MAXIMUS

"Opportunities for State Innovation in Health Insurance Programs"

Live Event & Webcast Transcript

Bruce Caswell: Well, welcome everyone. Can you hear me okay? Great. And please do continue to get your lunch and join us and get settled.

I have been asked to add one thing here at the beginning, and that is please silence your cell phones, if you will, because this event is going to be Webcast live.

So, good afternoon, and welcome to Newseum. This is absolutely a phenomenal venue for a great discussion. Today we're going to be talking about opportunities for innovation in state health insurance programs.

My name is Bruce Caswell, and I am the President of Maximus. We've been helping states manage and modernize their public health insurance programs for more than 20 years. We're proud to be presenting today's discussion on a very timely and important subject for the states.

So, first of all, just a little bit of background for you, before the Affordable Care Act became law in 2010, healthcare reform was primarily focused on state policy leaders, excuse me, entrusted with executing on their state's defined vision.

Because the Affordable Care Act is really a federal mandate, it provided opportunities for greater standardization in the states and across states in developing health insurance policies and coverage design.

While there are merits to standardization, it's pretty evident as well that there can be drawbacks from that. It reduces flexibility and innovation that has, for many years, been the hallmark of how states guide their programs.

There is one section of the Affordable Care Act, however, that importantly provides potential leverage to those states for innovation and to become those laboratories that we've known them to be historically.

And that's Section 1332 of the Act, which permits state innovation waivers beginning, importantly, in 2017.

Today we're here to start a discussion. And it's really just the beginning, I might note, on the opportunities that states have. And we are very fortunate today to be joined by a number of the nation's leading experts on the design and operation of public health insurance programs.

These experts are going to discuss what the waivers are, what the waivers are not, and what they can do to help states accomplish important changes. And these changes could be small tweaks to very large changes and major redesigns in their programs.

Section 1332 of the Affordable Care Act provides considerable discretion to states under the purposes of this waiver in collaboration with two federal departments, the Department of Health and Human Services and the Department of the Treasury.

Those are the agencies that are jointly responsible for the Affordable Care Act provisions that can be waived under the act. We are going to see that over the next few years this is going to be a learning process for all of us. And that's an important note because rules will be developed. And their initial waivers are going to be considered. So, it's going to be a bit of a journey.

To start building on that foundation of knowledge, MAXIMUS is very pleased to sponsor today's event. It's the first in a series of discussions that we intend to host. And we'd encourage you to join us as we attempt to stimulate some thinking in this area of state innovation waivers.

I do want to note that for further background, we've provided a two-page issue brief that you can pick up at the back of the hall as well as a white paper and a copy of a presentation that was recently given by some of today's panelists at an event that was sponsored by the Robert Wood Johnson Foundation's State Health Reform Assistance Network.

We've also made all these materials available to you on our Website, which is www.maximus.com. So, after today's discussion, we invite you to take a look at the materials, watch for more upcoming events and creative thoughts and--as this process continues to evolve on this very important provision of the Affordable Care Act.

So, let's go ahead and get the discussion started today. I'm very pleased to introduce our moderator, Krista Drobac. And Krista's going to walk us through the facts about the state innovation waivers.

A little bit of background on Krista, she has more than 20 years' experience in the federal and state government, as well as in public affairs. And she was previously the Director for the Health Division at the National Governors Association and also a senior advisor at the Centers for Medicare and Medicaid Services.

So, welcome, Krista, and thank you so much for being part of our panel.

Ms. Krista Drobac: Thank you. Thank you. It's a privilege to be here with such a distinguished group of people. I'm going to start by introducing our panel and then talk a little bit about Section 1332. And then we're going to have a free-flowing discussion and questions at the end. So, we definitely want audience participation.

I'd like to start by introducing Deborah Bachrach, who I have long known and has deep policy experience in both Medicaid and healthcare reform. She's a partner at Manatt, Phelps & Phillips, and primarily out of the New York office, but also here in DC.

She was the Medicaid Director and Deputy Commissioner of Health in New York for the New York State Department of Health and served as an advisor for both the Center for Healthcare Strategies, the Medicaid and CHIP Payment Access Commission, MACPAC, and Robert Wood Johnson. So, thanks for being here.

Cindy Gillespie, who I've also known for a long time, is the Senior Managing Director at McKenna, Long, & Aldridge. She has also extensive experience in long-term market opportunities in healthcare and health insurance reform.

She previously served as a counselor to the Massachusetts governor--am I allowed to say Mitt Romney?

Ms. Cindy Gillespie: You are.

Ms. Krista Drobac: It doesn't say his name here. But, you know. She had a leading role in the development of the Massachusetts Health Insurance Reform, which many of you know served as a basis for the ACA. And she's now--she was a senior advisor to the governor on policy and legislative matters.

Joel Ario, he worked too at CMS. He's a Managing Director at Manatt, Phelps & Phillips. And he has 30 years of experience helping to shape and implement public policy.

He was the first Director of the Office of Health Insurance Exchange at HHS and has the privilege of being an insurance commissioner in two different states that are on totally opposite sides of the country, Pennsylvania and Oregon. So, thanks, Joel.

And Dennis Smith, last but not least, the Managing Director at McKenna, Long, & Aldridge. He has extensive experience in health policy and was previously the Secretary of the Department of Health and Human Services in Wisconsin, as well as the Director of the Center for Medicaid and State Operations at CMS, and the Medicaid Director for Virginia.

So, between everybody here, there's a lot of people who originated a lot of deep thoughts about both health reform and Medicaid policy. So, thanks, everybody, for being here.

So, I'm probably the least qualified to give you the essence of 1332. But here we go. Everyone here knows a lot about it. So, they'll fill in where I miss something. The essence of 1332, I'm just going to refer to it as that.

I think everybody knows that it's the section of the ACA. People, I think, generally refer to it as the 1332 waivers. But really the essence is state innovation. And it, at its core, permits state governments to use funding that would otherwise have gone to individuals and businesses to aggregate that funding to create different ways to cover people.

So, it came out of an effort by Senator Ron Wyden and Bob Bennett from Utah. So, Wyden is, obviously, from Oregon. And the two of them came up with a bill called the Healthy Americans Act in 2007.

It was very different from what the ACA ended up being. But Wyden was very determined to have his fingerprints on that bill. Obviously, he was the third ranking Democrat on the committee. And he, again, was very focused on state innovation, given Oregon's history in state reforms. And so, he really pushed for 1332. He took that provision that was in the Healthy Americans Act.

It was called Empowering States to Be Innovative. And it became Waivers for State Innovation. So, you know, basically what Wyden always said is someone in Tampa Bay may be served by healthcare differently than someone in Coos Bay in Oregon. You know, so, he often made that speech about the differences in the bays. So, what does it allow you to do? What does it not all you to do? I think a lot of us, other than the four people sitting next to me, the rest of us in health policy sort of have this vague notion that you can waive a bunch of stuff.

But I'm going to just go through what you can and can't waive because it isn't just everything. I think the vision was you couple it also with Medicaid waivers. And you could couple it with a Medicare waiver to create one big package.

But within 1332, you can waive essential health benefits. You can waive the--either modify or eliminate--the certification for qualified health plans. You can waive the Exchange. You can waive the individual mandate. You can waive the employer responsibility requirements. So, you could take away the penalties for employers. You can then use the premium tax credits and aggregate them. And that federal funding becomes your funding stream then for covering the people in your state. So, that's a lot. That's a lot that you can do.

What you can't do is you can't waive the fundamental market reforms. So, you still cannot allow insurers to rate based on health status. You still have to ban annual lifetime limits. You still have all parents to keep their kids on insurance up to the age of 26. And there's a lot of discriminatory practices that you still can't waive. And of course, as I mentioned, you cannot waive--you can't modify Medicaid or Medicare or CHIP as part of a 1332 waiver.

The vision really was that you combine those waivers. So, an additional requirement is to qualify for a 1332 waiver. The state has to guarantee, basically, that the coverage is going to be as comprehensive as in the ACA.

So, it sounds interesting that you could waive the essential health benefits. But really, there aren't that many ways to prove comprehensive coverage. Right? So, you'd have to be pretty creative about how to have it as comprehensive.

It has to be at least as affordable. So, that's another real constraint in terms of, you know, what can you do. You can eliminate the middle levels. But you still have to have some packages that show at least as much affordability as what's in the ACA.

You have to cover at least as many people. So, again, a lot of things that you can waive, but if you waive the individual mandate, your coverage levels are going to probably go down. So, you how do you keep the same level of people in the pool?

And finally, you have to be budget neutral. And not only do you have to be budget neutral, but you have to submit a 10-year budget plan. So, they're going to know if in year six it goes way up, right? So, it has to be budget neutral.

And just a legislative sort of history note, the reason why the 1332 waivers don't go into effect until 2017, Wyden originally had them in 2014. But the Congressional Budget Office said if you're going to prove budget neutrality, you need a baseline. And you can't create a baseline in the same year that all the other coverage goes into effect.

So, it really was purposeful that they created it in 2017 saying that you could then take the ACA baseline so that we can ensure not only that it's budget neutral but that you're also covering as many people.

Now of course, Wyden made the argument, probably justifiably so, that states are making all these investments in 2014. And so are insurers. And then to change that in 2017 is a lot more investment and can be difficult. But CBO said the only way we're going to score it in a budget neutral way is if you have a good baseline.

So, the other thing I want to mention is that 1332 has to be tied to explicit state authority. So, if you can't find the authority in your existing statute, you do have to get the state legislature involved in allowing this because CMS has to see that state authority.

So, just quickly before we turn over to questions, if you did want to submit--if you are a state employee and you wanted to submit a waiver, I found it interesting that in the Paperwork Reduction Act, you know the CMS has to estimate the number of hours that everything takes. And they estimated it would take a state about 400 hours to apply for a waiver. I thought that was worth noting because I know that everyone's very busy. But--so, you have to talk about what your goals are.

So, what are your goals for coverage? You have to tell CMS why, you know, you're going to achieve these goals by using this waiver authority. You have to demonstrate sufficient authority at your state level.

You have to hold a pre-application hearing. So, there's a lot public input into all of this whole process.

And, finally, you have to include an actuarial analysis, an implementation timeline, and then that 10-year budget plan that I mentioned. So, it can achieve a lot of goals and provide a lot of flexibility.

But you've got to do a lot of deep thinking about what your goals are. So, that is sort of a short overview. I thought that the first question that we could talk about is what can you do with these--with this section that would achieve your policy goals?

So, what policy goals can you really achieve using 1332? And I'm just going to go down the line and start with Deborah.

Ms. Deborah Bachrach: Policy goals, so, first let me thank MAXIMUS for putting this together. I do agree with Bruce. I think we're at the start of a really interesting discussion on how do we use 1332 to advance the core features of the ACA in a different way.

So, two things, different way, core features, so here's where I come at. The goal that I found most intriguing and most important in the ACA, and remember, I come out of Medicaid, was the ability to look at a continuum of coverage, to take Medicaid, yank it out of the welfare state--space, and make it the foundation of a coverage continuum, so that I want to say in answer to Krista's question, let's look at a combined waiver.

We have a lot of experience, right, with Medicaid 1115 waivers. And we can see some of that experience in the regulations that have already come out. And those are mostly procedural.

But in many ways, they mirror what we've been doing for--right, Dennis--for decades with 1115 waivers. Dennis and I don't agree on a lot of things. I think we can agree on the process, though, is similar.

But so, let's take an 1115 waiver under Medicaid and combine it with a 1332 waiver. Let's aggregate the subsidies. And Krista talked about this. Let's take the subsidies that would otherwise go to individuals with incomes above Medicaid levels and up to 400 percent of the federal poverty level.

And think about how we smooth the coverage continuum, right? The ACA set up a coverage continuum we've implemented in at least the states that have already decided to expand Medicaid. It's a little clunky. It's not as smooth as we would like. Can we smooth it out by taking Medicaid and putting it together with the aggregated subsidies? Is this an opportunity for states that have resisted expansion and to think about it as part of a coverage continuum with the 1332 waivers?

It's an opportunity for states that say that subsidy cliff is a little bit too much at 138 percent. And maybe I can use the subsidies in such a way to smooth it. Maybe I can put in my 1115 waivers premiums for individuals above the poverty level.

That's not under 1332. But we've seen that already in expansion waivers under Medicaid. So, you can think of ways to put the two together, 1332 and 1115, and smooth and implement a more workable coverage continuum.

So, that's my blue sky, but grounded in reality, idea. What do you think, Cindy?

Ms. Cindy Gillespie: I'm going to come at it from a completely different way. So, you know, there are other states that are out there that have found, as Bruce said, they were working on innovation, working on ideas, had policy goals for what they wanted to achieve. And then the Affordable Care Act comes down and stops that. And instead, they have to try to implement a structure that's put on them. For those states, there's an opportunity to at

least in some areas take it back and begin to innovate again in areas where the federal government has, in my opinion, intruded for the first time.

And maybe they can get them out examples. The individual and small group market, a lot of the states knew they had issues with those markets. They were trying to figure out how to deal with small business, how to help them. Some of the states were looking, for example, at strengthening employer-sponsored insurance. They really wanted to build on the employer insurance base and do more with that.

So, a 1332, even if they don't go near adding an 1115, is a chance for a state to step back and say, all right, particularly with in 2016 the requirement that all small businesses between 50 and 100 employees now have to go into the small group market from the market they were in and will now have to buy plans with EHB.

And that's going to have a big impact on a lot of small businesses. So, a chance for the state to say, all right, what do I want to do to really make my individual and small group markets more effective? A state that really wants to look at employer-sponsored insurance, to me, for example, could take some of those tax credits, right? They could have exchanges, or they could privatize exchanges.

They could allow three shares to be done. There is a lot a state could do just looking over at this market, even if they don't ever look at the Medicaid piece.

Ms. Krista Drobac: Thank you. Joel?

Mr. Joel Ario: So, I'll just add a quick editorial comment, which is if the federal government does not delay the 51 to 100 market that Cindy just talked about, my experience as an insurance commissioner, every one of the insurance commissioners will recommend that they waive that requirement in the law in 2017 because no state has done that. It doesn't really work in the state marketplace. And so, leave that aside for a minute.

Ms. Cindy Gillespie: I agree.

Mr. Joel Ario: I think what we see between Deborah and Cindy is kind of the two broad approaches to 1332 waivers. Deborah, like me, kind of basically likes the ACA's structure. And so, we're thinking about reforms that kind of fit and really kind of deep dig down and improve certain elements of the law, more surgical, if you will. Cindy's still tin stomach about what's in this law.

I think we'll hear the same from Dennis. So, they look at it more broadly and step back and go, this is really an opportunity for a broader waiver.

And since Krista talked about Wyden, who was my senator in Oregon, certainly very important to this law, there's also a guy in the House, Tom Price, from the other side, who I remember having at NEIC here. And I asked him, so, why are you and Tammy Baldwin sitting here both supporting these grants to states? This is way before the ACA.

And he said, well, the only thing that Tammy and I agree on is that we have the courage of our convictions. And we're willing to put a lot of money into her states, the blue states, to do experiments if she lets me put a lot of money into the red states to do their experiments. And that's kind of the essence of the 1332. It's got bipartisan roots that allow the states to experiment. And so, you'll hear all the different ideas we talk are possible. The specific idea I would take is around the exchanges themselves.

When I was at the agency, I thought the public exchanges, the public marketplaces, were the end all and be all. And they were going to drive almost all the change in the marketplace and kind of grow and become really the centerpiece of the reformed market. Now five years out, I'm very intrigued that the private exchange movement out there has really grown and flourished.

They have been very adroit at playing off of the way the public exchanges are developing to create a really robust market and private exchanges for employers, and also servicing the public exchanges, by the way.

So, what I now see out in the marketplace is a continuum of different kinds of exchange approaches. Public ones are going to clearly be important. But there will also be these private opportunities, and states can mix and match between the public and private.

And so, I think on one end of the continuum, you'd have a state like Vermont, which is going to say there's real potential like a large employer to get scale here and use that leverage to really drive change in the marketplace. That is going to happen. But on the other end of the continuum, I think you're going to see other people, like Utah, say we really want to privatize as much of this as we can and outsource it to the private sector.

And under this law, this would be the most radical idea, to get one on Cindy's side of the equation. You can say we don't really need an exchange anymore. With all these different private exchanges and Web brokers out there and things you can get on your iPhone today, let's just have an eligibility function.

And then once someone is determined eligible for a tax credit, let's just give it to them and let them go purchase their insurance from any lawful seller. We don't need this portal filter to help people sort. There's plenty of different ways they can sort. You're now back at McCain 2008, basically. So, that gives you an illustration. I'd kind of be more in the favor of those activist exchange things.

I think you want to use your leverage. But if you want to, you could use it to literally let people go into the marketplace and purchase from any lawful seller.

Mr. Dennis Smith: This waiver is kind of the super waiver, the mega waiver, because it allows you to do so many things differently than in the past. I did a lot of Medicaid waivers. But you're dealing only with Medicaid at that point in time. You can't do anything else outside of that. The way you combine the 1332 with an 1115, it's--it is all still one single application. But of course, you have to tell the federal government what parts of Title 19 or 21 or 18 do you want to waive.

So, that's no--that's not any greater burden than what a state would already face. The 10-year baseline, I think, will be a challenge in all the waivers. It's all about the baseline. And that where are you compared to the baseline, it's, again, a reasonable requirement to have. The federal government does want it to be budget neutral. But I think there's, again, a lot that can be done within that baseline.

We were talking about so much money in the system. And parts of it, I think, I would add sort of all of the above. I think the idea of combining your Medicaid population with your CHIP with your tax credits, you know, at the end of the day, whether it's called a Medicaid grant or a tax credit, the bottom line, it's money, right?

States, I have not met a governor yet who doesn't think he can do--he or she can do a better job than the federal government can. This is the opportunity to prove it. And a waiver, in essence, says I don't want to do the law. I don't like Title 19. I don't like the constraints. Now you're saying I don't like the constraints of the ACA. I can do this differently and better.

So, I think that is the--whether you want to zero in on the small group market or whether or not you want to go after the dual eligibles, again, states have been talking about dual eligibles. There was a lot of excitement and electricity about taking on the duals. And everybody knows we have to get there. But I think, in many respects, we got bogged down because the federal government tried to prescribe too much at the beginning.

Waivers are about innovation. Remember where the Children's Health Insurance Program came from? Did Congress invent that? No. States were doing that first. Florida and New York, they're the ones who went out and created their own Children's Health programs before Congress came along and passed Title 21.

Title 21 has a lot of flexibility in it. States had so much ability to choose what benefit package you wanted to go after, what income level you were going after, et cetera. So, again, I think states, when they learn more about 1332, and there's not a lot of information out there right now about 1332, they've been so immersed and everybody's head's been under the water just implementing what the ACA was doing. Now states are going to come up from--for air a little bit and a do a little bit longer term thinking. But I think it's a fabulous opportunity for states.

Ms. Krista Drobac: So, as you can see, we have a very balanced panel, people who want to fix it, fix the rough edges of the ACA using 1332, and people who want to think big thoughts about how to potentially achieve the goals of the ACA in a totally different way.

So, I'd like to ask the two separate questions. First, to Deborah and Joel--talk about churn and the different networks and the kinds of, you know, jagged edges that you can smooth out with 1332. How would you--what are the mechanics of how you would work that out so that if I have different income from year to year, I'm not going back and forth between, you know, say, a PPO network and a Medicaid network?

And then for Cindy and Dennis, you both advised governors. What would you advise a Republican governor to do today if Medicaid expansion's off the table or, you know, there's

going to be no state-based exchange? What would you advise them to do? How would you use 1332 to both be politically palatable and also from a policy perspective help cover more people? So, I'll start with Deb and Joel.

Ms. Deborah Bachrach: So, let's start with the jagged issue. We don't--we started out with sort of broad vision. But there are jagged edges. There's those little pieces that just aren't working well. So, Joel and I have been interviewing some states.

And one state said we need the same definition of American Indian. That, you could use a 1332, maybe combined with 1115, maybe not. But let's get a consistent definition. We want the same enrollment effective dates. There are pieces that are smaller, that are kind of the one-offs that would make it easier to implement and to smooth across Medicaid and exchange at different income levels.

Then you could move into where I started, which is to think about taking the subsidies that are available to smooth the subsidy continuum, as you move from Medicaid into exchange coverage. A perfect example, we already see some premiums being effectuated for higher income individuals in Medicaid, so not high income, but higher income, those between 100 and 138 percent.

But then we might want to say instead of going from 2 percent of income for premium right to 3, maybe we want to introduce 2.5 percent. We could do that with a 1332 waiver. A lot of what we're trying to achieve came from what Senator Cantwell did with what we call the Basic Health Program, where she said a state can take 95 percent, not 100 percent, 95 percent of the tax credit and use it to cover individuals up to 200 percent.

Or you could say I want a plan with a higher deductible. I think we need to attract healthier people. And maybe we should have higher premiums, higher deductibles, lower premiums, higher deductible. And that's how I want to move it. So, that's about smoothing it across the income levels to be attractive to individuals at different income levels and to enable individuals to stay on coverage as their income changes.

And that's--it may be that a state sees that balanced differently than the ACA sees it. And that can be the red state or the blue state, but that we can now effectuate that balance differently.

And then I want to just add one more piece on the churn. I think we're going to focus a lot on what we can do with waivers. But we can address churn today without a waiver, right? We can offer Medicaid Managed Care plans through a state-based marketplace. We can have the insurance commissioner who's in an FFM state, a state with a federal marketplace, say I'm going to impose the same network adequacy rules as we're doing for state employees, as Medicaid is doing for Medicaid Managed Care. So, we can think a lot about smoothing under current law. And I think that's what you're seeing state Medicaid agencies in partnership with insurance commissioners and sometimes even with the agency that oversees state employees.

Employees think how do we start to reconcile differences so that your income doesn't put you into an entirely different silo? It simply alters your coverage paradigm.

Mr. Joel Ario: So, I--as usual, I agree with everything Deborah just said. There's another divide on this panel that cuts in a different way, which is, as you can see from that, Deborah is way into the details. She can understand every detail of Medicaid, write the laws around these things. And I think so that Dennis can too. Dennis can sit and write statutory language. Cindy and I may be a little more concepts and kind of political strategy.

So, I'll take Deborah's points and then put it in a kind of more broad scale dimension that I think is kind of interesting here, which is one thing I did learn from Deborah, is that Medicaid will be better over time if it's conceptualized as a form of insurance in the Medicaid--the way Medicaid is purchased and handled is managed more like an insurance product, the smart purchaser, instead of like a welfare type of program.

And so, let's apply that paradigm a little bit to what's been happening in Medicaid to kind of bring these two worlds together. As you say, the Medicaid as welfare paradigm, they still say it's out there. They are kind of trying to reinforce that paradigm. One dimension of that would be to say we want to impose work requirements on people who are going to get Medicaid. Nobody's talking about imposing work requirements on people who are going to get private insurance.

So, that's kind of the Medicaid as welfare paradigm. And it's not gotten a very good reception. And I don't think it should get a very good reception because Medicaid should move towards the insurance paradigm.

Now we get to the insurance paradigm. And then some of the federal government has gotten, you know, a little bit of challenge here because if you're really talking about that paradigm, well, then people should probably pay premiums.

I think you could have at least premiums, as Deborah said, down to 100. I come from a world in which in my other life where I'm, you know, thinking about charities and so forth, the concept is very much there that people do not value something that they get for free. There should be no free charity. There should always be something of a financial aspect to it. So, I think that you maybe bring some of those principles. There should be some principle, some premium in there.

And then you say, okay, well, if we're going to have a premium, then we'll also have consequences if you don't pay the premium. So, that's a harder one for the federal government to stomach so far. But they did now approve in Indiana a period there. And you can call it a lockout period and say it's punitive. I really think of it more like a delayed reenrollment. It starts to get kind of closer to the concept of, you know, you don't get to enroll whenever you want necessarily.

That's bridged too far so far for Medicaid. But that's the way you start thinking of premiums and consequences. And then you think of cost sharing. You could say, okay, well, we can't--you know, it's just cruel I think to have high cost sharing on people that have very low incomes.

But you can start thinking again like Indiana. Well, we can have an HSA underneath that that has some contribution from the person, also support from the government to back it up.

So, the more people are thinking about applying, you know, insurance principles to Medicaid and bringing these worlds together, and we can get away from this kind of rhetoric of, well, Medicaid's completely different than the exchanges we--and that's just something for poor people that I don't want to be any part of. We should be thinking of this stuff on a continuum as types of insurance arrangements.

Ms. Krista Drobac: Great. Thank you. So, which one of you wants to start and advise a governor?

Ms. Cindy Gillespie: Well, so, we--before we do that, I have to--Joel and I have this back and forth. And I think one of the important things, if I could just jump in, is you know what sometimes is the hardest: bringing together your Medicaid director and your insurance commissioner--.

Mr. Joel Ario: --Absolutely--.

Ms. Cindy Gillespie: --Right?

Mr. Joel Ario: Yes.

Ms. Cindy Gillespie: We are really marrying two worlds. And Joel talked about it conceptually. But on the ground, you've got two personalities from two different worlds. And neither quite gets the other one. And we've got to start changing that.

Ms. Krista Drobac: Have you noticed a change over the last three or four years? Because they've had to work pretty closely together.

Ms. Cindy Gillespie: I--well, I think you've noticed them talking together, right?

Mr. Joel Ario: Yep.

Ms. Cindy Gillespie: And just as I've educated Joel about Medicaid, and he's educated me about the private markets, I think when people--.

Mr. Joel Ario: --We do agree about that part, right? No.

Ms. Cindy Gillespie: We--so, I think that--I think it's starting. But I do think that's a tension. It's a tension between a public and a private insurance lens that we've got to bridge. And we bridge it with personality at the start.

Ms. Krista Drobac: So, isn't it the role of the governor to--?

Ms. Cindy Gillespie: --Yes--.

Ms. Krista Drobac: --To put them together and say figure it out?

Ms. Cindy Gillespie: That's a great segue. That's exactly right. I mean because ultimately both report to a governor.

Ms. Krista Drobac: So, you too--.

Mr. Joel Ario: --I want to hear how Cindy the governor on that--.

Ms. Krista Drobac: --So, you two, as the advisors to the governor--?

Ms. Cindy Gillespie: --Okay. So, I'll start very high level and let Dennis, as always, be the one to actually do the detail and substance. And I got to--I have to start it with this. I don't know of a single Republican governor who doesn't want their citizens to have health coverage. Let's start with that. I think there's sometimes a perception that for some reason Republican governors don't want their citizens to have healthcare. They do.

What you have when you're advising a governor who's sitting here with a mandate from Washington that is going to cost and have implications in their state that I think Washington doesn't always understand, you have a much more complex situation.

So, with a 1332, the first thing is, as we've all agreed 100 times, every single state is radically different, right? And within that, even the income levels in every state is radical different.

So, 400 percent of federal poverty in New York City is extremely different from 400 percent of federal poverty in America's Georgia. So, you start with the fact that most of these states where they have an expanded Medicaid, Medicaid expansion takes it well into the workforce.

And that's the first thing. And it becomes a big shift from ESI, which is partly why I was talking about they could look at a 1332 as a way to build on their current employer programs versus transfer that from an employer subsidy over to now it's a government tax payer subsidy.

So, that's sort of a big picture about why that to me is an issue as you look at some of the states. But these governors are sitting there with, all right, I would like to get coverage to my truly poor. I would like to get coverage further down the spectrum. As I do that, I don't want to upset the market that is working. I have some things I need to--want to improve over in these markets.

When you get into the southern mountain states, heavy, heavy, heavy small business, right? So, how do I really use this as an economic development tool? That starts with an analysis of, all right, if we didn't have to do what they have said, how would--what--let's go back in our thinking to before there was an ACA. What would we be doing? How would we do it? And how would we extend coverage to those in our state that are down at the lower levels, whatever level that state sets? And then how do we work out something that fits our state and our culture in this other perspective?

All of that combined with the most important person in a governor's life is never the insurance commissioner or the Medicaid Director or the HHS Secretary. It is their Secretary of Finance because the budget is the top thing, right? So, the budget drives

everything. And so, understanding that that budget person at the table is really going to drive how the governor develops any of these policies and the flexibility that you have.

So, with that intro at 100,000 feet, give it to Dennis.

Mr. Dennis Smith: Bring it down a little bit more to brass tacks. Again, governors would say the waivers that you haven't gotten, now is the opportunity to try again. I think immediately of Oklahoma, who's been trying to do a version of a three share program for quite some time, again, where the employer, the employee, and a government subsidy all come together to help spread the risk.

Again, some of the concepts that we use, if we go back to basic understandings of them, I think it's often helpful. What is insurance itself? Okay. Insurance is giving you access to healthcare. But it's also to protect you against the financial risk that your healthcare won't bankrupt you. So, there is--insurance is spreading risk across everyone.

I've said in the past, someone who is uninsured, we ought to really be saying you are self-insured. And you cannot afford to be. So, you need to join a pool somewhere. Which pool do you join? Again, the irony, Medicaid is not considered insurance. It's medical assistance. Somehow, we've turned the corner, though, to say, well, if I have a Medicaid card, I'm going to count you as insured, which is what we do.

So, what if a governor from a state that has heavily invested in a charitable system for providing healthcare, and also I think of the FQHCs around the country that provide care to 22, 24 million people. Should they be counted as being covered? Well, if I give them a card now and say you are a member of my ACO that I just formed, why should I not count that just as much coverage as Medicaid fee for service?

So, again, these are the things states go back to state-specific solutions to reflect the markets that they have. Again, as mentioned, as this is where a lot of the pushback from the states came from, which is the federal government is trying to do--to make all the rules. And it's just up to us to say okay. That is not the nature of governors. It's really not. They see themselves as problem solvers. They see themselves as caring about their citizens, very much as any politician in Washington does.

So, when the federal government comes and says we care more than you do, there's a natural resistance to doing that. So, again, states will come back, build on the systems that they have.

Again, we don't--we don't call it or count it as health insurance. But, again, the states deliver an incredible amount of care, which is what their citizens need. The last thing, work requirements were mentioned. And again, I think that this is where states will resonate with them, to say, look, if I can start differentiating, for example. Again, one of the things that I will have used in my own example, people below 138 percent of poverty, boom, you have to cover everybody below 138 percent.

Well, what--why couldn't we have done up to 100 percent? You would have gotten a lot more states already in the system if the administration would have said you can do any income level in between.

Even those under 100 percent of poverty don't all look alike in this respect. There's a great deal of difference between a--and I've used the example of my daughter was in graduate school. She--guess what? Her income was below 100 percent of poverty. Medicaid was never intended for her, though, I would argue.

On the other hand, a 55-year-old carpenter who falls off the ladder, gets hurt, loses his--and he's self--you know, he's self-employed and now can't work is in a very different situation. Don't I want to get him healthy again, back to work, back being a taxpayer, back into the system? And it's a point that I agree with Deborah on about, you know, the--it used to be the old Medicaid cliff.

You know, there was a built-in dis-incentive to work. It was a very rational economic decision on the part of that family, though. If you have a sick child, and you--I can't earn too much, or I will lose my coverage for my family, that's a rational economic decision. Now is an opportunity, though, to turn the Medicaid cliff into more of a bunny slope. Help to -- again, I would argue, some premiums, some cost sharing at lower levels. Again, we had 40 percent in Wisconsin, 40 percent of our adult on Medicaid were smokers. So, it's a little hard to say I don't have a little bit of money to contribute to my own healthcare costs.

And again, I think people are very generous to their neighbor. But they also want to see their neighbor doing what they can do for themselves as well. And to be a part of all this is to saying I am going to have personal responsibility here. I am going to participate. The work requirements, again, most people in Medicaid are in the workforce. So, again, the work requirement, it sort of landed with a thud with me a little bit because there--.

Mr. Joel Ario: --Can I ask you a question?

Mr. Dennis Smith: Sure.

Mr. Joel Ario: Because I think--I don't want to get off on this. But just a bigger question of I can't tell by the way you're saying it, should we be thinking about we want to get as much of Medicaid as possible to the Medicaid as insurance model? Or do you think Medicaid should still basically stay kind of conceptualized as a form of free kind of charity for people who can't afford anything else? I thought you were more in the camp of Medicaid as insurance as much as possible. But I couldn't tell from the way you were describing it.

Mr. Dennis Smith: No, again, Medicaid is not a program. It's really--it's several different programs serving several different populations. For the healthy population, and overwhelmingly, Medicaid population is healthy because half of them are kids, no, I don't expect a work requirement on the kids in Medicaid.

I'll just be clear about that, although I made my kids work at 16. They are on the path to insurance. But again, recognizing they're--they are in the workforce, but they're only working part time in some respects, not taking extra work because you would put them over

the eligibility threshold. And that's why I'm saying we smooth this out. It--then it doesn't matter. The--reversing the message, and the old message of Medicaid was don't work or don't work very much.

Now it can be work as much as you want to and as much as you can. And you won't lose your health insurance. You are simply changing who is paying the subsidy. And I think that that is again.

So, what I would argue to governors is the message is not just about healthcare. The healthcare message is very important in itself. But it's not just about healthcare. It's about how to get that 55-year-old self-employed carpenter back to work, back into the workforce, how to get people fully gainfully employed and not saying I don't want to--I'm not going to work that extra two-hour shift because it will mean then I will lose my coverage. So, it is a--you know, it--ACA to the states were sold its economic development because the federal government is going to launch airplanes over the country and drop bundles of money on you through the enhanced match rate.

That's not the right way to think of this. The right way to think of it is say we're going to get the citizens of our state healthy, back into the workforce. Again, there's no--there is no free money. The federal government doesn't have any free money to give to anybody, to any state, to any individual. It has to take it from somebody. Again, the 100 percent match rate, it's like what do I--if I'm a tax payer, if it came out of my federal pocket or my state pocket, I'm still paying the cost of the Medicaid expansion, right?

So, again, the real message of economic development is helping people to be healthy. And as a state, I can do that in my own way and get people back to work.

Ms. Krista Drobac: So, let's talk about some of the things that states are thinking about. So, I don't know if Oklahoma is thinking about a three share program. But--.

Mr. Dennis Smith: --They--absolutely--.

Ms. Krista Drobac: --After you said it, I'm sitting here thinking that's actually something that could be doable--.

Mr. Dennis Smith: --Yep--.

Ms. Krista Drobac: --Where you've got--because you could meet the affordability requirement. You could meet the coverage requirement. You could probably produce a 10-year budget because you could actually use--the money would actually go further if the employer is paying a third and the person is paying a third. Then the government only has a third. So, that's actually one big thought. Then if you guys could address maybe Hawaii, Vermont, any others--?

Mr. Dennis Smith: --If I could add also, the extent to which you have families, right now we're paying the most to divide that family each individually because Medicaid is paying a PMPM to a managed care company on three kids. And then the tax credits are paying for one of the spouse. And another spouse isn't getting anything, right, because that spouse is with

an employer. So, a family in Oklahoma covering the entire family under one package is actually going to save money. So, it's a way of reducing costs--.

Ms. Krista Drobac: --But have you thought more about how it might really work? Or do you know if they're thinking about it?

Mr. Dennis Smith: I haven't talked to anybody lately.

Ms. Krista Drobac: Okay.

Mr. Dennis Smith: But I--that one came initially to mind as a very natural way to save--to get back at--but--.

Ms. Krista Drobac: --Do you want to talk about Vermont or Hawaii?

Mr. Joel Ario: Let me talk about Hawaii quickly. Hawaii is a state that has had a different approach for a long time. They've had an employer mandate since 1974. And it's worked to get them the 92 percent coverage level.

So, where Massachusetts started with a high level of coverage before the ACA, and on top of that, it's gold and platinum type coverage, very different configuration than what people are choosing in the exchanges. So, they set out there with a relatively small state to start with. So, there's not a lot of potential for an exchange to gain a lot of scale, especially when you add on top of the small size the fact of 92 percent coverage.

And then you add in that they also really like their gold and platinum level coverages and the way in which the ACA is creating a lot more skin in the game for consumers. Again, the ACA has a lot of pretty conservative ideas in it, fairly high cost sharing. It's really the structure that drives people to silver plans to get those cost sharing reductions.

So, Hawaii's kind of on a different plane than that. And so, they've already started planning for a 1332 waiver. I think what people today could take away from Hawaii is the kind of planning process, which is to start with all the, you know, important leadership people in the state government involved in a taskforce and think through all the options.

They've reviewed all the different sections that you went through, Krista, of their potential waivers. They haven't made any decisions yet. But they very well may decide to kind of do something that basically shores up this employer-based system. I know what I've suggested. Well, maybe it might be interesting for you guys to think about coverage in a different way. Oh, no, no. Everybody loves the prepaid law. And they want to stay with their basic coverage.

So, I think they're ripe for some kind of 1332 waiver that fits the paradigm of what they have out there. And they, lo and behold, find a lot allies, a lot of the people that I talked to go. So, I understand what you're painting about the public exchanges and kind of silver and bronze. Please tell me that's not going to happen in the employer-based market. And the basic message is, no, sorry. That's kind of where employers are going through private exchanges too, but maybe not in Hawaii. Maybe Hawaii's different.

Ms. Krista Drobac: You two, any thoughts on states that are thinking interesting ways?

Mr. Dennis Smith: You could do Arkansas, Deborah, maybe.

Ms. Deborah Bachrach: Well, I think, as we were saying when we were waiting to come in here, there's virtually no state that you'd talk to that doesn't say I'm definitely going to do a 1332 waiver. Then you ask the follow-up question. What do you want to do with this--well, I don't know yet. But we're definitely doing it. So, I mean, I think that's what I would say. And I think that what's so important and something we've all alluded to it, is there are core principles of the ACA that you have to keep an eye on.

Cover the same number of people. Make it affordable. And comprehensive--and it's comprehensive. Those are core. After that, it's up to the state. And I think that's what's so important. And the state--and to sort of, Cindy, your point, every state looks different. I think there is a national consensus that coverage is good. We want people to have coverage. And we want it to be affordable, given your circumstances in a particular state. And then what's the best way to do it? Whether it's Georgia, and it's going to look different than New York City or Oklahoma. But we have those guard rails, those core principles that I think we have some national consensus around.

And now we can go to work on 50 different models to achieve those goals. And I think that's what we're all getting at, whether it's the Hawaii or what Vermont wanted to do or what Oklahoma might want to do.

So, Joel kicked me with--or kicked to me Arkansas, which I think is a tremendously exciting example. And we've been working in Arkansas for several years now. And what Arkansas is doing is they expanded Medicaid. But they took the Medicaid dollars to buy qualified health plans in the exchange, 200,000 people enrolled in Arkansas, almost all through qualified health plans in the exchange. And there's a real meshing of the markets, right, because the person who's coming in through what they call their Medicaid private option comes into the same plan he or she will be in when their income goes up.

And they move into the exchange without a Medicaid subsidy. And they move into a tax credit subsidy. And what's really interesting is the plan was conceived under a Democratic governor with a Republican legislature. And I don't know how many of you saw the new governor, the Republican governor's speech talking about the benefits of the expansion, recommending that it be extended through 2016, then revisited, as had always been the intent. And it was passed immediately by a legislature with more Republicans than when Governor Beebe had first passed it. So, you can start to see consensus emerging for a consolidation of the markets and for coverage.

So, I think that that's what 1332 starts to build on.

Ms. Krista Drobac: Cindy, would you agree with that?

Ms. Cindy Gillespie: Not particularly.

Ms. Krista Drobac: I had this--I had a feeling that you wouldn't agree on that. So, I wanted--.

Mr. Dennis Smith: --I think people are that, though, right? You like that the Medicaid people are in the private insurance?

Ms. Cindy Gillespie: How about the national convention? Completely, completely do think that makes a lot of sense. I want to take this in kind of a different direction if I could for a second because you were asking about states. And there is a group of states, you know, the 14 and DC, that have their own state-based exchanges. And those states have to look at a 1332 in a different way. And we've been talking about states that are basically working from the FFM, you know, in a lot of our conversations here.

But the states that are operating a state-based exchange, they've all gone through, you know, they've all gone through their early operations period. They're in various stages of effectiveness. And now they're in that period where they see sustainability on the horizon, the question of will this work for us in the long term? And in all of those states, I don't know of a one that is not struggling with that issue of sustainability.

They have an exchange set up. They are selling plans through it. And I'm not talking about the shop exchanges, which have almost no one in them, except in DC where Congress is in them as a small business. The--it's over--it's the individual exchanges. And even those that have been very successful and enrolled a lot of people don't see the path to sustainability.

And so, one of the big things 1332 gives them is the ability to take a look and say, all right, if I want to create a sustainable exchange, I don't have to follow all the rules that came down from the government in the ACA, the federal government in the ACA around this exchange. I can design it the way I want. And I think there will be a real look at those states, not just in population and how to emerge, like you said--.

Ms. Deborah Bachrach: --Yeah--.

Ms. Cindy Gillespie: --But also just the flat question of what am I going to do with this? How do I make it work? Joel's comment earlier, I 100 percent agree with. Some of them may well go I just want to privatize it. You know what? I am just--it doesn't--won't have to be a government or quasi-governmental entity anymore. So, I'm just going to privatize it. I'm going to say who wants it? Put it out for contract. Or give it to several. Or get rid of it completely, like you said, and figure out a system to where people buy, and they access the tax credit. And it's just an eligibility engine left, which can be over in Medicaid, right? And just work off of that eligibility.

There's a lot of things they can do. They can sell other products. You know, how many times have you heard, and I know you were like me, the state-based exchanges say why can't I sell something else?

I mean the way private exchanges are successful is they don't only sell health insurance. They also sell other things. They do other things. Why can't I do other things? You could.

In other words, it's a chance for those exchanges, and I think even as states look, I expect we will see state exchange boards, just like we are in Arkansas, right?

Taking a look and going all right, if I've got a 1332, what do I really want my exchange to look like going into the future? And how do I deal with some of these issues? It's--.

Mr. Dennis Smith: --I think to--.

Ms. Cindy Gillespie: --Their path to make this long-term--.

Mr. Dennis Smith: --To put one specific on that, if you read the statute about eligibility, it basically says the Secretary shall set up eligibility for everybody. So, they made a choice way back when I was there to say, well, we want that to be part of the exchange because we want the state exchanges to hook up between their tax credits and the Medicaid the way Deb and I've been talking about it here.

But they didn't have to make that choice. And in fact, when a couple of states came forward and said we're not ready with our eligibility system, which is the toughest part of an exchange to do from an IT perspective, the federal government said, yeah, our regs have always recognized it.

That can be a federal responsibility. We'll just retain it. And so, now in, you know, three states, Nevada, Oregon, and New Mexico, eligibility is handled by the federal government, even though those are state-based exchanges, which makes the count 16, Cindy, not 14. But that--those--because those count as state-based exchanges to me--.

Ms. Cindy Gillespie: --I don't count them--.

Mr. Dennis Smith: --And they continue to be state-based exchanges.

Ms. Cindy Gillespie: I don't count them.

Mr. Dennis Smith: And so, think about that then in the context of 1332. Federal government takes eligibility, pays for it. They put a big part of their sustainability costs on the federal side. They're going to use user fees. But it'll be the federal government worrying about how to do the user fee, not the state. And you hear a lot of the states complain that the reason they can't make themselves sustainable is because they have the federal government constantly changing and tweaking the eligibility rules in the system.

And it's just not a good business to be in if you've got a federal agency that's going to keep changing the--those--a big set of your operating principles. So, put that all aside. Now you've got your handoff. It becomes just like an employer-based situation. You get people who are on your roster, who've been declared eligible. And your job is to give them a shopping experience, manage the plans, do consumer assistance, the other functions after that. It gets to be a whole lot more sustainable and manageable.

Ms. Cindy Gillespie: And the Web brokers, I mean it's probably worth just mentioning the Web brokers that are out there that are hoping to eventually be able to be part of the FFM. I don't know if any of them are actually part of the SEMs yet.

Mr. Dennis Smith: Thirty-six Web brokers have contracts--.

Ms. Cindy Gillespie: --But they want to--.

Mr. Dennis Smith: --With the federal government. They came back on my watch and said we've been doing this for 20 years. They helped it. We actually know how to do it. I said it sounds like a good idea. And there are regs that say they basically instead of going to the federal portal to buy insurance, you can go to their site. And there's a back office connection to do this eligibility thing.

That has to be a fed--I think that has to be a government function. The IRS is not going to let private parties determine who gets big tax credits. But anyway, there is that mechanism. It's just been very clunky. But if they implemented that, which is, again, a tough IT challenge, then last year I was pulling my hair out going we've had this policy for two years.

There are 36 Web brokers. And the President could have said if it had been implemented don't worry that the federal portal is not working very well. Here's a list of 36 portals that you can go to, including eHealth, GetInsured, GoHealth, et cetera, et cetera.
You can go to all these portals. And they can service you just as well as the federal government. That could be done under the current law.

Ms. Cindy Gillespie: Exactly. And I would think for a 1332 that's going to be an attractive idea for a number of the red states--.

Mr. Dennis Smith: --Yeah--.

Ms. Cindy Gillespie: --Is to be able to work with the Web brokers.

Ms. Deborah Bachrach: Well, and then you put eligibility on the backs of the federal government. Then governors, let's come back to the governors. They can focus on their insurance markets. And how do they leverage their purchasing power across Medicaid, the qualified health plans, and state employees to drive health reform in their state, to drive payment and delivery reform, bring down cost?

Because let the feds to the, you know, the eligibility, and let them focus on their local markets. So, it blends the--everything we've been talking about in some sense. Do you want to talk about--okay. Because--yeah.

Ms. Krista Drobac: Okay. I'll step in here then.

Mr. Dennis Smith: Shouldn't this be about the two states and how they count or--?

Ms. Krista Drobac: --No, no, no, no. Just--.

Mr. Dennis Smith: --Okay--.

Ms. Krista Drobac: So, we're going to ask--I'm going to ask two more questions. And then we'll turn it over to audience for questions. You know, it depends on what you're--so, 1332 actually requires somewhat of a pause, right? So, if anybody in here, if you're a state policy maker or you know, they are harried, running in 12 directions, and not only trying to fulfill your operational responsibilities, but try to think big policy thoughts too.

So, one of the requirements of Section 1332, just practically, is to step back and say, okay, we've gone down this path. Where are our gaps? What do we need to fill in? And at least--I mean I think most of us here have had experience at the state level. You don't have the space and time to do that.

So, the other thing I noticed when I was at NGA was the power centers are different in every state. In some states, the insurance commissioner's really strong. In some states, the lieutenant governor is in charge of healthcare and is really strong, or the secretary of health is really strong. So, the drivers are in different cohorts.

Ms. Deborah Bachrach: Um-hmm.

Ms. Krista Drobac: And so, they may not actually be seeing their other compatriots, like, stepping back. But it really does take a measure of leadership to say stop. Let's figure this out. So, talk about what you're seeing at the state level in terms of policy makers trying to make that space, to think bigger about how to use 1332.

Mr. Dennis Smith: You should start on it.

Mr. Joel Ario: I started last time.

Mr. Dennis Smith: Well, you haven't talked for longer than the rest of us.

Ms. Deborah Bachrach: We've been talking so much.

Mr. Joel Ario: Well, I think, again, you've--you start with where you are. And Cindy mentioned sustainability. And that still sends shivers through the spines of the states' budgets. Again, talking about states that are in different places, those energy rich states a couple of years ago were feeling very good. And now they're feeling not so good, right, because the revenues aren't coming in.

So, every state starts with where they are. The dynamics of bringing--and you mentioned, you know, a lot of different powers. I mean governors have different levels of powers. The governor in Wisconsin is extremely powerful, the governor of Texas, actually, not so much so. So, in all of these, how you bring folks together is the way you do it in any other sort of way.

And to some extent, we've thought healthcare has been viewed as a--something else on its own. And to some extent, it's true. But more than that, the health of your population is tied to your economic prosperity.

At the local level, again, now you are seeing Florida, for example, the business community and the hospital associations now forging stronger relationships together. As I said, the first time around, the economic development was thought of as Washington dumping bundles of money as it flew across the country. But now the local folks are seeing, wait a minute. This is about a healthy workforce. It is about--at the beginning, hospitals were kind of leading the way somewhat on their own. And they were not as successful as they thought they were going to be.

So, they are--they're forming coalitions now. And the business community and the hospitals are coming back around together. So, you're seeing governors to some extent where, again, decisions were made in the past. We've overlooked a huge thing about the exchanges, which is people forgot that under the law and under the earlier instructions, states were going to have to have--the federal government was going to come out and review whether or not your exchange was going to work by January 2013.

So, again, states were backing up. I mean we took those deadlines seriously and came to the conclusion that we weren't going to be able to pull it off, whereas a lot of Washington, oh, that was all just political. It wasn't. It was--this was a huge assignment, very complex. We don't have all the rules yet even. State procurement laws, you didn't waive those. I mean there were a lot--states like Wisconsin came to the conclusion we just aren't going to be ready by 2013.

And we ought to just say that now. And instead, it was--they were sort of beaten up for the honesty of it. I'm sorry. I got off track. If you were--that's where we--that's where we were. And again, I think states, governors, legislatures now, it is an opportunity to rethink things over again and saw we ought to be looking this as the opportunity of what we can construct.

Again, just the message of itself, just the state innovation, is a powerful message out there to the states. And I think they're going to respond because the--because they--and there are still a lot of folks who are still coming around saying, look, if the ACA does get repealed, we're simply back to where we were.

And we had problems before that. And we had--you know, there were--nobody thought that--or very few people anyway thought we had a perfect system prior to the ACA. There was a lot of disruption that was caused in the ACA and a lot of angst to it. But again, the reality is if it did get repealed tomorrow, we simply go back to discussing the problems we were discussing before ACA was passed.

Mr. Dennis Smith: Two short stories, there was another panel back before the 2012 election. And I asked the question from the audience, what would his advice be to Governor Romney if he became president?

And he said in essence, take the six smartest governors on both sides of the aisle and bring them in and talk to them about what comes next. And then Governor Babbitt who was monitoring the panel said I want to ask you what you'd do if Obama's reelected. And he sort of sat back for a while. And he said same answer. It's too bad the President didn't take him up on that back then. But now is that opportunity.

And the second story is back in 2012, Krista hired Deborah and I to go around to six states and bring everybody together and talk about how they were going to put together their plan. And it was a very heady time. And everybody was talking about, you know, bridging the gap between insurance and Medicaid and all of that. And then what's basically happened since then is everybody went to the trenches to do that work. And then kind of all the planning and coordinating, a lot of it fell to the wayside, not all of it, but a lot of it.

This is a chance to recharge that with a little more knowledge and kind of hopefully have a more sustained way to keep it going. I don't know what your feel is. But, I feel like we got a bunch of energy, but it didn't--.

Ms. Deborah Bachrach: --I think we're still on the road again--.

Mr. Dennis Smith: --But it didn't really--it didn't have staying power.

Ms. Deborah Bachrach: Yeah.

Mr. Dennis Smith: And now we need to have some staying power with it.

Ms. Deborah Bachrach: But I want to give you two examples where governors' leadership, and I really want to come to Krista's point. Leadership is everything. And I'll give you two examples. One I already alluded to, which is in Arkansas with the Democratic governor, Governor Beebe, and a conservative legislature.

They--the leadership of the legislature, conservative Republicans, they worked hand in glove. And they passed the expansion by doing it through the private market. A new governor comes in with--Republican governor, more conservative legislature. And they extend it. And there was power. There was energy. And there was working. And it's working under the leadership of the governors, Republicans, Democrats, and the legislature.

Look at Governor Pence in Indiana. He was committed to his expansion. He talked regularly. You can look on the Web site, and he's got his timeline of how many conversations he had with Secretary Burwell. But he had a plan. It worked for Indiana. And he moved it through. But all of these examples, you show the same thing in New Hampshire with a Democratic governor and a Republican legislature.

With leadership out of the governor's office, or in some states it could be the lieutenant governor, you can see it working. And I go--I agree with Joel. Now with 1332, we've opened the door again for new energy to move some potentially very exciting coverage scenarios.

Ms. Cindy Gillespie: Could I add one thing to that? Because I agree completely on the leadership issue, 100 percent, and it's got to come from the top.

On a practical level, Dennis mentioned something. And I--a player that I think we should not forget in this, which is the hospitals, right? That--at the state level, that's where care comes from. And that is a major player. And it's interesting how often in these discussions there's not a recognition that the key player many times at the table there, the stakeholder you must deal with is your hospitals and your hospital systems. You cannot design a system that results in hospitals closing. You cannot design a system that does not work for them as a business.

And they have to be part of the table. And the key in the reset and the leadership is to then bring all the right stakeholders together, not just the ones whose voices are usually heard at the legislature, but actually to take a look at how care is being delivered in your state, what the business structure is around it.

And then from that, begin to design your reforms. And, you know, carefully done with a lot of buy in, you can get some pretty amazing places that fit that state uniquely. Deb and I talked a little bit last night about the difference between trying to look at a South Dakota, where they have an Indiana Health--.

Ms. Deborah Bachrach: --Right--.

Ms. Cindy Gillespie: --System, right? And you have a completely different set of structures and issues. You've got to have different folks at the table as you're designing in South Dakota than we did in Massachusetts. So--.

Ms. Krista Drobac: --I'm sure there's a bay in South Dakota that Wyden could have referred to.

Ms. Cindy Gillespie: Right.

Mr. Dennis Smith: --There's not much water in South Dakota.

Ms. Cindy Gillespie: Yes, right.

Ms. Krista Drobac: So, last question, it'll--might be short, maybe not. But it's a big political question hanging over us. And that is King v. Burwell. And everyone's all atwitter, obviously, in Washington, about what that means. But what does it mean in the context of 1332? Because if the subsidies do fall, and you are a federal state, could you use 1332 somehow to address that issue? Don't all jump at once to answer…but, Cindy, I know you had some thoughts about this.

Ms. Cindy Gillespie: I mean I'll just start with one thing, which is, you know, 1332s don't--you cannot have a 1332 before 2017. And we've all agreed. We've discussed that.

Ms. Krista Drobac: Right.

Ms. Cindy Gillespie: I don't know of anybody who says that the administration has the authority to push forward a 1332. It has to be 2017. So, if there were to be a decision and if the subsidies were to end in part of the 2015 or the 2016 year, 1332 is something that can be looked at for beginning in 2017. But between now and that time, there will--there will have to be some sort of bridge that moves to 2017.

Ms. Krista Drobac: You'd actually have to establish a state-based exchange so that you could wave the state-based exchange.

Ms. Cindy Gillespie: Not--well, I think one of the things that's going to be important, and we will see how this all comes down, and we'll see how the politics shape out, but I do think, at least on the Republican side, there's always been, and you've seen the legislation that's started dropping now with the concepts that started dropping now.

The state should have more flexibility, and that we should return to more of a federalism, state innovation sort of format. And if something like that emerges as the bridge that sits there between now and 2017, then I think you would find that King v. Burwell led to the ability for states to begin to innovate sooner and to begin to take and work more rapidly. And I think that partly fits in with something else we all say as we talk to each other. If a state's planning to do a 1332 for 2017, they need to be working now.

Ms. Deborah Bachrach: Yesterday probably.

Ms. Cindy Gillespie: Yeah.

Mr. Joel Ario: Well, there may even be a practical problem with accelerating. I will point out that the President surprised us all back in 2011 by saying he was in favor of accelerating 2017--1332 waivers into the present way back then. So, the administration's on record of accelerating this. It could be that somebody on the Republican side says that's a good idea.

But I think Cindy would have a much better read of whether that's possible or not. But I totally agree with her last point, which is after King v. Burwell, assuming it's decided against the federal government, I think it's unlikely that Congress--they had a tough time in the leadership agreeing to anything. And if they have to agree to something that also includes the President as a willing party, that's a pretty tall order. So, a possible way to do all this is kick the can down the road and say we want to give states that want to pick solutions here some amount of time to do it.

And we want to give them more flexibility. Call it 1332 or call it something else. But, create more flexibility for the states, rather than say that the--I have a hard time seeing the Republicans say that we're going to create a solution where the only thing the state can do is be in, what you guys call, the straightjacket of the ACA.

So, you can imagine these things blending together in that sort of way.

Ms. Cindy Gillespie: And setting up a state-based exchange is not easy. I mean--.

Mr. Joel Ario: --Well, no, I don't disagree. There's an announcement from the Center of American Progress this week. I think they're right about the fiscal issue, maybe right about the fiscal issue that there's going to be a pay forward here in Congress.

I don't think they're right about the 1332 issue. And we looked at it legally. We think it would be--there would be ways for all states to be able to come into a 1332 waiver. If you have a federal exchange, you're going to be limited in what you can do. But it doesn't preclude you from--.

Ms. Deborah Bachrach: --No--.

Mr. Joel Ario: --Doing all kinds of other things that are waivable. So, 1332 waivers will be available to SBM/FFM states, just maybe a different--with different sense of potential.

Ms. Cindy Gillespie: Let me--.

Ms. Deborah Bachrach: --But I think we all agree that 1332 is not the answer to a decision knocking out the subsidies.

Ms. Cindy Gillespie: Okay.

Mr. Joel Ario: Yeah. It's not going to--it's no panacea.

Ms. Cindy Gillespie: Right.

Mr. Dennis Smith: Right.

Ms. Krista Drobac: Do you want add anything else?

Mr. Dennis Smith: I just wanted to ask Joel a question. I wanted to make sure I understood what he was--he is saying because to some extent, I've thought if the federal government loses on this one, in a way, that could be a good thing, in the respect that you get to start over in many respects.

And things that were missing the first time around, the bipartisanship, the--everybody's ability to help influence the outcome, you would get a fresh start at that. But what you said--you say the President wouldn't do that?

Mr. Joel Ario: No. I--.

Mr. Dennis Smith: --If that's what is required, you think the President wouldn't go back to Congress and to say, look, these are benefitting 10 million people with a potential to benefit another 10 million people. Can't we come together on a solution to preserve that?

Mr. Joel Ario: I would hope that both sides have the rhetoric and the intent to come to agreement. I'm just saying the way I see Congress operating, I don't have--and the President, for that matter.

I'm not--I didn't mean to insinuate just Congress. Congress and the President operating today, I hold out little hope that before the 2016 election with all the different forces of extremism on both ends of the continuum here, that the Republican leadership and the President can mutually agree on a solution.

If the Republicans were to say we want to put these back into operation, and we only have minimal changes we want you to agree to, to get that done, easy. If the President was to say, you know, I'll make some changes, I think it could get done too. But I just think both sides are going to have a hard time, from what I've seen looking at other issues, agree to something. And they'll both say we have the--the President will definitely have the high road, right?

He will say you can just let--put them back into place and let the law continue until the next election. So, he's-- he can say that. And the Republicans can say, well, all you have to do is get rid of the individual mandate. And we can go forward. But it's going to be that kind of dialogue, is what I worry about.

Mr. Dennis Smith: Well--.

Ms. Krista Drobac: --All right. Let's open--.

Mr. Dennis Smith: --I just think we should let--.

Mr. Joel Ario: --Sorry--.

Ms. Krista Drobac: --Let's open it up to questions in case someone wants to talk about 1332 because we could definitely talk about politics.

Mr. Joel Ario: But we were right about bringing this up at the end. Yes.

Ms. Krista Drobac: Yes. Hi. Go ahead.

Ms. Debra Cohn: Debra Cohn with the American Medical Association. So, you sort of started getting into this a little near the end. But I mean to throw another dose of reality on what I think is very exciting in terms of the possibilities for 1332. But where's the money going to come from? I mean if the court does throw out the subsidies and the requirements for 1332 are linked to as--you know, people having--as many people having subsidies as they would have otherwise.

And the federal government needs to be budget neutral. And we know the states are not--most of them are not swimming in money. And given the political realities in Congress, I mean what are the maybe more innovative ways to think about money and how are we going to--how states would fund this?

Mr. Joel Ario: I would take it--well, go ahead.

Ms. Deborah Bachrach: 1332? I think that if we--we've conflated the two a little bit.

Ms. Cindy Gillespie: Yeah. Sorry. I think we--.

Ms. Deborah Bachrach: --Right--. Because I think if the subsidies go away, 1332 is still in place. But you wouldn't have access to the subsidy dollars if you're in an FFM state. So, you might--I mean it's very--you use--you could still use 1332 for another purpose.

Change your exchange, some of the things that Cindy talked about. So, I don't think it's--it's just that you wouldn't have access to subsidy dollars because you wouldn't have--because the residents in your state post-King wouldn't have access to tax credits.

Ms. Cindy Gillespie: If you think about it like this, and we're talking about in 2017, not in this bridge period of whatever happens, right? So, if you think about it like this, in 2017, when you do a 1332, in doing a 1332, you can establish a state-based exchange, which creates the access to the subsidies.

But that state-based exchange can basically be I'm going to have the Web brokers do it because all of a sudden all of those requirements around what is a state-based exchange go away. So, you can--you know, it's going to take work. This is all new. It's never been done, right? And it's going to take work. And it also has an issue of what whoever is in the administration at the time that this is being--a waiver's done, what they're agreeing to, obviously.

But, you've got some--I wouldn't--there is a difference between--and I'm not saying that any particular state would do this. But, there is a difference between establishing a state-based exchanged under the current rules that the states had to establish them under. And we saw how many of them struggled in doing that, right? I always used to say as that was going on the only governors that had any potential problems were those that were actually trying to do a state-based exchange.

Those that said no actually had a pretty easy ride because they didn't have the--and then it turned out it really was a difficult thing. By 2017, if in establishing a state-based exchange, it's--you know, you pass a piece of legislation that says we have it. And it's going to be run by whoever out in the private sector, fine. You've met the requirement for your waiver.

Mr. Joel Ario: Here's an easier way to think about it. If the--whatever CBO might say about a baseline--after the Medicaid expense was made voluntary, that did not preclude any state from accessing all of the Medicaid expansions. It's not like all of a sudden, oh, there should be old baselines here.

Ms. Cindy Gillespie: Yeah.

Mr. Joel Ario: So, we estimated only 10 states. So, now the 11th and 12th can't do it. Same thing here, whatever they might say and however that might constrain congressional action, all 50 states can still say I'm going to become a state-based exchange and get all of the subsidy money back.

Ms. Deborah Bachrach: So, the trick is, and it's sort of a combination of what you both said, how do you do a state-based exchange post-King quickly? We--maybe you can do it in '17 under a 1332. You can do it legally before '17. Practically is another story.

Ms. Cindy Gillespie: Yep.

Mr. Joel Ario: And the avenues are hiding in plain sight. That's another panel, but--.

Ms. Cindy Gillespie: --Yes.

Mr. Dennis Smith: I'd just--.

Ms. Krista Drobac: --Oh, Barbara. Hi, Barbara.

Mr. Dennis Smith: You know it's not going to be last word.

Ms. Barbara Smith: Hello. How are you?

Ms. Krista Drobac: Good. Do you have a question?

Ms. Barbara Smith: I do. Just in response to your comment and the ability to activate subsidies in the event King versus Burwell were to go the other way, obviously, one of the things, one of the mechanisms that becomes available is for the federal government to do what it did in New Mexico, which is to say, okay, we're just going to lease you the eligibility and enrollment systems.

You can rent all of this from us. And you can call it your state-based exchange with some governance put in place. And I think that that provides a pretty--I didn't introduce myself. I'm sorry. I will at the end.

I think that at the end of the day provides a clear mechanism for allowing the subsidy money to continue to flow. Now there are other problems because the states have a limited amount of time through which they can ask the federal government for establishment money. And we're sort of approaching the end of that period. So, they would have to move very--.

Mr. Joel Ario: --It's already--it's already gone.

Ms. Deborah Bachrach: --Yeah. It's already gone.

Mr. Joel Ario: But what you just said is one of the avenues hiding in plain sight.

Mr. Joel Ario: But I think we should get back to 1332 probably, right?

Ms. Deborah Bachrach: Right.

Ms. Barbara Smith: So, I'm Barbara Smith from Health Management Associates. I'm sorry.

Ms. Krista Drobac: Okay. We're going to let two more questions. Sorry. I lost track of time. It was so much fun. Is there another question? Oh, hi.

Ms. Sarah Wheaton: Hi. I'm Sarah Wheaton with Politico.

Ms. Krista Drobac: She's Sarah Wheaton with POLITICO.

Ms. Sarah Wheaton: I wanted to go back to some of the earlier discussions about the difference in Medicaid as being viewed as a welfare program and--versus a health insurance program.

In Arkansas, a lot of the opposition to the private option still is this idea that you're giving a benefit to able-bodied adults. And the people who voted against it yesterday said that was why the people who wrote the legislation extending the private option for two years, many of them are people who think the private option should end after two years.

You know, so, how--to--maybe to some of the more politically minded people in the--on the panel, how can this be bridged among people who just really on principle feel that a benefit like this should not be given to people who can work?

Mr. Joel Ario: I would argue that we're already seeing it bridge from an insurance perspective, that there are--the--what these governors are talking about that want to push the envelope are applying more insurance principles within Medicaid. And they're succeeding. There are still--they're not getting everything. But they are succeeding. And as that happens, I do, with all due respect to my friend over here, think it's harder to argue for some of the welfare type principles like we should apply work requirement in there and so forth.

So, the more you make Medicaid like insurance, you pay a premium, there's a consequence if you don't, there is some cost sharing that's higher than it's traditionally been, all of those things, now you're talking about people having a--the benefit of a bargain not getting handout. And you know, that's--that all I think moves the politics forward, although it hasn't moved Dennis off of work requirements. I mean--.

Ms. Deborah Bachrach: --Right. And I--.

Ms. Sarah Wheaton: Well would they actually don't want to do that either--.

Ms. Deborah Bachrach: --Well, I--but I think it's really important. We delinked Medicaid from welfare in 1996. And over the course of the time, what we saw was that most individuals on Medicaid are not getting cash assistance.

The vast majority, it really flipped. And they're not getting cash assistance because they're predominantly low income workers. Put aside our aged, blind, and disabled, and put aside children, obviously. So, the vast majority are low income workers. They work for companies, or they work for individuals that don't offer insurance, or they can't afford it.

And so, if you start with that premise, and then you couple it with what Joel said, you're now seeing cost sharing. And you know what we've looked at? The cost sharing rules that apply in Medicaid, if you eliminated deductible, they're exactly the same as a 94 percent AV

plan. That means a plan in the exchange that's open to the lowest income individuals. So, we all have to get out of the mindset of Medicaid is welfare and understand how much it's moved off since 1996 and then took a real leap forward in 2010.

And in some sense, when the Supreme Court made the expansion optional, it really got the juices going in states to think about how do we move it into the insurance paradigm? And when you do, you move into then value-based purchasing. And Medicaid becomes a smart purchaser driving payment delivery reform. So, I do think we're seeing that movement. And I do think you're seeing--whether you call it skin in the game or personal responsibility, it's happening. And it's blurring across income levels and up income levels.

Mr. Joel Ario: So, including us supporters of the ACA like this, I see Cindy stewing a little bit here, and Dennis.

Ms. Cindy Gillespie: Right.

Mr. Joel Ario: I think it's a good chance to get you guys on record. I mean what do you say to all this?

Ms. Cindy Gillespie: Well, we were going to filibuster till the end.

Ms. Deborah Bachrach: All right. You can say something.

Mr. Joel Ario: I want to hear the response here.

Mr. Dennis Smith: Well, again, the population below 100 percent of poverty, where you say you have cost sharing, but if it's not enforceable, that's not insurance, right? Because I'm still going to get it even if I don't pay for it--.

Ms. Deborah Bachrach: --But you still have a debt. You still have the debt.

Ms. Krista Drobac: --Count on Politico to start a big fight, right?

Mr. Dennis Smith: Well, again, if we want this to be insurance, then let it be insurance. Then Medicaid is the only one that does retroactive eligibility. That's not insurance.

Ms. Deborah Bachrach: Which was just waived in Indiana, and it's been waived in Tennessee.

Mr. Dennis Smith: Again, how many--how many times--are we just going to keep waiving it? Or are we going to have the program actually run--.

Ms. Deborah Bachrach: --Well, that's -.

Mr. Dennis Smith: --Where you don't need a waiver.

Mr. Joel Ario: --But that's--.

Mr. Dennis Smith: --Eighty-nine billion dollars of Medicaid spending now are through waivers. Why do we keep saying you have to come back to Washington on bended knee to get the waiver?

Mr. Joel Ario: So, you should press--you should press that point forward. The question is now we are above 100. We have these insurance principles applied. Then do you agree that that's a good thing and we should keep--we should keep the insurance paradigm for Medicaid?

Mr. Dennis Smith: For a--.

Mr. Joel Ario: --And do what Deborah helped do in Arkansas--.

Ms. Krista Drobac: --Joel's got the last question--.

Mr. Dennis Smith: --Start premiums then. And start premiums--.

Mr. Joel Ario: --They have premiums--.

Mr. Dennis Smith: --And then make them enforceable.

Mr. Joel Ario: They are enforceable.

Ms. Cindy Gillespie: You know there is another--there is another thing Sarah said, though, that is very important, which is a number of the people in Arkansas that voted for this extension through 2016 voted--were voting to end the private option, not in support of the private option. And I think that's just--.

Ms. Deborah Bachrach: --But I would just say just one thing. It was always done that way.

Ms. Cindy Gillespie: But let me--I understand. But I--We were talking politics. And they--.

Ms. Deborah Bachrach: --Okay--.

Ms. Cindy Gillespie: --Are expressing why they voted the way they did, right?

Ms. Deborah Bachrach: Fair enough.

Ms. Cindy Gillespie: So, they voted because they want to end it. Now Arkansas is doing, therefore, this whole thing we've been talking about when you think about it from a 1332 perspective. They are taking from now till the end of 2016 to try to figure out what they would like to design as the Arkansas system. They've already said they're going to look at a 1332, right?

So, Arkansas is a state that is actually saying we want to look at a 1332. Let's take these two years, like we all talked about. What is it we really want to look like? We were--we had to do this private option thing because we had to do it within the straightjacket of the ACA.

We had to agree to certain terms that they weren't thrilled about, as going--when they went to CMS, right? They got a really good deal. They are very proud of what they've done. They should be.

You should be very proud of what you helped them do. With that said, that doesn't mean they're going this is it. This is the end. Now they want to sit and go with the 1332 coming, what could we actually really do?

And how do we take this further the way we, with our conservative principles, think we should be going? And I think they're worth watching closely because they really are taking that on.

Ms. Deborah Bachrach: And that is a good point to add.

Mr. Joel Ario: Amen to that. Amen to that.

Ms. Krista Drobac: What a beautiful place to end. I got the last word. Please everyone join me in thanking our distinguished panel.

Mr. Bruce Caswell: And on behalf of Maximus, I'd love to thank you all for attending today. And thanks to Newseum for hosting us in such a great location.

I tell you I think this thing could go on this afternoon for another couple hours. And so one thing you can count on is there will be more Webinars, more panel discussions like this. It is the beginning of a journey. And I love the fact that, Deb, you said at one point, the waiver provisions, 1332, kind of set the guardrails. But 50 state innovations can follow.

There's so much potential here. Great discussion, thank you to the group. Thank you very much for your time today. And thanks to all of you.