

The Salt Lake Tribune

Delay in Utah Medicaid expansion decision draws fire

Health reform • Gov says the study of how to expand the program needs more work.

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THE SALT LAKE TRIBUNE

PUBLISHED: MARCH 19, 2013 08:13AM

UPDATED: MARCH 19, 2013 08:14AM

Utah Gov. Gary Herbert has said he won't pass judgment on Obamacare's Medicaid expansion without results from a state-commissioned study.

But Public Consulting Group (PCG) produced a first draft of the study six weeks ago, according to documents obtained by The Salt Lake Tribune. And a "final draft," updated to reflect changes recommended by the governor's budget and health advisers, has been under review since Feb. 19.

State health officials say key data elements remain missing. Utah Department of Health spokesman Tom Hudachko said the final report — from a draft that, at last count, measured 100 pages — will be ready for prime time "as soon as it's done," but he couldn't say when that might be.

Meanwhile, Democrats are losing patience and the policy landscape is shifting as states win federal approval to pursue alternatives, including a partial-expansion scenario under serious consideration in Utah.

"None of this has anything to do with studying the Medicaid expansion. That's just a ruse. It's just Governor Herbert dithering with another hard decision," said Sen. Jim Dabakis, D-Salt Lake City, referring to the quicker decisions of Republican governors in Arizona, New Jersey and elsewhere.

Others, such as Sen. Luz Robles, take Herbert at his word, believing the drafts had shortcomings and wanting the decision to be well-informed. But the Salt Lake City Democrat wonders, "How many changes can they make to this study? The numbers are what they are."

Few decisions are as politicized or divisive as the one facing states over Medicaid and whether to stretch the health safety net to cover millions of poor and uninsured.

There is no evidence in the hundreds of pages of memos and emails obtained by The Tribune of anyone attempting to influence or bias the study. Indeed, a Feb. 15 suggestion by Norm Thurston, the governor's health adviser, to send a draft to the conservative think tank Heritage Foundation for "expert review" was rejected by health officials.

"I don't think we should send one to someone with Heritage if we aren't sending it to other groups," responded Nate Checketts, who oversees Utah's Medicaid program.

But large portions of requested documents were blacked out, including emails deemed private because they reveal the governor's "contemplated policy or course of action." Health officials also refused to disclose "planning documents for release of the PCG analysis."

There is no hard deadline for deciding, but to be ready to offer benefits in 2014, Utah would have to decide by this fall or forgo hundreds of millions in federal funding.

"We need to take that money," said Dabakis, adding "this is tax money that Utahns have already paid or will have paid into."

One benefit of waiting, however, is it allows other options to ripen, argues Rep. Jim Dunnigan, R-Taylorville, House chairman of the Legislative Health Reform Task Force. "You think we have more options now? Just wait. Every day, there's new information coming [from the Obama administration]. That's the wonderful thing about states, let them be the innovators."

One idea floated by Herbert, according to talking points prepared for a February meeting with federal Health and Human Services officials, is the Arkansas model of using federal Medicaid dollars to buy private coverage.

Arkansas wants to do this for everyone below 138 percent of the federal poverty line, or \$15,000 for an individual. Utah is exploring the option for adults up to 100 percent of poverty.

So-called "premium assistance" programs are already operating in states now, including Utah, though on a small level.

They're politically palatable because they allow states to expand coverage without expanding Medicaid. And federal officials have signaled that if Arkansas takes this path, the state will still get its full share of federal funding.

There are caveats, though, said Judi Hilman, executive director of the Utah Health Policy Project. The insurance would have to have the same copayments and benefits as Medicaid. If not, states would have to tack on a wraparound policy.

And it's likely to be more expensive. The U.S. Government Accountability Office estimates private coverage costs about \$3,000 more per individual than public plans.

"We need to look at these alternatives," Hilman said, "and cost them out and ask: Do they really make sense?"

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