, they could later drop it, and we also noted that the enhanced Federal funding for systems modernization would remain available to States without regard to whether a State decides to expand coverage.

In mid-November, we issued further questions and answers, and on December 10th, we issued a comprehensive set of Q's and A's on a range of exchange and Medicaid matters. The releases continue as does the ongoing intensive technical assistance and support. Many States have been able to take the guidance, the tools, the technical support we are providing and move forward. This is a big job, and we are very much appreciative of all that needs to get done at the State level.

Let me assure you that we are eager to work with every single State no matter what their current stage of development may be, and I join Gary Cohen in saying that we are confident that every State can be ready in time for open enrollment on October 1st.

Thank you.

[The prepared statement of Mr. Cohen and Ms. Mann follows:]

STATEMENT OF

GARY COHEN, J.D.

DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT,
CENTERS FOR MEDICARE & MEDICAID SERVICES

AND

CYNTHIA MANN, J.D.

DEPUTY ADMINISTRATOR AND DIRECTOR
CENTER FOR MEDICAID & CHIP SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

ON
"IMPLEMENTATION OF THE AFFORDABLE CARE ACT'S EXCHANGES AND MEDICAID EXPANSION"
BEFORE THE

U. S. HOUSE OF REPRESENTATIVES COMMITTEE ON ENERGY & COMMERCE,
SUBCOMMITTEE ON HEALTH

DECEMBER 13, 2012

U.S. House of Representatives Committee on Energy & Commerce
Subcommittee on Health
"Implementation of the Affordable Care Act's Exchanges and Medicaid Expansion"
December 13, 2012

Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee, thank you for your interest in the recent efforts of the Centers for Medicare & Medicaid Services (CMS) to implement the Affordable Care Act. The Affordable Care Act ensures that American families will get the health care they need and protects Americans from the worst insurance company abuses. CMS is focused on strengthening the private health insurance market in order to make coverage more available, affordable, and accountable to Americans. Our work continues towards 2014 with the implementation of the Affordable Insurance Exchanges along with Medicaid's streamlined modernization and eligibility expansion. CMS has been steadily working with States, issuing guidance and providing technical assistance, as well as building Exchange infrastructure and initiating the many information technology (IT) and business activities needed to assure readiness for Exchange open enrollment beginning October 1, 2013.

Improving Private Health Insurance

Since enactment, CMS has worked to put into place the strong consumer protections that provide new coverage options and give consumers the tools needed to make informed choices about their health care included in the Affordable Care Act. These provisions allow for a stronger health insurance marketplace, and begin the transition to additional market reforms and the Affordable Insurance Exchanges to begin in 2014.

Increasing Private Health Insurance Options

The Affordable Care Act is strengthening the private health insurance market by making affordable, high-quality coverage accessible to millions of Americans. Because of important reforms in the Affordable Care Act, many young adults under 26 can now be covered under their parents' plans, people with costly pre-existing conditions are able to find health coverage, and health insurance companies are prohibited from denying children coverage on the basis of their

pre-existing conditions. The Affordable Care Act has helped 6.6 million young adults stay on their parents' plans until the age of 26, including 3.1 million young adults who are newly insured. The Pre-Existing Conditions Insurance Plan (PCIP) is helping over 90,000 Americans with pre-existing medical conditions access critical health care services. The Early Retiree Reinsurance Program (ERRP) has provided reinsurance payment support to more than 2,800 employers and other sponsors of retiree plans to help over 19 million individuals in plans that have received support.

Strengthening Private Health Insurance Protections

In addition to helping more people access private health insurance coverage, CMS is working to ensure private health insurance is working better for consumers. During the past two years, CMS has implemented important private health insurance reforms included in the health care law that are providing new rights and benefits to put consumers in charge of their health care. Specifically:

- Insurance companies cannot drop or rescind people's coverage because they made an unintentional mistake on their application, place lifetime limits on the dollar value of essential health benefits, or impose an annual dollar limit on essential health benefits of less than $2 million; and within 2014 they will no longer be able to place any annual dollar limits on essential health benefits.
- An estimated 54 million insured Americans are receiving expanded and lower-cost coverage of recommended preventive services, and have a new rights to appeal decisions made by their insurance company not to pay for medical care to an independent third party and to use the nearest emergency room without higher cost-sharing, regardless of whether it is in their plan's network.
- Health insurers and group health plans are required to provide a clear summary of benefits and coverage in a uniform format that can easily be compared by the millions of Americans shopping for private health coverage. If people are looking to buy private health insurance now, they also can compare plans at www.HealthCare.gov, which provides information about what health insurance coverage is available to consumers based on where they live.

Making Private Health Insurance Coverage More Affordable

The Affordable Care Act helps make coverage more affordable by providing States with resources to improve their review of proposed health insurance rate increases and by holding insurance companies accountable for increases in premium rates. The law strengthens States' rate review activities by providing $250 million in resources to build and upgrade States' premium rate review infrastructures, hire new staff, and improve the availability of rate review information to consumers. CMS has awarded $160 million to date and plans to continue to award grants to States to strengthen their rate review programs. Insurers in all States are now required to provide a justification for any rate increase of 10 percent or more, and all of those increases are reviewed by independent experts, who determine whether they are unreasonable. Additionally, the medical loss ratio (MLR) provision generally requires that insurance companies use at least 80 or 85 percent of premium revenue, depending on the market, to either provide or improve the quality of health care for their customers. Insurance companies that did not meet the MLR rule provided approximately 13 million Americans with more than $1.1 billion in rebates this year. By holding insurance companies accountable, together, rate review and the Affordable Care Act's MLR policy (or 80/20 rule) have yielded an estimated $2.1 billion in savings to consumers in one year.

Moving Private Health Insurance Forward

We are continuing our progress towards 2014 by releasing new rules, guidance, and grants to help shape a consumer-friendly insurance marketplace and prepare the insurance market for the implementation of the Exchanges. For example, on November 30, 2012, the Department released the proposed 2014 Notice of Payment Parameters which, when finalized, implements many of the key features of the premium stabilization programs along with additional guidance on the advance payments of the premium tax credit and cost-sharing reductions. Also in November of 2012, CMS issued proposed rules to implement Affordable Care Act provisions that would make it illegal for insurance companies to discriminate against people with pre-existing conditions, would make it easier for consumers to compare health plans based on the essential health benefits provided, and would promote and encourage employee wellness. Over the last two years, CMS has worked hard to prepare for the implementation of the Exchanges,

including publishing regulations that define the eligibility and enrollment processes for the Exchanges and Medicaid program, and providing financial and technical support for States establishing their Exchanges and Medicaid enrollment IT systems.

Guaranteeing Availability of Coverage and Fair Premiums

The newly proposed rules include health insurance market reforms (CMS-9972-P)[1] that would prohibit health insurance companies from discriminating against individuals because of a pre-existing or chronic condition, beginning in 2014. Under this rule, insurance companies would be allowed to vary premiums based only on age, tobacco use, family size, and geography, and only within a certain range for each factor. In addition, health insurance companies would be prohibited from denying coverage to any American because of a pre-existing condition or from charging higher premiums to certain enrollees because of their current or past health problems, gender, occupation, and small employer size or industry. These provisions guarantee the availability and renewability of coverage, as well as ensuring Americans receive fair health insurance premiums.

Additionally, the rule proposes that health insurance issuers maintain a single statewide risk pool for each of their individual and small employer markets, unless a State chooses to merge the individual and small group pools into one pool. This provision directs that the cost of health insurance is spread across all of an issuer's enrollees in the market, without regard to their health status. The proposed rule would also ensure that young adults and people for whom coverage could otherwise be unaffordable have access to a catastrophic plan in the individual market.

Stabilizing Premiums

The proposed Notice of Benefit and Payment Parameters for 2014[2] expands upon the standards set forth in the Premium Stabilization and Exchange final rules, and provides further information on risk adjustment, reinsurance and risk corridors programs, advance payments of the premium tax credit, and cost-sharing reductions. These programs are designed to reduce issuer incentives

[1] Health Insurance Market Rules: file:///C:/Users/M62Q/Downloads/CMS-2012-0141-0001.htm
[2] 2014 Payment Notice: http://www.ofr.gov/OFRUpload/OFRData/2012-29184_PI.pdf

to avoid sicker Americans, lower premiums in the individual and small group markets, protect against uncertain rate setting, and make insurance more affordable.

Providing Essential Health Benefits

The Essential Health Benefits proposed rule[3] (CMS-9980-P) outlines policies and standards for coverage of essential health benefits, while giving States flexibility to implement this provision of the health care law. States would have the flexibility to select a benchmark plan that reflects the scope of services offered by a "typical employer plan." This approach would give States the flexibility to select a plan that would best meet the needs of their citizens. If States choose not to select a benchmark, HHS proposes that the default benchmark will be the small group plan with the largest enrollment in the State. These plans are available for public comment.

Beginning in 2014, non-grandfathered health plans in the individual and small group markets must meet certain actuarial values, or the percentage of total average costs for covered benefits that a plan will cover. The actuarial values to meet are 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan. To streamline and standardize the calculation of actuarial values for health insurance issuers, the rules proposes a publicly available actuarial value calculator provided by CMS, which issuers can use to determine health plan actuarial values, based on a national, standard population. This approach provides consumers with the ability to more transparently compare plans available in the new marketplace in 2014.

Under the Essential Health Benefits proposed rule, beginning in 2015, CMS will accept state-specific claims data sets for the standard population if States choose to submit alternate data for the calculator. The proposed rule includes standards and considerations for plans with benefit designs that the actuarial value calculator cannot easily accommodate. Recognizing that simply calculating the actuarial value of a high-deductible health plan based on the insurance plan alone could understate the value of the coverage, CMS proposed that employer contributions to health savings accounts and amounts newly made available under health reimbursement accounts

[3] Essential Health Benefits: http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/html/2012-28362.htm

should count within the plan design. The proposed actuarial value calculator is posted on the Center for Consumer Information and Insurance Oversight website.[4]

CMS also provided guidance to State Medicaid programs outlining how existing Alternative Benefit Plans in Medicaid can meet the standards of the Essential Health Benefits provision. The guidance clarifies the policy which allows States to use commercial plans as their benchmarks for Medicaid benefits for the population of adults who will be newly eligible in 2014. In addition, the guidance offers flexibility on how States can design, define, and target benefit plans to meet the needs of their Medicaid population.

Encouraging Wellness

The Wellness proposed rule[5] (CMS-9979-P), jointly released by the Departments of Health and Human Services, Labor, and the Treasury, implements and expands policies to promote employment-based wellness programs that improve health and help control health care spending, while also ensuring that individuals are protected from unfair underwriting practices that could otherwise reduce benefits based on health status.

These three newly proposed rules are shaping the marketplace Americans use to obtain insurance in the individual and small group markets, both inside and outside the Exchanges. By establishing these rules for insurers, we are preparing important stakeholders for the law's full implementation in 2014.

Providing More Choices

The Affordable Care Act also creates a new type of nonprofit health insurer, called Consumer Operated and Oriented Plans (CO-OPs). The CO-OP program offers low-interest loans to eligible private, nonprofit groups to help establish and maintain new health plans. CO-OPs are directed by their customers and designed to offer individuals and small businesses additional affordable, consumer-friendly, high-quality health insurance options. Starting January 1, 2014, CO-OPs will offer health plans through Exchanges, and they may also offer health plans outside

[4] Actuarial Value Calculator: http://cciio.cms.gov/resources/regulations/index.html#pm
[5] Wellness: http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/html/2012-28361.htm

of an Exchange. To date, a total of 23 non-profits offering coverage in 23 States have been awarded loans for start-up and solvency requirements.

Establishing the Affordable Insurance Exchanges

CMS is continuing to work with States to implement Affordable Insurance Exchanges which, beginning in 2014, will provide improved access to insurance coverage choices for millions of Americans. The Congressional Budget Office has estimated that between 25 and 26 million people will ultimately receive coverage through the new Exchanges. Individuals will be able to access high-quality, affordable health insurance plan options through the Exchange market. This will be particularly helpful for consumers when they do not receive health benefits coverage through their employers. We expect the robust employer-sponsored insurance market to continue, with the additional protections and benefits described earlier that make private insurance fair and affordable for consumers.

Exchanges will make purchasing private health insurance easier by providing eligible individuals and small businesses with one-stop shopping where they can choose qualified health plans that best fit their needs.[6] New premium tax credits and cost-sharing reductions will help ensure that eligible individuals and families can afford to pay for the cost of a private qualified health plan purchased through the Exchanges.

The planning, development, and testing necessary to build the Exchanges is well underway. CMS has been diligently working with States through Exchange Planning and Establishment Grants to support their infrastructure. To date, 34 States and the District of Columbia have received approximately $1.8 billion in Exchange Establishment Level One and Level Two cooperative agreements to fund their progress toward building Exchanges. CMS also issued

[6] Essential health benefits must include items and services within at least 10 categories -- ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

guidance[7] to help States understand the full scope of activities that can be funded under the available grant funding as they work to build Exchanges.

CMS has encouraged States to establish their own Exchanges, and we have worked to provide States with the flexibility, guidance, regulations, and resources they need to do so. States are making progress towards establishing their own Exchanges. To date, HHS has received 35 letters from States in regards to the Declaration of an Exchange. Fifteen Declaration Letters have been received for State-Based Exchanges,[8] four declaring a State partnership Exchange,[9] and seven choosing to participate in a Federally-facilitated Exchange.[10] We have conditionally approved six State-Based Exchanges for 2014, and have received Blueprints from several more States.

The Exchange Final Rule, released on March 12, 2012 (CMS-9989-F),[11] offers a framework to assist States in setting up their Exchanges. It allows States to decide whether their Exchanges should be operated by a non-profit organization or a public agency, how to select and certify plans to participate, and whether to work with HHS on some key functions. The rule offers significant additional flexibility regarding eligibility determinations for Exchanges and insurance affordability programs. It also lays out standards for small businesses to get qualified health plan coverage through the Small Business Health Options Program (SHOP). Through the SHOP, employers can offer employees a variety of qualified health plans, and their employees can choose the plans that fit their needs and their budget.

HHS will operate a Federally-Facilitated Exchange in each of those States that do not establish a State-Based Exchange to ensure that residents of every State have access to the affordable health insurance offered through Exchanges in 2014. All Exchanges will open for enrollment in October 2013. The Federally-Facilitated Exchanges will operate in any State that chooses to

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[7] Exchange Establishment Cooperative Agreement Funding FAQs: http://cciio.cms.gov/resources/factsheets/hie-est-grant-faq-06292012.html
[8] State-Based Exchanges: California, District of Columbia, Hawaii, Vermont, Mississippi, Colorado, Connecticut, Kentucky, Maryland, Minnesota, New York, Oregon, Rhode Island, and Washington
[9] State partnership Exchange: Delaware, Illinois, Iowa, and North Carolina
[10] Federally-Facilitated Exchange: Alabama, Alaska, Arizona, Nebraska, Oklahoma, Texas, and Wisconsin
[11] Exchange Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf

utilize this model on a temporary or permanent basis. On May 16, 2012[12] and November 30, 2012,[13] CMS released guidance describing our approach to implementing a Federally-Facilitated Exchange. We will provide consumer support to help purchasers of health insurance determine eligibility and apply for a qualified health plan. For example, we are building a website with interactive capabilities and a call center. Consumers will be able to use this to compare qualified health plans, check their eligibility for affordability programs, and enroll in a qualified health plan.

CMS is building a tool called the data services hub to help with verifying applicant information used to determine eligibility for enrollment in qualified health plans and insurance affordability programs for all types of Exchanges, as well as for Medicaid and CHIP. CMS has completed the technical design and reference architecture for this work, and is establishing a cross-agency security framework and protocols, and has begun testing the hub. CMS is also establishing a system to determine consumer eligibility and a mechanism for eligible consumers to enroll in a qualified health plan. CMS has already released the elements of a streamlined, consumer-focused application that consumers applying for any insurance affordability program in all States that choose to use it will complete starting in the fall of 2013.[14] The application will help individuals and families identify various insurance affordability programs such as advanced payment of premium tax credits for Exchanges or Medicaid that may be available to help them get and pay for health insurance.

CMS has also released an Exchange Blueprint,[15] which sets forth the approval process for State-Based Affordable Insurance Exchanges. If a State chooses to operate its own Exchange, CMS will review and potentially approve or conditionally approve the State-Based Exchange no later than the statutory deadline of January 1, 2013. The Blueprint also sets forth the application process for States seeking to enter into a State Partnership Exchange in which the State will

[12] Federally-Facilitated Exchange Guidance: http://cciio.cms.gov/resources/files/ffe-guidance-05-16-2012.pdf
[13] Federally-Facilitated Exchange Guidance: http://cciio.cms.gov/resources/files/Files2/FFE%20Progress%20fact%20sheet.pdf)?
[14] Application Elements: http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10440.html
[15] Blueprint for Approval of Affordable State-Based and State Partnership Insurance Exchanges: hhttp://cciio.cms.gov/resources/files/hie-blueprint-11092012.pdf

operate the plan management or consumer assistance functions of the Exchange, or both. States may apply to operate a State Partnership Exchange by February 15, 2013. If a State decides not to operate an Exchange for its residents, CMS will operate a Federally-Facilitated Exchange in that State. CMS will consult with a variety of stakeholders to implement Federally-Facilitated Exchanges in those States. A State may apply at any time to run an Exchange in future years.

We are committed to providing States with the flexibility, resources, and time they need to deliver the benefits of the Affordable Care Act. On December 10, 2012, CMS issued Frequently Asked Questions[16] to respond to questions that we have received from States to ensure that States have all of the information they need to make their decisions. We will continue to provide additional guidance about the Exchanges as needed, and we will do everything possible to answer specific State questions on an one-on-one basis and provide technical assistance to States and stakeholders.

Moving Medicaid Forward

The Medicaid program provides care for more than 56 million Americans, and plays an important role in providing coverage for low-income children, pregnant women, people with disabilities and seniors needing long term care services and supports. Under the Affordable Care Act, Medicaid eligibility for adult coverage will be simplified and it will cover millions of low-income people who are uninsured today. Because Medicaid is jointly funded by States and the Federal government, and is administered by States, we both have key roles as responsible stewards of the program. Under the Medicaid Federal-State partnership, the Federal government sets forth a policy framework for the program and States have significant flexibility to choose options that enable them to deliver quality, cost-efficient care for their residents. Through our daily work with States, we are fostering health care transformation by finding new ways to pay for and deliver care that improves health and health care while lowering costs.

We are also modernizing the administration of the Medicaid program by moving from a paper-driven, process-intensive approach to more streamlined ways of doing business with States.

[16] http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf

Through our Federal-State partnership, CMS is working with States to build systems and standards that ensure Medicaid is working at optimal levels for beneficiaries, States, and health care providers. To help States fund these improvements, CMS has made available 90 percent matching funds for upgrades to State eligibility and enrollment systems through December 31, 2015 for eligibility system design and development, and the enhanced 75 percent matching rate will be available indefinitely for maintenance and operations of such systems as long as the systems meet applicable program requirements. Forty-eight States and the District of Columbia have been approved for over $2.4 billion in Federal matching for important investments to automate and modernize enrollment, eligibility, and other system operations.

To further reduce system costs, we have promoted ways for States to share elements of their system builds with each other, and we will be sharing the business rules for adopting modified adjusted gross income in the new eligibility systems. In addition we are designing, with extensive State and stakeholder consultation, a new combined and streamlined application that States can adopt (or modify subject to Secretarial approval). And, we will continue exploring opportunities to ease processes or provide States additional support for the administrative costs of eligibility changes implementing the new coverage provisions of the Affordable Care Act. These and other initiatives relating to state systems development will lower administrative costs.

This focus on improving Medicaid efficiency and modernizing its systems, at both the State and Federal level, ensures Medicaid coverage will be simplified, less burdensome for States and beneficiaries, enrollment will be coordinated with the Exchanges, and enrollment systems will be ready for the expansion in Medicaid eligibility provided by the Affordable Care Act in 2014. Thanks to new initiatives, new funding, and State efforts, today the Medicaid program is moving forward towards becoming a strong, modern program that provides quality care to the people we serve.

Streamlining Medicaid and Coordinating with the Exchanges

On March 23, 2012, CMS published its Medicaid eligibility and enrollment final rule (CMS-2349-F) which defines the streamlined, income-based rules set forth in the health care law. This

final rule provides States with flexibility and confirms the importance of coordination with the Exchanges to ensure the success of the Affordable Care Act in giving all Americans access to health coverage. Eligibility, enrollment and renewal processes will be modernized, building on the successful State efforts that are already underway.

In particular, the rule implements the simplified financial eligibility set forth under the Affordable Care Act by relying on a single "Modified Adjusted Gross Income" (MAGI) standard for determining eligibility for most Medicaid and CHIP enrollees and by consolidating eligibility categories into four main groups – adults, children, parents and pregnant women. The eligibility verification procedures are similarly modernized by relying primarily on electronic data sources, including through the Federal data services hub that links States with Federal data sources, which is being developed both for Exchange enrollment and Medicaid eligibility processes. These procedures reduce State and beneficiary burden, allowing Medicaid to work as quickly and efficiently as possible to get eligible people enrolled in a timely and efficient way.

The new MAGI rules and enrollment procedures are aligned with those that will apply for determining eligibility for an advance premium tax credit in the Exchange. Coordination with the Exchange is important to ensuring that consumers may apply for coverage and enroll in a plan through a single, streamlined process.

While ensuring coordination, the final rule also offers States flexibility in how they will design the system of coordinated eligibility determinations. The rule provides two options for States for applications submitted to the Exchange: the Exchange can determine Medicaid eligibility based on the State's Medicaid eligibility rules as it considers eligibility for advance payment of premium tax credits; or the Exchange can make a Medicaid eligibility assessment and rely on the State Medicaid and CHIP agencies for a final eligibility determination. Under either option, timely and coordinated eligibility determinations are ensured.

Since the issuance of these regulations, CMS has continued to provide guidance that gives States support to modernize their systems and ensure they operate seamlessly with the Exchanges. On

December 10, 2012, we issued Frequently Asked Questions to respond to questions that we have received from States.[17]

Expanding Eligibility

The Affordable Care Act not only modernized Medicaid eligibility rules and procedures, but it also included an eligibility expansion designed to close the coverage gap that now exists in the program for the lowest income adults. The law would bring eligibility for adults to 133 percent of the Federal poverty level (roughly $15,000 for a single individual and $30,600 for a parent in a family of four in fiscal year 2012). Currently, parents are covered at state-established income eligibility levels equal to about 64 percent of the Federal poverty level in the median State. Prior to the enactment of the Affordable Care Act, States could not cover other nonelderly adults—younger adults just starting out, older adults whose children are grown, and others without children—at any income level unless they were pregnant or disabled, except through a waiver.

The Supreme Court's decision this summer upheld all aspects of the Affordable Care Act, including the Medicaid provisions, except that a State may not, as a consequence of not participating in the low-income adult expansion, lose Federal funding for its existing Medicaid program. In effect, the decision means that the choice to expand is left to States. Other aspects of the law affecting Medicaid remain in place including the very generous Federal support that will be available for the expansion. The Federal government will pay the full cost of coverage for newly eligible adults in 2014, 2015, and 2016. Beginning in 2017, the rate drops gradually, reaching 90 percent in 2020 and staying there indefinitely. This is the most generous matching rate applied to any coverage group in the history of the program. We have recently provided guidance on the benefit flexibility available to States if they cover this new adult population; benefits will be designed by States by reference to commercial benchmark plans.

There is no deadline for a State to tell CMS its plans on the Medicaid eligibility expansion. We have advised States that they may choose to adopt the expansion at any time and if they adopt the expansion they may drop it at a later date if they so choose. We believe the very favorable

[17] http://medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/Governor-FAQs-12-10-12.pdf

financing and the flexibility available to States to design benefits and establish their delivery systems will encourage States to move forward with this opportunity to provide coverage to the poorest working families in their States and, in so doing, to dramatically reduce the burden of uncompensated care on their hospitals and other health care providers.

CMS continues to work closely with States to provide options and tools that make it easier for States to make changes in their Medicaid programs to improve care and lower costs. We have released guidance giving States flexibility in structuring payments to better incentivize higher-quality and lower-cost care, provided enhanced matching funds for health home care coordination services for those with chronic illnesses,[18] designed new templates to make it easier to submit section 1115 demonstrations and to make it easier for a State to adopt selective contracting in the program,[19] and developed a detailed tool to help support States interested in extending managed care arrangements to long term services and supports.[20] We have also established learning collaboratives with States to consider together five focus areas, including improvements in data analytics, value-based purchasing and other topics of key concern to States and stakeholders,[21] and the Center for Medicare and Medicaid Innovation has released several new initiatives to test new models of care relating to Medicaid populations.[22] We welcome continued input and ideas from States and others.

States can implement delivery system and payment reforms in their programs whether or not they adopt the low-income adult expansion. With respect to the expansion group in particular, States have considerable flexibility regarding coverage for these individuals. For example, States can choose a benefit package benchmarked to a commercial package or design an equivalent package. States also have significant cost-sharing flexibility for individuals above 100 percent of

[18] Health Homes for Enrollees with Chronic Conditions State Medicaid Director Letter: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf
[19] Revised Review and Approval Process for Section 1115 Demonstrations State Medicaid Director Letter: http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SHO-12-001.pdf
[20] On-line resource for Managed Long Term Services and Supports: http://www.medicaid.gov/mltss/#Link706872Context
[21] For more information, please visit: http://www.medicaid.gov/State-Resource-Center/MAC-Learning-Collaboratives/Medicaid-and-CHIP-Learning-Collab.html
[22] For more information, please visit: http://medicaid.gov/State-Innovations.html

the Federal poverty level, and we intend to propose other cost-sharing changes that will modernize and update our rules.

Additionally, we are interested in working with States to promote better health and health care at lower costs and have been supporting, under a grant program established by the Affordable Care Act,[23] State initiatives that are specifically aimed at promoting healthy behaviors. Promoting better health and healthier behaviors is a matter of importance to the health care system generally, and State Medicaid programs, like other payers, can shape their benefit design to encourage such behaviors while ensuring that the lowest income Americans have access to affordable quality care. We invite States to continue to come to us with their ideas, including those that promote value and individual ownership in health care decisions as well as accountability tied to improvement in health outcomes.

In the Years Ahead

In the coming months, we will implement enhanced payments for primary care physicians and integrated care models that improve care and lower costs. But more work remains as we continue our partnership with state leaders and other stakeholders to establish and implement the Exchanges and increase access to the Medicaid program. These new rules and programs are stepping stones on the path to fully implementing the Affordable Care Act. In the meantime, CMS will continue our hard work to strengthen health insurance options with the help of our partners in Congress, state leaders, consumers, and other stakeholders across the country. Thank you for the opportunity to discuss the work that CMS has been doing to implement the Affordable Care Act.

[23] Initial Announcement for the Medicaid Incentives for Prevention of Chronic Diseases: http://innovation.cms.gov/Files/x/mipcd_foa.pdf

Mr. BURGESS. Time is expired. Let me just note that the bells are signaling that the House is in recess subject to the call of the Chair. It is not a vote.

So I will recognize Mr. Smith for 5 minutes, sir.

STATEMENT OF DENNIS G. SMITH

Mr. SMITH. Thank you, Mr. Chairman. It is a pleasure to be with you and all the members of the subcommittee today. I thank Senator-elect Baldwin for being here and congratulate her. We look forward to your service in the Senate, ma'am.

I want to preface my remarks. I have a lengthy statement for the record, and really did take my statement from the perspective of implementation. I bring with that perspective two things. First, Wisconsin already has done much of the work that the Nation is going to be catching up to. We have 90 percent insurance coverage in the State, over 90 percent if you add in the people who are today already eligible for Medicaid. If they simply showed up and enrolled, we would have 93 percent coverage for the State. We also have, I think, been one of the leaders in integrated eligibility systems in which people can apply on the Internet as well as by mail, phone, and of course face to face. So we have done a lot of the work of what to expect an exchange would be faced with.

And I also bring experience from implementation at the Federal level. I was at the Centers for Medicare and Medicaid Services shortly after the Medicare Modernization Act of 2003 was passed, so was charged with part of the responsibility of preparing for implementation of the drug benefit. I would say CMS has a much more daunting job today than what we did in 2003 and yet in 2003 we were adjusting through the very last minute and in fact, even months into it, we still had State partners assisting the Federal Government because we couldn't quite pull it off all at once. But at that point in time, we had another eligible system called the Social Security Administration as a major partner that was trusted by our senior citizens. We had many things that were already intact. We knew exactly who we were enrolling. We were simply extending a new benefit to a set group of people. We knew a lot about their health care. So CMS has a far more daunting job than what we were charged with at that point in time.

There are lots of good people doing their very best at CMS. I do not envy for the job that they have. But from the perspective that I have been looking at this throughout, that we take deadlines seriously. The deadline that States faced was the Secretary of HHS was going to start reviewing States January 2013, as in next month, to see if we were going to be ready. We took that deadline very seriously and decided a year ago that that job was too big, and I would say today, we still do not know who is eligible, who will get paid, how will cost sharing be transferred between the Federal Government to a health plan or to someone else. We do not—again, all of the rules and everything else, we have still some very fundamental things. At the end of the day, you are trying to connect a buyer to a seller, and the fundamental things that are required to do that are not yet in place. So we would not have been ready to have that review. We took that deadline very seriously.

The Wisconsin experience again, we submitted as part of my statement real-life eligibility standards of what is going to be faced out there in converting to Modified Adjusted Gross Income, MAGI. MAGI inherently has marriage penalties involved in it. You are going to have different outcomes for similarly situated households making the very same income, and you are very going to have different outcomes of whether or not different members of the family are going to be eligible for Medicaid, whether they are going to be eligible for the tax credit or not eligible at all. I think when some of those inequities start coming to light, there are going to be a lot of unhappy people. I think in the Federal exchange again, and I gave some of our Wisconsin experience in terms of volume of what needs to be anticipated, we don't know again, call centers, who is that going to be for, what are the standards to be able to answer the phone in what period of time. The idea that you are going to train a whole set of eligibility workers who are going to know Wisconsin's Medicaid eligibility, it is a little hard to accept that, given the short period of time. Again, we are 10 months away.

Finally, affordability. Again, with the agreement of our partners at the Federal Government, we have been since last July modeling affordability. That is, we have been applying the percentage of income towards premiums because, again, Wisconsin has already expanded eligibility. We have parents, caretakers, adults up to 200 percent of the Federal poverty level, people on transitional medical assistance who have income well above 200 percent of the Federal poverty level. So we have been modeling those premiums, and again, that experience, I think, needs to give everyone pause for what we have found. People at the lower income level, they aren't thinking in terms of percentage of income. They think in dollar amounts: how much money is this going to cost me on a monthly basis. The good news at the lower income levels, we predicted pretty accurately what they were going to be willing to pay on average amounts of around $59 a month for their care, for their premium, and again, this is just the premium, this is not cost sharing. That is going to be applied on top of that. But when you get above 200 percent and that dollar amount has now gone above $200 a month, individuals have dropped by half. The law does not determine what affordability is. People will determine what affordability is, and I think it is going to be a vastly different experience.

Thank you.

[The prepared statement of Mr. Smith follows:]

State of Wisconsin
Department of Health Services

Scott Walker, Governor
Dennis G. Smith, Secretary

Statement of Dennis G. Smith
Secretary, Wisconsin Department of Health Services
On "State of Uncertainty: Implementation of PPACA's Exchanges
and Medicaid Expansion"
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
December 13, 2012

Chairman Pitts, Ranking Member Pallone, and members of the Committee, thank you for the opportunity to participate in today's important hearing, "State of Uncertainty: Implementation of PPACA's Exchanges and Medicaid Expansion." Although additional guidance was released by Secretary Sebelius on Monday, there is indeed still a great deal of uncertainty across the country as we are now less than 10 months away from when health insurance exchanges and eligibility changes to Medicaid systems must be operational. We believe the actual experience of many Americans will be different from the expectations that have been created. Thus, a good deal of irony will follow the uncertainty.

Today's hearing is focused on implementation, not policy. Accordingly, my remarks are intended to focus only on the challenges of implementation. It is not my intent to neither re-open past policy debates nor prolong current ones. However my avoidance of those policy discussions, in which there is great passion on both sides, should not be mistaken for support of the positions taken by the Obama Administration. Let me also be clear that Wisconsin Governor Scott Walker has not yet made a decision on a Medicaid expansion. Of course, taxpayers pay 100 percent of the cost regardless of

whether the funding comes from a state account or a federal account. Moreover, funding is not the only consideration for us and other states. The decision whether to expand Medicaid or not may also depend upon whether the federal government will relinquish some of its program control. We strongly believe that Medicaid for working families should be efficient and effective as well as more equitable. I would respond to those who insist that states cannot be left to act in the best interests of their citizens that more than half of the cost of Medicaid occurs because states that have expanded beyond the federal mandated requirements and also remind them of the success of the state Children's Health Insurance Program.

The Reality of the Current Budget

While today's hearing topic is uncertainty, I would like to share some of our realities. The cost of our current Medicaid program continues to increase while the percentage of the Wisconsin Medicaid programs paid with federal funds continues to decrease. Without budgeting for the implementation of PPACA, we have requested an 8.9 percent increase in general revenues for state fiscal year 2014. This compares to the 3.6 percent request for all state agencies and a 3.8 percent increase in general purpose tax revenues. If our request is approved by the Legislature, my Department will take nearly half of all additional tax revenues coming into the state next fiscal year. Included in our request is an increase of $196 million over the 2013-15 budget to make up for the lower match rate we will receive from the federal government during this period. We face other increased state costs to pay for Medicare obligations and a higher state contribution to fund the Medicare Part D drug benefit because of the federal government's inability to control the cost of Medicare.

In the current negotiations surrounding the "fiscal cliff," states are understandably concerned about potential cost shifts from the federal government to the states. In fact, Governor Walker, along with five other governors met with President Obama last week at the White House and expressed this very bipartisan concern.

In regards to the economy, even though the unemployment rate has declined, we have nearly 200,000 more parents, caretakers, non-disabled childless adults and children on Medicaid than were enrolled in July 2008. With Medicaid enrollment 25 percent higher than pre-recession levels, the best solutions will be found in getting the economy back on its feet again and everyone fully back to work.

Who is Currently Uninsured in Wisconsin?

The Current Population Survey (CPS) and the American Community Survey (ACS) estimate the total number of non-elderly uninsured individuals to be 553,600 (out of 558,400 total uninsured) out of our total population of 5.7 million people. In other words, more than 90 percent of our citizens already have health insurance coverage. If all of the individuals who are currently eligible for Medicaid would enroll today, our coverage would be nearly 93 percent. Accordingly, a primary consideration must be to do no harm to Wisconsin's current system of health insurance.

From the 553,600 non-elderly individuals who are uninsured, 267,200 are below 133 percent of the federal poverty level (FPL). Of these, 41,300 are children and 45,843 are parents/caretaker adults who are already eligible for Medicaid. There are another 26,200 children in families with income between 133 percent and 300 percent FPL who are uninsured but likely eligible for Medicaid. Therefore, approximately 113,000 individuals, or 20 percent of the total number of uninsured individuals are already eligible

for Medicaid. The state would not receive the 100 percent federal match for enrolling any of these individuals.

We estimate there is a total of 178,461 childless adults below 133 percent of FPL who are uninsured for whom the state would receive the temporary 100 percent match rate. Of these individuals, 130,350 childless adults are below 100 percent FPL. For the 48,000 individuals between 100 and 133 percent FPL, The U.S. Department of Health and Human Services (HHS) confirmed earlier this week they will be eligible for the tax subsidies if we do not expand Medicaid eligibility.

There are 21,709 childless adults currently enrolled in Medicaid. Even if HHS determines this group to qualify for the 100 percent federal match rate for these currently enrolled individuals, the additional payment for them clearly will not offset the cost of increasing Medicaid enrollment by 113,000 of the parents and children who are currently eligible. Thus, those who once believed that PPACA would be a windfall to the state budget will be disappointed. It is not reasonable or prudent to make budget decisions on the hope that only certain individuals who have the highest match rate will enroll. It is also important to recall that PPACA expanded Medicaid because it was cheaper for the federal government to have individuals in Medicaid rather than pay out tax subsidies.

Four Areas of Uncertainty

Even with some of the additional limited guidance HHS provided earlier this week, PPACA represents massive disruption to the distribution system of health insurance. To participate, will the health plans be required to hold financial risk as well as medical risk? Simply put, who pays and who collects? At this point, we do not know

how advanceable tax credits will be transferred from the federal Treasury to a health plan. Nor do we know how the low income subsidies for cost sharing will be processed.

Insurers are struggling with great unknowns as to how to price their products. Without utilization data, it is difficult to determine rates that will be actuarially sound and competitive. Everyone simply needs to know what the rules are in order to be compliant.

Getting at the heart of today's hearing, we find uncertainty and unforeseen outcomes in four areas: administration, affordability, cost, and simplification.

Administration

In addition to the 553,600 non-elderly individuals who are uninsured in Wisconsin, there are 180,000 people currently through the individual insurance market who will presumably want to shop the exchange. Another 360,000 individuals receive coverage in the small employer group market and are likely to be interested in at least browsing the exchange. Add in some employees from large employers and families in Medicaid whose income is above 100 percent FPL, and it is easy to envision that 1.5 million people in Wisconsin alone, more than 25 percent of our population will hit the health insurance exchange looking for the lower cost and, better coverage promised by the federal government.

To put this in greater perspective, even if only 20 percent of Americans try out the new exchange tool – one in five Americans, that is more than 62 million people nationwide. Or in other words, approximately the entire state populations of Wisconsin, Florida, and California combined. This is a reasonable assumption as the PPACA forecasts 36 to 40 million covered lives will be churned through the health insurance

market. All of these 36 to 40 million people will go through the new federal data services hub ("the Hub") to verify financial and non-financial eligibility information.

Many of these individuals will not know whether they are eligible for Medicaid, tax subsidies, or not eligible at all. Many of these individuals will not be comfortable using only online information and will want to talk with a live person who can assist them. Our experience in Wisconsin in this regard might be instructive. For the 12-month period of October 2011 through October 2012, the Department and our local government partners received a total of 379,450 applications for assistance. As the table below shows, 38 percent of the applications were handled in person, by telephone or mail.

Method	Volume	Percent
In Person	36,687	10%
Phone	31,117	8%
Mail-In	77,013	20%
On-Line	234,633	62%

Projecting the Wisconsin experience of processing eligibility and enrollment applications on a population of 40 million people yields the following results:

Method	National
In Person	4,000,000
Phone	3,200,000
Mail-In	8,000,000
On-Line	24,800,000

Assuming the federal government will end up processing half of the applications (participating state based exchanges and partnership states the other half); it will need to prepare to handle applications for seven million people who will conclude the internet does not meet their needs. Further, it is likely that a portion of the individuals applying on-line will require assistance from an eligibility worker. In Wisconsin, workers assist individuals on seven percent of those applications on-line. Most importantly, in Wisconsin each and every application submitted online requires review by an eligibility

worker, and while HHS envisions a streamlined process that does not require such review, one has to question how much fraud and abuse will go unchecked or the tax burden that individuals may face when the IRS attempts to reconcile at tax time. There is little to suggest the federal government is prepared to handle this volume or what the contingency plans are to ensure quality service to consumers.

We are very concerned that the lack of federal preparation will mean many of these people will turn to our local and county agencies by default and in frustration. It costs $150 to process each application regardless of whether someone turns out to be eligible. We have estimated that it may cost nearly $50 million over the next biennium in local and county eligibility worker costs to accommodate the increased volume as a result of the exchanges and a possible Medicaid expansion. With additional costs associated with systems changes, we estimate the total administrative cost to reach $65 million over the next biennium ($29 million state share).

Technical specifications related to the federally facilitate exchange (FFE) and federal data services Hub are just now starting to be released and HHS has stated publicly that the specifications are not complete and will be continuously updated. States do not have resources sitting on the bench waiting for HHS to provide complete information, and will be unable to integrate with the FFE on the timeline established. In building systems, especially when dealing with something so complex, sensitive, and critical as eligibility, you build, test, revise, and then implement. States are now in a position where they must accept the fact that work completed to date must be reviewed and significant rework may be required to comply with the ever changing federal guidance. To complicate this even more HHS has placed too many conditions on the enhanced funding

for systems development. Frankly, the most prudent decision for a state may be to forego changing their systems and avoid the Hub.

In short, we are not confident that the federal government has adequately prepared for handling an unprecedented number of applications, verifications, and enrollments. This leaves us uncertain on whether the federal government will be ready to effectively administer this program less than 10 months from now.

Affordability

The federal government insists that health insurance will be more affordable. But what is affordable will be decided by people, not government rulemaking. People do not always live their lives according to the assumptions made by government officials. Some Wisconsin residents will pay more and be required to purchase richer benefits than they choose to purchase today. Even after the application of tax subsidies, 59 percent of Wisconsin's individual market will experience an average premium increase of 31 percent.

40 percent of people currently in Wisconsin's individual market will be required to purchase benefits beyond their current coverage. This will likely lead to unnecessary utilization and increased health care costs which ultimately circles around to increases in premiums and cost sharing.

Since July, we have been applying the PPACA premium rules to adults on Medicaid with income at or above 133 percent FPL. Adults are required to pay the same percentage of their income now as they will be required beginning January 1, 2014. The premiums begin at 3 percent of income at 133 percent FPL and increase to 9.5 percent.

The results on average are consistent with our assumptions about participation rates. Overall, 77 percent are paying the required premiums. But as the premiums increase, participation declines. Individuals do not typically think about payments as a percentage of income, they view prices in absolute dollar terms. Enrollment of individuals with income between 200 and 300 percent FPL with an average monthly premium of $207.00 has dropped by 52 percent.

In Wisconsin, individuals at the lower income levels are more consistently paying their premiums compared to individuals at higher income levels. The results to date suggest that there may be an affordability "donut hole" for individuals that question the value of the health care that they will be required to purchase. If healthy individuals indeed conclude that their premiums are greater and the value of the benefits are less than meets their expectations, the Exchange could become a national high risk pool. If healthy individuals deem health insurance at PPACA prices to be unaffordable and risk paying the small penalty while assured of being able to get coverage later, the number of uninsured individuals will increase, not decrease.

And ultimately, we still do not have final rules on two fundamental issues – who is eligible and how will a health plan get paid – leaving us again uncertain about the affordability of PPACA.

Cost

The federal government assumes that adding 36 to 40 million covered lives to the health insurance market will lead to increased competition and a reduction in (premium) costs. But PPACA also fragments the market by separating the non-disabled, non-elderly

Medicaid population from the rest of the insurance pool, even by separating children from their parents.

We are concerned that the federalization of health insurance will lead to consolidation among health plans, which will ultimately drive costs higher yet. The big insurance companies can afford to become the banker if that is what the payment system demands.

The impact on employer sponsored insurance is perhaps the greatest unknown. We have 180,000 people in the individual market. There are more than three million lives in the large group market. Some health carriers fear its erosion, while others are planning for it and positioning themselves for massive employer disruption over time. It is not difficult to see that the large health plans that can play in all four spaces—large group, small group, individual, and Medicaid—can squeeze out the smaller, regional companies.

We see consolidation throughout the health care sectors—pharmaceuticals, hospitals, and physician practices. Federal officials frequently convey their belief that PPACA will stimulate competition. It is not difficult to foresee the opposite may occur.

Even if a state chooses not to expand Medicaid and enrollment remains as is, the effects of PPACA will still likely increase costs on the state in direct and hidden ways. Here are just two examples. First, the new tax on health plans will hit our Medicaid managed care plans. We have 700,000 people enrolled in managed care plans and those plans are certain to demand an increase in rates in order to pass the tax back to the taxpayers. If a health plan wants the privilege of marketing through the FFE, it will cost the plan another 3.5 percent of premiums. Here is a new twist on intergovernmental

transfers. The Centers for Medicare and Medicaid Services (CMS) will pay the Wisconsin Department of Health Services to make payments to managed care plans which will then pay the money back to the Internal Revenue Service (IRS). Collections by the IRS will increase – courtesy of CMS and the State of Wisconsin.

Additionally, while the federal government will cover the benefit costs of the primary care provider rate increase for Medicaid to match Medicare rates over the next two years, states are still required to pay for a portion of the administrative costs to implement the changes. Coupled with the fact that HHS just released final guidance on the provision only increases the administrative burden on states to develop a retroactive change to re-process claims and adjust them to the new rate. Of course, we are faced with the uncertainty of what happens after the temporary adjustment and federal match rate increase expire. Repeating the federal experience of the Medicare "doc fix" is not an appealing prospect.

Second, health care providers are also employers and will be affected by the mandate to provide health coverage to their own workers or pay a tax penalty. This may particularly affect small and mid-size employers such as personal care agencies or nursing homes that employ lower skilled workers. The Medicaid personal care rate is $16.08 per hour. Let's assume the average full time worker bills 1,500 hours a year and generates $24,000 of Medicaid revenue per year. If the provider chooses the less expensive option and elects to pay the $2,000 per employee penalty (excluding the first 30 employees), that works out to about eight percent of revenue per employee. The employer, of course, will expect an increase in Medicaid rates to offset the new cost.

In addition, Medicaid will have to compete against the new federal subsidies for providers. It is only prudent to anticipate that at some point, the state is certain to be forced to increase provider rates in order to ensure access for the Medicaid population. The amount of those increased rates, of which there is no additional federal match, remains uncertain at this point, adding to our overall uncertainty about the overall costs of PPACA.

Simplification

HHS seeks to create a streamlined process and application so that there is "no wrong door." In reality, HHS will force Wisconsin to make the current process and application more complicated. Wisconsin already has a streamlined, integrated eligibility application for Medicaid/CHIP, FoodShare (SNAP), TANF, and W2 and supports online application submissions. Each federal agency is establishing its own data use rules governing how the data can be used. For example, the IRS has indicated that the information provided by their agency through the new federal data hub can only be used for insurance affordability programs, the data cannot be used for determining eligibility for FoodShare. For Wisconsin this means that we will need to uncouple—not streamline—our integrated process. There is no added value to Wisconsin for integrating with the federal data Hub, only increased administrative cost and rules to follow to do what we already do today.

While federal officials talk simplification, implementation of PPACA seems to be going in the opposite direction. CMS needs to move to simpler solutions instead of more complex ones such as relying on the Hub which does not even exist today. We have yet to be able to match Social Security numbers with the Social Security Administration

(SSA) on a real time basis. Negotiations to do so have taken more than a year to complete, with more than 10 months to develop the integration with SSA at a total cost of $800,000. The insistence that the Hub, with integration to the SSA, IRS, and DHS, is going to be operational in 10 months is highly questionable.

MAGI-based eligibility rules are a set of new household composition and income counting rules established by PPACA. MAGI refers to "Modified Adjusted Gross Income," which is defined by U.S. tax code and will be used as the basis for determining Medicaid and CHIP eligibility for certain populations starting in 2014. There is no additional federal funding for the increase in enrollment due to covering to MAGI. In addition to changing which types of income and expenses are counted, MAGI introduces tax filing status and tax relationships as new factors in determining how households are tested for eligibility. The new rules are highly complex and will require massive systems and operational changes by state Medicaid agencies between now and January 2014.

MAGI, by virtue of basing eligibility on tax filing status and tax relationships, creates significant inequities in eligibility results for families that are nearly identical in make-up. It is expected that these complex rules will cause mass confusion for Wisconsin residents. Furthermore, it seems unreasonable to expect families to understand that how they file their taxes at the end of the year will impact the health insurance options available to them. Additionally, it is unclear how states are going to successfully implement these rules and explain them to customers without requiring local and county eligibility workers to become tax experts.

A few examples of the inequities and complexities of migrating to MAGI are attached as Appendix A.

The FFE will begin using MAGI to assess/determine eligibility for state Medicaid/CHIP programs in October 2013, even though it does not take effect until January 1, 2014. The FFE will verify income through the federal data Hub using IRS data. This method of verifying income will lack accuracy for many of those at lower income levels that are not required to file income taxes or whose records are not current. Medicaid agencies in most cases will need to confirm current income and may have to maintain dual systems to accommodate these referrals from the FFE to test eligibility under current determination rules as well as MAGI.

The FFE may tell consumers it looks like they are eligible for Medicaid based on the individual attesting to their income and then refer them to the Medicaid agency, but Medicaid may tell them they are not eligible because the FFE is not verifying attestations, or because they are not eligible based on current determination rules. This is hardly going to be a customer-friendly situation. Further, families that apply to the FFE may be sent in two different directions. Families with incomes between 133 percent and 300 percent FPL will be split with parents and caretakers enrolling in qualified health plans through the exchange and children being referred to states for enrollment in Medicaid. Again, we are uncertain that the federal government's attempt at simplification will actually benefit consumers and states.

Conclusion

Finally, in a previous governmental role, I served at the Centers for Medicare and Medicaid Services (CMS) during implementation of the Medicare Modernization Act of 2003 (MMA). The history of MMA holds some useful lessons for the topic at hand. In implementing a major new program, money is always important but timing is just as

critical to success. MMA was signed into law in December 2003, and the final rule was promulgated 13 months later in January 2005, giving everyone almost a full year to understand the rules before the benefits were to begin. Insurers were able to begin marketing plans in October 2005 and enrollment into the new Part D benefit began on November 15, 2005 for January 1, 2006 coverage.

Bear in mind that PPACA is far more complex than MMA. In MMA, we knew exactly the universe of people we were going to serve. We knew a great deal about their utilization of health care. We had a well-functioning enrollment system called the Social Security Administration that seniors knew and trusted. The average premium turned out to be about $5 less than original estimates. We had solid partnerships with all 50 states and the District of Columbia that filled some critical roles at critical times. There were multiple partners at multiple levels. Redundancy provided us with some flexibility to make last minute adjustments when things did not go exactly to plan. For example, our state partnerships allowed us to auto-enroll several million dual eligible into drug plans. Despite all of our preparation, there were plenty of problems to be patched after the program began. States continued to serve duals for several months well into 2006.

These were tremendous advantages compared to what CMS faces today in implementing PPACA. To increase the chance for success, the federal government needs more partners, not fewer. It needs to offer greater flexibility to solve problems, not less. But the hard line taken by the federal government, as further evidenced in the guidance this week, in response to state requests likely will mean federal officials and the American people will have to adjust their expectations for 2014.

Thank you for the opportunity to participate in today's hearing. I look forward to any questions you may have about Wisconsin's experience.

Appendix A

All examples below assume Medicaid eligibility levels of 138% of the FPL for parents and caretakers and 200% of the FPL for children.

MAGI and Tax Filing Examples

Mary and Brad are not married. They have a daughter in common, Jessica (age 10), and Brad has a son, Kris (age 15) from a previous marriage. Mary has $3,690/month in income from her job, and Brad has $2,100/month in income from his job.

Scenario 1

Both Mary and Brad are filing taxes. Brad is claiming Jessica and Kris as his tax dependents.
Mary's group includes herself. For a household of 1 with income of $3,690/month, Mary is at 396% FPL and is ineligible for Medicaid.
Brad's group includes himself, Jessica and Kris. For a household of 3 with income of $2,100/month, Brad is at 132% FPL and is eligible for Medicaid.
Jessica's group includes herself, Brad, Mary and Kris. For a household of 4 with income of $5,790/month, Jessica is at 301% FPL and is ineligible for Medicaid.
Kris' group includes himself, Brad, and Jessica. For a household of 3 with income of $2,100/month, Kris is at 132% FPL and is eligible for Medicaid.

Scenario 2

Both Mary and Brad are filing taxes. Mary is claiming Jessica as her tax dependent and Brad is claiming Kris as his tax dependent.

Mary's group includes herself and Jessica. For a household of 2 with income of $3,690/month, Mary is at 292% FPL and is ineligible for Medicaid
Brad's group includes himself and Kris. For a household of 2 with income of $2,100/month, Brad is at 166% FPL and is ineligible for Medicaid.
Jessica's group includes herself, Brad, Mary and Kris. For a household of 4 with income of $5,790/month, Jessica is at 301% FPL and is ineligible for Medicaid.
Kris' group includes himself and Brad. For a household of 2 with income of $2,100/month, Kris is at 166% FPL and is eligible for Medicaid.

There are a number of other inequities that are created as a result of basing Medicaid eligibility on tax rules.

The "Marriage Penalty"

Jack and Diane are married and will file their taxes jointly. They have two children, ages 5 and 8, whom they will claim as tax dependents. Diane earns $2,000/month at her job, while Jack receives $690/month in unearned income. Under MAGI, Jack and Diane and their children will be considered as part of the same household, and their income will be counted together. As a household of 4 with $2,690/month in income, the entire group is at 140% FPL. Under this scenario, the parents are ineligible for Medicaid and the children are eligible.

Rob and Anna are not married. They have two children, ages 5 and 8, whom Anna will claim as tax dependents. Anna earns $2,000/month at her job, while Rob receives $690/month in unearned income. Under MAGI, Anna's group will include her two children. The children's group will include both children and both parents. Rob's group includes just Rob. With a household of 3 with $2,000/month in income, Anna is at 126% FPL and is eligible for Medicaid. With a household of 4 with $2,690/month in income, the children are at 140% FPL and are eligible for Medicaid. With a household of 1 with $690/month in income, Rob is at 74% FPL and eligible for Medicaid.

In this scenario, Jack and Diane are both above 133% FPL and ineligible for Medicaid but Rob and Anna are both below 133% FPL and eligible for Medicaid – only because Jack and Diane are married and Rob and Anna are not.

Child Support Disregard

Lyle and Kate are married and have two daughters, ages 7 and 9. Kate has a son, age 13, from a previous marriage. Kate's son receives $300/month in child support, which is disregarded under MAGI rules. Kate and Lyle are filing jointly and claiming all three children as tax dependents. Lyle earns $1,600/month from his job, while Kate earns $1300/month from hers. As a household of 5 with $2,900/month in income, they are at 129% FPL under MAGI rules and are eligible for Medicaid.

Mike and Liz have two daughters, ages 7 and 9. Liz has a son, age 13, from a previous marriage. Mike and Liz are filing jointly and claiming all three children as tax dependents. Mike earns $1,600/month from his job, while Liz earns $1,300/month from one part-time job and $300/month from a second part-time job. As a household of 5 with $3,200/month in income, they are at 142% FPL.

Under this scenario, total income for both families is $3,200/month. Lyle and Kate are eligible for Medicaid because the $300 of child support income is disregarded under MAGI. Mike and Liz, whose income is also $3,200/month, are ineligible for Medicaid because all of their income is earned income, and therefore counted towards their eligibility.

Mr. BURGESS. Thank you. Time is expired.

I recognize Mr. Greenstein for 5 minutes for purposes of an opening statement, sir.

STATEMENT OF BRUCE D. GREENSTEIN

Mr. GREENSTEIN. Thank you, and good morning, Vice Chairman Dr. Burgess and Ranking Member Pallone and the distinguished members of the subcommittee. Thank you for the invitation to testify on Louisiana's position regarding the implementation of the Patient Protection and Affordable Care Act, PPACA, particularly as it relates to exchanges and Medicaid expansion.

My name is Bruce Greenstein. I am the Secretary of the Louisiana Department of Health and Hospitals, and Senior Health Policy Advisor to Bobby Jindal. Earlier in my career at CMS during the Bush administration, I oversaw Medicaid programs in the Northeast and led the Federal Government's efforts to reform the Medicaid programs in several States. In fact, I have two of my previous bosses here on the panel.

In my current role, I have broad responsibility over an array of health service areas including Medicaid, behavioral health, public health and disability and aging services. Before I begin, I would like to pause to recognize the position that we are in. It feels somewhat awkward to be here testifying on the implementation of one of the largest expansions of entitlement programs in nearly 50 years at the same time as ongoing discussions about Federal spending reductions to avert the fiscal cliff and raising the debt ceiling takes place. It is a little bit of a parallel universe.

Nevertheless, we are here. As you know, Louisiana has continually shared its concerns regarding the practical and policy ramifications of PPACA. Our decision not to assume the risk of building a State-based exchange is not the product of political positioning, rather it was made after careful analysis of the laws and regulations.

Beyond the past and ongoing legal challenges of the law, we have broad concerns about PPACA as policy. While the concept of a health insurance exchange is a good one, the PPACA-defined exchanges provide for rigid Federal control over coverage options available to consumers, raising costs and limiting choice. In fact, a study recently released by AHIP and the Louisiana Association of Health Plans estimates that PPACA premium tax will force policyholders in my State to pay over $2,000 more for single coverage and $4,500 more for family coverage for individuals over the next 10 years. Similar increases are noted for small and large group employers. This is a significant burden on individuals and families in Louisiana and across the country.

Beyond these concerns, there are major practical and implementation hurdles. With guidance having been largely delayed or altogether missing, the October 1, 2013, deadline to begin open enrollment seems unrealistic, considering the scope and complexity of building an exchange. The FAQs released earlier this week is certainly helpful but it is simply too little and too late.

The State's decision not to build an exchange should not be taken as general unwillingness to tackle a complex reform project. Rather, the number of remaining concerns and unanswered questions

simply do not give us the needed confidence. Regardless of the type of exchange that will operate within a State, there are five key issues fully outlined in my written testimony that need attention from Congress and action from HHS including administrative simplifications and adjustments to make timelines more realistic.

In addition to our concerns regarding the exchanges, we have serious reservations about blanket expansion of the existing Medicaid program without fundamental reforms to improve health outcomes and lower costs. While States now have a choice, it is not surprising that many remain reluctant, even with enhanced Federal funding. Some organizations have heralded the expansion as "a great bargain" for States. However, State leaders must be careful before accepting the long-term liabilities of expanding a 1960s-era entitlement program.

A recent Kaiser Family Foundation and Urban Institute report reveals that expansion creates winners and losers among States. There are cost estimates which we believe actually fail to capture the full administrative costs and other impacts. They vary widely among States. For example, the New England and Mid-Atlantic States combined will save almost $16 billion in State funds over 10 years. At the same time, South Atlantic States will be paying about $22 billion more. Governors in States like Massachusetts, New York, Maryland and Vermont combined will shift nearly $23 billion of State costs to Federal taxpayers. At the same time, my State alone is projected to pay nearly $1.8 billion, and this all comes from the same report.

Beyond the costs, we want to make sure we are providing individuals with access to coverage that makes sense for them, that it is cost-effective and gives them access to high-quality services. While groups like those who publish the report might declare victory through the simple act of handing out a Medicaid card, we know that that is simply not enough.

However, I believe this if administration and Congress begins to engage with States interested in pursuing market-driven health care reform, we can create a more sustainable and effective program. Specifically, these discussions should be driven by several tenets of Medicaid reform that include eligibility simplification and flexibility that would allow us to keep families together on one coverage product. These points are fully outlined in my testimony, and again in even more detail in a 31-point report issued by Republican Governors last summer.

President Obama himself said, "We can't simply put more people into a broken system that doesn't work." He is right. Today's Medicaid model doesn't give States adequate flexibility to improve health outcomes or lower overall costs. Instead of rushing to expand, the administration should first engage in earnest discussion with States like Louisiana that are eager to further reform their existing programs now rather than spend more money on a rigid and expensive program that will not work for all States.

Thank you. That concludes my testimony. I look forward to questions at the appropriate time.

[The prepared statement of Mr. Greenstein follows:]

Bobby Jindal
GOVERNOR

Bruce D. Greenstein
SECRETARY

State of Louisiana
Department of Health and Hospitals
Office of the Secretary

TESTIMONY

Hearing on

"State of Uncertainty: Implementation of PPACA's Exchanges and Medicaid Expansion"

December 13, 2012

Statement of
Bruce D. Greenstein
Secretary
Louisiana Department of Health and Hospitals

Before the
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

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Executive Summary

This testimony offers Louisiana's perspective regarding the challenges associated with implementation of the Patient Protection and Affordable Care Act (PPACA), particularly as it relates to the Health Insurance Exchange and the Medicaid expansion as it is contemplated in the law. Louisiana's decision to not assume the risk of building a state-based Exchange is based on concerns with the law and ensuing regulations, including:

- Outstanding legal challenges, including provisions related to the employer mandate, federally-facilitated Exchange subsidy, the preventative care mandate, Maintenance of Effort requirements, the origination clause, the Independent Payment Advisory Board (IPAB), and the legality of rulemaking/guidance, and
- Continuing policy concerns, including the impact of the Exchange as defined in PPACA on consumer choice, the cost of coverage and employers and their employees, and
- Ongoing implementation barriers, including a lack of formal guidance around federally-facilitated and "partnership" Exchanges and unrealistic timelines.

This testimony provides five key issues that need attention from Congress and action from HHS regarding Exchanges, including administrative simplification, the role of an Exchange, plan management responsibilities, eligibility determination and timelines for implementation.

This testimony also offers Louisiana's concerns regarding a blanket expansion of its Medicaid program without fundamental reforms to improve the program. It offers tenets of Medicaid reform necessary to improve the program regardless of a state's decision to expand. These tenets seek flexibility in Medicaid eligibility determination, program design, use of the private insurance market, financing, the waiver process and improved accountability.

Further, the testimony provides an overview of Louisiana's successful state-led health reform efforts.

Introduction

Good morning, Chairman Pitts, Ranking Member Pallone, and distinguished members of the Subcommittee. Thank you for the invitation to testify on Louisiana's position regarding the implementation of the Patient Protection and Affordable Care Act (PPACA), particularly as it relates to the Health Insurance Exchange and the Medicaid expansion as it is contemplated in the law.

My name is Bruce Greenstein, and I am the Secretary of the Louisiana Department of Health and Hospitals (LDHH) and senior health policy advisor to Governor Bobby Jindal. For over 20 years I have led efforts to improve health outcomes and quality, execute new quality initiatives and use innovative technology to solve health care challenges across the U.S. and globe. During President Bush's administration, I served as Associate Regional Administrator and as the Director of Waivers and Demonstrations for the U.S. Department of Health and Human Services (HHS). While at HHS, I oversaw the Medicaid programs in the Northeast and led the federal government's efforts to reform Medicaid programs in several states, including Massachusetts, Florida, Vermont and Iowa. In my current role leading Louisiana's health agency, I have broad responsibility over a vast array of critical and complex health service areas, including Medicaid, behavioral health, public health, emergency preparedness, health care facility licensure and regulation, health information technology, developmental disabilities and aging. At just over $8 billion, LDHH's annual budget represents roughly one-third of Louisiana's entire state operating finances and our Medicaid program provides health coverage for over 1.24 million Louisiana residents, or approximately 28 percent of our state's population.

PPACA Exchanges

On March 23, 2011, the State of Louisiana announced that it would not assume the risk of building a state-based health insurance Exchange as outlined by the Patient Protection and Affordable Care Act (PPACA). Since the PPACA was signed into law, we have repeatedly shared our concerns regarding its policy implications, lack of sufficient guidance and unreasonable timelines for implementation. With the Supreme

Court's decision in *National Federation of Independent Business v. Sebelius*, the Court agreed with the State of Louisiana that at least one of the over 450 provisions of the PPACA is unconstitutional and the provision requiring all individuals to have insurance coverage can only be upheld as a tax. Even after the Supreme Court's decision, there remain many questions about the legality of the PPACA involving issues fundamental to all Americans, including religious freedom and unjust taxation.

While the Supreme Court ruled on the Constitutionality of some parts of the PPACA, it was not an endorsement of its policy merits. In fact, Chief Justice Roberts underscored this fact when he wrote, "Members of this Court are vested with the authority to interpret the law; we possess neither the expertise nor the prerogative to make policy judgments." The PPACA remains a flawed law that fails to fix the fundamental existing problems in the United States health care system, particularly the unsustainable rising costs faced by American families and small businesses. Instead, we are faced with the prospect of a more tightly controlled federal-run health insurance market that will increase costs, undermine the private health care marketplace, and weaken private sector job creation.

The Supreme Court's decision also fails to resolve the operational concerns of implementing the law. With incomplete regulations and unrealistic deadlines, both states and the Federal government will struggle to have a health insurance Exchange ready for open enrollment on October 1, 2013 that is not beset with major complications for the insurance market and the respective residents of the states.

Exchange Legal Questions

Louisiana was one of 26 states that filed suit against the federal government concerning the legality of the PPACA, specifically focusing on two parts: § 1501 (the individual mandate) and Title II (the mandatory expansion of the Medicaid eligible population to 133 percent of the federal poverty level). In June of this year, the Supreme Court agreed that the mandatory Medicaid expansion was unconstitutional. They also ruled that

the individual mandate was unconstitutional under Congress's Commerce power, but upheld this provision as an example of Congress's taxing power, admitting that the purported penalty is actually a tax.

While the Supreme Court effectively rewrote the PPACA to uphold the individual mandate, they did not rule on the legality of the remainder of the law. Provisions that the Court did not rule on that are still being challenged include:

The Employer Mandate

The PPACA requires that all employers with fifty or more full-time employees provide adequate health care coverage to their employees. (§ 1513, §1514, and §10106). If they do not, these employers could face a tax of $2,000 or $3,000. [1]

Federally-Facilitated Exchange Subsidy

In the PPACA, state-based health Exchanges are authorized to provide premium assistance subsidies to individuals from 100% to 400% of the Federal Poverty Level. However, the PPACA does not expressly authorize Federally-facilitated Exchanges to do the same. Subsequent regulations from the Internal Revenue Service have interpreted the law so that all Exchanges are able to provide premium assistance. The legality of these regulations is currently being challenged.[2]

Preventive Care Mandate

Section 2713 of the PPACA allows for the Secretary to define preventive care services to be provided cost-free by all non-grandfathered insurance plans. In August 2011, the Secretary released a regulation that included contraceptive and some abortifacient services as preventative care. The regulation has been challenged by numerous groups and individuals (in over 35 lawsuits) who have

[1] *Liberty University et al v. Geithner et al*, No. 6:10-cv-00015-nkm (W.D. Va.).
[2] *Oklahoma v. Sebelius*, No. CIV-11-030-RAW (E.D. Okla.).

religious objections to paying for health insurance that includes coverage for contraception and some abortifacient services. [3]

Maintenance of Effort

The Supreme Court's decision invalidated the provision of the PPACA that coerced states to expand their Medicaid program by threatening existing Medicaid funding. Questions remain whether this applies to the maintenance of effort (MOE) requirement, requiring states to maintain their existing Medicaid eligibility until 2014.[4]

Origination Clause

The Supreme Court decision made it clear that the individual mandate is a tax, not a penalty as claimed by the administration. The PPACA originated in the Senate. The Constitution (Article I, Section 7, Clause 1) is clear that all taxes are to originate in the House, and thus the legislation has been contested as unconstitutional. [5]

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[3] *Belmont Abbey College v. Sebelius*, No. 1:11-cv-01989-JEB (D.D.C); *Colorado Christian University v. Sebelius*, No. 11-cv-03350 (D. Colo.); *EWTN v. Sebelius*, No. 2:12-cv-00501 (N.D. Ala.); *Priests for Live v. Sebelius*, No. 1:12-cv-00753 (E.D.N.Y); *Louisiana College v. Sebelius*, No. 1:12-cv-00463 (W.D. La.); *Ave Maria v. Sebelius*, No. 2:12-cv-00088 (M.D. Fla); *Geneva College v. Sebelius*, No. 2:12-cv-00207 (W.D. Pa); *Nebraska v. HHS*, No. 4:12-cv-03035 (D. Neb.); *Archdiocese of St. Louis v. Sebelius*, No. 4:12-cv-924 (E.D. Mo.); *Newland v. Sebelius*, No. 1:12-cv-01123 (D. Colo.); *Legatus v. Sebelius*, 2:12-cv-12061 (E.D. Mich); *Roman Catholic Archbishop of Washington v. Sebelius*, No. 1:12-cv-815 (D.D.C.); *Roman Catholic Archdiocese of NY v. Sebelius*, No. 1:12-cv-2542 (E.D.N.Y.); *Rev. Donald W. Trautman v. Sebelius*, No. 1:12-cv-123 (W.D.Pa.), *Most Rev. David A. Zubik v. Sebelius*, No. 2:12-cv-676 (W.D. Pa.); *Roman Catholic Diocese of Dallas v. Sebelius*, No. 3:12-cv-1589 (N.D. Tex.); *Roman Catholic Diocese of Fort Worth v. Sebelius*, No. 4:12-cv-314 (N.D. Tex); *Franciscan Univ. of Stubenville v. Sebelius*, No. 2:12-cv-440 (S.D. Ohio); *Roman Catholic Diocese of Biloxi v. Sebelius*, No. 1:12-cv-158 (S.D. Miss.); *Univ. of Notre Dame v. Sebelius*, No. 3:12-cv-00253 (N.D. Ind.); *Grace Coll. V. Sebelius*, No. 3:12-cv-00459 (N.D. Ind.); *O'Brien v. HHS*, No. 4:12-cv-00476 (E.D. Mo.); *Conlon v. Sebelius*, No. 1:12-cv-3932 (N.D. Ill.); *Triune Health Group v. Sebelius*, No. 1:12-cv-6756 (N.D. Ill.); *Catholic Diocese of Nashville v. Sebelius*, No. 3:12-cv-00934 (M.D. Tn.); *Hobby Lobby v. Sebelius*, No. 12-cv-1000 (W.D. Okla.); *College of the Ozarks v. Sebelius*, No. 6:12-cv-03428 (W.D. Mo.); *Tyndale House v. Sebelius*, No. 1:12-cv-815 (D.D.C. filed May 12, 2012); *Roman Catholic Archdiocese of Atlanta v. Sebelius*, No. 1:12-cv-3489 (N.D. Ga.); *Autocam Corp. v. Sebelius*, No. 1:12-cv-01096 (W.D. Mich.); *Korte & Luitjohan Contractos v. Sebelius*, No. 3:12-cv-01072 (S.D. Ill.); *East Texas Baptist University & Houston Baptist University v. Sebelius*, No. 4:12-cv-03009 (S.D. Tx); *Roman Catholic Archdiocese of Miami v. Sebelius*, No. 1:12-cv-23820 (S.D. Fl.); *Grote Industries v. Sebelius*, No. 4:12-cv-00134 (S.D. In.); *Criswell College v. Sebelius*, No. 3:12-cv-04409 (N.D. Tx); and *Annex Medical v. Sebelius*, No. 0:12-cv-02804 (D. Minn).

[4] *Mayhew v. Sebelius*, No. 12-2058 (1st Cir).

[5] *Sissel v. HHS*, No. 1:10-cv-01263-BAH (D.D.C.).

Independent Payment Advisory Board (IPAB)

Sections 3403 and 10320 of the PPACA created this 15-member federal board that is granted the authority to make payment changes for the Medicare program without approval from Congress. There are also no administrative or judicial reviews of these decisions.[6]

Legality of Rulemaking/Guidance

With many of the provisions of the PPACA, formal rules and regulations have only recently been released or are still forthcoming. Many of the policies are being implemented through unofficial "guidance". There are remaining questions about the legality of this procedure in light of the Administrative Procedures Act.

Policy Implications

While HHS has repeatedly said that the states serve as incubators of innovation, PPACA greatly limits states' ability to enact meaningful state-led health care reform. The concept of a health insurance exchange originated as a free market idea to lower the cost of health insurance by increasing the pool of those purchasing health insurance and giving consumers more choice to select the insurance coverage that best fits their needs. However, the PPACA Exchange is a rigidly constructed enterprise that creates a vehicle for the Federal government to tightly control the coverage options available to consumers, raising costs and limiting choice. Many employers will likely drop the health insurance coverage they currently provide to employees, leaving individual health care options to be determined by the federal government. Specifically, the negative consequences of the PPACA Exchange and associated insurance changes include:

Lack of Consumer Choice

When the PPACA was proposed, the President promised that if individuals liked their current health care insurance, they could keep it. However, the PPACA model will often force individuals into the

[6] *Coons v. Geithner*, No. CV-10-1714-PHX-GMS (D. Ariz).

broken, government-run Medicaid system and into heavily-regulated, government-run health care plans (deemed "minimal essential coverage" by the Federal government).

Individuals should have the right to select what health care plan is best for them, and not be limited to a one-size-fits-all product that that meets what a political process deems is "essential". By mandating that certain benefits be provided in all insurance plans, the price of premiums will likely increase, leaving individuals unable to continue the coverage they like at a price they can afford.

Increased Taxes

The PPACA requires that all Exchanges be financially self-sufficient by 2015. This will require the Exchange to generate revenue, either by instituting user fees in the Exchange market or in the entire insurance market— essentially a tax on all insurance plans purchased. In fact, in the recently issued regulation, "Payment Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014", HHS states that the FFE will charge a user fee in the exchange comparable to the user fees in state-based HIXs, capped at 3.5 percent of each enrollee. This will only further drive up the costs of premiums in the Exchange market for consumers and for individuals who will have to pay the premium assistance through their taxes.

The PPACA also includes a tax on insurance premiums, which is proposed to be paid for by "the industry." It is troubling that these same taxes will affect managed care organizations, proven mechanisms for more effectively controlling cost for Medicaid and Medicare, especially needed for states with limited financial resources.

The Louisiana Association of Health Plans (LAHP) and America's Health Insurance Plans (AHIP) report in a recently released study that the ACA premium tax will force policyholders to pay more for their health insurance. In Louisiana, an individual will pay $2,128 more for single coverage and

$4,512 more for family coverage over the next ten years. A small group employer will pay $2,589 more single coverage and $6,391 more for family coverage. A large group employer will pay $2,830 more for single coverage and $6,836 more for family coverage. A Medicare policyholder would pay $4,111 more for coverage, all within the same time period in Louisiana. This is a significant burden on individuals and families in Louisiana and across the country.

Impact on Employers and Employees

The employer mandate, a tax on employers with fifty or more employees who do not provide "adequate" health insurance coverage to their employees, is a disincentive to provide coverage. Already, businesses are attempting to modify their business structure to avoid the law's mandates (either by laying off employees or reducing the number of hours these employees work). Even those employers who provide coverage can be taxed an additional $3,000 if that employee is eligible and enrolls in coverage on the health insurance Exchange. So instead of building upon the existing insurance market, the PPACA is undermining it.

Implementation Concerns

The deadline for all Exchanges (both state and federally-facilitated) to be ready for open enrollment is October 1, 2013. However, we have serious concerns that exchanges will not be ready by that point, even in those states are electing to build a state-based Exchange. The guidance received from the Federal government is often delayed or not yet available. For a project as large and complicated as health care reform, this is an insurmountable hurdle for the states to overcome. There are numerous unanswered questions and major issues remaining about Exchanges and the provisions of the PPACA, including:

Exchanges in General

In order for an Exchange to be ready for open enrollment on October 1, 2013, its blueprint must be approved or conditionally approved by January 1, 2013. However, there have been no formal

regulations outlining objective guidelines that HHS will use to determine if an Exchange is conditionally approved or not. Our only understanding is that HHS will use a standard of whether a state-based Exchange is making "significant progress" towards the requirements for a state-based Exchange and will be operationally ready for initial open enrollment beginning October 1, 2013. This is not a sufficient standard for conditional approval.

HHS has assured states that there will be published cost comparisons between the Federally-facilitated Exchange, the state-based Exchange, and the partnership Exchanges. Other than the capped 3.5 percent user fee, these cost estimates have not yet been made public.

Federally-facilitated Exchanges

To date, in addition to the incomplete final rule for health insurance Exchanges, there is still not complete rulemaking regarding the Federally-facilitated Exchanges and their interactions with the respective states' eligibility systems. Promised in the March 2012 final Exchange regulation was further guidance regarding the Federally-facilitated Exchange. Since that point and other than the user fee explanation, only a questions and answers document, which does not bear the weight of law for either the federal government or the states, has been released.

Numerous contracts have been signed for the development of the Federally-facilitated Exchange, but these documents have not been made public. The State of Louisiana filed a Freedom of Information Act request within the last few months for these contracts and has still not received these documents. Senator Orrin Hatch of Utah requested similar documents in his role as Ranking Member on the U.S. Senate Committee on Finance and has not received a response. It is necessary for these documents to be made public so that states can make informed decisions concerning Exchanges.

Partnership Exchange

We understand a partnership Exchange to be a Federally-facilitated Exchange with certain functions run by the state. It is an option first introduced by an informal presentation and further expanded by a document entitled "General Guidance on Federally-facilitated Exchanges," but has yet to be defined in federal regulations. The final Exchange rule proposed no regulations regarding this option.

There has been no formal answer from the Federal government concerning whether the Federal government or the states will be responsible to pay for the state-run functions of a partnership Exchange. While HHS officials have repeatedly said that states will not be responsible for funding any portion of the FFE, including the Partnership, there is no formal regulation on how the state will be paid for conducting work on behalf of the Partnership Exchange or formally stating the roles, responsibilities and financing of either the FFE or the Partnership Exchange.

The Workings of an Exchange

The Exchange is required to provide premium tax credits to those between 100% and 400% of the federal poverty line. Originally projected to cost the federal government $462 billion between 2012 and 2019, these subsidies are now projected to be $574 billion during the same period by the Congressional Budget Office. Already, Medicare funding will be cut by $700 billion to pay for these premium tax credits. There is already some discussion that these levels of subsidies are unsustainable and that deficit reduction action could reduce the number of Americans eligible for premium assistance subsidies.

Essential Health Benefits and Actuarial Values

All plans in the individual and small group markets (including plans sold on the respective state Exchanges) must meet "essential health benefits." Regulations published last month say that these

benefits will be based off of the most popular small group plans in each state in addition to benefits specified by the PPPACA. At the same time, an "actuarial value calculator" to accurately determine actuarial values for plans sold on the Exchange was issued.

For those states with federally-facilitated Exchanges, HHS has indicated that they will be responsible for enforcing these essential health benefit standards outside of the Exchange, yet further burdening the states in enforcing a federally mandated law.

Reforms Needed

Many states, including Louisiana, have opted to allow the federal government to establish and operate the Exchanges as envisioned by the Patient Protection and Affordable Care Act (PPACA), and many still have not yet made a commitment. These decisions should not be taken as a general unwillingness to tackle a complex reform project. In fact, states have consistently demonstrated a strong commitment to promoting the health of our residents and have an on-the-ground perspective from years of health care innovations and from running our respective Medicaid programs. Rather, the number of remaining concerns and unanswered questions simply do not give us the confidence needed to accept responsibility for this project. Regardless of the type of Exchange that will operate within a state, we see five key Exchange issues that need attention from Congress and action from HHS: administrative simplification, improvements to the transaction processes, plan management, Medicaid/CHIP eligibility determination, and the timelines for implementation.

Simplification

The PPACA Exchange creates an extremely complex system to purchase insurance. For a consumer to access insurance on the Exchange, he or she will have to first qualify for advanced premium tax credits, and then select a plan. The Exchange will have to verify all of the information provided by the consumer, cross-checking it across federal data sources. In addition, Exchanges and Medicaid are required to use a single application and to determine or assess eligibility for both Medicaid and

premium tax credits. This process should be simplified to allow individuals to easily purchase and enroll in coverage they need.

Transaction Process

Through the extensive authority granted by PPACA, HHS should allow states the option of creating an Exchange that is limited to solely being a vehicle to facilitate the transaction between a buyer and a seller. All other regulatory responsibilities should rest with existing state authorities and agencies. Any Exchange should serve to maximize the health insurance coverage options available to a consumer, and many opportunities to streamline this process exist. For example, rather than requiring complex fund flows between the Exchange, the federal government, and the insurance companies, HHS should allow insurance companies to use their claims expenses against taxes owed on their insurance returns.

Plan Management

An Exchange should be focused on determining eligibility and facilitating the purchase of insurance. Plan management should be left to the expertise of the state, which has the most experience managing insurance plans and products in their respective markets. While states have been given the option to "partner" with the federal government by maintaining the plan management functions for Federally-facilitated Exchanges, it is not clear that this role allows true state control and discretion in plan management. In fact, HHS officials have made it clear that the state would be a "subcontractor" to the FFE. Even if the federal government is responsible for the technology that provides the information to the consumer, a state should still maintain control of the insurance market in every aspect. If a state chooses to assume the plan management functions for the Federally-facilitated Exchange, states need to have the option of controlling which qualified health plans they want in their state's marketplace following state rules, not the rules provided by HHS.

Medicaid/CHIP eligibility

States have long been responsible for the determination of an individual's eligibility for their respective Medicaid programs. Over time, they have developed systems to address fraud and abuse. It is not clear that a Federally-facilitated Exchange (FFE) will have the ability to match the expertise of the states, as evidenced by CMS's own published error rates as it relates to Medicare. Whether a state maintains the authority to determine eligibility for Medicaid or defers to the FFE, the state's policies and processes must be maintained. Furthermore, a state must not be held financially liable for an FFE's faulty determination or assessment. . If an FFE makes a faulty assessment or determination, the federal government should compensate the state for all costs the state incurred because of that erroneous enrollment, including state share and administrative costs

The use of Modified Adjusted Gross Income (MAGI) for eligibility determination, which is meant to simplify the process, actually complicates matters. Concepts like presumptive, retroactive, and transitional medical assistance eligibility that are no longer relevant under PPACA need to be discarded. Section 2202 of PPACA permits hospitals to allow presumptive Medicaid determinations. This should be, as stated in the law, at the option of the states not at the option of the hospitals.

Timeline

There are still many questions regarding the feasibility of the current timelines related to Exchange implementation. The targeted date to begin open enrollment is October 1, 2013, and states are still seeking complete regulatory guidance. States are also waiting for more complete information about the vast information technology systems necessary to support the Exchange. The federal government maintains that the necessary systems (the information hub, the actuarial value calculator, the FFE) will be ready in time, but states have no clear view of the current status or workflow of the federal government's progress. States also need to understand the contingency plan if these systems are not ready in time. It is becoming increasingly clear that more time is needed to permit success for any

type of Exchange. Once the necessary information is released, each state will need time to make a thoughtful and educated decision regarding its participation, and then sufficient time to complete the necessary procurements and enabling legislation within the context of each state's laws.

In addition to addressing these issues, Louisiana fully expects HHS to coordinate its efforts regarding implementation of a Federally-facilitated Exchange in an effort to mitigate the negative impact on either our private insurance market or the Medicaid program. Our hope is that HHS will adhere to the four guiding principles included in the "General Guidance on Federally-facilitated Exchanges". In this light we expect that HHS will:

- Provide a full and complete briefing to state officials regarding on-going implementation efforts;
- Schedule routine meetings to update state officials on the implementation status;
- Notify the state when all stakeholder, consumer, or any other public meetings or public outreach activities are scheduled;
- Work with the state on memorandums of understanding and/or contracts if the Federal-facilitated Exchange expects any support or assistance of the state so that the state is fairly and equitably compensated, including for the use of any state data used by the Federally-facilitated Exchange to verify income;
- Provide the terms of all contracts and names of all contractors who will be working in the state on the Federally-facilitated Exchange and the details about what activities these contractors will be involved in, including copies of all contracts;
- After the establishment of the Exchange, provide regular (at least semi-annual) updates on its utilization, cost (including long-term financial health), and its impact on the state's insurance market, including, but not limited to the information that must be provided pursuant to §1311(d)(7) of the PPACA;

- If any changes to the Federally-facilitated Exchange model are anticipated, the state is notified immediately; and
- Inform the state of any navigator grant recipients and provide copies of memorandums of understanding between navigators and the Federally-facilitated Exchange.

I respectfully urge Congress to carefully review HHS's plans for Exchange implementation. Hard questions should be asked regarding the ability to meet current timelines given the outstanding questions and technological developments that remain to be completed. Furthermore, as an integral part of this workflow, states must be at the table for these discussions regardless of the type of Exchange they are pursuing.

Medicaid Expansion

In addition to our concerns regarding the policy implications and implementation concerns of the Exchanges, we have serious reservations about a blanket expansion of the existing Medicaid program without fundamental reforms to improve health outcomes, clinical quality and lower costs. In August of 2011, Republican governors provided 31 policy solutions to improve Medicaid. To date, we have yet to engage in a meaningful dialogue with this administration about the practical problems states have observed through their considerable experience administering the myriad of existing public assistance programs.

Since the Supreme Court's ruling, each Governor and legislature is now faced with a decision regarding the expansion of the state's Medicaid program. However, faced with a decision to expand within the limits of the current Medicaid model, it is not surprising that many states remain reluctant—even with enhanced federal funding.

The Kaiser Family Foundation and the Urban Institute recently released a report calling the Medicaid expansion a bargain for states. What many states recognize though is that the Medicaid program is based on

an outdate model. Costing billions of dollars a year and producing inconsistent or subpar outcomes, the program is in desperate need for modernization.

Simply enrolling an individual in Medicaid does not guarantee their ability to access high quality health care services. Having a Medicaid card does not necessarily translate into better health. As administrators, we cannot afford to ignore the fact that we would be expanding an inefficient 1960s era entitlement program that limits choice and fails to fully integrate its recipients into the broader health care system. Without fundamental reform, expanding Medicaid is to millions of additional Americans is not the victory many claim it to be.

With a willingness to meaningfully engage with states interested in pursuing market-driven health care reform, we can create a reality where families share an affordable health coverage product with cost-sharing and benefit design that promotes value and achieves optimal health outcomes. We want states to become more efficient purchasers of care, investing in improved health and giving individuals greater choice for themselves and their families.

While each state will have its own set of considerations regarding the future of its Medicaid program, our hope is that the administration will open its doors for discussions with state leaders about the important issues in Medicaid today, regardless of their decision to expand. To make any health care reform truly successful, HHS should let states do what they do best – innovate and tailor solutions to the needs of their citizens. Specifically, there are several tenets of Medicaid reform and flexibility that should drive these discussions, focusing on eligibility, benefit design, cost-sharing, use of the private insurance market, financing and accountability.

Tenets of Medicaid Reform

1. **First, the process to determine Medicaid eligibility should be simple, accurate and fair.** There are far too many complicated categories of Medicaid eligibility. The process should be easier for consumers to navigate and states to administer. For any expansion, the rules for how to identify who is newly eligible for Medicaid versus those who would have traditionally been eligible must be administratively simple on the front end and not impose an overly difficult audit procedure at the end of the year. We cannot afford to base billions of dollars in payments to states on untested methodologies that pose significant risk to state budgets.

   Furthermore, HHS should immediately release all planning documents and the business plan for building the federal data hub—particularly how it will interact with a state's Medicaid program and the status of implementation. With additional information, states can be reassured regarding the implementation timeline and the states' role in interacting with the hub. This information is essential for states' ability to make timely and accurate decisions. Conversely, if the deadlines for the hub will not be met, the federal government should not waste any further taxpayer dollars. All components of the hub must be operational soon or states must have sufficient time to develop contingency plans.

   We also believe that the adoption and use of Modified Adjusted Gross Income (MAGI) will have a disruptive effect on the Medicaid eligibility system and create new inequities among households. States should not have to bear the additional costs of running multiple eligibility systems.

   The Exchanges should be held to the same program integrity rules and regulations as state Medicaid programs. States must maintain the authority for setting eligibility rules to protect the program's integrity.

2. **States should be allowed to design their program to promote value and individual ownership in health care decisions.**

   This includes using consumer-directed products, flexible benefit design and reasonable and enforceable cost-sharing requirements. States must be freed decades old rules that are no longer relevant to 21st century health care. Just like those of us with employer-sponsored coverage or Medicare, Medicaid recipients should not have free access to the emergency room for routine care. When individuals have no skin in the game, they are less likely to consume care responsibly.

3. **States should be able to make use of their private health insurance market through their Medicaid eligibility levels, program design and ability to offer premium assistance.**

   States should have the ability to set eligibility requirements for both their current enrollees and expansion population. For example, states should be allowed the flexibility to set their Medicaid eligibility limits at less than 138% Federal Poverty Level and still receive the enhanced FMAP.

   Additionally, the law currently prevents states from moving children enrolled in their state's CHIP program to their parent's insurance coverage purchased in an Exchange until 2019. With reasonable plans from a state to provide for continued coverage for currently enrolled children, HHS should waive CHIP maintenance of effort (MOE) requirements not set to expire until 2019. This would allow children to be enrolled in private health insurance plans with their parents or caretakers, rather than shifting healthy risk from the private health insurance market and separating families into different public and private health coverage programs. There is value in keeping families together and having them engage with only one health plan, which will ease their use and promote utilization of routine preventive services.

HHS should allow a state to grant "premium assistance" for individuals to buy-into the exchange market place at any income level, rather than be forced into the Medicaid system simply because they are low-income.

HHS should also return full authority to states for setting reimbursement and payment policies, including flexibility to promote value-based insurance design. States should also have full authority for contracting and oversight of managed care, including the ability to place any Medicaid recipient into a managed care setting.

4. **Finally, HHS should streamline Medicaid financing and improve the waiver process to give states more flexibility, coupled with greater accountability tied to improvements in health outcomes.**

   The process by which states negotiate for flexibility, called "waivers", is broken. Federal officials should have greater accountability for timely review of waiver applications. In particular, waivers already approved in other states should be fast-tracked for approval.

   HHS should allow states to opt-in to a more flexible long-term funding arrangement, allowing them to design programs that best meet their people's needs, rather than one-size-fits all programs that require the same package of services for every individual. At the same time, federal and state officials could agree to greater accountability for improvements in health outcomes, not just processes.

President Obama himself said that, 'we can't simply put more people into a broken system that doesn't work.' He is right, and today's Medicaid model doesn't give states adequate flexibility to improve health outcomes or lower overall costs. Instead of rushing to expand, the President and Secretary Sebelius should first engage in earnest discussions with states like Louisiana who are eager to further reform their existing programs now, rather than spend more money on a rigid and expensive program that will not work for states.

Example of State Innovation

Recent successful reforms in the Medicaid program have been driven at the state level. Louisiana has spent the last five-year working toward a complete redesign of its Medicaid program. Our first attempt at reform through an 1115 Research and Demonstration Waiver failed to gain traction at CMS after this administration took office and became focused on its own reform agenda. Instead, our state continued to fight for reform, and over the course of the past year has launched two major program transformations for Medicaid and our behavioral health system.

Bayou Health

Friday, June 1, marked a milestone in Louisiana's health care history, as the Department of Health and Hospitals finished the initial implementation of its new Medicaid delivery model, Bayou Health. The majority of Louisiana's 1.2 million Medicaid and LaCHIP recipients now have their care coordinated through a Health Plan network. Of the nearly 900,000 recipients who are part of Bayou Health, nearly 40 percent proactively chose a Health Plan for their families. New enrollees coming onto the program are making a proactive choice two-thirds of the time, marking an unprecedented level of consumer engagement in Louisiana's Medicaid program.

Bayou Health is the first fundamental transformation of Louisiana's Medicaid program since it was created in the late 1960s. More importantly, it was carefully designed to ensure better, more coordinated care for those who depend on us. The program's focus is on improved access to quality health care and better health outcomes for recipients. Under Bayou Health, DHH contracted with five Health Plans - Amerigroup RealSolutions, Community Health Solutions, LaCare, Louisiana Healthcare Connections and UnitedHealthcare Community Plan -- that are responsible for coordinating health care for recipients and working with them to address issues and empower them to take a more active role in their health.

The primary objectives of Bayou Health were to improve health outcomes, yield savings and improve budget predictability. With a nearly $7 billion Medicaid program covering 27% of population, it was unacceptable that we continued to deliver among the worst health outcomes as a date. Louisiana ranks 49th in most major national health rankings, earns an "F" in pre-term birth and infant mortality from the March of Dimes each year, and continually reports high rates of chronic disease and low utilization of preventive services.

Our health plan partners are contractually obligated and financially at risk to improve outcomes and better coordinate care. Bayou Health will collect and measure performance on 37 HEDIS quality measures. Plans are financially sanctioned quality or performance benchmarks are not reached. The program also includes more focus on preventive services, requirements for chronic condition management, and minimum standards for patient-centered medical homes (PCMH). Designed to improve access, our health plans are required to provide adequate provider networks that meet enforceable time and distance requirements. They have demonstrated their flexibility to negotiate rates with specialists to enroll providers that have not traditionally served the Medicaid population. Furthermore, they provide additional benefits to their enrollees as well as incentives for compliance with care recommendations and healthy behaviors.

Bayou Health is estimated to save Louisiana $135.9 million this fiscal year. Even after only a few short months of statewide implementation, the program has already demonstrated its ability to improve lives. Louisiana will continue to share information about Bayou Health and its effects on health outcomes through regular reports at MakingMedicaidBetter.com.

Louisiana Behavioral Health Partnership

In partnership with Magellan Health Services, we launched the Louisiana Behavioral Health Partnership in March to manage behavioral health services for Medicaid youth and adults as well as for people without Medicaid who are served in the safety net system. At full implementation, the Partnership is expected to manage care for about 100,000 adults and 50,000 youth with Severe Mental Illness or Addictive Disorders –

with a goal of ensuring access to care while reducing costs by moving people out of institutions into community-based settings.

Through the Partnership, Louisiana now has a single point of entry into our behavioral health system through a phone line manned by Louisiana professionals and clinicians 24-hours-a-day, 7-days-a-week. Since turning on its phones on March 1, 2012, Magellan has taken nearly 80,000 calls. The Partnership also includes an intensive case management program for special populations like pregnant women with addictive disorders and people with co-occurring disorders; and the plan works with the state's physical health Medicaid managed care companies (Bayou Health) to coordinate care for people with physical and behavioral health care needs.

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Mr. BURGESS. Thank you. Time is expired.

I recognize Mr. Alexander for 5 minutes for purposes of an opening statement.

STATEMENT OF GARY D. ALEXANDER

Mr. ALEXANDER. Good morning, Vice Chairman Burgess, Ranking Member Pallone and members of the committee. My name is Gary Alexander and I am the Secretary of Public Welfare for the Commonwealth of Pennsylvania. Thank you for asking me to discuss the operational implementation impact of the Affordable Care Act on the Commonwealth, and I encourage you to review my entire printed testimony.

We in the Commonwealth have never witnessed a law so vast with such demands on State resources and lack of Federal guidance. The ACA is not just about the expansion of Medicaid or establishing an insurance exchange. It is about the hundreds of Federal mandates and procedural requirements that have escaped public attention but which we must, by law, obey. The fine print of this legislation is so complex, even the Federal Government struggles to understand it. Consequently, the States cannot fully understand the law's impact on finances, staffing requirements, systems changes and operations. In short, this law completely overwhelms society's safety net for the needy.

Here are just a few of the problems in Pennsylvania created by the ACA. The law mandates that we expand our provider enrollment system to check with our Medicare data. Medicare databases, however, cannot handle automated changes. We will have to add staff resources to respond to 100,000 inquiries every month. We are mandated to create separate databases to accommodate IRS exchanges and some databases such as the Federal Death Master File we have not been given access to.

The ACA mandates that we adopt passive Medicaid renewals, radically changing Pennsylvania's tailor-made renewal systems that took years to refine and perfect. Unlike today, the ACA verification system will not be coordinated with other welfare programs, creating eligibility verification issues.

The ACA mandates that we use the National Correct Coding Initiative. Pennsylvania already performs this task through Claim Check, a federally approved system that cost Pennsylvania $12 million to develop. The difference now is that the new system will be micromanaged by the Federal Government.

The ACA mandates that we create new transaction methods for claim status and eligibility verifications. Our technology is more advanced than what is mandated, and no one will use the outmoded ACA method, but CMS has told us that the law requires us to develop it anyway.

The ACA mandates that States implement the Modified Adjusted Gross Income methodology to determine Medicaid eligibility by 2014. This mandate requires extensive eligibility changes and enhancements. That timeline is much too short for large IT system changes, which will prevent us from developing a system that delivers the best value to the taxpayers. This one change will cost the Commonwealth $250 million.

The ACA mandates that States have an HHS-approved single streamlined application. Pennsylvania already has one. We are struggling to include the changes and enhancements necessary to incorporate MAGI rules of Federal data.

The ACA mandates that we use Medicaid to cover the health care needs of children between the ages of 6 and 18 living in households with incomes between 100 and 133 percent of the Federal poverty level. Pennsylvania already provides health coverage for these children through CHIP, a much less costly program. The Federal Government is thus mandating that we switch to a more costly and less efficient program.

The ACA mandates that we cannot use asset tests, a welfare eligibility tool. When we removed the asset limit test for food stamps, we ended up with lottery winners on the program. We have since reinstituted the asset limit test but we are precluded from considering this tool for Medicaid.

The ACA allows hospitals to do presumptive eligibility determinations for Medicaid. This change could create conflicts of interest. As with many other aspects of the law, CMS has not provided the guidance necessary to implement this requirement. This may leave the States to pick up additional costs.

The ACA mandates us to pay primary care physicians Medicare rates. The feds will pay the difference through 2014. Thereafter, the States will be hit with increased costs. Starting in 2015, this change will cost Pennsylvania $45 million a year.

To summarize, some of the timelines in the law are unrealistic and many of the mandates impose unnecessary duplications of effort that some of our States have already achieved. These changes add to our costs, and as mandates often do, impose a one-size-fits-all approach, making our processes less efficient, not more.

We are told that the Federal Government will pay 90 percent of the costs of the ACA, making this a good deal. That claim overlooks the magnitude of the costs to the States. Ten percent of a huge number is still a very large number. Beyond that, the magnitude of the Federal deficits shakes our confidence that the Federal Government will be able to fulfill its end of the bargain. The ACA will likely have broader economic impacts that will also directly impact the Commonwealth. We do not have the time to go into these, but we note that businesses are already changing their hiring practices in order to transfer health care costs to the State. Perhaps the largest cost of the ACA is the failure to treat the States as true partners, which was the original intent of the Medicaid program. The Federal Government now dictates the States almost every detail of how to run this program. How is that a partnership?

Finally, the ACA invites bureaucratic gridlock that works against its desirable goal of securing greater affordable health coverage for more Americans. To fix the problem, States and localities must be engaged and viewed as partners to create innovative solutions. There is a great deal of work to be done to make this law more reasonable and less burdensome for States, businesses and all Americans. Thank you.

[The prepared statement of Mr. Alexander follows:]

Statement of Gary Alexander
Secretary of Public Welfare for the Commonwealth of Pennsylvania
Before the Committee on Energy and Commerce, Subcommittee on Health
December 13, 2012

The Challenges Facing Pennsylvania in Implementing the Health-Care Reform Law

Introductory Remarks

Chairman Pitts, Ranking Member Pallone, and members of the committee, I thank you for and appreciate this opportunity to discuss the impact of the Patient and Protection and Affordable Care Act (PPACA), as amended, on the Commonwealth of Pennsylvania.

Throughout this testimony, I refer to PPACA, as amended, as the Affordable Care Act, ACA, or the health-care reform law, and I will use all these terms interchangeably.

General Observations

In all my years of public service, I have yet to witness a law so vast with such breathtaking scope, demands on state resources, and lack of federal guidance. I am not even referring to the optional expansion of Medicaid or the establishment of the insurance exchange. I am speaking of the myriad of mandates and onerous procedural requirements that have escaped public attention, but with which Pennsylvania must, by law, comply. Moreover, Pennsylvania's Governor, Tom Corbett, and I are both concerned with the economic changes that will impact the Commonwealth, although we do not fully know the full extent of what those changes will be. Even the federal government has not determined what each of the law's provisions mean,

and we at the state level still do not know in a definitive way the full scope of their impact in terms of finances, staffing requirements, system changes, and operations. Furthermore, the federal government lacks the necessary resources to implement its own law. We also know that Congress will have to make changes to the law, which creates additional uncertainty for states and the citizenry.

The media has ignored the majority of challenges facing states. I have hundreds of policy, operational, and technical staffers working to implement this health-care reform law, and yet, we realized early on that we do not have the capacity or the financial resources to address all of the provisions and requirements of this complicated law. We have had to prioritize these requirements because we cannot do it all. Now, layer on top of this the fact that the U.S. Department of Health and Human Services (HHS) has not been timely or explicit in giving instructions to the states. Not that I blame HHS; it, too, is dealing with the enormity of the law. We had sent a letter to Secretary Kathleen Sebelius with twenty-one enumerated questions, and we are still awaiting answers to six of those questions. Thus, we do not have enough information and lack federal guidance regarding many aspects of the law. But there's more. Some of the timelines in the law are unrealistic. Some of the mandates impose unnecessary duplication of efforts, adding to our costs. Other mandates impose solutions we no longer use because we have adopted more advanced processes. Others are disconnected from the operational realities we face. Some mandates require access to federal systems that are beyond their technological capabilities. More generally, as mandates often are, they impose a one-size-fits-all approach and actually make our processes less efficient, not more efficient.

These costs are not simply high, but overwhelming. We are told that the federal government will pay 90 percent of the cost, making this a good deal because states only have to pay the remaining 10 percent. But this simple formula minimizes the magnitude of the total costs. Ten percent of a huge unknown number is still a very large number, and you still must come up with the 10 percent. A sale of 90 percent off the price of an item does a consumer no good if he cannot come up with the 10 percent. It is actually worse because these are not one-time costs, but ongoing costs. Given the magnitude of the ongoing federal deficits, I have doubts that the federal government will be able to fulfill its end of the bargain.

A major weakness of the health-care reform law is that it fails to engage the states, the laboratories of democracy, as true partners. The law shows little faith in this important feature of the American federal system. The terms of the law are inflexible and heavy handed, with the federal government dictating to the states how things ought to be. Instead of trusting the states, the law creates a host of boards and commissions that serve to create even more rules and further removes decisions from the people by centralizing rulemaking by federal bureaucrats. If the federal government wants to set all of the rules and parameters, then why involve the states at all? Why not have the federal government run the entire Medicaid program, as it does with Medicare? Short of that option, I encourage members of Congress to treat the states as partners, and look to them for innovation and new ideas. That type of relationship would lead to better outcomes, lower costs and a more robust economy.

Medicaid and State Budgets

Medicaid is the most significant budget cost for the states. One third of Pennsylvania's entire state budget is spent on Medicaid. We spend more on Medicaid than we spend on any other state priority, supplanting other important priorities including education and transportation. Medicaid is considered, rightly or wrongly, a "mandatory entitlement." Most other funding is discretionary. So there is less money for other state functions, which adversely impacts our schools, judicial systems, correctional institutions, and transportation infrastructure. We recently had to cut back state funding for higher education. We would not have been forced to make that choice had Medicaid expenditures not experienced exponential growth over the past ten years. Nationally, according to the HHS Office of the Actuary, Medicaid expenditures nearly doubled between federal fiscal years 2000 and 2010.

Keep in mind that when the Affordable Care Act was signed into law, states were already struggling to keep up with the runaway costs of Medicaid that have been slowly, but surely, crowding out other state funding priorities. The additional costs that the ACA adds to Medicaid are costs the states cannot afford.

The Hidden Cost of Expansion

Governor Corbett very much wants to address the problems of health-care coverage in Pennsylvania. We have innovative ideas on how to attain greater health coverage at sustainable costs. But the health-care reform law does not give us such flexibility; it only imposes a one-size-fits-all program that prevents innovation. If we expand Medicaid under the current rules,

we would lock ourselves into an unforgiving system, making innovation impossible or difficult. Who would suffer? Pennsylvania's most needy and vulnerable citizens.

Until we have the flexibility to build a program that increases affordable and cost-effective coverage, Pennsylvania will delay the decision about expanding Medicaid for adults. Under the constraints of the health-care reform law, I do not think we can afford the expansion. After viewing Monday's letter from HHS, it is disappointing to see that the Obama Administration continues to show little interest in working with states by not allowing enhanced matching funds for states that choose a partial expansion. This decision, as noted by other governors this week, is shortsighted and will hinder the decision-making process.

Pennsylvania already has 2.2 million people on Medicaid, 2.4 million counting the Children's Health Insurance Program (CHIP). Our forecasts estimate the ACA would add 800,000 to 1,000,000 more persons onto Medicaid. This means that the ACA would boost the proportion of our population on Medicaid or CHIP from the current 19 percent to more than 25 percent. If we add the 15 percent of Pennsylvania's population on Medicare, after subtracting for persons on both Medicaid and Medicare, we would end up with more than 40 percent of our population on a federal health-care program. This number would approach the total employment numbers in our state. We have 5.7 million employed persons. But after the ACA expansion, we would have approximately 5.4 million residents on Medicaid, CHIP, or Medicare.

The federal government is supposed to pay 100 percent of the cost for the newly eligible persons on Medicaid pursuant to the ACA for the first three years of the expansion. Yet we will

still incur costs: an estimated $222 million in the first state fiscal year of the expansion, $378 million in the second, and $364 million in the third. For the next four years, the Federal Medical Assistance Percentages (FMAP) rate slowly drops to 90 percent, and we estimate a cost of $883 million by state fiscal year 2020-21 as a consequence. Moreover, the Centers for Medicare and Medicaid Services (CMS) has yet to confirm that Pennsylvania would be eligible for the 100 percent reimbursement of costs, which leaves open the possibility that our FMAP rate would be lower. If this assumption is wrong, then our estimated costs are too low.

Furthermore, for the out years, our cost estimates may very well be overly optimistic, especially when we consider the fiscal situation of the federal government. It is not just that the federal government has been unable to balance its own budget since 2001. The problem is better explained by the sheer magnitude of the annual federal deficits and the enormous national debt. Over the past four years, the magnitude of the federal deficit has been, on average, larger than the entire annual Gross Domestic Products of all but twelve countries of the world.[1] Moreover, counting the total national debt, including that held by governmental entities, our debt exceeds our own Gross Domestic Product. In short, the federal government lacks a good track record when it comes to fiscal responsibility. Consequently, we see the FMAP rates as teaser rates that are unsustainable and will have to be lowered, pushing more of the costs onto the states in the near future.

1. For Federal Fiscal Year 2012, it is likely that Mexico's Gross Domestic Product exceeded the U.S. federal budget deficit, thus making it thirteen countries for FFY 2012. Data source: Central Intelligence Agency, *The World Fact Book*.

Insurance Exchange

Although my department has not been tasked with implementing an insurance exchange, this does not mean we will not be affected. My department will need to communicate with the federal hub in order to exchange information to determine Medicaid eligibility based upon current and new federal rules, including provisions related to federal tax credits.

Yesterday, Governor Corbett announced that Pennsylvania would not be pursuing a state-based exchange at this time. The Commonwealth, through our Insurance Department, had spent two years trying to understand the impact an insurance exchange would have on Pennsylvania and its insurance market. The governor continues to have strong concerns that "state authority" to run a health insurance exchange is illusory—when in reality, Pennsylvania would end up shouldering all of the costs by 2015, but have no authority to govern the program. With regulations still to be finalized and with more forthcoming, too many unknowns remain for Pennsylvania to move forward with a state-based exchange at this time.

The Many Other Mandates: A Heavy Lift

When my department first began analyzing the ACA, we enumerated 76 program changes—some optional, many mandatory. Nearly all changes require regulatory specifications and clarifications from federal agencies, mostly from CMS. It became obvious from the beginning that we did not have the staff resources to implement all of the changes. Therefore, we prioritized and focused on the ones we believed were the most important, did not require federal guidance on implementation, or were due first.

Like the federal government, we have limited human resources. The state employees needed to implement the provisions of the ACA are the same employees we depend on to administer the many other Medicaid mandates we follow on a day-to-day basis, as well as to maintain an efficient and accurate program. Additionally, this impacts non-Medicaid programs because these same resources must support other welfare programs administered by the Commonwealth. State governments have been faced with limited resources since the last recession; we do have not have resources to hire additional staff or contractors. Although the health-care reform law would provide 90-percent funding, we have to muster together the resources first—and the process to apply for the 90-percent federal match is itself a bureaucratic ordeal that involves staff time, which is not part of the 90-percent deal.

We attempted to estimate the total costs of implementing the health-care reform law, not including the expansion issue and the insurance exchange. This turned out to be a nearly impossible task. We don't have specifications from the federal government to estimate program costs and staff needs for many of the changes. Nor do we have the staff resources to work through in sufficient detail all the 76 major changes. Nonetheless, our fiscal office chose to estimate some of the larger items. My fiscal office estimated a cost of $134 million in state funds for state fiscal year (SFY) 2013-14. This cost nearly doubles to $267 million for SFY 2014-15. These are not the costs to expand Medicaid eligibility or to set up an insurance exchange. These are costs that are above and beyond expansion and the insurance exchange, and these are costs that we must incur to comply with the health-care reform law. Keep in mind that

these costs are only what we were able to quantify. We anticipate many other costs that we do not yet have enough specificity to quantify.

These state costs in the hundreds of millions of dollars may seem small to the federal government, but they are not small to the Commonwealth of Pennsylvania. They are larger than the total State General Fund budgets of many of our agencies. We had to cut back on many of our programs, and now we must allocate scarce resources to fund federal mandates instead of investing in education, highways, and other state priorities. Pennsylvania is also struggling to address a pension crisis. The combination of ACA mandates and the pension crisis will mean lean times for other state priorities going forward for the foreseeable future, severely restricting the decision-making options of our state legislature and its ability to make needed investments in infrastructure, projects that would create good-paying jobs and facilitate economic growth.

Permit me to specify ways in which the new law, as currently written, imposes huge costs and burdens on Pennsylvania.

Modified Adjusted-Gross Income (MAGI)

States are required to implement the Modified Adjusted Gross Income (MAGI) methodology to determine Medicaid eligibility, effective January 1, 2014. This mandate requires extensive eligibility system updates, changes, and enhancements including the following: income methodology to determine Medicaid; no asset test or income disregards (other than the required 5 percent disregard); incorporation of Internal Revenue Code rules for household-

composition and income-eligibility rules; and Medicaid net-income standards converted to equivalent MAGI standards. Those determined ineligible under MAGI rules must still have eligibility determined under the current Medicaid-income rules creating multiple methodologies that must be maintained. In addition, the MAGI methodology requires new written policies and procedures to be developed and implemented and will require staff training.

MAGI rules are a challenge, to say the least, for our information technology (IT) systems. The cost for the changes needed to current systems is estimated to be more than $250 million, given the various delays in receiving guidance.

Further, due to the short timeframes to implement MAGI, many shortcuts will be needed in the development, testing, and training processes. Accordingly, in many cases we may have to incur additional costs to fix any errors after implementation. The January 2014 deadline will require Pennsylvania to implement the MAGI changes in a big-bang approach.

In addition to hiring additional programmers, the state will be required to use its limited number of business analysts and project managers to focus solely on the implementation of the ACA. The current state budget is strained, and hiring freezes are in effect. Since this is such a large implementation and will require extensive resources, many current state priorities, including cost containment activities, will need to be put on hold. In difficult budget times, initiatives that contain costs and reduce fraud, waste and abuse are critical to balancing our budget.

CMS has set up a collaborative forum for states to share best practices and code. The reality is that the timeframes don't allow states to effectively use these resources, since most states are facing the same challenges in the development process.

Pennsylvania currently has an integrated eligibility system. Although the A87 Cost Allocation waiver is helpful to allow states to leverage the ACA systems changes for non-Medicaid programs, the ACA is forcing us to build multiple processes. For example, the federal hub and its link to the Social Security Administration (SSA) can only be leveraged by the Medicaid program. For our non-Medicaid programs, we will still need to maintain separate exchanges with other federal programs. The use of Federal Tax Information (FTI) is one example. The FTI data can only be used for MAGI eligibility and cannot be used for non-MAGI programs. The inability to use FTI information across programs forces states to use and maintain multiple methodologies to capture income information for eligibility determinations.

Even though CMS has allowed for 90-percent federal funding for all systems changes, the required 10-percent state funding is burdensome. As mentioned before, Pennsylvania's conservative estimate for all systems changes including staffing, development, project management, testing, independent verification and validation, training and implementation is more than $250 million. This will require approximately $25 million in state funding. In addition, Pennsylvania has a stand-alone CHIP program, and therefore the A87 Cost Allocation waiver does not apply. The cost to integrate the CHIP program into the Medicaid systems would only

be entitled to a 66 percent federal financial participation rate, as opposed to the 90 percent for other programs.

Disproportionate Share Hospital Payments

Disproportionate share hospital (DSH) adjustment payments are another area of concern. They provide funding to hospitals that: (1) serve a significantly disproportionate number of low-income patients; or (2) are located in an urban area, have 100 or more beds, and can demonstrate that more than 30 percent of their revenues are derived from state and local government payments for the indigent and care provided to patients not covered by Medicare or Medicaid.

States receive an annual DSH allotment to cover the costs of hospitals that provide care to low-income patients that are not paid by other payers, such as Medicare, Medicaid, CHIP or other health-care insurance. This annual allotment is calculated by law and includes requirements to ensure that the DSH payments to individual DSH hospitals are not higher than their uncompensated care costs.

Pennsylvania uses DSH funds to make payments to qualifying hospitals in accordance with the federal criteria identified above. In addition, teaching hospitals (academic medical centers) receive funding to promote training and access to additional medical personnel. Pennsylvania also uses DSH funding to provide several supplemental payment programs to support hospitals that provide access to a high volume of Medicaid individuals and specialized care (e.g., obstetrical and gynecological care, burn care, trauma care) to Medicaid and uninsured

individuals. The ACA makes significant changes to DSH funding, and there is little guidance in determining the fiscal impact of any DSH reductions on the Medicaid program and the hospital-provider community.

Expanded Provider Enrollment Requirement

The health-care reform law requires my department to make burdensome system changes to our Medicaid Management Information System (MMIS) for both claims and providers. While not all-inclusive, some of the more onerous changes from an operations perspective include the following: automating some screening and database checks; adding new fields and algorithms for fee collection and revalidation; entering additional information for every owner, manager, managing employee board member, and person with more than five-percent controlling interest; and requiring a national provider identifier (NPI) on all media.

Additionally, as things stand now, staff are to enroll all prescribing, ordering, and referring providers. This is a significant change for all states. However, Pennsylvania has 67,000 unique rendering providers, and we estimate that this requirement alone will add at least 50,000 more providers to the enrollment workload. All of those providers are subject to the same screening requirements. Additionally, we have to check whether Medicare collected the institutional fee or not. If they did not, we must do so for every institutional service location and track it accordingly. There is no fee for individual providers or groups. By our estimates, the combination of all these things results in at least a seven-fold increase in the volume of work for my staff.

We already have many provider record systems and many areas of intake. It is a heavy lift for us to change the current structure in terms of creating new standardized policies and processes, and reorganizing staffing accordingly.

The technical challenges are even more daunting. We are required to connect to federal databases, some of which do not even have basic indexing features. There are others that we still have not been given access to: for example, the Death Master File. Furthermore, we have notified federal agencies that it is impossible for us to implement these changes without modifications. To get the information we need, the Medicare database can only be queried manually, one provider at a time. It is simply not possible for us to conduct more than 100,000 manual queries each month. We have been actively working with CMS to get a better system in place, but the outcome and timing remain uncertain.

We are using Medicare requirements regarding site visits, fingerprinting, and background checks. However, we continue to await further guidance from CMS, and depending on how CMS promulgates the final requirements, we may need to implement additional enrollment steps and incur additional vendor costs to comply.

I cannot tell you the total cost of the system and personnel changes we will need to make pertaining to provider-enrollment requirements. I do not want to give you a specific number because it will not be accurate, but the cost will certainly be in the millions of dollars. We are still awaiting specifications from the federal government, and, quite frankly, the federal government's databases are not suitable for the tasks that are assigned to them. We now have

forty people across five offices working on day-to-day enrollment functions, and there is perhaps an equal number behind the scenes enabling the system to work.

Primary-Care Physicians

Another area of concern is the increased Medicaid payment rates for Primary-Care Physicians (PCP). For calendar years 2013 and 2014, the ACA requires state Medicaid payments to certain types of physicians for certain primary care services, like office visits, exams, consults, etc., to be at least 100 percent of the Medicare rate for those services. Like many states, Pennsylvania currently has Medicaid rates for these services that are below Medicare rates, so the ACA requirement will result in Medicaid fee increases. The federal government will fund the difference between the lower state Medicaid rate and the Medicare rate during 2012 and 2013. In theory, the fee increase will not impose additional Medicaid service costs on the states in those years. Absent additional federal legislation, however, the increased fee requirement and the additional federal funds only apply during the next two calendar years. Any continuation of the increased fees from that point on will involve additional state costs. It is unreasonable to expect that any state will be able to roll back those fees.

CMS has provided guidance on increased payment rates to PCPs, but it has not been timely. CMS issued the final rule only on November 6, 2012, yet it becomes effective on January 1, 2013. CMS has still not released the Medicare 2013 fees. CMS issued proposed rules back in May, and issued final rules in early November. The federal agency also issued several briefs, summaries and fact sheets over the past 12 months, and recently conducted an all-states call to discuss the final rule. CMS has promised additional managed-care-related technical assistance

from a contractor beginning in January. Additionally, the quality of the federal guidance has varied widely. The recent verbal guidance on the final rule during the all-states call seemed sufficient; however, we have requested, but not yet received, confirmation in writing. The technical assistance will not start until at least January, and the tardiness of this information necessitates late implementation and retroactive or make-up payments to providers. CMS has already acknowledged how unreasonable the timeline is by acknowledging that the states will have to implement this mandate after the required effective date.

National Correct Coding Initiative

The ACA-mandated National Correct Coding Initiative (NCCI) is an unnecessary, duplicative effort that only costs us money and diverts limited state resources. Under the ACA, states were required to implement Medicaid Procedure-to-Procedure Edits (PTP) and Medically Unlikely Edits (MUE) for practitioners, ambulatory surgery centers, outpatient hospitals and medical suppliers, beginning April 1, 2011. This implementation would prevent providers from being paid for services that were incidental or mutually exclusive and also stop the payment of services that exceeded the number of units deemed appropriate by CMS during the same date of service. These types of edits had been in effect previously for Medicare providers. Based upon the information supplied to CMS, Pennsylvania Medicaid was given approval by CMS to implement in two stages. Stage 1 pertains to the PTP edits and was implemented on December 1, 2011, and stage 2 pertains to the MUE edits and was implemented on November 1, 2012.

My department had already paid for ClaimCheck, which provided edits for mutually exclusive and incidental services. The NCCI edits now supersede the ClaimCheck edits under the

assumption that NCCI savings are much more significant, when in reality the department was already capturing these types of savings. CMS, PTP and MUE edits are at times in direct conflict with Pennsylvania Medicaid regulations, policy and billing directives. In order to prevent a claims payment conflict with the Pennsylvania Medicaid regulations, each quarterly update must be reviewed to determine when the CMS rules conflict with the Pennsylvania Medicaid rules. CMS only publishes the quarterly updates toward the end of the previous quarter, which does not leave the department sufficient time to review the new PTP pairings and MUE's before the beginning of the quarter in which they are effective. Requests for deactivation need to be forwarded to CMS in order for the department to provide claims payment that mirrors our policy, regulations and billing-guide directives. Updates to our claims-payment system (PROMISe) must be completed when the NCCI edits conflict with the department's policy, regulations and billing-guide directives. Many hours of work by two separate bureaus are dedicated to the review of the quarterly updates. In the last quarterly review, more than 250,000 PTP edits needed to be reviewed, which resulted in other work projects being set aside.

Administrative Simplification

Administrative simplification provisions of the ACA may seem harmless enough, but they cannot simplify a process no one is using. As some of the less-publicized provisions of the ACA, administrative simplification has the seemingly innocuous goal of decreasing the administrative burden for both payers and providers (hospitals, physicians, and allied-care practitioners). Section 1104 of the Affordable Care Act directs the HHS Secretary to implement new "operating rules" that will govern the exchange of health-data transactions, such as eligibility, claim status,

electronic funds transfers, electronic-remittance advices and new data identifiers, such as health plan IDs. These new "operating rules" will be implemented over the next three to four years, beginning January 1, 2013.

The first two transactions that require changes to be implemented are the claim-status transaction and the eligibility-verification transaction. There are two types of claims status transactions that are to be implemented on January 1, 2013: batch and interactive transactions. Both use a standardized protocol, and the information provided in the transaction is limited. Pennsylvania Medicaid has found that a majority of providers prefer to use our Internet portal to determine a claim status. Since January 2012, we have only one provider that uses the nightly batch transactions and no providers that use the interactive transaction.

When the Office of Medical Assistance Programs within my department requested enhanced funding for the implementation of these transactions, we noted that we would be requesting a waiver of the implementation of the interactive transaction. This waiver was requested in August due to the lack of return on investment, based on the fact that we do not have providers using this form of transaction. The cost to implement this transaction is estimated to be approximately $50,000. In late November, we received notification from CMS that they do not have the authority to amend statutory and regulatory requirements. We are now working on a timeline to implement a transaction that very possibly no one will use. This appears to be an area where we could have saved both state and federal financial resources.

Program Integrity

With regards to the program-integrity provisions in the ACA, Pennsylvania already has been doing most of them and has been far ahead of the game. While the provisions on program integrity are mostly good, one provision will be difficult to implement. Section 6402(h) of the ACA requires the suspension of Medicare and Medicaid payments pending investigation of credible allegations of fraud. This provision requires states to suspend payments to individuals or entities based upon credible allegations of fraud, unless HHS and the state find good cause not to do so. While this provision may be well-intended, the criteria that constitute "credible" must be defined, and the intricacies are difficult to implement and operationalize. The basis of a credible allegation for fraud-referral purposes must be detailed in a notification to the provider when payment is suspended. Documentation and reporting requirements have added complexity to the fraud-referral and tracking process. Finally, providers have raised due-process concerns because the payment is suspended one day after referral, and the state is required to notify the provider within five days of the suspension.

Other Challenges

The health-care reform law requires states to have an HHS-approved, single streamlined application. We already have one in Pennsylvania, but we are struggling with incorporating the updates, changes, and enhancements to incorporate MAGI rules and interaction with the federal data hub. CMS has not provided their final drafts of the online or paper application, has not defined all application data elements and fields, and has not provided necessary guidance on the interaction processes between the federal hub and a state's web-based applications.

Pennsylvania covers the health-care needs of children between the ages 6 and 18 living in households between 100 percent and 133 percent of the federal poverty level through CHIP. CMS, however, has said that the health-care reform law requires us to fund these children through Medicaid, not CHIP, a less costly program.

The new MAGI rule mandates that resource-limit tests, also known as asset-limit tests, be excluded for eligibility. I question the wisdom of mandating their exclusion. Although Pennsylvania currently excludes asset-limit tests for Medicaid families with children under the age 21, this was an option selected by Pennsylvania. We do, however, have asset-limit tests for other welfare populations, as the test remains an important tool to determine welfare eligibility for programs including food stamps.

Pennsylvania has an integrated eligibility system and must incorporate MAGI rules and logic into the system for Medicaid-eligibility determinations. This mandate requires incorporating into the eligibility system new rules and logic, keeping current rules and logic for non-MAGI groups and maintaining existing rules and logic for other programs, such as the Supplemental Nutrition Assistance Program (SNAP), cash assistance, and the Low Income Heating Energy Assistance Program (LIHEAP). This task is not easy. There are many complexities in designing, developing, testing and implementing all necessary system requirements. While CMS has acknowledged that many states do have an integrated eligibility system, it has not formally addressed questions, comments and concerns presented from states.

States must maintain Medicaid eligibility standards, methodologies and procedures that are no more restrictive than those in effect on March 23, 2010, the date the ACA was enacted. These are known as Medicaid Maintenance of Effort (MOE) provisions, which for the adult population is set to expire when the HHS secretary determines that an exchange, either federal or state-based, is fully operational in a state, scheduled for January 1, 2014. The MOE provisions for children under age 19, for both Medicaid and CHIP, are effective through September 30, 2019. This MOE requirement has been a stumbling block for states to implement needed cost savings and reforms. In fact, the ACA has been effective in blocking many innovative ideas on cost containment and operational reforms that would have resulted in better-quality outcomes for recipients. Even efforts to "go green" by implementing paperless application processes are precluded by MOE requirements.

ACA also contains provisions regarding administrative "passive" renewals. This involves completing benefit renewals for ongoing eligibility using data sources and sending a notice of eligibility at renewal. If eligibility cannot be determined through the use of data sources, states are to send a pre-populated form. Renewals for individuals enrolled through MAGI-based rules could be limited to no more than once every 12 months. These requirements would necessitate substantial system changes to the current eligibility and auto renewal/semi-annual review systems to meet requirements. States would need to develop and implement new written policies and procedures. Staff training also would be necessary. CMS has not yet provided guidance and definitive clarification on these processes, nor has CMS provided necessary guidance and clarification on the interaction processes between the federal hub and a state's eligibility and enrollment system.

ACA allows a hospital to be a qualified entity to do presumptive eligibility (PE) determinations for Medicaid. It requires the establishment of policies and procedures, which will entail system updates and Medicaid-eligibility training provided by the state. CMS stated that verification is not required by the Medicaid agency to authorize presumptive eligibility for Medical Assistance. This may contradict, or possibly preempt, Pennsylvania state law because verification of income must be provided prior to Medical Assistance authorization. Moreover, states have raised program-integrity concerns because they may be financially liable for any services paid to the hospital under PE, regardless of whether an individual is later found ineligible. CMS has not provided the final guidance or definitive clarification necessary to implement this requirement.

The exchange of information to verify the income and eligibility of applicants and beneficiaries is required and must have adequate safeguards in place. It requires system updates and new written policies and procedures to be developed and implemented. States have concerns with the safeguarding and sharing of information, especially with integrated eligibility systems and with the electronic transfer of data in the verification process. CMS has, likewise, not released final guidance on this provision.

Letter to Secretary Sebelius

We have had a chronic issue with the timeliness of directions received from HHS. The poor response rate confirms the inability of HHS to cope with the magnitude of the health-care reform law. On August 23, 2012, I wrote to Secretary Kathleen Sebelius, enumerating twenty-one questions that Pennsylvania needs answers to before it can move forward with ACA

implementation. More than three months later, I have not received a direct response. We were able to glean answers to a number of those questions through various avenues, including a letter sent by Secretary Sebelius to the governors of various states just this past Monday. Even so, multiple questions in my letter remain unanswered. Of those answered, numerous responses demonstrate complete inflexibility. For example, CMS answered that we will have to run two concurrent databases and are prohibited by the health-care reform law to consolidate them into a single, more cost-effective system. Not only is this decision costly to Pennsylvania but it also could mean delays in receiving services for consumers. As another example, CMS told us that we had to change the financing of health care for children ages 6 through 18 from CHIP to Medicaid, thus costing the taxpayers additional funds and removing authority from the state.

Economic Impact on States

The challenges and costs discussed above will be worse in practice when the full weight of the health-care reform law impacts the general economy. I say this because our analyses are based on a static picture of the economy and the current configuration of business practices. The reality will be much more dynamic. We will certainly witness cost-avoidance behavior on the part of businesses that will move many more persons onto the Medicaid rolls.

Let me explain. The health-care reform law assesses a fee of $2,000 per full-time employee, excluding the first thirty employees, on employers with more than fifty employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit. Employers with more than fifty employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee

receiving a premium credit or $2,000 for each full-time employee, excluding the first thirty employees. Penalties do not apply to employers with under fifty employees. This creates an incentive to use more part-time and less full-time employees.

We are already seeing this shift, according to data from the Bureau of Labor Statistics. The recent drop in the unemployment rate has been because companies are hiring more part-time workers, not because of full-time hiring. This trend will become institutionalized; already companies have been changing their business models to utilize part-time help at low wages and no benefits. This trend will only increase over time as businesses look for ways to cut costs.

The economic impact extends beyond the trend toward business relying more and more on part-time help, as opposed to full-time help. The taxes on the health-care industry contained in the ACA, such as the tax on medical devices and insurance companies, will increase the cost of providing health care, making the name of the law a misnomer. In combination with the anticipated cuts to Medicare providers because of the ACA, these same providers will be looking to offset their losses. Consequently, health care will become even more expensive in the private market and for the federal government. As health-care insurance costs rise, this will increase the amount of federal dollars needed for the tax credit and cost-sharing reductions.

What this means is that even more people will become eligible for Medicaid or will be forced into government health care than our original estimates predicted.

Recommendations

My first recommendation is to upgrade the federal information technology systems before you mandate states to create interchanges with them. Federal agencies lack resources and sophistication to fully implement the health-care reform law. Congress ought to alter deadlines or suspend requirements for those areas where federal agencies are inadequately prepared.

Second, there are too many mandates imposed upon the states all at once. We cannot handle them all within the expected timeframe on top of the already burdensome mandates from Washington that we must follow. Not only do states lack the resources to comply with all these mandates, but the federal government also lacks the resources to adequately offer guidance. Furthermore, the implementation of the ACA needs to be a partnership, not a top-down relationship where the federal government dictates each and every term to the states.

Third, allow states to innovate and come up with solutions better suited to their specific circumstances. One way to accomplish this would be to grant waivers to the states from ACA requirements. Also, draft the waiver authority broadly to increase flexibility in favor of the states and allow for an expedited federal approval process with streamlined reporting requirements that are understandable to the taxpayers. Waivers mean nothing if they cannot be implemented for several months.

Fourth, provide the ability for states to seek a "superwaiver" for demonstration projects, whereby a state could devise a system to integrate and coordinate better outcomes across all welfare programs that would empower recipients and improve outcomes. I would include all

welfare-related programs: health care, food stamps, housing, child-care, cash assistance, and social security disability.

Fifth, keep a close eye on DSH payments. Like the Commonwealth, Pennsylvania's providers continue to face fiscal strains that over time will result in less access and poorer quality of health care for our residents. DSH payments are designed to compensate them for uncompensated care. The ACA cuts DSH payments even though the ACA does not guarantee a commensurate reduction in uncompensated costs. If uncompensated costs remain high even after the ACA is fully enacted, Congress must work with the states to reform this program and ensure that reform takes into account the unique programs different states have.

Sixth, it is much more preferable that we allow for innovation by the states, but if the federal government insists on mandating system changes, then the federal government should pay for them all. If this is unacceptable, then at the very least, there should be a 90/10 split, which ought to be extended beyond the December 2014 termination date.

Closing

The choices you make as national legislators on the implementation of the ACA will exert consequences on the states and our nation for years to come. Like many of my counterparts in other states, I have strong concerns about the unfunded and inflexible mandates as well as the timeframes associated with the national health-care reform law. The mandates have costs for the states that will have to be paid for by state and federal taxpayers and supplant other

funding priorities, including education and infrastructure. Also keep in mind that every $100 spent on Medicaid benefits incurs $5.50 in administrative costs. Pennsylvania pays roughly $2.48 of that amount. So whenever the federal government increases spending on programs like this and pays 100 percent of the increased costs, administrative costs will also increase for the states.

Finally, the ACA invites bureaucratic gridlock that works against its desirable goal of securing greater affordable health care coverage for more Americans. If we want a system that will work efficiently and effectively, states and localities must be engaged and viewed as partners to create innovative solutions to provide opportunity for our citizenry. The health-care reform law as it stands is not only beyond the capacity of state governments to fully comply with, it is also beyond the resources of the federal government. There is a great deal of work to be done to make this law more reasonable and less burdensome for states, businesses and all Americans.

Thank you for taking the time to hear my testimony. I look forward to any questions that you may have.

Mr. BURGESS. The gentleman's time is expired.

I recognize Dr. Sharfstein for 5 minutes for the purpose of an opening statement, sir.

STATEMENT OF JOSHUA M. SHARFSTEIN

Mr. SHARFSTEIN. Thank you. Good morning, Chairman Burgess, Ranking Member Pallone, members of the Health Subcommittee. I am Dr. Joshua Sharfstein, Secretary of the Maryland Department of Health and Mental Hygiene. In this position, I oversee our State's Medicaid program and I also serve as Chair of the Board of the Maryland Health Benefit Exchange. I am grateful for the opportunity this morning to speak with you about the implementation of the Affordable Care Act in Maryland. I am also a pediatrician, and with respect to the last three speakers, all my distinguished colleagues from other States, I think I am the answer to the Sesame Street question of "Which one of these is not like the other?"

My testimony today will include, one, background on the key elements of Maryland's health care system and the importance of improved access to care and cost control; two, a description of how broad public engagement has guided Maryland's process implementing the Affordable Care Act; three, specific details on how Maryland with the support of HHS is customizing the tools in the new law; and four, a summary of the economic value of health care reform implementation in our State.

So first, a little background. Over the course of several decades, Maryland has pursued innovation in health care financing and insurance markets to expand access to care, control costs and promote health. Important aspects of Maryland's system include a unique all-payer approach to hospital payment; a small group market that has modified community rating and serves more than 400,000 Marylanders; a high-risk pool, a health information exchange that includes data from all hospitals and allows doctors to have access to help patients at the point of care; An all-payer pilot for medical homes to improve primary care; and a Medicaid and CHIP program that covers children up to 300 percent of the Federal poverty line and expanded in 2008 to include parents of dependent children with incomes up to 116 percent of poverty.

Now, I came onboard a couple years after that expansion, and I met some of the more than 97,000 Maryland parents who are covered, and I heard how the coverage allowed them to get back to work, to get over injuries that had happened, and I have met one like the mother on the Eastern Shore who said that because of coverage, "Now if I have to pick up a prescription, it is not I am not going to have to have the money, I am going to have to take it away from groceries." You know, hearing that from somebody where they don't have to take money from groceries in order to pay for health care is something that, you know, we deal with all the time at the State level, and I think it was the legacy of expanding Medicaid and having it be positive for the State that kind of overshadowed the implementation and kind of was what happened right before the Affordable Care Act passed.

Now, despite this progress, major challenges face our health care system, challenges that are common to many States including sig-

nificant numbers of citizens who are uninsured, substantial disparities in health care, rising health care costs.

So the second thing I would like to talk about is public engagement in the State. From the day after the Affordable Care Act was signed, Maryland has been working with hundreds of interested people from doctors, hospitals, insurance brokers, businesses and others, carriers, to design and think through how this set of tools could work for the State. That is included in early consensus that it made sense for Maryland to operate its own health insurance exchange, expand Medicaid and take advantage of other options within the law. There was wide understanding that the various aspects of the law that included allowing kids to stay on their parents' coverage, improving seniors' access to prescription drugs also provided great benefits to the State. There was a major report in 2011 that led to the exchange getting established in the legislative session. There are nine members of the board including six public members, and we have had more than six advisory committees with all sorts of representation and engagement across the State. They have met dozens of times. We have had numerous public input sessions, and that led to a second law that passed in 2012 that adopted a series of recommendations, 27 recommendations on how to structure the exchange. All these things were up to Maryland under the way the law was structured.

We have made multiple decisions to tailor the law. These include allowing insurance brokers to sell inside the exchange and continue to be paid directly by carriers like they are now, selling adult dental plans as an option for participants, designing the Maryland Health Connection as a consumer portal for access, and today Marylanders can send a text message of "connected" to be notified when coverage is available. We have been customizing Medicaid including women in private health plans to become newly eligible for Medicaid to stay in their private plans while having Medicaid dollars pay for their premiums, and in making all these individual decisions, and there are many more in my written testimony, we have had tremendous support from both CCIIO and Medicaid as part of the regular process that they use to engage with State officials, and that is extended across into development of an integrated IT system which we have been working on for the last 2 years and will really be a leap forward for the State in terms of access to care and coverage.

The last thing I just wanted to mention is that there was an independent economic analysis by the University of Maryland, Baltimore County, on the impact of health care reform implementation in Maryland, and the study found that implementation would benefit the State economy by about $3 billion per year and create more than 26,000 jobs. It would benefit the State's budget by more than $600 million through 2020 through a series of mechanisms that are described in the testimony, and that it would generate more than $800 million in additional tax revenue just because of the economic activity. This incoming revenue exceeds the State cost of the Medicaid expansion, both considering the direct expansion and the potential woodwork effect.

So I go around the State talking about all this work that is being done in the State, and people don't ask me about the rules and the

guidance and our decisions; they ask me about when help is coming, and we are really excited for this to really launch next year.

Thank you.

[The prepared statement of Mr. Sharfstein follows:]

Implementation of the Affordable Care Act in Maryland

Testimony of Dr. Joshua M. Sharfstein

Secretary, Maryland Department of Health and Mental Hygiene

Before the Subcommittee on Health, Energy and Commerce Committee
U.S. House of Representatives

December 13, 2012

Good morning, Chairman Pitts, Ranking Member Pallone, and members of the Health Subcommittee. I am Dr. Joshua M. Sharfstein, a pediatrician and Secretary of the Maryland Department of Health and Mental Hygiene (DHMH). I oversee our state's Medicaid program and serve as Chair of the Board of the Maryland Health Benefit Exchange. I am grateful for the opportunity this morning to speak with you about the implementation of the Affordable Care Act in Maryland.

My testimony today will include:

(1) Background on the key elements of Maryland's health care system and the importance of improved access to care and cost control;

(2) A description of how broad public engagement has guided Maryland's progress implementing the Affordable Care Act;

(3) Specific details on how Maryland, with the support of the U.S. Department of Health and Human Services (HHS), is customizing the tools of the new law; and

(4) A summary of the economic value of health reform implementation to Maryland, according to an independent analysis by the University of Maryland, Baltimore County.

Background

Over the course of several decades, Maryland has pursued innovation in health care financing and insurance markets to expand access to care, control costs, and promote health.

Important elements of Maryland's health care system include:

- An all-payer approach to hospital payment that eliminates cost-shifting and provides a unique set of mechanisms to improve the value of care;
- A small group market that features guaranteed issue and modified community rating and serves more than 400,000 Marylanders;
- A high-risk pool called the Maryland Health Insurance Plan that provides coverage for more than 20,000 Marylanders who cannot currently obtain health coverage through the individual market;
- A health information exchange that allows doctors and hospitals to obtain information about patients quickly, efficiently, and confidentially;
- An all-payer pilot for primary care medical homes; and
- A Medicaid and CHIP program that covers children up to 300% of the federal poverty line and that expanded in 2008 to include parents of dependent children with incomes up to 116% of the poverty line.

As a result of this most recent Medicaid expansion, more than 97,000 Maryland parents currently have coverage. I've met some of these parents and listened to their stories. For many, injury or illness had pushed them out of jobs or school. Coverage helped them get back on their feet to support their families. In an interview, one mother who lives on the Eastern Shore reported:

> She no longer worries about her husband getting injured on the job and not having insurance. She says having access to health care, "... gives you that freedom to be less stressed. And if I need to go to the doctor I'm not going to be, 'Where am I getting this money from?' I can just go and not worry about it. Or, if I have to pick up a prescription it's not, 'I'm not going to have the money I'm going to have to take it away from

groceries.'"[1]

Despite this progress, major challenges face Maryland's health care system – challenges that are common to most U.S. states. In 2011, more than 700,000 of our citizens were uninsured; substantial disparities in health outcomes remain across the state; and rising health care expenditures and insurance premiums are creating serious concerns about affordability.

Our priorities include further expanding access to care, addressing health disparities, and improving the value of health care by lowering costs, improving the coordination of care, and achieving better outcomes.[2] Our goals include supporting a healthy workforce, healthy families, and a growing economy.

Public Engagement

On March 23, 2010, Congress passed and President Obama signed the Affordable Care Act. Starting the next day, Maryland began a process of public engagement that has defined our state's approach to implementation.

On March 24, 2010, Governor Martin O'Malley signed an executive order establishing the Maryland Health Care Reform Coordinating Council to study the impact of the new law – chaired by Lt. Gov. Anthony Brown and the Health Secretary. In 2010 alone the Council and its workgroups held more than twenty public meetings across the state and received more than 200 written comments. By January 2011, a broad consensus had emerged that:

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[1] Health Care for All. Faces of Maryland's Newly Insured. 2010. Retrieved from http://healthcareforall.com/faces-of-marylands-newly-insured/.

[2] Sharfstein J, Herrera L, Milligan C. Health Care Reform: Caring About Costs, Too. Baltimore Sun. 27 September 2012.

- Marylanders will benefit from many provisions of the Affordable Care Act, such as allowing children to remain on their parents' policies, eliminating pre-existing conditions in the insurance market, expanding seniors' access to prescription drugs, and covering preventive services;
- Maryland should develop a state-based health insurance exchange to integrate our insurance model with our broader initiatives in coverage and delivery system transformation;
- Expanding Medicaid is the best decision for Maryland's providers, the state economy, and the uninsured, who will gain a pathway to primary and preventive health care services rather than simply accessing emergency room services, and
- Health reform provides an opportunity to advance efforts to control costs, expand our health care workforce, integrate behavioral health services, and address unacceptable health disparities.

During the 2011 state legislative session, informed by a report from the Coordinating Council,[3] the Maryland General Assembly passed legislation authorizing the creation of a state-based exchange as a public corporation and an independent unit of state government.[4]

The statute, signed in April, 2011 by Governor O'Malley, established a governing board of nine, including six public members. The law mandated the completion of six studies covering

[3] Maryland Health Care Reform Coordinating Council. Final Report and Recommendations. Retrieved from http://www.healthreform.maryland.gov/wp-content/uploads/2012/03/FINALREPORT.pdf.

[4] Maryland General Assembly. Maryland Health Benefit Exchange Act of 2011. 2011 Laws of Maryland, Ch 2. Retrieved from http://mlis.state.md.us/2011rs/chapters_noln/Ch_2_hb0166T.pdf.

(1) how to finance the Exchange, (2) how to define the small group exchange, (3) the development of market rules to mitigate risk, (4) an operating model, (5) an advertising approach, and (6) the creation of a program to assist Marylanders in navigating the Exchange and selecting from its plans.

To complete these studies, the Board turned to the deep wells of knowledge and experience in our state. We established four advisory committees with 66 Marylanders serving. Committee chairs included local health officials, advocates, insurance brokers, business owners, physicians, and researchers. These committees met a total of 22 times in 2011.

The work of these committees culminated in the Board making a series of 27 specific recommendations for the policy structure of the health benefit exchange to the legislature.[5] These recommendations included keeping the non-group and small group markets separate, giving the Exchange the authority to set minimum standards for insurers, and establishing a program to combat waste, fraud and abuse. By this point in time, there was such broad consensus that the legislature and Governor O'Malley adopted virtually all of these recommendations in a second exchange-related bill in the 2012 legislative session.[6]

The Board of the Maryland Health Benefit Exchange has hired a management team, led by Rebecca Pearce, with substantial experience in the insurance industry. To guide implementation, the team recently convened new advisory committees on outreach and plan management. Many more public meetings of these groups have occurred. Maryland has also

[5] Maryland Health Benefits Exchange. Recommendations for a Successful Maryland Health Benefits Exchange. A Report to the Governor and Maryland General Assembly. Retrieved from http://dhmh.maryland.gov/exchange/pdf/HB0166_MHBE-Report_of_2of2_12-23-11_OGA_1204.pdf.

[6] Maryland General Assembly. Maryland Health Benefit Exchange Act of 2012. 2012 Laws of Maryland, Ch 152. http://mlis.state.md.us/2012rs/chapters_noln/Ch_152_hb0443T.pdf

received public input on plans for exchange financing and essential health benefits. All of our Board meetings are public; we've met in Baltimore, Cecil, and Montgomery Counties and most meetings have at least 40 observers. Information about the Exchange and its meetings is available online at www.marylandhbe.com.

These public consultations – and those yet to come – are the cornerstone of our approach to implementing the Affordable Care Act in Maryland. Getting input helps us make the best decisions and also helps us identify missteps early so we can change course. This broad and inclusive strategy has put us in position to succeed in 2014.

Customizing the Affordable Care Act

Maryland has made multiple decisions to tailor implementation of the Maryland Health Benefits Exchange and the Medicaid expansion to the unique environment in our state. Significant efforts have been made to integrate the Exchange and Medicaid to create a seamless experience. We have also strived to integrate popular aspects of the existing private insurance market.

Through statute, regulation, and policy, Maryland has made many decisions on the shape of the Maryland Health Benefit Exchange. These include:

- To provide for a fair playing field, requiring that insurers over a certain size participate in the state-based Exchange;
- Allowing insurance brokers to sell inside the exchange and continue to be paid directly by carriers, receiving compensation comparable to what they receive now;
- Developing a connector program for outreach based on specific regions in the state;

- Selling adult dental plans as an option for participants;
- Setting a path for involvement of essential community providers in health plans;
- Establishing a partnership program to allow Maryland's third party administrators to continue managing the majority of our small group market; and
- Designing the "Maryland Health Connection" as the consumer portal for access to coverage. Today, Marylanders can send a text message of "Connected" to 69302 to be notified when coverage is available.

Led by our Medicaid Director Charles Milligan, Maryland is also taking advantage of the flexibility available to states with respect to the Medicaid expansion. Examples of our choices include:

- Allowing women in private health plans who become newly eligible for Medicaid as a result of a pregnancy be allowed to stay in their private plans while having Medicaid dollars pay their premiums;
- Using new tools to re-balancing long-term care services away from institutional settings such as nursing homes toward community and home-based care; and
- Integrating our existing eligibility structure at local health department and social service offices into a new online eligibility system.

Creating a state-based exchange in tandem with expanding Medicaid has allowed for significant collaboration and integration. We are developing a seamless eligibility system that has one entry point for the uninsured, regardless of whether they qualify for Medicaid or private insurance. Outreach programs and customer services will also be integrated, and we

are taking steps to ensure that individuals who "churn" between Medicaid and Exchange plans based on changes in their income will receive continuous care.

Throughout this process, Maryland has received critical guidance and technical assistance from both the Center on Consumer Information and Insurance Oversight (CCIIO) and the Center for Medicaid and CHIP Services (CMCS) at the Centers for Medicare and Medicaid Services (CMS). This support has been provided through multi-state meetings and regular consultation available to all states. CCIIO and CMCS have also provided Maryland-specific input on policy and implementation since our early efforts to begin implementation and have allowed Maryland flexibility to make choices that will most benefit our state. An internal working group has regular technical assistance phone and in-person meetings with CCIIO and CMSC, which have resulted in highly valuable guidance on technical issues such as eligibility rules and processes, income determination, and consumer assistance strategies.

Funding from the CCIIO has been essential to our ability to rapidly implement the Affordable Care Act. Maryland was one of a small number of states to be awarded the Early Innovator Grant in March, 2011. We received $6.2 million to support early IT work, such as the development of a prototype for modeling the point of access for the Exchange and integration with state legacy and the federal portal systems. Second, we received a Level 1 Establishment Grant in August, 2011 in the amount of $27 million. This funding has been used to fund the initial administration and operation of the Exchange and to scale-up the prototype infrastructure into an operational platform ready to be deployed. Finally, we received a Level 2 Establishment Grant in August, 2012. This grant, worth $123 million, is supporting the Exchange's operations, program integration, and education and outreach. Much of this funding

will also be used to develop applications that allow for instantaneous eligibility determinations and transfer of information to plan issuers and state agencies.

A key challenge to effective implementation of health care reform in Maryland is developing an IT strategy that addresses new Medicaid eligibility rules and the launch of the Exchange. Our existing Medicaid eligibility system is antiquated and has significant limitations. Funding from HHS is giving Maryland the opportunity to develop a modern infrastructure that will have lasting value for state residents.

We have developed a set of requirements and selected a lead contractor and set of software vendors in February, 2012 who are working to prepare for the October, 2013 launch. We are well into a series of development sprints and have shared many tools and documents with other states to help them prepare for implementation. We have developed and are executing the approach to link the new eligibility system with nearly ten other systems in the state, most notably Medicaid's payment system.

None of this work is simple, but it is worth the effort. We have a tremendous, dedicated team working together to solve problems and put Maryland in a position to succeed. We are very pleased that on Monday, Maryland was one of six states to receive provisional certification for our state-based exchange from HHS.

Economic Analysis

A central goal of implementing the Affordable Care Act has always been to help Marylanders find affordable health coverage that allows them to maintain their health and quality of life. A recent study in the *New England Journal of Medicine* shows that state-led

expansions of health coverage translate into better health and significantly reduced mortality rates among individuals with low income.[7] It is also the case that implementing the Affordable Care Act will have positive effects beyond improved health. In addition to improving the health of our citizens, the law will improve the health of the Maryland economy.

In July 2012, the Hilltop Institute, a nonpartisan research organization at the University of Maryland Baltimore County, released the results of a study of how implementation of the Exchange and Medicaid would impact health coverage and the state economy.[8] Through the use of a simulation model, they were able to predict how many individuals would gain coverage, changes to the state unemployment rate, and the impact on the state budget.

According to the study, the Affordable Care Act will expand health coverage to 284,000 Marylanders through the Exchange and 187,000 through the Medicaid expansion. This will result in more than 95 percent of U.S. citizens in Maryland having health insurance. As more individuals gain health insurance, this creates additional economic activity in the health care industry, which then affects other aspects of the state economy.

The study estimated this new economic activity would, by 2020, benefit the state by around $3 billion per year and create more than 26,000 jobs. It also estimated that the Affordable Care Act would benefit the state's budget by more than $600 million through 2020 – through such mechanisms as prescription drug rebates, a reduced need for state-funded prescription drug assistance, and increased revenues from premium assessments as the

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[7] Sommers BD, Baiker K, Epstein AM. Mortality and Access to Care among Adults after State Medicaid Expansions. New England Journal of Medicine 2012;367:1025-1034.

[8] Hilltop Institute. Maryland Health Care Reform Simulation Model, Detailed Analysis and Methodology. Retrieved from http://www.hilltopinstitute.org/publications/SimulationModelProjections-July2012.pdf

number of insured individuals grows. In addition, the economic activity generated by the law is estimated generate more than $800 million in additional state and local tax revenue by 2020. According to the projection, this incoming revenue exceeds the state cost of the Medicaid expansion – both considering the direct expansion and the potential "woodwork" effect of more people obtaining coverage in existing eligibility categories.

Conclusion

Implementation of the Affordable Care Act puts Maryland on a path for better health, a healthier workforce, and a stronger economy. Guided by public input and engagement, Maryland plans to make good use of the many tools that the law provides.

As the Secretary of Health, I travel the state speaking to and hearing from Marylanders about health care reform. I always take questions. The questions are generally not about the latest Board decisions, recent guidance from CMS, or news from Washington, DC. The questions are driven by personal experience: about pain after an accident, or a feared cancer diagnosis, or concern about the future of a child with chronic disease, or a struggle with the emerging complications of diabetes. And the most common question I hear is: "When is help coming?"

With respect to our state-based exchange and the Medicaid expansion, I say that we are very close. I am candid that much work remains to be done. I tell them that we are looking forward to a leap forward for health in January 2014.

Thank you for the opportunity to testify, and I look forward to your questions.

Mr. BURGESS. The time is expired.

We will note that there is a vote on the floor. I believe, though, we have time for Dr. Allison to go ahead with your 5 minutes at which time we may take a brief recess for votes, so proceed, sir.

STATEMENT OF ANDREW ALLISON

Mr. ALLISON. Thank you, Mr. Chairman. My name is Andy Allison. I am the Medicaid Director in Arkansas. I am also the President of the National Association of Medicaid Directors. I appreciate the committee's invitation to Arkansas and to other States represented on this panel to hear about these important issues.

My written testimony, which I have submitted, addresses the two main challenges that Medicaid faces today. Foremost is the challenge of the fiscal duress brought on by long-term rates of growth in the Medicaid program and also by the loss to our tax base suffered as a result of the economic shift that occurred in this country beginning in 2008. The second challenge is really an opportunity, and that is, the option for States created in the Affordable Care Act to extend health insurance coverage to poverty-level adults through the Medicaid program. I want to focus my brief remarks this morning on the decision Arkansas faces about whether to take up this option.

Governor Beebe expressed his support for the Medicaid expansion this summer. His decision came after CMS confirmed that the expansion remains optional and could be revoked in the future. His support for the expansion is driven by the benefits it would provide to State taxpayers, for the State's safety net, especially hospitals, and to the beneficiaries of the expansion themselves.

Arkansas has a great many low-income uninsured adults, and we know that Medicaid saves lives, it improves health and it provides financial protection. The decision of whether to expand Medicaid in Arkansas now rests with its General Assembly, who meet beginning in January for three months. A supermajority, a 75 percent vote, is required to appropriate funds in Arkansas regardless of their source. This is the challenge. The legislature's decision may rest heavily on the financial implications of expansion for the State. Arkansas's estimates of the size of the Medicaid expansion use as a starting point the Urban Institute's March 2011 State-level projections of the expansion. To those estimates, Arkansas added both costs and enrollees. The estimates include some crowd-out of private insurance, include the woodwork effect. Current eligibles represent about 14 percent of the expected new enrollment. It also includes the added administrative costs. Overall, the gross costs of the expansion total about $900 million per year including both Federal and State payments.

But there are also expected savings for the State of Arkansas associated with the expansion. The first source of savings stems from our expectation that a number of populations currently served through traditional Medicaid will migrate or will otherwise transition into the new expansion group of eligibles, thereby qualifying for a much higher Federal match rate. Key examples are individuals who currently enroll in Medicaid because of pregnancy or because they have suffered a catastrophic, high-cost medical event. In the future, these populations will already have health insurance

when these changes in their health status occur, and there will be no reason for them to switch to the old eligibility categories, which carry with them a much lower Federal match rate.

The second source of savings to the State is a reduction in State spending on uncompensated care. If Medicaid expansion is approved, more than 200,000 additional Arkansans will have a payer for their health care. Consequently, uncompensated care provided by State programs outside of Medicaid should decline significantly. Program areas affected include health costs to the Department of Corrections as well as State subsidies to community health centers, community mental health centers and public hospitals.

Finally, because of the unusual nature and size of the optional Medicaid expansion, Arkansas is making the unusual decision to consider its macroeconomic impact. If the State legislature approves the expansion, Federal Medicaid payments to the State are expected to grow by around $800 million per year. Given Arkansas's small size versus the Federal tax base, Arkansas assumes in its estimates that Federal Medicaid payments for the expansion will come from taxpayers in other States. Put simply, Arkansas's economy will be hundreds of millions of dollars larger if it chooses to expand Medicaid, and this difference in the State's tax base will have some impact on tax revenue. All told, we estimate that the fiscal benefits will outweigh the costs and the expansion on net is expected to save or increase State tax dollars by $44 million in fiscal year 2014, $115 million in State fiscal year 2015, and about $700 million between now and 2025.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Allison follows:]

Testimony of Andrew Allison, Ph.D.
Director, Division of Medical Services, Department of Health Services, State of Arkansas
Before The
Committee on Energy and Commerce
Subcommittee on Health
U.S. House of Representatives
"State of Uncertainty: Implementation of PPACA's Exchanges and Medicaid Expansion"
December 13, 2012

My name is Andy Allison. I am Arkansas's Medicaid Director, and I run the Division of Medical Services at the Department of Human Services in Little Rock. I have been in this position for a year, and before that Directed Kansas' health care programs, including Medicaid, for 6 years. I'm also the current and outgoing President of the National Association of Medicaid Directors, which I helped establish in 2010 as an independent organization in order to strengthen the voice of program directors in national policy discussions. I want to thank the Committee for inviting me and the other states represented here today to discuss these critical policy issues.

In my testimony I would like to describe for you the decision process Arkansas is going through to determine whether to expand the Medicaid program under the authority granted by the Patient Protection and Affordable Care Act of 2010, and also provide comments on the future of the Medicaid program. The seismic economic shift that began in this country in 2008, along with passage of the ACA in the Spring of 2010, have in my view combined to make the present period arguably the most important in Medicaid's history. The risks and opportunities associated with the twin challenges of expansion and fiscal duress are compounded by what has, at times, been nearly overwhelming uncertainty regarding the future of the program. Unresolved debates in the courts and in Washington regarding the program's size, shape, and funding have made it more difficult for states to plan and improve the program even though the need to plan and improve is greater than ever, as is the opportunity to serve more Americans who need Medicaid's services.

State consideration of the Medicaid expansion: Arkansas faces many challenges. It is one of the poorest states in the U.S. More than three out of four (78%) of Arkansans earn at or below 400% of the federal poverty level. The median household income for Arkansas is the third lowest in the country at $38,413.

Lack of insurance is a significant problem for many Arkansans. One-quarter (25%) of 19-64 year olds are uninsured. This leads to problems in accessing and affording needed health care: 16.5% of Arkansans recently reported being unable to see a doctor due to cost. Arkansas's high rates of uninsurance are associated with growing uncompensated care costs. In 2010, uncompensated care costs to Arkansas hospitals were estimated at more than $338 million. In addition to the costs borne by hospitals for uncompensated care, Arkansas families with health insurance also pay for uncompensated care through increasing premiums. Premiums for insured Arkansans have risen an estimated $1,500 a year to cover the cost of uncompensated care. Arkansas families' average health insurance premiums nearly doubled over ten years to reach $11,816 in 2010.

DHS estimates that expanding Medicaid would result in an additional 250,000 Arkansans receiving coverage through Medicaid. In other states that have already expanded their Medicaid programs, the expansions have led to reduced adult mortality as well as higher levels of health insurance coverage, financial stability, access to health care and health status. [Sources: Benjamin D. Sommers, Katherine Baicker and Arnold M. Epstein, "Mortality and Access to Care among Adults after State Medicaid Expansions" New England Journal of Medicine; 367:1025-1034; September 13, 2012. Katherine Baicker and Amy Finkelstein, "The Effects of Medicaid Coverage — Learning from the Oregon Experiment," New England Journal of Medicine; 365:683-685; August 25, 2011.]

Medicaid Expansion in Arkansas – status of state's decision: Pursuant to the U.S. Supreme Court's decision in *NFIB v. Sebelius*, states now have the option to choose whether or not to expand their Medicaid programs to cover low-income adults. After receiving written confirmation this summer from the Centers for Medicare and Medicaid Services that states that cover the expansion group could later drop the coverage, Governor Mike Beebe offered his full support of expansion. His public support followed an already expressed inclination to moving forward after receiving detailed estimates from the Department of Human Services showing a positive net fiscal impact of Medicaid expansion on the state budget, particularly in light of the financial duress that Arkansas hospitals would experience without expansion, and recognizing the tremendous good that health insurance coverage would do for the more than 200,000 low-income adults who will gain coverage as a result of the expansion. A small number of staff in my agency are developing plans for a Medicaid expansion and are working closely with counterparts in the Arkansas Insurance Department to identify ways to enhance continuity of coverage and coordination of care for families and individuals who experience changes in income or family status and need to switch between Medicaid and private sources of coverage in the health insurance exchange.

The decision of whether to expand Medicaid now rests with the Arkansas General Assembly. A supermajority (75%) vote is required to appropriate funds in Arkansas, regardless of source. In order for the Department to extend coverage to the expansion group of poverty-level adults, the Legislature will need to increase my agency's budget by approximately $500 million to cover expenses between January and June 2014. Arkansas's Legislature convenes its 2013 session in January and is scheduled to meet for approximately three months. Arkansas's Legislature will experience significant turnover as a result of the November 2013 elections, and it is too soon to extend any prediction regarding the new Legislature's choice.

Note: DHS' estimates do not include inflation in either the costs or the savings items. Since inflation would tend to increase virtually all cost estimates as well as macroeconomic (tax) effects, its inclusion in the estimates would tend to make all of the dollar amounts in the estimates larger, thereby inflating the nominal value of the projected savings in the out years. To better communicate the impact of expansion to policy makers in Arkansas, inflation was ignored. Dollar costs in each year are intended to reflect "real" 2012 dollars.

Estimated (gross) costs of the Medicaid expansion in Arkansas: Arkansas DHS first released comprehensive estimates of the impact of Medicaid expansion in July 2012, and recently updated those

estimates. The newer estimates will form the basis for legislative requests for appropriations that would be necessary as a result of the expansion. DHS estimates that the ACA Medicaid expansion would, if implemented in Arkansas, generate net savings or increased tax receipts totaling in excess of $700 million dollars for the time period from federal fiscal year 2014 through 2025. The gross costs of the Medicaid expansion total approximately $900 million per year by 2017 and include estimated reimbursements and other payment to providers for services covered under the expansion (for the expansion group) or under the regular Medicaid program (for current eligibles who enroll as a result of the "woodwork" effect of the ACA expansion) as well as added administrative costs. DHS estimates that the net state savings of expansion persist in the long run, even after the percentage of expansion costs funded by the federal government fall to 90% in 2020. Along with this testimony, I am sharing the more detailed year by year estimates that we have recently updated, and will now explain the assumptions and analysis that have gone into those estimates.

Enrollment: Arkansas DHS's estimates of the size of the Medicaid expansion use as a starting point the Urban Institute's March 2011 state-level projections of the expansion, which includes an estimate of additional enrollment due to "crowd-out." Crowd-out is when a government expansion of coverage displaces private insurance by inducing individuals to sign up for Medicaid instead of private coverage, or by inducing business to not offer insurance to their employees because some or all could enroll in Medicaid instead. Arkansas's Medicaid expansion estimates also include an additional 29,000 Medicaid enrollees (over and above the Urban Institute estimates) to allow for additional crowd-out, great program participation due to more effective outreach and enrollment, or other factors that might increase Medicaid enrollment in Arkansas. Overall, DHS's estimates assume a participation rate in Medicaid that is significantly higher than the Urban Institute's March 2011 state-level estimates. This estimate of additional participation helps protect Arkansas from the unexpected costs of enrollment that might occur if crowd-out is unusually high in Arkansas. In DHS's updated November 2012 estimate of the Medicaid expansion, a three-year ramp-up period is included to more realistically project the length of time it would take to reach full participation in the expansion. This three-year ramp-up coincides with the period of highest federal contributions to the costs of the expansion population, and its inclusion has very little (net) fiscal impact on the state.

Costs per person: DHS's estimates of costs per new enrollee in Arkansas's Medicaid expansion estimates use as a starting point two separate but coinciding estimates of the cost of the adult expansion population. The first source is an estimate for 2011 from the Urban Institute, which pegged per-person costs at around $295 per person using a variety of sources, and which was adjusted for the expected health status and health care needs of the expansion population. The second source is Arkansas's direct experience with working adults in approximately the same income range of the expansion population through ARHealthNetworks – also under $300 per person. ARHealthNetworks is a state-initiated, Medicaid-financed limited expansion of coverage to low-income workers in small businesses. Like the Urban Institute, DHS's estimates assume that new eligibles will be less expensive, on average, than adults currently participating in Arkansas Medicaid due to their higher income, work status, the fact that the expansion population will – by definition – not be categorically disabled, nor will they qualify for the

expansion because they (unlike some parents in Medicaid now) have incurred very large health care bills.

There are likely to be some relatively high cost newly-eligible expansion enrollees who have significant physical or behavioral health needs, but are not (yet) disabled. However, there are a limited number of these individuals – and they are only in the new eligible category until they obtain a federal disability status. They will be dramatically outnumbered by low-income workers who are expected to have lower costs (as described above). Costs for these individuals should be incorporated into the Urban Institute estimates we used as a starting point given their comprehensive methodology. Even so, the possibility that there could be more high-cost individuals than Urban already accounts for, or that their costs could be higher than expected, helps explain the use of a per-capita cost figure somewhat higher than Urban's March 2011 estimate.

DHS's estimates or participation and costs per person interact. The most likely new eligibles to enroll are those with the highest costs, i.e., those who most frequently seek services, incur costs, and come into contact with providers who are motivated to help the individual enroll in Medicaid. Arkansas's estimate of participation after the three-year ramp-up period is aggressive, and likely includes individuals with better health and lower health care need than those included in Urban Institute's March 2011 estimates, which served as the starting point for our cost assumptions. However, to be conservative, DHS's estimates do not raise the per-person cost estimates for the expanded Medicaid population during the period in which the federal government is paying the full costs of the expansion (thereby minimizing the expected gains from the expansion's macroeconomic impact on tax revenue), and also do not lower the per-person cost estimate when full participation is reached (and the state begins to pay for a percentage of these costs).

Woodwork effect: Health needs and medical bills are assumed to increase the likelihood of enrollment. Those currently enrolled in Medicaid are presumed to be more likely than those (eligibles) that have not enrolled to have incurred significant health bills, or otherwise have the greatest health needs. Providers, for example, often help facilitate or otherwise encourage patient enrollment in Medicaid to help assure a source of payment for the services provided. As a result, currently eligible non-participants are less likely than participants to have seen a provider. Therefore, those current eligibles that enroll because of the ACA's "woodwork" effect, e.g., from increased outreach, publicity, and streamlined enrollment procedures, are assumed to have fewer and less costly health needs than those already participating in Medicaid.

Administrative costs: Administrative costs: Costs also include administrative expenses associated with both groups of new enrollees (new eligibles and woodwork enrollees). Arkansas's administrative costs are low (approximately 4% of service costs), and include some fixed costs that would not increase with additional enrollees. Arkansas estimates an additional administrative cost of approximately $14 million per year at full implementation associated with the expansion. DHS' estimates include a predicted amount of new administrative spending for the expansion for added costs related to claims processing, provider and customer support, oversight and engagement. The total new administrative costs are estimated at $7.4 million all-funds in 2014 and $14 million all-funds in 2015 and each year thereafter.

The state general revenue impact for administrative costs would be $2.1 million in 2014 and $4 million per year in following years. Costs of the expansion are born primarily by the federal government in each year, but especially in the 2014-2016 period when the federal matching rate for new eligibles is 100%.

Estimates of Savings and increases in State General Revenue due to Medicaid Expansion: There are also expected savings for the State of Arkansas associated with the Medicaid expansion. Projected savings come from three general areas: (1) savings from the natural migration or explicit transition of select Medicaid populations to the newly eligible expansion group; (2) savings from reductions in uncompensated care costs provided by state agencies outside of the Medicaid program; and (3) savings from additional tax revenue associated with new federal spending that is contingent on the state's decision to expand Medicaid.

Transition populations: A number of populations currently served through traditional Medicaid will migrate or will otherwise transition into the new eligible group, resulting in savings to the state. Medicaid transition populations include those currently participating in Medicaid or CHIP who will end up participating in the Medicaid expansion instead. They also include the ARKids B population, since the Federal government essentially picks up the full tab for them beginning in October 2014. Transition populations include ARHealth Networks, Arkansas's Medicaid waiver expansion group, since the Medicaid expansion (and to a lesser extent new tax subsidies) provides more complete coverage. Transition populations also include some of the state's "medically needy," or "spenddown" Medicaid enrollees. The medically needy group that is assumed to transition to full coverage under the expansion represents those who currently have to medically impoverish themselves in order to reach Arkansas sub-poverty income thresholds. Under the expansion, these individuals will already be insured by Medicaid (and to a lesser extent new tax subsidies) due solely to their low income when they incur large health bills, and will not need to qualify under the older and more restrictive eligibility rules.

ARHealthNetworks is a healthcare benefits program designed for small businesses and self-employed individuals without medical coverage. The population currently on the program will be able to receive coverage in the future via Medicaid expansion or with subsidies through the health insurance exchange, depending on their income level. DHS estimates that transitioning this program will save approximately $12 million a year in state general revenue.

ARKidsB – enhanced FMAP – Arkansas's current FMAP = + additional 32% FMAP increase =100% federal funding for this program starting October 1, 2015 will generate a projected $23 million a year savings in SGR –

AFDC Medically needy spend-down: Arkansas provides temporary Medicaid coverage to parents with low- but excessive incomes who experience a significant health care expense and, after netting out these health care bills, meet the income criteria for the program. These individuals may have suffered a catastrophic acute care cost and have spent nearly all their income on associated bills. Counting these bills against their income as a "spend-down," these individuals are subsequently considered to be "medically needy" for sox month intervals. Following an expansion of Medicaid, parents will be highly

likely to have coverage before they incur the high-dollar health care costs, and if so are unlikely to be able to spend down enough income to become Medicaid eligible under the old rules. Although Arkansas would be obligated to maintain this eligibility category even after a Medicaid expansion, DHS estimates that the category will largely de-populate.

Pregnant women: In Arkansas, Medicaid currently pays for nearly 66% of all births. Under current pregnant women eligibility categories, women become eligible due to pregnancy status and lose coverage shortly after the birth of their child. After 2014, with the implementation of the health insurance exchanges and through Medicaid's new eligible group, a large percentage of these women will already be covered before becoming pregnant and their coverage will not be tied to pregnancy status. This will improve continuity of care and coordination of coverage. A single streamlined application will ask about pregnancy status at the time of application. If not pregnant at the time of application, the women will be enrolled in the new eligible group. Arkansas estimates a savings of $21 million in state general revenue from transitioning a large percentage (75%) of pregnant women to the new adult group. We have just learned about the positive impact on coverage of low-income pregnant women. Under 2012 regulations published by CMS, it is now clear that pregnant women will no longer need to wait until they are pregnant to have access to affordable care. Many will be covered through private insurance, and others will already be covered through the Medicaid expansion before they become pregnant. When they become pregnant, they will not need to switch back to Medicaid – nor transition from the new expansion Medicaid group back to the old (existing) Medicaid pregnant women eligibility group. They can simply remain in the affordable health plan they already have. This will promote continuity of coverage, better preventive and prenatal care, and will save the state millions of dollars. Also note that pregnant women above 138% of poverty will not have access to Medicaid after January 2014, and this will help promote private (and continuous) coverage for them and their families. Many more women will already be covered.

Achieving fiscal sustainability in Medicaid. I would like to conclude my remarks by addressing the fiscal duress the Medicaid program is facing. With two negligible exceptions, Medicaid spending in this country has grown as a percentage of the value of the nation's economic output every year since it was created. In Arkansas that growth has been even more pronounced in the last decade: Medicaid spending grew by 1.5 percentage points of the state's economic output over the 2001-2011 period. Obviously that trend cannot continue forever, a point that observers of Medicaid and other entitlement programs have been making for quite some time. Arkansas and other states have recognized that the time to address the long-run imbalance between growth in Medicaid and growth in the tax base that supports it. As it has become clearer in the economic aftershocks of the near-meltdown of our financial markets in 2008 that we now live in a somewhat different economy – and are not simply experiencing an especially long recession -- state interest in reducing growth in Medicaid spending has taken on a new and, in some cases, unprecedented urgency. Since 2010, even with historically high levels of persistent unemployment, Medicaid spending growth has abated as states' imperative to manage costs has grown and the level of activity directed towards wise stewardship of public resources has intensified. In Kansas, where I helped lead state health care programs from 2006 through 2011, the Medicaid program is being transformed by a comprehensive, state-of-the-art implementation of

managed care. In Arkansas, we are engaged in comprehensive payment reforms designed to move almost completely away from a fee-for-service system that rewards utilization, and creating in almost every corner of the program, a focus on paying for quality outcomes and efficiency. Our goals are to transform and improve health care, and to slow the rate of growth in costs by as much as 2 percentage points per year. In other markets and with other types of goods, quality and value both improve over time. We are deciding in Arkansas that it is time to expect, support, and incentivize that kind of improvement in health care as well.

State innovation in Medicaid -- Arkansas' Payment Improvement Initiative: Arkansas is in the midst of creating a sustainable patient-centered health system that embraces our Triple Aim: (1) improving the health of the population; (2) enhancing the patient experience of care, including quality, access, and reliability; and (3) reducing, or at least controlling, the cost of health care. Achieving this Triple Aim will require transforming our care delivery system from fragmented and encounter-based care to coordinated, patient-centered and cost-effective care, organized around consumers' comprehensive health needs across providers and over time. It also requires shifting away from pure fee-for-service payment mechanisms that lead to fragmented care with incentives to over-utilize services, to value-based payment mechanisms that reward effective care coordination and superior outcomes with respect to both quality and cost containment. The description I offer of Arkansas' plans is taken from the state's application to the Center for Medicare and Medicaid Innovation's State Innovations Model (SIM) grant program. Arkansas is one of the many states seeking to take advantage of CMMI's offer of financial support, technical assistance, and programmatic flexibility to aid in the transformation of their health care systems through the Medicaid program. Arkansas is requesting support to offset the hundreds of millions of dollars of investments needed in its health system over the next few years to generate billions in savings in the years that follow. This level of federal support is critical in Medicaid, and appropriately reflects the fact that the proceeds of innovation achieved by any one state Medicaid program, reflected in both program outcomes and fiscal relief, will accrue disproportionately to other states and the federal government. Without substantial federal aid and assistance for innovation, states will be faced with the choice to essentially donate most of benefits of its investments in change to other states and the federal government.

Our goal is to fully develop this system within the next 3-5 years by adopting a model that integrates two complementary strategies for promoting clinical innovation on a multi-payer basis across the entire state: population-based care and episode-based care.

Population-based care delivery. Within 3-5 years, most Arkansans will have access to a medical home that offers a local point of access to care and proactively looks after his or her health on a "24-7" basis. Special needs populations with developmental disabilities (DD), those requiring long-term services and support (LTSS), and those with serious behavioral health (BH) needs will also have access to health homes.

– The medical home will support patients to connect with the full constellation of providers who together form their health services team, customized for their personal care needs and with a focus on prevention and management of chronic disease. For patients with chronic conditions, the medical home

will assist with monitoring their progress and coordinating care among what will often be a multi-disciplinary provider team. The medical home will bear responsibility for coordinating care to address the complete health needs of a population.

– The health home will be accountable for the full experience of individuals with special needs—the frail elderly, those with developmental disabilities, those with severe and persistent mental illness, and other high needs behavioral health clients. Accountability will include health outcomes, streamlining care planning, and ensuring each person has a single integrated plan across all types of care. To accomplish this, health home providers will work closely with consumers, their families, and other direct service providers, offering support and coaching in a community setting. The health home complements the medical home: the medical home will continue to retain responsibility for diagnosis, treatment, and referral, while the health home will help to ensure proper follow-up, treatment adherence, and communication between providers, individuals receiving services, and their families.

Episode-based care delivery. Within 3-5 years, substantially all acute care and complex chronic conditions (50-70% of total health care spending) will be proactively managed by a principal accountable provider (PAP), who will embrace their role as the "quarterback" responsible for quality, access, and efficiency of all services delivered in response to a patient's immediate needs. PAPs will be evaluated on their performance over entire episodes of care, with an expectation of coordinated, team-based management of services. Better data will help PAPs to understand and improve their performance over time, thus enhancing quality and outcomes and increasing cost-effectiveness of care.

Arkansas has developed and successfully implemented the first wave of episodic payment reforms, which focused on pregnancy and birth, attention deficit hyperactivity disorder, and upper respiratory infections. Arkansas worked closely with providers at the state level to develop the new payment incentives, and achieved regulatory approval at both the state and federal level this past summer. CMS' support for Arkansas' initiative is noteworthy. Arkansas was able to obtain approval from the Centers for Medicaid, CHIP and Survey and Certification (CMCS) for the new payment mechanisms through the standard Medicaid state plan amendment process in less than 90 days despite the ground-breaking nature of the changes, which introduce both positive and negative financial incentives associated with high-quality and efficient use of services. The nature of the amendments that were ultimately approved could serve as a model for other states, and greatly streamlines future additions to Arkansas' payment reforms (and there could be dozens if not a hundred or more to come). To help states transform their Medicaid programs and set Medicaid on a sustainable path, the pace and scale of such innovation will need to increase significantly -- potentially stretching the boundaries of current federal law, regulations, policies, and approval process.

Reduced state spending on uncompensated care for the uninsured: If Medicaid expansion is approved, approximately 250,000 additional Arkansans will have a payer for their care; consequently, uncompensated care provided by state agencies outside of Medicaid should substantially decline. Program areas affected may include health costs for state prisoners, state subsidies to community health centers and community mental health centers, and (unmatched) state funding of the University of Arkansas for Medical Sciences hospital that helps them close the gap on unfunded care. DHS

estimates that offset savings for state spending on the uninsured will total $22 million in savings starting in 2014 and will rise to $58 million by 2019 and years thereafter.

Additional tax revenue: Arkansas' decision to expand Medicaid under the ACA would carry with it significant macroeconomic consequences for the state. Without the expansion, federal Medicaid payments to the state (e.g., as reimbursement for added state reimbursements to providers) will be approximately $800 million less than they would be if the state did choose to expand Medicaid. Conversely, if the state Legislature approves the expansion, federal Medicaid payments to the state are expected to grow by around $800 million. Given Arkansas' small size versus the Federal tax base -- approximately 1% of all federal revenues associated with the added federal Medicaid payments would come from Arkansas taxpayers -- Federal Medicaid payments are treated in DHS' estimates as if they came from taxpayers in other states. Put simply, Arkansas' economy will be hundreds of millions of dollars larger if it chooses to expand Medicaid, and this economic expansion will have some impact on state tax revenue. To estimate the impact of additional federal Medicaid payments on Arkansas' economy and tax receipts, the Department made the simplifying assumption that each new federal dollar entering the state's economy through the Medicaid program during a fiscal year would be taxed once at an average rate of 4%. A more sophisticated analysis would have more carefully identified the proportion of federal dollars that would, through increased Medicaid reimbursements and administrative costs, accrue to Arkansas businesses and individual taxpayers as income, the rate of income taxation applied, the consumption rate of spending for those businesses and individuals, and the subsequent rate of state taxation of that consumption spending, including a reasonable assumption about the number of times a new federal dollar might cycle through to new tax-paying entities (i.e., the "multiplier" effect). In lieu of such a sophisticated analysis, the Department instead made the very conservative assumption that the new federal payments would not cycle, and would be taxed just once as income at an average rate of 4%. The 4% tax revenue assumption generates a savings to the state of over $13 million in 2014 and in excess of $30 million in state general savings in years thereafter.

Mr. BURGESS. The gentleman's time is expired.

I would note that there is still over 7 minutes left on the vote on the House floor, so if it is agreeable with everyone, we will start with questions. I would ask that members who feel it necessary to leave because they are so slow that it takes them 7 minutes or over 7 minutes to get to the floor, that we do leave quietly, but the committee will remain in session and we will recess when there is literally no time left on the votes.

So I will start with myself, and Director Cohen, if I could, sir, I ask you, on November 26 of this year, Health and Human Services released the long-awaited rule detailing the essential health benefits that must be covered by any health plan offering a plan in the PPACA exchange. While I understand this rule has far-reaching consequences on health care premiums, benefits that must be provided to those newly eligible for Medicaid and Federal and State budgets. Now, according to the notice in the Federal Register, the rule was approved at the Centers for Medicare and Medicaid Services by Administrator Tavenner on August 1, 2012. That is 3 months before. Yet the rule did not receive approval from Secretary Sebelius and the Office of Management and Budget until 2 weeks ago. So what this committee would like to know is, why did it take nearly 3 months for the administration staff to conduct technical work and review and yet the public will have only 4 weeks to review during this period of public comment on the rule that was issued on November 26? And I would also note that this is a time of year where people's focus is generally on things other than long-awaited rules. So can you speak to that, sir?

Mr. COHEN. Thank you, Chairman Burgess. I would be happy to. You know, we put out a bulletin on the essential health benefits quite some time ago and got comment on that bulletin and so the public and interested parties had an opportunity to provide public comment on essential health benefits before the proposed rule was put out. There were some changes in the proposed rule from what had been in the bulletin but by and large what is in the bulletin is what is in the proposed rule, so actually I think there has been ample opportunity for the public to comment on the rule, and they will have the additional formal comment period as you mentioned.

Mr. BURGESS. So it is your opinion that Wisconsin, Pennsylvania and Louisiana had actually during that 3-month hiatus from the time the rule left HHS and circulated through OMB and came back, they actually knew what the rule was going to be and could be confident that they knew what the rule was going to be and could begin to make their plans accordingly?

Mr. COHEN. They had the bulletin, which laid out our approach to essential health benefits using the benchmark approach, which basically said as the law does that essential health benefits are based on what is in a typical employer plan and they knew that the State had the option to choose from a range of available benchmark plans. Yes, they knew that.

Mr. BURGESS. All right. I didn't plan to ask this question, but Mr. Smith, can you tell us, was Wisconsin absolutely confident that what came out in August was circulated in a bulletin or a pamphlet was going to be what the rule eventually would be?

Mr. SMITH. Well, again, I think we still have questions about what the essential health benefit package is.

Mr. BURGESS. Thank you. I accept that as your answer. That is going to be a no.

So let me just ask you, Mr. Cohen, on November 20th, a paper that I don't normally read that is called the New York Times—some people have heard of it—published an article by Robert Pear that the essential health benefits rule had been delayed—I am quoting here—"had been delayed as the administration tried to avoid stirring up criticism from lobbyists and interest groups in the final weeks of the presidential campaign." Now, that is accurate that there was a presidential election between August 1, 2012, and November 26, 2012. That is a fair statement, is it not?

Mr. COHEN. Yes. I believe President Obama was reelected.

Mr. BURGESS. Well, that being the case, was the rule delayed so as not to interfere with that happy occasion that you just referenced?

Mr. COHEN. I am not aware of what Mr. Pear's sources might be for that and I am not aware that that happened, no.

Mr. BURGESS. Well, certainly for, you know, those of us who were preparing to lay down in the Elysian Fields of the Affordable Care Act, it did strike us as strange that the rule was available for discussion in August but not published as a rule until after Election Day, and not just under the auspices of the Affordable Care Act, there does seem to be a regulatory push now out of several Federal agencies to get things moving and up off the deck now that the election is settled. I know that—I am not cynical but, you know, there are people in Washington who are and would look at that and, again, I don't read that newspaper, but apparently they felt that there was some relationship.

Thirty-three months delay on the fundamental rule necessary for the operation of these exchanges does cause some of the people who are cynical in this town to repeatedly ask the question: what is the holdup? And this an important deal what you all are doing and it does seem to be—it appears to me that it is possible that these cynical people could be correct, that it was held up for political reasons.

So what I am saying to you is, we are going to have a series of questions, and it is too long to go into here but I would appreciate—it has been hard to get information out of your agency, in all honesty, sir. The Governors have had trouble. Members of Congress have had trouble. I would appreciate the expeditious handling of those questions when they come to your attention.

Mr. COHEN. We will do the best we can.

Mr. BURGESS. My time is expired. All right. The vote on the floor is a motion to instruct conferees on the National Defense Authorization Act. The committee will stand in recess and will convene immediately after the last vote.

[Recess.]

Mr. BURGESS. The committee will reconvene. The committee is reconvened, and the Chair recognizes the ranking member of the subcommittee, Mr. Pallone of New Jersey, 5 minutes for questions, sir.

Mr. PALLONE. Thank you, Mr. Chairman. The title of this hearing is: "State of Uncertainty: Implementation of PPACA's Exchanges and Medicaid Expansion." I want to say, Mr. Chairman, that I think the title is provocative and I think it does a disservice to the progress and the people of this country with regard to the ACA. The fact is, the ACA has prevailed and it is the law of the land. It means that people have already experienced positive changes from the Affordable Care Act, whether it is through the elimination of lifetime limits, the ability to stay on their parents' health insurance plan, coverage of preventative benefits with no cost sharing. Lower prescription drugs costs are another provision of this law. In any case, the Affordable Care Act is improving the lives of Americans already, and over the next decade, 30 million Americans who otherwise would be uninsured could have access to health care. Millions more will be put in charge of their health care as opposed to being at the mercy of insurance companies and the arbitrary limits and fine print denying coverage for critical services or overly burdensome cost sharing. And States have the options of flexibility to help make this a reality for their residents, and CMS has been working with those States that have been ready and wanting to move forward and make this work.

My questions are to Mr. Cohen and Ms. Mann. Critics have cited a dearth of information, lack of answers, an inability to move forward. You have heard that from some of the other panelists. Can you talk about your outreach efforts to States, the engagement with them, the types of assistance you have provided over the past 2 years?

Mr. COHEN. Thank you, Ranking Member Pallone. I am happy to do that.

Just in 2012 alone, CCIIO has hosted 119 different events of different kinds for States that total approximately 215 hours of technical assistance. We have done 69 webinars that over 3,000 State people have participated in. We had 48 teleconferences. Over 2,500 State workers have participated in those. And we have held two in-person conferences where people have come in, over 1,000 attendees have come to those, so we have been—in addition to that, we are on the phone literally every day with people from the States helping them, answering their questions, and enabling them to move forward.

Mr. PALLONE. I appreciate that.

Ms. Mann, and then I want to ask Dr. Sharfstein.

Ms. MANN. Sure. Thank you, Mr. Pallone. You know, I think it has been a very different experience than past experiences in CMS where you usually put out guidance, put out regulations and hope for the best. We have been very aggressive with our partners at CCIIO to reach out to States and to bring them in partly for our decision-making and certainly for their decision-making as they are going forward by topic, by groups of States as well as very much individually. We do gate reviews on their systems developments individually with States. We do that together with CCIIO so that we are providing some coordinated technical assistance and support. We have pulled together work groups and learning collaboratives of groups of similar interest so that we can help them think about how to problem-solve with respect to the issues that are utmost in

their minds, and we have provided and increasingly are providing different tools for them so that as they are moving forward looking at our regulations, looking at our guidance and thinking about how to implement, they have easier ways of doing it than if they just reinvented the wheel and did it on their own.

Mr. PALLONE. All right. Thank you.

Dr. Sharfstein, can you talk about the interactions you have had with the Centers for Consumer Information and Insurance Oversight in preparing your State-based exchange for Maryland?

Mr. SHARFSTEIN. Sure. We have had a terrific interaction. There are regular opportunities for all States that we have taken advantage of, and we have regular consultation, and what we have been really impressed with is that both CCIIO and CMS have really met us where we are on a particular issue. Sometimes it is general help. Sometimes it is very, very specific. And they have been really willing to move at the speed that we are moving on a particular issue and work together across organizations. So from Maryland's perspective, the assistance we have gotten from HHS and the spirit of cooperation and support has allowed us to really customize implementation in a way we think works for our State.

Mr. PALLONE. Thank you.

I am going to try to get a question in to Mr. Allison. Despite claims to the contrary, the ACA was fully paid for when passed, and if repealed would actually increase this country's budget deficit by more than $100 billion, and the ACA contains strong cost-containment measures aimed at reducing health care costs the right way by improving care. I was interested in Arkansas's payment reform efforts. It seems aligned with the activities of the Center for Medicare and Medicaid Innovation. Could you tell us a little more about these payment reforms and how that would bring down costs, not just slash benefits or cost-shift?

Mr. ALLISON. Yes, absolutely. We believe in Arkansas that the incentives that we face and the activities that we are engaged in and our payment improvement initiative are wholly aligned with the objectives of the Center for Medicare and Medicaid Innovation, CMMI. We are engaged in moving away from fee-for-service in order to pay for outcomes in health care instead of the process that we currently pay for. We are paying for team-based outcomes. We are engaged in population-based reforms. We are looking for patient-centered care, and if we look for that, that means we are going to have to pay for it. We haven't done that in the past, and we are engaged in dramatic and sweeping changes working also with our private health insurance partners in Arkansas. We have worked very closely with CMS to make the first of these changes implementing in October through our State plan, not through waiver, an incentive-based episodic treatment payment reform that incentivizes for ADHD, for perinatal care and for upper respiratory infection, concentrated accountability and incentives for team-based care, and that happened very quickly and we appreciate CMS's support in that.

Mr. PALLONE. Thank you.

Mr. BURGESS. The gentleman's time is expired. I recognize the gentleman from Illinois, Mr. Shimkus, for 5 minutes for your questions, sir.

Mr. SHIMKUS. Thank you, Mr. Chairman. Thanks for being here. When you hear both sides, it is kind of like a Jekyll and Hyde. Will this turn out to be the Jekyll or will this turn out to be the Hyde, and I don't think we really know yet, unfortunately.

The Patient Protection and Affordable Care Act implies that health insurance will be affordable in the exchanges. The claim put forth was that if you like your insurance, you can keep it, and that health care costs would go down. That is how it was sold to us, most of us, some of us reading the bill but most of us passing the bill before we could read it. The CMS recently proposed a 3.5 percent fee on all plans offering plans in a Federal exchange. Are you afraid this fee will get passed on directly to individuals and families purchasing coverage in your State? And this is a question for Mr. Smith and Mr. Greenstein and Mr. Alexander, and if you could be short, because there is a couple more questions I want to ask.

Mr. SMITH. Well, they will be passed not only on to the purchaser in the exchange but these also apply to Medicaid managed care plans as well, so there is a direct impact on the State budget for these new fees.

Mr. SHIMKUS. So more costs?

Mr. SMITH. Yes, sir.

Mr. GREENSTEIN. Yes, it puts these plans at a competitive disadvantage as well, and we fully expect that those costs get passed on rather than absorbed with already small margins for the plans that participate, at least in Medicaid managed care.

Mr. SHIMKUS. Great. Mr. Alexander?

Mr. ALEXANDER. The short answer is yes. I think I would concur with my colleagues.

Mr. SHIMKUS. Great. I appreciate the shortness of those answers.

Mr. Cohen and Ms. Mann, do you know what our national debt is right now? Just the national debt. It is on every debt Web site in the world. Sixteen trillion dollars. Do you know what our deficit spending of this country has been the last 4 years? In essence, how much we have spent more than we have taken in? You don't know. Do you know?

Ms. MANN. I don't have that information right here.

Mr. SHIMKUS. OK. Mr. Cohen, do you know?

Mr. COHEN. I don't know the exact number.

Mr. SHIMKUS. Well, in 2009, it was $1.4 trillion. In 2010, it was $1.2 trillion. In 2011, $1.3 trillion. That is more spending than we have taken in. In 2012, I don't know, $1 trillion. Already this year, first quarter, first two months, $292 billion more in spending than we have taken in, which if you push that through to the full year, it is probably $1.7 trillion additional deficit added to the $16 trillion debt. That is part of this debate because Medicare and Medicaid are entitlement programs, and that is part of the reason why we are going to be here until Christmas and New Year's and have all the battles.

Let me go to just—again, for Mr. Smith, Mr. Alexander and Mr. Greenstein, and this is really about the State of Illinois now. Estimates from earlier this year have the State of Illinois unpaid bills growing to $34 billion in 5 years. That will be $2 billion more than Illinois's total projected revenue that year. The biggest problem? Can you guess what the biggest problem is, Mr. Smith?

Mr. SMITH. Medicaid.

Mr. SHIMKUS. Mr. Greenstein?

Mr. GREENSTEIN. Medicaid.

Mr. SHIMKUS. Mr. Alexander?

Mr. ALEXANDER. Medicaid.

Mr. SHIMKUS. Illinois's Medicaid has been on an unsustainable path for years and expected to increase more than 40 percent over the next 5 years to about $12 billion by 2017. Overall, this will create an estimated $21 billion in Medicaid payment backlogs, and this figure doesn't even factor in the unknown additional costs from new Medicaid requirements from—what would you guess, Mr. Smith?

Mr. SMITH. Medicaid.

Mr. SHIMKUS. From the new health care law and the Affordable Care Act. Mr. Alexander?

Mr. ALEXANDER. I concur.

Mr. SHIMKUS. What do you believe will be the result for Medicaid providers and patients if these backlogs remain? What do you think, Mr. Smith?

Mr. SMITH. Well, again, I think we have been looking at what happens to the Medicaid rates themselves. We are expecting to have to—again, I know there is a lot of discussion about the FMAP for the newly eligibles, but this affects the entire program. Otherwise we will not have providers who will see Medicaid payments unless the rates go up.

Mr. SHIMKUS. Mr. Greenstein?

Mr. GREENSTEIN. Yes, I worry about the participation in Medicaid from the provider perspective, but I also worry about programs like education that get crowded out within the context of the State's budget because we continue to consume a greater proportion of the overall budget in our health care costs.

Mr. SHIMKUS. Mr. Alexander?

Mr. ALEXANDER. I concurred with the last one, so I was going to say I concur, but I would like to just add to Mr. Greenstein's that the crowding out of other priorities is extremely important for Pennsylvania infrastructure. It's extremely important in transportation. So the growth of these programs growing to 10 percent while revenues are growing at 2 percent keep crowding out education, transportation and thus have a direct impact on jobs.

Mr. SHIMKUS. Thank you very much. Yield back my time, Mr. Chairman.

Mr. BURGESS. I thank the gentleman for yielding. The Chair now recognizes the gentlelady from California, Ms. Capps, for 5 minutes for the purposes of questioning.

Mr. WAXMAN. Mr. Chairman.

Mr. BURGESS. The Chair recognizes the ranking member of the full committee, Mr. Waxman. I am sorry. I didn't see you sitting there.

Mr. WAXMAN. Thank you, Mr. Chairman. I thought I was next.

Medicaid is an expensive program but we have a lot of people who are very poor in this country, and we can save a lot of money if we didn't give them health care. Now, I suppose, Mr. Smith, Mr. Greenstein and Mr. Alexander, you think the way to solve the Med-

icaid problem is to put it in a block grant. Is that correct? Mr. Smith, do you like a block grant? Yes or no.

Mr. SMITH. Yes.

Mr. WAXMAN. Mr. Greenstein?

Mr. GREENSTEIN. If given the choice, I would take it, gladly.

Mr. WAXMAN. Mr. Alexander?

Mr. ALEXANDER. Absolutely.

Mr. WAXMAN. OK. You three would like a block grant on Medicaid. That simply shifts the costs. So the States can cut back on services for these people and the disabled and poor will go without health care. Your idea is not going to succeed. That was one of the issues in the presidential campaign, and you lost.

So we have Medicaid, and let us accept that fact. You are running the programs. You ought to be supporting the program you are running in your States. The Medicaid expansion in the Affordable Care Act is a tremendous step forward for our health care system, and it is going to improve the lives of tens of millions of Americans. The expansion will dramatically reduce uncompensated-care costs in States around the country. It will provide States with extremely generous enhanced match rate from the Federal Government. We crafted this piece of Affordable Care Act to ensure that Medicaid expansion would not only be good for Americans' health but for the health of State budgets.

And a new report from the Kaiser Family Foundation shows just how beneficial this expansion will be to States around the country. The report found that over the next decade, with the Federal Government paying for well over 90 percent of the cost, Arkansas will reduce its uninsured population by nearly 150,000, Louisiana by 270,000, Maryland by 140,000, Pennsylvania by over 310,000, and Wisconsin by nearly 125,000. I doubt that a block grant would accomplish those goals. The report also found that these States could dramatically reduce uncompensated-care costs through the Medicaid expansion, over $25 million in savings in Arkansas, over $260 million savings in Louisiana, nearly $180 million in savings in Maryland, over $875 million in Pennsylvania that would be saved, nearly $250 million in Wisconsin. These are big, staggering, impressive numbers.

But even more impressive is the fact that in two of the States here today, the report found that given the generous Federal match rate expanding Medicaid and dramatically reducing the number of uninsured would actually decrease the State's overall Medicaid budget, saving an additional $250 million in Wisconsin and $1.75 billion in Maryland.

Mr. Allison, I assume you can talk about the importance of engaging in a detail that factual comprehensive analysis of the Medicaid expansion in Arkansas and the conclusions it led you to. You think it is going to be a good deal for your State, don't you?

Mr. ALLISON. I believe it is going to be a very good financial deal for the State of Arkansas.

Mr. WAXMAN. Well, these expansions are going to be a good deal but it seems to me that the three witnesses in the center of the table have an ideological view that they would like the world redone.

Now, the Affordable Care Act is a pretty important piece of legislation, and Dr. Sharfstein, since your exchange planning is well underway, I understand that insurance companies are sending in a great number of letters saying they want to sell insurance in the exchange. And I am curious to know, are you concerned that insurers won't show up or do you think they are going to show up? What are you seeing so far?

Mr. SHARFSTEIN. We asked insurers in Maryland to send letters of intent to participate in the exchange, and we have gotten more insurers interested than actually serve the Maryland market now. So we think that under the Affordable Care Act in 2014, it is going to be drawing new insurers in Maryland including, you know, plans that are very focused on better health, improved value, and it is going to be a real positive for the market in the State.

Mr. WAXMAN. Well, it just shows, if we have more insurance companies willing to offer insurance policies, the competitive model for the consumer choice is going to be more successful under those circumstances. I submit that the competitive model that Mr. Greenstein indicated he would like to see, which is called a consumer market-driven health care reform, is not going to work for Medicaid patients. Nobody is going to be vying for those Medicaid patients and all the range of services that Medicaid provides.

The ACA has been law for nearly 3 years now. It has an impressive list of accomplishments, and the basic reforms are still ahead of us. After full implementation, over 30 million American uninsured will get quality, affordable care, etc. But the point I want to make is that many of us fear that the purpose of this hearing is simply to say that we can't move forward, we can't implement the law, that somehow we don't have the information needed to do it. That is flat-out wrong. It seems to me this is just the latest approach to try to undo the Affordable Care Act. Republicans have failed to repeal the law. They didn't want to pass it in the first place. Then they wanted to repeal it. They didn't win the presidential election. They didn't find that the law was declared unconstitutional. Let us not buy into this next line of attack that the law must be delayed. Let us recognize that we have got a law. Whether you wanted it or not, it is the law of the land. Many of us think it is going to do a lot of good. We are seeing a great deal of success already, and I think this hearing is just fitting for this Congress. It is a Groundhog Day Congress over and over and over again—"It can't work. We can't do it. We can't afford to cover people. Our debt is too great." Well, let us make this thing work.

Mr. BURGESS. The gentleman's time is expired.

Mr. SMITH. May I respond, Mr. Chairman?

Mr. BURGESS. Please.

Mr. WAXMAN. Wait a second, Mr. Chairman. If we are going to have the witnesses start responding, then I am going to be able to respond to them, I presume. My time is expired. I had the opportunity to use my time as I saw fit, and I don't think this is an open-ended question to have witnesses respond, unless you guarantee that I can come back and respond to them. If you want to open the hearing up to a two-way exchange, I am willing to do that, but you do have other members waiting to be recognized.

Mr. BURGESS. I do think as a matter of courtesy that we ought to allow our witnesses to respond. That has long been the practice in this committee. But as the ranking member sees difficulty with that, we will recognize Mr. Murphy and perhaps Mr. Smith, if you will hold that thought, we will get a chance for you to visit with us.

Mr. Murphy, you are recognized for 5 minutes for questions, sir.

Mr. MURPHY. Thank you, Mr. Chairman.

Mr. Alexander, you are from Pennsylvania and so am I, and you recognize that this is the law of the land, the Affordable Care Act? Am I correct on that?

Mr. ALEXANDER. Yes.

Mr. MURPHY. Are you trying to stop or undo its implementation?

Mr. ALEXANDER. I don't think anyone is trying to stop anything. I think we are trying to make sense of it.

Mr. MURPHY. So let me ask you a number of things you said in your testimony, I want to ask you about that. You identified a number of problems that Pennsylvania is having, and certainly the other witnesses are welcome to respond to these too, but a number of those key ones, I wanted to ask about. You had mentioned that we have the CHIP program, the Children's Health Insurance Program, in Pennsylvania. I know when I was a State senator, I worked on that as well. And you feel that actually works in a less costly manner and has good quality in the program. Is this something that you are able to ask—according to the law, are you able to ask for a waiver to use that instead of the other program right now as the law stands? Do you know?

Mr. ALEXANDER. I don't know of any waiver to be able to make that change.

Mr. MURPHY. Is that something you would recommend that Congress address in terms of allowing for waivers?

Mr. ALEXANDER. I think so. I think if things are working in the State, they should be kept that way, and especially if recipients are happy.

Mr. MURPHY. Ms. Mann, are you aware, are States allowed any waivers for programs like that if they have a problem they think is working well?

Ms. MANN. There is a wide range of waivers that are available for States. One of the things about the changes in the law that brings the CHIP kids over into the Medicaid program is right now their younger siblings are already eligible for Medicaid, so one of the reasons for the changes is to put families together. Right now we have children in the same family, same income——

Mr. MURPHY. I appreciate that. I am not opposed to bringing people together.

Ms. MANN [continuing]. They are in different programs, depending upon their age.

Mr. MURPHY. I know when we did the prescription drugs bill for Medicare, Pennsylvania already had a program for that and we were able to work in legislation to make sure that they did work smoothly, so that might be something we might want to work on in the future, and I would certainly hope that you can get together with Mr. Alexander.

Mr. Alexander, you also said you can't use an asset test. What do you think is the benefit of having an asset test and what do you see in the law that restricts that?

Mr. ALEXANDER. Well, an asset test is a program integrity tool to be able to ferret out if families or individuals have high incomes or assets that would—not incomes but assets that would—that they shouldn't be on the program. So for example——

Mr. MURPHY. Such as?

Mr. ALEXANDER. So for example, if somebody, you know, owned a large home and cars and they had these assets or specific accounts, we would be able to utilize them, the same way we do with the food stamp program.

Mr. MURPHY. So you would like those same rules to be able to be applied?

Mr. ALEXANDER. It should be an option. It was an option prior and it should be an option.

Mr. MURPHY. Would you see similar things with regard to presumptive eligibility as another way of making sure that people who need these programs are eligible?

Mr. ALEXANDER. It is another program integrity measure to be able to—presumptive eligibility would presume that people are eligible. We still don't have guidance from CMS as to who would be on the hook for that money if these individuals later on are found not eligible. Would the State be paying that bill? Would the Federal Government be paying that bill? I don't think anybody should be paying that bill.

Mr. MURPHY. And I'm assuming you would ask for the same sort of assistance with what you referred to as adoption of passive Medicaid renewals, duplication of efforts, one-size-fits-all? Are you asking, Congress, Mr. Secretary, that one of the things we should do is either find out if we are missing something in the law to clarify that and in absence of that to look to this committee to pass some laws or rules that would help you do that so you are not adding to your costs if you are able to do things better?

Mr. ALEXANDER. I think that would be very helpful. The more you engage the States, the better. We are on the ground. We know how to run these programs, and I think that the more information you have from all of the States be very important. The purpose in these programs is to provide quality care to low-income individuals, and we at the State level have to be vigilant in terms of being able to prevent people that have the ways and means to provide for themselves.

Mr. MURPHY. Thank you.

Mr. Smith, do you have any comments on those questions?

Mr. SMITH. I would agree with Secretary Alexander. I think he summarized them very well.

Mr. MURPHY. Thank you.

The other witness, Mr. Greenstein?

Mr. GREENSTEIN. Sure. I would echo that sentiment in that every day with a finite budget, at least in our State, we don't have the option to run large deficits so we have to balance our budget every year, and that if there are resource decisions to make on how we allocate those resources, we would like to see those resources fo-

cused on the people that need them the most rather than those that have the means to pay for part of the care themselves.

Mr. MURPHY. Thank you. I see I am out of time.

Mr. Chairman, I would hope you would ask the witnesses who have some specific recommendations that we might do some legislative actions that they would submit to you in writing some of those recommendations. And with that, I yield back, sir.

Mr. BURGESS. The record will remain open for 5 legislative days for witnesses to submit.

The Chair recognizes the chairman emeritus of the full committee, Mr. Dingell.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy.

Mr. Cohen, we appreciate you being here this morning, and I have the following questions to be answered yes or no. Recently we have heard a lot of talk about a $63 ACA fee that will go into the Reinsurance Fund. In your opinion, is this a tax? Yes or no.

Mr. COHEN. No.

Mr. DINGELL. It is not in the U.S. Internal Revenue Code. Is that right?

Mr. COHEN. Correct.

Mr. DINGELL. So we can call this a fee as opposed to a tax. Is that right?

Mr. COHEN. Yes.

Mr. DINGELL. Now, CMS had the authority to set this free through Section 1341 of ACA. Is that true?

Mr. COHEN. Yes.

Mr. DINGELL. Now, Mr. Cohen, this section does not set the per-insured fee, instead, it sets out a total amount to be raised. Is that right?

Mr. COHEN. Yes.

Mr. DINGELL. This fee will be $63 in 2014, lower for 2015 and 2016. Is it true that this fee is short term and will end after the total amount is realized in 3 years?

Mr. COHEN. Yes.

Mr. DINGELL. Now, Mr. Cohen, I happen to be just a poor Polish lawyer from Detroit so I want to make sure I understand this correctly. The fee goes into a Reinsurance Fund that will stabilize premium costs in individual insurance markets. Is that correct?

Mr. COHEN. Yes.

Mr. DINGELL. Now, Mr. Cohen, this will help ACA to provide funds to insurance companies who deal with a large amount and a large number of vulnerable populations, those with serious pre-existing conditions and high health care costs. Is that right?

Mr. COHEN. Yes.

Mr. DINGELL. So essentially it is a reinsurance fund. Is that right?

Mr. COHEN. It is.

Mr. DINGELL. Now, Mr. Cohen, this fee will lower insurance premiums in the individual market because insurers will not have to factor in the costs of disproportionate high costs of enrollment of high-risk patients. Is that correct?

Mr. COHEN. Yes.

Mr. DINGELL. And isn't it true that this in turn will benefit employer plans and employees with stable prices because they will no

longer have to pay for the cost shift that occurs when there are people out there without the insurance or the means to pay for health care? Yes or no.

Mr. COHEN. Yes, it will.

Mr. DINGELL. Now, at the end of the day, this fee guarantees those in dire need of insurance or constituents with preexisting conditions are covered and by so doing we actually lower and stabilize the cost of health care for all of our citizens. Is this correct?

Mr. COHEN. Yes.

Mr. DINGELL. Thank you, Mr. Cohen.

Now I want to say a few things, Mr. Chairman. We have the law of the land, the Affordable Care Act, and I am hearing no end of carping and complaining about it, but the hard and simple fact of the matter is that the health care costs in this country are running away from us and will destitute the Nation. We have to do something to get it dealt with. We have to get all the people covered and we have to see to it that we deal with the problems of inadequate health care for our people in the future. This is a very serious matter. It is going to attack almost every single program including Medicare and Medicaid, and the costs that the State are being compelled to meet with regard to Medicaid.

I find myself very distressed because I feel that I am kind of in the company of a bunch of people who are looking at the donut and seeing only the hole. You know, we confront a situation where we have to address these problems by making intelligent investments, and one of the things that I find that terrifies me is, we have got a lot of people in this country who can look and who can see the cost of everything but they can't see the value of anything, and the value of what we are trying to do here is to see to it that everybody has health care, to see to it that the health care of this country is affordable and available to all of our people and to see to it that the people of this country have a system which makes available to the ordinary citizen the right of health care, and it is, in my view, a right. It is not a privilege. There are a lot of people around here who seem to look at it as a privilege and they will do everything they can to save money on seeing to it that some other poor bastard doesn't have health care. So I am hopeful that we will look at this as an investment in the future of the country and that we will try and do something to see to it that the health care in this country, which potentially is the greatest and the best in the world, is shared amongst the people and that they are not denied this and they are not dying because they don't have health care.

So I hope that this hearing will lead us to an understanding of these points, and I yield back the balance of my time.

Mr. BURGESS. The gentleman yields back. At this time I recognize the gentleman from Louisiana, Dr. Cassidy, for 5 minutes for questions.

Mr. CASSIDY. Just so folks now, we have had some effectively implied allegations that some of us don't care about access to affordable care. I actually am a doctor who Tuesday and Monday will be in a safety-net hospital for the uninsured or the poorly insured, which includes Medicaid. And so just let us get that on the record.

I have got lots of questions so hopefully I can run over. Mr. Cohen, I am not clear. Will CMS propose something about allowing

premiums to go into health savings accounts? Will that money of the premium which goes into the health saving account, will that be considered as regards the MLR? You follow what I am saying? So Medical Loss Ratio, will that—please.

Mr. COHEN. Yes, it will be considered first-dollar coverage for purposes of the MLR to the extent that it is spent.

Mr. CASSIDY. So if someone does not spend their money in their health savings account, the insurance company does not get credit for an expenditure as regards the MLR?

Mr. COHEN. That is right.

Mr. CASSIDY. So if somebody is frugal and doesn't go and buy overpriced goods, does preventive medicine on their own, takes care of themselves, keeps their weight down, etc., the insurance company will be penalized?

Mr. COHEN. No, they are not penalized.

Mr. CASSIDY. But it won't count against the MLR, and you are going to come back and take a portion of that and you are going to come back and make them rebate that cost. Is that correct?

Mr. COHEN. Well, the Medical Loss Ratio provision of the 80/20 rule requires that insurance companies spend 80 cents of every premium dollar on actual health care. If the money isn't spent——

Mr. CASSIDY. Deposited in the HSA does not count as an expenditure, it is only if the patient spends the money.

Mr. COHEN. Right.

Mr. CASSIDY. So we are trying to hold down cost but we are basically putting in incentives to spend the money. By the way, it is hard to keep a straight face when Mr. Waxman speaks about access to affordable care. The only thing I have heard about this bill is that premiums have gone by $2,500 since it was passed. It is kind of curious, isn't it?

Dr. Sharfstein, only 65 percent of doctors in Maryland accept Medicaid patients. That is a statistic I can give you the source from, Health Affairs. How many of those Medicaid patients unable to find a primary care doctor seek their care in an emergency room? Do we know those statistics? Some States do know that statistic.

Mr. SHARFSTEIN. I don't know if I have a specific answer to that.

Mr. CASSIDY. Then let me go on because I have limited time. I don't mean to be rude to any of you. I apologize.

Now, the issue is, in Maryland Medicaid, I presume there is no deductible.

Mr. SHARFSTEIN. Correct.

Mr. CASSIDY. Now, you all guys make out like a bandit. If I was a big blue State, I would be all for this expansion, because according to Kaiser Family Foundation, you are going to save $500 million over 10 years. Why wouldn't you be for it? But let me put myself in the role of someone that I might be seeing Tuesday morning in a hospital if I were in Maryland instead of Louisiana. You are making 140 percent of Federal poverty level. The State grabs the money. Man, we are glad. It helps our budget. But now I am on the exchange. I have a $2,000 deductible. As Mr. Smith points out, I am paying $600 a year in a premium. Do we really think that family at 140 percent of Federal poverty can afford that $2,000 deductible?

Mr. SHARFSTEIN. Well, from my perspective, this has a lot to do with compared to what. Someone at——

Mr. CASSIDY. Compared to your current Medicaid plan.

Mr. SHARFSTEIN. A hundred and forty percent, there is no access to Medicaid, so they have no——

Mr. CASSIDY. Well, I thought you said in your testimony that you have up to 200 percent of poverty level in your Medicaid plan.

Mr. SHARFSTEIN. No, we do not.

Mr. CASSIDY. Oh, then I misunderstood.

Mr. SHARFSTEIN. For an adult. So they had no access. So we are able to give them affordable access through a subsidy.

Mr. CASSIDY. Now, OK, let us just take that person at 140 percent. Do we really think they are going to be able to afford that $2,000 deductible? By the way, if I was an insurance plan, I would be moving to your State too. Now we have the Federal Government telling you you have to buy insurance. It isn't competition; it is a forced market. Do we really think that family at 140 percent of Federal poverty can afford that $2,000 deductible?

Mr. SHARFSTEIN. Well, we certainly think that there is a lot of value for them, and part of what we are going to be doing and what we are working with, so many people in Maryland, is to figure out how to develop an outreach plan that engages——

Mr. CASSIDY. Even though it is going to cost them $2,000? I tell you, I like Mr. Smith's line. It is not a percentage, it is the dollar amount, and when you are at 140 percent of Federal poverty, $2,000 might as well be $50,000.

Mr. SHARFSTEIN. It is not every family that has to pay $2,000.

Mr. CASSIDY. Only if they access the insurance portion.

Let me go to Mr. Allison—Dr. Allison. I am sorry. Dr. Allison, in your testimony, you mentioned that the State of Arkansas will have to come up with $500 million between January and June 14 to implement this plan. Is that correct?

Mr. ALLISON. That is not correct, sir. What will——

Mr. CASSIDY. That is your testimony.

Mr. ALLISON. That is not what the testimony says. The testimony says that the legislature will have to appropriate $500 million for the second half of State fiscal year 2014. That would include, in this case, almost all Federal funding.

Mr. CASSIDY. So that is going to be all Federal dollars? It won't be State dollars?

Mr. ALLISON. Almost all Federal funding.

Mr. CASSIDY. OK. So they have to appropriate Federal dollars?

Mr. ALLISON. Correct.

Mr. CASSIDY. OK. That is interesting. And the economic aspect of this—by the way, let me just point out, the Kaiser Family Foundation study that Mr. Waxman had proposed is going to cost Louisiana $1.8 billion over 10 years, Arkansas $1.2 billion, and that is assuming that we don't have to raise taxes on the Federal or State taxpayer to pay for this extra money, which is an assumption which seems a little silly.

I am over time. I yield back. Thank you.

Mr. BURGESS. I thank the gentleman for yielding back. The Chair now recognizes the gentlelady from California, Ms. Capps, 5 minutes for the purposes of questions.

Mrs. CAPPS. Thank you, Mr. Chairman, and to all of our witnesses, thank you for your testimony today and for your availability.

I want to give you, Mr. Cohen, just a minute to respond to the previous question Mr. Cassidy asked about the Medical Loss Ratio and the HSA contributions, but if you could be very brief?

Mr. COHEN. So what we have said is that the 80/20 rule says insurance companies have to spend 80 cents of every premium dollar on care, so to the extent that the HSA dollars are actually expanded, they will be counted towards that 80 cents that the insurance company has to spend.

Mrs. CAPPS. Thank you very much.

I want to address some questions to you, Ms. Mann. The Affordable Care Act includes a provision that will bump up the payment for primary care providers in Medicaid to the rates we currently pay through Medicare. On average, this will improve primary care reimbursement by 67 percent on average nationally. In my State of California, the increase will be even more important, 113 percent increase for current reimbursement. Could you explain why raising primary care reimbursement for Medicaid providers is so important and how this will benefit patients but also the health care system as a whole, the role it plays?

Ms. MANN. Of course. In the Medicaid program and in changes going on in the health care marketplace more generally, there is real appreciation of the value of primary care, and to avoid unnecessary high utilization of specialty care, to avoid catastrophic care, people need regular primary care preventive care, and what this primary care boost does is encourage more primary care practitioners to enroll in the Medicaid program, participate in the Medicaid program and to provide a greater share potentially of their hours of service to Medicaid beneficiaries. So we are very excited about the opportunity to expand and deepen access, particularly around primary care, and to reduce costs overall as a result.

Mrs. CAPPS. Absolutely. I share your belief in that. As I understand it, the research on provider rates shows that States with higher rates have greater numbers of providers accepting new patients and States that have increased their rates have seen more providers willing to increase their participation. Given that, do you think that increasing rates to Medicare levels for primary care physicians with both increase the number of physicians participating in the program and allow some who are already participating to increase the number of Medicaid patients they see? That's a big problem right now.

Ms. MANN. I do think it will boost participation. I think there is a general agreement that it will boost participation. I do want to say that I think that rates are one of many factors that help us make sure we have good provider participation in the program but this will go a long way to assure greater participation, particularly in the needed area of primary care.

Mrs. CAPPS. Thank you. And as you may know, there is a lot of talk from some in Congress that the Medicaid primary care payment bump should be used to pay for SGR. I have consistently voted to get rid of the SGR, and we even did so in the House version of health care reform. But this pay-for idea is frankly, in

my opinion, foolish. This would literally incentivize providers to take care of our seniors at the expense of the poor and the health care community, providers and patients alike, agree. You may have a comment on this, or I can move on and ask another question.

Ms. MANN. I appreciate your support for assuring good primary care in the Medicaid program. Thank you.

Mrs. CAPPS. Now, when States expand Medicaid under the Affordable Care Act, they pull in Federal dollars to provide health insurance to millions of people who don't have it now. Right now these uninsured people are relying on health care safety-net providers and programs that are paid for by State dollars. Many of our States can't afford to do this. Won't States be able to actually save some significant dollars in their State health budgets on programs that pay for uncompensated care, on mental health savings, etc.? In fact, the net cost to State budgets of expanding Medicaid could be quite negligible, or even a net gain. Is that correct?

Ms. MANN. I think that is absolutely correct. Different States have done their studies and different organizations have done studies, and it obviously varies by State but the amount of the increase overall under the Kaiser study that people have been citing today of the Medicaid expansion, just looking at the expansion, it is less than one-half of 1 percent in terms of the impact on States' budgets, notwithstanding the big change in the number of people who would gain coverage, but then as you say, there's offsetting savings. Uncompensated care will be reduced. And Governor Sandoval came out this week and supported the Medicaid expansion. One of the things he cited in Nevada is the reduction in State funding for mental health services that will no longer be necessary. Those were funded by the State to fill in the gap, and that gap will be filled through the Medicaid expansion.

Mrs. CAPPS. Thank you very much for answering.

And Mr. Chairman, as I close, I ask unanimous consent to enter the following letters into the record opposing this pay-for idea: a letter from the Family and Children's Health Groups and Providers, a letter from the majority of our Nation's physicians and a letter from the California Children's Hospital. I request that these be submitted.

Mr. BURGESS. Without objection, so ordered.

[The information follows:]

December 12, 2012

Dear Senator/Congressperson:

As organizations dedicated to the health of children, we respectfully urge you to protect access to health services for children by preserving current law's payment increase for primary care services financed by Medicaid. While our nation should be proud of the significant progress we have made in enrolling eligible children in Medicaid, guaranteeing that children have access to primary and specialty care has been much harder.[1]

Section 1202 of the Health Care Education and Reconciliation Act requires state Medicaid agencies to reimburse specified participating physicians at Medicare rates for primary care services for two years. Regulations require that the increased payment include qualified primary care services furnished "under the personal supervision" of a physician, including those provided by nonphysician providers such as nurse practitioners and physician assistants. The policy is set to take effect in a matter of weeks on January 1, 2013.

The primary care payment increase is a critical step toward enhancing access to health care for the nation's children covered by Medicaid. Currently, on average, Medicaid reimburses pediatricians 30 percent below Medicare rates for comparable services. While a number of factors have been found to deter or discourage provider participation in Medicaid, low payment consistently has been found to be the top participation barrier. In a recent survey, 74% of respondents rated "low provider payment" "very important" as a participation barrier.[2]

Low payment rates have built significant barriers to provider participation in the Medicaid program and create concerns about the ability of children to access the medically necessary health care services they are entitled to under the program. Section 1202 applies to general pediatricians and pediatric subspecialists as physicians eligible for the payment increase. These physicians and nonphysician providers who work with them play a vital role in the provision of primary care services for children with the most complex health challenges. Their inclusion in the payment increase is essential to ensuring the greatest possible impact on improving access to care for children.

We urge Congress to oppose any proposals that would eliminate the Medicaid primary care payment increase. Elimination of this policy would negatively impact access to care for children and further burden the Medicaid system. If we may provide further information or otherwise be of assistance, please contact Robert Hall at 202/347-8600 or RHall@aap.org.

Sincerely,

American Academy of Family Physicians
American Academy of Ophthalmology
American Academy of Pediatrics
American College of Cardiology
Association of Maternal & Child Health Programs
Children's Hospital Association

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[1] "Although Medicaid and CHIP enrollment reached 54% of the total U.S. infant and child population in 2010 (up from 32% in 2000 according to CMS data), pediatricians' combined Medicaid and CHIP caseload increased merely 3 percentage points to an average of 36% over the last decade, according to the AAP survey and a similar study conducted in 2000." See AAP News Vol. 33 No. 7 July 1, 2012, pp. 21 (doi: 10.1542/aapnews.2012337-21).
[2] Ibid.

Children's Advocacy Institute
Children's Defense Fund
Community Catalyst, New England Alliance for Children's Health
Cystic Fibrosis Foundation
Doctor's for America
Families USA
Family Voices
Foster Family-based Treatment Association
Healthy Teen Network
Medicaid Health Plans of America
National Alliance of Children's Trust and Prevention Funds
National Association of Social Workers
National Coalition on Health Care
National Partnership for Women & Families
Nemours
North American Council on Adoptable Children
The Alliance for Children and Families
The National Alliance to Advance Adolescent Health
The Society for Social Work Leadership in Healthcare
ZERO TO THREE

December 5, 2012

The Honorable John Boehner
Speaker
U.S. House of Representatives
Washington, DC 20515

The Honorable Eric Cantor
Majority Leader
U.S. House of Representatives
Washington, DC 20515

The Honorable Kevin McCarthy
Majority Whip
U.S. House of Representatives
Washington, DC 20515

The Honorable Nancy Pelosi
Minority Leader
U.S. House of Representatives
Washington, DC 20515

The Honorable Steny Hoyer
Minority Whip
U.S. House of Representatives
Washington, DC 20515

The Honorable Harry Reid
Majority Leader
U.S. Senate
Washington, DC 20510

The Honorable Richard Durbin
Majority Whip
U.S. Senate
Washington, DC 20510

The Honorable Mitch McConnell
Minority Leader
U.S. Senate
Washington, DC 20510

The Honorable Jon Kyl
Minority Whip
U.S. Senate
Washington, DC 20510

Dear Sirs and Madam:

As organizations representing the majority of the nation's physicians, we write to express our strong opposition to proposals that would eliminate the Medicaid primary care payment increase that was recently finalized in a final rule issued by the Centers for Medicare and Medicaid Services (CMS) and scheduled to be implemented on January 1.

Elimination of this policy further burdens the already challenged Medicaid system of today. Patients will face obstacles to connecting with a patient-centered medical home and will be forced to rely on episodic, acute care services provided in other settings, foregoing the more cost-effective coordinated and preventive care services that primary care physicians provide. Policies aimed at improving access to physicians in the Medicaid program are strongly supported by our organizations because we understand that investments such as these lead to better quality of care for patients and decreased costs for state governments.

The Medicaid payment increase ensures that Medicaid payments for eligible physician services in all states are no less than Medicare, independent of whether a state has chosen to participate in the Medicaid expansion authorized by the Affordable Care Act (ACA). By doing so, it will improve access to care for persons enrolled in both the existing Medicaid program and persons who may become newly eligible for Medicaid in states that accept the federal dollars to expand Medicaid.

Over the past few years, our nation has taken significant steps towards improving access to health care for the uninsured and underinsured. A principal part of this effort has been the investment in primary care as the foundation of our nation's health care system. Expanding access to physicians, especially primary

care physicians, is a priority for federal and state governments, as well as commercial insurance plans. Private and public health care systems are making this investment as a means of improving access to health care for patients and as a means of improving the overall quality and efficiency of care provided.

Our members are dedicated to working individually and collectively to ensure that all patients, including low-income working families who depend on Medicaid, have access to needed primary care services. However, many physicians do not participate in the Medicaid program due to poor payment rates that, historically, are well below the actual costs of providing care. This results in reduced access to care for the most vulnerable patients and higher costs to federal and state governments.

Although a principal goal of this Medicaid policy is to improve access to primary care, the policy also increases payments to many subspecialists in internal medicine and pediatrics, with the purpose of increasing participation and access to their services.

A key to achieving our joint goals of ensuring increased access and improved quality is ensuring that Medicaid and Medicare payment policies are aligned with the access and quality goals established by public and private health care systems. The Medicaid payment increase is an important policy that attempts to better align payment rates with cost of care for primary care physicians, thus increasing access to primary care physicians for millions of Medicaid patients.

We urge you to oppose elimination of the Medicaid primary care payment increase.

Sincerely,

Academic Pediatric Association
Alliance for Academic Internal Medicine
AMDA - Long Term Care Medicine
American Academy of Allergy, Asthma & Immunology
American Academy of Family Physicians
American Academy of Neurology
American Academy of Orthopaedic Surgeons
American Academy of Pediatrics
American Association of Clinical Endocrinologists
American Association for the Study of Liver Diseases
American College of Allergy Asthma and Immunology
American College of Cardiology
American College of Chest Physicians
American College of Osteopathic Family Physicians
American College of Osteopathic Internists
American College of Osteopathic Pediatricians
American College of Physicians
American College of Rheumatology
American Gastroenterological Association
American Geriatrics Society
American Medical Association
American Osteopathic Association
American Pediatric Society
American Society for Blood and Marrow Transplantation
American Society of Clinical Oncology
American Society of Hematology

American Society of Pediatric Hematology/Oncology
Association of Medical School Pediatric Department Chairs
Infectious Disease Society of America
Joint Council of Allergy Asthma and Immunology
MEDNAX National Medical Group
National Physicians Alliance
North American Society for Pediatric Gastroenterology, Hepatology and Nutrition
Pediatric Orthopaedic Society of North America
Pediatrix Medical Group
Renal Physicians Association
Society for Adolescent Health and Medicine
Society for General Internal Medicine
Society for Pediatric Research
Society of Hospital Medicine
The Endocrine Society

Medical Association of the State of Alabama
Alabama Academy of Family Physicians
Alabama Chapter, American College of Physicians
Alabama Chapter, American Academy of Pediatrics

Alaska State Medical Association
Alaska Chapter, American College of Physicians
Alaska Osteopathic Medical Association

Arizona Medical Association
Arizona Academy of Family Physicians
Arizona Chapter, American College of Physicians
Arizona Osteopathic Medical Association
Arizona Chapter, American Academy of Pediatrics
Arizona Society of the American College of Osteopathic Family Physicians

Arkansas Medical Society
Arkansas Academy of Family Physicians
Arkansas Chapter, American College of Physicians
Arkansas Osteopathic Medical Association
Arkansas Chapter, American Academy of Pediatrics

California Medical Association
California Academy of Family Physicians
California Chapter, American College of Physicians
Osteopathic Physicians and Surgeons of California
California Chapter 1, American Academy of Pediatrics
California Chapter 2, American Academy of Pediatrics
California Chapter 3, American Academy of Pediatrics

Colorado Medical Society
Colorado Academy of Family Physicians
Colorado Chapter, American College of Physicians
Colorado Society of the American College of Osteopathic Family Physicians
Colorado Chapter, American Academy of Pediatrics

Connecticut State Medical Society
Connecticut Academy of Family Physicians
Connecticut Chapter, American College of Physicians
Connecticut Chapter, American Academy of Pediatrics

Delaware Academy of Family Physicians
Delaware Chapter, American College of Physicians
Delaware State Osteopathic Medical Society
Delaware Chapter, American Academy of Pediatrics

Medical Society of the District of Columbia
District of Columbia Academy of Family Physicians
District of Columbia Chapter, American College of Physicians
District of Columbia Chapter, American Academy of Pediatrics

Florida Medical Association
Florida Academy of Family Physicians
Florida Chapter, American College of Physician
Florida Society of the American College of Osteopathic Family Physicians
Florida Chapter, American Academy of Pediatrics

Medical Association of Georgia
Georgia Academy of Family Physicians
Georgia Chapter, American College of Physicians
Georgia Chapter, American Academy of Pediatrics

Hawaii Medical Association
Hawaii Association of Osteopathic Physicians and Surgeons

Idaho Medical Association
Idaho Academy of Family Physicians
Idaho Osteopathic Medical Association
Idaho Chapter, American Academy of Pediatrics

Illinois State Medical Society
Illinois Academy of Family Physicians
Illinois Chapter, American College of Physicians
Illinois Chapter of the American College of Osteopathic Family Physicians
Illinois Chapter, American Academy of Pediatrics

Indiana Academy of Family Physicians
Indiana Chapter, American College of Physicians
Indiana Chapter, American Academy of Pediatrics

Iowa Medical Society
Iowa Academy of Family Physicians
Iowa Chapter, American College of Physicians
Iowa Osteopathic Medical Association

Iowa Chapter of the American College of Osteopathic Family Physicians
Iowa Chapter, American Academy of Pediatrics

Kansas Medical Society
Kansas Academy of Family Physicians
Kansas Society of the American College of Osteopathic Family Physicians
Kansas Chapter, American Academy of Pediatrics

Kentucky Medical Association
Kentucky Academy of Family Physicians
Kentucky Chapter, American College of Physicians
Kentucky Chapter, American Academy of Pediatrics

Louisiana State Medical Society
Louisiana Academy of Family Physicians
Louisiana Osteopathic Medical Association
Louisiana Chapter, American Academy of Pediatrics

Maine Medical Association
Maine Chapter, American College of Physicians
Maine Osteopathic Association
Maine Chapter, American Academy of Pediatrics

MedChi-The Maryland State Medical Society
Maryland Academy of Family Physicians
Maryland Chapter, American College of Physicians
Maryland Chapter, American Academy of Pediatrics

Massachusetts Medical Society
Massachusetts Academy of Family Physicians
Massachusetts Chapter, American College of Physicians
Massachusetts Chapter, American Academy of Pediatrics

Michigan State Medical Society
Michigan Academy of Family Physicians
Michigan Chapter, American College of Physicians
Michigan Association of Osteopathic Family Physicians
Michigan Osteopathic Association
Michigan Chapter, American Academy of Pediatrics

Minnesota Medical Association
Minnesota Academy of Family Physicians
Minnesota Chapter, American College of Physicians
Minnesota Osteopathic Medical Society
Minnesota Chapter, American Academy of Pediatrics

Mississippi State Medical Association
Mississippi Academy of Family Physicians
Mississippi Chapter, American College of Physicians
Mississippi Osteopathic Medical Association
Mississippi State Society of the American College of Osteopathic Family Physicians

Mississippi Chapter, American Academy of Pediatrics

Missouri State Medical Association
Missouri Academy of Family Physicians
Missouri Association of Osteopathic Physicians and Surgeons
Missouri Society of the American College of Osteopathic Family Physicians
Missouri Chapter, American Academy of Pediatrics

Montana Medical Association
Montana Academy of Family Physicians
Montana Chapter, American College of Physicians
Montana Chapter, American Academy of Pediatrics

Nebraska Medical Association
Nebraska Academy of Family Physicians
Nebraska Chapter, American College of Physicians
Nebraska Chapter, American Academy of Pediatrics

Nevada State Medical Association

New Hampshire Medical Society
New Hampshire Academy of Family Physicians
New Hampshire Chapter, American College of Physicians
New Hampshire Osteopathic Association
New Hampshire Chapter, American Academy of Pediatrics

Medical Society of New Jersey
New Jersey Academy of Family Physicians
New Jersey Chapter, American College of Physicians
New Jersey Chapter, American Academy of Pediatrics

Medical Society of the State of New York
New York Chapter, American College of Physicians
New York State Osteopathic Medical Society
New York Chapter 1, American Academy of Pediatrics
New York Chapter 2, American Academy of Pediatrics
New York Chapter 3, American Academy of Pediatrics

New Mexico Medical Society
New Mexico Academy of Family Physicians
New Mexico Chapter, American College of Physicians
New Mexico Chapter, American Academy of Pediatrics

North Carolina Medical Society
North Carolina Academy of Family Physicians
North Carolina Society of the American College of Osteopathic Family Physicians
North Carolina Chapter, American Academy of Pediatrics

North Dakota Medical Association
North Dakota Academy of Family Physicians
North Dakota Chapter, American College of Physicians

North Dakota Chapter, American Academy of Pediatrics

Ohio State Medical Association
Ohio Academy of Family Physicians
Ohio Chapter, American College of Physicians
Ohio Osteopathic Association
Ohio State Society of the American College of Osteopathic Family Physicians
Ohio Chapter, American Academy of Pediatrics

Oklahoma State Medical Association
Oklahoma Osteopathic Association
Oklahoma Chapter, American Academy of Pediatrics

Oregon Medical Association
Oregon Academy of Family Physicians
Oregon Chapter, American College of Physicians

Pennsylvania Medical Society
Pennsylvania Academy of Family Physicians
Pennsylvania Chapter, American College of Physicians
Pennsylvania Osteopathic Medical Association
Pennsylvania Osteopathic Family Physicians Society
Pennsylvania Chapter, American Academy of Pediatrics

Rhode Island Medical Society
Rhode Island Academy of Family Physicians
Rhode Island Chapter, American College of Physicians
Rhode Island Chapter, American Academy of Pediatrics

Puerto Rico Chapter, American Academy of Pediatrics

South Carolina Medical Association
South Carolina Academy of Family Physicians
South Carolina Chapter, American College of Physicians
South Carolina Osteopathic Medical Society
South Carolina Chapter, American Academy of Pediatrics

South Dakota State Medical Association
South Dakota Academy of Family Physicians
South Dakota Chapter, American College of Physicians
South Dakota Chapter, American Academy of Pediatrics

Tennessee Medical Association
Tennessee Academy of Family Physicians
Tennessee Chapter, American College of Physicians
Tennessee Osteopathic Medical Association
Tennessee State Society of Osteopathic Family Physicians

Texas Medical Association
Texas Academy of Family Physicians
Texas Osteopathic Medical Association

Texas Society of the American College of Osteopathic Family Physicians
Texas Chapter, American Academy of Pediatrics

Utah Medical Association
Utah Chapter, American Academy of Pediatrics

Vermont Medical Society
Vermont Academy of Family Physicians
Vermont State Association of Osteopathic Physicians & Surgeons
Vermont Chapter, American Academy of Pediatrics

Virginia Academy of Family Physicians
Virginia Chapter, American College of Physicians
Virginia Osteopathic Medical Association
Virginia Society of the American College of Osteopathic Family Physicians
Virginia Chapter, American Academy of Pediatrics

Washington State Medical Association
Washington Academy of Family Physicians
Washington State Chapter, American College of Physicians
Washington Chapter, American Academy of Pediatrics

West Virginia State Medical Association
West Virginia Academy of Family Physicians
West Virginia Osteopathic Medical Association
West Virginia Chapter, American Academy of Pediatrics

Wisconsin Medical Society
Wisconsin Chapter, American College of Physicians
Wisconsin Chapter, American Academy of Pediatrics

Wyoming Medical Society
Wyoming Chapter, American College of Physicians
Wyoming Chapter, American Academy of Pediatrics

Cc: Members of Congress

CALIFORNIA
CHILDREN'S
HOSPITAL
ASSOCIATION

1215 K STREET SUITE 1930
SACRAMENTO, CA 95814
916.552.7111
916.552.7119 FAX
www.ccha.org

December 12, 2012

Dear Member of the California Delegation:

I write on behalf of the California Children's Hospital Association to urge you to protect access to health services for children by preserving current law which allows for a two-year payment increase to primary care services financed by Medicaid. Guaranteeing that children always have access to primary and specialty care at the appropriate time has been challenging in California due in part to the low-reimbursement for services under the Medicaid program. Low payment rates have built significant barriers to provider participation in the Medicaid program and create concerns about the ability of children to access the medically necessary health care services they are entitled to under the program.

Section 1202 of the Health Care Education and Reconciliation Act requires allows Medicaid agencies to reimburse specified participating physicians at the Medicare rates (if higher than their Medicaid rate) for primary care services for two years. Regulations require that the increased payment include qualified primary care services furnished "under the personal supervision" of a physician, including those provided by non-physician providers such as nurse practitioners and physician assistants. The policy is set to take effect on January 1, 2013, and the state of California is working to develop their implementation plan.

The primary care payment increase is a critical step toward enhancing access to health care for the nation's children covered by Medicaid. Currently, on average, Medicaid reimburses pediatricians 30 percent below Medicare rates for comparable services. While a number of factors have been found to deter or discourage provider participation in Medicaid, low payment consistently has been found to be the top participation barrier. Section 1202 applies to both general pediatricians and pediatric sub-specialists. These providers play a vital role in the provision of primary care services for children with the most complex health challenges. Their inclusion in the payment increase is essential to ensuring the greatest possible impact on improving access to care for children.

We urge Congress to oppose any proposals that would eliminate the Medicaid primary care payment increase or use it to pay for another measure. Elimination of this policy would negatively impact access to care for children and further burden the Medicaid system. I am pleased to discuss this matter with you further if you require additional information. I can be reached at 916-552-7111.

Sincerely,

Lucinda Ehnes
President & CEO

Mr. BURGESS. I would also likewise like to insert into the record a letter from the Governor of my State. We have had several good States testify here today. Governor Perry also wrote a letter on this subject, and I would like to have that made part of the record as well, so without objection, so ordered.

[The information follows:]

OFFICE OF THE GOVERNOR

RICK PERRY
GOVERNOR

July 9, 2012

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

In the ObamaCare plan, the federal government sought to force the states to expand their Medicaid programs by – in the words of the Supreme Court – putting a gun to their heads. Now that the "gun to the head" has been removed, please relay this message to the President: I oppose both the expansion of Medicaid as provided in the Patient Protection and Affordable Care Act and the creation of a so-called "state" insurance exchange, because both represent brazen intrusions into the sovereignty of our state.

I stand proudly with the growing chorus of governors who reject the PPACA power grab. Thank God and our nation's founders that we have the right to do so.

Neither a "state" exchange nor the expansion of Medicaid under the Orwellian-named PPACA would result in better "patient protection" or in more "affordable care." What they would do is make Texas a mere appendage of the federal government when it comes to health care.

The PPACA does not truly allow states to create and operate their own exchanges. Instead, it gives the federal government the final say as to which insurance plans can operate in a so-called "state" exchange, what benefits those plans must provide, and what price controls and cost limits will apply. It leaves many questions to be answered later through federal "future rulemaking." In short, it essentially treats the states like subcontractors through which the federal government can control the insurance markets and pursue federal priorities rather than those of the individual states.

Through its proposed expansion of Medicaid, the PPACA would simply enlarge a broken system that is already financially unsustainable. Medicaid is a system of inflexible mandates, one-size-fits-all requirements, and wasteful, bureaucratic inefficiencies. Expanding it as the PPACA

provides would only exacerbate the failure of the current system, and would threaten even Texas with financial ruin.

I look forward to implementing health care solutions that are right for the people of Texas. I urge you to support me in that effort. In the meantime, the PPACA's unsound encroachments will find no foothold here.

Sincerely,

Rick Perry

Rick Perry
Governor

RP:kwp

cc: The Honorable David Dewhurst
The Honorable Joe Straus

Mr. BURGESS. And the Chair now recognizes the gentleman from Georgia, Dr. Gingrey, 5 minutes for questions, sir.

Mr. GINGREY. Mr. Chairman, thank you very much, and I want to thank all seven witnesses for bearing with us through the break and the vote series.

My question is over a concern that I have in regard to the exchanges and the authority of the Secretary in regard to rulemaking, and I am going to direct my questioning to the Secretary of the Department of Health Services in Wisconsin, Mr. Dennis Smith, and hopefully we will be able to get all this done within 5 minutes.

The recently released request for information regarding health care quality for exchanges on November 27th specifically mentions a Section 1311 of PPACA which directs quality health plan issuers to, among other things, implement quality improvement strategies as directed by the Secretary. Specifically, subsection H of 1311 would allow the Secretary to prevent physicians from treating patients in the exchange unless they implement such mechanisms to improve health care quality the Secretary may by regulation require.

Let me restate that. Physicians must follow quality directives as defined by the Secretary or lose their business. Mr. Smith, are you aware of this provision in the law?

Mr. SMITH. I am not familiar with that section, no, sir.

Mr. GINGREY. OK. Well, let me ask you this then. In this provision, you may not know this either, but the word "quality" is not defined in the statute. So it is safe to assume that the Secretary, not just Secretary Sebelius but every Secretary to follow, Republican or Democratic administration, will be able to define through regulation what that word "quality" means. Yes or no?

Mr. SMITH. I believe that is the correct interpretation. I think quality—again, we have tried to introduce quality performances into a variety of parts of our programs, both in managed care and the fee-for-service world. Again, this is another one of our concerns that we are going to have State standards, then we are going to have Federal standards.

Mr. GINGREY. Well, it is a huge concern of mine as a physician member, and I know very well what "quality" means in regard to the specialty of obstetrics and gynecology as defined by the American College, the same thing for the American College of Surgeons, you know, the specialty societies define quality. If the Secretary decided to use this provision in the law under 1311(h) and it is there very clearly, and she or any Secretary uses this provision to determine, let us say, for example, mammographies for women under 50, did not improve their health care because of false positives, like her, U.S. Preventive Services Task Force did back in 2009. You all remember that. Would a physician be able to treat patients in the exchange if they prescribed a mammogram for a 49-year-old woman? Can you answer that for me?

Mr. SMITH. I don't think I can.

Mr. GINGREY. Well, I can answer it for you. The answer is no. If the Secretary decided that physicians who performed abortions were not practicing quality medicine because they endangered the life of a child, could the Secretary run providers who performed

abortions out of business? And I will answer that one for you too. The answer is yes.

Mr. Chairman, I believe that this language in 1311 would allow the Secretary to control what physicians prescribe, what health care patients can access. Is there a single person in this room who thinks that the Secretary should have that kind of authority whether it is a Republican or a Democrat?

Mr. Chairman, I have a bill, 6320, which repeals this clearly dangerous provision, and I plan to reintroduce this bill in the 113th Congress, and I hope that this committee in a bipartisan fashion can work together in this effort because look, I don't know whether this Section 1311 or subsection H was an intentional provision or unintended consequences. I would rather like to think unintended consequences. But this is a thing you get in a 2,700-page bill that you have to pass and then finally find out what is in it, and maybe you will like it and maybe you won't, but this clearly is a provision where any Secretary of Health and Human Services can pretty much determine what the quality of care is for physician providers in one of these exchanges in the 50 States and the territories and the District of Columbia and any specialty when each specialty society has clearly defined what is quality care but yet the Secretary now can just say well, you know, you are not providing quality care as determined by me under Section 1311 and therefore you are basically out of business, you can't be part of a provider panel in the exchanges. This is clearly wrong and has to be repealed, and Mr. Chairman, I have probably gone a little beyond, but I will yield back now and just remind my colleagues H.R. 6320 just repeals that section and hopefully in a bipartisan way we can get that done in the 113th, and I yield back.

Mr. BURGESS. The gentleman yields back. The Chair now recognizes the gentlelady from Wisconsin, Ms. Baldwin, for 5 minutes for your questions, please.

Ms. BALDWIN. Thank you, Mr. Chairman.

I am very proud of the work we did in this committee to pass the Affordable Care Act because access to affordable health care is an essential pillar of middle-class economic security. Many States are making very impressive progress in moving health care reform forward. We have heard Maryland and Arkansas as two great examples of two States that have, it seems, put politics aside and are doing the very hard work involved in implementation because they know it is the right thing to do for families and small businesses and others in their States.

While these States have moved forward and certainly others have across the Nation, I have really been concerned about my home State of Wisconsin and the way it has been holding back. Earlier, Wisconsin returned an Early Innovator Federal grant that would have enabled our State to build a Wisconsin-run health insurance exchange. Building a State-based exchange, in my opinion, would have provided families and businesses with more choices for the quality coverage that our State has been known for providing to our citizens for years. I am committed to bringing people together and working collaborative to make our Nation's new health law work for my home State of Wisconsin and other States. Our State has a strong tradition and history. Secretary Smith, you

talked about that history and tradition of being a national leader in advancing health care reforms, and it is my hope that we can continue in that proud tradition by extending our Medicaid eligibility so that those who need health coverage the most have access to it.

Secretary Smith, you mentioned in your testimony, and I read Governor Walker's comments, I believe, yesterday that he has not made a decision as of this moment of whether our State will participate in the Medicaid expansion. Is that correct?

Mr. SMITH. That is correct.

Ms. BALDWIN. I want to delve a little bit deeper in terms of a timeline in mind for making that final decision. I know you held some press availability yesterday in the State of Wisconsin in anticipation of this visit to Washington, DC. You made some comments that concern me about this impending decision. You said the math is just not going to work out, and yet the State has not yet completed its financial projections. There were comments you made about still continuing to build modeling, and yet you say it is a straightforward calculation. Based on those quotes, what is the timeline that you contemplate for doing that math and having the decision move forward with the administration?

Mr. SMITH. Thank you so much, and again, if I can clarify, my comments about the math were a very specific part of that in terms of whether or not the Federal Government would buy out our existing childless adults population so, again, my comment was, we have about 21,700 childless adults. Even if we get 100 percent FMAP for them, that is not going to entirely offset the cost of all the new people who would come in to the program. That is what my comments were in reference to.

Ms. BALDWIN. So in terms of just a timeline for the overall calculations that you need to do, how soon can we expect to hear?

Mr. SMITH. The Governor's budget, he will include in the Governor's budget that decision whether or nor to expand.

Ms. BALDWIN. OK. So when the Governor's budget is released, we will know about—that is when he will announce his decision?

Mr. SMITH. Yes.

Ms. BALDWIN. OK. Thank you.

Well, I just want to repeat that I believe it is crucially important that our State expand the coverage. According to the Kaiser Commission on Medicaid and the Uninsured, over 200,000 Wisconsinites could gain Medicaid coverage through the Affordable Care Act Medicaid expansion, and if it is uncertainty that we are concerned about, surely those 200,000 people in Wisconsin deserve the certainty of knowing that quality and affordable care will be there for them.

You know, we know the impacts for those 200,000 people. Accessing preventive care can forestall more expensive and costly and sometimes deadly illnesses, and 200,000 people who we hope would be living healthier and more productive lives, are better able to manage chronic illnesses that they might experience. With 100 percent Federal funding for the new Medicaid population through 2016, then phasing down to 90 percent funding after that point, our State could actually save a quarter of a billion dollars in Medicaid costs and another quarter of a billion, $250 million in uncom-

pensated-care costs, factors that we heard testimony from the Secretaries of Health in other States, and on that topic, although I see I am running out of my time, I was going to ask Director Allison to talk a little bit more about some of the other savings that you have realized that your State, Arkansas, can recognize. Given that I have run out of time, we will follow up in writing afterwards. Thank you.

Mr. BURGESS. The Chair thanks the gentlelady. We would recognize the gentlelady from Illinois, Ms. Schakowsky, 5 minutes for your questions, please.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

First, I want to thank Director Mann for working with Cook County, Illinois, my county, on the waiver that will allow Cook County to early enroll more than 115,000 individuals who will be eligible for Medicaid in 2014. You have given us the opportunity to get a head start on providing the many people who need the health care who are eligible for the care to be enrolled, so thank you very much.

I wanted to set the record straight on a couple of things too. There was some talk about the expenses for Illinois that were made earlier. The Federal Government is going to provide almost $157 million to Illinois to support insurance coverage for 898,000 Illinoisans with Medicaid, reducing our uninsured population by about half. How fantastic is that. And Illinois will save $953 million in uncompensated expenditures, and actually there will be increase in the cost for Illinois, about 1 percent, and look at what we are getting. I mean, it is just a miracle to me.

I also wanted to point out that in terms of the overall increase in insurance cost that actually yes, costs for insurance have increased less than before the Affordable Care Act was passed, and the ACA saved an estimated $2.1 billion on health insurance premiums through the Medical Loss Ratio and Rate Review. Almost 13 million consumers received a check because their insurance company spent too much money, over a billion dollars, and Rate Review saved consumers about a billion dollars. That is individual and small group markets. So these are victories, I think.

A number of people on the panel have talked about the problem that somehow the Affordable Care Act messes up your opportunity to get rid of fraud and eligibility requirements, etc., and I wanted to talk for a minute about Pennsylvania. My understanding is that in the late summer, the Pennsylvania Department of Welfare began notifying hundreds of thousands of families by mail that they had 10 days to provide necessary documentation in order to keep their children enrolled in Medicaid, and if the family missed the deadline or even if they met the deadline, if the Department of Public Welfare failed to process the paperwork within 10 days, they were dropped from Medicaid, and in fact, 89,000 children were dropped from Medicaid. Here is my point. Are some of these so-called problems an excuse and the opportunity to set up barriers to actually bump people from the rolls? I think it is completely unfair, and Mr. Alexander, you certainly do have an opportunity to answer. To say that not only do you only have 10 days to keep your children in Medicaid, but if we can't process your papers, then we are going to bump you off of Medicaid and that happened to 89,000

children. That is included in your fraud prevention numbers, and I think that it is a fraud to do that to children. So what do you think?

Mr. ALEXANDER. Well, thank you very much for your comments. When we arrived, Governor Corbett arrived and I arrived at the department, we had hundreds of thousands of cases that had not been processed in years and left piling up in county assistance offices, and it is our duty as a State where mandated by Federal law to follow the laws that you pass.

Ms. SCHAKOWSKY. Ten days?

Mr. ALEXANDER. And indeed we do that. We went through meticulously to make sure that whichever family was eligible was eligible and whichever family was not eligible was not eligible. Now, this was not about children because we determined this as a family, so we are talking about families and individuals, not just children.

Ms. SCHAKOWSKY. My understanding is that the records show that the 89,000 figure represents only children.

Mr. ALEXANDER. There were much more than 89,000. Now let us get to what we did do. We meticulously went through after we sent them notices per Federal law. We followed the law and followed the regulations.

Ms. SCHAKOWSKY. Is 10 days the regulation?

Mr. ALEXANDER. It was more than 10 days. We followed the regulation. We followed the law. We sent them notices. If they did not reply, then they were terminated. So if they did not reply within the accounted time, then they were—so we gave them every chance possible to——

Ms. SCHAKOWSKY. And what if you couldn't——

Mr. ALEXANDER. And even after that, we had done outreach.

Ms. SCHAKOWSKY. And what if you couldn't process? My understanding is if the Department of Public Welfare failed to process the paperwork within 10 days, they were dropped.

Mr. ALEXANDER. That is incorrect. By law, it is a 30-day time period, so we gave them ample time, and in fact, it was extended past the 30 days for them to be able to contact us, and we told all of the families that if you come in and contact us and come in and have your paperwork, we will get you right back on the program. The point of the matter is, Congresswoman, is that when you come into a department like this and you have hundreds of thousands of cases that are piled up and hadn't been gone through in years, there is a problem. We have a process that is given to us by Congress. We follow those laws. We have State rules and regulations that we need to follow. Now, if somebody tells us not to follow rules and regulations and they pass laws to that effect, then we will do that accordingly but we followed all of the rules and regulations. We have reached out to the families. We want everyone that is eligible for Medicaid to be on Medicaid, but if you are not eligible, then we don't want you on the program. There is a difference. We are here to serve the truly needy eligible families and children.

Mr. BURGESS. The gentlelady's time is expired. The Chair recognizes the gentleman from New York.

Ms. SCHAKOWSKY. Can I just say, with due respect, I have different numbers and I would like to submit them for the record.

Mr. BURGESS. The Chair would entertain a glance at those records. I recognize Mr. Engel for 5 minutes for questions, please.

Mr. ENGEL. Thank you. Thank you very much, Mr. Chairman.

I want to talk about two issues and try to do it fast because I want to get it all in involving DSH payments and the "do gooder" States. I made sure when we were crafting the Affordable Care Act that my State, New York, which is a so-called do-gooder State was not penalized for it, and also DSH, because we have a lot of indigent people in the New York City metropolitan area, I wanted to make sure that we were not penalized.

So the New York Medicaid program already covers most categories of individuals beyond the Affordable Care Act expansion threshold and plans to extend additional coverage to non-pregnant childless adults, thereby fully meeting the ACA parameters by 2014. However, it is projected that after the ACA is fully implemented in New York, 10 percent of our residents will still remain uninsured, which means DSH funding will still be important.

Ms. Mann, I know you and I spoke about the importance of DSH funding to New York a few months ago. I just want to reiterate how important this funding is to those States which already have broad eligibility for their Medicaid programs or do plan to expand their Medicaid programs. I hope the upcoming regulations will not punish these States, these States who did the right thing by expanding Medicaid eligibility with disproportionately deep DSH cuts. I don't know that you have to answer, but as you know, that is a very big concern of mine.

Let me ask Dr. Allison and Dr. Sharfstein, can you briefly talk about how declining funding for uncompensated care and DSH influenced your decision to push for Medicaid expansion in your States?

Mr. SHARFSTEIN. Sure. Maryland, just to give one very specific example from Maryland because we have a unique way of funding uncompensated care, about a billion dollars a year in uncompensated care goes into a pool on the hospital side and there is about a 7 percent assessment that goes on every single person's hospital bill in the State for every service to pay for that uncompensated care. So when that goes down because more people get covered, everybody benefits—small businesses, individuals, the State through the Medicaid program and so it is one of the factors that we use to see, and in Maryland it is very explicit because of this system, you can really see the specific savings that will accrue across the State. It is sort of eliminating a hidden tax.

Mr. ENGEL. Dr. Allison?

Mr. ALLISON. Congressman, we estimate so far we have found about $90 million per year that the State spends on non-Medicaid programs for uncompensated care. The legislature, the Governor will have to make decisions about how to use that funding going forward. We have assumed in our estimates that at least half of that would be diverted to the State general fund, really as an offset to the Medicaid expansion, which is not very different, by the way, from the Urban Institute's assumptions.

Mr. ENGEL. Thank you. Let me talk about the do-gooder State issue. As I mentioned before, New York has worked hard to ensure that low-income and vulnerable New Yorkers have access to health

care services by expanding eligibility for Medicaid beyond the Federal requirements even prior to the expansion included in the Affordable Care Act. Though the Federal support for newly eligible populations is incredibly generous, and the law includes provisions to benefit these do-gooder States, the reality is that New York will not see the same Federal support as States which have historically been less generous with their eligibility thresholds.

So regardless of that, I am proud of the fact that New York intends to further expand its Medicaid program to meet the ACA threshold of 138 percent of the Federal poverty level. It is estimated that the State of New York will save $2.3 billion a year as a result of this enhanced Federal Medicaid support. With the Federal Government providing 100 percent of the funding for newly eligible populations for the first 3 years and providing at least 90 percent of the funding beyond, I simply cannot understand why a State would choose not to provide health care coverage to its neediest citizens.

So let me quickly ask both Dr. Sharfstein and Dr. Allison. Dr. Sharfstein, in your written testimony, you stated, and I quote, "Expanding Medicaid is the best decision for Maryland's providers, the State economy and the uninsured." Can you elaborate on the input you received from health care stakeholders regarding the Medicaid expansion?

Mr. SHARFSTEIN. Sure. After the Affordable Care Act was passed, there was a process that involved hundreds of Marylanders, many of whom have submitted comments, the business community, the provider community, advocates, uninsured individuals, and there was a real consensus across the State that it made sense to expand coverage, that it not only has been proven to reduce mortality and improve health outcomes but it would have great benefits to Maryland's health care system and economy, and so Maryland has moved forward from that point based on, you know, input that we received from across the State.

Mr. ENGEL. Dr. Allison, same question to you. What input did you receive from health care stakeholders regarding a possible Medicaid expansion in Arkansas?

Mr. ALLISON. Virtually all of the health care stakeholder associations in Arkansas have come you in favor of the Medicaid expansion. They understand the good that it would do for their patients. They understand the harm that it would do to them as the safety net if Medicaid were not expanded.

Mr. ENGEL. Thank you. And Ms. Mann, did you want to make a comment on what I mentioned before about States do not get punished if they expanded their Medicaid eligibility? Am I done, Mr. Chairman?

Mr. BURGESS. Yes, we have got other members who have been waiting a long time, Mr. Engel.

Mr. ENGEL. OK.

Mr. BURGESS. The gentleman's time has expired. At this point the Chair would like to recognize the gentleman from Utah, Mr. Matheson, 5 minutes for your questions, please.

Mr. MATHESON. Thank you, Mr. Chairman. I appreciate you holding this hearing. With tomorrow being the deadline for States to declare their intentions with regard to the Affordable Care Act

exchanges, I would like to focus my time on some outstanding questions that remain with regard to the function of the exchanges. There are other issues about the law I would like to address such as how the health insurance tax would be assessed and what effect it will ultimately have on consumers, but my time is limited as if the jurisdiction of our committee.

Now, the Affordable Care Act envisions a seamless process for consumers to access health insurance coverage through the exchanges or expanded Medicaid or CHIP coverage, depending on eligibility. One of the potential unknowns in this process is the issue of how to provide for uninterrupted coverage for those whose eligibility changes during the course of the year due to fluctuations in income. The statute is not clear as to whether these consumers would be able to maintain their existing coverage or if they will be required to move between private coverage and Medicaid as their income shifts through the year. This potential for churning could not only place significant administrative burdens on consumers and on plans but could also threaten continuity of care as consumers move between plans with different provider networks. In the end, it is going to lead to adverse health outcomes for the beneficiary.

So I guess I will direct the question, maybe Ms. Mann would be the one to answer this. Can you provide some clarity on this issue about how these individuals will be assessed and how best the system can maintain continuity of coverage for people who may fall into this situation?

Ms. MANN. Absolutely. It is a very important question. The Affordable Care Act and the regulations ensure that there will be continuity of eligibility if income changes so the rules and the law are pretty explicit about ways in which there should be no gap in coverage if somebody's eligibility changes from Medicaid to the exchange or from the exchange to Medicaid, but there is the issue of continuity of plan and provider, and in our recent questions and answers that we released on December 10th, we gave three options for States to consider to try and minimize this disruption of care. One of the first things States can do if they are running a State-based exchange is, they are encouraged to have the same plans doing business on the exchange as they are doing business in the Medicaid and the CHIP program and then families have an ability, even if their eligibility changes, to stay in the same plan.

Beyond that, we have noted some premium assistance options that States can use inside their State, options in the Medicaid program. It is a way of assuring continuity of coverage. They can purchase the coverage for a Medicaid- or CHIP-eligible person by contracting with a qualified health provider that happens to be doing business on the exchange. That way, if that individual's eligibility changes from Medicaid and CHIP to eligibility on the exchange for a premium tax credit, they would switch to a tax credit for Medicaid but they wouldn't have to switch plans.

Mr. MATHESON. Thank you. My home State of Utah is one of several States deciding on which health exchange approach is most appropriate for our residents, and our Governor has raised some very relevant questions recently with regard to how the different approaches may operate, some of which I would like to explore with you, if I could. If several States band together to form a multi-State

exchange, what role would State regulators play in enforcing State law? Have we thought about that?

Mr. COHEN. State regulators will have the same role that they do today in terms of reviewing policy forms, making sure they are consistent with any State law, State mandates, for example, as well as with the Federal law so there shouldn't be a change in the role of State regulators in a multi-State exchange.

Mr. MATHESON. Is that also the same if they are under the Federal exchange?

Mr. COHEN. Yes.

Mr. MATHESON. Do State policymakers relinquish any ability to provide counsel, advice or influence on the operation of a Federal exchange should the State opt out of operating their own State-based exchange?

Mr. COHEN. I think that we are always interested and will continue to be interested in working with States to make the exchanges work best for their State, whether it is a federally facilitated exchange or not. I think that there are some important decisions that States get to make themselves if they are in a State exchange or a State partnership exchange. For example, one example is just how the thing will be funded. We have proposed one funding mechanism which will work in the Federal exchange, but States could use a different funding mechanism if it is a State exchange.

Mr. MATHESON. Thank you, Mr. Chairman. I will yield back.

Mr. BURGESS. The gentleman yields back. The Chair recognizes the gentleman from Virginia, Mr. Griffith, for 5 minutes for your questions, sir.

Mr. GRIFFITH. Thank you, Mr. Chairman, and I appreciate all of you all being here. I know it has been a long day, and I look forward to working with each of you and the members of this committee as we move forward.

Mr. Chairman, I will yield my time to you for questions that I believe you may have.

Mr. BURGESS. I thank the gentleman for yielding.

Mr. Smith, and again, to everyone on the panel, thank you for your indulgence today. I believe it is the policy of this committee, we invite smart people to come and tell us what they think about things. If there is an opinion that needs to be offered, I think it should be offered.

So Mr. Smith, a long time ago, Mr. Waxman offered some comments to which you wanted to respond. I know we have kind of removed the immediacy of your response to those questions, but if you had comments you would like to make, we would love to hear them now.

Mr. SMITH. Thank you, Mr. Chairman. I appreciate that greatly, and it is nice to be with a bunch of smart people.

The question about block grants, and I wanted to respond in a couple of different ways. First, the State Children's Health Insurance Program is a block grant. That was one of the most successful programs that everyone has claimed great credit for. There are different forms of block grants. There was a per capita cap approach that during the Clinton administration, Clinton administration officials supported that type of approach. The block grants themselves, again for States, we do believe we can run these programs more

efficiently and more effectively than under Federal rules. First of all, more than half of Medicaid dollars are spent because States have expanded beyond Federal requirements. We have added eligibility, we have added benefits well beyond what the Federal law expands. So again, sort of the perspective that if the Federal Government doesn't require it, the States aren't going to do it, the history is actually the opposite. States have expanded beyond what the Federal requirements are, so we believe very strongly States can indeed be trusted.

Most of the money is in people who are either senior citizens needing long-term care or individuals with disabilities. In Wisconsin, we have in fact lowered the cost of care because we have been able through waivers put people into private sector managed care situations. Again, regular Medicaid fee-for-service is the most expensive type of care, and in many respects least appropriate because the care is not being provided for.

So from my perspective, when I look at all of these Medicaid dollars that are being spent under the different formulas that have been offered, which guarantee Federal dollars growing by population at least medical CPI or CPI plus one, I say absolutely, I can make that deal work. If my Federal dollars are guaranteed, I become more efficient. The State therefore actually increases the Federal match rate because the State match goes down because the Federal dollars are guaranteed to be there. So absolutely, we can make that situation work. Again, I go back to the very beginning before legislation was even put out. In December of 2008, Chairman Baucus at the Finance Committee put out a paper saying there is $700 billion in excess spending in the health care system. Through Medicare and Medicaid, the government spends almost half of those dollars. Medicaid and Medicare therefore do indeed have to be brought to the table, and there is a great deal of overutilization in the system. From our perspective, again, it is not the cost of health care, it is the excess cost of health care. The excess cost of health care is what we are going after. We have done it successfully in Wisconsin. We think we can go even further.

Mr. BURGESS. Well, along that line, I am terribly disappointed to hear Mr. Cohen's response to the Medical Loss Ratio question and health savings accounts. You know, Mr. Pallone, I sat on this committee with you down at the kids' table while we heard all the comments about how to bring down cost of health care. That is what the Affordable Care Act was supposed to do. Remember the word "affordable" is in the title. If we wanted to bring the cost of health care down, we would have invited Governor Mitch Daniels to this committee and asked him how he did that in his State, 11 reduction over 2 years. He did it with a health savings account for his State employees. It was voluntary, but he found out something important: people when they spend their own money for health care, something magic happens, even if it wasn't their own money in the first place. It sounds like from your interpretation of the Medical Loss Ratio, that effect is going to be lost. That is yet more one failing of this very large law that came into being under very difficult circumstances.

I will yield back my time and recognize Dr. Christensen 5 minutes for questions.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman, and thank you to all the witnesses for your patience and being here with us today. I too am very proud of the work that we in this committee did on the Affordable Care Act and I don't want to see any of the gains lost. I want to see every one of the over 30 million people who are going to receive coverage receive coverage including the 20 or so million who will receive coverage through Medicaid expansion, and a large percentage of those are people of color for whom the Tri-Caucus worked very hard as we put together this law to ensure that African Americans, Hispanics, Native American and Asian Americans had access to health care. I wanted to go to our one of our poorer States that is not about to accept the Medicaid expansion, I don't think. No Medicaid expansion, no State exchange.

Mr. Greenstein, you mentioned in your testimony that Louisiana has some of the worst health statistics and your State has some of the most persistent health disparities in the Nation. Numerous studies have shown that expanding access to health care through programs like Medicaid help to reduce health disparities. The National Urban League released a report last week about the economic cost of health disparities and found that the health disparities cost this Nation more than $82 billion in direct health care spending in just one year, and the highest burden, of course, is in the South where health disparities cost about $35 billion in just one year. So aren't you concerned that not expanding Medicaid would exacerbate the disparities in your State, leaving more people as the sickest in our Nation and also increase the financial costs in the end because they are going to come to you at some point without having preventive care, without having health care maintenance, when they are very sick and cost the State more?

Mr. GREENSTEIN. Thank you very, very much to focus the attention on what all the coverage is supposed to address, which is people's health status and the health outcomes. Indeed, in my State and many other States nearby, we see great disparities in diabetes, in obesity, and they are dramatic. We have looked at the outcomes for people on Medicaid and those without insurance, and we don't see a great deal of difference. This is distressing. We have a system that is not turning out the kind of health outcomes that we would expect for the amount of money that we put in.

We have looked very deeply at expanding Medicaid, and let me share with you some of the numbers around it. I believe Chairman Waxman went through the numbers in Louisiana that we would expand Medicaid, how many people that don't have insurance would get it, and he cited about 265,000. When we looked at our numbers in the first year alone, 467,000 people would join the Medicaid rolls. Of that, 187,000 people already have private health insurance today. We would see a cannibalization of the private health insurance market taking generally healthy risk from a system where people pay some portion of their care and move that into Medicaid. Hospitals, doctors would see reimbursement levels reduced. So this it not an easy way to think through that expansion equals better health outcomes for everyone. It doesn't.

Mrs. CHRISTENSEN. Nothing, as I understand it, precludes you from making changes within the Medicaid system to address some of the areas that, you know, may not be working so that where you

now see that Medicaid-covered patients don't do any better than patients how are insured.

Ms. Mann, is there anything that—I have heard several of the panelists say that, you know, the law dictates to the States, does not allow them the flexibility? Is that the case, or can't they also fix whatever is wrong with their Medicaid system?

Ms. MANN. They can, and we would hope that they do, and we will be prepared to work closely with Louisiana to do just that. There is a study in Oregon that recently came out that looked at people on Medicaid and people not on Medicaid had a control group. It was considered a gold standard study. It showed definitively that the care and the well-being and the health outcomes for the people receiving the Medicaid coverage were far superior to those who weren't having health care coverage and who were uninsured. There are lots of issues in Louisiana that are difficult, are challenging for anyone to tackle, but the evidence around the country is that you can make Medicaid work well for beneficiaries and improve health outcomes. The discretion around designing the program, determining the delivery system, contracting with the providers, those are all decisions that are fundamentally State decisions in the Medicaid program.

Mr. SMITH. May I offer an idea on eligibility? You mentioned Native Americans as a specific population. When we are switched to Modified Adjusted Gross Income, in Medicaid currently where Native Americans are exempt from cost-sharing entirely in the program, in Wisconsin, we disregard certain income that is available to them as members of the tribe. That gets changed under MAGI. Those people will become tax-credit eligible where they will be paying cost-sharing rather than Medicaid eligible.

Mrs. CHRISTENSEN. I don't think that is the case, but my time is up and, you know, I hope that Ms. Mann and Mr. Cohen will have a chance to respond to that because I don't think that is the case.

Mr. BURGESS. The gentlelady's time is expired. I recognize a member of the full committee, Mr. Sarbanes, 5 minutes for your questions, please.

Mr. SARBANES. Thank you, Mr. Chairman, and thank you for letting me participate today in the hearing. I appreciate it very much.

I just want to say to Mr. Cohen and Ms. Mann, thank you for your tremendous work on this. It is incredibly exciting actually what you are doing because you are helping to build an expanded infrastructure that is going to provide more access to millions of Americans and over time I think also begin to reign in health care costs in a very effective way for individuals and for the system as a whole.

I wanted to ask you, Ms. Mann, real quickly, what do you anticipate when we get to the end of this process in terms of the number of States that will actually have done a State-based exchanged versus those that will have done a partnership exchange versus those who will be federally facilitated? Any kind of sense of where——

Mr. COHEN. I think that is actually for me. We don't know yet. There is a deadline on the State-based exchange that is coming up this Friday. So far we have heard from 14 States and the District

of Columbia have said they want to be State-based exchanges. There may be more by Friday but we don't know that. The second deadline that comes along is February 15th of next year, which is when we have asked States to tell us that they want to be in a partnership exchange, so we will know more in February as far as how many are going to work with us.

Mr. SARBANES. All right. Well, let me ask you, Dr. Sharfstein. First of all, thanks for being here. Congratulations on the work in Maryland. I know you and Governor O'Malley and others that are a part of this effort have really been part of the vanguard in demonstrating that these State-based exchanges can work and can get in place, and we are very proud of that in Maryland.

I wanted to ask you, in view of the fact that States soon will be making a judgment about whether they think they can stand up a State-based exchange and in other instances will be look at the partnership model, you talked to your colleagues around the country who are making these decisions. What are the kinds of anxieties they express to you that you are able based on Maryland's experience to say look, there is a way to do this and, you know, whether it is certain technical things that you would comment on or just the process of sort of how you get consensus behind it and get people comfortable moving forward, what are you saying to your colleagues who maybe want to get there but are worried a little bit about it based on the Maryland experience that can give them some comfort and confidence that they can do this?

Mr. SHARFSTEIN. Sure. Thanks for your question, and thanks for your leadership in Maryland. We really appreciate it.

There is a lot of engagement with the States that are moving forward on the State-based exchanges. There are a number of calls that happened. There is exchange of documents. Sometimes it is very explicit like a document or analysis that we will do other States will use directly or we will use something that they have done, and sometimes it is more just talking over, you know, different situations. A couple days ago up in west Baltimore, we had a meeting of the exchange board, probably 75 people in the public watching. We worked our way through a bunch of issues that we have been talking to our peers around the country, how billing would be done. We resolved that the exchange would take the first payment but the carriers would do the payments after that, and that is an issue where there is, you know, different ways to go. We have figured out a way to partner effectively with insurance brokers and we adopted some policies related to that. We decided to offer adult dental and vision plans if possible in the exchange.

So for each of these things, there is a discussion, and I understand there are a lot of details involved but, you know, we have gotten energy from talking to people about those details both within our State and with other States, and systematically step by step, you know, moving forward with each part.

Mr. SARBANES. I just want to emphasize that from the beginning of this process, obviously a State looking at it without any peers having undertaken the process, without CMS and others having, you know, fully gotten into it yet, you could look at it and it would appear very daunting, and States like Maryland decided, you know, we want to get out in front of this thing and other States did as

well. But we are now at a point as a result of this where the expertise that results in CMS, practical expertise about how implementation of this can happen, plus the expertise that resides in a peer group of States that have started to build these exchanges, have created the models, have looked at the computer systems and how all that is going to work. It means that States that, you know, maybe didn't get started as fast as they could are now if they make the judgment to go forward are going to come to the table with a, let us call it a support group or a network of people that hammer through a lot of these issues and they will be able to get where they need to go maybe faster than you had to do it starting from scratch, but that is important, I think, in making people understand that this is very feasible, and if people get into this and start working on it, we are going to get this framework in place. Thank you very much.

Mr. BURGESS. The gentleman's time is expired. That concludes the questions from the members of the subcommittee and members of the full committee who wished to ask questions. We have time, I think, for two follow-up questions, one from each side.

The Chair will recognize Dr. Cassidy for our side.

Mr. CASSIDY. First, let us just give some reality to some of the quotes regarding Medicaid expansion improving health care. That Oregon study you quote, Ms. Mann, was a study limited to Oregon on an outpatient basis, and there is some evidence that people felt better just because they won the lottery. Secondly, as regards the New England Journal of Medicine article you quote, Dr. Sharfstein, it was by driven by New York solely, and in fact, in Maine, although it was not statistically significant, the Medicaid expansion resulted in poorer outcomes among those who were on Medicaid. Now, it was not statistically significant but that was entirely driven by the State of New York.

And as regards Mr. Engel speaking of the do-gooder States, I will point out that New York pays physicians less well than does Louisiana and Texas, and only 60 percent of physicians in New York accept Medicaid. That is not access.

Now, that said, just to clear up the record a little bit, now that we know, Mr. Smith, that the one thing that has been shown to lower costs, which is health savings accounts, will not be allowed in the MLR unless it is actually spent, i.e., we are no longer lowering costs, we are now encouraging insurance companies either not to sell them or perhaps insurance company to encourage a person to sell it, what data do you have in your State on the effect of the increased premium cost on someone who is, say, 200 percent of Federal poverty level who is currently employed with employer-sponsored insurance, dumped into the expansion as McKinsey Quarterly says about 30 percent of these employers will do, now has an actuarial value of 60 percent, what do you project is going to happen to that person?

Mr. SMITH. Thank you, Mr. Cassidy. Again, we have been modeling the PPACA premiums in Wisconsin Medicaid since the first of July.

Mr. CASSIDY. So you actually are seeing—this is not a computer model, you have actually got real-life data?

Mr. SMITH. Yes, sir. This is the actual experience. Wisconsin has already expanded Medicaid coverage. We have parents, caretakers, relatives up to 200 percent of poverty. Some of our eligibility groups have transitioned to medical assistance, individuals with income above 300 percent of poverty. We have started applying only the premiums, not any of the additional cost-sharing.

Mr. CASSIDY. Not the $2,000 deductible?

Mr. SMITH. No, sir, this is only premiums, not any additional cost-sharing that would be in effect. So in the results to date, people at the lower income level, again, because they are looking at a dollar amount, they are not thinking of a percentage——

Mr. CASSIDY. Yes, in Washington, we speak about percentages but we are actually talking about a dollar amount.

Mr. SMITH. Yes, sir, so at 133 to 150 percent of poverty, again, because the poverty level includes not only someone's income but also the size of the family, and so a percentage of your gross income. So——

Mr. CASSIDY. Please hurry.

Mr. SMITH. I apologize. For people making over 200 percent of poverty, the average now of $200 premium, participation was cut in half. So people are saying we are not paying $200.

Mr. CASSIDY. So 50 percent more people are without insurance?

Mr. SMITH. Fifty percent of people who had been enrolled dropped their Medicaid coverage when premiums——

Mr. CASSIDY. So when that working family's employer puts them on the exchange and they have an actual value of 80 percent with the employer but it may be 60 percent on the bronze level, they are facing premiums and deductibles they never faced before, they are dropping their coverage potentially?

Mr. SMITH. Exactly, because you have, again, the employer——

Mr. CASSIDY. This is good for the American worker?

Mr. SMITH. I think the results are going to be quite different.

Mr. CASSIDY. And this is not theoretical, this your actual experience, correct?

Mr. SMITH. Yes.

Mr. CASSIDY. Now, Mr. Greenstein, we speak of percentages in DC, isn't it interesting, and that Kaiser Family Foundation based on the Urban League speaks about how much Louisiana is going to get, but actually it is going to cost our State, according to that study, $1.8 billion over 10 years.

Mr. GREENSTEIN. We suspect that those figures actually are understated and don't capture the full administrative costs.

Mr. CASSIDY. And they also, I might say, probably understate the amount of taxes that will have to be raised for those costs, a macro effect that it has ignored. Continue.

Mr. GREENSTEIN. Likely. When we looked at the study, we recognized that there were very large shifts in winners and losers. Some States end up reducing their overall burden, some States increase. But when we talk—and a good part of the discussion today has been about how States are going to save so much money by Medicaid expansion. It is just shifting cost from one place to another. At the same time, this is all net new spending.

Mr. CASSIDY. I agree with that. So one more question for Ms. Mann or Mr. Cohen.

Mr. BURGESS. We better cut it off.

Mr. CASSIDY. Oh, my gosh.

Mr. BURGESS. You can submit it in writing. You have until December 27, sir.

Mr. CASSIDY. Thank you all.

Mr. BURGESS. I recognize the ranking member of the subcommittee 5 minutes for your questions, please.

Mr. PALLONE. Thank you, Mr. Chairman.

Ms. Mann, I just wanted to give you an opportunity to respond to the comments made by Mr. Smith, if you would.

Ms. MANN. On the issue of the block grant, I think, is where I was trying to jump in.

Mr. PALLONE. Whatever you like.

Ms. MANN. Yes. A couple things to say. Thank you for the opportunity. One, Mr. Smith harkened back to noting that the Children's Health Insurance Program is essentially a capped allotment, it functions as a block grant. That is true, and what we need to recall, I know it is hard to remember back that far, is that in the early years of the CHIP program, States ran out of money. States were desperate because the dollars allotted was what Congress thought they needed and of course it was a set amount of dollars, and it turned out that the enrollment was higher and the needs were higher, and States were on the verge of shutting down their programs or putting their State dollars on the table to cover children. That is the nature of a block grant. It is a capped amount of money and it shifts risks onto States and ultimately onto vulnerable Americans who are covered by those programs. Mr. Smith talks about who can do a better job, can the States do a better job, can the feds to a better job. It is really not about trust. It is really about having a financial partnership that works. I would submit that without that financial partnership, we would be moving into 2014 with States operating 20-year-old legacy systems if we didn't provide some additional Federal funding to help States finance their eligibility. I would submit probably without that flexible financing, we would not have had the situation where over the years people with HIV and AIDS were able to get the care that they needed, expensive care, and then were able to live healthy and productive lives, or poor children with leukemia or with autism were able to get effective care to help them. When you have a capped amount of money where the Federal Government says that it is all I am going to do and I am going to do no more, we risk those kinds of results.

What we need and what is good about that partnership, while it is fraught with some tensions, is that it keeps us all at the table to make sure the program is as strong as possible. We all have incentives to get better care and to do that at lower cost, and that partnership helps us get there.

Mr. PALLONE. Thanks. And I just wanted to give Dr. Sharfstein and Mr. Allison an opportunity to talk briefly in closing. Why is Medicaid expansion the right answer for your States, and if you had to convince the three other States here, what would you say to them about it?

Mr. SHARFSTEIN. I would ask them to spend some time with individuals who would get coverage and who need coverage or who ben-

efit from Medicaid coverage. I think we all agree that there needs to be more value in health care. I think we all agree that we need to get excess cost out, but I think basic services and basic health care for people shouldn't be consider excess.

A couple nights ago, I was at a church in Howard County with about 300 people in the developmentally disabled community, and a mom got up and talked about what Medicaid meant for her daughter born with a heart defect, and it was just a harrowing story, and then the little girl ran across and basically gave me a hug, and it was a moment where we could just stop and say this is what Medicaid stands for.

We want to get Medicaid to work. We need health care to work, but it shouldn't be don't expand, keep people out first. It should be, let us get people in and move forward with the health care system.

Mr. PALLONE. OK. Thanks.

Mr. Allison?

Mr. ALLISON. Congressman, thank you for the opportunity. I would just say that Congress passed and the Supreme Court upheld a law that provides significant incentives to States to save the lives of its own citizens, to improve their health, to provide to them financial protection. I represent a poor State with many who are uninsured and who without this support never be able to afford care. We know that care makes a difference. It may be that we face challenges in the future to assure that this remains financially sustainable, the new commitment that we are making, but I would just encourage my fellow States to consider the opportunity which has presented itself now.

Mr. PALLONE. OK. Thank you very much. Thank you, Mr. Chairman.

Mr. BURGESS. The gentleman yields back his time, all time having expired on the committee.

Mr. Pallone, there was a unanimous-consent request from your side about providing some data about Pennsylvania, and without objection, I am going to make that part of the record.

[The information follows:]

This Week in Poverty: 89,000 Children in Pennsylvania Lose Medicaid
Greg Kaufmann on June 29, 2012 - 9:20 AM ET
The Nation.

Since August 2011, 89,000 children in Pennsylvania have lost their Medicaid coverage, including many with life-threatening illnesses who were mistakenly deemed ineligible. The state currently hasn't a clue whether many of these children have any healthcare coverage at all.

How did this happen?

In late summer, the Pennsylvania Department of Welfare (DPW) began notifying hundreds of thousands of families by mail that they had ten days to provide necessary documentation in order to keep their children enrolled in Medicaid. If the family missed the deadline—*or even if they met it but DPW failed to process the paperwork within the ten days*—they were dropped from Medicaid.

Federal law indeed requires that families prove their Medicaid eligibility annually. Pennsylvania requires verification every six months. During the previous administration, under Democratic Governor Ed Rendell, caseloads grew as a result of the recession, while county assistance offices were shorthanded due to budget cuts. Caseworkers simply couldn't keep pace with the workload and there was a backlog of renewal applications.

Enter Republican Governor Tom Corbett and his anti-spending, anti-government secretary of public welfare, Gary Alexander. They decided to plow ahead with their new approach to eligibility verification: ten days to receive and process the overdue renewals, and an assumption of ineligibility if the applications weren't reviewed during that time period.

Predictably, the offices couldn't keep up with the new deluge of mail. It doesn't seem a stretch to suggest that a Republican administration—hostile to Medicaid—had identified a weakness in the system, exploited it, so that it could reduce spending while bolstering its claim that the system is broken.

Who are some of the victims wronged by the Corbett-Alexander approach to children's health? A 5-year-old with leukemia; a 2-year-old with a congenital heart disorder; a severely disabled 12-year-old who requires home healthcare; 9-year-old twins, one with autism, the other with a hearing impairment; a 1-year-old with cerebral palsy.

Imagine, a parent of a toddler battling cancer, and suddenly a need to—as one advocate put it—"engage in a Kafkaesque process of getting your kid back on Medicaid."

What is also deeply disturbing is this: normally when a child is no longer Medicaid-eligible in Pennsylvania parents are referred to the Children's Health Insurance Program (CHIP), a federally subsidized healthcare program for low-income kids. The state takes great pride in near universal coverage of children—it offered one of the first CHIP programs in the country in 1992. But as advocates watched Medicaid enrollment fall off a cliff—89,000 dropped between August 2011 and January 2012—CHIP enrollment remained flat.

http://www.thenation.com/blog/168665/week-poverty-89000-children-pennsylvania-lose-medicaid

Where the hell are the kids? advocates began to ask.

DPW's initial explanation was that the 89,000 kids dropped included families that moved out of state or were no longer income-eligible. But, when pressed for an accounting, DPW's own analysis revealed that the number of families falling within these categories is paltry.

Secretary Alexander also played games with the numbers. As recently as May 1, during an interview on Pennsylvania public radio, he said: "It wasn't children that were removed, it was families. We call them cases—so that there are parents and children."

But Pennsylvania Partnerships for Children, a nonpartisan organization dedicated to improving the health, education and wellbeing of children and youth throughout the state, says that simply isn't true. It points to DPW's own records, which show that the 89,000 figure represents children dropped from Medicaid.

Secretary Alexander also offered this explanation for the state's actions: "The problem we have, of course, is that we have federal rules and regulations that we have to follow and we have to do those redeterminations every six months."

Actually, the problem the secretary has is either ignorance or lying: federal law requires eligibility renewals only once a year, and in some states even a verbal statement regarding income is sufficient.

Alternatives to DPW's current neglectful approach have been offered: What about following up with phone calls and multiple mailings to ensure that children weren't improperly denied coverage? Or a moratorium on dropping kids from the program until DPW is certain it is adequately processing the renewals? Or at least halting six-month eligibility reviews of children with the most serious illnesses? All of these options are permitted under federal law.

Every proposal or idea has been rejected, and tens of thousands of kids remain virtually disappeared by the Corbett-Alexander approach to healthcare.

Pennsylvania Set to Eliminate Safety Net of Last Resort

"On Sunday, nearly 70,000 Pennsylvanians with disabilities will lose their sole source of income overnight," legal aid lawyer Michael Froehlich of Community Legal Services in Philadelphia told me yesterday.

The sudden elimination of the "safety net of last resort"—the General Assistance (GA) program—is especially troubling when one considers who is currently eligible for it: disabled or sick adults without children; domestic violence survivors, many of whom have just fled abusers (lifetime benefit capped at nine months); adults participating in alcohol and other drug treatment programs (also capped at nine months); adults caring for someone sick or disabled, or an unrelated child; and children living with an unrelated adult.

http://www.thenation.com/blog/168665/week-poverty-89000-children-pennsylvania-lose-medicaid

In all, over 90 percent of recipients are temporarily or permanently disabled. The 68,000 people in the program—or just about one in every 200 residents—receive approximately $205 per month. Those funds enable many people to rent a room, pay for transportation to needed appointments, cover co-pays, or escape abuse. DPW estimates that eliminating the GA program will save the state $150 million annually.

According to Froehlich, when the GA rolls were trimmed in 1982, 1994 and 1996, people were provided sixty days notice. But this time "many people won't find out until they go to withdrawal their money next week to pay their July rent."

There are reports that the welfare office in Philadelphia is bringing in additional guards to protect staff on Monday.

Froehlich and Community Legal Services are part of PA Cares for All, a coalition of more than 100 organizations that initially fought to save the program and then offered an alternative proposal: eliminate GA assistance for approximately 40,000 people, but maintain it for 30,000 of the most sick and disabled; plus children, domestic violence survivors and people actively participating in drug and alcohol treatment programs. That plan would cost $42.1 million annually, and allow an annual savings of $107.9 million.

"We've just tried every way we can to mitigate the harm," said Froehlich.

The coalition has pressed its case on both moral and economic grounds. In a May 22 "Open Letter to Pennsylvania House and Senate Members," the coalition writes: "No child should be homeless. In fact, no one should be homeless. People with disabilities and older adults should be able to live safely and with dignity. Women and children should be able to live free from violence, especially in their own homes."

The coalition also argues that cutting the program makes absolutely no fiscal sense.

"The loss of General Assistance will be more expensive for taxpayers," the letter reads, noting that if just 7 percent of current recipients enter the criminal justice system, $150 million in savings from eliminating the program will suddenly be a $9 million overall cost to taxpayers. If just 1 percent of current recipients end up in psychiatric hospitals the overall cost of eliminating the program will be $20 million; and if just 20 percent end up in homeless shelters that will mean a $23 million hit to taxpayers instead of any savings. (And the coalition projects that the number of current GA recipients turning to the shelter system will be much higher than 20 percent; people will quickly overwhelm the shelters, houses of worship and human services providers.)

According to Froehlich, the most frustrating part about this decision is that the resources are available if Governor Corbett or the legislature had any interest at all in preserving the program. In fact, the state just announced a $1.65 billion tax credit to Shell Oil over twenty-five years in order to bring an ethylene cracker plant to Western Pennsylvania. According to the Pennsylvania Budget and Policy Center, "the 400 permanent jobs at the plant will come at a hefty price to taxpayers, $165,000 per year per job, or $4.125 million per job over the 25-year life of the program."

http://www.thenation.com/blog/168665/week-poverty-89000-children-pennsylvania-lose-medicaid

"And the administration's saying we can't come up with $42 million for our alternative proposal to help the very most vulnerable, most needy Pennsylvanians?" said Froehlich.

Froehlich has begun getting calls from clients who are asking, "What's next? What are we going to do?"

"I don't have an answer for most of them," he said. "I got nothing."

Poverty and Pride

Tomorrow is the last day of LGBT Pride Month: a time for individuals to be visible and out, and for a movement of LGBT and non-LGBT people to demonstrate that we're here and not going anywhere. It's also a time to reflect on the progress we've made and to recommit to the work that remains in order to achieve full equality.

Some of that work involves paying much more attention to LGBT folks living in poverty.

A report issued by the Movement Advancement Project, Family Equality Council, and Center for American Progress (CAP)—"All Children Matter: How Legal and Social Inequalities Hurt LGBT Families"—notes that there are now an estimated 2 million children being raised in LGBT families, and they are twice as likely to be poor than children of heterosexual married couples. The average household income for LGBT families with children is 20 percent less than heterosexual couples with children. LGBT families live in 96 percent of US counties, and same-sex couples in the South are more likely to be raising children than those in other regions of the country.

"It's true, we actually don't just live in California, New York and DC," says report co-author Jeff Krehely, vice president of LGBT research and communications at CAP. "We live all across the country—some of us have kids, some of us don't. We're all races and ethnicities, and our earnings run the gamut. We basically reflect the diversity of this country."

Krehely says that even national advocates sometimes fail to recognize LGBT diversity, and the demographics in the South are a great example of that. He suggests that a lower cost of living combined with less social mobility for low-income families might explain why so many LGBT families remain in a region "not exactly known for being welcoming to gay people or minorities."

"But knowing these kinds of demographics isn't just about thinking more accurately about LGBT realities," says Krehely. "It's about being more effective as an advocate and realizing, for example, if we say, 'We're not going to get marriage equality in Mississippi or Alabama anytime soon, so we're not going to play in those states,' well, then we're leaving behind a lot of people—including some of very the people who are most in need, and most in need of our advocacy."

At the heart of the economic struggles for LGBT families rich, poor, and in between, is what the report calls the "legal stranger" issue. In contrast to a child of a heterosexual couple, a child born

to (or raised by) two LGBT parents "may have one parent deemed a legal stranger by law, threatening to undercut family permanency." These children lack protection when their parents' relationship dissolves or a parent dies; the relationship to his or her parents will be recognized in fewer than half of all US states; fear of a parent's deportation hangs over the heads of too many children of bi-national, same-sex couples.

"Say one parent is here on a student visa or a work visa," says Krehely. "The visa expires—that parent could be deported, taken away from his or her kids. It's more than just heart wrenching. If that parent is the breadwinner—the family's economic security is at stake. This all impacts the well being of kids when there is this kind of instability in terms of emotional support, love, being taken care of and being provided for financially and materially."

The legal stranger definition also leads to difficulties accessing the safety net since benefits depend on "legal" household size and income. Cash assistance, health insurance, child care assistance, educational loans and other forms of assistance may not be available to LGBT families due to the narrow legal definition of family. LGBT families often can't take advantage of the Child Tax Credit or Earned Income Tax Credit—both of which have a significant anti-poverty effect and ease the financial costs of raising children. Social Security and Survivors Benefits are denied if a non-recognized parent dies, even if the children were financially dependent on the parent, and even if the parents are legally married in their state; surviving same-sex spouses are also denied benefits.

"The legal stranger issue is something that most people who don't know much about LGBT people can relate to," says Krehely. "Everybody gets into positions where you rely on those relationships to help a family member in need. What would happen if that just didn't exist for you? "

Some of the recommendations the report makes include: recognizing LGBT families across safety net programs and providing equitable treatment in the tax code; passing parental recognition laws at the state level to fully protect children in LGBT families; legalizing and federally recognizing marriage for gay and lesbian couples; creating stronger support services for LGBT families, particularly families of color, low-income and transgender parents.

Pride Month is great, but there are eleven other months in the year that require the same kind of commitment if we are going to get the work done. You can get involved with the groups that authored this report, Immigration Equality, Half in Ten, and many others. Anti-poverty advocates also can ensure that the concerns of LGBT people are addressed in their ongoing work.

"This isn't about 'special rights,'" says Krehely. "It's about leveling the proverbial playing field."

The Supreme Court and Medicaid

When I heard the news about Chief Justice John Roberts's big surprise for America I was just as excited as the next guy. But then I read that the Court struck down the formidable stick that the

http://www.thenation.com/blog/168665/week-poverty-89000-children-pennsylvania-lose-medicaid

legislation provided the federal government to compel states to expand Medicaid. Suddenly, a good day for most Americans seemed—as usual—like a mixed bag or worse for the poor as decisions on Medicaid expansion would be left to the states (see Pennsylvania above for implications).

I tweeted—because I try to do that just like the young folks now: "not to be a buzz kill, but I think the #Medicaid decision potentially sucks for poor people. Fed gov loses stick to compel states to expand."

Then I did what I should have done *before* I tweeted (which is why I used to avoid tweeting altogether) and surveyed people who know a hell of a lot more about this stuff than I do. Here are some observations from the Center on Budget and Policy Priorities for your consideration if you are still trying to figure out the implications:

"The typical state [Medicaid program] only covers working parents who make less than 63 percent of the poverty line ($12,790 a year for a family of three) and non-working parents with incomes below 37 percent of the poverty line ($7,063 a year). Only a handful of states provide coverage to any low-income adults without dependent children.... The Medicaid expansion would cover these poor and low-income adults by expanding Medicaid to 133 percent of the poverty line ($25,390 for a family of three). CBO assumed an additional 17 million adults would receive Medicaid coverage by 2022, as a result.... The federal government will bear nearly 93 percent of the costs of the Medicaid expansion over its first nine years.... Because the expansion is such a good deal for states, they should move forward and cover low-income adults in their states. But what happens in states that do not go ahead and provide coverage? The poorest adults—primarily parents and other adults working for low wages—will be left out in the cold."
—Judy Solomon, vice president for health policy, Center on Budget and Policy Priorities

"The single biggest challenge may lie in the decisions that states make regarding health coverage for uninsured people living below the poverty line—primarily working-poor parents and other adults who work for low wages.... A state would have little basis for refusing to implement the Medicaid expansion, other than for narrow ideological reasons. But in any state that does refuse to implement the expansion, a shocking inequity will arise. People with incomes between 100 percent and 400 percent of the poverty line will be eligible for subsidies to help them afford coverage in the new health insurance exchanges. But people below the poverty line will not be eligible, because the Affordable Care Act assumes they'll be in Medicaid instead."
—Robert Greenstein, president, Center on Budget and Policy Priorities

I think it's safe to say that a lot of work lies ahead to make sure that the poor aren't once again cut out of a good deal.

Houston Janitors (continued)

The story of Adriana Vasquez and 3,400 fellow janitors down in Houston continues to gain traction. *Nation* editor Katrina vanden Heuvel wrote about it in her weekly column for the

http://www.thenation.com/blog/168665/week-poverty-89000-children-pennsylvania-lose-medicaid

Washington Post, and her tweet brought the story to the attention of NPR's *Here & Now*. *The Matthew Filipowicz Show* also gave the story quite a bit of airtime.

This Sunday, civil rights activist and actor Danny Glover will visit the city to meet privately with a delegation of janitors. They will later be joined by faith and civil rights leaders at a news conference at 2 PM (Third Ward Multi-Services Center, 3611 Ennis Street).

"It's magnificent. It's great that an actor like Danny Glover cares about janitors—you just don't see that very often," Vasquez told me. "I hope this will bring further attention to the plight of janitors and working people in Houston and across the United States."

Get Involved
Act Now to Support WIC

Events

Welcome Home the Nuns on the Bus: Monday, July 2, 12–1 PM, United Methodist Building, 100 Maryland Avenue NE, Washington, DC. The Soul Sisters wrap up their nine-state, twenty-eight-city bus tour to call attention to the House Republican-passed Ryan budget and the damaging effects it would have on poor, vulnerable and struggling people throughout America. Help give them the welcome and thanks they deserve.

50 Years Since *The Other America*: Understanding & Addressing Poverty in the 21st Century: Tuesday, July 10, 9am – 5pm, The Newseum Knight Conference Center, Washington, DC. Leading researchers, practitioners, and journalists will assess how economic and policy trends are affecting poverty today, and will discuss promising new policies and strategies for lifting and keeping Americans out of poverty.

2012 Kansas Conference on Poverty: July 25–27, Hyatt Regency, Wichita, Kansas. I'll be there and I'm honored to be speaking. But I'm also staying for the whole shindig, because I'm going to learn a lot from the people running this show, and so can you. The Kansas Association of Community Action Programs and the Kansas Community Action Network have their fingers on the pulse of poverty and what's happening in the anti-poverty community. Plus Deborah Weinstein, executive director of the Coalition on Human Needs, is keynoting. My opinion: through her thirty years of advocacy experience she's pretty much like some sort of Jedi Master on all things poverty-related. It's kinda scary.

Articles and Other Resources

"EITC Encourages Work and Success in School and Reduces Poverty," Jimmy Charite, Indivar Dutta-Gupta, and Chuck Marr

"Children's Share of Federal Budget Decreasing," First Focus

"Evidence Free Policy Decisions: Driving an Epidemic," Dr. Deborah Frank

http://www.thenation.com/blog/168665/week-poverty-89000-children-pennsylvania-lose-medicaid

"Homeless Families Turn to City for Help Hind No Rooms, Risk Child Welfare Inquiry," Annie Gowen

"Women Who Don't Have Anything Close to 'It All'," Katrina vanden Heuvel

"Faith Reflection on the May Jobless Numbers and Older Workers," Interreligious Working Group on Domestic Human Needs

"Cutting Food Stamps While Giving the Sugar Lobby Billions," Zaid Jilani

Vital Statistics

US poverty (less than $22,314 for a family of four): 46 million people, 15.1 percent of population.

Children in poverty: 16.4 million, 22 percent of all children, including 39 percent of African-American children and 35 percent of Latino children.

Number of poor children receiving cash aid: one in five.

Poverty rate for people in female-headed families: 42 percent.

Single mothers with incomes under $25,000: 50 percent.

Single mothers working: 67 percent.

Deep poverty (less than $11,157 for a family of four): 20.5 million people, 6.7 percent of population. Up from 12.6 million in 2000.

Increase in deep poverty, 1976–2010: doubled—3.3 percent of population to 6.7 percent.

Americans with no income other than food stamps: 6 million, 2 percent of population.

Twice the poverty level (less than $44,628 for a family of four): 103 million people, roughly 1 in 3 Americans.

Families receiving cash assistance, 1996: 68 for every 100 families living in poverty.

Families receiving cash assistance, 2010: 27 for every 100 families living in poverty.

Impact of public policy, 2010: without government assistance, poverty would have been twice as high—nearly 30 percent of population.

Quote of the Week

http://www.thenation.com/blog/168665/week-poverty-89000-children-pennsylvania-lose-medicaid

"Nothing like this in recent history." —Pennsylvania resident and longtime advocate for children and families, on the state's Medicaid debacle

http://www.thenation.com/blog/168665/week-poverty-89000-children-pennsylvania-lose-medicaid

Mr. BURGESS. But Mr. Alexander, I think in fairness to you, I am going to submit a question to you about this data and I would be very grateful for your reply to that. The same courtesy will be afforded to Ms. Schakowsky as well, and I want to remind all members, I said earlier 5 business days, it is actually 10 business days to submit questions for the record, and we will ask the witnesses to respond to those questions promptly. Members should submit their questions by the close of business on Thursday, December 27th, and by happy occurrence, we will be here on Thursday, the 27th.

So without objection, the subcommittee is adjourned.

[Whereupon, at 1:29 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Opening Statement of the Honorable Fred Upton
Subcommittee on Health
Hearing on "State of Uncertainty: Implementation of PPACA's Exchanges and Medicaid Expansion"
December 13, 2012

(As Prepared for Delivery)

Only 13 months remain until PPACA is fully implemented and many questions still remain unanswered, leaving states in the dark about the future of the health insurance markets as well as clouding the status of their largest annual budgetary expenditure. Families are also left wondering whether their personal health plan that protects them today will be around in 2014 at a price they can afford.

States continue to express their frustration with the federal government's delay to provide the rules of the road of this massive regulatory undertaking. Since enactment of the president's law nearly three years ago, thousands of pages of regulations have been issued for states to review and analyze. Yet despite the daily rules and notices printed in the federal register, basic questions remain unanswered. For example, no final rules detailing federal benefit mandates and actuarial value have been issued for health plans operating in the exchanges. Benefit requirements and cost-sharing rules for those newly eligible for Medicaid remain unresolved.

Despite numerous requests for guidance after the Supreme Court declared PPACA's Medicaid mandate unconstitutional, states received little information from the administration for five months - until just three days ago, when the administration finally issued a non-binding "Frequently Asked Questions" document. This release however only addressed a fraction of questions. It should also be noted the administration issued the guidance for states with only three days remaining until tomorrow's HHS deadline forcing states to make a final decision on an exchange. This is not the way the federal government is supposed to work – especially when one-sixth of our economy is being transformed.

If the administration's inability to respond and answer states' questions and concerns is any indicator of how the rest of PPACA is going to be implemented, America faces indefinite uncertainty.

The administration's actions to date show that states are servants, not partners, under PPACA. The administration has not shown any willingness to work in partnership with the states; it is no wonder so many states have said no to the law's exchanges and Medicaid expansion.

Rep. Joseph R. Pitts
Opening Statement
Energy and Commerce Subcommittee on Health
"State of Uncertainty: Implementation of PPACA's Exchanges and Medicaid Expansion"
December 13, 2012

On January 1, 2014, less than 13 months from now, the Affordable Care Act's health exchanges and Medicaid expansion are to be up and running.

The health care law was passed over 33 months ago. Since then, the Obama Administration has released thousands of pages of regulations, and yet has failed to give states the critical information they need to make informed decisions about whether to set up state-based health exchanges and whether to proceed with the Medicaid expansion.

The Administration has been particularly non-communicative on these topics.

On July 2nd of this year, the National Governs Association (NGA) sent Health and Human Services (HHS) Secretary Kathleen Sebelius a detailed letter raising concerns and questions from the bipartisan group of governors in light of the Supreme Court ruling striking down the ACA's mandate on states to expand their Medicaid programs.

On July 3rd, the National Association of Medicaid Directors sent a similar letter to the Centers for Medicare and Medicaid Services (CMS).

And, on July 10th, the Republican Governors Association (RGA) sent a letter to President Obama outlining basic operational and implementation questions related to ACA.

The RGA sent yet another letter to Secretary Sebelius on July 23rd after CMS failed to substantively answer the 30 specific questions posed in its earlier letter.

Unfortunately, the responses to these letters were merely formal thank you and receipt of acknowledgement letters or incomplete responses with general information.

On August 20th, Full Committee Chairman Fred Upton and I sent a letter to CMS requesting an update regarding the Administration's failure to respond to the states' specific questions. On October 4th, we sent a similar letter to Sec. Sebelius.

My home state of Pennsylvania sent three letters of its own to HHS this year asking for clear guidance on exchange and Medicaid expansion issues, dated January 26th, August 23rd, and September 26th. None of them were answered.

Apparently, HHS believes that its "Frequently Asked Questions" release of December 10th provides states with all of the guidance needed to make these critical decisions, despite having no firm answers on benefit mandates, actuarial value, and the details of the federal exchange.

HHS continues to trumpet the "flexibility" states will have in running their own health insurance exchanges. However, the ACA is quite clear that it is HHS – not the states – that has the power to make all key determinations.

In *state*-run exchanges, HHS will choose the essential benefits that must be paid for by individuals and families; select the doctors and other health care professionals that allowed to provide care in exchange plans; decide whether your plan's provider network is "adequate" (regardless of whether it covers your doctor); impose price controls on health coverage; establish cost-sharing requirements regardless of their effect on premiums; impose certification and decertification plan requirements written by HHS; and determine whether state exchange rules conflict with or prevent the application of federal regulations; among many others.

That is not "flexibility."

Tomorrow, December 14th, is the deadline by which states are to inform HHS if they will set up and run their own health exchanges. Based on the lack of guidance from HHS, the illusion of true flexibility, the uncertainty surrounding what is expected of the states and how the exchanges and expansion will be paid for, Pennsylvania Governor Tom Corbett announced yesterday that he will not pursue a state-based health insurance exchange, and he is delaying a decision on whether the state will expand its Medicaid program.

Enrollment in the health exchanges is to begin October 1, 2013. As of today, only 18 states have decided to run their own exchanges.

These next 13 months will see a flood of new regulations from Washington and impossible burdens placed on states.

I would like to thank all of our witnesses for being here today. I am interested in hearing from our Administration witnesses what efforts they have taken to work with states on these important decisions and what plans they have to help the states meet the quickly approaching implementation deadlines.

From our state witnesses, I am hoping to learn about their experiences with the law and with HHS, and I would give a special welcome to Gary Alexander, Secretary of the Department of Public Welfare in my home state of Pennsylvania.

Gary Cohen's Hearing
"Exchanges & Medicaid Expansion"
Before
House Energy & Commerce Committee
Subcommittee on Health

December 13, 2012

The Honorable Joseph R. Pitts

1. **It appears that the Administration is ignoring the letter of the law when it's convenient. I have a series of legal questions related to highly questionable action taken by the Administration during implementation.**
   a) **Can you point to the provision of the law that defines what a "state partnership exchange" is or provided HHS the authority to create such an entity?**

Answer: Yes. A State Partnership Exchange is a variation of a Federally-facilitated Exchange as authorized in section 1321(c) of the Affordable Care Act. This section establishes that if a state will not have an Exchange operational by January 1, 2014, or has not taken actions to implement the requirements to operate an Exchange, then HHS shall either establish and operate an Exchange or take such actions as are necessary to implement an Exchange in that state. A State Partnership Exchange is simply a form of the Federally-facilitated Exchange called for in the statute, and because HHS is committed to flexibility for states, the State Partnership Exchange enables states to engage actively with the Federal Government in the operation of certain aspects of an Exchange with which they have considerable expertise.

   b) **Can you explain what provision of the law provides CMS the authority to fund a "state partnership exchange" with money allotted under 1311(a)? This provision of the law makes no mention of a state partnership exchange.**

Answer: Yes. Under section 1311(a)(3), funds may be used "for activities (including planning activities) related to establishing" an Exchange. Activities undertaken by a State Partnership Exchange contribute to the establishment of an Exchange.

2. **Please provide us the number of states who as of today have submitted an application to CCIIO to run an Obamacare state-based exchange.**

Answer: As of December 13, 2012, fourteen states and the District of Columbia have submitted applications or letters of intent to run State-Based Exchanges.[1]

[1] They are California, Hawaii, Vermont, Mississippi, Colorado, Connecticut, Kentucky, Maryland, Minnesota, New York, Oregon, Rhode Island, Washington, and Idaho.

3. **Please provide the Committee with a detailed list of all contracts entered into by HHS related to the creation, development, planning, staffing, or any other activity related to federally facilitated exchanges administered by the Secretary under authority granted to HHS by Section 1321(c) of PPACA. The response should include the dollar amount and summary of the scope of work associated with each contract.**

Answer: As part of the efforts to implement the Federally-facilitated Exchange and to provide key support both to states that plan to operate Exchanges, Medicaid, and the state Children's Health Insurance Program (CHIP), CMS released a request for proposals (RFP) on June 24, 2011. CMS awarded two separate task orders to two separate contractors. A contract for the Data Services Hub was awarded to Quality Software Services, Inc. (QSSI) on September 30, 2011. The Hub is an important part of the infrastructure that will enable all Exchanges, regardless of the model, and state agencies administering Medicaid and CHIP to provide accurate and timely eligibility determinations. Functioning as a sophisticated router system, the Hub will enable Exchanges and state agencies administering Medicaid and CHIP to securely obtain information from Federal data sources, such as the Internal Revenue Service, Social Security Administration and Department of Homeland Security to verify key elements of the application.

The contract for the Federally-facilitated Exchange portion of the original RFP was awarded to CGI Federal on September 30, 2011. Under this contract, CGI will help to build and support the information technology systems of the Federally-facilitated Exchange.

4. **Please provide the Committee with a detailed list of all expenditures incurred by CCIIO related to implementation of PPACA. The response should include the dollar amount, summary of work associated with each expenditure, and source of funding.**

Answer: Please refer to the attachment for a list of all expenditures incurred by CCIIO related to implementation of the Affordable Care Act, which includes a description of the work and source of funding associated with each expenditure.

The Honorable Michael C. Burgess, M.D.

1. **While the federal government can continue to push deadlines and hold rules, the States and health plans are left on the hook. Have you considered the economic implications if plans are not equipped with the necessary guidance to begin enrollment in a few months? If we are not prepared to go live – have you contemplated the financial impact on health plans who will be required by statute to meet requirements but have not been given the tools to do so?**

Answer: Since the Affordable Care Act became law, CMS has been working with many stakeholders, including states and issuers to implement the law. CMS has issued numerous regulations, guidance documents, and fact sheets. In addition, CMS has already issued several proposed rules which will soon become final, that issuers need to price policies for the 2014 plan year. We continue to hold weekly calls with issuers, and release rules, guidance and other documents so that all issuers can be ready for 2014. This work will continue as states prepare and CMS implements the Federally-facilitated exchange. Lastly, CMS has hosted 119 events for states, totaling approximately 215 hours of technical assistance in 2012. States that want to move forward have the information they need and CMS stands ready to work with any state that wishes to implement an Exchange. We are confident both states and issuers will be ready for open enrollment in 2013.

2. **Can you explain how the actuarial value calculation will work for family plans? My understanding is that the calculator provides the AV for self-only coverage but it is unclear how AV for a family plan will be calculated.**

Answer: Actuarial Value (AV) is an average of expected plan spending across a population, calculated at the plan level, not the individual. The AV calculator works the same for self-only coverage as it does for family coverage. As directed by statute, AV is calculated with respect to a standard population. The difference between calculating AV for a self-only policy as opposed to a family policy is that the amount of expected plan spending increases in proportion to the number of enrollees in a plan.

3. **The Obama Administration and HHS have commonly referred to the states as "partners" with the federal government in the Exchanges. Yet, to date, only 18 states have committed to running an exchange. Why do you think participation is so low? Furthermore, how does HHS plan to coordinate their operation of a federally-facilitated exchange with existing state laws and regulations?**

Answer: We are committed to flexibility for states, and each state makes its own decisions about whether or how to establish an Exchange, based on its own circumstances. States initially electing to have a Federally-facilitated Exchange (FFE) may transition to a State-based Exchange for 2015 or beyond.

When establishing an FFE, we are working closely with States to preserve existing state programs, laws, and the responsibilities of the state insurance department wherever possible. If CMS operates an FFE in a state, we will work with the state to avoid any unnecessary duplication of activities and regulatory oversight. All call center and website personnel for the FFE will be trained on relevant state insurance laws and Medicaid eligibility standards so that

they can advise consumers about state-specific concerns. CMS has been and will be in constant contact with states while developing the FFE, and will remain in communication to provide updates after the FFE is established.

4. **In your testimony you refer to the role the federal exchange will play nationwide. The Administration has continually promised to provide operational details regarding the federal exchange. Will the Administration put forward an actual rule related exclusively to the federal exchange or will you continue to issue informal guidance on the entity that will be running the insurance market in more than 30 states?**

Answer: In states that do not elect to establish a State-based Exchange, HHS will operate a Federally-facilitated Exchange (FFE). Regardless of the Exchange model, the standards codified in 45 CFR Parts 155, 156, and 157 (Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, published March 27, 2012, or "Exchange Final Rule") will apply. Since publishing the Exchange Final Rule, CMS has released several documents clarifying the FFE operations including: the interaction between the FFE and state Medicaid and CHIP agencies, general guidance on the FFE guidance outlining plan management and consumer support functions for states performing these functions, and multiple questions and answers. CMS will and continue to be in frequent contact with states while developing the FFE, and will provide updates to states after the FFE is operational.

5. **In your testimony you referred to the federal data hub that HHS will use to determine eligibility, enrollment, and subsidies in the federal exchange. The Administration has continued to refer to this 'federal data services hub', but has not provided any guidance or direction on the hub. When does the Administration plan to release guidance on this federal data services hub?**

Answer: CMS has been in close contact with States as they develop information technology systems to support Exchanges. In May 2011, CMS released Guidance for Medicaid and Exchange Information Technology (IT) systems, version 2.0.[2] This is the primary IT guidance that CMS has given to states, and was designed to assist states as they design, develop, implement, and operate technology and systems projects related to the establishment and operation of Exchanges as well as coverage expansions and improvements under Medicaid and the state Children's Health Insurance Program (CHIP), and premium tax credits and cost-sharing reductions under the Affordable Care Act. In addition, as issues have arisen, CMS has clarified in regulation, such as the Exchange final rule as well as other guidance, specific policies that inform state development of IT systems and their interaction with the data services Hub, including what applicant information must be verified with Federal data sources. In recent months, CMS has also shared with states detailed descriptions and specifications for the various eligibility verification and reporting services that will be provided by the data services Hub.

6. **How will the federal data services hub interact with state data systems in approving qualified health plans, multi-state plans, bridge plans? How will the federal hub**

[2] The guidance is available at http://cciio.cms.gov/resources/files/exchange_medicaid_it_guidance_05312011.pdf.

coordinate information between three different federal agencies, state Medicaid agencies, state insurance departments, and health plan?

Answer: The Hub will not have a role in certifying any health plans as qualified health plans. The Hub is a critical piece of infrastructure that will help all Exchanges and state agencies administering Medicaid and CHIP to communicate with one another. The Hub will help the Exchange and Medicaid agency provide accurate and timely eligibility determinations while protecting consumer privacy and security. Functioning as a sophisticated router system, the Hub will enable Exchanges and state agencies administering Medicaid and CHIP programs to securely share information with other data sources, such as the Internal Revenue Service, Social Security Administration, and Department of Homeland Security to verify factors of eligibility, including citizenship and immigration status and income. The Hub will also support the transmission of enrollment data for the Federally-facilitated Exchange to qualified health plans. The Hub will not store any personal information; it will route specific eligibility and enrollment information to the relevant data source.

7. **Who will have ultimate authority for eligibility decisions and qualified health plan certification? Will the federal contractors working on the hub be delegated responsibility?**

Answer: Exchanges are required to certify qualified health plans. It is not a function of the Hub, which, as noted above, serves only as an information routing device. 45 CFR Part 155 Subpart K describes Exchange responsibilities with respect to certification of qualified health plans, and 45 CFR Part 156 Subpart C describes qualified health plan minimum certification standards. The entity responsible for certification depends on the type of Exchange. In states electing to operate their own exchange, the State-based Exchange will be responsible for certifying qualified health plans. In states electing to operate a State Partnership Exchange, HHS will take the results of state reviews of qualified health plan applications but will ultimately be responsible for certifying qualified health plans. In states where a Federally-facilitated Exchange is operating, HHS will be responsible for certifying qualified health plans.

With respect to eligibility, an Exchange is responsible for determining eligibility for enrollment in a qualified health plan, advance payments of the premium tax credit and cost sharing reductions. States have the option to have the Exchange determine eligibility for Medicaid or to assess eligibility for Medicaid, in both cases using the state's eligibility rules and subject to certain standards. As previously noted, the Hub will provide connections to data sources used by Exchanges and state agencies to support eligibility and enrollment operations, but the Hub will not make eligibility decisions.

8. **Are pediatric dental benefits included in the list of 10 essential health benefits?**
   a. **Will qualified health plans inside the Exchange (and outside in the individual and small group markets) have to offer pediatric dental benefits?**

Answer: Section 1302 of the Affordable Care Act outlines the requirements for health plans to cover the ten categories of the essential health benefits (EHBs). Section 1311(d)(2)(B)(ii) of the Affordable Care Act, as codified in 45 CFR 155.1065, allows the pediatric dental component of

EHBs to be offered through a stand-alone dental plan in an Exchange. If a stand-alone dental plan is available in an Exchange, section 1302(b)(4)(F) of the Affordable Care Act permits QHPs offered in that Exchange to exclude coverage of the pediatric dental component of the EHBs.

In addition, beginning on January 1, 2014, section 2707(a) of the Public Health Service Act requires health insurance issuers that offer non-grandfathered health insurance coverage in the individual or small group market to ensure that such coverage includes the EHB package under section 1302(a) of the Affordable Care Act. Section 2707(a) extends the requirement to offer the EHB package to non-grandfathered individual and small group market plans outside the Exchange.

b. To be clear, pediatric dental coverage IS REQUIRED to be offered in the Exchange but NOT BY Qualified Health Plans, only be standalone plans?

Answer: Pediatric oral services are among the ten categories of benefits that are listed as EHBs in section 1302 of the Affordable Care Act. Consistent with the statute, these benefits may be offered as part of a qualified health plan or as a stand-alone dental plan. While qualified health plans have the option to omit the pediatric dental EHB if there is a stand-alone dental plan in the Exchange, the QHPs can also decide to include the pediatric dental EHB. Further, if there is not a stand-alone dental plan offered through a particular Exchange, the QHPs in that Exchange must cover the pediatric dental benefits that are EHBs.

c. Does that mean individuals and families purchasing coverage in the Exchange (and outside in the individual and small group markets) have to buy 2 plans in order to meet the requirement to carry Essential Health Benefits (both a pediatric dental standalone plan and another QHP)?

Answer: The Affordable Care Act does not require individuals and families to purchase a stand-alone dental plan. The Affordable Care Act requires health insurance issuers that offer health insurance coverage in the individual and small group markets inside and outside Exchanges, beginning on January 1, 2014, to ensure that such coverage includes the EHB package. As stated above, if a qualifying stand-alone dental plan is available in an Exchange, section 1302(b)(4)(F) of the Affordable Care Act permits QHPs offered in that Exchange to exclude coverage of the pediatric dental component of the EHBs. In this way, the ten full EHBs must be available to all consumers inside of the Exchange, but HHS does not interpret the Affordable Care Act to require individuals and families to purchase a stand-alone dental plan.

d. Will HHS/the Exchange issue a certificate of qualified pediatric dental coverage to purchasers?

Answer: As directed by statute, Exchanges must allow limited-scope dental plans that meet certain certification standards to be offered on Exchanges. Section 45 CFR 155.1065 of the Exchange Final Rule states that stand-alone dental plans must meet QHP certification standards, except for any certification requirement that cannot be met because the plan covers only the pediatric dental EHB. The section describes other specific standards that apply to stand-alone dental plans and include a requirement that the plan cover at least the pediatric dental EHB.

Thus, no stand-alone dental plan that does not include the pediatric dental EHB will be allowed to be offered on an Exchange.

e. **How will the IRS know if someone has actually purchased coverage that includes all 10 Essential Health Benefits?**

Answer: This question is outside the purview of CMS; we would refer you to the Internal Revenue Service. We note that there are several types of coverage identified in the statute as Minimum Essential Coverage. Section 5000A(f) of the Internal Revenue Code contains a list of these types of coverage. Not all coverage that is recognized as minimum essential coverage is subject to the EHB requirements of the Affordable Care Act. Beginning January 1, 2014, new non-grandfathered plans in the individual and small group markets must offer coverage that meets the EHB requirements.

f. **So it is possible that a single individual or a family without children will be able to decline purchase of pediatric dental benefits?**

Answer: Section 1302 of the Affordable Care Act outlines the requirements for health plans to cover the ten EHB categories. The only exception permitted under section 1302 is for QHPs offered through an Exchange to exclude coverage of the pediatric dental EHB if there is a stand-alone dental plan offered in the Exchange. Section 1311 of the Affordable Care Act requires all Exchange stand-alone dental plans to cover the pediatric dental EHB. In this way, sections 1302 and 1311 require that the full set of EHBs be offered to people purchasing coverage through the Exchange. However, HHS does not interpret these sections to require the purchase of the full set of EHBs. Thus, in an Exchange, a person (with or without a child) could purchase a QHP that does not cover the pediatric dental EHB without purchasing a stand-alone dental plan. This interpretation would not preclude a state from requiring the purchase of stand-alone dental coverage in a State-based Exchange.

g. **Won't a separate, standalone pediatric dental plan in the exchange lead immediately to significant adverse selection since it will be purchased by those who know that their family will have dental issues?**

Answer: The inclusion of stand-alone dental plans in Exchanges is required by statute. Because the pediatric dental benefit involves mostly routine and preventive care, a family's decision to purchase pediatric dental benefits may not necessarily be directly linked to dental health status.

h. **Isn't lack of pediatric dental coverage something that has been a significant health problem in the Medicaid? Presumably the Medicaid population will be taken care of, but doesn't the way this is being implemented give you concern for the health of the near-poor individuals and families in the Exchange who may forego pediatric dental benefits?**

Answer: CMS views oral health as inseparable from overall health and dental care as an essential element of primary care for children. All children enrolled in Medicaid and CHIP have coverage for dental services, though ensuring access to these services remains a concern that we

are working to address. In Medicaid, children's dental benefits are required through the Early Pediatric Screening, Diagnostic, and Treatment (EPSDT) benefit. In CHIP, the children's dental benefit became mandatory in FY 2010 through the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). CMS has been working with its Federal and state partners, as well as the dental and medical provider communities, children's advocates, and other stakeholders to improve access to pediatric dental care. CMS is currently working with states to develop oral health action plans, strengthening technical assistance to states and Tribes, improving outreach to providers, developing outreach to beneficiaries, and partnering with other governmental agencies in order to meet our goals to increase the rate of children who receive preventive dental services.

Pediatric oral services are among the ten categories of benefits that are listed as EHBs in section 1302 of the Affordable Care Act. As previously noted, section 1311(d)(2)(B)(ii) of the Affordable Care Act, as codified in 45 CFR 155.1065, allows the pediatric dental component of the EHB to be offered through a stand-alone dental plan in an Exchange. If a stand-alone dental plan is available in an Exchange, section 1302(b)(4)(F) of the Affordable Care Act permits QHPs offered in that Exchange to exclude coverage of the pediatric dental component of the EHB.

The Honorable Marsha Blackburn

1. **Mr. Cohen, I am growing concerned with the timing and lack of guidance from CCIIO on the administration of the cost-sharing reduction subsidy. In particular, the lack of attention to the operational challenges certain qualified health plans will face in tracking and reporting on the subsidy is troubling. The systems used for tracking and adjudicating the Part D drug benefit subsidy are not necessarily portable to the commercial market. Furthermore, the Medicare low income subsidy benefit does not have to be coordinated across ten separate benefit categories (the essential health benefits) as will the cost sharing subsidy reduction. Thus, companies will need more time to build out their claims systems to accommodate the administration of the ACA subsidy, yet the proposed rule requires that these systems be in place on day 1 for proper tracking and reporting. I'm wondering if this issue has been brought to your attention and do you intend to allow additional time for companies to make the proper changes to their claims systems?**

Answer: On December 7, 2012, the Department published the proposed Notice of Benefit and Payment Parameters for 2014. Standards for cost-sharing reduction subsidies are outlined in this proposed rule that include a simplified methodology, advance payments to issuers, and annual reconciliation. After reviewing public comments, the Department will finalize this rule in early 2013. Exchange open enrollment begins in October 2013 and we are continuing to work with issuers.

The Honorable Joe Barton

1. **There will be people who, because of the mandated change to MAGI eligibility determination and the 5% income disregard, will newly qualify for Medicaid, even though a state's eligibility levels do not change. Will CMS recognize these newly eligible people as an optional expansion population? If not, will states be eligible for 100% FFP for this population since they were not previously eligible?**

Answer: The Federal matching rate for newly-eligible beneficiaries, which starts at 100 percent in 2014 and phases down to 90 percent in 2020 and beyond, is only available for adults in the new low-income group in states that expand Medicaid to 133 percent of the Federal poverty level (FPL). If a state expands coverage to this group and there are individuals in the adult group, who, because of the change to modified adjusted gross income (MAGI) methodologies meet the definition of newly-eligible, the state will be able to claim the enhanced Federal matching for them. For a state that does not expand, the change to the MAGI methodology alone would not result in the higher Federal matching rate being available, as the conversion, under the law, does not affect eligibility levels, but simply how they are calculated..

2. **In the response to Question 34 of the December 10 FAQs to state Governors, Secretary Sebelius says that that CMS will support options for the Medicaid expansion population that encourage personal responsibility, depending on the design of the program, and invites states to come to you with their ideas. Why is this limited to only the expansion population? Why are states discouraged, and even prohibited, from implementing policies to encourage greater personal responsibility, such as cost-sharing, with the entire Medicaid population?**

Answer: Many Governors have articulated an interest, as you have here, in adopting cost-sharing requirements for Medicaid beneficiaries. Medicaid already permits certain cost-sharing, and we have committed to provide additional authority and flexibility to states in this area. Existing cost-sharing requirements for Medicaid recipients vary based on family income, and there is significant state flexibility to impose cost-sharing for individuals with incomes above the poverty line. Many state Medicaid programs already charge copayments for prescription drugs, non-emergent emergency room visits, and dental services. Acknowledging the desire for greater authority in this area, CMS plans to publish a proposed rule in 2013 asking for comments on updating and simplifying policies around cost-sharing requirements to promote the most effective use of services and to assist states in identifying cost-sharing flexibilities. CMS also plans to propose to allow states to establish higher cost-sharing for non-preferred drugs, and to impose higher cost-sharing for non-emergency use of the emergency department. This cost-sharing flexibility would apply to individuals at all income levels.

3. **In that same December 10 FAQ, in response to a question on whether CMS will approve global waivers with an aggregate allotment, state flexibility, and accountability if states are willing to initiate a portion of the expansion, Secretary Sebelius answers,**

> **"Consistent with the guidance provided above with respect to demonstrations available under the regular and enhanced matching rates, CMS will work with states on their proposals and review them consistent with the statutory standard of furthering the interests of the program"**

Can you provide any insight or additional details on what that means and how that would look for states? For example, when Arizona asked for a waiver amendment to implement a no-show fee of $25 for missed Medicaid physician appointments, they were told "ok" IF they:

i. **Lowered the fee to $3**
ii. **Excluded the two most populous counties where a significant number of the Medicaid recipients live**
iii. **Required providers to submit plans certifying that Medicaid recipients be notified of all appointments 48 hours in advance, offered notification in multiple ways (phone/text/email) and tracked how notifications were given.**

Would requirements like these be part of a global waiver you refer to or do you envision greater flexibility for states?

Answer: We are interested in working with states to promote better health and health care at lower costs and have been supporting, under a grant program established by Section 4108 of the Affordable Care Act, state initiatives that are specifically aimed at promoting healthy behaviors that help prevent chronic disease. Promoting better health and healthier behaviors is a matter of importance to the health care system generally, and state Medicaid programs, like other payers, can shape their benefit design to encourage such behaviors while ensuring that the lowest income Americans have access to affordable quality care. We invite states to continue to come to us

with their ideas, including those that promote value and individual ownership in health care decisions as well as accountability tied to improvement in health outcomes.

Attachment – Question 4
1/31/2013

Center for Consumer Information and Insurance Oversight (CCIIO) Outlays Through September 30, 2012

1. Consumer Assistance Grants

Consumer Assistance Grants Outlays		Cumulative Total (Actual $$) 09/30/2012
Total Consumer Assistance Grants	$	$10,750,819

This funding provides for federal grants to States to establish, expand, or provide support for the establishment of independent offices of health insurance consumer assistance or ombudsman programs. In the ACA, Congress appropriated $30 million in FY 2010 to establish health insurance consumer assistance programs. As a condition of receiving grant funds, consumer assistance or ombudsman programs must: assist consumers with filing complaints and appeals, assist consumers with enrollment into health coverage, and educate consumers on their rights and responsibilities with respect to group health plan and health insurance coverage. In addition, these programs must collect data on consumer inquiries and complaints to help the Secretary identify problems in the marketplace and strengthen enforcement.

2. Grants to States for Premium Reviews

Grants to States for Premium Reviews Outlays		Cumulative Total (Actual $$) 09/30/2012
Grants	$	33,533,359
Total Rate Reviews	$	33,533,359

The statute, authorized in Section 2794 of the Public Health Services Act as amended by the ACA, directs the Secretary to carry out a program to award grants to states to help them develop, or improve and enhance their current health insurance rate review and reporting processes, and provide information and recommendations to the Secretary. Congress has appropriated $250 million to be awarded in federal fiscal years (FFYs) 2010-2014.

3. Temporary High Risk Insurance Pool (PCIP)

Temporary High Risk Insurance Pool (PCIP) Outlays		Cumulative Total (Actual $$) 09/30/2012
Payroll	$	5,633,990
Travel	$	128,677
Training	$	2,365

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Supplies	$	6,163
Other Contracts	$	58,277,790
Direct Payments - Federal Fallback	$	808,126,798
Federal Fallback Reimbursable Payments	$	90,549,094
State High Risk Pool Direct Payments to States	$	1,069,739,394
Total PCIP	**$**	**2,032,464,271**

Congress appropriated $5 billion to fund the Pre-Existing Condition Insurance Plan (PCIP) Program to make health insurance available to uninsured individuals who have been denied coverage due to a pre-existing condition. Funding for this temporary program is used to pay claims and administrative costs in excess of premiums collected from enrollees in the program.

4. Temporary Reinsurance Program (ERRP)

			Cumulative Total (Actual $$) 09/30/2012
Temporary Reinsurance Program (ERRP) Outlays			
	Total ERRP	**$**	**4,901,620,255**

Congress appropriated funding of $5 billion for the Early Retiree Reinsurance Program (ERRP) program. This funding reimburses sponsors with certified plans for a portion of the cost of health benefits for early retirees and their spouses, surviving spouses and dependents. The program provides reimbursement to participating employment-based plans for a portion of the cost of health benefits for early retirees and their spouses, surviving spouses and dependents.

5. Affordable Insurance Exchanges Grants to States

			Cumulative Total (Actual $$) 09/30/2012
Affordable Insurance Exchanges Grants to States Outlays			
	Total Exchanges Grants	**$**	**192,091,431**

Section 1311(a) of the Affordable Care Act provides grant funding to states for activities related to establishing an Exchange. These grants are available for states seeking to establish a State-based Exchange, to build functions that a State elects to operate in partnership with the Federal government, and to support state activities to build interfaces with a Federally-Facilitated Exchange. Grants may be awarded through December 31, 2014 for all types of Exchanges, and grant funds are available for approved and permissible establishment activities. The first year of Exchange activity is critical to ensuring Exchange self-sufficiency.

6. Consumer Operated and Oriented Plan Program (CO-OP)

			Cumulative Total (Actual $$) 09/30/2012
Consumer Operated and Oriented Plan Program (CO-OP) - Program Account Outlays			
	Total CO-OP (Program)	**$**	**38,279,379**

Attachment – Question 4
1/31/2013

Consumer Operated and Oriented Plan Program (CO-OP) - Financing Account Outlays		Cumulative Total (Actual $$) 09/30/2012
Total CO-OP(Program)	$	56,652,674

This funding provides loans to capitalize eligible prospective CO-OPs with a goal of having at least one CO-OP in each state. The statute permits the funding of multiple CO-OPs in any state, provided that there is sufficient funding to capitalize at least one CO-OP in each state. The statute directs the Secretary to give priority to applicants that will offer CO-OP qualified health plans on a statewide basis, will use integrated care models, and have significant private support. At the time of this hearing, $3.4 billion was available to carry out the program. However, since that time, the American Taxpayer Relief Act of 2012 rescinded 90 percent of the unobligated balance and transferred the remaining funds into a contingency account.

7. Health Insurance Implementation Fund

Health Insurance Implementation Fund Outlays		Cumulative Total (Actual $$) 09/30/2012
Total Implementation Fund	$	$122,279,040

The Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) appropriated $1,000,000,000 to the Office of the Secretary to allocate at the discretion of the Secretary to provide additional funding for Federal administrative costs related to implementation ACA. This funding has supported CCIIO contracts related to the Federally Facilitated Exchanges and oversight responsibilities, CCIIO infrastructure expenses and staff payroll. This amount does not include funding solely related to oversight and technical assistance provided to state-based Exchanges.

8. General Department Management

General Department Management Outlays		Cumulative Total (Actual $$) 09/30/2012
Total General Department Management	$	63,355,299

This funding provides supplemental funding for implementation of the Affordable Care Act requirements by contractors.

Attachment – Question 4
1/31/2013

9. Program Management

Program Management Outlays		Cumulative Total (Actual $$) 09/30/2012
Total Program Management	$	20,061,293

These funds pay for travel, training, supplies, contracts, and salaries and benefits of employees that administer and implement the Insurance Exchange Marketplace program. These funds also account for employee salaries for which the direct appropriations (e.g., Health Insurance Premium Review program) do not otherwise allow for funding of those costs.

Cindy Mann's Hearing
"Exchanges & Medicaid Expansion"
Before
House Energy & Commerce Committee
Subcommittee on Health

December 13, 2012

The Honorable Joseph R. Pitts

1. **You note in your FAQs to states from late last year, that states are not allowed to receive 100 percent federal match (or the enhanced match) if they decide to expand their Medicaid eligibility levels up to a level less than 138% of FPL. I'm sure you recognize that the budget deficits states face for FY 2013 alone were in the tens of billions. Because there is in fact a state cost associated with any expansion, why not provide states the flexibility they need to implement a partial Medicaid expansion below 138% of FPL at the enhanced FMAP- especially when there is existing authority for you to do so under the statute?**

Answer: Congress directed that the 100 percent matching rate be used to expand coverage for adults to 133 percent of the Federal poverty level (FPL). The law does not provide for a phased-in or partial expansion. As such, and as we said in our recently released Frequently Asked Questions document, we will not consider partial expansions for populations eligible for the 100 percent matching rate in 2014 through 2016. If a state that declines to expand coverage to 133 percent FPL would like to propose a demonstration that includes a partial expansion, we would consider such a proposal, at the regular Federal matching rate, to the extent that it furthers the purposes of Medicaid. For newly-eligible adults, States will have flexibility under the statute to provide benefits benchmarked to commercial plans and they can design different benefit packages for different populations.

In 2017, further demonstration opportunities will become available to states under State Innovation Waivers with respect to the Exchanges, and the law contemplates that such demonstrations may be coupled with section 1115 Medicaid demonstrations. These waivers offer states significant flexibility while ensuring the same level of coverage, affordability, and comprehensive benefits at no additional cost to the Federal government. We will consider section 1115 Medicaid demonstrations, with the enhanced Federal matching rates, in the context of these overall system demonstrations.

2. **Last year, the Republican Governors Association released a comprehensive document outlining key flexibilities and reforms they believe to be important in sustaining the future of the Medicaid program for the most vulnerable Americans in their states. With that organization now representing 30 states, have you reviewed such flexibilities and do you intend to work with states to ensure a more expedited waiver process so that states with innovative models can move forward without waiting years for CMS approval?**

Answer: We appreciate the feedback and suggestions from our state partners in order to meet our shared goal of continually improving operational efficiencies to better serve Medicaid beneficiaries. We recently outlined many of the programmatic flexibilities currently available to

states in a letter to Governors. We continue to outline additional flexibilities and work directly with our state partners to determine where additional flexibility would improve the program.

Additionally, we have taken a number of steps to improve the way the Centers for Medicare & Medicaid Services (CMS) interacts with states. With respect to section 1115 demonstrations, we created a template, which is now available on Medicaid.gov, that states can use in developing new applications. We believe the template will help states ensure the demonstration application contains required elements and enable CMS to review the application more efficiently.

In addition to improving the process for submitting 1115 demonstration applications, we have also issued two State Medicaid Director letters[1] that provide states with information related to creating integrated care models. In the second of these communications, we outlined how States could pursue these models through the state plan process without an 1115 demonstration.

Finally, we are working on the development and release of our "MACPro Portal," which will provide states with an online tool for, among other things, electronically submitting State Plan amendments. We believe that the adoption of MACPro will streamline State-Federal administrative activities.

3. You have recently issued a final rule on the two-year physician payment bump in Obama Care, which took effect on January 1st of this year. From your perspective, who will continue to pay these enhanced rates on January 1, 2015 when the program sunsets?

Answer: CMS has published a Final Rule implementing the Affordable Care Act provision that helps states boost their payment rates to primary care providers to the rates paid by Medicare in 2013 and 2014. Under the provision, the Federal government will pay 100 percent of the increased cost associated with increasing the Medicaid rates to Medicare levels. This new enhanced payment will help ensure that people enrolled in the Medicaid program will be able to easily access providers and services they need. Increasing Medicaid primary care reimbursement to Medicare rates will help ensure that states are able to construct robust provider networks for current and future beneficiaries and ensures that doctors are paid the same for treating Medicare and Medicaid patients. This bump in payment rates recognizes the important role of primary care and preventive services by better rewarding physicians for providing this care. We are confident that a sufficient number of providers will continue to participate in the Medicaid program after the enhanced rates end in 2014 and CMS will continue, as we do now, to work with states to ensure a sufficient number of providers are available to meet the needs of Medicaid beneficiaries.

4. In their July 2012 letter, the Medicaid Directors asked whether or not the expansion of Medicaid to children enrolled in foster care is optional? Can you please walk through Medicaid coverage for foster children and what the eligibility levels are for foster children, what the income eligibility caps are and when individuals are able to transition to private coverage?

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[1] Letters are available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-001.pdf and http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-002.pdf.

Answer: The only foster care children for whom Medicaid enrollment is required are children receiving foster care maintenance payments under title IV-E of the Social Security Act. Otherwise, a foster care child can qualify for Medicaid based on meeting the State's requirements for the various mandatory and optional groups covered by the State. However, Medicaid coverage for "former foster care children" is required starting in 2014.

Sections 2004 and 10201(a) and (c) of the Affordable Care Act add a new section 1902(a)(10)(A)(i)(IX) of the Social Security Act under which states must provide mandatory Medicaid coverage for individuals under age 26 who were in foster care and receiving Medicaid when they turned age 18 or aged out of foster care at a higher age. Eligibility under the adult group at § 435.119 of the regulations (as specified in the March 23, 2012 Medicaid eligibility Final Rule at http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/html/2012-6560.htm) will not take precedence over coverage under the mandatory group of former foster care children.

The Honorable Michael C. Burgess, M.D.

1. **The Affordable Care Act includes an annual tax on health insurance companies that not only applies to the commercial market but to plans covering Medicaid beneficiaries as well. Statutory actuarial soundness requirements suggest that the insurer tax must be accounted for when States set reimbursements for these Medicaid plans. Milliman, an independent actuarial firm, concluded that the application of the insurer tax to Medicaid will result in costs to State and Federal governments of $13.6 billion and $24.8 billion, respectively. In light of that, what is CMS doing to prevent the potential impact this will have on Medicaid costs both to States and the Federal government? Does it make sense to assess a tax that is ultimately covered by State and Federal dollars?**

Answer: Under current regulations, states are required to construct actuarially-sound capitation rates which are subject to specified standards and to approval by the Centers for Medicare & Medicaid Services (CMS). Actuarially-sound capitation rates are based on services covered under the state plan, services provided under the contract, and costs related to providing these services.

2. **You noted in your FAQ document this week that the Department is backing away from the proposed blended rate, which the President has proposed as his key Medicaid reform proposal twice in Congress. Please explain why the Administration has made such a switch and provide details on what your alternative proposal is for Medicaid reform and deficit reduction?**

Answer: We continue to seek efficiencies and identify opportunities to reduce waste, fraud and abuse in Medicaid, and we want to work with Congress, states, and stakeholders to achieve those goals while expanding access to affordable health care. The Supreme Court decision has made the higher matching rates available in the Affordable Care Act for the new groups covered even more important to incentivize states to expand Medicaid coverage. The Administration is focused on implementing the Affordable Care Act and providing assistance to States in their efforts to expand Medicaid coverage to these new groups.

3. **You also noted in your FAQ document this week that the Department may work with states in 2017 who had not yet expanded through an 1115 waiver to possibly provide greater flexibilities to the state and some level of an enhanced federal match. If you believe that flexibility is available in 2017, why not in 2014?**

Answer: Congress directed that the enhanced matching rate be used to expand coverage for adults to 133 percent of the Federal poverty level. The law does not provide for a phased-in or partial expansion and as such, we will not consider partial expansions for populations eligible for the 100 percent matching rate in 2014 through 2016. Therefore, in the first three years of the expansion, only states that wish to fully implement the Medicaid expansion are eligible for the enhanced matching rate. In 2017, when demonstration opportunities become available to states under State Innovation Waivers, we will consider section 1115 Medicaid demonstrations, with the enhanced Federal matching rates, in the context of overall system demonstrations.

4. **Are pediatric dental benefits included in the list of 10 essential health benefits?**
   a. **Will qualified health plans inside the Exchange (and outside in the individual and small group markets) have to offer pediatric dental benefits?**

Answer: Section 1302 of the Affordable Care Act outlines the requirements for health plans to cover the ten categories of the essential health benefits (EHBs). Section 1311(d)(2)(B)(ii) of the Affordable Care Act, as codified in 45 CFR 155.1065, allows the pediatric dental component of EHBs to be offered through a stand-alone dental plan in an Exchange. If a stand-alone dental plan is available in an Exchange, section 1302(b)(4)(F) of the Affordable Care Act permits QHPs offered in that Exchange to exclude coverage of the pediatric dental component of the EHBs.

In addition, beginning on January 1, 2014, section 2707(a) of the Public Health Service Act requires health insurance issuers that offer non-grandfathered health insurance coverage in the individual or small group market to ensure that such coverage includes the EHB package under section 1302(a) of the Affordable Care Act. Section 2707(a) extends the requirement to offer the EHB package to non-grandfathered individual and small group market plans outside the Exchange.

b. **To be clear, pediatric dental coverage IS REQUIRED to be offered in the Exchange but NOT BY Qualified Health Plans, only be standalone plans?**

Answer: Pediatric oral services are among the ten categories of benefits that are listed as EHBs in section 1302 of the Affordable Care Act. Consistent with the statute, these benefits may be offered as part of a qualified health plan or as a stand-alone dental plan. While qualified health plans have the option to omit the pediatric dental EHB if there is a stand-alone dental plan in the Exchange, the QHPs can also decide to include the pediatric dental EHB. Further, if there is not a stand-alone dental plan offered through a particular Exchange, the QHPs in that Exchange must cover the pediatric dental benefits that are EHBs.

c. **Does that mean individuals and families purchasing coverage in the Exchange (and outside in the individual and small group markets) have to buy 2 plans in order to meet the requirement to carry Essential Health Benefits (both a pediatric dental standalone plan and another QHP)?**

Answer: The Affordable Care Act does not require individuals and families to purchase a stand-alone dental plan. The Affordable Care Act requires health insurance issuers that offer health insurance coverage in the individual and small group markets inside and outside Exchanges, beginning on January 1, 2014, to ensure that such coverage includes the EHB package. As stated above, if a qualifying stand-alone dental plan is available in an Exchange, section 1302(b)(4)(F) of the Affordable Care Act permits QHPs offered in that Exchange to exclude coverage of the pediatric dental component of the EHBs. In this way, the ten full EHBs must be available to all consumers inside of the Exchange, but HHS does not interpret the Affordable Care Act to require individuals and families to purchase a stand-alone dental plan.

d. **Will HHS/the Exchange issue a certificate of qualified pediatric dental coverage to purchasers?**

Answer: As directed by statute, Exchanges must allow limited-scope dental plans that meet certain certification standards to be offered on Exchanges. Section 45 CFR 155.1065 of the Exchange Final Rule states that stand-alone dental plans must meet QHP certification standards, except for any certification requirement that cannot be met because the plan covers only the

pediatric dental EHB. The section describes other specific standards that apply to stand-alone dental plans and include a requirement that the plan cover at least the pediatric dental EHB. Thus, no stand-alone dental plan that does not include the pediatric dental EHB will be allowed to be offered on an Exchange.

e. **How will the IRS know if someone has actually purchased coverage that includes all 10 Essential Health Benefits?**

Answer: This question is outside the purview of CMS; we would refer you to the Internal Revenue Service. We note that there are several types of coverage identified in the statute as Minimum Essential Coverage. Section 5000A(f) of the Internal Revenue Code contains a list of these types of coverage. Not all coverage that is recognized as minimum essential coverage is subject to the EHB requirements of the Affordable Care Act. Beginning January 1, 2014, new non-grandfathered plans in the individual and small group markets must offer coverage that meets the EHB requirements.

f. **So it is possible that a single individual or a family without children will be able to decline purchase of pediatric dental benefits?**

Answer: Section 1302 of the Affordable Care Act outlines the requirements for health plans to cover the ten EHB categories. The only exception permitted under section 1302 is for QHPs offered through an Exchange to exclude coverage of the pediatric dental EHB if there is a stand-alone dental plan offered in the Exchange. Section 1311 of the Affordable Care Act requires all Exchange stand-alone dental plans to cover the pediatric dental EHB. In this way, sections 1302 and 1311 require that the full set of EHBs be offered to people purchasing coverage through the Exchange. However, HHS does not interpret these sections to require the purchase of the full set of EHBs. Thus, in an Exchange, a person (with or without a child) could purchase a QHP that does not cover the pediatric dental EHB without purchasing a stand-alone dental plan. This interpretation would not preclude a State from requiring the purchase of stand-alone dental coverage in a state-based Exchange.

g. **Won't a separate, standalone pediatric dental plan in the exchange lead immediately to significant adverse selection since it will be purchased by those who know that their family will have dental issues?**

Answer: The inclusion of stand-alone dental plans in Exchanges is required by statute. Because the pediatric dental benefit involves mostly routine and preventive care, a family's decision to purchase pediatric dental benefits may not necessarily be directly linked to dental health status.

h. **Isn't lack of pediatric dental coverage something that has been a significant health problem in the Medicaid? Presumably the Medicaid population will be taken care of, but doesn't the way this is being implemented give you concern for the health of the near-poor individuals and families in the Exchange who may forego pediatric dental benefits?**

Answer: CMS views oral health as inseparable from overall health and dental care as an essential element of primary care for children. All children enrolled in Medicaid and CHIP have coverage for dental services, though ensuring access to these services remains a concern that we

are working to address. In Medicaid, children's dental benefits are required through the Early Pediatric Screening, Diagnostic, and Treatment (EPSDT) benefit. In CHIP, the children's dental benefit became mandatory in FY 2010 through the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). CMS has been working with its Federal and state partners, as well as the dental and medical provider communities, children's advocates, and other stakeholders to improve access to pediatric dental care. CMS is currently working with states to develop oral health action plans, strengthening technical assistance to states and Tribes, improving outreach to providers, developing outreach to beneficiaries, and partnering with other governmental agencies in order to meet our goals to increase the rate of children who receive preventive dental services.

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The Honorable Joe Barton

1. **There will be people who, because of the mandated change to MAGI eligibility determination and the 5% income disregard, will newly qualify for Medicaid, even though a state's eligibility levels do not change. Will CMS recognize these newly eligible people as an optional expansion population? If not, will states be eligible for 100% FFP for this population since they were not previously eligible?**

Answer: The Federal matching rate for newly-eligible beneficiaries, which starts at 100 percent in 2014 and phases down to 90 percent in 2020 and beyond, is only available for adults in the new low-income group in states that expand Medicaid to 133 percent of the Federal poverty level (FPL). If a state expands coverage to this group and there are individuals in the adult group, who, because of the change to modified adjusted gross income (MAGI) methodologies meet the definition of newly-eligible, the state will be able to claim the enhanced Federal matching for them. For a state that does not expand, the change to the MAGI methodology alone would not result in the higher Federal matching rate being available as the conversion, under the law, does not affect eligibility levels, but simply how they are calculated.

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Answer: Many Governors have articulated an interest, as you have here, in adopting cost-sharing requirements for Medicaid beneficiaries. Medicaid already permits certain cost-sharing, and we have committed to provide additional authority and flexibility to states in this area. Existing cost-sharing requirements for Medicaid recipients vary based on family income, and there is significant state flexibility to impose cost-sharing for individuals with incomes above the poverty line. Many state Medicaid programs already charge copayments for prescription drugs, non-emergent emergency room visits, and dental services. Acknowledging the desire for greater authority in this area, CMS plans to publish a proposed rule in 2013 asking for comments on updating and simplifying policies around cost-sharing requirements to promote the most effective use of services and to assist states in identifying cost-sharing flexibilities. CMS also plans to propose to allow states to establish higher cost-sharing for non-preferred drugs, and to impose higher cost-sharing for non-emergency use of the emergency department. This cost-sharing flexibility would apply to individuals at all income levels.

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Can you provide any insight or additional details on what that means and how that would look for states? For example, when Arizona asked for a waiver amendment to implement a no-show fee of $25 for missed Medicaid physician appointments, they were told "ok" IF they:

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iii. **Required providers to submit plans certifying that Medicaid recipients be notified of all appointments 48 hours in advance, offered notification in multiple ways (phone/text/email) and tracked how notifications were given.**

Would requirements like these be part of a global waiver you refer to or do you envision greater flexibility for states?

Answer: We are interested in working with states to promote better health and health care at lower costs and have been supporting, under a grant program established by the Affordable Care Act, State initiatives that are specifically aimed at promoting healthy behaviors that help prevent chronic disease. Promoting better health and healthier behaviors is a matter of importance to the health care system generally, and state Medicaid programs, like other payers, can shape their benefit design to encourage such behaviors while ensuring that the lowest income Americans have access to affordable quality care. We invite states to continue to come to us with their ideas, including those that promote value and individual ownership in health care decisions as well as accountability tied to improvement in health outcomes.

The Honorable Tammy Baldwin

1. **A central question with regard to the Medicaid expansion in Wisconsin remains the federal matching rate for our eligible population of non-caretaker adults under 138 percent of the poverty level. The FAQ issued on December 10, 2012 appears to clarify that Wisconsin would initially receive the 100 percent federal match rate for all or nearly all of those adults because our existing coverage, which has been capped, is a limited benefit. Does the US Department of Health and Human Services agree with the assessment in the recent Urban Institute and Kaiser Family Foundation's report that the 11 states with limited benefit programs, including Wisconsin's BadgerCare Core program, will receive the higher 100 percent match rate in 2014 for all expansion-eligible adults?**

Answer: The Centers for Medicare & Medicaid Services (CMS) understands that the determination of how to apply the appropriate Federal matching rate to services for eligible beneficiaries will have an impact on states' budgets. CMS is working directly with states to help them make this determination.

In the specific case of Wisconsin, the answer will depend on the nature of the health benefits coverage provided under the BadgerCare program as in effect on December 1, 2009.

The Affordable Care Act establishes a new adult eligibility group (see section 1902(a)(10)(A)(i)(VIII) of the Social Security Act), beginning on January 1, 2014, for individuals whose income is up to 133 percent of the Federal poverty level. Furthermore, the Federal matching rate for the expenditures for individuals in the new adult eligibility group who meet the definition of "newly-eligible" (in section 1905(y)(2) of the Social Security Act) is 100 percent beginning January 1, 2014. Such increased Federal matching is lowered to 90 percent effective January 1, 2020. The Affordable Care Act defines a "newly-eligible" individual as an individual "who, as of December 1, 2009, is not eligible under the state plan or waiver of the plan for full benefits or for benchmark coverage....or for benchmark-equivalent coverage." We will work with the state to determine whether the BadgerCare program, as in effect on December 1, 2009, offered such coverage.

State of Wisconsin
Department of Health Services

Scott Walker, Governor
Dennis G. Smith, Secretary

February 4, 2013

Joseph R. Pitts
Chairman
Committee on Energy and Commerce
Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Chairman Pitts:

Thank you again for the opportunity to appear before the Subcommittee on Health on December 13, 2012, to provide important testimony regarding the uncertain state impacts of the Patient Protection and Affordable Care Acct (PPACA), Exchanges and Medicaid Expansion.

Per your request I am providing responses to the additional questions submitted by Members following the hearing. Should you have any further questions please do not hesitate to contact me.

Sincerely,

Dennis G. Smith
Secretary

1 West Wilson Street • Post Office Box 7850 • Madison, WI 53707-7850 • Telephone 608-266-9622 •
dhs.wisconsin.gov
Protecting and promoting the health and safety of the people of Wisconsin

The Honorable Michael C. Burgess, M.D.

1. In Secretary Sebelius' letter to states on Monday, December 10, 2012, she cited that states are likely to see net savings from the Medicaid expansion. In my home state of Texas there are 3.3 million people currently enrolled in the Medicaid program. This costs Texas taxpayers $7 billion annually from the state's general revenue fund alone. Medicaid provisions in the Patient Protection and Affordable Care Act (PPACA) are projected to add an additional $9.1 billion in order to maintain current service levels in Texas and it is unclear how the state will cover those extra costs. **How will your respective states (Wisconsin, Pennsylvania, and Louisiana) cover the costs incurred due to the health care law—both in the first three years, when federal funding is available, and into the future?**

   In the current biennium, the increase in funding for our Medicaid programs was provided through a disproportionate share of new state revenues and diversion in resources from other priorities such as education. We believe that without fundamental Medicaid reform, this experience is likely to be repeated and continue well into the future.

   Wisconsin has not yet made a decision on expanding Medicaid. We will do so as part of the state's biennial budget process. We have done considerable analysis as input to the decision making process, but even at this late date, we still do not know key information. Wisconsin had previously expanded eligibility for adults but we do not know whether we will receive the 100% federal matching rate for the childless adult population. That decision will swing hundreds of millions of dollars between the federal budget and the state budget over time. Of course, the taxpayer pays 100% of the cost regardless of which government entity is paying.

   You will note that Secretary Sebelius indicated that States are "likely" to see net savings from the Medicaid expansion. That is far from a guarantee and fails to reflect future obligations. Several provisions in PPACA shift costs back to States over time. While the PPACA provides enhanced funding for the new adult group starting in 2014, it does not account for other residual impacts that States are most certain to face as a result. Of these we are most concerned with the impacts on existing populations due to the individual mandate, employer behavior, and provider rates. If the PPACA's individual mandate has a similar impact as the one contained in the Massachusetts's law, States existing Medicaid populations could see a significant increase due to the potential woodwork effect.

   We believe it is most prudent to project a high take-up rate after all, that is the goal and expectation. Based on previous experience in the state Children's Health Insurance Program (CHIP), and the highly anticipated outreach campaign that will begin this year, it seems likely that States will realize this impact. As you know, PPACA contains no enhanced funding for the increase to existing populations. Large employers are facing a daunting decision in 2014, provide affordable health coverage as dictated by PPACA or drop coverage and pay a penalty. The PPACA includes a penalty on employers for employees that receive federal tax credits offered through exchanges, or employer sponsored coverage that is deemed unaffordable based on the employee's income. In both situations, it may be in the employer's financial interest to simply pay the penalty and allow the employee to obtain

coverage through the exchange, or through the state's Medicaid program. The Annual Employer Health Care Benefits Survey for greater Milwaukee shows that as many as 10 percent of Wisconsin's largest employers may drop coverage, which would equate to more than 300,000 Wisconsin employees losing employer sponsored coverage. Of these 300,000 employees, we estimate that as many as 16,000 would be eligible for Medicaid. Finally, we are very concerned about the impact on provider rates. Should coverage of the existing populations increase we do not believe the provider community is adequately prepared to handle the resulting demand and increased utilization. There will be tremendous pressure to increase rates. It is obvious that HHS recognizes this dynamic given the PPACA provision to increase Medicaid primary care physician rates. But what about the rest of the provider community? States that do not increase program rates may see access restricted, sending more people into emergency rooms and urgent care clinics for routine care.

Certainly, it is likely that some individuals currently on Medicaid will migrate to the health exchange and tax subsidies. But on balance, we do not believe savings will offset the costs over time.

Do you anticipate your states seeing the supposed "net savings" the Secretary claims will accrue to states?

For the reasons previously cited we are skeptical that States are likely to realize a net savings due to the expansion. In fact, the headline in the *Milwaukee Journal Sentinel* on January 26, 2013 read, "State Could Save Money by Not Expanding Medicaid Program." We also believe States and will be left trying to find additional state revenues or reductions in other state priorities, such as education, to cover other impacts associated with the PPACA.

2. After reading portions of the law and regulations that have been issued, it seems very clear that the design and operation of exchanges are controlled by the requirements of the statute and rules issued by HHS—regardless of whether a state chooses to run it or default into a federal exchange. There seems to be a discrepancy related to federal versus state authority under the law which prompts the following questions:

    a. Must states follow new federal requirements related to essential health benefits?

    b. Must states follow federal requirements related to guaranteed issue and community rating?

    c. Must states follow new federal rules regarding medical loss ratio?

    d. What about requirements related to network adequacy?

In light of these requirements, does the law provide you any real discretion or flexibility to oversee and design your insurance markets as you see fit?

There are important distinctions between the statutory requirements and how the Secretary has chosen to use her authority. We were initially hopeful that state-based exchanges that met the functional requirements of the statute would be possible. But this optimism faded over

time as regulatory and sub-regulatory guidance became available. We also stress that we took seriously the statutory deadlines that the Secretary would begin reviewing state exchanges in January 2013. We had to make critical decisions and commitments of state resources that could not wait for the delays that have occurred. Now, of course, deadlines have been further delayed and key functional parts such as the data hub will not work as previously promised. Our decision not to pursue a state based exchange has been validated by events.

Many of the problems associated with the exchanges were could have been avoided had the federal government chosen to given States true flexibility. Instead, the federal government will is going to spend billions of dollars creating massive new government agencies that will leave consumers confused and frustrated. Scarce resources will be wasted as we are getting systems changes in a piecemeal fashion. This will mean much work will have to be redone.

We continue to believe that the federal government lacks the experience and knowledge necessary to regulate a competitive health insurance market in Wisconsin. We are very concerned about the impact to our competitive and diverse health insurance market that has served the people of Wisconsin so well.

Federal exchanges that begin in October 2013 are not going to be the "real time," consumer friendly experience that has been promised. The federal government has yet to share a viable business plan for bringing federal exchanges on line. Nor has it shared its contingency plan.

3. You noted in your testimony that you are not confident the federal government has adequately prepared for handling an unprecedented number of applications, verifications, and enrollments in 2014. **With more than $14 Billion in overpayments made in the Medicaid program each year due to poor eligibility review, what policy changes do you recommend that can ensure states and the federal government are enrolling individuals properly?**

There are various sources of Medicaid overpayments. Overall, PPACA will likely make the situation worse, not better. Start with repealing the new provision giving hospitals the right to provide presumptive eligibility. Allowing a provider, with no opportunity for the state to intervene, the authority to commit taxpayer dollars should be viewed as an impermissible delegation of authority. One of the basic tenets of public administration is responsibility and authority should not be separated. When they are separated, unintended consequences are sure to follow.

Medicaid is also one of the most complicated eligibility systems to run efficiently and accurately. PPACA has shifted the burden of proof from individuals applying for the program to the state which raises concerns. Of all of the public assistance programs, the value of Medicaid benefits is at the top of the list. For the vast majority of individuals and families on Medicaid, these services will be provided at no cost to them. Requiring appropriate documentation and procedures to protect the taxpayer's interest should not be viewed as a burden or an unrealistic expectation. It is also a mistake to place a disproportionate reliance on automated data systems because they are not currently capable

of doing everything policymakers think they can do. There will always be a human element to the process.

In order to minimize eligibility determination errors, the federal government would be wise to follow Wisconsin's lead in accessing and utilizing the most current financial and non-financial data sources. The majority of low income individuals seeking health care do not file annual income taxes, and relying on attestations for those individuals seeking the new federal tax credits will result in exceedingly higher error rates and overpayments. Furthermore, eligibility for Medicaid and tax credits should be synchronized. Using 18-month old tax records for those individuals that do file taxes annually will result in frustration at filing should the individual's income have increased resulting in an unforeseen tax burden. HHS and IRS are investing millions in a federal data services hub that will do nothing to prevent these types of overpayments but simply move current information around more efficiently. Instead they should be investing in a way to obtain information that is current and accurate.

Federal regulations also assume armies of insurance agents, navigators, and community helpers are going to be trained in complex policies that still have not been finalized.

The Honorable Marsha Blackburn

1. **I'm curious if you agree with the numerous independent studies which show the health insurance tax will drive up premiums for individuals, families, small businesses, and seniors, result in higher overall health care costs, and slow job growth.**

   Wisconsin agrees with these studies. The new excise tax facing insurers in 2014 will come on top of the existing medical loss ratio requirements, and insurers will be forced to pass on these additional costs through higher premiums and cost sharing for individuals, employers, and public assistance programs. Many small employers in the health care sector, such as nursing homes and home health agencies will be hit with new costs that they will expect to pass back to the Medicaid program.

2. The health insurance tax also covers Medicare Advantage and Medicaid Managed Care. As a result, the government is taxing itself. **Particularly for our state witnesses, do you think that the health insurance tax will negatively impact your state Medicaid program?**

   Yes, Wisconsin believes that the State will minimally need to make up for 40 percent of the tax increase through higher capitation rates or a comparable tax shift for the existing populations enrolled in a managed care program.

How will your state respond? Are you likely to raise taxes or cut other programs and services?

The Wisconsin BadgerCare Plus Program will likely cover the increased tax through taking a larger share of the state's general revenue and/or reduce funding for other state priorities such as education as a result of the gap created by the tax.

Since the authors of the law states at the time that the health insurance tax was intended to pay for the subsidies in the exchanges and the Medicaid expansion, shouldn't the federal government delay or reconsider altogether the collection of this tax since many states have opted to run their own exchange or expand their Medicaid programs?

Now that the differences between the authors' assumptions and economic realities are apparent, federal officials have an obligation to reconsider the inequities and unintended consequences that accompany PPACA. Reform was supposed to lower the cost of health care. That fundamental promise is not being kept. As the flaws in PPACA are exposed, the authors have the obligation to fix them, not merely shift blame for their poor design and flawed economic theories to the States.

PPACA provides no direction to what HHS or IRS must do with unspent funds. Why should the IRS collect this tax, and drive up costs, harm and already fragile economy, for benefits that do not seem to be imminent?

This could not be more true in the State of Wisconsin. Wisconsin has already achieved the majority of PPACA's objectives having one of the nation's lowest uninsured rates in addition to outstanding quality of care. PPACA has the potential to actually increase the number of uninsured in Wisconsin due to the loss of employer-based coverage and costlier health care for individuals and employers.

If you accept the premise of why the tax was included in the law, would you not delay or reconsider the collection of the tax now, in order to conform it to the reality in the marketplace?

Yes, minimally the tax provision should be modified to be conditional on the actual impacts as a result of PPACA. With that said, even a delay or reconsideration of the tax likely creates sufficient uncertainty for insurers that they will need to factor in some type of increase as it is based on enrollment premium and would be applied retroactively.

3. First off, I understand that most States have adopted Medicaid managed care to improve outcomes and lower costs in their program. In fact, more than two-thirds of States use comprehensive managed care to cover more than half of all Medicaid beneficiaries across the country. **Wouldn't you agree that managed care—and the organizations that provide it—are essential partners in delivering care to enrollees and are poised to cover the majority of the expansion population?**

For SFY12 Wisconsin's non-elderly/disabled managed care enrollment is 85 percent. Consequently, if Wisconsin expanded coverage to the new adult group in 2014 the vast majority would be enrolled in managed care and it would be very important that we work closely with these organizations in developing a benchmark health plan that provides essential benefits.

4. We all are aware that many States are still facing very hard budget choices. State lawmakers are trying to find savings anywhere they can, and many are looking to expand managed care in order to make Medicaid more efficient. **Why has CMS dragged its feet in approving managed care waivers and allowing states to use proven approaches to controlling program costs and improving quality?**

   CMS should do more to help States implement innovative service delivery models. In Wisconsin, we spent more than a year negotiating with CMS on the design of a medical home for foster children. We have also been trying to work with CMS on the design of a managed care model we call "Virtual PACE," which aims to truly integrate funding streams and care delivery for Medicaid enrollees who are also Medicare eligible and who live in nursing homes. The goal of the project is to improve care outcomes for recipients while also securing savings for both the state and federal government. We remain enthusiastic to work with Melanie Bella and the Medicare-Medicaid Coordination Office. But it has become apparent over time that there is great resistance to change in other CMS offices. It is frustrating when senior CMS officials publicly and frequently acknowledge that there are excess costs in serving the dual-eligible population that are avoidable but maintaining the status quo seems to be the priority for the agency.

   If the federal government truly intends to bring innovation to health care, it is going to have to re-examine its underlying perspective that the federal government must control every decision. There are several examples of federal initiatives within CMS that are failing because of unnecessarily rigid and prescriptive federal policies. Innovation, by its very nature, involves risk-taking and challenging the status quo. The creativity of States should be welcomed, not stifled.

5. Even though States are trying their hardest to control Medicaid costs, they still continue to increase. **What's the average annual increase in Medicaid program costs? And what is driving the cost increases?**

   Total expenditures in the Wisconsin Medicaid program grew by 42 percent from SFY 2008 to SFY 2012. The program has experienced cost increases in recent years both in enrollment and costs per enrollees. Caseloads increased by nearly 40 percent during that same time period. Costs per enrollee increased by an average of 5 percent from 2004 to 2009, but has slowed since. Before factoring in the impact of PPACA, we project that total Medicaid costs in Wisconsin (reflecting both enrollment and cost per enrollee) will grow by 3.9 percent in SFY 13, 1.3 percent in SFY 14, and 4.4 percent in SFY 15. Nationally, Medicaid expenditures are expected to grow by 6 percent through 2015. The below average growth we project for Wisconsin's Medicaid program, compared to the national average, stem from cost savings reforms that we have implemented in the last two years.

6. **How does the rate of Medicaid cost growth compare to the rate of growth in payments made to managed care organizations to deliver Medicaid benefits?** If the costs of Medicaid benefits are increasing each year, it stands to reason that payments to managed care organizations would need to be adjusted accordingly so these companies could cover their increasing claims expenses. But rates are not keeping pace. **Why don't rates reflect Medicaid market realties?**

   In Wisconsin, we set Medicaid managed care rates to reflect current service utilization among HMO enrollees. Federal rules require states to set Medicaid managed care rates that are "actuarially sound." Each year, the Department works with its actuaries to project what services HMO members will use, based on prior year trends. The cost of these services is then calculated based on current fee for service rates, with additional allowances for administration and case management.

7. One of the reasons that States seek flexibility for the Medicaid Programs is due to the fact that medical inflation continues to skyrocket. Frankly, States want to shift that financial risk to the private sector. But in doing so, shouldn't we make sure that both the States and Federal Government are adequately acknowledging the costs that drive rates paid to managed care organizations? CMS and States have the authority and responsibility to ensure that rates for managed care organizations are sufficient. **What is your Agency doing to ensure an adequate rate for these managed care organizations? If we fail to ensure the rates are sufficient, won't these companies be forced to leave the market just when the Medicaid program is scheduled to expand? Haven't some companies already gotten out of managed care in some States because the rate environment was no longer viable?**

   As stated in the answer to question 6, the Department conducts a rigorous actuarial analysis to develop managed care rates. These rates are reviewed and approved by CMS. While some managed care organizations have chosen to leave certain Medicaid product lines in specific regions of the state for their own business reasons, Wisconsin Medicaid continues to have a very robust managed care program with several high quality, financially sound HMOs participating.

State of Uncertainty: Implementation of PPACA's Exchanges and Medicaid Expansion
Responses to follow-up questions
Bruce D. Greenstein, Secretary
Louisiana Department of Health and Hospitals
January 30, 2013

The Honorable Michael C. Burgess, M.D.

1. **In Secretary Sebelius' letter to states on Monday, December 10, 2012, she cited that states are likely to see net savings from the Medicaid expansion. In my home state of Texas there are 3.3 million people currently enrolled in the Medicaid program. This costs Texas taxpayers $7 billion annually from the state's general revenue fund alone. Medicaid provisions in PPACA are projected to add an additional $9.1 billion in order to maintain current service levels in Texas and it is unclear how the state will cover those extra costs. How will your respective states (Wisconsin, Pennsylvania, and Louisiana) cover the costs incurred due to the health care law – both in the first three years, when federal funding is available, and into the future? Do you anticipate your states seeing the supposed "net savings" the Secretary claims will accrue to states?**

   ANSWER: Louisiana has chosen not to participate in the Medicaid expansion due in part to the long-term liabilities associated with growing the entitlement program. In fact, the Kaiser Family Foundation and the Urban Institute report recently released reveals that the expansion creates winners and losers among states. Their cost estimates, which actually fail to capture the full administrative costs and other impacts, vary widely among states. For example, the New England and Mid-Atlantic region states combined will save almost $16 billion in state funds over 10 years. During that same time, states in the South-Atlantic, will be paying at least almost $22 billion more. The Governors of Massachusetts, New York, Maryland and Vermont combined alone will shift nearly $23 billion of state costs to federal taxpayers. At the same time, my state is projected in the same report to see a growth in state costs of at least nearly $1.8 billion.

2. **After reading portions of the law and regulations that have been issued, it seems very clear that the design and operation of exchanges are controlled by the requirements of the statute and rules issued by HHS – regardless of whether a state chooses to run it or default into a federal exchange. There seems to be a discrepancy related to federal versus state authority under the law, which prompts the following questions-**

   a. **Must states follow new federal requirements related to essential health benefits?**
   b. **Must states follow federal requirements related to guaranteed issue and community rating?**
   c. **Must states follow new federal rules related to actuarial value?**
   d. **Must states follow new rules regarding medical loss ratio?**
   e. **What about requirements related to network adequacy?**

   In light of these requirements, does the law provide you any real discretion or flexibility to oversee and design your insurance markets as you see fit?

   ANSWER: The State of Louisiana agrees with your concern regarding lack of flexibility in the design and operation of the Exchanges. Because we can discern no meaningful difference between a state running its own Exchange or a state deferring to the Federal government, the State of Louisiana

decided not to accept the risks associated with assuming the responsibility for creation and operation of a State-Based Exchange.

The Federal government requires that either states enforce most of the requirements you cited on its insurance market (for the Medical Loss Ratio, HHS has primary enforcement authority) or the federal government will step in and enforces these requirements mandated by the PPACA in the state. HHS has repeatedly said that it does not want this responsibility and wants States to retain their traditional regulatory authority over insurance. However, HHS has not provided complete information about how a State is supposed to pay for enforcing these Federal requirements.

For example, the PPACA requires that all plans on the small group and individual marketplaces meet essential health benefits and actuarial value. This applies to plans both inside and outside of the Exchange. In recent guidance, the federal government has stated that it expects a state, no matter what Exchange model it will have, will enforce these wider market reforms. However, there is no guaranteed funding stream to do this. For 2014, HHS has said grant funding will be available. However, past 2014, "HHS anticipates continued funding, under a different funding vehicle..." This funding vehicle has not been specified. HHS therefore expects that if state law does not meet the standards prescribed by the PPACA, federal law will preempt the state law and the state will enforce the federal requirements without a funding stream for reimbursement of the S\state's expenditures. It makes no sense for states to take this additional role and thus become responsible for these additional costs, especially since HHS will assume regulatory authority of the specific requirement if the state enforcement does not meet federal standards.

With this high level of regulation on states' private insurance markets, there is no opportunity for states to have discretion or flexibility to innovate their insurance markets for our residents' benefit.

The Honorable Marsha Blackburn

1. **I'm curious if you agree with the numerous independent studies which show the health insurance tax will drive up premiums for individuals, families, small businesses, and seniors, result in higher overall health care costs, and slow job growth.**

   ANSWER: Yes, the PPACA-defined Exchanges provide for rigid federal control over the coverage options available to consumers, raising costs and limiting choice. In fact, a study recently released by AHIP and the Louisiana Association of Health Plans estimates that the ACA premium tax will force policyholders in my state to pay over $2,000 more for single coverage and over $4,500 more for family coverage for individuals over the next ten years. Similar increases are noted for small and large group employers. This is a significant burden on individuals and families in Louisiana and across the country.

   See the report here: http://www.ahip.org/News/Press-Room/2012/Health-Insurance-Tax-to-Raise-Costs-for-Louisiana-Consumers,-Employers-by-More-than-$1-Billion.aspx

2. **The health insurance tax also covers Medicare Advantage and Medicaid Managed Care. As a result, the government is taxing itself. Particularly for our state witnesses, do you think that the health insurance tax will negatively impact your state Medicaid program? How will your state respond? Are you likely to raise taxes or cut other programs and services?**

ANSWER: Yes, the health insurance tax will impact the cost of our Medicaid managed care program, Bayou Health. According to a Milliman study from January 2012, the PPACA health insurer fee is expected to raise Medicaid managed care rates between 2.1% to 2.4% in the State of Louisiana over the next few years, which means that there will be a cost to the State in the hundreds of millions of dollars. It is uncertain how our state will respond to these additional costs. However, given our state's lean fiscal picture, it is likely that additional service reductions in other programs would be necessary. Managed care has proven itself to lead to savings for state Medicaid programs, and this health insurer tax penalizes states for sound fiscal management.

3. **Since the authors of the law stated at the time that the health insurance tax was intended to pay for the subsidies in the exchanges and the Medicaid expansion, shouldn't the federal government delay or reconsider all together the collection of this tax since many states have opted not to run their own exchange or expand their Medicaid programs? PPACA provides no direction to what HHS or IRS must do with unspent funds. Why should the IRS collect this tax, and drive up costs, harm an already fragile economy, for benefits that do not seem to be imminent? If you accept the premise of why the tax was included in the law, would you not delay or reconsider the collection of the tax now, in order to conform it to the reality in the marketplace?**

   ANSWER: The State of Louisiana shares concerns regarding the PPACA's requirement that we must pay this tax instead of providing needed health care services to our residents. It is not clear to our State why Congress decided to include this tax in the PPACA. However, the State of Louisiana supports the complete repeal of this tax or a change to this law exempting Medicaid managed care programs from this burdensome tax.

4. **First off, I understand that most States have adopted Medicaid managed care to improve outcomes and lower costs in their programs. In fact, more than two-thirds of States use comprehensive managed care to cover more than half of all Medicaid beneficiaries across the country. Wouldn't you agree that managed care - and the organizations that provide it – are essential partners in delivering care to enrollees and are poised to cover the majority of the expansion population?**

   ANSWER: While Louisiana is not participating the expansion as envision by PPACA, we agree that Medicaid managed care organizations are essential partners in improving health outcomes and better controlling costs. Louisiana launched a comprehensive statewide managed care program in 2012, which now covers two-thirds of our state's 1.24 million Medicaid enrollees. Participants choose among five health plans, divided between two models of delivery and financing: fully capitated MCOs and limited risk shared-savings organizations. The program is expected to save Louisiana $135.9 million in the current fiscal year. Furthermore, health plans will be measured against an exhaustive set of quality and performance metrics, facing financial rewards or penalties based on their performance.

5. **We all are aware that many States are still facing very hard budget choices. State lawmakers are trying to find savings anywhere they can, and many are looking to expand managed care in order to make Medicaid more efficient. Why has CMS dragged its feet in approving managed care waivers and allowing states to use proven approaches to controlling program costs and improving quality?**

   ANSWER: It is not clear to Louisiana why CMS has been slow to approve some reform efforts. Louisiana submitted a comprehensive research and demonstration waiver request to CMS in December 2008. Early in 2009, became clear to the state that CMS under President Obama and

Secretary Sebelius would not be taking action on our request. CMS's lack of interest in pursuing Louisiana's innovative state-led reform effort forced the state to pursue other avenues to enact reform. In Louisiana's case, we ultimately sought authority through a State Plan Amendment (SPA), which necessitated timely action by CMS, but did not offer as much flexibility as an 1115 research and demonstration waiver.

6. **Even though States are trying their hardest to control Medicaid costs, they still continue to increase. What's the average annual increase in Medicaid program costs? And what is driving the cost increases?**

ANSWER: According to CMS's National Health Expenditure (NHE) report, Medicaid spending nationally grew 2.5% to $407.7 billion in 2011. This is down from growth rates of 5.9% in 2010, 8.8% in 2009, 5.9% in 2006 and 6.4% in 2007. Since 2000, the average annual national Medicaid growth rate is 7.1%. The NHE report projects growth rates of 9.2% in 2012 and 7% in 2013.

Once normalized by the impacts of money management techniques, Louisiana's true Medicaid spending growth rate has been lower than the national growth rate or anticipated national growth rate since 2008. Since 2000, Louisiana's average annual Medicaid growth rate is 5.6%.

These increases in costs can be attributed to a number of factors. Medicaid spending typically has an inverse relationship with economic performance. Spending growth accelerated during the recent recession period as enrollment surged in many parts of the country. Enrollment growth in Louisiana peaked in 2008, at nearly 8% in one year.

Increases in service utilization, coupled with medical cost inflation, also contribute to cost growth in the program. Service utilization increases among long-term care programs can have the largest impact on overall cost as individuals age into the system. Louisiana has taken steps to address cost growth in its home and community-based waiver programs, and is actively seeking innovative ways to manage long-term care programs going forward.

7. **How does the rate of Medicaid cost growth compare to the rate of growth in payments made to managed care organizations to deliver Medicaid benefits? If the costs of Medicaid benefits are increasing each year, it stands to reason that payments to managed care organizations would need to be adjusted accordingly so these companies could cover their increasing claims expenses. But rates aren't keeping pace. Why don't rates reflect Medicaid market realities?**

ANSWER: In Louisiana, the rates paid to managed care organizations do reflect Medicaid market realities under its managed care prepaid program. Our managed care plans are paid a risk-adjusted, actuarially sound capitation rate. This means that payment rates have been set based on historical utilization in the Louisiana Medicaid program for the services included in the plans' scope of responsibility. Louisiana works with its external, independent actuaries to ensure that the rate is adequate and meets applicable federal requirements.

While our managed care program is still in its infancy, we are continually evaluating different aspects of the program. We have made some adjustments to rates as additional services were brought under the scope of the MCOs or calculations were refined. Louisiana will regularly update its rates (up or down) based on ongoing utilization trends and changes in the program.

Another significant point is that managed care plans have more tools at their disposal than fee-for-service Medicaid to better control costs and improve outcomes, primarily by preventing non-emergent use of the ER and unnecessary utilization of in-patient hospitalizations. Louisiana expects its

managed care health plans to better manage unnecessary utilization than has historically occurred in the legacy Medicaid program, slowing the program's rate of growth.

As the Medicaid managed program begins to provide information to Louisiana regarding its actual experience, those costs and claims experience are being considered as rates are determined for future periods.

It is important to note that there were some decreasing trends recognized within the Medicaid program prior to the effective date of the managed care program in Louisiana. Although the historical experience was not assumed to continue indefinitely, if a managed care organization's actual experience is materially different than what was assumed, there are processes for states to review and adjust accordingly. Louisiana is currently in discussions with the managed care organizations to understand their actual experience as well as identify overall care and cost management objectives for the program. It is important for states to maintain open and clear communications with its managed care plans.

8. **One of the reasons that States seek flexibility for their Medicaid Programs is due to the fact that medical inflation continues to skyrocket. Frankly, States want to shift that financial risk to the private sector. But in doing so, shouldn't we make sure that both the States and the Federal Government are adequately acknowledging the costs that drive rates paid to managed care organizations? CMS and States have the authority and responsibility to ensure that rates for managed care organizations are sufficient. What is your Agency doing to ensure an adequate rate for these managed care companies? If we fail to ensure that rates are sufficient, won't these companies be forced leave the market just when the Medicaid program is scheduled to expand? Haven't some companies already gotten out of managed care in some States because the rate environment was no longer viable?**

ANSWER: Some states have experienced the exit of managed care plans from the Medicaid managed care programs. In Connecticut, for example, there has been a complete exit in the market. Other states have seen various plans enter and leave the market.

We agree that an adequate rate for the provision of services is, as described, a key element in the ongoing functioning of a Medicaid managed care program. The determination of an adequate rate, however, includes multiple issues that warrant consideration. Although rates are ultimately defined as specific per member per month (PMPM) amounts, various actuarial and policy considerations play a role in how such amounts are determined.

In Louisiana's case, the Medicaid managed care program will reach a full plan year or experience on February 1, 2013, and therefore, understanding the managed care organization's experience remains a work in progress. Louisiana is working with the plans to obtain reliable encounter data, documenting the type and cost of services provided. Once encounter data is readily available for analysis, this will help the state and the managed care organizations better understand how the tools the plans have implemented have impacted costs and outcomes.

We agree that managed care rates should reflect cost drivers associated with that type of delivery system; however, such an approach must also include assumptions regarding expected care and cost management. The managed care organization's costs are relevant to the rate process, but cannot be taken in isolation and must be evaluated in the context of expected performance. To that end, Louisiana is in the process of obtaining multiple sources of information regarding managed care

organization's actual experience in providing services and is seeking to use such information in the rate setting process.

Given the infancy of the program, some of this information will be provided directly by the plans, subject to review for accuracy, completeness and relevance of any information provided to the state.

Gary D. Alexander
Secretary
PA Dept. of Public Welfare
January 30, 2013

RE: December 13, 2012 Health Subcommittee hearing follow-up questions from Rep. Burgess and Rep. Blackburn

The Honorable Michael C. Burgess, M.D.

1. **In Secretary Sebelius' letter to states on Monday, December 10, 2012, she cited that states are likely to see net savings from the Medicaid expansion. In my home state of Texas there are 3.3 million people currently enrolled in the Medicaid program. This costs Texas taxpayers $7 billion annually from the state's general revenue fund alone. Medicaid provisions in PPACA are projected to add an additional $9.1 billion in order to maintain current service levels in Texas and it is unclear how the state will cover those extra costs. How will your respective states (Wisconsin, Pennsylvania, and Louisiana) cover the costs incurred due to the health care law – both in the first three years, when federal funding is available, and into the future? Do you anticipate your states seeing the supposed "net savings" the Secretary claims will accrue to states?**

   In Pennsylvania we project there will be a net cost increase for the commonwealth of $222 million in the first year and totaling $4.1 billion through 2021.

2. **After reading portions of the law and regulations that have been issued, it seems very clear that the design and operation of exchanges are controlled by the requirements of the statute and rules issued by HHS – regardless of whether a state chooses to run it or default into a federal exchange. There seems to be a discrepancy related to federal versus state authority under the law, which prompts the following questions-**

   The ACA requirements referenced are amendments to the Public Health Service Act (PHSA). Under the PHSA, state laws continue to be applicable "except to the extent that such standard or requirement prevents the application of a requirement" of the PHSA. See 42 U.S.C. §300gg-23, §300gg-62. Against that background:

   a. **Must states follow new federal requirements related to essential health benefits?**

      Yes. Under §2707 of the PHSA, added by §1201 of the ACA, all individual and small group products offered in the state must include the essential health benefit package as set forth in §1302(a) of the ACA. Note that under §1302(b)(4) of the ACA, the Secretary of Health and Human Services is authorized to "periodically update the essential health benefits."

   b. **Must states follow federal requirements related to guaranteed issue and community rating?**

      Yes. Under §2702 of the PHSA, as amended by §1201 of the ACA, each employer in the small group market and each individual in the individual market

is guaranteed to be issued a policy by a health insurance issuer to whom they apply for coverage. Under §2701 of the PHSA, added by §1201 of the ACA, community rating (allowing limited variations only based on family size, geography, age, and tobacco use) is required in the state's individual and small group markets.

c. Must states follow new federal rules related to actuarial value?

Yes. Under §2707 of the PHSA, added by §1201 of the ACA, all individual and small group products offered in the state must include the EHB package as set forth in §1302(a) of the ACA. That subsection describes the EHB package as including the specifically listed benefits, limited cost-sharing, and actuarial value levels of coverage.

d. Must states follow new rules regarding medical loss ratio?

Yes. Under §2718 of the PHSA, added by §1001 of the ACA, all health insurance issuers in the individual and small group markets must satisfy the 80% MLR requirement unless the state is granted an exception if the 80% level may destabilize the individual market in the state. All health insurance issuers in the large group market must satisfy the 85% MLR requirement, unless a state imposes a higher percentage.

e. What about requirements related to network adequacy?

Yes. Under §2702(c) of the PHSA, as amended by §1201 of the ACA, health insurance issuers in the individual and group markets are subject to broad network adequacy requirements. Regulations issued pursuant to the ACA (at 45 C.F.R. §156.230) have articulated more precise network adequacy requirements for qualified health plans that may be offered on an exchange.

In light of these requirements, does the law provide you any real discretion or flexibility to oversee and design your insurance markets as you see fit?

No. As noted above, the state only has flexibility if its market rules do not "prevent the application" of the ACA/PHSA requirements. In reality, it will be difficult for states to see innovation in their insurance markets because of the requirement that state laws not to prevent the application of the federal laws. Current regulations promulgated by Health and Human Services do not provide states with meaningful flexibility to regulate their insurance markets.

During the hearing, you engaged one of the Subcommittee members in a discussion on Pennsylvania's enrollment of individuals into Medicaid. Could you please elaborate on Pennsylvania's previous experience on Medicaid eligibility determinations and enrollment?

Longstanding statutory and regulatory requirements require the Pennsylvania Department of Public Welfare ("Department") to conduct semi-annual and annual reviews to determine continuing recipient eligibility for certain public assistance programs, including Medical Assistance (MA). Over a period of time, a backlog of MA eligibility

reviews ("redeterminations") developed. Beginning in July 2011 and continuing through December 2011, the Department took reasonable steps to resolve this operational backlog in a timely manner to ensure continued compliance with program requirements.

The Department's goals in connection with this operational effort were to resolve the backlog of eligibility redeterminations, to continue to ensure that those receiving benefits under the program are eligible, and to ensure that the program is being soundly administered.

To accomplish these goals, the Department reemphasized with program staff the requirements to apply existing policies and procedures for all redeterminations in accordance with applicable federal and state law. Through the efforts of the Department staff, the backlog of eligibility redeterminations was essentially resolved by the end of December 2011.

During the Hearing certain data was noted which allegedly demonstrated a significant decline in Pennsylvania MA enrollment. In fact, Medicaid enrollment data shows that 2,243,850 individuals were enrolled in Pennsylvania as of July 2011, and 2,199,885 individuals were enrolled as of August 2012. The overall numbers above are consistent (less than a 2% difference), and demonstrate that there was not a mass decrease in enrollment.

It is important to remember the fact that recipient eligibility is not static, as household circumstances change (for example, recipients move into the workforce, recipients move out of state, etc.), therefore, eligibility redeterminations, as required by law, are a common-sense practice to ensure program integrity. . In conducting these legally-required eligibility redeterminations, the Department ensures that both federal and state public resources are utilized in accordance with its legal authority.

4. **Governor Corbett announced yesterday that Pennsylvania would default into a federal exchange. In his announcement, he stated "It would be irresponsible to put Pennsylvanians on the hook for an unknown amount of money to operate a system under rules that have not been fully written." Can you elaborate further on how Pennsylvania will be on the hook for the cost of administering a program where the bulk of major rules will be written by the federal government?**

   Exchanges are required to be self-sustaining, i.e., no federal grant funding, for continued operations beyond January 1, 2015. ACA §1311(d)(5). These funds may be generated by "assessments or user fees or otherwise", but in any event will need to be sufficient to operate the exchange in accordance with all of the laws and regulations issued by the federal government, as well as any operational rules not codified.

5. **As you mentioned during the hearing, Pennsylvania has some experience with asset tests. However, the Affordable Care Act does not allow for the use of asset tests when determining Medicaid eligibility. Should Congress be concerned that millionaires might become eligible for Medicaid?**

   The sole use of modified adjusted gross income (MAGI) as the income eligibility standard is an incomplete measurement of an individual's wealth and provides a distorted

picture of who is truly in need of assistance. Eliminating states' ability to use asset tests could easily allow individuals with sufficient means to provide for themselves enrolling in Medicaid or other government programs – reducing the ability of states to use their limited resources to provide for those most in need. Pennsylvanian raised this question, among many others, in an August 2012 letter to Secretary Sebelius asking if this was truly the intent of HHS – to date we have received no response.

The Honorable Marsha Blackburn

1. **I'm curious if you agree with the numerous independent studies which show the health insurance tax will drive up premiums for individuals, families, small businesses, and seniors, result in higher overall health care costs, and slow job growth.**

   Yes. We expect that the taxes and other fees required of health insurance issuers will be factored into the premium costs of policies. We also expect the overall effect of the ACA taxes and charges, as well as EHB and other market requirements, will result in a net increase in premium costs for most policyholders.

2. **The health insurance tax also covers Medicare Advantage and Medicaid Managed Care. As a result, the government is taxing itself. Particularly for our state witnesses, do you think that the health insurance tax will negatively impact your state Medicaid program? How will your state respond? Are you likely to raise taxes or cut other programs and services?**

   The annual health insurance tax included in ACA is expected to be an industry-wide excise tax passed-through to consumers. State governments could be responsible for part of the tax as a Medicaid consumer. The level of state responsibility for the tax depends on the portion of the tax that Medicaid managed care plans are able to pass along to consumers in each individual Medicaid managed care market. To avoid the tax, states could seek to contract with Medicaid managed care providers that are exempt from the tax. However, price considerations must be weighed in light of other provider factors, including breadth of the network, ability to coordinate care and quality measures.

3. **Since the authors of the law stated at the time that the health insurance tax was intended to pay for the subsidies in the exchanges and the Medicaid expansion, shouldn't the federal government delay or reconsider all together the collection of this tax since many states have opted not to run their own exchange or expand their Medicaid programs? PPACA provides no direction to what HHS or IRS must do with unspent funds. Why should the IRS collect this tax, and drive up costs, harm an already fragile economy, for benefits that do not seem to be imminent? If you accept the premise of why the tax was included in the law, would you not delay or reconsider the collection of the tax now, in order to conform it to the reality in the marketplace?**

   The issue of collection and applicability of the taxes contained within the ACA are issues of federal law and not under the purview or jurisdiction of the states.

4. **First off, I understand that most States have adopted Medicaid managed care to improve outcomes and lower costs in their programs. In fact, more than two-thirds of States use comprehensive managed care to cover more than half of all Medicaid beneficiaries across the country. Wouldn't you agree that managed care - and the organizations that provide it – are essential partners in delivering care to enrollees and are poised to cover the majority of the expansion population?**

   Pennsylvania has a long history of Medicaid managed care, dating back to the early 1990's. By March 1, 2013, Pennsylvania will have implemented full statewide Medicaid managed care, and the vast majority of our current Medicaid recipients will be enrolled in physical and behavioral health managed care plans. We strongly believe in the benefits of managed care delivery systems and the ability of our contracted plans to provide better value for the state's money, as evidenced by our expansion of Medicaid managed care throughout the state, so we would certainly agree the managed care plans are essential partners in delivering care. At this point any new enrollees into the Medicaid program, regardless of whether the state decides to expand the program, will be enrolled in a managed care organization for the reasons we cite above.

5. **We all are aware that many States are still facing very hard budget choices. State lawmakers are trying to find savings anywhere they can, and many are looking to expand managed care in order to make Medicaid more efficient. Why has CMS dragged its feet in approving managed care waivers and allowing states to use proven approaches to controlling program costs and improving quality?**

   In Pennsylvania's recent experience, we have not found CMS to have delayed its approval of our Medicaid managed care waivers. In December, 2012 CMS approved a renewal of our managed care waiver, involving consolidation of two previous geographically-oriented managed care waivers and the completion of our statewide managed care expansion.

6. **Even though States are trying their hardest to control Medicaid costs, they still continue to increase. What's the average annual increase in Medicaid program costs? And what is driving the cost increases?**

   Over the last five years Pennsylvania has seen Medicaid program costs grow at an annual rate of approximately 5.6 percent. Some of the key drivers of Medicaid cost growth are:

   - Lack of flexibility in the program to incentivize healthy behavior
   - Patient acuity
   - Service utilization
   - New expensive technology
   - New drug treatments
   - Loss of federal funding (FMAP)
   - Increasing numbers of patients with high cost needs
   - Growing elderly population
   - Stagnant economy

7. **How does the rate of Medicaid cost growth compare to the rate of growth in payments made to managed care organizations to deliver Medicaid benefits? If the costs of Medicaid benefits are increasing each year, it stands to reason that payments to managed care organizations would need to be adjusted accordingly so these companies could cover their increasing claims expenses. But rates aren't keeping pace. Why don't rates reflect Medicaid market realities?**

   The Medicaid program continues to grow at an unsustainable rate, placing incredible strain on the Commonwealth budget. In fact, the Medicaid program now consumes more of our budget than any other state expenditure. With that challenge in mind, the Commonwealth continues to work with its Managed Care Organizations to find innovative ways to curb the growth in healthcare costs and, at the same time, provide fair rate adjustments as is required by law. The MCOs are our valued partners that provide critical access to healthcare for Pennsylvanians. Pennsylvania will always ensure that the MCOs receive the rate increases necessary to do their job.

8. **One of the reasons that States seek flexibility for their Medicaid Programs is due to the fact that medical inflation continues to skyrocket. Frankly, States want to shift that financial risk to the private sector. But in doing so, shouldn't we make sure that both the States and the Federal Government are adequately acknowledging the costs that drive rates paid to managed care organizations? CMS and States have the authority and responsibility to ensure that rates for managed care organizations are sufficient. What is your Agency doing to ensure an adequate rate for these managed care companies? If we fail to ensure that rates are sufficient, won't these companies be forced leave the market just when the Medicaid program is scheduled to expand? Haven't some companies already gotten out of managed care in some States because the rate environment was no longer viable?**

   All states are required by law to develop Medicaid managed care rates that are actuarially sound. The regulation (*42 CFR 438.6(c)*) sets forth the requirements that must be followed by states in the development of Medicaid managed care rates. It is important that Managed Care Organizations are compensated fairly to ensure their ongoing participation in the marketplace.

January 16, 2013

Mr. Andrew Allison, Ph.D.
Director, Division of Medical Services
State of Arkansas, Department of Human Services
112 West 8th Street
Little Rock, AR 72201-4608

Dear Dr. Allison:

Thank you for appearing at the Subcommittee on Health hearing entitled "State of Uncertainty: Implementation of PPACA's Exchanges and Medicaid Expansion."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for 10 business days to permit Members to submit additional questions to witnesses, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please e-mail your responses, in Word or PDF format, to carly.mcwilliams@mail.house.gov by the close of business on Wednesday, January 30, 2013.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

The Honorable Marsha Blackburn

1. **I'm curious if you agree with the numerous independent studies which show the health insurance tax will drive up premiums for individuals, families, small businesses, and seniors, result in higher overall health care costs, and slow job growth.**

   The subject matter is beyond my area of expertise. In addition to the premium tax the ACA includes numerous other provisions affecting both the cost of health care to individuals and the cost of health insurance, as well as the sources of payment for both. For each individual, family, business, or state government, it is the net impact of all of these factors that will drive their insurance purchasing and related economic decisions. The net financial impact may differ substantially both within and across the different groups identified above. My area of focus is the Medicaid program and I do not have the background to evaluate the net impact of the ACA on individuals, families, small businesses and seniors.

2. **The health insurance tax also covers Medicare Advantage and Medicaid Managed Care. As a result, the government is taxing itself. Particularly for our state witnesses, do you think that the health insurance tax will negatively impact your state Medicaid program? How will your state respond? Are you likely to raise taxes or cut other programs and services?**

   The State of Arkansas does not use managed care companies to administer its program, and we have not assessed the impact of this tax.

3. **Since the authors of the law stated at the time that the health insurance tax was intended to pay for the subsidies in the exchanges and the Medicaid expansion, shouldn't the federal government delay or reconsider all together the collection of this tax since many states have opted not to run their own exchange or expand their Medicaid programs? PPACA provides no direction to what HHS or IRS must do with unspent funds. Why should the IRS collect this tax, and drive up costs, harm an already fragile economy, for benefits that do not seem to be imminent? If you accept the premise of why the tax was included in the law, would you not delay or reconsider the collection of the tax now, in order to conform it to the reality in the marketplace?**

   I am not familiar with the funding required by the federal government to support exchange-based insurance subsidies and state-initiated Medicaid expansions, and am not in a position to comment on the scenarios described in the question.

4. **First off, I understand that most States have adopted Medicaid managed care to improve outcomes and lower costs in their programs. In fact, more than two-thirds of States use comprehensive managed care to cover more than half of all Medicaid beneficiaries across the country. Wouldn't you agree that managed care - and the organizations that provide it – are essential partners in delivering care to enrollees and are poised to cover the majority of the expansion population?**

   The State of Arkansas has not chosen to use managed care companies to administer Medicaid benefits.. To the contrary, Arkansas is engaged in a multi-payer statewide effort to develop and implement a comprehensive set of outcomes-based financial incentives that reward providers, rather than insurers, for improvements and efficiencies in health care.

5. **We all are aware that many States are still facing very hard budget choices. State lawmakers are trying to find savings anywhere they can, and many are looking to expand managed care in order to make Medicaid more efficient. Why has CMS dragged its feet in approving managed care waivers and allowing states to use proven approaches to controlling program costs and improving quality?**

   I would defer this question to representatives from CMS who are familiar with the timing and content of managed care waiver approvals.

6. **Even though States are trying their hardest to control Medicaid costs, they still continue to increase. What's the average annual increase in Medicaid program costs? And what is driving the cost increases?**

   The average annual increase in Arkansas Medicaid service costs between fiscal year 2007 and fiscal year 2012 was approximately 5.5%. However, costs in Arkansas Medicaid grew at an annual rate of less than 3% through the first 6 months of state fiscal year 2013. Cost growth over the previous five years was driven primarily by increases in service use per enrollee. Overall, spending per enrollee – consisting primarily of increases in service use -- explains 61% of the growth in Arkansas Medicaid spending over the last five years, while growth in the number of enrollees – especially the disabled -- explains the rest (39%). In the first half of state fiscal year 2013, per-person spending fell slightly, while enrollment continued to climb. Enrollment increases in 2013 are due primarily to growth in the number of aged and disabled beneficiaries. Growth in the number and costs of serving disabled beneficiaries explains just over half of the growth in Medicaid costs nationally between 1975 and 2009 [51.2%, source: MACPAC's June 2012 Report to the Congress on Medicaid and CHIP, page 81], and explains nearly exactly the same percentage of growth in Medicaid costs in Arkansas over the last five years [50.9%].

7. **How does the rate of Medicaid cost growth compare to the rate of growth in payments made to managed care organizations to deliver Medicaid benefits? If the costs of Medicaid benefits are increasing each year, it stands to reason that payments to managed care organizations would need to be adjusted accordingly so these companies could cover their increasing claims expenses. But rates aren't keeping pace. Why don't rates reflect Medicaid market realities?**

   I am not aware of research that demonstrates an unequivocal difference in cost growth in states that use managed care companies to administer Medicaid benefits. Arkansas does not use managed care companies to administer Medicaid benefits, and as a result I do not have access to information on annual costs for services reimbursed through Medicaid managed care companies.

8. **One of the reasons that States seek flexibility for their Medicaid Programs is due to the fact that medical inflation continues to skyrocket. Frankly, States want to shift that financial risk to the private sector. But in doing so, shouldn't we make sure that both the States and the Federal Government are adequately acknowledging the costs that drive rates paid to managed care organizations? CMS and States have the authority and responsibility to ensure that rates for managed care organizations are sufficient. What is your Agency doing to ensure an adequate rate for these managed care companies? If we fail to ensure that rates are sufficient, won't these companies be forced leave the market just when the Medicaid program is scheduled to expand? Haven't some companies already gotten out of managed care in some States because the rate environment was no longer viable?**

With their unmatched size and programmatic diversity, states and the federal government are well-positioned to internally finance the insurance risks associated with programs such as Medicare and Medicaid. Nevertheless, Arkansas is engaged in an effort to share the financial rewards of innovative improvements in care and service delivery with those who provide care and services to Medicaid beneficiaries. In this statewide multi-payer effort to transform health care payments, Arkansas Medicaid has not chosen to use private managed care companies. I am not familiar with the decisions of Medicaid managed care companies to leave markets in other states.

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