UTAH HEALTH POLICY PROJECT

2369 West Orton Circle Suite 20 | West Valley City | UT 84119 | www.healthpolicyproject.org

UHPP | Sustainable Health Care Solutions for Underserved Utahns

June 30, 2019

Utah Department of Health,
Division of Medicaid and Health Financing
P.O. Box 143102
Salt Lake City, UT 84114-3102

Re: Comments on Utah's 1115 Waiver Amendment Request

Dear Dr. Miner:

Utah Health Policy Project (UHPP) is a nonpartisan, nonprofit organization dedicated to advancing sustainable health care solutions through better access, education, and public policy—including providing affordable and accessible insurance coverage to as many people as possible. UHPP's mission focuses on underserved Utahns. Since 2006, UHPP has worked to develop policies that create a health system that provides better access to higher quality health care at a lower cost. We pride ourselves on being an open resource for the public, community leaders, the media, businesses, health care providers, and policymakers. Our unbiased approach strives to find solutions that best fit Utah. We bring individuals and organizations to the same table, recognizing that effective and long-term solutions are fostered by authentic collaboration among disparate stakeholders. UHPP's primary role is to ensure the consumer's voice is represented.

UHPP was a part of the steering committee behind the successful Proposition 3 ballot initiative effort to fully expand Medicaid in Utah, after working tirelessly for five years to expand through the legislature. It was disappointing to see the legislature overturn the will of the people in pursuit of a limited plan with an array of strings attached in Senate Bill 96.

UHPP is commenting on that limited proposal, in response to Utah's Section 1115 Per Capita Cap Demonstration Application. These waiver amendment requests will restructure the Medicaid program in Utah in a way that will be harmful to Utahns and set a dangerous precedent, attempting to change the purpose of Medicaid. UHPP appreciates the opportunity to advocate for consumers and comment on these waiver requests.

Deficiencies in the Transparency Process

It was not acceptable to skip public comment on the enrollment cap and work reporting requirement under the "Bridge Plan" that was implemented on April 1, 2019. Health and Human Services implemented section 1115(d) in September of 2010 to "ensure transparency at each stage of the demonstration development."[1] Additionally, according to Final Rule, Section 10201(i) of the Patient Protection and Affordable Care Act, implemented February 2012, the State is required to give the public "adequate opportunities to provide meaningful input into the development of State demonstration projects."[2] The purpose of the rule changes is to encourage a "meaningful level of public input,"[3] which was not adequately enforced by the state before the enrollment cap and work reporting requirements were requested under SB 96.

The State said that because the public was given the opportunity to comment on enrollment caps and work reporting requirements as a part of the 2018 1115 waiver request under HB 472, there was no reason to repeat the process before the "Bridge Plan" partial Medicaid expansion was implemented on April 1, 2019. However, the waivers were not identical. Even if they were, that still violates the transparency process of the 1115 waiver, which requires public input at *every stage* of the waiver application process. Additionally, the State did not hold public comment in more than one location in May 2018, under the HB 472 waiver request, as required by the 2012 Final Rule. The lack of a second location during the 2018 comment period, combined with the lack of any public input ahead of the 2019 "Bridge Plan waiver" approval shows an inadequate transparency effort.

This is especially glaring given the context of the voter-approved Medicaid expansion last November, which was the ultimate public comment on the Medicaid program. The public's clear desire for a full Medicaid expansion last November makes the issue with the State's unwillingness to facilitate adequate public comment even more problematic.

Partial Expansion

Utah Health Policy Project opposes the effort to restrict enrollment by only granting eligibility to those below 100% of the Federal Poverty Line (FPL). Approving a partial expansion is contrary to the requirement that 1115 waivers must serve a demonstration purpose. There is no demonstration value in allowing Utah to receive the 90% enhanced federal match rate while excluding a population originally included under the law. Furthermore, with the already approved enrollment limit, these policies all seem to point to one purpose: capping Medicaid with no consumer safety net in mind.

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[1] "Federal Register / Vol. 75, No. 180 / Friday, September 17, 2010 / Proposed Rules ." *Department of Health and Human Services*, Centers for Medicare and Medicaid Services, 17 Sept. 2010, www.govinfo.gov/content/pkg/FR-2010-09-17/pdf/2010-23357.pdf.

[2] *Federal Register, Volume 77 Issue 38 (Monday, February 27, 2012)*, www.govinfo.gov/content/pkg/FR-2012-02-27/html/2012-4354.htm.

[3] Ibid

Consumers between 100-138% FPL—approximately $1,000 to $1,400 per month for an individual—have little to no disposable income. Although there are generous premium assistance subsidies and cost-sharing reductions on the Affordable Care Act (ACA) individual market for patients above 100% FPL, there are still out of pocket costs connected to accessing care. Even modest copays add up quickly if an individual needs to see a doctor or fill a prescription. Combine this financial barrier with the fact that low-income individuals have higher health care risks, higher health care needs, higher rates of chronic illness[4], higher rates of mental illness[5], and it is a recipe for disaster for the consumers who are locked out of Medicaid under a partial expansion scenario. Individuals in this income bracket generally cannot put what little extra income they do have on health care when there are other pressing financial issues to deal with. Medicaid is a much more comprehensive and affordable insurance option for this population. Research has shown that "low-income households with Medicaid spend a smaller portion of their annual budget on health care compared to non-Medicaid households."[6] Access to affordable health care leaves more room in low-income budgets for housing, food, and other essentials. Allowing this partial expansion will not fully increase access to health care in Utah, and it will allow our coverage gap to persist.

Enrollment Cap

UHPP opposes the enrollment cap proposed in this waiver and approved in the earlier "Bridge Plan". This policy will effectively create an arbitrary wall between those who get coverage and those who don't based on their spot in line—not their income, need, or other eligibility criteria. Enrollment caps cut off the number of people who can sign up for Medicaid, which leaves people stuck in the coverage gap without access to care, which is in direct conflict with the decision Utah voters made in 2018 to close the coverage gap. Although enrollment caps were previously granted in Utah for the Primary Care Network program and the Targeted Adult Medicaid expansion program, they were the main reason that these programs failed to fill major gaps in coverage.

UHPP is concerned that the enrollment cap approved by CMS is not tied to any set limit on the number of enrollees, and the fact that the legislature could draw the line as soon as they feel it is no longer "practicable" to fund Medicaid expansion. Utah voters approved a sales tax to pay for full Medicaid expansion, and SB 96 contains a provision that will trigger the enrollment cap as soon as the expansion expenses exceed that sales tax appropriation. However, in the wake of the opioid epidemic, flexibility in the Medicaid budget to account for unexpected public emergencies is necessary. The repercussions of the enrollment cap would negatively affect the

[4] Woolf, Steven H, et al. "How Are Income and Wealth Linked to Health and Longevity." *Urban Institute*, Center on Society and Health, Apr. 2015, www.urban.org/sites/default/files/publication/49116/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf.

[5] Sareen, Jitender. "Relationship Between Household Income and Mental Disorders: Findings From a Population-Based Longitudinal Study." *Archives of General Psychiatry*, American Medical Association, 4 Apr. 2011, jamanetwork.com/journals/jamapsychiatry/fullarticle/211213.

[6] Majerol, Melissa, et al. "Health Care Spending Among Low-Income Households with and without Medicaid." *The Henry J. Kaiser Family Foundation*, 29 Mar. 2016, www.kff.org/medicaid/issue-brief/health-care-spending-among-low-income-households-with-and-without-medicaid/.

state's ability to manage such events. Without preparing for more economic downturns or future public health crises, Utah is setting itself up for problems in the future. Once the line is drawn with an enrollment cap, people immediately lose access to care and there is no waiting list. People must wait until enrollment reopens and they are allowed to come back and try again. This will do real harm to patients who need care.

Furthermore, cutting enrollment does nothing to control actual health care costs. This waiver appears to be created under the assumption that limiting Medicaid enrollment will control general costs. That is not true. Health care *prices* are the driver behind health care costs, and until the state and federal governments tackle those prices, costs will continue to climb. Additionally, those who are uninsured will continue to use the health care system, but in a less efficient way, and so attempts to control costs by simply cutting people off programs and services will be futile.

This waiver neglects to demonstrate any type of impact on enrollment. The State claims that there will be the same number of enrollees with and without the waiver. However, the purpose of an enrollment cap is to limit enrollment, that is impossible. This is another example of where transparency is lacking in this waiver process.

Work Reporting Requirement

Utah Health Policy Project opposes any barriers to gaining and keeping eligibility- including community engagement/work effort/work requirements. Other safety net programs, like Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP), demonstrate that these requirements act as a barrier—even to working people, and even with exemptions in place. Additionally, now that an evaluation of Arkansas' work requirement has been published, not only do work requirement not encourage work, they largely lead to disenrollment. A recent New England Journal of Medicine study shows exactly the result that health care advocates warned would occur: an increase in the unemployment rate and an increase in the uninsured rate among the population targeted by the work reporting requirement in that state.[7] This is concrete evidence that work requirements don't encourage work—they only encourage disenrollment of eligible people.

Arkansas is the only state where these work reporting requirements have been implemented, and in 2018, more than 18,000 individuals lost Medicaid coverage due to the requirement barrier. Only 2,000 individuals have re-enrolled, and fewer have found employment since.[8]

[7] Sommers, Benjamin. "Medicaid Work Requirements - Results from the First Year in Arkansas | NEJM." *New England Journal of Medicine*, www.nejm.org/doi/full/10.1056/NEJMsr1901772.
[8] Wagner, Jennifer. "New Arkansas Data Contradict Claims That Most Who Lost Medicaid Found Jobs." *Center on Budget and Policy Priorities*, 19 Mar. 2019, www.cbpp.org/blog/new-arkansas-data-contradict-claims-that-most-who-lost-medicaid-found-jobs.

Many populations in Utah will be harmed by a reporting requirement, including service industry workers or seasonal employees in Utah's tourism industry may not have enough hours per week to week to meet a work reporting requirement.

Work reporting requirements also disproportionately impact Medicaid enrollees with chronic conditions or disabilities and result in intentional or unintentional discrimination against these disabled patients.[9] Allowing a disability exemption is not enough to protect disabled consumers from the harm of work reporting requirements. Individuals with undiagnosed or invisible disabilities will struggle to sufficiently document their illnesses in order to satisfy exemption requirements, and the act of applying for an exemption is itself a red tape barrier to care.

Data from both the Pennsylvania[10] and Wisconsin[11] food stamp programs indicate that tens of thousands of adults lost nutrition benefits, despite exemptions for those mentally or physically unfit for employment. Otherwise-eligible enrollees may not understand what is required of them or be able to complete paperwork. They may not be able to travel to appointments to be assessed for exemptions.

The purpose of the Medicaid Act is to enable states to furnish medical assistance to low-income individuals who cannot afford the costs of medically necessary services. Work requirements are neither medical assistance nor a service provided to Medicaid beneficiaries. Work reporting requirements in Arkansas and Kentucky have twice been ruled illegal by a federal court because they don't support Medicaid's purpose of helping beneficiaries get medical care or services to become more independent.

Work reporting requirements also ignore Medicaid's essential role as a safety net for people in need. Medicaid's enrollment fluctuates with the economy and enrollment increases during downturns as employer contract the number of employees they have. Conditioning Medicaid eligibility on completion of work activities is exactly backward in its attempt to provide a safety net for the public. Attaching Medicaid to work only succeeds in kicking people off of a program that enables many to reach sufficiency and transition to employer sponsored insurance without punitive measures.

There is a correlation between work and health, but a review of the literature on the subject from Kaiser Family Foundation shows that good health must come first, noting, "being in poor health is associated with increased risk of job loss, while access to affordable health insurance has a positive effect on people's ability to obtain and maintain employment."[12]

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[9] "Taking Away Medicaid for Not Meeting Work Requirements Harms People with Disabilities." *Center on Budget and Policy Priorities*, 14 Mar. 2019, www.cbpp.org/research/health/taking-away-medicaid-for-not-meeting-work-requirements-harms-people-with.

[10] Woodall, Candy. "30,000 Pa. Residents Lose Food Stamps over Federal Work Requirements." *Pennlive.com*, Pennlive.com, 26 July 2017, www.pennlive.com/news/2017/07/30000_pa_residents_lose_food_s.html.

[11] Wisconsin State Journal. "Under Wisconsin's New Work Law, 41,000 Lost Food Stamps, 12,000 Found Jobs." *Twin Cities*, Twin Cities, 28 Apr. 2016, www.twincities.com/2016/04/21/under-wisconsins-new-work-law-41000-lost-food-stamps-12000-found-jobs/.

[12] Antonisse, Larisa, and Rachel Garfield. "The Relationship Between Work and Health: Findings from a Literature Review." *The Henry J. Kaiser Family Foundation*, 7 Aug. 2018, www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/.

The State was not forthright in their depiction of the effects this policy will have on enrollment. The State showed that 70% of Adult Expansion beneficiaries will meet the requirements and that 75-80% of those beneficiaries will comply. The State did not overtly say that the remaining 20-25% who will not comply will lose coverage, and they neglected to do the math and list the actual number of enrollees who could lose their care. UHPP calculated the number of those losing coverage to be around 7,000 enrollees, however, Utah's Medicaid Director was heard saying it could be as high as 10,000 beneficiaries. Additionally, this may not fully account for coverage losses, as indicated by looking at the results in Arkansas, where many of those kicked off of Medicaid actually fulfilled the work requirement, they just may not have been able to report it in time or without technical complications. This is another example of lack of transparency in the 1115 waiver process. UHPP contests the State's claim, as demonstrated in their matching "with waiver" and "without waiver" numbers, that there will be no impact to enrollment because a work reporting requirement is designed to implement cuts to enrollment.

With new evaluation data available about the damaging effects of this policy on consumers, there is no place within the 1115 waiver demonstration approval process for this type of reporting requirement.

Per Capita Cap Funding Mechanism

Utah Health Policy Project opposes the per capita cap funding mechanism in this proposal. The requested per capita cap aims to reduce costs by limiting coverage and makes no attempt to address why Medicaid health care costs are increasing. The per capita cap funding arrangement limits the financial responsibility of the federal government and shifts all the pressure and risk onto states, who in turn shift the risk onto low-income people.

The State will inevitably have less money under a per capita cap, and this will lead to cuts to Medicaid enrollment and/or services. This limited funding structure will force state lawmakers to make difficult decisions regarding which enrollees to lockout, and which programs, services, and budgets to cut. This all leads to patients losing their health care. That intention is clear, as an enrollment cap has already been approved.

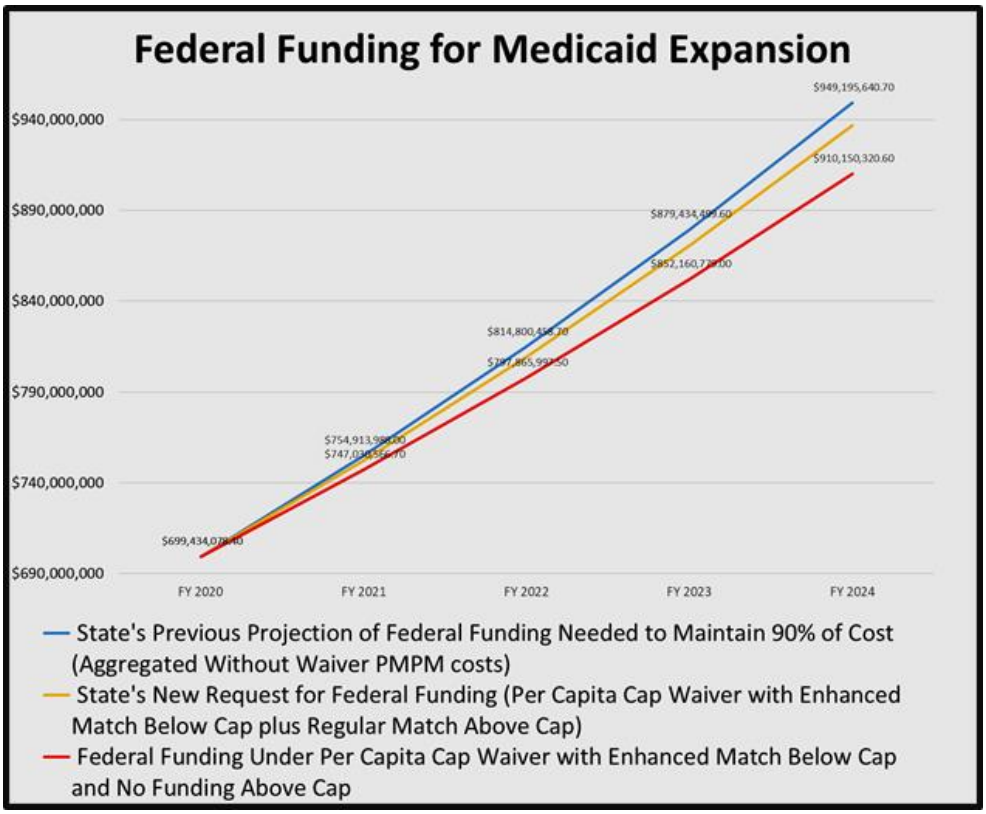
The only flexibility the state gains under a per capita cap is the flexibility to make cuts that are usually illegal under Medicaid law. In 2017, the Congressional Budget Office predicted that per capita caps would result in cuts to Medicaid amounting to more than one-third of the program.[13] UHPP is extremely concerned about the impact this kind of funding structure limitation would have on patients and programs.

A per capita cap will never offer the state a better deal with the federal government than the current relationship available to any state that fully expands Medicaid. Per capita caps create

[13] Park, Edwin. "CBO: Senate Bill Cuts Medicaid by More Than One-Third by 2036." *Center on Budget and Policy Priorities*, 11 Oct. 2017, www.cbpp.org/blog/cbo-senate-bill-cuts-medicaid-by-more-than-one-third-by-2036.

an increasing gap between the state's financial need and the federal government's financial support. Medicaid enrollment is often unpredictable as states experience unexpected economic recessions, natural disasters, or public health crises. The open-ended flexibility in the traditional match-rate system is a critical part of Medicaid's success.

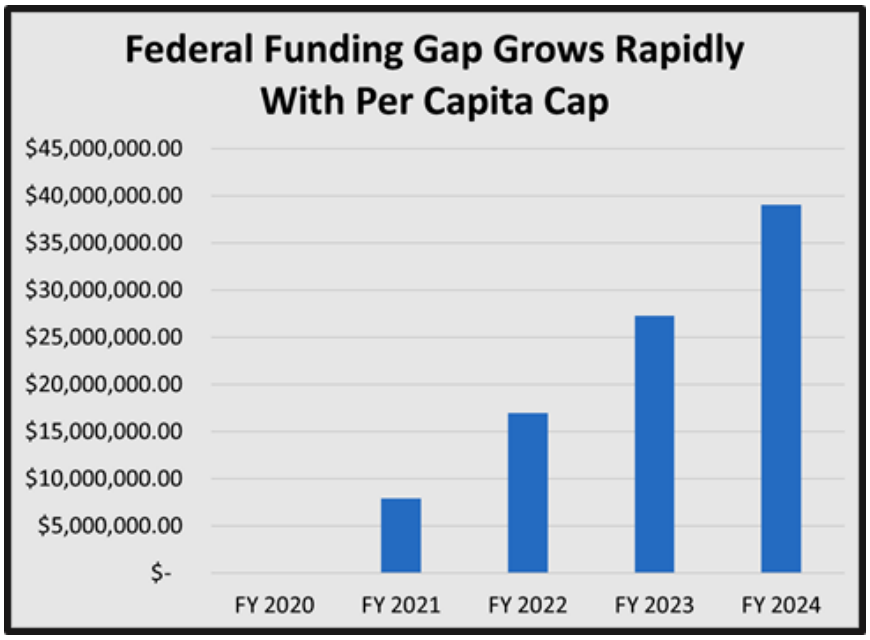
Utah Health Policy Project extrapolated from numbers provided in the waiver to better understand what would happen to the State's budget if a per capita cap is approved, finding that under a per capita cap, without the traditional match-rate budget flexibility, the state of Utah will face a $39 million dollar deficit by 2024. This shortfall would be even more extreme if Utah were to experience a disaster or public health crisis. This would never happen under a traditional Medicaid expansion, as the federal government would always be required to pay 90% of the program regardless of any unexpected enrollment fluctuation in Utah.



In the graph above, each trending line represents the portion of Utah's Medicaid budget that the federal government will pay in each of Utah's three pending scenarios. The three scenarios are: a full Medicaid expansion (90% Federal, 10% State); a per capita cap expansion with traditional match rate after the cap is reached (90% Federal/10% state until cap and then 68% Federal/32% State over the cap); and a traditional per capita (90% Federal/10% State until the cap is reached and then 100% State responsibility over the cap).

The top blue line of the graph above shows the amount of money the state initially assumed would be needed from the federal government to cover 90 percent of the cost of expansion.

The yellow and red lines below show the amount of funding the state is requesting through either a traditional per capita cap or the proposed negotiated per capita cap. The chart below illustrates the increasing gap between the federal funding Utah will need, and the federal funding Utah will get over time. This gap in funding will only increase with time, as shown below, and would grow even more dramatically in the event of a public health crisis or natural disaster.



Utah will be short $39 million in federal funding by 2024 under a traditional per capita cap. If the state is granted a negotiated per capita cap with the traditional funding match past the capped amount (which has never been tried or approved) the state would still be $12.5 million short by 2024. Instead of dipping into the state's general fund to compensate for this budget deficit, the state will implement the enrollment cap at any time to immediately eliminate the state's responsibility for paying a higher match rate to cover this population. When the state uses the enrollment cap, the uninsured rate will increase, bringing along uncompensated care troubles to hospitals, providers, and again, the consumer. Overall, each of these capped Medicaid scenarios leave vulnerable patients locked out of eligibility, losing services, and losing benefits-- leaving them to face high health care costs alone with no safety nets to fall back on.

The waiver calls for the state to work with CMS to establish a per enrollee base amount of federal funding, categorized into three enrollment groups, for the first demonstration year with trending for future demonstration years. This system would not accurately reflect the cost of care for the variety of individuals who would be covered under the expansion. There are people of all ages, in all three categories, living with disabilities or chronic medical conditions. Variations in illness, disability, and ongoing health needs cannot be adequately addressed by division into three simple groups. Such variation makes it very challenging to establish realistic baseline cap amounts sufficient enough to meet the State's needs. In addition, the Medical Consumer Price Index can fluctuate considerably from year to year, making it difficult to

establish a realistic growth rate. Utah's relatively young and healthy population has resulted in low per-capita spending levels in recent years, but a per capita cap system would tie the state to those low levels, even as population demographics change and the population ages.

Lock-Out due to Intentional Program Violation

UHPP opposes the proposed lockout for intentional program violations. This is an unnecessary provision since there are already plenty of protections against fraud in the Medicaid program. For calendar year 2017, there were 745 suspected intentional program violations in the Utah Medicaid program. This represents approximately 0.2% of Utah's Medicaid population, and these are purely suspected violations. Out of those, around 351 would be eligible for Medicaid expansion today. The State estimates that 500 enrollees from the expansion population will be locked out of Medicaid for 6 months if this portion of the waiver is approved. That number suggests that as a percentage of IPVs during 2017, the expansion population would disproportionately be affected by this type of ruling.

From other studies, including the recent work requirement study published in The New England Journal of Medicine, it is clear that when Medicaid recipients are kicked off of the program, they are less likely to return even, when they become eligible again, leading to long-term loss of care.[14] This rule is not in line with the purpose of Medicaid, which is to provide health insurance coverage to those who are eligible.

A recent study titled "The Impact of Medicaid Expansion on Continuous Enrollment: A Two-State Analysis" showed that "even short gaps in insurance coverage can be harmful by compromising access to effective medical services and prescription drugs."[15] This study compared Utah and Colorado and found that "following expansion, Medicaid enrollees in Colorado gained an additional 2 months of coverage over 2 years of follow-up and were 16 percentage points less likely to experience a coverage disruption in a given year compared to concurrent trends observed for enrollees in Utah."[16]

This lockout policy is explicitly expecting to have ramifications to enrollment, and up to 500 beneficiaries are anticipated to lose coverage. Still, the State's numbers in the waiver claim that there will be no impact to enrollment, which is impossible if this part of the waiver is implemented.

[14] Sommers, Benjamin. "Medicaid Work Requirements - Results from the First Year in Arkansas | NEJM." *New England Journal of Medicine*, www.nejm.org/doi/full/10.1056/NEJMsr1901772.

[15] Gordon, Sarah H., et al. "The Impact of Medicaid Expansion on Continuous Enrollment: a Two-State Analysis." *SpringerLink*, Springer US, 21 June 2019, link.springer.com/article/10.1007/s11606-019-05101-8.

[16] Ibid .

EPSDT Changes

The Early and Periodic Screening, Diagnostic and Treatment benefit package is the gold standard of care for children and young adults age 19 and 20. This program is vital to the health and wellbeing of kids and families. This range of health services sets children and young adults up for success and helps prevent future health issues—benefitting the whole state from a public health perspective. Eliminating this benefit for young people on Medicaid is unnecessary and harmful. These changes were not in Senate Bill 96, and were not requested by the legislature. The Utah Department of Health does not need to ask for these changes, which will only harm Utah's most vulnerable youth at a crucial state in their life.

Conclusion

The State claims under the "Goals and Objectives" section that this 1115 waiver will lead to "lowering the uninsured rated of low-income Utahns" and "provide continuity of coverage for individuals" and "providing fiscal sustainability through new financing models and state flexibility." That would be true under the full Medicaid expansion approved by voters. But this is not a true Medicaid expansion. This waiver uses an arbitrary enrollment limit to cap enrollment and establishes a per capita cap, setting funding for Utah's Medicaid program below what is needed. It is therefore impossible for the state to fully meet their stated goal and objective. This waiver request does not fulfill the purpose of Medicaid, which is to provide health insurance for low-income people. These requests cannot provide continuity of coverage to Medicaid beneficiaries because the work reporting requirement and lockout for intentional program violations intentionally interrupt that coverage. The two-state analysis study says 'transitions between different types of health insurance and short gaps in coverage can also negatively impact enrollees. Switching coverage can erode continuity."[17] The policies requested in this waiver application will lead to coverage loss and gaps in coverage, as stated covertly by the State in the waiver.

The State's claim that this waiver will increase fiscal sustainability is questionable at best. This waiver does nothing to address the reason why health care costs are rapidly increasing and does nothing to address why, specifically, the Medicaid budget is increasing. With enrollment limits, gaps in funding needed to sustain the program, and with no safety nets in place, this waiver attempts to cap costs, but not to control costs. Therefore, these proposals will not address the State's fiscal sustainability concerns.

Further, Medicaid recipients who lose coverage will still need to access the health care system, but they won't have insurance, so that does not lead to any type of fiscal sustainability for the patients who rely on the Medicaid program. The purpose of Medicaid is to provide coverage for those who are eligible, and this waiver abandons that purpose under the guise of cost control.

[17] Ibid