Transcript provided by the Kaiser Family Foundation[1]
(Tip: Click on the binocular icon to search this document)

Medicaid Expansion in Health Reform: National and State Estimates of Coverage and Cost
Kaiser Family Foundation
May 26, 2010

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

[START RECORDING]

DIANE ROWLAND: Good morning and welcome to the Barbara Jordan Conference Center for this discussion today of the Medicaid Expansion Option in Health Care Reform, looking at national and state estimates of both coverage impact and cost.

I'm Diane Rowland, the Executive Vice President of the Kaiser Family Foundation and the Executive Director of our Commission on Medicaid and the Uninsured, so obviously these estimates are of great importance to us as we try to look at the potential impact, not only at a national level but in the states of these coverage expansions, that allow childless adults to finally be covered under the Medicaid program and all individuals with incomes up to 133-percent of the poverty level.

There are many aspects of health care reform that will affect the states ultimately; this is just one piece. So there are other interactions that this study obviously does not take into account. Health reform as you know has lots of moving parts. So this is just a focus in on one aspect of health care

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

reform and not an attempt to give you all of the integrated impacts that may be there.

We know that the Congress, as it considered health reform, depended on the Congressional Budget Office, to give them estimates of the potential impact of these provisions on the nation and on health care spending at the federal level. But the CBO does not do state by state estimates, so we have tried to take and be as true to the CBO total numbers as possible and take a look at how that might distribute across the states.

There're a few caveats that I'd like to lay on the table before we begin. First of all, modeling is modeling, predicting is predicting and it's all based on trying to look at previous behavior to assume future behavior. There are obviously going to be many challenges and choices that states will make as they implement this health care reform bill. So this model tries to assume how things might happen in the future and it'll give you different ways to look at that, but it cannot in any way, say this going to be exactly how it's implemented.

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

That's also because one of the lessons of Medicaid is that not all states will behave the same. So if you have to make an assumption that all the states will have similar participation rates, you know that some states will fall behind and some states will move forward more aggressively.

So in looking at these numbers I think it very important to bear in mind that the impact of the Medicaid expansions will vary across the states and that individual states will undoubtedly be taking on the task of doing their own estimates of the impact, not only of these provisions but of the coverage in the exchanges as individuals above these income levels can become eligible for coverage through the exchange and get subsidized coverage. They'll be looking at other trade-offs in terms of the Medicaid legislation itself, that may affect their cost savings.

So, that I think as you look at these numbers it's very important to bear in mind that they give you a sense of how the numbers may distribute out by state, but they're not as firm and final as they will be in 2019, when we finally know what's happening with the legislation.

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

I do think that it's important to get some sense of how different states will fare - how those states that have had very low coverage levels, under Medicaid, will see their roles in increase; how states that have covered some of the individuals that are going to be covered under Medicaid now, under state-only programs will fare - and so that's why we've presented these numbers today. Take them with the caveats that we'll give you, but see them as a way of looking, at least, underneath the national numbers to get some sense of the variation of what will go on at the state level.

So I'm very pleased that we're able to finally put these numbers out and to have an ability to share them with you. We're going to start today by asking Robin Rudowitz, the Associate Director of our Kaiser Commission on Medicaid and the Uninsured here at the Kaiser Family Foundation, to just give you a brief overview of the provisions of the law, that we've tried to look at.

Then John Holahan, the Director of Health Policy Research Center at the Urban Institute and the lead author on the analysis will present the key findings. Then we're going

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

to turn to Alan Weil the Executive Director of the National Academy for State Health Policy and a member of our Kaiser Commission on Medicaid and the Uninsured, for some perspectives on the numbers, the state actions and the likely impact of a health reform and the Medicaid expansion.

So without further adieu, I'm going to turn to Robin to kick off our discussion. Thank you.

ROBIN RUDOWITZ: Thanks, Diane, and thanks everyone for coming today. As Diane said, I'm going to provide a brief overview of some of the key provisions in the Medicaid laws that relate to coverage and then turn it over to John.

What we see today when we look at the Medicaid program is that Medicaid definitely provides affordable and comprehensive coverage for certain categories of low-income individuals. The financing for the program is shared between states and the federal government.

The federal government on average pays about 57-percent of those costs. Medicaid also provides assistance for those dually-eligible for Medicare and Medicaid and also is the biggest payer and provider for long-term care services.

Medicaid is a critical player in the overall health care system.

What we see with health reform is that the new law essentially builds on many of these current roles by really expanding coverage to those who were previously not eligible, adding a lot of additional federal financing for that coverage, and also providing some more care coordination for the dual eligibles and new options related to long-term care. With health reform, Medicaid becomes an even more critical player in the overall health care system.

Again, when we look at Medicaid today we see that Medicaid along with CHIP has been a provider of comprehensive coverage for children, much more broadly than other categories of individuals and that coverage for parents has been much more limited in the Medicaid program and that coverage for childless adults, prior to health reform, was generally prohibited, unless the state had a waiver to cover those individuals or state funded program. There is also quite a bit of variation in coverage across the states.

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

Again, with health reform, we see that Medicaid is really a key element in providing new coverage to individuals, really broadening coverage for low-income individuals. On top of Medicaid, there're new subsidies for individuals with moderate income to purchase coverage in new health insurance exchanges.

Of course there's the maintenance and strengthening of employer sponsored coverage. I think the glue that holds a lot of this together is really the individual mandate for coverage and changes to health insurance market reforms that are all part of the overall legislation to expand coverage more broadly.

To look at the Medicaid provisions a little bit more specifically; we know that the new law expands Medicaid to nearly all individuals with incomes up to 133-percent of the poverty level by 2014. Those are individuals who are under 65, who are not otherwise eligible for Medicare. The law also specifies that states that currently offer coverage for individuals above that threshold, must maintain that coverage until these new health exchanges are operational in 2014.

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

We know that the bill also provides a lot of additional funding–federal financing for people who are newly eligible for coverage. In fact there's full federal financing for those who are newly eligible from 2014 to 2016 and then the federal share phases down to 90-percent by 2020.

For states that have been leaders in coverage and have provided coverage for childless adults through a Medicaid 1115 waiver, there's some additional financial assistance from the federal government for those states. For these childless adults in those states, the increase in the match will phase up to 90-percent by 2020. The law maintains the current match rate that states have for individuals who are currently eligible for coverage.

We know that states also don't need to wait until 2014 to start to expand coverage for childless adults. There's an option to do that right now with the regular federal matching rate for Medicaid and we know that the District of Columbia and Connecticut are early adopters of this option for coverage. Very importantly the law also requires a simplification and coordination of eligibility and enrollment across Medicaid and

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

the exchange, again to have those eligibility systems more integrated to promote coverage.

When we look at the share of uninsured adults at or below 133-percent, similar to the overall experience with the uninsured, there's a lot of this population in the South and the West. So we know that these states will be most greatly affected by the new Medicaid expansions that are provided for in the law.

So with that, I'm going to turn it over to John to talk about the specifics of the study.

JOHN HOLAHAN: Okay, thank you Robin. So the purpose of our study was to look at the impact of the Medicaid expansion for adults below 133-percent of the federal poverty line -what that would mean, both at the national level and by state, for increases in Medicaid enrollment and reductions in the uninsured; what changes there would be in federal, state, and total Medicaid spending between 2014 and 2019.

This includes the impact of the differential matching rates that Robin talked about where states will get their current matching rates on any new enrollees among current

eligibles, get a much higher match on new eligibles that starts at 100-percent and phases down to 90-percent, and then a phase in of a higher matching rate for states that have covered people through Section 1115 waiver programs.

It will phase in and actually save them money compared to what they're spending now. The last thing we did was to look at increases in enrollment and state and federal spending relative to what enrollment and spending would have been without reform.

So, in other words, we projected out what enrollment and spending would be, by state, generally following CBO projections of growth in both of those, and to establish a baseline so you could look at the impact of new enrollment and spending relative to where states would have been if there had been no reform.

To just highlight basically what we found is that Medicaid expansions will significantly expand coverage and reduce the number of uninsured; it's sensitive to what you assume about participation that we'll talk about.

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

The federal government will pay a very high share of new Medicaid spending in all states; the increases in state spending are pretty small compared to the increases in coverage and relative to what states would have spent if there had been no reform. This is even more true if you include the savings the states will have in current spending on the uninsured.

All states spend money to support uncompensated care as do localities. Some states have state funded programs and much of that can be replaced. We did not do that, so I think that there's a strong likelihood that we are over-stating the increase in state spending.

A few things about methods - we used the two years of the current population survey, we adjust the data for changes in population, incomes, insurance coverage, out to 2014. We adjust for the Medicaid undercount that's thought to be there in the current population survey. We used a procedure developed elsewhere to eliminate undocumented immigrants, because they're not eligible for basic services. The cost per person comes from MEPS, so it reflects the health status of the

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

people we're bringing into the program and then we grow that cost by CBO projections.

The eligibility simulation - the current eligibility is determined by a fairly complicated and detailed, state level, simulation model that identifies various pathways by which people come into Medicaid.

That's important because states, what's a new eligible is where you start now, in terms of establishing current eligibility and goes up to 133 and it's important to identify people who are eligible for Section 1115 waivers because of the way they're treated in terms of expanded matching rates. We used two different sets of participation rates and apply them in each state in the same way.

The first, which we call the standard, was an effort to approximate the rates used by CBO and as you'll see, we come out very close in terms of the numbers of new enrollment and new spending. Those participation rates are pretty close to what we see today for the new eligibles.

That is what we're observing in a voluntary world today and not much increase among current eligibles. An example,

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

what's the take up rate among those who are uninsured – it's about 57-percent, in the standard participation scenario.

In the enhanced, we assume that participation rates will be higher, that there'll be aggressive outreach efforts on the part of advocates, that providers will want to get people enrolled in Medicaid so they get paid, and so that we will see higher participation rates than we do today.

So the enrollment among the previously uninsured would be 75-percent and we'll see larger increases among those who are currently eligible. In other words, those who are currently eligible but not enrolling, some share of them will now come in.

In the presentation we focus on three types of states, those that are low coverage, we used Texas as an example. These are states that will have fairly large increases in coverage and most of these will be new eligibles. Then there're states that have broader coverage, typically for parents, they'll have a lot of new eligibles for childless adults but they'll also have a lot of current eligibles and to

the extent we have higher participation amongthose current eligibles, their states will feel that effect more.

Then the third state is those that are now covering childless adults, the seven states with Section 1115 waiver programs and they'll have some combination of new enrollment among current eligibles, some new eligibles and the higher matching rates on the people they're already covering.

The last thing we did, as I mentioned before, was to establish a baseline for enrollment and spending, growing it out to 2019, using states own Medicaid spending data, as the base and then projected out with CBO numbers on enrollment and spending.

Diane laid out a few caveats. I want to add to that, there are many ways when you do something that's this complicated, and try to do it at the state level, that you can be in error and be different than what states may do themselves.

There are issues with the survey: it's very hard to get the eligibility simulation right, what you assume about participation rates really matters, the growth rates for both

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

enrollment and spending out over time matters. So if we can get in the ballpark, I think we've done our job, and I think that more or less we did, with the exception of, it would have been great to have done a few other things that we couldn't.

So what did the study not address? It looked at–it did not look at the effect of Health Reform beyond the coverage and cost impact of Medicaid. In other words we didn't look at the impact of subsidies. We didn't look at what would happen if states shifted those people who are above 133-percent from Medicaid into exchanges.

For some states that have particularly large medically-needy populations, they could save a lot of money from this. We didn't estimate the savings from reductions in states' payments for uncompensated care. There are a number of states that have state-funded programs that will no longer be necessary and virtually every state and localities within those states make payments for uncompensated care to support the uninsured. A lot of that can go away and those savings would offset any new state spending on Medicaid That is not in this.

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

The impact of the provisions that affect children, how that's going to play out is going to different across states. I think that most states will save. The impact of physician fee increases, beyond 2014, will states feel compelled to continue those fee increases, we didn't try to speculate about that.

We didn't look at the effect of reduction of DSH payments. They're relatively small on Medicaid; I don't think it would have made a big difference. We didn't look at the impact of states voluntarily coming and expanding the coverage to childless adults before 2014, but there again, states would only do that if they were going to save money.

So I think, overall, most of the things that we omitted would lead to an overstatement of what states will have to do in terms of expenditures.

So, some results - we estimate that under the standard scenario, where we're trying to hit CBO benchmarks, that 15.9 million new enrollee's would be in Medicaid; CBO had 16. Now these are all largely newly eligible people, but there's some increased participation who are currently eligible.

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

The impact of the Medicaid expansion - we reduce the number of uninsured by 11.2 million. The effect on the uninsured is going to vary among states, but in general the impact is quite large. 44.5-percent of the uninsured adults below 133-percent of poverty would now be covered because of Medicaid.

In Texas, in states with low coverage today, there are much bigger impacts on the uninsured. Texas gets almost half of the uninsured population in that pool. California a little bit smaller, 41.5 but still large. New York, because they've already covered so many people, the percentage impact on their remaining uninsured population is relatively small.

So, remember that that 49.4 in Texas is off of a very large base of uninsured people. The 14.8 is off of a smaller base, so in a sense, the effects are really bigger, in a way, than they look.

The costs - we estimate the federal spending would be 443.5, CBO is at 434. We estimate the state spending at 21.1; it's so predominantly federal, because so many of the new

enrollees are new eligibles, and for them there is an extremely high federal match.

The next figure shows the share across states; on balance, is 95.4-percent of all new spending would be federal. It would be 95.3-percent in Texas, where almost everybody is a new eligible. It falls a little bit in California because California has a larger base of current eligibles, so we're going to bring in more enrollees from that pool.

New York has almost all of their costs paid, because there're a lot of things going on there; there's a higher match on the expansion population, that is the childless adults that they're already covering, than there is today. So New York and the other waiver states, save money on that population.

New York would also have some new eligibles among childless adults, between 100 and 133-percent of poverty, and for them they would get the very high match on new eligibles. They would also have current eligibles, or new enrollment among current eligibles, where they would receive their current match, but that's offset by the other provisions.

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

The next slide looks at enrollment and spending relative to the baseline that I described before. In other words, relative to what would have happened if there had been no reform.

So overall there's a 27.4-percent increase in 2019 in enrollment. State spending would go up by 1.4-percent, federal spending 22.1-percent, over what would happen in the absence of reform.

You can see that the biggest impacts in enrollment are in Texas—low coverage states, I think, cause it's true generally in states with lower levels of coverage. Texas has a 46-percent increase in enrollment, would see its own spending increased by 3-percent and about a 39-percent increase in federal spending relative to what otherwise would have happened.

The numbers decline in California, still a sizable increase in enrollment and an increase in federal spending. In New York, there's a smaller increase in enrollment, because coverage is already so broad. New York as I described, it was shown in the last slide, would have virtually no new spending

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

and that's largely attributed to the match on childless adults being higher and a 3.3-percent increase in federal spending.

The other thing that's going on here is that Texas is a large expansion upon a relatively small base, whereas New York is a smaller change on top of a huge base of Medicaid spending already. So, the changes that you see are substantially less.

The matching rates - for years, as long as I've been doing things on Medicaid, it's always been 57-percent; you can just plug that in. Under this it would go to 61.6-percent, the matching rate increase would go to 67.4 from 60.6-percent in Texas.

You go to the other side, in New York, it goes from 50 to 50.8 and that's because New York had a larger amount of spending now, that will continue to be, except for the expansion populations, be matched at current rates. So New York does not see the big increase in state matching dollars that you see in the lower coverage states.

Now a couple of slides on the results from the enhanced match. The one on the left is what we saw before; under the higher participation rates, Medicaid enrollment would go up to

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

about 22.8 billion, we would see a 17.5 million drop in the uninsured; it's about a 70-percent reduction in the number of uninsured adults in that below 133-percent.

The federal share goes down a little bit because, under the higher participation rate, we're bringing more enrollees among current eligibles for whom there is the current match. You can see particularly how far it drops for New York. Also for California, because they have a lot more current eligibles, a lot more opportunity for new enrollment among those current eligible's and the matching rate for them, as I said, is lower.

Here is a repeat of the previous slide; shows the overall increase but with an enhanced participation rate, so overall enrollments would increase 39.3-percent. Even with that larger increase, state spending relative to the baseline is 2.9-percent. Federal spending goes up to 26.5-percent and you can see again, it's quite large in low coverage states and much smaller in states that already have high levels of coverage. The increases in matching rates are slightly bigger than we saw in the last slide.

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

So let me wrap up. So I think what this tells us is that the Health Reform Law will substantially expand Medicaid, it'll have a big impact on the uninsured. This is especially true in states with low coverage today. Most of the new spending will be borne by the federal government.

States will have relatively small spending increases, relative to what they would have had in the absence of reform. This will bring in large amounts of federal revenues; it'll mean that they will cover a large number of low income people, that were getting care one way or another, in their states - less care obviously, but some.

As Diane mentioned, this is going to vary a lot across states. We put up two participation rate scenarios. Some will probably fall into one, maybe in the enhanced model and others more the standard or maybe even less. How that plays out will have an effect on a lot of things.

States that go slow will have lower increases in spending, they're going to cover fewer people, there's less impact on the uninsured, less new federal dollars coming. Then the opposite is true in the more aggressive states.

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

The final point is really important, that the new coverage will reduce the need for state payments for uncompensated care. I mentioned this already. There's a lot–virtually every state–not virtually every state, every single state and many localities - now spend a fair amount of money to provide for the uninsured. Much of the need to do that will go away.

The need for state-funded insurance programs, like in Connecticut, Pennsylvania, Minnesota, and others will no longer be there and those states will benefit. There will be savings that we did not account for. Other states that, one way or another, put money into hospitals or clinics to support the uninsured, will be relieved of much of that burden.

So, I think that if we had been able to account for that, that we would show that the savings to states, from no longer having to bear as large a burden as they do now, for uncompensated care, would probably be greater than their new obligations for Medicaid spending. I'll stop at that.

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

ALAN WEIL: I appreciate this opportunity to offer a perspective which is neither a response nor a rebuttal, but that's how it's listed in the agenda.

I think I'm primarily here to answer one very simple question, with a complicated answer; which is given the summary findings which suggest a pretty good deal for states, why aren't states all standing up and cheering? There are three answers: shoes, capacity and uncertainty.

Let me start with shoes. I'm often—I did say shoes. I'm often asked if the Medicaid expansion is a good deal for states and I give people the image of walking into a shoe store and seeing a $200 pair of shoes on sale for $20. Is that a good deal? Well if you like the $200 pair of shoes it's a great deal because you only have to pay $20.

If you look in your wallet and you see a 10 and a couple of ones and you've got some change in the bottom of your pocket and you're not sure you can come up with the $20, it doesn't really matter what a good deal it is. Much of the difference in perspectives in state response to the Medicaid expansion has to do with whether they're focusing on what

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

they're going to get, which is a lot more than they have to put in, or whether or not they feel that they can afford the relatively small amount that they'll have to put in. So that's the simple answer.

The slightly more complex answer has to do with capacity. We are looking at the possibility facing up to 50-percent increases in enrollment. That raises serious concerns about provider and delivery system capacity, managed care plans, hospitals, physicians, primary care, specialists.

States already struggle in this area, and they worry about whether or not they can meet the increased demand. Eligibility systems capacity; there's tremendous simplification of eligibility in the Reform Law, but that's a change, and it has to interact—the new systems have to interact with the new exchanges. You have to measure who's newly eligible as opposed to who was eligible; this is a tremendous capacity demand on state administrative systems.

There are overall administrative capacity issues, just in terms of enrolling and reaching all of these folks, and that again, with a significant increase in enrollment, the need for

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

that capacity in a time of very tight state budgets is of significant concern.

Finally, as John mentioned, this is all happening on the context of much broader changes that are also placing demands on states and their ability to run their programs. So they're looking at exchanges and high risk pools and all sorts of other changes in the context of Health Reform that make this, what may seem on its own a manageable set of changes, to feel somewhat overwhelming.

The third reason for state concern has to do with uncertainty. I appreciate and think that the analysis that's been done here is extremely valuable. It's probably the best you can do and that's a really important starting point. But there are tremendous sources of uncertainty in these estimates.

John already mentioned participation rates and I think we really don't know what that's going to look like, but there are other areas of uncertainty. The employer response, behavioral response, whether or not we actually do see, maybe not immediately, but over time a real shift of employers moving

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

out of coverage, putting their moderate income folks in the exchange, their lower income employees into Medicaid.

That's an unknowable set of changes. Provider rates; as the program grows and the need for capacity goes up, the ability to always pay, and be the lowest payer and pay on the margin, may no longer seem viable. There is a short-term increase in rates that the federal government will support. What will be the pressure to sustain those after the federal support goes away?

States are very concerned about even getting to 2014. This analysis is after that date. Until then states are in the worst fiscal conditions they've ever seen. They're concerned about how the enhanced match through the Recovery Act is always sort of the next thing that will be dealt with, but it's not certain it will be there all the way through 2014 - puts a great deal of risk in front of the states.

Then there's the risk of how federal oversight will change over time. To put it simply; states have experience that the larger the federal share is in paying for a program, the more over time the federal government sets the rules and is

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

more directive about how the dollars will be spent. So, as even with a large federal share, which sounds good, there's concern about how that will play out, with respect to state flexibility running their programs.

Now I should also say that a lot of the uncertainty is about opportunities that are very positive. John already mentioned the reduced burden of uncompensated care, which I think is a very important point. I take it even a bit further and say that it's not just reduced burden but it's the possible increased efficiency around the spending that now is institution-based and instead could be delivery system-based through coverage. So there are real potential increases in efficiency through those changes.

Of course there are broader potential improvements in the delivery system within the Medicaid program - great emphasis on the dual-eligibles, who account for 42-percent of Medicaid costs. We've got demonstrations about pediatric accountable care organizations, safety net capitation models; there are lots of opportunities that this expanded population

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

and a simplified system could yield some real improvements in efficiencies, within Medicaid.

Of course then there's the ability to join those opportunities, with larger delivery system reforms, coordinating with Medicare, state employees and the private sector in some of the broader initiatives designed to improve the efficiency of the delivery system.

So there's a lot of uncertainty here, both positive and negative. Now I will just say I appreciate that the Urban Institute and the Kaiser Foundation did not try to model all of those aspects. It would give us, I think, a false sense of precision.

I would also agree that the estimates do appear conservative - when opportunities were available to estimate higher or lower, they took the more conservative approach in terms of what the risks are to states. Conservative in the sense that I think that this is less favorable to states than it actually will turn out to be. I guess conservative needs to be defined in this context.

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

So I think that those make this extremely valuable. I would just conclude by saying, that given the relatively small incremental increase in costs for states, and I realize these numbers are very large, but still as a share, the increment is quite small. Ultimately the primary state reaction to these estimates is based on their feelings about baseline -Not about changes from baseline.

We've had a long standing debate in this country over the relative responsibilities of the federal government and the states in Medicaid and in covering low income populations. Really what this analysis shows us is that Health Reform did not fundamentally alter the relationship between the states and the federal government.

For many years, many people have been calling for a massive shift in responsibility or a re-allocation of responsibility. This didn't do that. So if you are sort of hoping and holding out hope that this would take all of the health care costs off of the state budgets, it didn't happen. If you really felt that the federal government was playing too

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

large a role in defining what coverage looks like for low income populations, that didn't happen.

So at the end of the day, I think mostly this is a great tool for states, but largely they're going to look at this through a pre-existing lense of how they felt about Medicaid in general and that the changes, in the end, are actually, from a state budget perspective, quite incremental.

DIANE ROWLAND: Thank you Robin, John, and Alan. I would point out that some of those other changes to Medicaid, like having the federal government assume responsibility for dual-eligibles are also things that Urban Institute and John have modeled for us and that are available on our website.

So we have a lot of different ways of looking at state impacts. I think that this really does show that it's hard to predict the future but that it's also hard to prepare for the future if you don't have some assessment of where you might be going. Particularly looking at the lower participation rates in the standard option versus those in the enhanced, show you what the impact of a fully enforced individual mandate, combined with real outreach might be in a state that wants to

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

be aggressive. If you look at a state that's less aggressive, you'll see more likely lower levels.

So all of this is likely to be a blend. We know there are states that have shifted some of their state-only populations and when they get those onto full federal financing, like Wisconsin, it will really produce a lot more savings than are demonstrated in some of the results here.

With that in mind, we're going to open it up to your questions and please direct them to one of our panelists if you have a direct question or a general one and identify yourself when you ask. Vic, who is also well-known for producing state by state numbers.

VIC MILLER: Yes, Vic Miller, I'm with GAO now, and I'd like to compliment both the Foundation and John for the work. You can't do embroidery until you have a pattern and people will embroider on this, but it's a first step and well done.

I do have a question as to have you looked at the Actuary's numbers on the cost–he hasn't done state by state publication but he has a much smaller cost to the states, even smaller than yours. Is there a comparison you can make?

JOHN HOLAHAN: You know I've looked at that report, but not that, so I guess I couldn't comment-

VIC MILLER: Comes to 3.6 billion for the states, it's very small.

JOHN HOLAHAN: Well it could have been that-you know if you bring in provisions for-I mean the states could drop coverage for the medically-needy, for example, above 133. They could-I think the children's provisions could save states some money. So, I mean there are things that we didn't do, that could provide savings. I'm just not sure what they did.

VIC MILLER: And once again, that's not a criticism [interposing].

JOHN HOLAHAN: Yes, right.

DIANE ROWLAND: Okay, yes.

MORNING GROPPE: Morning Groppe with the Gannett and the Indianapolis Star, your high end scenario did not include-anticipate 100-percent participation. In Indiana the governor, his initial estimate was based on 100-percent participation. His argument is that if somebody, even if they have insurance now, if they can get on Medicaid for free, why wouldn't they do

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

that. So, why do you rule out the possibility of 100-percent participation for all those nearly eligible?

JOHN HOLAHAN: Oh, probably for a lot of reasons. I mean there's a lot of people now who are eligible for Medicaid that keep their employer coverage and surprisingly even keep non-group coverage rather than go into Medicaid. The mandate doesn't apply to most people who are eligible for Medicaid because of not being tax filers, so they'll–undoubtedly there will be people who will stay out, cause they're not facing a penalty.

I think that is what's behind CBO's thinking that since the penalty wouldn't apply why would you see anything different than what we see today, in terms of participation rates. So, I'd be shocked if they would go to 100-percent. I think it's–I don't know why they're doing that, other than creating a pretty, probably a pessimistic scenario.

MALE SPEAKER: Good morning, we are a Medicaid System Implementer and my question is on slide four. They're talking about like 130–the point number or bullet number–second bullet, which talks about greater than 133-percent of federal poverty

level. Is it greater than 133-percent? It's on slide four or figure four.

JOHN HOLAHAN: I'm sorry, you're asking about the maintenance of effort?

MALE SPEAKER: Yes, it says key Medicaid coverage provision that slide.

JOHN HOLAHAN: Right.

MALE SPEAKER: I think its slide four.

JOHN HOLAHAN: Right.

MALE SPEAKER: Look at the second bullet please?

JOHN HOLAHAN: So what's the question?

MALE SPEAKER: Is it–it says like to maintain Medicaid coverage for adults great than 133-percent of federal poverty level. So is it correct?

ROBIN RUDOWITZ: Yes, that's correct. For states that have coverage right now–

MALE SPEAKER: Okay, for right now.

ROBIN RUDOWITZ:–for adults that are above 133-percent of poverty.

MALE SPEAKER: Alright.

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

ROBIN RUDOWITZ: There's a maintenance of effort, until the state exchanges are fully operational.

MALE SPEAKER: Thank you.

DIANE ROWLAND: Okay.

IRENE IHEAR: Thank you for the presentation. Irene Ihear , MPH. My question is; how long was the study, as far as the duration? Like how long did you all-

ROBIN RUDOWITZ: Take to do it?

IRENE IHEAR:-yes.

JOHN HOLAHAN: [Laughter] Yes it was a long-I don't know. I can't remember, months, three or four months probably.

JENNA STENTO: Hi, Jenna Stento from Avelere Health. This question is for John as well. I'd previously seen some estimates from the Urban Institute for the Senate Finance Committee, estimating increase in Medicaid enrollment and they're a little bit different. I was wondering if you could explain any differences in methodology.

JOHN HOLAHAN: They're probably a little different, in that I think the participation rates were slightly different. I can't see why the ones for our standard scenario would be

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

very different from those. What? Yes, I mean, we did certain estimates from them.

They took them and did a lot of things [laughter] to split federal and state shares and things like that, that we did not have anything to do with, even though it said at the bottom of those pages that got handed out all over the country that they were done by the Urban Institute. Yes, there was a fair amount of them out there we didn't know about.

DIANE ROWLAND: They were also done earlier in the process. These were done subsequent to having actual legislative language to work with. So I think that would probably explain some of the variation. But the standard scenario here should be fairly close to what was considered by CBO.

CBO does not release its participation rates, so that John tried to back into them and come up with the national numbers, which is why we show you the national numbers being very close to CBO and then distribute them out. Question?

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

PAUL HIGGINS: Paul Higgins from the organization that doesn't release its participation rates [laughter]. My question is for John please–

DIANE ROWLAND: You could tell us what they are if you'd like [laughter].

PAUL HIGGINS: So my question–my question for John, you said you had done some work that helped to identify the relative magnitudes of the health costs of the population that is currently uninsured to level 133 and how that would compare to like, let's say, the current competence for Medicaid. Now, I'm curious what you found and what were those relevant [inaudible].

JOHN HOLAHAN: Oh God, I can't [laughter]–that goes back a while. Oh wow, I don't think I can remember. But its MEPS based and then they have MEPS data where the spending will vary depending on health status and some other characteristics in your current coverage before you become eligible under a new regime.

Then we benchmark those to MMIS, Medicaid Management Information System, and then grow them by your projections.

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

So, to get more precise than that, I'd have to go back and restructure it, but that's more or less what happened.

DIANE ROWLAND: It's why it took a long time to do the study [laughter], so maybe six months is a long time to remember.

JOHN HOLAHAN: Right.

DIANE ROWLAND: And we have a question in the back.

JULIE ROVNER: Julie Rovner from National Public Radio. I know the study only goes through 2019, and Robin you touched on this a little bit, but it went by pretty fast. What happens after 2019? I know that the enhanced match goes down a little bit, so do you have some sort of vague estimate of how much more states would then have to pay in terms of their participation when that enhanced match starts to go down?

ROBIN RUDOWITZ: The matches stay at 90-percent 2020, so it phases down to 2020, to 90-percent, but we have not done estimates beyond.

JULIE ROVNER: Do you have some idea of what kind of impact that would have on the–on what states would look at–what impact on the baseline that would then have for the states?

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

JOHN HOLAHAN: Yes, we have—we have the estimates for each year between 2014 and 2019, so the state—the federal share would be what we have in 2019. Of course, population's going to grow, incomes will raise or fall or whatever, and so the underlying population may be different, but the match on new eligibles goes down to 90-percent. What we presented was an average of that federal share over those six years, so it'll be a little lower than what we presented, but not a lot.

JULIE ROVNER: What I'm asking though, is that after that it would still be substantially into the future—into the next 10 years, it would still be substantially more than it had been—than it would be relative to baseline, substantially more federal and less state, going into the future even though that really enhanced match goes down, because it stays at 90-percent?

JOHN HOLAHAN: That's my understanding unless they change the law; I mean there're no provisions that it's going to do anything but stay there.

JULIE ROVNER: I'm just guessing that there will be—that people will look at the study and say, well you're just

taking this really high five years, and so it's an artificial picture. I guess what I'm saying is that into the future, because it stays at 90-percent, that going into the future it's also going to continue to be very largely federal and the states still won't have to put up a lot of money to get a lot of people covered?

JOHN HOLAHAN: Right. The only versions of this we had data for—I mean the number of tables that we produced was unbelievable and you just can't present it in any manageable way. So, since a lot has been made of the six year numbers, the 2014 to 2019, that's what we focused on, but yes.

DIANE ROWLAND: But the full report has the 2019 numbers—

JOHN HOLAHAN: Actually it does.

DIANE ROWLAND:—which is really reflective of the future, if you just take that one year, because that's when all of the phase down of the match triggers in. Jocelyn.

JOCELYN GUYER: Jocelyn Guyer, Georgetown University. It struck me that you had said that there's a very good chance that for nearly all states these estimates overstate the impact

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

and a part of it is that you really were looking at a piece of the analysis, which was the cost of the Medicaid expansion and not everything else that might affect things.

So is there a way to help us get a sense of the magnitude if we were—if you were to be able to take into account some of the offsetting savings from uncompensated care? Is that going to wipe out any costs that states might have? I mean, can we get some sense of the magnitude of what it would mean to take into account the uncompensated care burden that we're lifting off those states?

JOHN HOLAHAN: Well let me—I've tried to do a rough ball park kind of estimate of that and there's a paper that I did with Jack Hadley that was published in 2008, on the cost of uncompensated care in the system; the number that—the amount of money spent by state and local governments was 17.2 billion.

If I took that and grew it out to 2019, and said what if you saved half of that, because you no longer had to put those dollars into covering the uninsured, the number comes up around 80 billion. Under the standard scenario the states

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

money was 21, so I think it would more than offset it, even if I'm off a bit on that.

DIANE ROWLAND: We also know from states like Wisconsin, which we show as having costs here that they are likely instead to really see savings, because they're transitioning individuals who they are covering with state only dollars but are not counted as the waiver population, in as childless adults, so that they will get full federal financial participation for them.

There's also the increased match on CHIP, for children that's not accounted for here because this focus is on adults. So that in the aggregate, I think many states, like Wisconsin, could in fact see savings, like New York does, because of some of these shifts.

BRIAN BLAZE: Hi, I'm Brian Blaze from George Mason University and this question is for Alan. Some states, particularly in the Southwest, have floated the idea of ending their Medicaid programs on the expectation that the individuals below 133-percent of the federal poverty level would be eligible for the federal subsidies. I'm wondering if your

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

organization has done an analysis of the law and if that's possible? Thanks.

ALAN WEIL: I do not think, but I would not want to go too far on a limb, that there's reason to think that those under 133 would be eligible for subsidies under the law, if a state withdrew from the Medicaid program. I don't think that's a safe read.

I would also say that if states started moving in that direction, I think there are 535 people in this town who would say that's not quite the deal we thought we had and they might, although I know they'd be hesitant to reopen the health reform legislation, I think that would be a big enough shot across the bow that I think it would be reasonable to expect some sort of a response.

It is certainly true that as the federal share climbs and the amount that states have in declines, that states start wondering whether or not they should just back away, but I've never seen a state, once the idea has actually gone past sort of the rhetorical stage, into the actual analytic stage, and real people and real providers start looking at the

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

implications, I've never seen that conversation actually go very far.

DIANE ROWLAND: I think it's also important to note that the individuals that are newly eligible are not the only group you would have to withdraw from Medicaid. You would have to withdraw from the entire Medicaid program, including your elderly, your dual-eligibles, your nursing home population, your disability population. So it's a far bigger choice than just around whether you want to cover the newly mandated people or not. Yes.

HECTOR: Hector [inaudible] from the National Council Meeting [misspelled?] I'm interested since this was an individual level data set, if we have a sense of the different populations that will be enrolling. If they're Hispanics, if they're African Americans, if they're single individuals; get a little bit more of a profile? I don't know if you were able to do that with this data.

JOHN HOLAHAN: We didn't; it's something we could do, but no, we had our hands full, so [laughter].

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

DIANE ROWLAND: This was basically trying to sort who came in under which categories since the matching rates, as John explained, were different if you were a current eligible or if you were coming in as a new eligible or if you were coming in as an 1115 waiver and in fact the analysis didn't even pick up the changes for state only coverage of individuals. So, the next level we'll give John some more work and ask him to look at how it differs by other characteristics.

ALEC MACGILLIS: Hi, Alec MacGillis with the Post. I'm a little surprised that the overall match rate in the low coverage states hasn't gone up even more. If you have a 50-percent increase in enrollment in a state like Texas and those people are all being covered at 100-percent down to 90, why wouldn't it go up more than, from 60 to 68-percent. It seems like you'd be getting a much bigger jump.

JOHN HOLAHAN: Oh yes, there–right–they're a relatively low cost population. Relative to this people who are in the base, and the base includes long-term care, it includes q-care spending on a population that's sicker than the one you're bringing in. I think that's primarily it.

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

ALEC MACGILLIS: But wouldn't-does that get at the match rate though?

JOHN HOLAHAN: Well the match rate includes the base and the new, right?

ALEC MACGILLIS: Right.

JOHN HOLAHAN: So the bigger the base, the less affect the expansion is going to have on the change in the match rate.

ALEC MACGILLIS: Okay.

DIANE ROWLAND: It's not just the match rate for the new population, it's the overall match for the disability population, for the entire program.

ALEC MACGILLIS: Right, okay. And then also, I was a little surprised that the federal spending share would be-was as high as 95-percent in the standard scenario, given that you'd have-you think you'd have more current eligibles being brought in who would be coming in at the lower, at the existing match rates, and would bring that number down.

JOHN HOLAHAN: Our assumption was that most of the new enrollment was among new eligibles. That if you have a participation rate that's in that mid-50-percent range, if you

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

augmented the participation rate of current eligibles it would end up being quite a bit higher than what you're assuming for new eligibles which doesn't seem to make sense. So, I think, we sort of came to the conclusion that you had to assume not much change in current eligibles.

ALEC MACGILLIS: Then quickly just to follow up on that–

DIANE ROWLAND: Cause basically that's the difference between the standard and the enhanced.

ALEC MACGILLIS: Right.

DIANE ROWLAND: The enhanced picks up a lot more eligible but not enrolled in the standard.

ALEC MACGILLIS: Picks up more–which is my last question to that point; why–just very generally, why don't we think more people will be coming forward to take this sort of, this quote free thing. I understand that the mandate doesn't have much effect on them, but still why is it not higher than 50-percent under the standard rate?

JOHN HOLAHAN: Well that's–I mean I think the idea is that this is what we now observe, when people are made eligible

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

for Medicaid and if you don't make–and if they're not subject to the mandate, because of being low income, then why would you expect it to be different? I mean I think that's the argument being made, at least that's our assumption about the argument being made by CBO. By using its participation rates we were able to match costs and enrollment pretty well.

DIANE ROWLAND: Alan, I think you can speak about outreach.

ALAN WEIL: Yes, so before I get to outreach, there is in the new law, a dramatic simplification of the eligibility standards and depending on how that plays out and how the information flows work with the exchange, we could actually see sort of a cultural shift in what it means to apply for Medicaid. From going to a county office, with reams of paper, things getting lost and finally, people not making their way through the system, to a much more streamlined process, because eligibility is simpler and there has to be this relationship with the exchange that has also a simple eligibility standard.

That's not going to happen the first day. That might over time–we might see some yield, but I think–so I think it's

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

reasonable to hope, actually that over time, the participation rates would increase, but again it's a hope like many of the others that it's hard to sort of estimate what the size of that is or the magnitude. It's just sort of the direction that we would think things would move.

With respect to outreach I'm not certain I'm going to say what Diane thought. I mean states are also going to differ, as they do now in the resources they put into seeking out those who are eligible and bringing them in. The simplifications of renewal, all kinds of processes remain under the control of the states and in tight budget times, states have been scaling some of that effort back. Again, if they're primarily concerned about these numbers they may stay scaled back. If things work out well that could also change.

I think there's good reason to feel that there's uncertainty here, but I think it would be risky to assign a new number not based on any experience that we have, that says well actually, the participation rates going to go up and certainly 100-percent is just not a realistic number.

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

DIANE ROWLAND: We've clearly learned from CHIP experience that a federal and state combined effort to do outreach and enrollment can really boost these participation rates up substantially. So I think this is a sign that if it's going to work, it's going to need a concerted effort at both the federal and state level to do outreach. It's also the variation among states, one of the reasons why applying a uniform set of participation rates in both scenarios is probably true for some states and not for others.

JOHN HOLAHAN: I think I should say, I think another reason why you might see in a lot of states something closer to the enhanced match is the providers,particularly the hospitals are going to get cutbacks in DSH payments, more from Medicare than Medicaid. It's going to be a real—much to their advantage to get people signed up and so.

KARL POLZER: Karl Polzer, American Health Care Association, this Medicaid expansion's going to intersect with the employer-based system, both inside and outside the exchange, so I think, with respect to the previous question, from when I read it, if they go to the exchange and they're

under 133-percent of poverty, the exchange is supposed to facilitate enrollment in Medicaid.

Then outside the exchange there's the option to go onto Medicaid for that population. Did you do an estimate of, I guess–what, how many of those folks that newly enroll for this expansion, would have had–otherwise would have had employer-based coverage?

JOHN HOLAHAN: Yes, we did and it's in the estimates of the dropping of employer and non-group coverage are in the paper, right? They vary depending on whether you’re currently eligible or new eligible and which participation rate.

DIANE ROWLAND: Okay, I think we have time for one last question.

LYNDA FLOWERS: Lynda Flowers, AARP, I just wondered if you'd done some thinking about the impact of pent up demand among a middle age population that's getting into the chronic disease area of their lives and what that might do to participation rates? I could see that not sort of falling outside the norm in terms of the normal pattern of participation rates?

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

JOHN HOLAHAN: We did not and no, so I guess I have to think about that one, on how that would play and affect anything, but we didn't.

ALAN WEIL: Can I just say that anecdotally is maybe not quite the right word, but there are states that do expansions here and there, and there generally seems to be a reasonable off setting between the pent up demand scenario, which would suggest higher costs, and the open the door and a lot of people who right now, only entered the system when they're sick, and now that the doors more open they enter it when they're healthy, and so that would argue for lower cost.

So you can sort of draw both scenarios, but I think the practical experience suggests that they balance out pretty well, and they may actually tend a little bit more towards the less than average expense side than the higher. Now obviously, when you're doing this large and expansion, that's going to change the distribution, but you also have the subsidy levels also affect who comes in the door. So that's the experience I'm aware of.

LYNDA FLOWERS: Well one-

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

JOHN HOLAHAN: I think the population will come in as incredibly diverse in terms of age and health status and so, yes. I'd agree with that.

DIANE ROWLAND: So we have a lot to look at, a lot to monitor. I think this analysis at least sets forth some targets that may or may not prove to be real in the states, but it does give you some sense of where the biggest impacts of at least this provision and this expansion will be. We'll obviously be back with many more similar analyses, so we hope you'll join us again.

I want to just thank John for the work that Urban did to put this together and our panelists for participating so admirably today [applause].

[END RECORDING]

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