Exhibit 37

FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

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Health Reform Issues: Key Issues About State Financing and Medicaid

The new health reform legislation (the Patient Protection and Affordable Care Act) includes a Medicaid expansion which helps to extend health coverage for more low-income Americans and eliminate state variation in the current program. Medicaid is jointly administered and financed by states and the federal government, so changes to Medicaid will have a direct impact on states.

Currently, states face severe budget crises as a result of the recession and the scheduled end of temporary federal fiscal relief as of December 31, 2010, half-way through most state fiscal years. This current situation makes states wary of any new fiscal obligations tied to health reform. However, despite state concerns health reform is expected to result in significant new coverage and new federal financing that are expected to have positive implications for individuals and state economies. There are also implications for state financing related to provisions beyond coverage and for implementation of the new law that are examined in this brief. In summary:

1. ***New coverage from Medicaid expansion in health reform will result in more coverage, increased federal revenues, declines in uncompensated care costs and better access to health care for individuals.***

    - Small investments by states will result in significant returns in federal revenues and increased coverage for low-income individuals.
    - Large increases in federal Medicaid revenues will have a positive effect on state economies.
    - Increased coverage will result in declines in uncompensated care costs and other opportunities for state savings.
    - The Medicaid expansions will mean financial security and increased access to health care services for individuals.

2. ***The new health reform law includes opportunities for payment reforms in Medicaid.***

    - Some reforms could help improve care delivery and save money over time.
    - New options for community-based long-term care services and focus on high cost populations could help to generate savings over time.

3. ***States will need to make some new investments in administrative capacity and efforts to expand access to effectively implement health reform.***

4. ***The expiration of the enhanced Medicaid funding from the American Recovery and Reinvestment Act (ARRA) can hinder efforts to implement health reform.***

5. ***The impact of the Medicaid expansions and other Medicaid provisions in health reform will vary across states and will depend on how reforms are implemented by the federal government and states.***

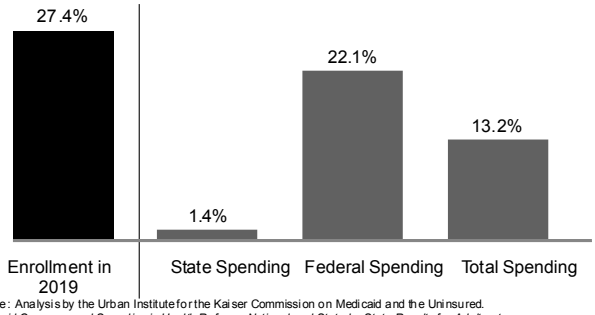
1. ***New coverage from Medicaid expansion in health reform will result in more coverage, increased federal revenues, declines in uncompensated care costs and better access to health care for individuals.***

Small investments by states will result in significant returns in federal revenues and increased coverage for low-income individuals. The health reform law establishes a new, minimum standard for Medicaid coverage that is uniform across the country. Specifically, the PPACA requires states to extend Medicaid eligibility to nearly all individuals under age 65 with income up to 133 percent of the FPL by January 1, 2014. For most states, this will mean providing Medicaid to adults without children for the first time, as well as increasing their income eligibility threshold for parents. The law specifies different match rates for individuals eligible for coverage as of December 1, 2009 (regular Medicaid match); those made newly eligible for coverage under health reform (full federal financing for 2014-2016 and then 90 financing by 2020) and for certain expansion states (an enhanced match rate for coverage of certain childless adults that is phased in to equal 90 percent in 2020).

Similar to cost estimates prepared by the Congressional Budget Office (CBO), an analysis prepared by the Urban Institute shows that changes related to the Medicaid expansion in health reform will increase federal costs by $443 billion and state costs by $21 billion over the 2014 to 2019 period.[1] This means that the federal government is expected to pay for 95% of the new coverage costs for Medicaid coverage for adults. The Urban study shows that by 2019, an additional 15.9 million adults will be covered by Medicaid, a 27 percent increase over baseline projections compared to only a 1.4 percent increase in projected state spending relative to what states would have spent in the absence of reform. (Figure 1)

Figure 1

Enrollment and Spending Increases Over Baseline 2014-2019



Source: Analysis by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured. *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL.* May 2010.

Increased coverage will result in declines in uncompensated care costs and other opportunities for state savings. Expanded Medicaid coverage and reductions in the uninsured are likely to reduce the need for state payments to hospitals and other providers for uncompensated care costs. In 2008, states and local governments contributed $17.2 billion for uncompensated care costs.[2] Without health reform, spending for uncompensated care would grow as the number of uninsured was expected to increase. While some individuals will remain uninsured, there should be opportunities for states to redirect current spending for care of the uninsured. States may also be able to reduce spending for other programs targeted provide services to individuals without coverage such as state-funded mental health services.

In 2014, states with state-funded coverage programs for low-income childless adults will see savings when these individuals will be transitioned to Medicaid coverage as new eligibles with the federal government paying the full costs of coverage for these individuals for 2014 to 2016. Some of these states could see savings before 2014 because states have the option to expand coverage to childless

[1] Holahan J and Headen I, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults At or Below 133% FPL,* Kaiser Commission on Medicaid and the Uninsured, May 2010.
[2] Hadley J et al, *Covering the Uninsured in 2008: A Detailed Examination of Current Costs and Sources of Payment, and Incremental Costs of Expanding Coverage,* Kaiser Commission on Medicaid and the Uninsured, August 2008.

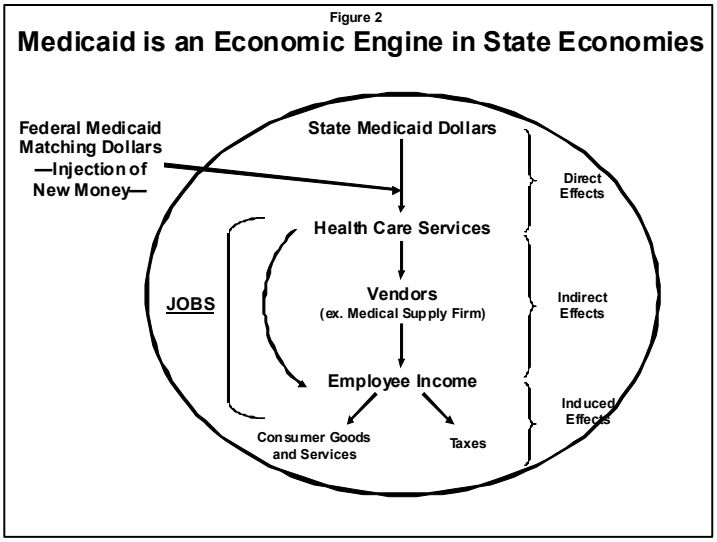
adults now with the regular Medicaid match rate and then still qualify for the higher match rates that take effect in 2014. For example, the District of Columbia is taking advantage of the early option to move state-funded coverage of childless adults into Medicaid and be able to draw down their regular federal matching rate for this coverage (70 percent). Beginning in 2014, the District of Columbia would then be able to cover this same population with the higher, "newly eligible" match rates.

Under the law, states are required to maintain current eligibility levels for adults with incomes above 133 percent of poverty in Medicaid until 2014 and for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019. Some states with broader coverage today could see savings in 2014 by transitioning coverage for individuals with incomes above 133 percent FPL into the exchange. States are also likely to see savings related to coverage for children. The health reform law extends funding for CHIP through 2015. If CHIP is reauthorized in 2015, the law provides an increase in the federal match rate of 23 percentage points (capped at 100 percent). If CHIP is not reauthorized, and states may be able to transition children with incomes above 133 percent of poverty into comparable coverage plans in the exchange which could also generate savings for states.

Large increases in federal Medicaid revenues will have a positive effect on state economies. Large increases in federal funding from the Medicaid expansions will yield economic gains for states. Medicaid spending generates economic activity including jobs, income and state tax revenues at the state level within the health care sector and beyond due to the multiplier effect of spending. The economic impact of Medicaid in health reform is intensified because small amounts of new state spending will result in significant federal matching dollars that will flow into the economy.[3] (Figure 2)

Figure 2

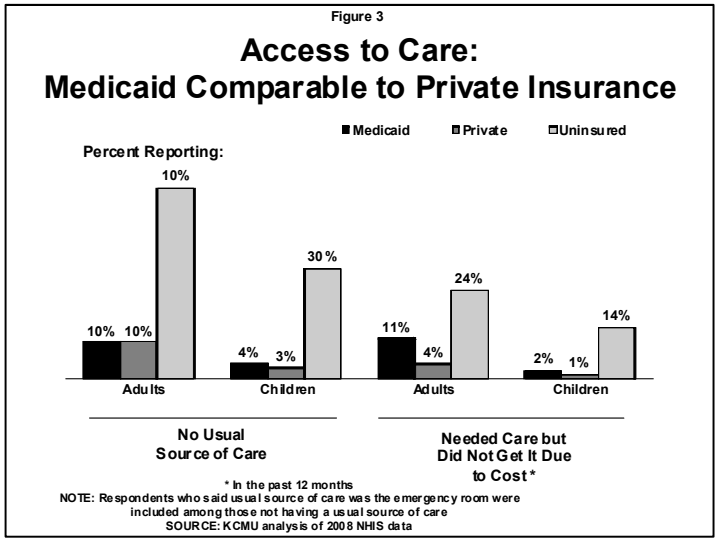
Medicaid is an Economic Engine in State Economies



[3] Kaiser Commission on Medicaid and the Uninsured, *The Role of Medicaid in State Economies: A Look at the Research,* January 2009.

The Medicaid expansions will mean financial security and increased access to health care services for individuals. Expanded Medicaid coverage will increase access to care, reduce unmet health care needs, and improve quality. Both children and adults covered by Medicaid are much more likely to have a usual source of care than people without insurance. Children with Medicaid are also far more likely to have seen a doctor and dentist, and adults with Medicaid are far more likely to get preventive care than the uninsured. Across these measures of primary and preventive care, access in Medicaid and private insurance is roughly equivalent, even though Medicaid enrollees are sicker and more disabled than those with private insurance and despite concerns about low provider participation rates. Enrollment in public coverage is associated with improved quality of care among previously uninsured children as well as improvements in social health outcomes, including school attendance.[4] Medicaid also protects against high out-of-pocket costs. Research shows that, under the most popular insurance offered under the Federal Employees Health Benefits Program (FEHBP), a family with a relatively healthy child may still face significant out-of-pocket costs; families with more extensive needs for care or lower income may face much heavier out-of-pocket burdens. Medicaid's strict limits on cost-sharing help to ensure that, for the low-income people the program serves, cost is not an obstacle to obtaining care .[5] (Figure 3)

Figure 3



2. *The new health reform law includes opportunities for payment reform in Medicaid.*

The new health reform law includes opportunities for payment reforms in Medicaid that could help improve care delivery and save money over time. The new law includes an array of changes and the creation of demonstration programs that will help states experiment with changes to payment and care delivery that could increase access and generate cost savings over time. First, the legislation increases reimbursement rates for primary care to Medicare levels with full federal financing in 2013 and 2014. The law establishes the CMS Innovation Center designed to test, evaluate, and expand different payment structures and methodologies that improve quality and reduce costs in Medicare, Medicaid, and CHIP programs. State will have the option to provide coordinated care through a health home for individuals with chronic conditions and receive a 90% match for two years for health home services including care management, care coordination and health promotion. The legislation also establishes the Federal Coordinated Health Care Office (CHCO) within CMS to align Medicare and Medicaid financing, benefits, administration, oversight rules, and policies for dual eligibles, the most expensive group of Medicaid enrollees.

The legislation authorizes grants for programs to promote healthy behaviors (weight control, smoking cessation, cholesterol reduction, and diabetes prevention / management); demonstrations to test bundled payment approaches for acute and post-acute care; demonstrations for global payments for large safety-net hospital systems, and demonstrations to allow pediatric medical providers organized as accountable care organizations to share in cost-savings.

[4] Kaiser Commission on Medicaid and the Uninsured, *Medicaid Beneficiaries and Access to Care*, October 2009.
[5] Alker J et al. *Children and Health Care Reform: Assuring Coverage That Meets Their Health Care Needs.* Kaiser Commission on Medicaid and the Uninsured, 2009.

The new law also makes a number of changes related to Medicaid reimbursement for prescription drugs. The law specifies that all of the revenue associated with the increase in rebates will accrue to the federal government. This could result in a loss of revenue from state supplemental rebates on drugs, but states could see some additional savings related to the provisions to extend the drug rebate to Medicaid managed care plans.

New options for community-based long-term care services and focus on high cost populations could help to generate savings over time. On the long-term care side, states will have new options and fiscal incentives through the Community First Choice Option and the State Balancing Incentive Program to balance the delivery of long-term care services between community-based care and more costly institutional care in Medicaid. Over the long-term the new community living assistance services and supports (CLASS program) will generate some long-term care savings for Medicaid. CLASS provides qualifying individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions paid by either payroll deductions or direct contributions.[6]

3. ***States will need to make some new investments in administrative capacity and efforts to expand access in order to effectively implement health reform.***

Under the new law, states are expected to have new administrative responsibilities related to Medicaid including outreach and enrollment, integrating Medicaid with the new exchanges, applying new income standards and ensuring access. Modernizing eligibility and enrollment will be challenging and may require new systems that will need to be coordinated with other health coverage requirements in the new exchanges. The current recession has resulted in cutbacks in Medicaid administration in terms of staff and funding that could compromise states' ability to effectively implement health reform. States generally get a 50 percent match rate on administrative services for Medicaid, but in some cases there may be more favorable match rates for new systems. CMS will need to work with states to develop guidelines, regulations and to provide technical assistance around administrative responsibilities as states move forward to implement reform. As states are gearing up and organizing for health care reform implementation, 37 states will face gubernatorial elections in the fall with potential changes in leadership which may complicate and slow implementation efforts.

In addition to gearing up for new administrative functions around eligibility and enrollment, states will need to ensure access to care for current and new Medicaid enrollees. This will require efforts to enhance provider networks, expand the use of mid-level practitioners to deliver care and examine reimbursement rates. States will want to focus on better organizing systems of care to promote efficiencies and better quality. The law includes new options for states to achieve these goals, but these efforts could require new investments from states.

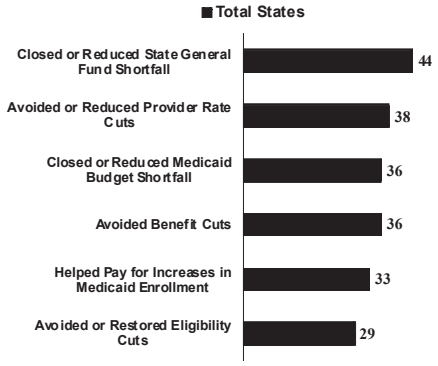
[6] Kaiser Family Foundation, *Health Care Reform and the CLASS Act,* April 2010.

4. ***The expiration of the enhanced Medicaid funding from the American Recovery and Reinvestment Act (ARRA) can hinder efforts to implement health reform.***

As states work to adopt budgets for state fiscal year 2011, they are faced with severe budget shortfalls stemming from high unemployment, record declines in revenue as well as increasing demand for public programs like Medicaid. The American Recovery and Reinvestment Act (ARRA) provided states with an estimated $87 billion in fiscal relief from October 2008 through December 2010 in the form of an increase in the federal share of Medicaid funding provided that states could not restrict Medicaid eligibility. The ARRA funds helped states to balance budgets and support their Medicaid programs, but the scheduled expiration of the funds will create a financing cliff in the middle of SFY 2011 at a time when states will still need assistance. Congress is considering an extension the Medicaid financing in ARRA which will help states manage the immediate strains on Medicaid related to the recession and help to strengthen Medicaid's role for health reform. Both the House and Senate were expected to vote on this issue by the end of May 2010. (Figure 4)

Figure 4

How States Used ARRA Enhanced Medicaid Funding in FY 2009



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2009.

5. ***The impact of the Medicaid expansions and other Medicaid provisions in health reform will vary across states and will depend on how reforms are implemented by the federal government and states.***

Today there is a great deal of variation across states in terms of Medicaid coverage, the uninsured, state fiscal capacity, leadership and priorities. Given this variation, it is no surprise that the impact of health reform will vary across states. In addition, the ability to advance coverage through Medicaid will depend heavily on both federal and state actions to implement the new law. Some states may not aggressively implement health reform and therefore not see significant reductions in the uninsured while other states will have higher levels of participation because of effective outreach and enrollment strategies and therefore will see greater reductions in the number of uninsured. So, what individual states assume about participation among those newly eligible and those currently eligible for coverage will affect coverage and cost estimates. In addition, states may have different estimates about the effect of various provisions in the law affecting Medicaid including the impact of the changes related to prescription drugs, long-term care options and payment reforms.

There will also be fiscal impacts for states related to provisions in health reform beyond the scope of Medicaid including additional reductions to the uninsured due to the mandate and new subsidies for coverage for individuals with incomes between 133 and 400 percent of poverty and additional responsibilities related to setting up a new health insurance exchange. However, focusing on Medicaid, even after accounting for fiscal impacts of changes in the law beyond coverage, for relatively small amounts of new state spending, states are expected to see huge advances in coverage, and significant new federal revenue.

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