UTAH HEALTH POLICY PROJECT

HEALTH MATTERS

Health Matters E-Newsletter

July 29, 2011

In this issue…

MEDICAID REFORM: *WHAT HAPPENED TO THE PUBLIC INPUT??*

We have, together with advocates and stakeholders, combed over the Medicaid 1115 waiver proposal submitted to the Centers for Medicare and Medicaid (CMS) by the Department of Health on July 1, and we have *serious concerns about it.* We organized a call with CMS, and they are very interested in our input. During the conference call we highlighted our most serious concerns, including increased cost sharing, priority list/rationing of benefits, ACO (Accountable Care Organization) quality standards, client incentives, and forced disenrollment from an ACO. CMS is eager to hear our/your concerns and is committed to working with advocates and other stakeholders as waiver negotiations get underway between the state and CMS —we have another call scheduled with CMS in August, after they've had some time to analyze the waiver proposal. To read more about our concerns click here. *See more documents related to the state's waiver application, including a Synthesis of Stakeholders' Input which UHPP created for the Medical Care Advisory Committee (advisory body to Medicaid) here.*

MAKING THE MOST OF THE JULY INTERIM SESSION

EXECUTIVE APPROPRIATIONS (LEADERSHIP)

The Executive Appropriations Committee meeting featured a report on proceeds from the Tobacco Tax Revision (HB196s01 sponsored by Rep. Ray in the 2010 session). What we learned should be of keen interest to advocates and beneficiaries of Medicaid in Utah: The tax increase that went into effect July 1, 2010 has resulted $15 million more revenue than anticipated!

UHPP comment: This is good news for programs funded by the General Fund and we strongly urge using this windfall to fund critical Medicaid programs, specifically vision care and adult dental. As Utah works to reform how Medicaid is delivered and paid for, we urge decision makers to marry the goals of improved health outcomes with cost containment. Sadly, the waiver process has emphasized the latter at the expense of the former. Restoration of critical Medicaid services like vision and dental care will help contain costs over the long term by creating healthier Medicaid recipients. Without these services, the state will fall short on several key goals of Medicaid reform, including medical homes, reliable access to primary care, and emergency room avoidance. To read more about the need for these programs click here.

HEALTH + HUMAN SERVICES (HHS) INTERIM

No items related to health reform or Medicaid policy on HHS agenda for the July 20th meeting.

BUSINESS + LABOR INTERIM

No health care related items on B+L agenda for the July 20th meeting.

HEALTH SYSTEM REFORM TASK FORCE

Utah's Health System Reform Task Force met on July 20th to consider two topics: 1) how Utah's reform does or doesn't fit with the coming federal reforms (ACA), and 2) employee wellness programs as a cost containment tool.

Utah and Federal Health Reform. Cathy Dupont, Associate General Counsel, reviewed the basic features of Utah Health Reform, pointed out where it is compatible with federal statute and regulations, and suggested key policy issues and choices the Task Force might want to consider.

Dupont recalled the guiding principles of Utah's health reform:
1) Individuals and families should own their own health insurance, which should be portable (not tied to employer);
2) Utahns should be able to choose the plan that best suits their situation;
3) Families should be able to aggregate premium contributions from multiple sources to pay for one policy;
4) Insurers should compete on risk--not avoid it; and
5) The government should act as a facilitator.

One of the main features of Utah's health reform is, of course, the Utah Health Exchange. Utah's Exchange is essentially a "SHOP" (Small Business Health Option Program)—one of two types of Exchanges included in the ACA, the other is for the individual market—and could be ACA compliant with a few tweaks, according to Dupont. Utah's Exchange would only need to include businesses with up to 100 employees (currently the limit is 50 employees); put plans into the federal tier system (bronze, silver, etc) for apples-to-apples comparison; and "beef up" Utah's rate review process. "Utah is in a very good position to meet the 2013 deadline for SHOP… but there are significant policy decisions for the Task Force to consider," stated Dupont.

Dupont then presented **5 implementation policy choices** for consideration by the Task Force. We found her comments helpful in terms of summarizing the differences between federal and state health reform, giving us a sort of to-do list for the state.

- **Statewide risk adjuster:** Utah has a risk adjuster for the Utah Health Exchange, but not for the small group market outside of the Exchange. To ameliorate the *adverse selection* (when a market becomes a magnet for the sickest and highest cost individuals) that typically occurs when all people are *guaranteed issue* of health insurance (cannot be turned away because they are or have been sick), the ACA requires *statewide* risk adjustment, If Utah does not want to do this, the federal government will.
- **Eligibility and calculation of federal premium subsidies/tax credits:** The American Health Benefit Exchange (for individuals seeking insurance) must include eligibility determination for the subsidies that will be available in the individual market (people who don't have employer sponsored insurance and buy an individual policy). Since this is a federal program, Utah may want to consider letting the feds run this.
- **Individual mandate:** Utah has a statute that prohibits a mandate to buy insurance. Utah will have to decide if they will take on the enforcement of a mandate, and if so, the state would need to change the statute. Alternatively, Utah can let the federal government enforce this.
  UHPP comment: The Feds might as well oversee this, as it will be enforced through the IRS' income tax filing process.
- **Essential benefit package:** Utah should voice an opinion about what should be in the essential benefit package, as this will determine costs of products offered.
- **Medicaid:** States are expected to have a "no wrong door" approach to Medicaid enrollment beginning in 2014. In addition, Medicaid will be expanded to cover everyone with incomes up to 133% of the Federal Poverty Threshold—with the feds picking up the tab for the newly eligible. Utah needs to consider whether it wants to include eligibility in the Exchange, or if this duplicates services.

UHPP comment: Missing from Dupont's list is whether Utah will operate an American Health Benefit Exchange in the first place—that's the one for the individual market—or let the feds do it. And while, yes, Utah's Exchange, with some changes, might be deemed a credible SHOP by Health and Human Services, Utah policymakers have yet to address **affordability:** how will Utahns, especially those in lower wage jobs in small businesses or the self-employed, pay for rising premiums without resorting to high deductible policies that carry too high out-of-pocket costs? When the Task Force talks about "cost containment" we ask "for whom?" We also ask: how does the Utah Health Exchange measure up to the state's own principles for reform? The Exchange does allow employees to choose the plan that works best for them from a dizzying array of options (over 140 plans!), but Utahns getting insurance through the Exchange are not owners of their own insurance nor is it portable—it's still employer sponsored insurance. The Exchange is designed to allow aggregation of premiums from multiple sources, but it's still too small (157 small businesses so far) to make this an effective tool to assist Utah consumers, or no real effort has yet been made to use the premium aggregator to motivate more small business to offer coverage in the first place.

Wellness Programs as a Cost Containment Strategy. The Task Force heard testimony about some of the wellness programs offered in Utah, namely PEHP's "Healthy Utah" and "Waist Aweigh," and from the following insurers: Educators Mutual, SelectHealth, Regence (BC/BS), and Humana. There are two types of wellness incentive programs: participative and results based. Participation programs reward people for participating in wellness events and programs regardless of health outcomes. Results-based programs reward people for meeting health targets like weight loss, smoking cessation, and controlling diabetes. All of the testimony offered to the Task Force about wellness incentive programs was positive, suggesting that such programs can decrease costs to insurance companies because employees submit fewer medical claims. They

also can decrease costs to employers in terms of increased productivity due to of fewer illnesses and absences attributable to illness. And, they can help employees save money on insurance premiums. However, it is not clear if they improve employee health, in part because healthy employees are more likely to enroll in a wellness program than not healthy ones! In fact, the incidence of obesity and poor diabetes management is increasing despite wellness incentive programs, according to SelectHealth.

UHPP comment: Wellness incentive programs are an important piece of controlling rising health care costs *if they are not coercive.* If a wellness incentive program penalizes the unhealthy with premium surcharges or limited policy choices (like automatic enrollment in high deductible plans) they will do more harm than good, as the least healthy pay more and more, and either drop coverage all together or delay or forgo needed care. See the recent Salt Lake Tribune article for a fair treatment of the issue.

2nd SPECIAL SESSION

HB2003 Health Insurance Amendments (formerly known as SB294 2nd substitute, Patient Access Reform), sponsored by Rep. Jim Dunnigan, was heard on the House floor on July 20th in the 2001 2nd special session—and passed 46 to 23. This is the "last minute" bill re-purposed by Rep. Dunnigan on the last day of the 2011 legislative session, later vetoed by the Governor, reworked and renamed for the special session.

The bill still contains a provision that allows insurance companies to increase the standard slope ratio range for age band rating and for family tiers to 6:1 (the standard is 4:1, and ACA guidelines, coming online in 2014, restrict the ratio to 3:1) in an effort to bring in the "young immortals" by allowing carriers to lower rates for the young immortals—but at greater cost to the older and sicker insureds.

New to the current bill is that insurers *outside of the Utah Health Exchange* can offer 4, 5, or 6 family tiers (the standard in the Exchange is 4; new tiers proposed include one-employee-one-child tier and an employee-spouse-and-one-child tier). This will lower costs for small families but raise them for larger families and, more worrisome perhaps, create two insurance markets in Utah—one in and one out of the Exchange.

Rep. Dave Clark testified against the bill, noting that it undoes carefully crafted legislation from the 2010 session and that, having two markets has proven to create more problems than it solves in the past. Rep. Dunnigan countered that it is not a mandate, and most insurers who play in the Exchange will use the same tiers and rate band for their products both in and out of the Exchange because it is too expensive for them to do differently.

UHPP Analysis

This raises the question of *why change it at all*? Will it indeed "let the market be the market" as Rep. Dunnigan argues, possibly producing an innovative new way to do things that the others can then copy? Or is it just tinkering with Utah's insurance code to no lasting effect? Does it serve Utah consumers to move these tiers and rate band ratios back and forth every year in legislation?

ON THE FEDERAL FRONT

TAKE ACTION!!! MEDICAID MATTERS!

Despite overwhelming public support, Medicaid faces continued threats from policymakers who are willing to make a budget deal that sacrifices heath care for those who need it most, while billionaires get tax breaks and rich CEOs enjoy tax loopholes. We need a plan for deficit reduction that reflects our values, that protects our most vulnerable neighbors, and that doesn't shift more burdens onto middle class families and states.

This issue is just too critical and a quick phone call from constituents (including you!) will have a big impact. Just follow these directions:

1. **Dial 888-876-6242** to make a toll-free call to Capitol Hill.

2. Urge your senators and house members to protect Medicaid within the negotiations to address our nation's debt limit.

You can also add:

- Extreme cuts to Medicaid could result in nursing home funding cuts, which would force many seniors out of their nursing homes.

- Irresponsible cuts to Medicaid would also undermine access to health care for many of our littlest Americans. America's children need access to their doctor. Cutting care for kids puts America's future at risk.

- It's important to bring down the deficit, but the approach must be balanced with both spending cuts and revenue increases and must be done without gutting critical lifelines like Medicaid.
- Here is a side by side comparison of the two plans currently being debated.

MENTAL HEALTH AND THE ACA ***NEW UHPP POLICY BRIEF!***

Mental health is as important as physical health both for quality of life and lifespan. Too often, and for too long, mental health has been left out of the health care coverage equation. Treatment has been out of reach for many people facing mental illness or addiction simply because they are uninsured. For people who *do* have coverage, access to mental health care can be limited to non- existent—and costly— due to pre-existing exclusions or deductible and cost sharing obligations.

People who need mental health resources have a lot to gain from the Affordable Care Act (ACA) health coverage expansions and insurance reforms. For example, the ACA will do away with discriminatory practices of the insurance industry like denying coverage for pre-existing conditions. For information on these and other impacts, click **here.**

ON THE STATE FRONT

REELING IN HEALTH CARE COSTS—WHAT'S IN THE ACA? ***NEW UHPP POLICY BRIEF!***

Just about everyone can agree that health care costs are out of control. The good news is that federal health reform (the Affordable Care Act or ACA) has lots of cost containment it! Really, it does. The US spends more on health care than any other industrialized country, and expenditures keep growing, even though many Americans don't reap the benefits. Over 16% of Americans (14% of Utahns) do not have any kind of health insurance. And, the number of people who have private health insurance is dropping. For those that do have insurance, premiums are projected to hit 24% of median family income by 2020! See our new brief—"We'll Show You Cost Containment!"—about just what the ACA includes to reel in the rising costs of health care in the US.

THE LONG AWAITED EXCHANGE REGULATIONS RELEASED JULY 11

Health + Human Services released the Exchange regulations Monday, July 11. The regulations balance federal requirements with flexibility for states to design health insurance exchanges for the individual and small group markets that fit with their states' characteristics. The regulations are long (topping out at 171 pages of explanation and comment on the regs), and UHPP is still digesting them. What we do know, is that HHS is

seeking public comment on a whole slew of provision and processes. You can get the regulations on UHPP's webpage here, and our handy chart showing where HHS is looking for input here.

UHPP WEB PAGE UPDATES

UHPP's Implementation Station is designed to help you make sense of federal health reform (also known as the Affordable Care Act or ACA) and Utah's progress with implementation. Visit any of the links on this page to understand how health reform will impact Utahns and all Americans—and your family.

New additions to the Implementation Station include information on health equity in reform and on mental health in reform. Check back often, it is updated every month! (☺)

HHS' Exchange Regulations are finally here. The 75 public comment period ends in early September. See our guide to what HHS is looking for input on here.

Mental Health and the ACA ***NEW UHPP POLICY BRIEF!***

We'll Show You Cost Containment! ***NEW UHPP POLICY BRIEF!***

ANNOUNCEMENTS:

Utah Medicaid Partnership (UMP)
Wednesday, August 24, 10:00-11:20
This meeting will focus on UMP's state priorities for the 2012 Utah Legislative Session. Bring your funding and policy priorities!

U-SHARE
Wednesday, August 24, 11:30-1:30
This will be a strategy and planning meeting. Come ready to hammer out our strategic plan. Bring your lunch! Give us your input

Monthly Meeting
Wednesday, August 3,
Join us for a meet and greet with the Department of Insurance and DWS. The meeting will take place at DWS 1. Insurance portion starts at 2:40 pm.
You can access the agenda here.

Upcoming Health Disparities Conference.
Theme: "Utilizing Local Media to Promote the National Partnership for Action and to Raise Awareness of Health Disparities Affecting Utah Communities"
Date: August 16, 2011, 8:00 am -2:00 pm Location: Salt Lake City, Utah

Target Population: Public health professionals, media professionals, health care providers, academia, community leaders, community-based organizations, faith-based organizations, and community workers.

-Organized by: The Utah Department of Health, Office of Health disparities Reduction.

See flyer for more information and registration