July 2004

Overview of the Utah Section 1115 Waiver

On February 8, 2002, the Secretary of Health and Human Services (HHS) approved a "Section 1115" Medicaid waiver proposal submitted by the state of Utah. Utah's waiver allows the state to make significant changes in its Medicaid program. The waiver reduces coverage for previously eligible parents and uses the "savings" from this reduction to finance an expansion that provides a narrow benefit package to some adults who were not previously eligible for Medicaid. Thus, while more people qualify for Medicaid-funded coverage under the waiver, the initiative is not expected to cost the federal government or the state more than would have been spent without the expansion. According to longstanding federal practice, all Section 1115 waivers must be "budget neutral" for the federal government and, thus, cannot result in increased federal spending.

Utah's waiver accomplishes budget neutrality in several ways:

- Per person expansion costs are low. Newly eligible adults have benefits limited to primary care, with no coverage for services such as hospital care (other than emergency care), specialty care, and mental health services. They also pay an enrollment fee and co-payments.
- The state can limit spending by restricting the number of people who enroll in the expansion (without a waiver, Medicaid rules would require the state to enroll all eligible persons who apply).
- The state offset the costs of the expansion with reductions in benefits and increased cost sharing for low-income parents who were eligible for Medicaid prior to the waiver (those receiving cash assistance "TANF" benefits, those who recently left TANF for employment, and those who are medically needy and spend down to qualify).

Utah implemented its waiver on July 1, 2002. The state estimates that, prior to the waiver, there were 152,000 uninsured adults in the state.[1] Also, there were about 3,500 adults who were enrolled in the fully state-funded Utah Medical Assistance Program (UMAP), who became eligible for the waiver expansion. The state closed enrollment to adults eligible for the expansion in November 2003, when about 19,000 adults were enrolled. As of May 2004, about 14,700 adults were enrolled in the waiver expansion, including about 880 former UMAP recipients.[2] Over 50,000 applications for the expansion had been denied as of May 2004.[3] Over half of the denials were due to lack of applicant information or nonpayment of the enrollment fee,[4] suggesting that people may be facing procedural and/or financial barriers to enrollment. The impacts of the benefit reductions and increased cost sharing for previously eligible parents and of the significantly reduced benefit package for newly eligible adults are being evaluated.

An approved waiver amendment was implemented in August 2003. The amendment allowed the state to provide a $50 individual and $100 family subsidy for the purchase of private coverage to people who would be eligible for the expansion but who have access to employer sponsored insurance. As of May 2004, 55 adults were enrolled in the program.

The attached Utah Section 1115 Waiver fact sheet describes the initiative in more detail.

[1] Betit, R., "Background on Utah's New Medicaid Waiver," February 9, 2002.
[2] Primary Care Network Enrollment as of May 2004, Utah Department of Health
[3] Ibid.
[4] Ibid.

UTAH SECTION 1115 WAIVER

Status as of July 2004

- Submitted November 26, 2001, approved February 8, 2002, and implemented July 1, 2002
- Amendment submitted November 8, 2002, approved May 30, 2003, and implemented August 2003
- PCN enrollment closed November 2003

Overview

- Utah's approved waiver allows the state to use Medicaid funds to provide a significantly restricted benefit package, called the "Primary Care Network" (PCN), to parents and other adults with incomes below 150% of poverty, who were previously ineligible for Medicaid and who generally do not have access to employer-sponsored insurance (ESI). Some adults eligible for the "PCN" received somewhat broader services under a state-funded program prior to the waiver. All "PCN" beneficiaries pay an enrollment fee and copayments. The state can cap PCN enrollment based on availability of state funding. Enrollment in the PCN is currently closed.
- The waiver also allows the state to offset the cost of the "PCN" expansion by increasing cost sharing and reducing benefits for about 17,600 current Medicaid beneficiaries, primarily parents who receive TANF or who recently left TANF because of employment. The state refers to this reduced coverage as "Non-Traditional Medicaid."
- The waiver does not affect persons 65 and older and blind or disabled individuals who were eligible prior to the waiver (those with incomes below poverty or who spend down to qualify for coverage) or previously eligible children, pregnant women, and women with breast or cervical cancer; these groups continue to receive the full Medicaid benefit package, which the state refers to as "Traditional Medicaid." However, the state legislature approved benefit reductions and copayment increases for non-pregnant, adult Traditional Medicaid enrollees that took effect in 2003.
- In February 2003, the state sent a notice to providers, advising them that they could deny services to Traditional Medicaid, Non-Traditional Medicaid, and PCN beneficiaries who are unable to pay required copayments.
- The approved amendment, known as Covered at Work, allows the state to use Medicaid funds to provide premium assistance to parents and other adults who would be eligible for the "PCN," but who have access to employer-sponsored insurance.[5] Participating individuals receive subsidies for up to five years. Generally, all individuals receive the same subsidy; monthly subsidies are $50 for an employee only and $100 for an employee and his or her family for the first two years and then decrease over the remaining three years.[6] There are no minimum requirements for subsidized coverage other than the state's general insurance laws; as such, subsidized coverage can be more limited than and have higher cost-sharing than the state's Medicaid coverage. The state can cap enrollment in Covered at Work based on availability of state funding.

Individuals Covered By Waiver

	Eligible for Non-Traditional Medicaid	Eligible for the PCN (Subject to an enrollment cap)	Eligible for Covered at Work (Subject to an enrollment cap)
Eligible Prior to Waiver	• Parents with incomes below TANF eligibility levels (0-50% FPL) • Parents eligible for TMA • Parents with high medical expenses who "spend down" to qualify	(No individuals who were eligible for Medicaid prior to the waiver will be in the "PCN")	(No individuals who were eligible for Medicaid prior to the waiver would receive premium assistance)
Newly Eligible Under Waiver (Some previously eligible for state-funded program)	(No newly eligible individuals will receive "Non-Traditional Medicaid")	• Parents 50-150% FPL • Other adults 0-150% FPL Must be age 19-65, uninsured for ≥6 months, and generally not have access to ESI. (Those with access to ESI & a premium share >15% of monthly income are eligible.)	• Parents 50-150% FPL • Other adults 0-150% FPL Must be age 19-65, uninsured for ≥6 months and have access to ESI and a premium share >5% of monthly income.

Table Notes:
TMA refers to Transitional Medical Assistance and primarily includes parents transitioning from welfare to work
Some newly eligible adults previously received services through the state-funded Utah Medical Assistance Program, which provided care for acute and life-threatening conditions to single childless adults with income <$337 per month (46% FPL in 2002).
Other adults include blind and disabled adults whose incomes exceed blind and disabled eligibility limits that existed prior to the waiver.

[5] They also must have a required premium share that exceeds 5% of their monthly income. Those whose share is less than 5% of monthly income are not eligible. Those whose share exceeds 15% of monthly income can choose between receiving premium assistance and enrolling in the "PCN."
[6] The subsidy decreases by 20% each year over the remaining three years. In all years, the subsidy will not exceed the employee's premium share; if the premium share is less than these amounts, the subsidy will only cover the cost of the premium share.

Premiums/Enrollment Fees, Benefits, and Cost Sharing

(This table shows coverage and cost sharing for a selected list of benefits; other benefits not shown on this list may also be covered.)

	Traditional Medicaid		Waiver Coverage: Non-Traditional Medicaid		Waiver Coverage: PCN		Covered at Work
Premiums/ Enrollment Fees	None		None		$50 enrollment fee.		No minimum benchmark standards other than state's general insurance laws. Required premiums, cost sharing, and covered benefits will vary by insurance policy. Benefits may be more limited than and cost sharing may be higher than the state's Medicaid benefit packages.
Groups Exempt from Cost Sharing	Children; Pregnant women; Institutionalized individuals;		None		American Indians/Alaska Natives when using IHS or tribal system		
Benefits & Cost Sharing	**Covered**	**Benefit Limits Copayments/ Coinsurance**	**Covered**	**Benefit Limits & Copayments/ Coinsurance**	**Covered**	**Benefit Limits & Copayments/ Coinsurance**	
Inpatient Hospital	✓	$220 per admission	✓	$220 per admission			
Outpatient Hospital	✓	$2 per visit	✓	$3 per visit			
Emergency Room	✓	$6 for nonemergent use	✓	$6 for nonemergent use	✓	$30 per visit	
Physician Services	✓	$2 per visit **$3 per visit for non-pregnant adults in Feb 2003**	✓	$3 per visit Preventive services exempt from copayments	**L**	Coverage only for primary care (no specialty care) $5 per visit Preventive services exempt from copayments	
Lab and X-ray	✓		✓		**L**	Coverage only for primary care services 5% coinsurance for lab >$50 and x-ray >$100	
Ambulance	✓		✓		✓		
Non-emergency Transportation	✓						
Home Health Care	✓		✓				
Long-term Care	✓						
Prescription Drugs	✓	$1 per prescription; up to $5 per month **$3 per prescription, up to $15 per month for non-pregnant adults in Feb 2003**	**L**	7 drugs/month; exceptions allowed $2 per prescription; full cost for name brand when generic available	**L**	4 drugs/month; no exceptions $5 per generic; 25% of cost for name brand when no generic and full cost when generic available	
Mental Health and Chemical Dependency	✓		**L**	30 inpatient & 30 outpatient days/year $3 per outpatient visit			
Durable Medical Equipment	✓		✓		**L**	Coverage only for equipment for recovery 10% coinsurance	
Dental	✓	Adult coverage limited to relief of pain and infection.	✓	Coverage limited to relief of pain and infection.	✓	Coverage limited to relief of pain and infection. 10% coinsurance	
Vision	✓	Only pregnant women & children covered **Non-pregnant adult coverage eliminated Jan 2003**	**L**	$30 benefit limit; one exam/year; eyeglasses not covered	**L**	$30 benefit limit; one exam/year; eyeglasses not covered $5 per visit	
Hearing							
PT, OT, SLP	✓	Only pregnant women & children covered **Non-pregnant adult coverage eliminated Jan 2003**	**L**	16 visits/year for PT & OT combined; SLP not covered $3 per visit			
Other Provisions			$500 out-of-pocket maximum per enrollee, per calendar year		$1,000 out-of-pocket maximum per enrollee, per calendar year		

TABLE NOTES: L = Limits on amount, scope, or duration of benefit as compared to state's basic Medicaid benefit package.
PT = Physical Therapy, OT = Occupational Therapy, SLP = Speech Language Pathology Therapy

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