



OPT OUT PROVISIONS IN FEDERAL HEALTH REFORM

New law affirms Utah's need to innovate & build on state reforms

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EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (PPACA, the final package of federal health reforms) is now the law of the land, though its implementation will be anything but straightforward. From an implementation standpoint, the final bill provides states with plenty of choices to make over the next few years to fine tune the reforms to better suit local needs.

Utah's political leaders have already honed in on the opt-out provisions within PPACAⁱ, but they may not find what they're looking for. In general, the opt-out provisions hold states to the same robust standards for affordability and scope of benefits as the federal reforms. The reality is that while PPACA gives states tremendous flexibility to administer specific provisions, states have little discretion in rejecting the reform altogether. For most elements of reform, if a state chooses not to administer a given provision, the federal government will step in and do it for them and their citizens. For example, PPACA allows states to set up and administer the new health insurance exchanges – the market places where health insurance will be sold to small businesses and uninsured individuals – however, if a state declines to participate, the federal government will take control and operate the exchange within the state. So at the end of the day, whether Utah decides to participate or not, there will be an exchange to shop for and compare affordable, quality health plans within the state.

Nonetheless, in recognition of the innovative role they have played in reforming their own health care systems, states with significant reforms underway can seek special permission through what is called a super-waiver to implement reforms designed to cover the uninsured – but not until 2017. Between now and then, states will see that they have enough latitude within the current federal framework to innovate and build on their own strengths and values. For key provisions of reform, for example the new Exchanges, states can operate the program with federal oversight. And of course, nothing is stopping states from adding on to the scope or reach of reforms, particularly in relatively untested areas like cost containment, where Utah can shine.

The notable exception to this 'federalism within limits' rule involves Medicaid. PPACA requires states to extend Medicaid coverage to all adults earning less than 133% of poverty. Rather than agreeing to this expansion, some of Utah's leaders have expressed interest in pulling out of Medicaid altogether, no matter what the consequences. And the consequences are severe. Unlike with other elements of reform, PPACA does not allow the federal government to step in and operate Medicaid for the states. As illustrated below, choosing to eliminate Medicaid would result in the complete unraveling of the health care safety net; for starters, it would immediately double the number of uninsured Utahns; to many persons with disability or children with special health care needs who depend on Medicaid for their survival, it would bring certain death or irreversible harm. With Medicaid supporting over 53,000 jobs, the impact of turning away \$1.5 billion in federal Medicaid dollars on the economy would be profound. This brief examines the different opt-out provisions and presents recommendations on the best course of action for Utah. We begin with the opt-out provisions within PPACA.

OPT-OUT PROVISIONS WITHIN PPACA

Section 1321(e) permits states with exchanges operating before January 1, 2010 (only Massachusetts and Utah), to continue operating their exchanges if the state succeeds in insuring “a percentage of its population projected to be covered nationally.” PPACA is estimated to cover 94% of the U.S. population. If Utah can reach this threshold, the federal government will “presume that [the] Exchange meets the standards under PPACA.” This provision was written with Massachusetts in mind, where reforms have extended decent, affordable health care coverage to 94.6% of the population. Utah could possibly qualify for this, the “Massachusetts Waiver,” but only after making significant changes in the goals and timetable of state reform.

Utah is entering the third year of state health reform. So far the state’s reform measures have not resulted in *any* noticeable decrease in the state’s uninsured; however, this is not too surprising given state leaders’ resolute determination to capture savings and efficiencies as a first step in reform and then re-invest those savings in cost-effective health care coverage. Research, however, has proven that the way to bend the cost curve is through coverage, not around itⁱⁱ – but so far to no avail. Maybe now, with the 94% Massachusetts Waiver challenge on the table, state leaders will reconsider the need for a mandate and robust affordability and benefit standards.

The federal government will in all likelihood require that a qualifying state’s exchange meet the standards laid out for other exchanges, however, this requirement is left up to the discretion of the Secretary of Health and Human Services. Based on conditions articulated for other opt out provisions (see section 1331 below), however, we believe that Utah’s Exchange would need to meet the regular exchange standards around cost sharing and benefit packages. As we have argued in earlier publications, these are the minimum standards needed to achieve the goals of federal – and state – reform.ⁱⁱⁱ

From now until 2014 when the new Exchanges come on line, there would be little harm in shooting for the 94% benchmark. Even if the newly insured Utahns ended up with high-deductible ‘swiss cheese’ coverage, Utah’s All Payer Database could help to pinpoint and quantify the drawbacks and cost shifts that result from swiss cheese coverage that people can’t afford to use. Section 1321(e) has no impact on PPACA’s requirement that states expand eligibility for Medicaid to 133%. The only way to opt out of this is by opting out of all of Medicaid (*see below*).

Section 1321(c) gives states the option to administer and operate the exchanges themselves or allow the federal government to do so. If a state elects not to participate, the federal government will contract with a nonprofit organization to set up and administer the exchange. This section of the law was clearly drafted to comply with the requirements set forth in *New York v. U.S.*, 505 U.S. 144 (1992) – the Supreme Court authority against the federal government commandeering the states to enforce federal laws.

Sec. 1331, as modified by Sec. 10104, requires the Secretary to establish a basic health program under which a state may enter into contracts to offer one or more standard health plans providing at least the essential health benefits to eligible individuals in lieu of offering such individuals coverage through an Exchange. This provision further specifies the requirements for such a plan and how funds that would have gone to the Exchange for such individuals would be transferred to the state.

We cannot imagine Utah wanting to do this, since this provision would be tantamount to, in so many words, ‘growing government’ and taking the state even further away from the Exchange, the one concept that Utah has in common with federal health reform. Even if state leaders wanted to explore this option, the state would have to meet the same robust standards for cost sharing and benefits as the regular reforms – a nonstarter for Utah. PPACA section 1332 contains a more extensive opt out or ‘super waiver’ available in 2017, though this brings certain risks and unknowns for states.

Sec. 1332 authorizes a state to apply to the Secretary for the waiver of specified requirements under PPACA with respect to health insurance coverage within that state for plan years beginning on or after January 1, 2017. It further directs the Secretary to provide for an alternative means by which the aggregate amounts of credits or reductions that would have been paid on behalf of participants in the state’s Exchange will be paid to the state for purposes of implementing the state plan. This is the Wyden amendment, and it was added on to the main bill in a final, if half-hearted nod to bipartisanship. Oregon Democratic Senator Ron Wyden is the chief sponsor of the bipartisan Healthy Americans Act (HAA), which proposed far more sweeping health reforms in 2008, though these included a mandate. As such, this amendment opens the door to possibly worthy alternatives—like the HAA. But 2017 is a long time to wait for any state. States like Utah will get antsy to do something else before that point—under the new law of the land, all the state really can do is pull out of Medicaid altogether. This would be unwise, not to mention grossly inhumane.

BEYOND THE OPT-OUT OPTIONS: PULLING OUT OF MEDICAID

Because Medicaid and CHIP are state-federal partnerships, a state wishing to oppose federal reforms could choose to eliminate these programs and deny coverage to low-income citizens earning less than 133% of poverty within their state. If a state goes in this direction, PPACA does not provide the federal government with a clear mechanism to step in and help provide coverage to these poor Americans. While PPACA could make subsidies available to individuals in households with incomes over 100% of federal poverty who lose Medicaid because their state eliminated the program to purchase coverage on the new exchange, that coverage would likely not be as comprehensive as Medicaid. A limited benefit package could cause significant problems for people with disabilities, low-income seniors, people with chronic illnesses and adults on the path to self sufficiency. Further, those in households earning less than poverty would be left completely out in the cold, ineligible for subsidies on the exchange and without access to Medicaid or CHIP.

Utah Medicaid and CHIP currently serve nearly 300,000 low-income children, seniors, people with disabilities, pregnant women, and extremely poor parents (incomes < 44% of poverty).^{iv} In 2014 PPACA expands Medicaid coverage to everyone—including all adults with household income less than 133% of poverty—about 150,000 low-income adults in Utah. Rather than agreeing to this expansion, Utah could choose to eliminate its Medicaid and CHIP programs entirely—instantly doubling the state’s number of uninsured from 300,000 to 600,000.

The damage inflicted by such a decision is hard to quantify. Clearly it would impact many thousands of children, people with disabilities, and seniors that rely on Medicaid to help pay for their care. By and large Medicaid recipients are sicker and thus require more care than those receiving coverage in the private market. Their health care needs will not go away simply because they no longer have coverage. Rather, they will be forced to seek care from other sources, most likely emergency rooms.

Authentic charity care, a concept touted by the conservative Sutherland Institute, can go a long way in helping the medically underserved in Utah. But its limits in addressing the full spectrum of needs are well documented.^v It is one thing to donate a surgery to remove a brain tumor; but it is far less realistic to expect a medical institution or medical practice to donate all the follow up care needed to stay cancer free or the continuity of care needed to manage chronic conditions like diabetes or high blood pressure.

But the impact would not stop there. The federal government currently pays about 80% of the \$1.9 billion cost of Medicaid and CHIP, with the state picking up the remainder of the cost. By eliminating Medicaid entirely, Utah would be removing about \$1.5 billion dollars from Utah's healthcare system, hampering its ability to serve *all* Utah residents. A recent analysis by Jan Crispin, Senior Economist at the University of Utah Bureau of Business and Economic Research, illustrates the impact of Medicaid dollars on Utah's economy. The \$ 1.5 billion in federal funds and \$400 million in state funds spent on Medicaid and CHIP support 53,200 jobs in the state paying \$1.4 billion dollars in wages and returns over \$200 million to the state coffers every year. These jobs and associated economic activity would be difficult if not impossible to replace if Utah eliminated Medicaid and CHIP.^{vi}

According to the US Department of Commerce's Bureau of Economic Analysis, Utah's total gross domestic product amounts to nearly \$88 billion dollars. A \$1.9 billion loss of Medicaid and CHIP funding amounts to a 2% decline in the state's GDP. For a sense of scale, this 2% decline can be compared to the 3.7% decline in GDP the United States experienced during the recession of 2007-2009 – let's not go there.^{vii} This loss of funding will be felt in many ways:

1. Fewer health care providers in the state, which impedes access to cost-effective care for everyone, including those with insurance.
2. Higher health care premiums and other costs on those who do have insurance. Because the health care needs do not go away when someone loses their health insurance, those costs must be picked up by others who can pay. Right now an estimated 17% of premium costs reflect the cost shift from uncompensated care.
3. Higher health insurance costs will result in more businesses and insurances dropping their health care coverage – and we're back where we started. From 2000 to 2009 insurance premiums for Utah's families rose 4.3 times faster than median earnings.^{viii}

Given the impact on the state's economy and lives of its citizens, the elimination of Medicaid and CHIP should not be considered lightly, and certainly cannot be justified as a gesture of protest against federal health reform. The harm caused is just too great.

ⁱ Salt Lake Tribune (May, 2010). Utah Weighs Options for Opting Out of Federal Health Reform. http://www.sltrib.com/D=g/ci_15035840

ⁱⁱ Commonwealth Fund (2007). Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending. <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/Dec/Bending-the-Curve--Options-for-Achieving-Savings-and-Improving-Value-in-U-S--Health-Spending.aspx>

ⁱⁱⁱ Utah Health Policy Project (2009). Strengthening Utah's Health Insurance Exchange. http://www.healthpolicyproject.org/Publications_files/USHARE/StrengtheningTheExchangeFinal.pdf

^{iv} Utah Department of Health (March 2009). Medicaid and CHIP Enrollment Data.

^v Joel S. Weissman, et al (2003). Limits to the Safety Net: Teaching Hospital Faculty report on their Patients' Access to Care. *Health Affairs*. <http://content.healthaffairs.org/cgi/content/full/22/6/156>

^{vi} Jan Crispin (February 2009). Medicaid Economic Impact Calculator Update. Bureau of Economic and Business Research, University of Utah.

^{vii} US Department of Commerce Bureau of Economic Analysis (June 2009). Gross Domestic Product by State

^{viii} Families USA (2009). Costly Coverage: Premiums Outpace Paychecks in Utah.