WAIVER WATCH ISSUE BRIEF #2:
THE UTAH PRIMARY CARE NETWORK

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Our work is aimed at strengthening the voice of consumers and communities wherever decisions shaping the future of our health system are being made. Community Catalyst strengthens the capacity of state and local consumer advocacy groups to participate in such discussions. The technical assistance we provide includes policy analysis, legal assistance, strategic planning, and community organizing support. Together we're building a network of organizations dedicated to creating a more just and responsive health system.

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Overview

On February 8, the federal government granted Utah permission to modify its state Medicaid program to implement something called "The Primary Care Network Program" (PCN). This paper summarizes the waiver and highlights the political and policy issues raised by the Utah proposal.[1]

In the context of proposals circulating in some states to dramatically reduce eligibility, the Utah waiver appears, at least at first glance, to be relatively benign. There is no reduction in eligibility and even some potential expansion of coverage. However, the Utah waiver creates a troubling precedent because it marks the first time that reductions in benefits and increases in cost-sharing for one very low income population will be used to finance an expansion for another group. In addition the Utah waiver:

- Permits substantial levels of cost sharing for certain currently eligible beneficiaries – parents of SCHIP enrollees.
- Creates a benefit package for newly eligible enrollees that leaves significant barriers to care in place, even for nominally covered services.
- Imposes a $50 enrollment fee on very low-income adults that is likely to discourage many would-be applicants.
- Caps enrollment -- i.e. abrogates the entitlement to coverage -- for childless adults, a population not traditionally eligible for Medicaid, and also for parents with incomes above 55% of the federal poverty level (FPL).

In the worst-case scenario, the Utah waiver will reduce access for the currently insured while offering the appearance of access for the currently uninsured poor but not the substance. At best, some very low income people on Medicaid will pay more and lose some benefits while others will gain limited access to physician services and prescription drugs, albeit with substantial cost-sharing remaining.

Eligibility for Utah's Public Insurance Programs

The Utah waiver proposes no changes in eligibility standards for children, people with disabilities or seniors. Coverage for other adults is expanded to 150% FPL -- about $13,000 for an individual, and $22,500 for a family of three -- but only for a limited package of benefits. (Eligibility, benefits and cost sharing requirements for the new plan are summarized in Tables 1 and 2 below)

Financing

The expansion is financed by increasing cost sharing and reducing benefits for certain existing Medicaid beneficiaries, i.e. parents of SCHIP recipients. Cost sharing requirements include increases in co-payments for physician visits and prescription

drugs and a $100 per admission co-payment for hospitals. Reductions in benefits include mental health, transplants, vision and hearing services, home health and various therapies.

Most of the savings are assumed to come from cost sharing. There is no explicit discussion of the extent to which savings are attributable to recipients paying a portion of the bill and which are attributable to reductions in utilization because recipients are unable to pay the cost-sharing amounts. No new state funds are committed to the expansion.

The tables below summarize eligibility for Utah's current medical assistance programs and show how that will change under the new waiver. They also compare cost sharing requirements under the traditional Medicaid program and the PCN expansion. It is important to note that the level of cost-sharing permitted by the waiver could easily claim over 25% of the weekly income of the very poor enrollees who would be covered. For example, an individual at 75% of the FPL would have to pay more than this for any trip to the emergency room even without a hospital admission, and potentially much more if he or she required a brand-name pharmaceutical.[2]

Table 1: Eligibility for Utah Medical Assistance Programs

Population	**Current Income Standard**	**Proposed Changes**
Children	200% FPL (about $30,000 for a family of three)*	No change
Parents	55% FPL (a little over $8,000 per year)	New cost sharing and reduced benefits below 55% FPL; Primary care/ ambulatory care services only plus cost sharing 55-150% FPL
Elderly and Disabled	100% FPL	No Change
Adults w/o dependent children**	48% FPL	Eligibility expanded to 150% FPL for primary care/ ambulatory care services only (with cost sharing)

*Note that CHIP enrollment is currently capped
**This program is funded solely by the state and offers very limited benefits

Table 2: Comparison of Benefits and Cost Sharing Under Utah PCN Plan and "Non-Traditional" Medicaid*[3]

Benefit	PCN Cost Sharing	Comparison with cost sharing for currently eligible parents under waiver
Physician services	$5	$3
Urgent care	$5	$3
Ambulance	No co-pay	No co-pay
Emergency room	$30	$6 (if non emergent visit)
Lab and x-ray	5% above $50 for lab and above $100 for x-ray	No co-pay
Vision/Hearing screening	$30 cap on reimbursement No glasses	$30 cap on reimbursement No glasses
Prescription drugs	$5 for generic, 25% for brand, limit four Rx/ month	$2
Out-of-pocket maximum	$1000 per enrollee/year (applies only to covered services)	$500 per year
In-patient and out-patient hospital services	100% of cost (Not covered)	$220 per admission
Specialty care	100% of cost (Not covered)	$3
Mental health and substance abuse treatment	100% of cost (Not covered)	$3 (30 visit max)

* The PCN covers parents with incomes 55-150% FPL, and adults without dependent children with incomes 0-150% FPL.

Role of Private Insurance

At the same time it received permission from the federal government to offer the PCN program, Utah also adopted a law that would allow insurers to offer a limited benefit package identical to that available through the PCN program.[4] In justifying its support for this proposal, the executive branch has expressed the intention of eventually making the PCN program available through private insurers rather than through -- or in addition to -- a public program. It is unclear what the cost implications of such a move would be, or whether those implications have been taken into account in the financial calculations underpinning the waiver. It is possible, however, that some people will purchase the limited benefit instead of a more comprehensive package with the result being even more hospital bad debt.

Federal Requirements
In keeping with its posture of state flexibility, the federal government is requiring little with respect to monitoring the impact of the Utah waiver. Primarily it is asking the state to monitor the impact of enrollment fees on parents and their children. Apparently there is a concern that enrollment fees will prevent entire family units from applying even though children are exempt from the fee. The state is also being required to enroll people in full Medicaid, rather than the PCN, if they are eligible.[5]

Discussion

The Utah PCN waiver could have serious implications both in Utah and beyond. Although it is difficult to forecast the future, there are a number of likely outcomes of the Utah approach.

- **Children may lose coverage**

Parents may not understand that the enrollment fee and the limited benefit package applies only to them and not to their children. As a result, parents may choose not to enroll in the PCN and fail to enroll their children in Medicaid as well.

- **Interest in the PCN program may be less than anticipated.**

An estimated 25,000 people are expected to take advantage of the new coverage. It remains to be seen whether the combination of an enrollment fee, the lack of coverage for the most expensive services, and substantial out-of-pocket costs will function to suppress interest among those who are potentially eligible. It is worth noting here that the goal of 25,000 enrollees is actually quite modest since according to some estimates, the eligible population is at least twice that number.[6] Nevertheless, even if the access expansion covers fewer people than anticipated, the benefit reductions remain in place.

- **Adverse selection**

Those who do enroll are likely to be sicker than average. The enrollment fee and co-payments present a substantial disincentive to enrollment to those who don't have any immediate and costly health needs that would be covered by the PCN plan. People with significant and ongoing out-of-pocket drug costs are perhaps the likeliest to enroll. If PCN enrollees are sicker than anticipated, it will likely throw off the financial assumptions, resulting in fewer people being allowed to enroll, or deeper cuts in benefits for currently eligible beneficiaries.

- **Increased free care/ bad debt**

One underlying assumption of the waiver is that access to primary care and prescription drugs will reduce the free care and bad debt burden on hospitals, but there is much debate over whether that actually will occur. A spokesperson for the Utah Hospital and Health System Association has called the plan a "grand experiment" that they hope will reduce reliance on emergency rooms and the need for in-patient care. Other hospital officials are skeptical, predicting that the PCN

program will erect huge barriers to care and result in a major cost-shift to hospitals. [7] Reductions in free care are supposed to be the result of previously uninsured people gaining access to primary care and prescription drugs, but to the extent that cost-sharing requirements discourage newly insured people from seeking care or filling prescriptions, the benefits of offering these services may not be realized. In addition, increases in free care and bad debt could come from current Medicaid beneficiaries who are unable to afford their new substantial co-payments as well as from people who are diagnosed with conditions that require treatment and that would otherwise have gone undetected, at least in the short run.

- **Delays in seeking treatment appropriately**

As noted above, cost sharing may cause people to delay treatment. This may also reduce the efficacy of any treatment that is received. Therefore, the benefits anticipated from offering primary care coverage may not accrue.

- **Impact on total spending is unclear**

The Utah waiver is based on the premise that increased cost-sharing will save the Medicaid program money, and that these savings can be used to finance expanded eligibility. While it is generally well established that cost sharing reduces the demand for medical care in general and that poor people are particularly sensitive to cost increases, the overall impact on expenditures for the Medicaid program is not certain. Savings will accrue because a portion of the bill is shifted onto beneficiaries. As a result, however, some people will avoid care at the early stages. Thus delays in treatment and increases in ambulatory care sensitive hospitalizations could offset some of these savings. A pioneering study by the Rand Corporation on the effect of cost sharing on the Medicaid program in California found that savings from reductions in physician care were offset by increased hospitalizations.[8] In addition, as noted above, enrollment fees and high cost-sharing requirements may result in PCN enrollees being sicker than anticipated. Therefore there is a distinct possibility that Utah will save less than anticipated from the benefit reductions and cost sharing requirements imposed on those individuals who currently are eligible, while spending more than anticipated on a per-person basis in the PCN program (although these higher per member costs could be offset by lower than anticipated enrollment).

Policy and Politics

The Utah waiver raises a number of policy and political issues that advocates across the country need to consider. These issues include

- How to respond to the current federal approach to budget neutrality, which makes cutting benefits much easier than expanding coverage,
- How to respond to the argument that it is better to give more people a lesser level of coverage than to provide better benefits for fewer people, and
- How to protect access to care for current and new Medicaid beneficiaries who are facing substantial cost sharing requirements.

Should there be an effort to change the way CMS applies federal budget neutrality?

CMS's current interpretation of budget neutrality makes it very difficult for states to pursue expansions without reducing benefits for current recipients. If the state itself is unwilling to commit any new funds, it becomes even more difficult. Budget neutrality means that the federal government must be convinced it will not pay any more in federal matching payments to a state than it would in the absence of a waiver. However, the administration is not entirely consistent in the way it applies this principle.

For example, a state could expand coverage for parents with full Medicaid as a state option and then, as a second step, seek a waiver to trim benefits to these parents and use the savings to offer coverage to "non-categorically eligible individuals" e.g. childless adults. However, states are not allowed to capture those "savings" from a hypothetical expansion, in one step. If they were, states could expand coverage to those who are not categorically eligible for Medicaid (e.g. adults without dependent children) without cutting benefits for current enrollees.

Although this approach holds current beneficiaries harmless, a potential drawback is that it invites "Medicaid lite" packages and creates divisions among different groups of very similar beneficiaries. Therefore, proponents of expanding coverage and defenders of the Medicaid program may not consider such packages to be beneficial in the long run, as discussed below. Furthermore, any approach that holds existing enrollees harmless requires states to put real money on the table to finance the expansion.

Unable to access savings from a "hypothetical expansion," states must look elsewhere for room under their federal budget cap to expand coverage for non-categorical adults. Two places to look are unspent SCHIP funds and Disproportionate Share Hospital (DSH) funds. Unfortunately, each of these potential sources has its drawbacks.

Over the next several years, the level of federal SCHIP funding will decrease, an artifact of the original funding formula. The so-called "SCHIP dip" will make it harder for many states to use SCHIP funds to finance expansions, although there is a threshold question of whether it is even appropriate to use SCHIP funds for adult coverage if substantial numbers of potentially eligible children remain uninsured.

The problem with using DSH funds comes first from the extreme difficulty of determining how DSH funds are currently spent. States and hospitals tend not to make the DSH funding formula transparent, so it is often hard for advocates to determine how their state's DSH funds are allocated and whether they actually are being used to promote care for the uninsured. Second, to the extent that hospitals are already receiving DSH funding, they tend to be vociferous opponents of efforts to reprogram those dollars.

How should advocates respond to the notion of covering more people by reducing benefits for others?

In Utah consumer advocates were reluctant to come out in strong opposition to the proposed changes in policy. In contrast, many advocates at the national level have been extremely critical. For example, Ron Pollack of Families USA has said, "The Utah waiver approved by the Bush Administration will do considerably more harm than good for low-income families." Leighton Ku of the Center on Budget and Policy Priorities likens the Utah waiver to "thinning the soup."[9] In contrast, Judi Hillman of Utah Issues has expressed cautious optimism about the waiver, at least in public.[10]

This reluctance at the local level may stem from many factors. To some extent, it may result from an assessment that opposition is futile and more likely to harm ongoing working relationships than to produce any concrete benefits. The particular circumstances of Utah—its conservatism and what one advocate describes as a "culture of politeness"--may have contributed to the stance taken by advocates. Another factor may be the "divide and conquer" nature of the Utah waiver. Local advocates are perhaps not able to easily navigate between the needs of the uninsured and the Medicaid population.

In addition, with state budget cuts on the table, advancing alternatives for real expansions that require an increased commitment of state funds becomes much more difficult. Utah advocates were forced to defend against service rollbacks and cost-sharing increases even greater than those proposed in the waiver. These proposed cuts claimed the attention of both advocates and the media, reducing the level of public scrutiny devoted to the waiver while making proposals for more comprehensive expansion seem less credible.

There were alternatives, however, at least in theory. Utah has unspent SCHIP money and could have raised the tobacco tax by more than the eighteen cents approved in the most recent budget to finance the state share of an expansion. Also, Utah's health costs on a per-member-per-month basis are quite high. This suggests that savings may be possible through better management without cutting benefits.

The circumstances that made opposition to the Utah waiver difficult are not unique to Utah. There are many other conservative states and many other states where budget deficits and proposed cuts are placing advocates on the defensive. Advocates need to consider in advance how they will respond to proposals to expand coverage by reducing benefits. Unless Medicaid advocates can both offer compelling alternatives and mobilize a base of support that extends beyond beneficiaries, more "Utahs" are probable.

Another question for advocates to consider is how to respond to "Medicaid lite" packages if they can be done without taking benefits away from those who already have them. Utah not only financed it's expansion by taking benefits away from those who had them, it also offered a Medicaid eligible population a much more restrictive benefit package than any that had been approved previously. Advocates need to

consider whether and for whom they would accept a scaled-down benefit package. The strategic concern is that such packages may exert downward pressure on benefits for other Medicaid populations, and perhaps in the private insurance market as well.

How can advocates preserve access in the face of new cost sharing requirements? In the face of the Utah waiver and the probability of others like it, advocates need to consider new strategies for preserving access. Two that may be worth considering -- and that also are logically linked -- are educating Medicaid recipients about their right to receive treatment even if they don't pay their co-payments, and encouraging providers to waive cost-sharing requirements.

Under Medicaid law, services cannot be denied for failure to make a co-payment. However, beneficiaries generally do not know this and so they may be reluctant to seek care appropriately. Educating clients about their right to treatment, whether or not they can pay, is one approach to countering the negative effect co-payments have on access to care.

A related, and stronger approach is to encourage providers to waive cost sharing. In Utah, for example, care providers could be encouraged to define Medicaid and PCN enrollees as eligible for free hospital care. Some providers may claim that such an action runs afoul of federal "anti-kickback" rules, but that is not the case. A legal memo on this subject is available from Community Catalyst.

Conclusion

In relying on benefit cuts and cost sharing increases to finance a Medicaid expansion, the Utah PCN waiver breaks new ground in the Medicaid program. However, the financial underpinnings of the waiver are highly speculative as cost savings may be lower and spending may be higher than anticipated. Similarly, the Utah approach may do more to harm access to care for current Medicaid enrollees than it does to improve access for the currently uninsured.

The Utah PCN waiver challenges defenders of the Medicaid program and advocates of expanded coverage to think through their own approaches to a variety of issues. They should, for example, be prepared to respond to proposals that expand coverage for some while cutting benefits for others. Other important questions raised by the Utah waiver include how should advocates respond to the current federal approach to budget neutrality, how to preserve access for low-income people in the face of increased cost-sharing requirements, and how to advance proposals that provide meaningful coverage expansions in the face of the current budgetary and political realities.

The ability of advocates to respond creatively and successfully to the issues raised by the Utah PCN network may have a significant impact on the Medicaid program nationwide.

Resources

For additional information on HIFAwaivers and Medicaid see the following websites

- Community Catalyst Website www.communitycat.org
- The National Health Law Program www.healthlaw.org
- Kaiser Commission on Medicaid and the Uninsured www.kff.org
- Families USA www.familiesusa.org

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1 Copies of the Utah proposal and HHS approval letter are available on the National Health Law Program website, www.healthlaw.org

2 25% of the weekly income of an individual at 75% FPL is about $32. A trip to the emergency room is $30 not including physician fees, lab fees or the cost of prescription drugs.

3 A complete list of benefit limitations and cost sharing is included in the Utah PCN Operational Protocol

4 1A-22-633 Utah Code Annotated as amended

5 HHS approval letter, op cit

6 Taylor, When More Means Less, Modern Healthcare, 2/18/02

7 ibid

8 Newhouse et al, "Copayments and the Demand for Medical Care: the California Medicaid Experience,7Bell Journal of Economics, (Spring 1978)

9 BNA Health Policy Report 2/18/02

10 Deseret News 2/10/02