

medicaid
and the uninsured

**A CASE STUDY OF THE UTAH PRIMARY CARE NETWORK WAIVER:
INSIGHTS INTO ITS DEVELOPMENT, DESIGN, & IMPLEMENTATION**

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kaiser commission medicaid and the uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

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EXECUTIVE SUMMARY

In 2002, Utah utilized section 1115 waiver flexibility to expand primary care coverage to adults not previously eligible for Medicaid using savings from coverage reductions for previously eligible parents. Utah's waiver expansion, called the Primary Care Network, provides coverage for primary care, without coverage for hospital (other than emergency room) or specialty care to parents and other adults. In light of the Primary Care Network's limited benefits, the state established informal systems for enrollees to seek donated specialty and hospital care. When it implemented the Primary Care Network, Utah discontinued a fully state-funded program, called the Utah Medical Assistance Program (UMAP), which provided care for acute and life-threatening conditions to very poor adults who were not eligible for Medicaid. The state expected individuals receiving UMAP care to enroll in the Primary Care Network. To offset the expansion costs, the state reduced benefits and increased cost sharing for already eligible Medicaid parents; this reduced coverage is called Non-Traditional Medicaid. Finally, through a later waiver amendment, the state also implemented Covered at Work, a program that provides premium subsidies to people in the expansion population who have access to employer-sponsored insurance.

The Utah waiver was novel because of the limited benefits provided to the expansion population and how it was financed. This report provides insight into design, development, and implementation of the Utah waiver. It is based on interviews with key stakeholders, including state officials, legislators, legislative staff, advocates, providers, and researchers that were conducted in Spring 2003, less than a year after the waiver was first implemented. It also includes analysis of state enrollment data and quarterly reports. In addition to the site visit and enrollment analysis, researchers from the Kaiser Commission on Medicaid and the Uninsured and the National Opinion Research Center conducted a telephone survey of individuals affected by the waiver, profiling their health status, access to care, utilization of care, and financial situations. Results from this survey have been published elsewhere.¹ What follows are key findings from the case study conducted shortly after program implementation.

Development and Design

State officials and other respondents reported that a major impetus behind the waiver was then Governor Leavitt's interest in expanding coverage for low-income working adults.

The expansion was designed to serve as transition coverage for low-income working adults, with the goal of providing preventive and primary care and eventually preventing and reducing illness and reducing uncompensated care in the state's health care system. The federal government's active encouragement of waivers was viewed as an opportunity to pursue the coverage initiative. A second factor was that UMAP costs had exceeded expected costs for several years, and there was increasing pressure from the state legislature to reduce these costs. The waiver enabled the state to refinance spending for this state-funded program with federal match funds.

Most respondents recognized the waiver design as the best that could be achieved within the state's environment at the time. The waiver was designed primarily by the state with little input from other stakeholders. This process allowed for fast development and approval of the

¹ See Artiga et al., "Can States Stretch the Medicaid Dollar Without Passing the Buck? Lessons from Utah," *Health Affairs*, March/April 2006, Vol. 25, No. 2.

waiver, but created frustration among some stakeholders. State officials noted that, when designing the waiver, they were faced with the trade-off of covering fewer people with full benefits versus covering more people with limited benefits, and that they chose the route of providing “less to more.” Advocates expressed concerns about increased demands on primary care providers and the absence of a formalized system for providing Primary Care Network enrollees inpatient hospital and specialty care. However, advocates and state officials recognized that the waiver was a financially and politically feasible option for the state at the time. Overall, respondents were generally supportive of the state’s effort to expand coverage, even though there were some concerns about the program design. Most were taking a “wait and see” attitude to see how well the program design would work in practice.

Implementation and Enrollment

The state began enrolling people in the Primary Care Network in July 2002 and reached its enrollment cap of 19,000 adults in November 2003. In the months following, enrollment declined reflecting program attrition, reaching less than 15,000 toward the end of May 2004. Since then, the state has held a number of brief open enrollment periods, and, as of May 2005, 18,088 people were enrolled. While former UMAP enrollees were intended to transition to the Primary Care Network, less than one in five (18%) of the 3,500 former UMAP enrollees were enrolled as of May 2005. Enrollment in the Covered at Work premium assistance program has been very limited—72 adults as of May 2005.

Implementation occurred quickly, enabling people to begin receiving coverage, but some key stakeholders were not adequately prepared. The waiver was implemented quickly, giving new enrollees rapid access to primary care coverage. However, the state staff was still learning policies and procedures after enrollment began and faced new pressures due to the increased complexity and size of orientation sessions. Beneficiaries lacked comprehensive informational materials and many were confused about their coverage; some were frustrated by the limits on their coverage. Providers were confused about billing practices, unsure of which benefits were covered for which individuals, and unclear on how the donated hospital and specialty care system for Primary Care Network enrollees worked.

Some eligible individuals appeared to experience problems affording the Primary Care Network enrollment fee. When the waiver was initially implemented, all eligible individuals were required to pay an annual \$50 enrollment fee. According to respondents, this fee was unaffordable for some individuals, particularly the lowest income individuals. Sponsorship of the fee by charitable organizations and others helped some, but a number of people, particularly those in rural areas, did not have access to this assistance. The state has since taken steps to reduce the enrollment fee for some of the lowest income eligible individuals.

Donated Hospital and Specialty Care for Primary Care Network Enrollees

Respondents expressed concerns about the efficacy of the donated hospital and specialty care system for Primary Care Network enrollees. In light of the lack of hospital and specialty care coverage in the Primary Care Network, the state made an informal agreement with the hospitals in the state to provide a set amount of charity care to enrollees and made case managers at the Department of Health available to try to help enrollees obtain donated specialty care. Advocates and providers commented that, although well-intentioned, the system does not

guarantee enrollees access to necessary and timely specialty care and does not provide good continuity of care, particularly for enrollees outside of the Salt Lake City area. It was further noted that some primary care providers were stretching the scope of their services by providing care that they would usually refer to a specialist in order for the care to be covered by the Primary Care Network. Respondents noted that enrollees did appear able to access hospital care, but expressed concerns regarding the sustainability of the donated hospital care system since hospitals reported providing care in excess of the agreed upon amount and an inequitable distribution of this donated care across the state's hospitals.

Non-Traditional Medicaid Reductions for Already-Eligible Parents

The coverage reductions for parents in Non-Traditional Medicaid received little attention. Parents covered by Non-Traditional Medicaid experienced benefit reductions and cost sharing increases under the waiver. Soon after these changes were implemented, the state legislature also approved a number of benefit reductions and cost sharing increases outside of the waiver to address growing budget problems. These changes affected the parents covered by Non-Traditional Medicaid as well as other adult Medicaid beneficiaries who were not impacted by the waiver (e.g., elderly and disabled adults). Overall, respondents' comments regarding the waiver reductions for parents were fairly limited. Generally, they did not view the waiver reductions as a separate or more significant issue than the reductions approved by the state legislature. However, a few respondents commented that some Non-Traditional Medicaid beneficiaries were experiencing problems accessing needed care due to both the waiver and other reductions.

Conclusion

The interviews for this case study were conducted soon after the waiver was implemented, allowing little time for the impacts of the waiver to fully develop. However, these findings offer insights into the waiver development, design, and implementation process, providing some important lessons. The findings from Utah show that a state can utilize waiver flexibility to quickly expand coverage for some services to a limited group of previously uninsured people. They also illustrate the strong interest in publicly-financed coverage among low-income and poor adults, who are not eligible for Medicaid in many states.

Further, Utah's experience highlights the importance of involving stakeholder groups in the design of any major program change and of educating relevant groups and preparing necessary materials prior to implementation. While the state's fast design and implementation process allowed it to rapidly begin expansion enrollment, the lack of key stakeholder involvement and education created significant challenges.

Finally, Utah's experience shows that waiver coverage expansions are limited by their fiscal constraints, which can drive restrictions on both the number of people that can enroll and the scope of benefits for which they are covered. Providing limited benefits may enable a state to cover more people, but may leave beneficiaries and providers facing significant challenges to assuring access to uncovered care.

I. INTRODUCTION

In 2002, Utah utilized increased waiver flexibility offered by the Administration to implement an expansion in primary care coverage using savings from reducing benefits and increasing cost sharing for previously eligible parents. Waivers allow states to alter their Medicaid programs in ways not otherwise allowed under federal law. They do not provide states any additional federal financing—longstanding federal policy requires that waivers be budget neutral for the federal government. This means that federal costs under a waiver cannot be more than projected federal Medicaid costs without the waiver. The federal government enforces budget neutrality by establishing a cap on federal financing for the state. Because of the budget neutrality requirement, states that use waivers to expand coverage must create offsetting savings or redirect existing federal funds to finance the expansion.

Utah's waiver was novel because the state financed the waiver expansion by reducing coverage for existing beneficiaries and it provided a significantly more limited benefit package to expansion enrollees than previously seen in Medicaid. As states continue to seek ways to sustain and expand coverage to their low-income populations within an environment of constrained resources, Utah's experience may prove instructive. This report provides insight into design, development, and implementation of the Utah waiver. It is based on interviews with key stakeholders, including state officials, legislators, legislative staff, advocates, providers, and researchers that were conducted in Spring 2003, less than a year after the waiver was implemented. It also includes analysis of state enrollment data and quarterly reports. In addition to the site visit and enrollment analysis, researchers from the Kaiser Commission on Medicaid and the Uninsured and the National Opinion Research Center conducted a telephone survey of individuals affected by the waiver, profiling their health status, access to care, utilization of care, and financial situations. Results from this survey have been published elsewhere.² What follows are key findings from the case study conducted shortly after program implementation.

II. BACKGROUND

Prior to the waiver, Medicaid coverage in Utah was available to low-income children and pregnant women, elderly and disabled individuals receiving SSI, and very poor parents (with incomes up to 54% of poverty or \$8,688 for a family of three in 2005), parents who recently left Temporary Assistance for Needy Families (TANF) because of employment, and parents with high medical expenses who “spent-down” to qualify for Medicaid. Adults without dependent children were not eligible for Medicaid regardless of their incomes, reflecting the fact that states cannot cover these adults with federal Medicaid funds under current law.

In addition, Utah had a fully state-funded program, known as the Utah Medical Assistance Program (UMAP), which provided care for acute and life-threatening conditions to adults not eligible for Medicaid who were in very poor health and facing difficult financial circumstances, including homeless individuals. Prior to the waiver, this program was experiencing substantial cost increases, and the legislature was planning to discontinue its funding.

² See Artiga et al., “Can States Stretch the Medicaid Dollar Without Passing the Buck? Lessons from Utah,” *Health Affairs*, March/April 2006, Vol. 25, No. 2.

In February 2002, Utah received federal approval to make changes to its Medicaid program through a Section 1115 waiver; it implemented its waiver in July 2002 (Table 1). Under the waiver, Utah: 1) Expanded coverage for a package of primary care services, called the Primary Care Network, to low-income parents and other adults who were not previously eligible for Medicaid; 2) Reduced benefits and increased cost sharing for parents already eligible for Medicaid; this reduced coverage is called Non-Traditional Medicaid; and 3) Implemented a premium assistance program, known as Covered at Work, under a later waiver amendment.

Elderly, blind, and disabled individuals; children; and pregnant women were not impacted by the waiver and continued to receive the state’s full Medicaid benefit package, now called “Traditional Medicaid.” However, soon after the waiver was implemented, the state legislature approved several benefit reductions and copayment increases (that did not require waiver authority) to address the state’s growing budgetary problems. These changes affected both Non-Traditional Medicaid enrollees and non-pregnant, adult Traditional Medicaid enrollees. (Some of these benefits have since been reinstated.)

Table 1: Overview of Utah’s Medicaid Program, September 2005

	Traditional Medicaid	Non-Traditional Medicaid	Primary Care Network	Covered at Work
Eligibility	Elderly, blind, & disabled <100% FPL Children 0-6 <133% FPL Pregnant women <133% FPL Children 6-18 <100% FPL Women with breast and cervical cancer	Parents w/incomes below TANF eligibility levels (0-54% FPL) Parents eligible for TMA Parents with high medical expenses who “spend down” to qualify	Parents 50-150% FPL Other adults 0-150% FPL (Age 19-65, uninsured for ≥6 months, no access to ESI).	Parents 50-150% FPL Other adults 0-150% FPL (Age 19-65, uninsured for ≥6 months, access to ESI).
State can cap enrollment	No	No	Yes	Yes
Enrollment Fee/Premiums	None	None	\$50 annual fee (lower for some eligible adults)	Premium costs that exceed subsidy
Benefits	Full State Medicaid Benefit Package	Some limits not found in Traditional Medicaid, e.g.: <ul style="list-style-type: none"> • No coverage of non-emergency transportation • 30 inpatient and 30 outpatient days per year for mental health services • 16 visits per year for physical therapy and occupational therapy, combined • \$30 vision benefit limit, no coverage of eyeglasses • Dental care limited to relief of pain and infection 	Primary care services only; no coverage for hospital (other than emergency) or specialty care) Limits on covered services, e.g.: 4 drugs per month Durable medical equipment only covered for recovery needs \$30 vision benefit limit, no coverage of eyeglasses Dental care limited to preventive care	\$50/month subsidy for an individual or \$100/month subsidy for a family for up to 2 years Decreasing subsidy amounts for an additional 3 years
Copayments	For non-pregnant adults: \$2-\$6 for some services and \$220 per hospital admission Services can be denied based on inability to pay	\$2-\$6 for some services and \$220 per hospital admission Services can be denied based on inability to pay \$500 out of pocket maximum per year	\$5-\$30 copays and 5%-10% coinsurance for some services Services can be denied based on inability to pay \$1,000 out of pocket maximum per year	Vary based on subsidized private plan

The Primary Care Network

To be eligible for the Primary Care Network, adults must have income below 150% of poverty (\$24,135 for a family of three in 2005), be uninsured, and not have access to employer-sponsored insurance. All adults covered by the state-funded UMAP became eligible for the Primary Care Network, and UMAP was discontinued when the waiver was implemented. Eligible individuals must pay an annual enrollment fee, which was initially set at \$50 for all eligible individuals. Primary Care Network enrollees receive benefits limited to primary care, with no coverage for hospital care (other than emergency care), specialty care, and mental health services. There are also limits on some covered benefits, including a limit of four prescription drugs per month. Enrollees pay copayments ranging from \$5-\$30 depending on the service; and up to 10% coinsurance for some services.

In light of the limited benefits in the Primary Care Network, the state made an informal agreement with the hospitals for them to voluntarily provide a set amount of charity care to enrollees, based on the amount they estimated they were spending on unreimbursed care for former UMAP enrollees. Hospitals across the state currently have agreed to provide up to a total of \$10 million annually in charity care for Primary Care Network enrollees. Additionally, enrollees can access case managers at the Department of Health (DOH) to try to connect with specialists willing to provide care free of charge. If enrollees receive hospital or specialty care and are unable to secure this charity or donated care, they can be billed for and become liable for the costs of their care. However, according to the state, in practice, Primary Care Network enrollees are almost never charged for inpatient hospital care.

Non-Traditional Medicaid

Utah offset the costs of the Primary Care Network expansion by reducing benefits and increasing cost sharing for previously eligible parents, including very poor parents (with incomes below 54% of poverty or \$8,688 for a family of three in 2005), parents who recently left TANF because of employment, and parents with high medical expenses who “spent-down” to qualify for Medicaid. The state terms this reduced coverage Non-Traditional Medicaid. These parents became subject to copayments, including \$6 per non-emergent use of the emergency room, \$3 per outpatient office visit, and \$2 per prescription drug. They also lost coverage for non-emergency transportation and most dental services and faced new benefit limits, including a mental health care limit of 30 inpatient and 30 outpatient days per year, an annual \$30 vision benefit limit and vision care limited to one exam per year without coverage for eyeglasses, and a limit of 16 visits per year for physical and occupational therapy combined.

Covered at Work

Through a later waiver amendment, the state implemented a premium assistance program, known as “Covered at Work” for the expansion population. Covered at Work provides premium subsidies to parents and other adults who would be eligible for the Primary Care Network, but who have access to employer-sponsored insurance.³ Individuals participating in Covered at

³ Individuals are eligible for Covered at Work if their ESI premium costs exceed 5 percent of their gross monthly income and the employer pays more than 50 percent of premium costs. Employees with premium costs that exceed 15 percent of their monthly income can choose between receiving premium assistance and enrolling in the Primary Care Network.

Work receive subsidies for their premium costs (paid directly to the insurer or employer) for up to five years. After five years, they are no longer eligible for assistance. Generally, all individuals receive the same subsidy regardless of their premium costs. Monthly subsidies are \$50 for an employee only and \$100 for an employee and his or her family for the first two years; they decrease over the remaining three years. There are no minimum requirements regarding benefits and cost sharing for subsidized coverage other than the state's general insurance laws. Enrollment in Covered at Work is capped at 6,000 adults.

Other Changes

After implementing the waiver, the state notified providers that they could deny services to Traditional Medicaid, Non-Traditional Medicaid, and Primary Care Network beneficiaries who are unable to pay required copayments. Additionally, following implementation of the waiver, a number of private insurance carriers expressed concern that state insurance laws did not allow them to provide coverage as limited as the Primary Care Network. The state legislature later passed a law allowing private carriers to offer similar, significantly restricted coverage. However, since the law passed, we know of no private carrier that has begun offering such coverage.

III. FINDINGS

Waiver Development and Design

Primary factors that led to the waiver were the Governor's interest in expanding coverage to working adults and the pending elimination of the state-funded UMAP program. State officials and other respondents reported that the major impetus behind the waiver was then Governor Leavitt's interest in expanding coverage for low-income working adults. Respondents noted that the expansion was designed to serve as transition coverage for low-income working adults, with the goal of providing preventive and primary care and eventually preventing and reducing illness and reducing uncompensated care in the state's health care system. The federal government's active encouragement of waivers was viewed as an opportunity to pursue such a coverage initiative. A second factor was that costs of the state-funded UMAP program had exceeded expected costs for several years. There was increasing pressure from the state legislature to reduce program costs, and it appeared that the legislature would no longer continue to fund the program. In 2001, negotiations between the Department of Health (DOH) and the legislature resulted in a "one-year reprieve" for elimination UMAP program funding, on the condition that DOH identify a way to draw down federal match funds for UMAP enrollees. The waiver enabled the state to refinance coverage for UMAP eligibles with federal match funds.

The waiver was designed by the state with minimal input from other stakeholders. State officials said they proceeded with the waiver with limited input from other stakeholders because they wanted to complete the waiver process rapidly due to concerns about lack of funding for the UMAP program in fiscal year 2002. Additionally, they wanted to capitalize on Secretary Thompson's visit to Utah for the 2002 Winter Olympics and have the Secretary sign approval for the waiver at that time. According to state officials and advocates, the waiver was designed by the DOH in consultation with the Secretary of the Department of Health and Human Services. Other stakeholders in the state were not involved in the initial design process. Advocates and providers noted that, although they were well-informed about the waiver proposal, they never

had any significant opportunity to affect its design. Some expressed frustration over their limited involvement in designing the waiver.

Most respondents recognized the waiver design as the best that could be achieved within the state’s environment at the time. State officials noted that, when designing the waiver, they were faced with the trade-off of covering fewer people with full benefits versus covering more people with limited benefits, and that they chose the route of providing “less to more.” During the waiver development process, advocates expressed concerns about increased demands on the existing safety net of primary care providers and the absence of a formalized system for providing Primary Care Network enrollees inpatient hospital and specialty care. However, advocates and state officials recognized that the waiver was a financially and politically feasible option for the state at the time. In state fiscal year 2002, the state was facing a nearly \$200 million budget shortfall.⁴ As such, no new money was available for a coverage expansion. The waiver did not require additional state funds and leveraged new federal funds by refinancing the previously fully state-funded UMAP program with federal match funds. Further, state officials, advocates, and legislative staff noted that legislators were willing to support the waiver because it gave the state the authority to cap enrollment and, thus, the ability to quickly limit program costs. Overall, respondents were generally supportive of the state’s effort to expand coverage, even though there were some concerns about the program design. Most were taking a “wait and see” attitude to see how well the program design would work in practice.

Certain unique aspects of the Utah community made the waiver design feasible. Almost all respondents indicated that Utah could implement a program that relies so heavily on donated and charity care because the community has such a strong history of and belief in providing charity. Respondents also recognized that Utah has a small and close-knit group of state officials, advocates, providers, and other key stakeholders that place a strong emphasis on working together. This helped enable the state to garner support for the waiver and facilitated its quick implementation.

Implementation

The state implemented the waiver very quickly, which provided rapid access to primary care coverage but also created challenges. The waiver proposal was approved in early February 2002 and implemented five months later in July 2002. State officials reported pursuing this quick implementation schedule in order to get the program up and running as fast as possible to begin giving people access to primary care. This fast implementation schedule enabled the state to quickly expand coverage for primary care services, but it also appeared to create some challenges. According to the state’s quarterly reports, in some cases, policies and practices regarding coverage and payment for benefits were still being developed after the waiver was implemented. Advocates, providers, and state officials noted that state staff, providers, and other key stakeholders were not adequately prepared for the Primary Care Network program to begin operations and that there was a substantial amount of confusion surrounding the program when it began enrollment.

Orientation sessions were challenging for state staff and beneficiaries. Orientation sessions were mandatory for Primary Care Network beneficiaries, which more than quadrupled class sizes

⁴ <http://www.governor.utah.gov/dea/ERG/ERG2002/BudgetHB.PDF>

and greatly increased the burden on orientation staff.⁵ According to state reports, orientation sessions were also difficult for staff because some enrollees were frustrated or confused during orientation sessions.⁶ When the waiver was initially implemented, staff explained all three Medicaid programs—Traditional Medicaid, Non-Traditional Medicaid, and Primary Care Network—during each orientation session. State officials reported that many individuals had difficulty understanding the multiple programs, particularly those in households with family members in more than one program. They also noted that, in some cases, individuals became upset when they learned that they had fewer benefits and more cost sharing than others. In particular, the former UMAP population was frustrated with the loss of the UMAP program and the limits of Primary Care Network benefits.⁷ The state addressed these issues by conducting orientation sessions solely for Primary Care Network enrollees. However, this created other challenges—for example, individuals with children receiving Traditional Medicaid had to return for a separate orientation session.⁸ State officials also noted that there were no formal informational materials available for beneficiaries when the waiver was implemented. Staff developed some very basic materials that could be used in the short term, but the lack of a comprehensive set of materials, particularly a participating provider list, proved problematic. According to respondents, many beneficiaries were confused about the program and experienced difficulties locating participating providers.

Providers noted that they lacked important information at implementation. Providers and state officials commented that many providers did not know which services were covered for the new Primary Care Network and Non-Traditional Medicaid programs when the waiver was implemented. Further, providers reported that they lacked adequate instructions on how to bill for services under the new programs and regarding how the specialty referral program operated. Providers also reported confusion due to new insurance cards that were issued to beneficiaries. The new cards were color-coded to denote whether a beneficiary was in Traditional Medicaid, Non-Traditional Medicaid, or the Primary Care Network; the cards did not have any language denoting the beneficiary’s program. Because providers generally make black and white photocopies of insurance cards for their charts, they were unable to determine in which programs their patients were enrolled, and, as such, which services were covered. DOH was notified of this problem, and the cards were later changed and reissued.

Enrollment

In the first year of operations, the state enrolled over 1,000 people per month in the Primary Care Network, reaching its enrollment cap of 19,000 adults in November 2003. In the months following, enrollment declined reflecting program attrition, reaching less than 15,000 toward the end of May 2004. Since then, the state has held a number of brief open enrollment periods, and, as of May 28, 2005, 18,088 people were enrolled. State enrollment data show that 60% of enrollees are parents and over two-thirds (67%) have incomes below poverty, with over four in ten (41%) having incomes below 50% of poverty. While UMAP enrollees were intended to transition to the Primary Care Network, as of late May 2005, less than one in five (18%) of the 3,500 former UMAP enrollees were enrolled.

⁵ Primary Care Network of Utah, Quarterly Report, December 31, 2002.

⁶ Ibid

⁷ Ibid

⁸ Ibid

Enrollment in the Covered at Work premium assistance program has been limited. As of late May 2005, 72 adults were enrolled the Covered at Work program. Further study is needed to determine why enrollment in the Covered at Work program has been so limited. One reason cited by state officials is that employers often only have open enrollment periods for their coverage once a year, limiting the opportunities eligible individuals have to utilize Covered at Work assistance. Other analysis of premium assistance programs has also found that limited availability of employer-sponsored coverage among low-income workers and difficulty affording premium costs also contribute to low enrollment levels.⁹

Advocates and some providers commented that the \$50 enrollment fee was unaffordable for a number of eligible adults, particularly the lowest income adults. State enrollment data also suggest affordability problems for some eligible adults. As of December 2004 (the most recent date for which application denial/closure reasons were included in state enrollment data), one in five (20%) denied or closed Primary Care Network applications were due to unpaid enrollment fees. An additional 26% were due to lack of information; some of these individuals may not have completed the application process because they could not afford the fee. State officials and advocates noted that some groups in the community developed “sponsorship” programs to help beneficiaries pay the enrollment fee, but access to this assistance is inconsistent across the state and quite limited outside of the Salt Lake City area.

In response to affordability problems, the state reduced the enrollment fee to \$15 for individuals receiving General Assistance welfare payments and to \$25 for other adults with incomes below 50% of poverty. While this helped some individuals, respondents commented that others still had difficulty paying the reduced fees. State officials recognized that the fee has created barriers for some individuals but they also commented that they view the fee as an important program component because they believe it helps individuals to value their care, encourages them to use care appropriately, and assists in preparing them for a transition to private coverage.

Advocates and providers noted that some eligible adults have not enrolled because they do not perceive the Primary Care Network’s benefits as worth the cost of the enrollment fee. They remarked that this was primarily an issue for individuals formerly enrolled in the UMAP program, since they generally have significant health care needs that require specialty care that is not covered. They also noted that some individuals prefer to self-pay for care at community health centers when they need services rather than paying the Primary Care Network enrollment fee and that some individuals plan to wait until they need care before they pay the fee.¹⁰ Finally, state officials and advocates noted that some individuals may not enroll because of stigma associated with the Medicaid program, particularly individuals in small communities. Officials noted that they have made efforts to market the Primary Care Network in ways that reduce this stigma.

⁹ Alker, Joan, “Serving Low-Income Families through Premium Assistance: A Look at Recent State Activity,” Kaiser Commission on Medicaid and the Uninsured, October 2003.

¹⁰ However, they may not be able to enroll if enrollment is closed at the time they seek coverage.

Views on Donated Specialty and Hospital Care Systems

Some respondents noted that the lack of coverage for specialty care in the Primary Care Network was creating significant challenges for enrollees and providers. Advocates and providers commented that, although well-intentioned, the donated care referral system does not guarantee Primary Care Network beneficiaries access to necessary and timely specialty care and does not provide good continuity of care. It was noted that it is particularly difficult to get individuals access to procedures, because they often require donation of more than one medical professional’s time, as well as a medical facility or equipment to perform the procedure. It was also noted that individuals outside of the Salt Lake City area have increased difficulty accessing specialty care, as there is not an existing network of providers willing to donate care in these areas. Salt Lake City residents benefited from a pre-existing network of donated care organized by the nonprofit Health Access Project, which agreed to help find specialty care for a limited number of PCN enrollees each month through their network of over 400 participating physicians in the Salt Lake City area.

Respondents commented that some primary care providers are stretching the scope of their services by providing care that they would usually refer to a specialist in order to obtain Primary Care Network coverage for the services. Some providers were concerned about the potential liability they may face if they recommend a treatment or make a referral for which the patient is not covered. As a result of such concerns, as well as the overall increased program complexity, respondents noted that some providers are no longer participating in Medicaid or are limiting their care to existing Medicaid patients and not accepting new Medicaid patients.

Respondents noted that Primary Care Network enrollees are generally able to access hospital care, but they expressed concerns about the donated hospital care system. The state made an informal agreement with the hospitals to provide a set amount of donated charity care for Primary Care Network enrollees—up to \$10 million annually. State officials said this amount was determined based on the amount hospitals were estimated to be spending on uncompensated care for UMAP enrollees in the years prior to the waiver. Officials and hospital representatives commented that the amount was slightly higher amount than what the hospitals were paying in uncompensated care for UMAP enrollees, but that the hospitals agreed to this amount because their spending for enrollees would be capped at this level. According to state officials and the hospitals, no plans were made for if the \$10 million cap was reached. In more recent communications, hospitals have reported that they annually exceed the cap, that there is an inequitable distribution of the donated funds across the state's hospitals, and that there is still no formal arrangement in place to help hospitals defray additional uncompensated care costs after the cap is reached.

A “dummy claims” system was designed to track expenditures toward the cap—hospitals file claims for care of Primary Care Network enrollees and the costs associated with these claims count toward the cap. Hospital representatives noted that they were not sure how accurate this expenditure tracking system is, as the hospitals have limited incentive to file claims for which they do not receive actual reimbursement. The state formed a formal utilization review committee that reviews whether specific hospital claims should count toward the cap. Those claims that are not approved become “private pay” and, thus, become a debt for the individual.

Views on Non-Traditional Medicaid Reductions

The reductions in coverage for parents in Non-Traditional Medicaid received little attention. Parents covered by Non-Traditional Medicaid experienced benefit reductions and cost sharing increases under the waiver. Soon after the waiver reductions were implemented, the state legislature also approved a number of benefit reductions and cost sharing increases outside of the waiver to address growing budget problems. These changes affected the parents covered by Non-Traditional Medicaid as well as other adult Medicaid beneficiaries who were not impacted by the waiver (e.g., elderly and disabled adults). Overall, respondents' comments regarding waiver reductions for parents were fairly limited. Generally, they did not view the waiver reductions as a separate or more significant issue than the reductions approved by the state legislature, and most did not feel that the changes had significantly impacted beneficiaries' access to care. However, a few respondents commented that some Non-Traditional Medicaid beneficiaries were experiencing problems due to both the waiver and other reductions. For example, they noted that the loss of dental coverage has been problematic for some individuals as well as the new limits on rehabilitation services, particularly for individuals needing rehabilitation following surgery.

IV. CONCLUSION

The interviews for this case study were conducted soon after the waiver was implemented, allowing little time for the impacts of the waiver to fully develop. However, these findings offer insights into the waiver development, design, and implementation process, providing some important lessons.

The findings from Utah show that a state can utilize waiver flexibility to quickly expand coverage for some services to a limited group of previously uninsured people. They also illustrate the strong interest in coverage among low-income and poor adults, who are not eligible for Medicaid in many states.

Further, Utah's experience highlights the importance of involving stakeholder groups in the design of any major program change and of educating relevant groups and preparing necessary materials prior to implementation. While the state's fast design and implementation process allowed it to rapidly begin expansion enrollment, the lack of key stakeholder involvement and education created significant challenges.

Finally, Utah's experience shows that waiver coverage expansions are limited by their fiscal constraints, which can drive restrictions on both the number of people that can enroll and the scope of benefits for which they are covered. Providing limited benefits may enable a state to cover more people, but may leave beneficiaries and providers facing significant challenges to assuring access to uncovered care.

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