

MEDICAID EXPANSION OPTIONS

A Report Prepared for Governor Gary R. Herbert

HEALTH SUMMIT 2013

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State of Utah

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September 26, 2013

Governor Herbert,

It is my pleasure to report the work prepared for you by the Medicaid Expansion Options Community Workgroup. Members of the workgroup have spent many hours this summer examining different proposals regarding the option to expand Medicaid for certain groups of adults. As you will see from the attached summaries and fact sheets, the workgroup has analyzed options which provide more information for your consideration than just a straight expansion of the Medicaid fee-for-service coverage model.

This workgroup report completes the second step in the process you outlined for making a decision on Medicaid expansion. The first step of this process began when we commissioned the Public Consulting Group (PCG) to provide an independent analysis of the costs and benefits of a possible Medicaid expansion. It was completed when we received PCG's final report in June. A summary of the PCG report is included in this document.

You also asked that we provide you a menu of options regarding Medicaid expansion, as well as obtain input on factors in addition to the fiscal impact described in the PCG report. In order to meet that request, we put together this workgroup comprised of a variety of stakeholders including business leaders, community and government leaders, legislators, advocates for low-income individuals and families, and other stakeholders from the health care industry.

We charged the workgroup to collect additional information for the State's decision regarding the Medicaid expansion options by:

- *Collecting input from voices in the community that haven't been heard yet*
- *Collecting input on factors other than just financial considerations*
- *Considering other options beyond full expansion or status quo*
- *Providing input on which options would be best for Utah*
- *Identifying key advantages and disadvantages of primary options*

As you will see from this report, the workgroup did a tremendous job of identifying the opportunities, challenges, costs, potential sources of payment, and levels of coverage for each option. We believe this work will provide you and the Legislature with well-reasoned input from individuals knowledgeable in the health care industry and familiar with the population that would be impacted by the potential Medicaid expansion.

We look forward to the next phase of the Medicaid optional expansion decision making process. We anticipate continued discussion with you, your staff, and legislators as we review these options over the upcoming months and determine whether or not there is a Medicaid expansion option that is right for Utah.

Sincerely,

W. David Patton
Executive Director
Utah Department of Health



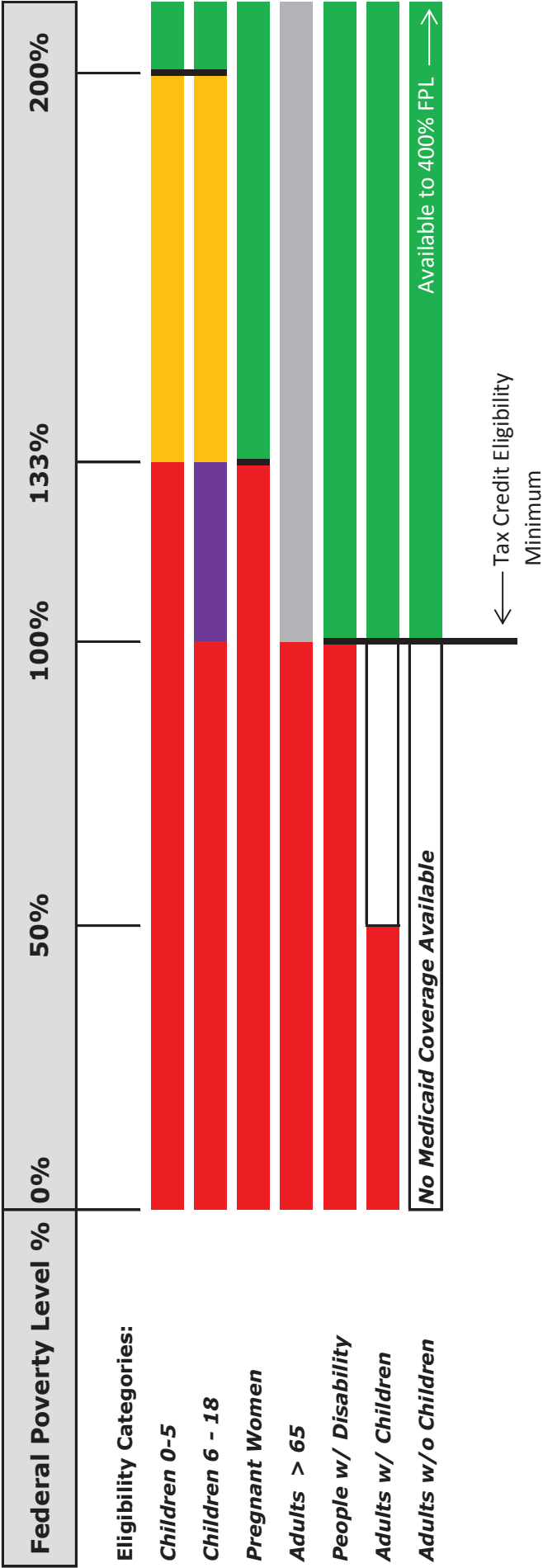
ELIGIBILITY FOR MEDICAL ASSISTANCE

The U.S. Supreme Court’s 2012 ruling on the Patient Protection and Affordable Care Act (ACA) left Utah with the option of expanding its Medicaid program to cover adults who earn up to 138 percent of the federal poverty level (FPL). The following charts show coverage levels in 2014 for different eligibility groups by FPL. The first chart shows levels if Utah chooses not to do a full expansion. The second chart shows levels if Utah pursues the optional expansion. The charts show coverage under the following programs:

- current Medicare, Medicaid, and Children’s Health Insurance Program (CHIP)
- mandatory Medicaid expansion
- optional Medicaid expansion
- federally facilitated marketplace with tax credits
- no coverage program

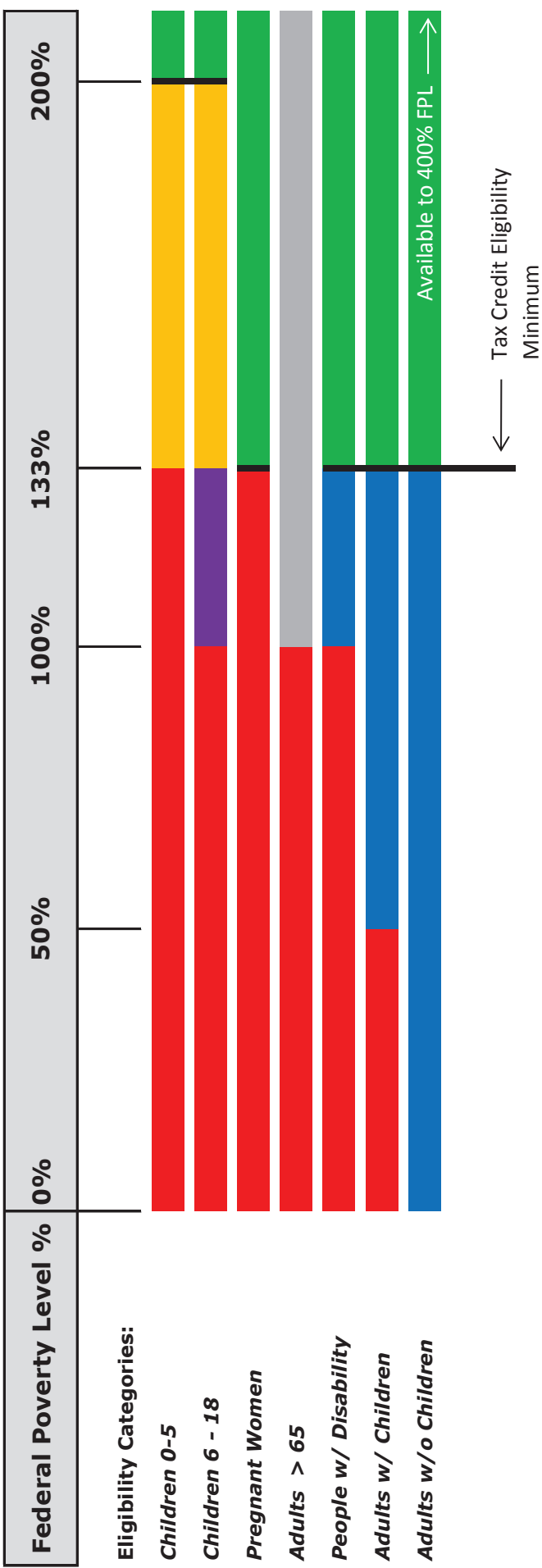
Income Limits for Medicaid, CHIP and Tax Credit Eligibility

No Optional Medicaid Expansion



- = current Medicaid eligibility
- = current CHIP eligibility
- = mandatory ACA changes to Medicaid eligibility
- = eligible for Medicare
- = eligible for Tax Credits for use in the Exchange (up to 400% of FPL)

Income Limits for Medicaid, CHIP and Tax Credit Eligibility



- = current Medicaid eligibility
- = current CHIP eligibility
- = mandatory ACA changes to Medicaid eligibility
- = optional Medicaid ACA expansion eligibility
- = eligible for Medicare
- = eligible for Tax Credits for use in the Exchange (up to 400% of FPL)

PUBLIC CONSULTING GROUP

SUMMARY OF COST/BENEFIT ANALYSIS

The Utah Department of Health (UDOH) commissioned the Public Consulting Group (PCG) to produce a cost-benefit analysis to provide information for policy makers as they consider the pros and cons of potential expansion options for the state's Medicaid program under the Affordable Care Act (ACA). This report provides a model of the future for Utah's Medicaid program under five scenarios. The five scenarios are:

SCENARIO 1	MANDATORY ONLY No optional expansion – only includes the expected increases in Medicaid enrollment due to the mandatory changes to the program required by ACA and to an increase in the number of currently eligible individuals that enroll in the program
SCENARIO 2	FULL OPTIONAL EXPANSION, FULL BENEFITS Medicaid expanded for adults to 138% federal poverty level (FPL) with Traditional Medicaid Benefits
SCENARIO 3	FULL OPTIONAL EXPANSION, BENCHMARK BENEFITS Medicaid expanded for adults to 138% FPL with benefits that meet the ACA's Essential Health Benefits requirements
SCENARIO 4	PARTIAL OPTIONAL EXPANSION, FULL BENEFITS Medicaid expanded for adults to 100% FPL with Traditional Medicaid Benefits
SCENARIO 5	PARTIAL OPTIONAL EXPANSION, BENCHMARK BENEFITS Medicaid expanded for adults to 100% FPL with benefits that meet the ACA's Essential Health Benefits requirements

TOTAL COST/(SAVINGS) TO UTAH STATE GOVERNMENT FOR MANDATORY EXPANSION ADDED TO OPTIONAL EXPANSION SCENARIOS			
	One Year Total 2014	Three Year Total 2014-2016	Ten Year Total 2014-2023
Mandatory Only	\$7,272,797	\$39,082,298	\$220,563,690
Mandatory + Scenario 2	\$(11,349,052)	\$(9,678,599)	\$378,437,803
Mandatory + Scenario 3	\$(11,349,052)	\$(9,678,599)	\$336,872,046
Mandatory + Scenario 4	\$11,657,707	\$95,862,577	\$582,119,372
Mandatory + Scenario 5	\$7,354,271	\$72,240,715	\$512,664,652

COSTS TO THE STATE

PCG has found that the impacts of the ACA on Medicaid eligibility and enrollment will initially save the state money but will eventually have an overall cost to the state. These costs include the administrative costs to state agencies of providing services to the increased client load.

Additionally, under a full expansion (Scenarios 2 and 3), the cost increases over time as the Federal Financial Participation (FFP) declines from covering 100% of the expansion population in 2014 to an eventual federal coverage of 90% of the costs in 2020 and beyond. The enhanced cost sharing from the federal government will not be available for the

partial expansion (Scenarios 4 and 5) to 100% FPL, thus the current FMAP is applied for these scenarios – which results in higher costs to the state.

SAVINGS TO THE STATE

Potential savings coming to the state are accounted through individuals gaining insurance and no longer generating uncompensated care; savings to current public assistance programs (the state's share of Mental Health and Substance Abuse Services, Primary Care Network, Inmate Inpatient Services, High Risk Pool Savings); and finally changes to the state's medically needy program.

ESTIMATED HIGHLIGHTS OVER THE NEXT TEN YEARS:

Mandatory Only:

- Increase Medicaid enrollment by 60,202 adults and children
- Increase Medicaid service and administration costs by \$805 million (due to federal matching money, the state share of this increase will be \$221 million)
- Generate an additional \$22 million in state tax revenues
- Generate an additional \$17 million in county tax revenues
- Generate \$554 million statewide in economic impact, create 802 new jobs

Full Optional Expansion, Full Benefits:

- 123,586 additional adults would enroll in Medicaid
- Medicaid service and administration costs will increase by \$3.2 billion (due to federal matching money, the state share of this increase would be \$260 million)
- State public assistance programs would save \$110 million
- County public assistance programs would save \$2 million
- Generate an additional \$113 million in state tax revenues
- Generate an additional \$90 million in county tax revenues
- Hospitals and community health centers would save \$814 million in uncompensated care
- Generate \$2.9 billion statewide in economic impact, create 4,160 new jobs

DATA SOURCES:

This report relies on state and public sources for its data. The state of Utah provided a significant amount of data, including information from the Department of Human Services, Department of Workforce Services, Department of Health, and the Department of Corrections. Data from state agencies was supplemented with Utah specific data from public sources – specifically the Current Population Survey (CPS), the Medical Expenditure Panel Survey (MEPS), and the Kaiser Family Foundation.

SUMMARY OF MEDICAID EXPANSION OPTIONS

FULL EXPANSION WITH FULL BENEFITS

This option would expand Medicaid to adults up to 138% of the federal poverty level (FPL), approximately \$27,000 per year for a family of three. Adults in the expansion would receive the same Medicaid coverage that is available to aged, blind, and disabled individuals today. Newly eligible adults in Weber, Davis, Salt Lake, and Utah counties (urban) would receive services through Accountable Care Organizations (ACOs). While newly eligible adults in all other counties (rural) would receive services generally through a fee-for-service arrangement.

This option would not cover undocumented individuals or newly arrived immigrants.

Federal Match	Estimated 2020 Cost of Services and Administration (state funds)*	Estimated 2020 State Savings (state funds)*	Estimated 2020 Increased Enrollment*
New match rate**	\$40.8 million	\$4.7 million	111,000

* Based on Public Consulting Group (PCG) figures

**100% through 2016, 95% in 2017, 94% in 2018, 93% in 2019, 90% in 2020 and beyond

FULL EXPANSION WITH BENCHMARK BENEFITS

This option would expand Medicaid to adults up to 138% FPL. Adults in the expansion would receive benefits based on the selection of a benchmark package, similar to the process used to determine benefits for the Children's Health Insurance Program (CHIP) today. The newly eligible adults in urban counties would receive services through ACOs. The newly eligible adults in rural counties would receive services generally through a fee-for-service arrangement.

This option would not cover undocumented individuals or newly arrived immigrants.

Federal Match	Estimated 2020 Cost of Services and Administration (state funds)*	Estimated 2020 State Savings (state funds)*	Estimated 2020 Increased Enrollment*
New match rate**	\$33.4 million	\$4.7 million	111,000

* Based on Public Consulting Group (PCG) figures

**100% through 2016, 95% in 2017, 94% in 2018, 93% in 2019, 90% in 2020 and beyond

PREMIUM SUBSIDY PLUS PARTIAL MEDICAID EXPANSION

This option would expand Medicaid to adults up to 138% FPL using different benefits for different income groups. Adults up to 100% FPL (almost \$20,000 per year for a family of three) would receive benefits based on the selection of a benchmark package, similar to the process used to determine benefits for CHIP today. Adults in this population who live in urban counties would receive services through ACOs. Adults in this population who live in rural counties would receive services generally through a fee-for-service arrangement. Adults (along with pregnant women and children already on Medicaid) from 101-138% FPL would receive assistance through a premium subsidy to purchase private health insurance through their employer, if available, or through an exchange-like marketplace.

This option would not cover undocumented individuals or newly arrived immigrants.

Federal Match	Estimated 2020 Cost of Services and Administration (state funds)*	Estimated 2020 State Savings (state funds)*	Estimated 2020 Increased Enrollment*
New match rate**	Unknown [Subgroup estimated costs might be similar to Full Expansion with Full Benefits Option – \$40.8 million]	Unknown [Subgroup estimated costs might be similar to Full Expansion with Full Benefits Option – \$4.7 million]	111,000

* Based on Public Consulting Group (PCG) figures

**100% through 2016, 95% in 2017, 94% in 2018, 93% in 2019, 90% in 2020 and beyond

PARTIAL EXPANSION WITH BENCHMARK BENEFITS

This option would expand Medicaid to adults up to 100% FPL. These adults would receive benefits based on the selection of a benchmark package, similar to the process used to determine benefits for CHIP today. Newly eligible adults in urban counties would receive services through ACOs, those in rural counties would receive services generally through a fee-for-service arrangement. Adults with access to private health insurance through their employer would receive assistance through a premium subsidy to purchase that health insurance.

Adults over 100% FPL would receive coverage through the federally facilitated marketplace and would not be part of the Medicaid program.

This option would not cover undocumented individuals or newly arrived immigrants.

Federal Match	Estimated 2020 Cost of Services and Administration (state funds)*	Estimated 2020 State Savings (state funds)*	Estimated 2020 Increased Enrollment*
Option as presented by the subgroup suggests that Utah request the new match rate** for new adults	New match rate: \$16.2 million Current match rate: \$39.2 million	\$1.9 million	54,000

* Based on Public Consulting Group (PCG) figures

**100% through 2016, 95% in 2017, 94% in 2018, 93% in 2019, 90% in 2020 and beyond

BLOCK GRANT-LIKE WAIVER

This option would expand Medicaid to adults up to 138% FPL using different benefits for different income groups. Adults up to 100% FPL would receive benefits based on the selection of a benchmark package, similar to the process used to determine benefits for CHIP today. ACOs would be expanded statewide and all newly eligible adults up to 100% FPL would receive services through an ACO. Adults from 101-138% FPL would receive assistance through a premium subsidy to purchase private health insurance through their employer, if available, or through an exchange-like marketplace. All newly eligible adults would have access to a health savings account to help them appreciate premiums and cost sharing.

In addition, through a waiver, the state would accept the risk for the cost of services provided to individuals in the expansion. If the costs exceeded projections, the state would have to pay the costs with all state funds. If the costs were below projections, the state could use the savings to cover additional individuals or to offer additional benefits to existing groups.

This option would not cover undocumented individuals or newly arrived immigrants.

Federal Match	Estimated 2020 Cost of Services and Administration (state funds)*	Estimated 2020 State Savings (state funds)*	Estimated 2020 Increased Enrollment*
New match rate**	Unknown [Subgroup estimated costs might be similar to Full Expansion with Benchmark Benefits Option – \$33.4 million]	Unknown [Subgroup estimated costs might be similar to Full Expansion with Benchmark Benefits Option – \$4.7 million]	111,000

* Based on Public Consulting Group (PCG) figures

**100% through 2016, 95% in 2017, 94% in 2018, 93% in 2019, 90% in 2020 and beyond

UTAH PREMIUM PARTNERSHIP PLUS

This option would expand Medicaid to adults up to 138% FPL. Adults (along with currently eligible children, pregnant women, and parents) up to 138% FPL would receive assistance through a premium subsidy to purchase private health insurance through their employer, if available, or through an exchange-like marketplace. Individuals would have access to a health savings account to help them appreciate premiums and cost sharing.

This option would not cover undocumented individuals or newly arrived immigrants.

Federal Match	Estimated 2020 Cost of Services and Administration (state funds)*	Estimated 2020 State Savings (state funds)*	Estimated 2020 Increased Enrollment*
New match rate**	Unknown [Subgroup estimated costs might be similar to Full Expansion with Full Benefits Option – \$40.8 million]	Unknown [Subgroup estimated costs might be similar to Full Expansion with Full Benefits Option – \$4.7 million]	111,000

* Based on Public Consulting Group (PCG) figures

**100% through 2016, 95% in 2017, 94% in 2018, 93% in 2019, 90% in 2020 and beyond

PERSONAL WELLNESS RESPONSIBILITY MODEL

The subgroup did not determine a specific FPL for coverage; instead, it discussed covering low-income families. These families would include newly eligible adults along with currently eligible children, pregnant women, and parents. Families would receive coverage together. Families would receive assistance through a premium subsidy to purchase private health insurance through their employer, if available. If employer sponsored insurance is not available, families would receive assistance through a premium subsidy to purchase private health insurance. Families would have access to a health savings account to help them appreciate premiums and cost sharing.

The State could not take advantage of this option until 2017 because the waiver authorizing this type of option is not available until then.

This option would not cover undocumented individuals. It is possible this model could cover newly arrived immigrants; however the subgroup did not specifically address this group.

Federal Match	Estimated 2020 Cost of Services and Administration (state funds)	Estimated 2020 State Savings (state funds)	Estimated 2020 Increased Enrollment
Not applicable, Utah would likely negotiate a global budget for federal funds	Unknown	Unknown	Unknown

STRENGTHENING UTAH'S HEALTH CARE SAFETY NET

This subgroup was part of the Medicaid Expansion Options Community Workgroup, as well as the Legislature's Health System Reform Task Force. The subgroup did not determine a specific FPL for coverage; instead, it discussed covering low-income, homeless, and uninsured individuals and families. It identified principles for operating a charity care network. It also identified challenges for primary care and for costs and funding. The subgroup will continue its work after the Governor's Health Innovations Summit and will eventually make a report to the Health System Reform Task Force.

Federal Match	Estimated 2020 Cost of Services and Administration (state funds)	Estimated 2020 State Savings (state funds)	Estimated 2020 Increased Enrollment
Not applicable	Unknown	Unknown	Unknown

MANDATORY ONLY

Although the Supreme Court decision in 2012 allowed states to choose if they wanted to expand Medicaid to adults, it did not eliminate other mandated changes to the Medicaid program. As a result, asset tests will be removed for children, pregnant women, and parents beginning January 1, 2014. Income eligibility for children ages 6-18 will be raised from 100% FPL to 138% FPL. In addition, it is assumed that many currently eligible individuals will enroll in the program because of all the discussion regarding coverage, penalties, and marketplaces.

If Utah does not expand Medicaid to adults, eligibility for tax credits on the federal Health Insurance Marketplace will be at 100% FPL (rather than 138% FPL with the optional expansion). Adults between 100-138% FPL will be eligible for the tax credits in the marketplace (an estimated 57,000 in 2020).

Federal Match	Estimated 2020 Cost of Services and Administration (state funds)*	Estimated 2020 State Savings (state funds)*	Estimated 2020 Increased Enrollment*
Current match rate (approximately 70%)	\$25.7 million	None	51,000

* Based on Public Consulting Group (PCG) figures

Note: Cost and enrollment information have been presented in this summary for 2020 because it is the first year the state will face the full 10% costs of any potential expansion and therefore would be the best reflection of ongoing costs for the option. In addition, because the fact sheets used different years to discuss the costs and benefits of the options, it is hoped that presenting a common year for all options will make comparison between options easier.

At-a-Glance Comparison of Workgroup Options

September 26, 2013

Eligibility Groups Impacted	Full Expansion with Full Benefits	Benchmark Expansion with Premium Subsidy plus Partial Expansion	Partial Expansion with Benchmark Benefits	Block Grant Like Waiver	Utah Premium Partnership Plus	Responsibility Model	Strengthening Utah's Health Care Safety Net	Mandatory Only
Adults without dependent children	X	X	X	X	X	X		
Parents over 50% FPL	X	X	X	X	X	X		
Parents under 50% FPL		X		X	X	X	X	
Pregnant Women		X		X	X	X	X	
Children		X		X	X	X	X	
Aged, blind, disabled		X			X			
FPL for Medicaid Coverage for Adults								
0-100%	X	X	X	X	X	TBD	X	
101-138%	X	X	X	X	X	TBD		
Program Features								
Traditional Medicaid benefits	X						X	
Benchmark benefits		X	X	X				
Premium Assistance - Individual Insurance		X	X	X	X	X		
Premium Assistance - Employer - Sponsored Insurance		X	X	X	X	X		
Wrap Around for Premium Assistance			X	X	X			
One Card, One Family		X		X	X	X		
Health Savings Accounts			X	X	X			
High Risk Individuals in Traditional Medicaid			X	X				
Accountable Care Organizations (ACOs)	X	X	X	X	X	X	X	
Require Medicaid Waiver		X	X	X	X	X		
Features Requiring a Waiver								
Require participation in managed care or premium assistance		X	X	X				
Charge cost sharing above regulatory levels			X	X				

At-a-Glance Comparison of Workgroup Options

September 26, 2013

	Full Expansion with Full Benefits	Benchmark Benefits	Premium Subsidy plus Partial Expansion	Partial Expansion with Benchmark Benefits	Block Grant Like Waiver	Utah Premium Partnership Plus	Personal Wellness Responsibility Model	Strengthening Utah's Health Care Safety Net	Mandatory Only
State at Risk if Spending Exceeds Estimates						X	X		
State Keeps Some of Savings if Savings Exceeds Estimates									
Savings goes to cover more people						X			
Savings covers addition of dental, vision, or autism services						X			
Federal Funds Based on Per Person Calculation						X			
Circuit Breaker if Federal Match Rate Drops	X	X	X	X	X	X	X		
Require Congressional Action									
Source of Payment									
Increased demand on General Fund	X			X					X
Tobacco Master Settlement Agreement	X	X				X			
Set aside savings from early years to fund later years	X								
Transfer existing state-funded health care spending	X	X	X	X	X	X	X		
Capture increased taxes from economic impact of expansion	X	X	X	X	X	X			
Provider assessments	X	X	X	X	X				
Temporary sales tax							X		
Federal Match									
New Enhanced Match (100% down to 90%)	X	X		X		X			
Requesting New Enhanced Match			X						
Existing Match (70%)									X
Potential of a Delayed Start Date									
Expect Program Change in 2017 with Availability of 1332 Waiver				X	X	2017			

FULL EXPANSION WITH FULL BENEFITS

SUMMARY

Under this option, the State would expand Medicaid coverage to 138% of the federal poverty level (FPL) to adults that had not been previously eligible for Medicaid. These adults would include parents with dependent children, as well as adults without dependent children. Service costs for these newly eligible adults would be covered at the new federal match rate (100% through 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and beyond). This option would not change coverage or income levels for individuals currently eligible for Medicaid.

Adults in the expansion would receive the same Medicaid coverage that is available to aged, blind, and disabled individuals today. Coverage for this option would be provided through Medicaid's current provider system. The new adults in Weber, Davis, Salt Lake, and Utah counties (urban) would receive services through Accountable Care Organizations (ACOs). The new adults in other counties (rural) would generally receive services through a fee-for-service arrangement.

This option would not require changes to existing state and federal laws or regulations. This option could be implemented through a Medicaid state plan amendment and would not require a waiver.

OPPORTUNITIES

The strengths of this option are:

- Would likely receive quick approval by the Centers for Medicare and Medicaid Services (CMS) because it follows the original expectation of how Medicaid would be expanded
- One of the simplest options to administer and implement because it uses the existing program to provide care to new enrollees
- Allows parents of low income children to be on the same health plan as their children
- Provides the maximum amount of care to the maximum number of adults
- Because it provides the traditional benefit to these adult groups, it reduces the incentive for these individuals to seek a Medicaid disability determination and thereby keeps the individuals in the newly eligible group which has a higher federal match rate
- Increases federal funding coming to the state, which would likely generate increased economic activity and create new jobs

CHALLENGES

The weaknesses of this option are:

- It is unknown if the state's provider community can effectively care for an additional 111,000 individuals who currently have not been getting regular, coordinated health care
- It is more expensive to cover the traditional benefit package than the benchmark benefit package
- The option requires significant public expenditures over the next 10 year (estimated at \$3.2 billion in state and federal funds)
- There is significant political opposition to a traditional Medicaid expansion as originally envisioned in the Affordable Care Act (ACA)

COST & SOURCE OF PAYMENT

Full Expansion, Full Benefits is labeled as Scenario 2 in the Public Consulting Group's (PCG) State of Utah Medicaid Expansion Assessment. Using PCG's Scenario 2 numbers, it is estimated that by 2020 it would cost the State of Utah \$35.6 million per year to provide services to this group. These figures do not include administrative costs or potential savings from reduced reliance on other public assistance programs and increased tax revenues generated from increased federal spending in the state. In addition, these figures do not include the increased costs to the State due to the mandatory Medicaid changes from the ACA. It is estimated that by 2020 federal costs for this option would be \$320.4 million per year.

Options for paying the state share of these costs include:

- Reappropriate savings from programs paid for at the current match rate or with all state funds that would be covered by Medicaid at the new match rate (e.g., Primary Care Network)
- Appropriate increased revenues from enhanced economic activity to fund this option
- Assess health care providers that will receive increased payments from the increase in the number of covered individuals
- Implement a general tax increase

WHO IS COVERED

This option would cover parents above current eligibility levels up to 138% FPL. Adults without dependent children would also be covered up to 138% FPL. Using the PCG estimates for Scenario 2, it is estimated that this option would cover 111,000 individuals by 2020.

This option would not cover the following groups:

- Legal, documented immigrants who have been in the country less than five years
- Undocumented immigrants

Legal, documented individuals not covered by this option could obtain coverage by enrolling in the federal Health Insurance Marketplace. They would be eligible for tax credits and cost sharing protections. Undocumented immigrants could continue to receive care through community health clinics and other facilities that serve the uninsured.

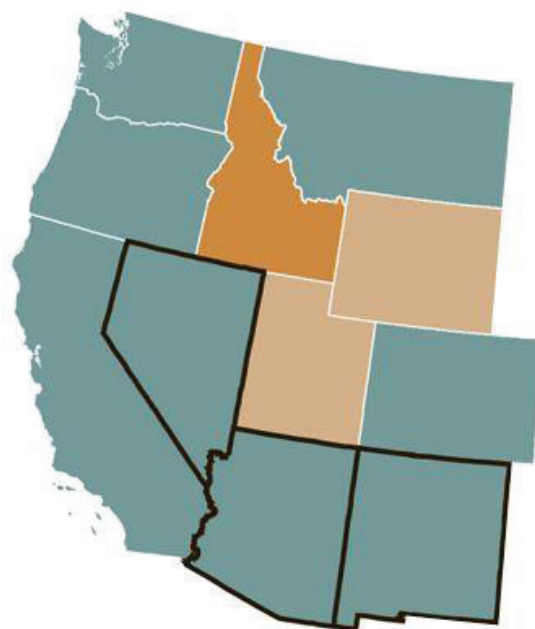
FULL EXPANSION WITH BENCHMARK BENEFITS

SUMMARY

The full Medicaid expansion with benchmark benefits would provide basic coverage to more than 123,000 Utah adults not currently eligible for Medicaid. This is the most beneficial proposal for the taxpayer and will ensure that many more Utahns have access to affordable coverage. This model allows the state to implement without further federal negotiation while qualifying for the full initial 100% federal Medicaid match rate (phasing down to 90%/10%).

The benchmark package is more cost effective for the State, as it is a more limited benefit package than traditional Medicaid. The benchmark package meets the definition of a qualified health plan with the 10 essential health benefits.

Coverage would be provided to individuals earning up to 138% of the federal poverty level (FPL). This expansion option will close the coverage gap resulting from the June 2012 Supreme Court decision that delegated the Medicaid expansion decision to the states. Without the Medicaid expansion, thousands of Utahns living in poverty will not have any options for affordable coverage.



■ Governors Support Expanding
■ Exploring Options
■ Not Expanding Medicaid

*States outlined in black are the states with Republican governors committed to expanding Medicaid

OPPORTUNITIES

The strengths of this option over 10 years are:

- Significant Economic Impact: Generates \$2.3 billion statewide economic impact, creating more than 3,000 new jobs
- Cost effective to Taxpayer: Most economical way to extend coverage to low-wage adults and parents
- Significant Budget Savings: State and county public assistance programs save around \$112 million
- GF Revenue: More than \$150 million in tax revenues
- Reduces/Stabilizes Premium Cost: Reduction in cost-shift to private coverage (higher premiums) to provide care to uninsured
- Reduction in Uncompensated Care: Creates \$814 million in uncompensated care savings for Utah hospitals and community health centers
- Timely Implementation: Easier to implement; does not require Medicaid waivers, negotiation, changes in federal law, or the risk of lawsuits
- Federal Taxpayer Dollars Returned: Leverages \$2.3 billion in federal funding to expand an operational and efficient Medicaid program
- Family Health Plans: Keeps families on the same health plan
- Patient Centered: Enhances continuity of care and access to patient-centered health homes
- Family Coverage: More children receive coverage when their parents have access to health coverage
- Healthy Workers: Healthy and productive workforce
- Large Employers Benefit: Protects large employers from paying shared responsibility penalties when employees get tax credits on the insurance marketplace
- Protects Against Higher Premiums: Keeps premiums relatively lower than states that do not expand Medicaid
- Health Care Access: Better access to both physical, mental health and substance use disorders services
- Consistent Funding: The federal government has been a reliable partner in the match funding of our Medicaid program
- Competitive Advantage: Maintains Utah's competitive health care cost/access advantage in the West

CHALLENGES

The weaknesses of this option are:

- Potential strain on health care workforce
- May incentivize employers against providing coverage to employee

COST & SOURCE OF PAYMENT

It is estimated that this option would cost the state of Utah approximately \$116 million over the first ten years, or \$11.6 million annually. The federal government pays for 100% of the cost of the expansion in the first three years (2014-2016). In the fourth year the state would see a net savings. The first year that the state would experience a net cost is 2018. For the years after 2020, when the state share is maximized at 10%, the state would have a net cost of around \$25 to \$35 million annually. On average, it will cost the state around \$116 annually per new beneficiary over the first 10 years.

There are many options for paying the state share of these costs. The first two options fund the Full Expansion at no additional expense to the Utah taxpayer.

- The Master Settlement Agreement (MSA) or the Tobacco Settlement Payments
 - o Redirect the \$14.5 million currently being directed annually into the General Fund (diverted in 2011 from the Permanent State Trust Fund to General Fund) into a restricted account to pay for the Medicaid expansion. Between the years 2014-2020, this accumulates \$87 million for full expansion costs.
 - o As the CHIP Program ends in 2019, redirect the Tobacco Settlement Restricted Account for CHIP into the Medicaid Expansion restricted account. (\$10.5 million annually).
 - o The permanent State Trust Fund, the trust fund portion of the MSA, currently has \$113 million accumulated since FY 2000.
- Hospital Provider Tax
 - o A small increase in the hospital provider tax will cover the cost.
- Since the expansion will generate \$85.9 million dollars in state tax revenue, set aside some of that revenue to the state's general fund to fund the expansion.
- Set aside a portion of current budgetary surplus to fund Medicaid expansion in later years
- Create Medicaid trust using state dollars saved during the first five years expansion to help pay for future years
- New taxes on insurance premiums and/or providers to capture monies currently spent on charity care and divert them to Medicaid coverage.

WHO IS COVERED

This option would cover childless adults and parents from 0% FPL to 138% FPL. Currently, childless adults who are NOT pregnant, disabled or elderly do not have access to Medicaid. Parents living in a household with an income less than 44% FPL have access to Medicaid. The average premium in Utah for an individual is around \$3,000; for a family of four, with two parents covered, is around \$6,000.

MAXIMUM HOUSEHOLD INCOME			
Current Medicaid		Medicaid Expansion	
Individual Adult	Parents in Family of Four	Individual Adult	Parents in Family of Four
NO COVERAGE	\$10,362 (44% FPL)	\$15,856 (138%FPL)	\$32,499 (138% FPL)

Full Expansion results in more equitable access to health care for all Utah residents. This option would cover nearly 100,000 individuals by 2017. This option would not cover undocumented immigrants and immigrants without permanent residency status.

Groups who are not covered by this option would obtain coverage by purchasing coverage on the individual market, pay for their care out-of-pocket, or utilize Utah's existing charity care system and Community Health Centers.

PREPARED BY THE FULL EXPANSION SUBGROUP:

Sen. Gene Davis, Rep. Rebecca Chavez-Houck, David Entwistle, Karen Crompton, Alan Pruhs, Matt Slonaker

PREMIUM SUBSIDY PLUS PARTIAL MEDICAID EXPANSION

SUMMARY

The Premium Subsidy plus Partial Medicaid Expansion option would provide Medicaid coverage to adults living in poverty who are currently not eligible for Medicaid and provide premium subsidy support using Medicaid funds to adults with incomes between 101% and 138% of the federal poverty level (FPL) to purchase employer sponsored coverage or coverage on the federal Health Insurance Marketplace. This proposal will ensure that all citizens in Utah have access to affordable coverage, allow the state to qualify for the enhanced 90/10 federal Medicaid match rate by providing Medicaid funded coverage to all adults with incomes below 138% FPL.

This option attempts to bridge two competing Utah values: private market solutions and cost-effective use of tax dollars. On one hand, Utah's Medicaid Accountable Care Organizations and traditional Medicaid program provide the most cost-effective care to enrollees and to the taxpayer. On the other, there is a strong philosophical belief among many in our state that private employer sponsored and individual market coverage is a better vehicle to pay for care for Utahns who cannot afford it. By providing adults in poverty coverage through our traditional Medicaid program with a new adult benchmark benefit package, we ensure the poorest and most vulnerable receive coverage through our proven cost-effective and high quality program. For adults above poverty, we provide premium subsidies that strengthens our employer sponsored and individual health insurance markets. The majority of new enrollees under this proposal will be receiving coverage through the private market.

This option would require 1115 waiver authority from the Centers for Medicare and Medicaid Services (CMS), allowing the state to limit adults between 101% to 138% of FPL to a premium subsidy program.

OPPORTUNITIES

The strengths of this option are:

- Utah would be more likely to qualify for the full 90/10 federal match rate than under a partial expansion proposal.
- Helps preserve employer sponsored coverage by allowing adults above poverty to use a Medicaid funded subsidy to purchase their employer sponsored plan.
- Limits churning between health coverage programs by allowing adults whose incomes fall below 138% retain their private health coverage using a subsidy.
- Pays providers commercial rates for enrollees with incomes above 100% FPL (majority of new enrollees).
- Reduction in cost-shift to private coverage to provide care to uninsured.
- \$2.9 billion statewide in economic impact, creating over 4,160 jobs (PCG report - Medicaid Expansion Traditional Benefit Package).
- Greater cost-sharing for enrollees, particularly enrollees with incomes above 100% FPL.

CHALLENGES

The weaknesses of this option are:

- Administratively more complex than a full Medicaid expansion.
- Requires an Section 1115 Waiver from the federal government.
- Likely more expensive to taxpayers than a traditional Medicaid expansion.

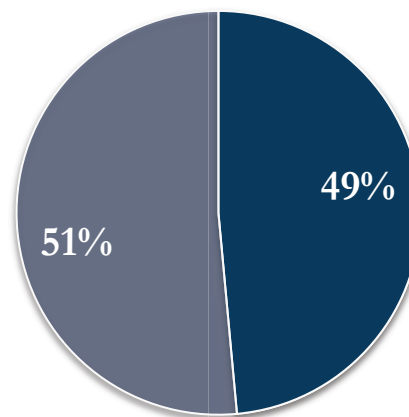
COST & SOURCE OF PAYMENT

No formal study has been done to evaluate the cost of this option. The Premium Subsidy/Partial Medicaid Expansion Model recognizes that the adult Medicaid benchmark package is less expensive than traditional Medicaid, but that the premium subsidies to purchase qualified health plans are more expensive than a full expansion of Medicaid. Therefore, the PCG Report's, Full Expansion, Full Benefits scenario likely gives the closest estimate of costs and savings. This scenario would save the state of Utah approximately \$5.2 million in 2017. However, beginning in 2018 this scenario would cost the state approximately, \$570,000 and costs would gradually increase to \$34.7 million in 2023 as the federal match rate is reduced to 90/10.

PCG REPORT-SCENARIO 2	
2017	\$(5,179,236.93)
2018	\$569,560
2022	\$30,862,922
2023	\$34,686,320

IN THIS MODEL, MAJORITY OF NEW ENROLLEES GET COVERAGE IN PRIVATE MARKET

- Traditional Medicaid (<100% FPL)
- Private Market Coverage (>100% - 133% FPL)



Options for paying the state share of these costs include:

- Hospital assessment ~\$150 million
- Appropriate former funding going from HIP Utah to Medicaid ~\$8 million.
- Additional tax revenue to the state's general fund due to expansion ~\$8.5 million.
- Use CHIP funding by ending program ~\$1 million general fund, \$10.5 million tobacco settlement funds.

It is estimated that this option would cost the federal government approximately \$315 million per year in 2023.

WHO IS COVERED

This option would cover childless adults and adults with children with incomes below 138% FPL. The PCG Report estimates that 49% of those adults would be in the traditional Medicaid program and 51% would be in the private market.

MAXIMUM HOUSEHOLD INCOME			
Traditional Medicaid		Private Market Subsidy	
Individual	Family of Four	Individual	Family of Four
\$11,490 (100%FPL)	\$23,550 (100% FPL)	\$15,856 (138%FPL)	\$32,499 (138% FPL)

This option would cover 123,000 individuals by 2017 and ensure that all citizens and legal permanent residents have access to affordable health coverage. This option would not cover uninsured immigrants without permanent residency status.

PREPARED BY THE FULL EXPANSION SUBGROUP:

Sen. Gene Davis, Rep. Rebecca Chavez-Houck, David Entwistle, Karen Crompton, Alan Pruhs, Matt Slonaker

PARTIAL EXPANSION WITH BENCHMARK BENEFITS

SUMMARY

This option would provide coverage to adults not currently eligible for Medicaid who meet residency and citizenship requirements.

Coverage would be provided up to 100% of the federal poverty level (FPL). Premium subsidies would be provided through the exchange for those who are employed and would include higher cost sharing than traditional Medicaid. Special needs populations would be served under traditional Medicaid. Individuals with income over 100% FPL would not be covered by Medicaid but would have access to coverage through health insurance exchanges.

Individuals under 100% FPL who didn't have access to employer-sponsored health insurance would be provided coverage through managed care in those areas of the state where enrollment in a health plan is mandated and through the Medicaid Prepaid Mental Health Program.

These newly eligible adults would receive a benefit that is actuarially equivalent to the benchmark plan (PEHP basic plan with sufficient mental health benefits included to comply with federal mental health parity requirements) and an added focus on lower cost sub-acute care model.

Utah will request the new Federal Medical Assistance Percentage (FMAP) for this partial expansion for three years. The new FMAP starts at 100% match and then ratchets down to 90% match. Receiving the new FMAP would require approval under 1115 waiver authority from the Centers for Medicare and Medicaid Services (CMS). It should be noted that prior to enactment of the Affordable Care Act, Utah could have expanded coverage at the current FMAP rate (approx. 70/30) and CMS has indicated they would likely not approve the new FMAP for a partial expansion.

This option would require updating the current state statute, rules and State Plan that govern the Medicaid program. In addition, the state would have to submit an 1115 waiver request for new FMAP for a Medicaid expansion that extends to 100% FPL rather than 138% FPL, as included in the Affordable Care Act.

OPPORTUNITIES

The strengths of this option are:

- Takes expansion only to level where federal tax credits on the exchange come into play.
- Reduces risk of currently insured in private market converting to public coverage (crowdout).
- If CMS grants the new FMAP, covering fewer people through Medicaid reduces the risk of overextending the Medicaid budget.
- Expands Medicaid on Utah terms and footprint but does not overexpose the state financially.
- Brings federal dollars to Utah to reduce uncompensated care and cost shift to employers.
- Provides access points to primary care and chronic disease management giving alternatives to 911-calls and uncompensated emergency room use and hospitalizations.
- Many under 100% FPL are less healthy than the average population. Partial expansion shifts these higher health risk individuals to a federal program thereby reducing the cost shift to the employer market.
- Mitigates losses to hospitals and providers from reductions in federal funding designed to cover the uninsured (DSH, substance abuse, etc.).

CHALLENGES

The weaknesses of this option are:

- Have to seek CMS approval for full 100% FMAP which may be a difficult political process. Without 100% FMAP, partial expansion is more expensive than full expansion according to the PCG report and not recommended by the subgroup.
- Leaves 48,897 Utahns uninsured by Medicaid and leaves federal funds on the table.
- Some people may remain uninsured as premiums may be unaffordable to those at 101% – 138% FPL even

with tax credits, perpetuating poor health, increased mortality and uncontrolled health care costs due to cost shifting from uninsured to insured patients.

COST & SOURCE OF PAYMENT

Costs presented here are Department of Health estimates based on the Public Consulting Group's State of Utah Medicaid Expansion Assessment. The estimates did not include adjustments to costs for the use of premium assistance for employer-sponsored health insurance or traditional Medicaid for those with special needs.

If CMS were to approve new FMAP for a partial expansion, it is estimated that this option would cost the state of Utah approximately \$13.7million per year starting in 2020. If CMS only approves current FMAP for a partial expansion, the cost to the state of Utah would be approximately \$36.7 million starting in 2020. These figures do not include potential savings from reduced reliance on other public assistance programs or from increased tax revenues generated from increased federal spending in the state.

Options for paying the state share of these costs include:

- County funds currently used to provide services for adults not eligible for Medicaid could be used to provide the state match for the behavioral health services components of the benchmark health plan.
- State funds currently used for providing medical services to adults not eligible for Medicaid could be used for the state match for a portion of the remainder of the benchmark health plan benefits.

If CMS were to approve new FMAP for a partial expansion, it is estimated that this option would cost the federal government approximately \$123.2 million per year starting in 2020. If CMS only approves current FMAP for a partial expansion, the cost to the federal government would be approximately \$100.1 million starting in 2020.

WHO IS COVERED

This option would expand coverage to all adults currently not eligible for Medicaid and who meet residency and citizenship requirements.

This option would cover 46,112 individuals by 2017. This would leave 48,897 individuals without coverage under Medicaid.

This option would not cover the following group:

- Adults with incomes 101% - 138% FPL. Those individuals are eligible for coverage through the health insurance exchanges.

The group not covered by this option would obtain coverage by using tax credits to purchase health insurance through the exchanges. Individuals with incomes 101% – 138% FPL that did not purchase coverage would receive services through a variety of community resources. In other words, nonprofit charity care providers would continue to provide care to the uninsured. EMTALA requirements would remain in place and uncompensated life-saving care would be provided by hospitals.

PREPARED BY THE PARTIAL EXPANSION SUBGROUP:

Rod Betit, Kristy Chambers, Adam Trupp, Rep. Jim Dunnigan

BLOCK GRANT-LIKE WAIVER

SUMMARY

Under this option, the State would request a waiver that would operate much like a block grant. The waiver would allow additional flexibility in providing coverage to newly eligible adults in exchange for the State taking some of the risk if the costs of providing that coverage exceed projections.

This option would provide coverage to adults not currently eligible for Medicaid. In order to qualify for the new federal match rate, coverage would be provided up to 138% of the federal poverty level (FPL). This option would not change coverage or income levels for individuals currently eligible for Medicaid.

This option would provide coverage through premium assistance, managed care, and health savings accounts. Individuals above 100% FPL would receive premium assistance while most individuals below 100% FPL would receive benchmark coverage through Medicaid Accountable Care Organizations (ACOs). Health savings accounts would be used to help individuals appreciate premiums and other cost sharing.

This option would require 1115 waiver authority from the Centers for Medicare and Medicaid Services (CMS). The State could amend its existing 1115 waiver or it could submit a separate 1115 waiver request for this option.

This option would not require changes to existing state and federal laws or regulations. Although a true block grant would require a change in federal regulations and direction from Congress, this option seeks to achieve a similar arrangement through an 1115 waiver.

OPPORTUNITIES

The strengths of this option are:

- Waiver would be based on per person costs for each eligibility group. Utah would not be at risk for increased enrollment or a change in the mix of enrollees.
- Waiver would contain a circuit breaker that would end the agreement if the federal match rate changed.
- Method of providing services would highlight the strengths of private health insurance and Utah's unique ACOs.
- If the waiver rates are lower than current Medicaid rates (or what Medicaid rates would have been without a waiver), then Utah will have budget savings (or reduced demands for budget increases).
- If Utah experiences costs lower than the waiver rates, the savings could be used to add individuals to the program or to provide services not currently covered by Medicaid (e.g., adult dental), preferably for items that are one-time in nature.
- Unlike a compact or true block grant, the waiver would not require Congressional action.

CHALLENGES

The weaknesses of this option are:

- Utah would be at risk if costs exceed projections within waiver.
- Waiver would require CMS approval. CMS may not approve desired flexibility.
- ACOs may not be a viable option in all counties in the near future.

COST & SOURCE OF PAYMENT

In general, the cost of this option will be similar to the estimates that the Public Consulting Group (PCG) produced for Full Expansion, Benchmark Benefits (Scenario 3) in its State of Utah Medicaid Expansion Assessment. Additional analysis would be needed to determine the impact on costs for the use of premium assistance for individuals from 100-138% FPL and for the use of health savings accounts.

Using PCG's Scenario 3 numbers as a basis, it is estimated that this option would cost the state of Utah \$28.2 million per year starting in 2020. These figures do not include administrative costs or potential savings from reduced reliance

on other public assistance programs and increased tax revenues generated from increased federal spending in the state. In addition, these figures do not include the increased costs to the state of Utah due to the mandatory Medicaid changes from the Accountable Care Act.

The state share of these costs should generally be borne by those who experience the greatest benefit from the expansion. In general, revenues should come from the following sources (listed in priority order):

- Reappropriate savings from programs that will now be covered by Medicaid (e.g., Primary Care Network)
- Appropriate increased revenues from enhanced economic activity to fund this option
- Assess hospitals since they will receive increased payments from the increase in the number of covered individuals
- If other options are insufficient, implement a general tax increase

It is estimated that this option would cost the federal government \$253.8 million per year starting in 2020.

WHO IS COVERED

This option would cover adults with dependent children above current eligibility levels up to 138% FPL. Adults without dependent children would also be covered up to 138% FPL.

Using the PCG estimates for Scenario 3, it is estimated that this option would cover approximately 111,000 individuals by 2020.

This option would not cover the following groups:

- Legal, documented immigrants who have been in the country less than five years.
- Undocumented immigrants.

Legal, documented individuals not covered by this option could obtain coverage by enrolling in the federal Health Insurance Marketplace. They would be eligible for tax credits and cost sharing protections. Undocumented immigrants would continue to receive care through community health clinics and other facilities that serve the uninsured.

PREPARED BY THE BLOCK GRANT AND COMPACT SUBGROUP:

Wes Smith, Michelle McOmber, Royce Van Tassell, Sen. Todd Weiler

UTAH PREMIUM PARTNERSHIP PLUS

SUMMARY

This option would expand Utah's Premium Partnership (UPP) program by providing people with premium subsidies to purchase coverage in the private market in-lieu of the Affordable Care Act's Medicaid expansion.

Utahns have long been suspect of the wisdom of providing health coverage through Medicaid. As a result, many policy leaders in our state have looked for ways to use the private insurance market to help low-income families in need. UPP is an example of such an approach.

Currently, UPP makes employer sponsored health insurance more affordable for low-income working individuals and families by providing a premium subsidy to help cover the employee's share of health costs. This proposal builds on this successful approach by expanding UPP to adults and families who do not have an offer of employer sponsored coverage. This option would provide these families with a subsidy to purchase coverage on the individual market and set up a health savings account to help educate these families on how to spend their health care dollars more wisely.

Providing premium subsidies strengthens our employer sponsored and individual health insurance markets by expanding their risk pools with relatively healthy low-income adults. This will help reduced premium cost for everyone purchasing coverage in these markets.

This option would require 1115 waiver authority from the Centers for Medicare and Medicaid Services (CMS), allowing the state to use Medicaid funds to help pay for a premium subsidy program.

OPPORTUNITIES

The strengths of this option are:

- Grows enrollment private market health coverage instead of state Medicaid rolls.
- One family, one card—allows families to enroll in same health plan.
- 123,000 Utahns receive health coverage and the improved health and financial security that health coverage provides (PCG report).
- Helps preserve employer sponsored coverage by allowing adults above poverty to use a Medicaid funded subsidy to purchase their employer sponsored plan.
- Limits churning between health coverage programs by allowing adults to keep their private insurance coverage regardless of their income.
- Reduction in cost-shift to private coverage to provide care to uninsured or to compensate for low reimbursement by Medicaid.
- State public assistance public programs would save \$110 million (PCG report).
- County public assistance programs would save \$2 million (PCG report).
- \$2.3 billion statewide in economic impact, creating over 3,000 jobs (PCG report benchmark expansion).

CHALLENGES

The weaknesses of this option are:

- Administratively more complex than a traditional Medicaid expansion.
- Requires an 1115 waiver from the federal government.
- Likely more expensive to taxpayers than a traditional Medicaid expansion.

COST & SOURCE OF PAYMENT

No formal study has been done to evaluate the cost of this option. Recognizing that the premium subsidies to purchase qualified health plans are more expensive than a full expansion of Medicaid, the PCG report's, Full Expansion, Full Benefits scenario likely gives the closest estimate of costs and savings. This scenario would save the state of Utah approximately \$5.2 million in 2017. However, beginning in 2018 this scenario would cost the state approximately, \$570,000 and costs would gradually increase to \$34.7 million in 2023 as the federal match rate is reduced to 90/10.

Options for paying the state share of these costs include:

- Provider assessments (Hospital, Accountable Care Organizations, Physicians, Dentists, Pharmacy) ~\$150 million.
- Appropriate former funding going HIP Utah to Medicaid~\$8 million.
- Additional tax revenue to the state's general fund due to expansion~\$8.5 million.
- Use CHIP funding by ending program~\$1 million general fund, \$10.5 million tobacco settlement funds.

PCG REPORT-SCENARIO 2	
2017	\$(5,179,236.93)
2018	\$569,560
2022	\$30,862,922
2023	\$34,686,320

It is estimated that this option would cost the federal government approximately \$315 million per year in 2023.

WHO IS COVERED

This option would enroll adults with household incomes below 138% FPL in private health coverage. It would give families between 100% and 138% of FPL the option to enroll their children in private coverage.

MAXIMUM HOUSEHOLD INCOME	
Private Market Subsidy	
Individual	Family of Four
\$15,856 (138% FPL)	\$32,499 (138% FPL)

This option would cover 123,000 individuals by 2017 and ensure that all citizens and legal permanent residents have access to affordable health coverage. This option would not cover uninsured immigrants without permanent residency status.

PREPARED BY THE BLOCK GRANT AND COMPACT SUBGROUP:

Wes Smith, Michelle McOmber, Royce Van Tassell, Sen. Todd Weiler

PERSONAL WELLNESS RESPONSIBILITY MODEL

SUMMARY

The high-level objective is to create a distinctively Utah approach to providing medical assistance for low-income individuals and families.

Background

Section 1332 of the Affordable Care Act (ACA) allows states to propose alternative ways of covering their population with the Secretary's approval. State proposals must provide equivalent coverage to the same populations with no added expense to the federal government.

Past Medicaid waivers in states like Indiana and Rhode Island show that, as a population, the low-income uninsured are grateful to have health insurance coverage and are willing to contribute to their health insurance coverage, resulting in positive utilization and quality outcomes through a new model of patient engagement and health care value.

Principles

- **The Family is the Unit** – Treat families as a unit with interrelated needs and resources
- **Private Insurance Model** – Capitalize on the private sector's ability to create high-value solutions
- **Aligned Incentives** – Reintroduce incentives for families to seek better jobs and earn higher incomes; create a Bridge to Self Sufficiency
- **Patient Engagement** – Give patients a vested interest in seeking better value in the health care system

Program Framework

- **Premium Assistance** - Support the purchase of family-based private coverage for low-income families using a sliding scale
- **Incentives** – Provide financial incentives for patients to be wise consumers who seek value in their health care; encourage cost-effective choices and discourage inefficient care
- **Health Savings-style Account** – Provide member-driven and cost-sensitive financial assistance to low-income families that incentivizes

Program Details

- **The Family** – Families are treated as a single unit instead of having different eligibility and coverage for individuals within a household. They enroll together in a family policy so they have one insurance card, participate in the same provider network, and have the same benefit package. Financial assistance is also at the family level and represents a shared family resource creating an incentive for them to work together as a unit toward self-sufficiency.
- **Employer Coverage** – If a family has access to employer coverage through their employer or union, they can enroll in that coverage option. This takes advantage of available employer contributions and enrolls families on the type of plan they expect to have when their income rises.
- **Family Policies** – Families that do not have access to employer coverage will choose a contracted plan and enroll as a family. Contracted plans would be provided by private organizations (such as ACOs) that provide access to high value care.

The Utah Personal Wellness & Responsibility Account

This approach represents a new model of providing financial assistance to low-income families that preserves and enhances incentives to seek high value care and become self-reliant.

- Many, if not most, participating families will have responsibility for some level of premium, co-pays, deductibles, or other cost-sharing under the plan they choose.
- The account provides financial assistance in a way that preserves incentives for value-seeking behavior that would otherwise be removed if cost-sharing was completely eliminated.
- This account works similar to a Health Savings Account, and is funded with a mix of public (state and

federal) funds and possibly family contributions at a level that is sufficient to cover the family's cost-sharing requirements.

- As families use health care, their out-of-pocket costs are deducted from their Account, modeling the type of plans typically offered to higher income families.
- The key to the success of this program is that the family must realize some ownership of the funds in the account in order to create an incentive to be cautious about how they spend the money in the account. There must be some positive, significant benefit to keeping the money instead of spending it.
- Families could be allowed to convert some or all of their account balance to be used for payment of future premiums, future cost-sharing or non-covered medical expenses when their income increases and they leave the program.
- The amount allowed to be converted could be contingent on demonstrated personal responsibility, such as meeting preventive care targets.
- In addition to incorporating proper incentives regarding utilization, this approach also creates better work incentives, creating a Bridge to Self Sufficiency.

OPPORTUNITIES

The strengths of this option are:

- Treats families as a unit
- Builds on private sector
- Restores incentives
- Bridge to Self Sufficiency
- Direct access to tax money we paid

CHALLENGES

The weaknesses of this option are:

- Relies on continued federal funding
- Under current law, cannot be approved until 2017
- May not be effective for severely disabled or institutionalized patients

COST & SOURCE OF PAYMENT

Under Section 1332, the state can propose an alternate model for covering its citizens as long as it doesn't increase the federal deficit. It is anticipated that the state would request a federal appropriation equivalent to what the federal government would have had to pay if Utah fully implemented the ACA's requirements. This is essentially a request to give Utah its fair share of federal funds and let the state decide how best to cover its citizens.

There will also likely be a need for additional state appropriations to fully fund the program. The levels of fund depend critically on program specifics, but it is plausible that the current level of state funding (growth adjusted) could be adequate.

WHO IS COVERED

"Low income families" would be covered. This could be defined as below 100% or 138% FPL (or something else). The choice of cut-off would affect the level of federal funding available.

Since the ACA contains other provisions for people above 100% FPL, the end result would likely be that virtually all Utahns have access to some form of coverage.

SECTION 1332/TAX RECOVERY SUBGROUP:

Greg Poulsen, Chad Westover, Michael Hales, Rep. Rhonda Menlove

STRENGTHENING UTAH'S HEALTH CARE SAFETY NET

A FRAMEWORK FOR FORMALIZING CHARITY MEDICAL CARE IN UTAH

SUMMARY

Charity care is medical care given without expectation of remuneration for services. This concept is commonly referred to as the “health care safety net.”

Utah currently has a diverse health care safety net. Although generous charity care is donated by dedicated professionals and benevolent provider organizations, segments of Utah’s safety net lack coordination and universal access. Much positive work is already happening, but there is tremendous potential to refine and expand the existing efforts.

The principles and framework contained within this document will form the foundation for the development of a proposal for a coordinated, statewide private sector approach to universal, basic health care for Utah’s medically underserved populations and geographic areas.

A working group (The Charity Care Subgroup) was organized and chartered to provide research and analysis to the Executive and Legislative Branches of Utah State Government. The Charity Care Subgroup is accountable to:

- Medicaid Options Community Work Group (Executive)
- Health Reform Task Force (Legislative)

Research expectations and deliverables are outlined in H.B. 160.

Research work currently in process includes:

- Identification of medically underserved populations and areas within the state
- Identification of barriers in the current health care delivery and payment models to the promotion of a comprehensive charity care system
- Identification of resources currently available for medically underserved populations and geographic areas
- Development of a model for an improved safety net

OPPORTUNITIES

Utah’s charity care network should . . .

- Be comprehensive, coordinated and well-publicized
- Emphasize health education, self-responsibility and prevention
- Include primary and secondary care, Rx, lab, x-ray, dental and behavioral health/substance abuse treatment
- Be outcome-oriented and documented, including qualitative and quantitative measures of effectiveness
- Utilize a standardized electronic medical records storage and retrieval system
- Incorporate elements of a Patient-Centered Medical Home

CHALLENGES

1. Primary Care

- A standard system for medical record storage and collection has not been embraced statewide
- Many people do not know how to access care through the existing safety net
- Many primary care physicians are not aware of available options and do not know how to advise patients
- Current safety net providers are experiencing capacity issues, which are likely to increase
- Some uninsured individuals and families do not have a primary care provider – they migrate to wherever treatment is available
- Providers who charge nominal fees-for-services need statutory relief from malpractice litigation in Utah

2. Cost and Sources of Funding

- Based on potential scale, public/private partnerships to address initial capital outlays for structures and equipment
- Ongoing administrative costs necessary to maintain the coordinated, statewide infrastructure and network
- Annual and sustainable operating funds from private individuals, corporations, religious organizations, grants and endowments

WHO IS COVERED

- Low-income, homeless and uninsured individuals and families
- Temporary Medicaid recipients
- Anyone who “falls through the cracks” of the health care system

CHARITY CARE AND SELF-RELIANCE SUBGROUP:

Pamela Atkinson, Stan Rasmussen, Rep. Michael Kennedy, Sen. Allen Christensen, other members as invited by the Legislative Health System Reform Task Force

MANDATORY ONLY

WHAT HAPPENS IF UTAH CHOOSES TO DO ONLY THE MINIMUM REQUIRED BY THE ACA?

SUMMARY

When considering the needs of low-income adults, it is important to take into account that the Affordable Care Act contains provisions that will provide programs or opportunity for the vast majority of the uninsured to obtain coverage with no additional action required by the state. In 2011, 62,000 uninsured adults had incomes below 100% of the Federal Poverty level and would not have access to subsidized coverage through the exchange. Even of these, many would have other options available. For example, they may be currently eligible for Medicaid or would have a strong incentive to seek additional employment to raise their income and become eligible for premium subsidies. Ultimately, the number of uninsured with no true access will represent a significantly smaller burden on the charity care or safety net system, allowing us the opportunity to focus resources more narrowly and provide better care at a lower cost without creating new programs.

BACKGROUND

In 2005, Utah's policy leaders put forward the ambitious goal of cutting the number of uninsured Utahns in half within 10 years (from 10% to 5%). It was argued that if more people had coverage, the burden of caring for the remaining uninsured would be manageable and price pressure from cost-shifting would be greatly reduced. Before many of the ideas coming from that initiative could be implemented, the federal government passed the Affordable Care Act (ACA) in 2010, pushing forward a federal vision of how to reduce the number of uninsured and pre-empting many of the state's designs and proposals.

Key provisions of the ACA are intended to provide new opportunities for broad classes of people to obtain affordable coverage, including:

1. Mandatory changes in eligibility rules for children and some adults under 200% of the Federal Poverty Level (FPL)
2. Requiring all direct purchase of individual and family policies to be guaranteed issue (cannot be denied), no pre-existing conditions exclusions, and modified community rating (sick people don't pay more)
3. Allowing all dependents up to age 26 (married or single) to be covered on their parents' policy
4. The creation of a massive subsidy program for people between 100-400% FPL who can't get coverage through work to help them purchase individual coverage through an insurance exchange
5. Requiring employers with more than 50 employees to provide affordable coverage for all full-time employees
6. Special provisions for American Indians, Alaska Natives, and recent legal immigrants giving them expanded access to new and existing programs

While the jury is still out on the full impact of each of these provisions on premiums and enrollment, as a general rule, the overlap should provide new opportunities for many previously uninsured Utahns to obtain health coverage. In particular, it would seem that virtually all children and middle to high income adults should have access to some form of coverage in 2014, either through an employer or by taking advantage of one of these new federal provisions.

Due to the Supreme Court ruling exempting states from the requirement to cover low-income adults through an expanded Medicaid program, the policy debate has been appropriately focused on adults with incomes below twice the federal poverty level. The aim of this document is to compare how those adults fared in 2011 with programs and options available to them in 2014 assuming that the state does not opt to expand Medicaid for low-income adults.

INITIAL OBSERVATIONS

According to the Census Bureau's 2012 Current Population Survey (CPS), there were around 1.6 million Utah adults (ages 18-64) in 2011. Of these, about 35% (561,000) were in families with incomes below 200% FPL.

Figure 1 illustrates CPS estimates for health coverage for these adults in 2011. 45% were covered through private

employer-sponsored coverage. 7% were covered under private direct-purchase policies, and 16% were on some form of public coverage (Medicare, Medicaid, or Military). 32% were reported being uninsured during 2011.

Health Coverage, Low-Income Utah Adults, Ages 19-64, under 200% of the Federal Poverty Level, in thousands

Source: 2012 Current Population Survey

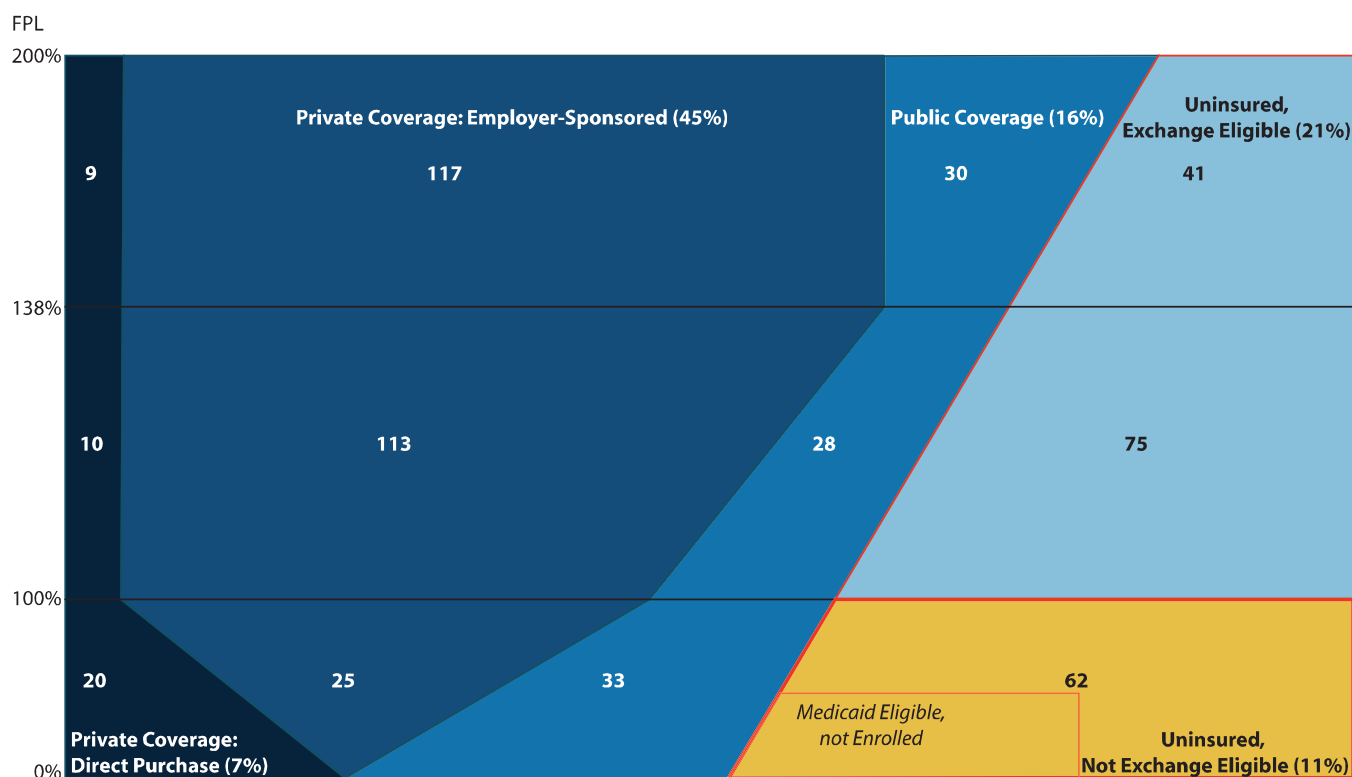


Figure 1. 2011 Health Coverage for Low-Income Utah Adults

WHAT HAPPENS IN 2014?

Under the provisions of the ACA, we should expect some movement of covered adults from one form of coverage to another, such as movement from employer-sponsored coverage to subsidized direct-purchase plans through the exchange, but with very few exceptions, adults with an opportunity for coverage in 2011 would still have a coverage option under the ACA's 2014 programs. Furthermore, virtually all of the 116,000 uninsured adults at 100-200% FPL would have access to heavily subsidized plans through the Exchange if not through their employers.

What about the approximately 62,000 adults in families with incomes below 100% FPL? With no Medicaid expansion, how will they get access to coverage or health care after 2014? Here are some possibilities:

1. **Medicaid eligible, but not enrolled** – Adults near the bottom of this income category that are parents of dependent children are already eligible for Medicaid through the Low Income Families with Children (LIFC) program. In Utah, the income cutoffs for eligibility are generally in the range of 25-40% FPL depending on family size. It is anticipated that a non-trivial fraction of the 62,000 adults below 100% FPL are eligible for this existing program or could qualify for Medicaid based on being pregnant, blind or disabled. It is generally known that some of the uninsured do not enroll in public assistance because they do not have immediate health needs but will apply for coverage if a significant need arises.
2. **Work-Welfare Incentives** – One feature of not expanding Medicaid that is rarely mentioned is the work incentive it would create. Families at 100% FPL would have guaranteed access to a Silver Plan with an enhanced actuarial value of 94% and premiums capped at 2% of family income. Adults currently below 100% FPL can qualify for this subsidized coverage through the exchange if they can report income at or above 100% FPL.

Ignoring the incentives for fraudulent income reporting, this creates a powerful incentive for these adults to seek additional opportunities to increase family incomes. With the potential value of these subsidies (see Table 1) exceeding \$15,000 for some families, we could predict a non-trivial response to this work incentive.

Family Size/Composition	Age of Adults Estimated	Premium Subsidy
One Adult, One Child	Age 25	\$2,720
Two Adults, One Child	Both Age 40	\$7,243
One Adult	Age 64	\$8,824
Two Adults	Both Age 64	\$17,798
Notes: 1. Does not include the value of Cost Sharing Reductions (reduced co-pays and deductibles) 2. Assumes all children would enroll in Medicaid Source: kff.org Interactive Subsidy Calculator		

Table 1. Estimated Premium Subsidies for Adults at 100% FPL

Table 2 shows the number of minimum wage hours worked per week and reported income required to qualify for subsidized exchange coverage. It should also be noted that this income does not necessarily have to be from formal employment, but could come from working informal jobs, such as mowing lawns, baby-sitting, or cleaning houses for neighbors and friends.

Family Size	Minimum Wage Hours per Week (\$7.25)	Reported Income
One	30.5 hours	\$221
Two	41.1 hours	\$298
Three	51.8 hours	\$376
Four	62.5 hours	\$453

*Add about 10.7 minimum wage hours per week or \$77 for each additional family member

Table 2. Minimum Wage Hours/Income Required for 100% FPL

3. **Coverage through other sources** – Adults below 100% will also have an incentive to seek coverage through other ACA-based solutions:
 - a. Full-time employment – There is an increased incentive to seek full-time employment with benefits, especially with the virtual elimination of all “full-time non-benefited jobs.”
 - b. Those under age 26 may be eligible for coverage through parent plans or may enroll in student health plans.
 - c. Purchase of private guaranteed issue coverage at modified community rates – While not every low-income family will be able to afford the unsubsidized premiums, there are some who can, especially early retirees and others who have access to non-income resources or students who are temporarily low-income and have access to short-term credit or family support. Note that in Figure 1, there were an estimated 20,000 low-income adults enrolled in direct purchase plans in 2011 suggesting that for at least some low-income adults, direct-purchase is an option.
4. **Employment Dynamics** – It is important to remember that the uninsured form a dynamic population that fluctuates through time as people experience changes in employment, income and other circumstances. Estimates suggest that at any given point in time, as many as half of the currently uninsured will become insured within a year and that one-fifth will stay uninsured for less than three months. (Source: CMS analysis of the 2001 Medical Expenditure Panel Survey)

5. **Charity or Safety Net Care** – Ultimately, there will still be some low-income adults that cannot or will not take advantage of these opportunities, such as those whose mental or physical health conditions make it difficult to work and who do not qualify for public coverage. In 2011, many of these individuals would have relied primarily on safety net or charity care for urgent health needs. However, by comparison to the size of the population needing a solution in 2010, the size of the “Doughnut Hole” population in 2014 will be significantly smaller. Figure 2 compares the relative size of the uninsured population in 2005, the initial goal of the Health Reform Initiative and the gap remaining after the ACA’s provisions. In 2014, since the number of individuals needing to rely on safety net or charity care resources will be dramatically reduced, it presents an important opportunity for the state to explore ways of strengthening the safety net or charity system to provide better quality care for the small number of low-income adults with no other options.



Figure 2. Relative size of the “Doughnut Hole” with previous goals related to the uninsured

SUMMARY AND CONCLUSIONS

1. The ACA will have a significant effect on reducing the number of uninsured low-income adults without any state intervention. Most low-income adults will be able to buy subsidized coverage through the exchange.
2. An estimated 11% of adults below 200% FPL are currently uninsured and would not immediately qualify for exchange coverage. However, a significant number of these adults currently have access to Medicaid through the LIFC program, and a very strong and realistic work incentive exists for many others to increase their family’s total work hours in order to become exchange eligible. Yet others would have an incentive to seek better employment, enroll in student health plans or get covered under a family member’s policy.
3. The net number of uninsured low-income adults should be dramatically lower than it was in 2011, allowing safety net and charity resources to be more narrowly targeted to providing for the needs of those that have no affordable options.



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