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TESTIMONY

Hearing on

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

December 13, 2012

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

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Executive Summary

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

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

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

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

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

Introduction

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

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

PPACA Exchanges

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

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

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

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

Exchange Legal Questions

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

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

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

The Employer Mandate

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

Federally-Facilitated Exchange Subsidy

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

Preventive Care Mandate

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

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

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

Maintenance of Effort

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

Origination Clause

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

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

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

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

Independent Payment Advisory Board (IPAB)

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

Legality of Rulemaking/Guidance

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

Policy Implications

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

Lack of Consumer Choice

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

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

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

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

Increased Taxes

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

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

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

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

Impact on Employers and Employees

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

Implementation Concerns

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

Exchanges in General

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

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

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

Federally-facilitated Exchanges

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

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

Partnership Exchange

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

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

The Workings of an Exchange

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

Essential Health Benefits and Actuarial Values

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

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

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

Reforms Needed

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

Simplification

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

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

Transaction Process

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

Plan Management

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

Medicaid/CHIP eligibility

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

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

Timeline

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

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

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

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

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

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

Medicaid Expansion

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

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

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

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

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

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

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

Tenets of Medicaid Reform

1. **First, the process to determine Medicaid eligibility should be simple, accurate and fair.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Example of State Innovation

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

Bayou Health

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

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

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

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

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

Louisiana Behavioral Health Partnership

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

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

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

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