



## Leveraging Medicaid to Make Coverage Affordable for Low-Income Utahns

### BACKGROUND

Business and community leaders have reached consensus to guarantee health insurance for all Utahns—and not a moment too soon. Between 2000-04 Utah premiums paid by workers increased 5 times faster than wages.

	Change in Average Premium Paid by Workers	Change in Average Wages
<b>Utah</b>	66.3%	13.2%
<b>U.S.</b>	35.9%	12.4%

*Source: The Lewin Group for Families USA, 2004*

Last September the United Way Financial Stability Council introduced an ambitious proposal designed to address the 3 pillars of health reform: cost, quality, and access.<sup>1</sup> The plan is structured around the concept of an Exchange. Like a matchmaker, the Exchange links eligible Utah residents with approved insurance plans and helps them pay for the plans using pre-tax dollars, employer premiums and premium subsidies. Each insurer licensed in Utah would be required to offer a minimum or “essential benefit package” structured as a continuum of services that cost more out of pocket as treatments become more elective.

This is a good starting point for the broader reforms, however low-income people (<150% of the poverty level) are not in a position to make real choices based on cost. If a service is not covered, they will simply go without.<sup>2</sup> This is why states with robust reforms already underway have a strong base of public coverage (Medicaid and CHIP) upon which to build coverage expansions. Parents in Massachusetts, for example, can access Medicaid up to 200% of the poverty level (FPL), and premium subsidies to support access through the *Connector* (Massachusetts’ version of the Exchange) are available for households with income up to 300% FPL. **Utah is not Massachusetts; but we are in a unique position to make coverage truly affordable.** Utah is one of a few states with generous 3-to-1 Federal Medicaid match. By investing one dollar Utah receives three dollars back to support coverage solutions that make sense for individuals at all points along the income scale.

The best way to guarantee access and manage costs—including Medicaid costs—over the long term is to shift toward community rating (where risk is shared across the entire pool of covered lives). The United Way proposal includes this critical provision along with a controversial requirement to purchase insurance. The latter is needed to bring the young and healthy into the risk pool, another prerequisite for reducing costs. As noted by Massachusetts-based policy analysts, **a generous definition of affordability will help maintain political legitimacy of this requirement by helping people respond voluntarily to incentives to purchase insurance.**<sup>3</sup> Medicaid can help in two ways:

- 1) make coverage accessible to those without affordable options on the Exchange, like low-income parents;
- 2) leverage Federal matching funds to subsidize coverage *inside* the Exchange.

### HOW TO ADDRESS AFFORDABILITY IN UTAH

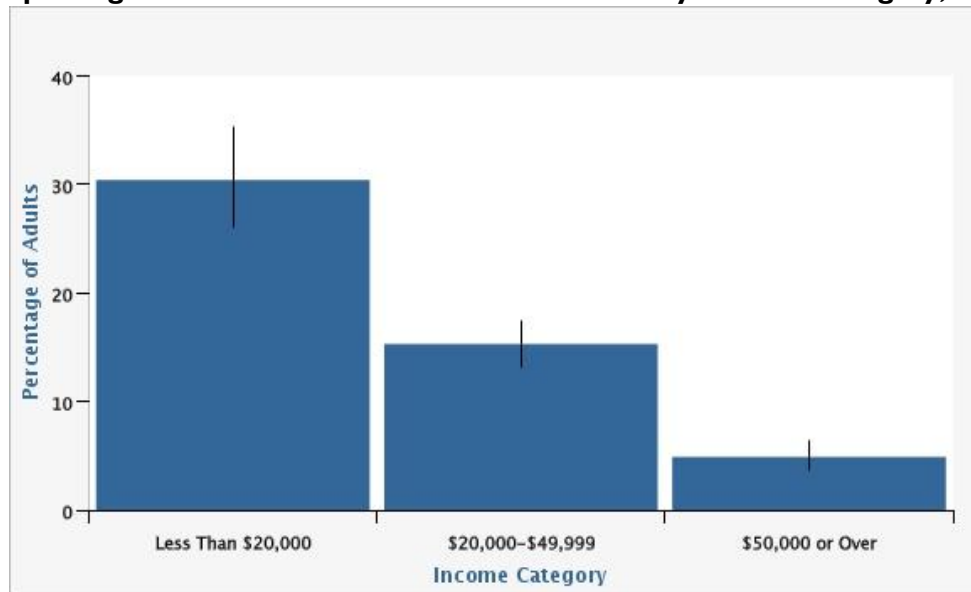
There is no getting around it: making decent coverage affordable in a state like Utah with very low spending on Medicaid will cost money.<sup>4</sup> Utah has two options to address affordability. First, Utah should take advantage of its generous 3-to-1 federal Medicaid match rate and bring low-income parents’ eligibility for Medicaid up to 150% FPL. This is not only a cost-effective way to cover low-income working parents, but can be done without a federal waiver. Second, Utah can take advantage of the new flexibility offered by the Bush Administration to re-direct or leverage Medicaid funds currently used for uncompensated care to subsidize coverage in the private market for

childless adults and parents over 150% of the poverty level.

### ⊙ Leverage Medicaid Matching Funds to Cover Low-Income Parents

Utah is fortunate to have a very generous Federal-State Medicaid match rate of nearly 3 to 1. For every dollar Utah spends on Medicaid, the Federal government provides \$3. Therefore, Utah can decrease the amount of state dollars needed to cover low income parents by expanding Medicaid to this population. This expansion is simple to achieve. Under Federal Medicaid regulations (section 1931 of the Social Security Act) states can expand Medicaid to “categorically eligible” groups like parents, children, and pregnant women. A specific benefits package can be designed for this population, knowing that cost is a significant barrier to seeking health care in the right time and place and that deferred care is more expensive.

**Adults Reporting Cost as a Barrier to Care in Past Year by Income Category, Utah, 2006**



Source: Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health

### ⊙ Take Advantage of President Bush’s Affordable Choices Waiver to Cover Childless Adults and Subsidize Premiums

Childless adults are a difficult population to cover with Federal funds, and any federal Medicaid waiver must be budget neutral. Massachusetts had a significant (\$1.6 billion) free care fund it used to draw down matching funds to subsidize premiums for individuals of modest means. Other reforming states have ample Disproportionate Share Hospital funds (DSH, which are federal funds devoted to hospital emergency care for the uninsured), which can be converted to cost-effective coverage. Unfortunately, Utah has very little of either. President Bush recently announced a new *Affordable Choices* Waiver initiative that would allow Utah to corral a portion of our limited DSH money (\$16 million) and direct those funds to create premium subsidies for childless adults. Utah could use this waiver to help finance premium subsidies for childless adults. Since our DSH allotment is so meager, Utah will also need to negotiate additional flexibility from CMS to impose an assessment on providers to draw down additional Federal matching funds. To augment these efforts, Utah can:

- 1) Convert resources devoted to its Primary Care Network (PCN ) program to the new Medicaid waiver;
- 2) Negotiate new options for meeting waiver budget neutrality requirements based on a projection of savings derived from the alignment of financing and treatment decisions with clinical science.

<sup>1</sup> United Way Financial Stability Council (2007). Health Care Proposal.

[http://uwfinancialstability.org/index.php?option=com\\_content&task=view&id=18&Itemid=30](http://uwfinancialstability.org/index.php?option=com_content&task=view&id=18&Itemid=30)

<sup>2</sup> Leighton Ku, Elaine Deschamps, and Judi Hilman (2004). The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah’s Medicaid Program. Center on Budget and Policy Priorities. [www.cbpp.org/11-2-04health.pdf](http://www.cbpp.org/11-2-04health.pdf)

<sup>3</sup> Christine Barber and Michael Miller (2007). *Affordable Health Care for All: What does Affordable Really Mean?* Community Catalyst. <http://www.communitycatalyst.org/issues?id=0001>

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<sup>4</sup> Ibid (2007). *A Consumer Guide to Creating a Health Insurance Connector*. Community Catalyst.