

REPORT 1 OF THE REPORT OF THE COUNCIL ON MEDICAL SERVICE (A-05)
State Options to Improve Coverage for the Poor
(Reference Committee A)
(June 2005)

EXECUTIVE SUMMARY

Since 2000, the number of people living in low-income families has increased by 8 million, and 5 million more people have become uninsured. For the first time, states will collectively spend more on Medicaid than any other program, including K – 12 education. Continuing levels of unemployment, combined with a slow recovery in tax revenues, has made it difficult for many states to initiate new efforts to improve coverage for the poor beyond public sector program expansions or waivers. Nonetheless, a few states have pursued alternative approaches such as partnering with the private sector to contribute to employer-sponsored coverage premiums, developing health-care related ballot initiatives, and even attempting “comprehensive” health care coverage strategies.

This report reviews the current status of the Medicaid program, including the waiver process and the ongoing challenges facing the program; describes some alternative approaches to improving coverage to the poor; and highlights the varied initiatives undertaken in the following five states: Arkansas, Florida, Maine, North Carolina, and Utah. The Council has focused on these states to simply provide a glimpse of some selected strategies for improving health insurance coverage for the poor, and cautions that these efforts by no means encompass the full range of possible approaches being undertaken by states. In addition, the report briefly describes alternative approaches pursued by states, such as partnering with the private sector to contribute to employer-sponsored coverage premiums, and developing health-care related ballot initiatives.

Given competing priorities at the national level, combined with a still struggling economy, the Council on Medical Service believes that a state-based approach continues to be the most politically viable strategy at this time for achieving some level of progress in improving health insurance coverage for the poor.

As a result, the Council recommends that the AMA reaffirm existing policy, which advocates for changes in federal rules and financing to support the ability of states to develop and test different models for improving health insurance coverage for patients with low incomes without incurring new and costly unfunded federal mandates or capping federal funds. The Council also recommends that the AMA urge national medical specialty societies, state medical associations, and county medical societies to become actively involved in and support state-based demonstration projects to expand health insurance coverage to low-income persons. In addition, the Council recommends that the AMA encourage state governments to maintain an inventory of private health plans and design an easily accessible, consumer-friendly information clearinghouse for individuals, families, and small businesses on available plans for expanding health insurance coverage.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1 - A-05
(June 2005)

Subject: State Options to Improve Coverage for the Poor

Presented by: William H. Beeson, MD, Chair

Referred to: Reference Committee A
(Alfred Herzog, MD, Chair)

1 At the 2004 Annual Meeting, the House of Delegates adopted Resolution 118 (A-04), which, in
2 part, calls for the Council on Medical Service to conduct a study of “various alternatives and
3 demonstration projects for expanding health insurance coverage for low-income persons and on
4 progress concerning development of new state options for improving the effectiveness of public
5 health safety net programs.” The Board of Trustees referred the requested study to the Council on
6 Medical Service for a report back to the House at the 2005 Annual Meeting.

7
8 Any discussion of state options to improve health care for the poor implicitly suggests inclusion of
9 state Medicaid programs. Medicaid continues to be the central feature of the nation’s current
10 strategy to provide access to health care for low-income Americans. Although the federal and state
11 governments share the responsibility for financing the program, Medicaid represents either the first
12 or second largest line item in every state budget. Expanding the Medicaid program and the State
13 Children’s Health Insurance Program (SCHIP) have been traditional means to address the poor and
14 uninsured populations. Despite the distress that Medicaid is facing, states have found creative
15 ways to meet the needs of low-income individuals in an incremental fashion.

16
17 With the assistance of the AMA’s Advocacy Resource Center, the Council conducted an informal
18 survey of state medical associations to gather information on state efforts to improve coverage for
19 the poor. Although 20 states responded, few addressed new and innovative efforts outside of the
20 traditional expansions or waivers of Medicaid and SCHIP programs. At the Council’s September
21 2004 meeting, representatives of the American Academy of Family Physicians, the American
22 Academy of Pediatrics, the American College of Emergency Physicians, the American College of
23 Obstetricians and Gynecologists and the American College of Physicians met to share information
24 for possible inclusion in the report. All five organizations were co-sponsors of Resolution 118 (A-
25 04). The Council appreciates the timely and thoughtful information provided by members of the
26 Federation.

27
28 This report reviews the current status of the Medicaid program, including the waiver process and
29 the ongoing challenges facing the program; describes some alternative approaches to improving
30 coverage to the poor; and highlights the varied initiatives undertaken in five selected states.

31 BACKGROUND

32
33
34 As previously discussed in Council on Medical Service Reports 8 (A-03) and 1 (I-03), the
35 Medicaid program was enacted as Title 19 of the Social Security Act (SSA) in 1965, as an
36 afterthought to the enactment of Medicare. Medicaid’s establishment as a joint federal and state
37 venture, unlike Medicare’s federal design, preserved state control over programs for the poor. In

1 1997, the SCHIP program was created to extend coverage to children in families with incomes too
2 high for Medicaid eligibility, but too low to purchase their own coverage.

3
4 The federal and state governments finance Medicaid jointly, with the federal government matching
5 state Medicaid spending for specific people and benefits, based on a formula that compares each
6 state's per capita income to the national average. The federal share of Medicaid spending varies by
7 state, known as the Federal Medical Assistance Percentage (FMAP), and ranges from 50% to 77%,
8 with an average of 57% of funding coming from the federal government. The formula used to
9 calculate the FMAP seeks to narrow the gap between relatively wealthy and relatively poor states
10 (measured as per capita income) by providing higher rates to poorer states. In order to receive
11 federal matching funds, states are required to provide a set of mandatory benefits to a mandatory
12 group of beneficiaries. Mandatory populations include children through age 5 at or below 133% of
13 the federal poverty level (FPL), children aged 6-19 in families with incomes at or below 100% of
14 FPL, certain adults in families with eligible children, pregnant women with incomes at or below
15 133% of FPL, disabled and elderly social security income (SSI) beneficiaries, certain working
16 disabled, and Medicare beneficiaries who are also eligible for Medicaid.

17
18 Medicaid benefits vary widely from state to state. Within states, benefits also vary depending on
19 age and other eligibility categories. The Medicaid statute requires participating states to provide
20 certain mandatory benefits in order to receive federal matching funds. The statute also permits
21 states to receive matching funds for statutorily defined optional benefits. Roughly two-thirds of all
22 Medicaid spending is for optional benefits. Optional benefits include prescription drugs;
23 intermediate care facilities for individuals with mental retardation (ICFs/MR); personal care
24 services authorized by a physician; case management services; prosthetics; rehabilitative services;
25 physical therapy; clinic services; and diagnostic, screening, and preventive services.

26
27 States have wide discretion to determine which benefits to offer Medicaid beneficiaries, and they
28 can institute "nominal" cost-sharing for beneficiaries other than children, pregnant women, any
29 terminally ill patients receiving hospice care, and the medically needy who had to "spend down" to
30 qualify for Medicaid. Specifically, states are allowed to charge a deductible of up to \$2 per month
31 per family, a co-payment ranging from fifty cents to \$3, and a co-insurance requirement of 5% of
32 the payment rate for the item or service. States may also charge higher cost-sharing, up to twice
33 the "nominal" amounts, for non-emergency services provided in a hospital emergency room, if it
34 can be shown that the beneficiary had alternative non-emergency outpatient options that were
35 available and accessible.

36 37 Medicaid Waivers

38
39 There are multiple methods to obtain waivers to permit experimental coverage projects under the
40 Social Security Act (e.g., 1915(b) Managed Care Waivers, 1915(c) Home and Community Based
41 Service Waivers, 1915(b/c) Combination Waivers, Section 1115 waivers, Medicaid Managed Care
42 Waivers, and amendments to Section 1931). Section 1115 waivers and Section 1915(b) waivers
43 are frequently used to enhance a state's flexibility to cover those with low-incomes.

44
45 Section 1115 of the Social Security Act authorizes the Secretary of the Department of Health and
46 Human Services (HHS) broad authority to waive provisions in Title 19, the Medicaid Statute.
47 Section 1115 waivers were developed to provide mechanisms for states to use federal funds in
48 ways that would test and evaluate innovative coverage and delivery approaches. Section 1115

1 waivers are not new; rather they have been used to authorize programs over the past 40 years. The
2 waiver process is experimental in design, and while some waiver programs have met success,
3 others have faced major challenges.
4

5 Waivers may extend coverage to children, pregnant women, those with HIV/AIDS, and low-
6 income adults. In addition, waivers can be used to extend pharmacy coverage to certain low-
7 income or disabled individuals, or they can be used to extend family planning services and supplies
8 to an expanded population. There is no single standardized application format, because each 1115
9 proposal is a unique research and demonstration effort designed to allow states flexibility to test
10 new ideas of policy merit.

11
12 In August 2001, HHS launched a major new Section 1115 waiver initiative, the Health Insurance
13 and Flexibility and Accountability (HIFA) initiative. The goal of HIFA is to “increase the number
14 of individuals with health insurance coverage within current level Medicaid and SCHIP resources.”
15 Specifically, one component of the federal Section 1115 HIFA waiver policy is that waivers that
16 expand coverage must be “budget neutral” for the federal government. Between 2001 and 2004, 10
17 state HIFA demonstrations were approved. For example, the state of Utah received approval to
18 implement a Medicaid 1115 waiver to help finance an expansion of coverage to low-income adults
19 that did not previously qualify for health care coverage under Medicaid. Utah’s HIFA waiver
20 program is described later in this report.

21
22 The Social Security Act prevents states from mandating that beneficiaries receive their coverage
23 from a single provider or health plan, and requires that the state provide beneficiaries with the
24 freedom to choose comparable services across the entire state. However, Section 1915(b) waivers
25 allow states to enroll beneficiaries in a mandatory managed care program. For example, North
26 Carolina initiated a primary care case management program that uses a waiver for a demonstration
27 project that may limit a beneficiary’s care to a particular health care provider. North Carolina’s
28 Section 1915(b) waiver program is also described in this report.

29 30 Medicaid Challenges

31
32 Approximately two-thirds of Medicaid enrollees are in working families. Medicaid also is the
33 single largest insurer of children and maternity care in the United States. In sum, the Medicaid
34 program is the nation’s health care safety net providing health care services to more than 52 million
35 low-income children, families, seniors and people with disabilities in Fiscal Year (FY) 2004. Since
36 2000, the number of people living in low-income families has increased by 8 million, and 5 million
37 more people have become uninsured. Medicaid enrollment growth is expected to increase by 4.7%
38 in FY 2005 (State Fiscal Conditions and Medicaid, Kaiser Family Foundation, November 2004).

39
40 In addition, approximately 42% of all Medicaid spending for benefits is for elderly and disabled
41 individuals who are dually eligible for Medicare and Medicaid (The Kaiser Family Foundation,
42 Medicaid: Issues in Restructuring Federal Financing, January 2005). As a result of the Medicare
43 Modernization Act of 2003 (MMA), “dual eligibles” will be provided drug benefits under
44 Medicare Part D beginning in January 2006, and this group will no longer be eligible for drug
45 benefits under Medicaid. However, through a repayment system known as “clawback,” states will
46 have to pay the federal government a monthly sum to help cover prescription drug benefits under
47 Medicare for “dual eligibles.” For all states, the total 2006 contribution is estimated at \$6 billion,
48 and total contribution is expect to rise to \$15 billion by 2014. Accordingly, many states are

1 concerned that providing drug coverage for these groups will shift more financial responsibility to
2 state Medicaid programs.

3 In the aggregate, the cost of meeting acute and long-term care needs of the poor, elderly, and
4 disabled is growing faster than current state tax revenues. As a result, the Kaiser Commission of
5 Medicaid and the Uninsured reported that between FY 2002 and FY 2005:

- 6
- 7 • All 50 states froze or reduced health care provider payment rates and implemented prescription
8 drug cost controls;
- 9
- 10 • 38 states imposed eligibility restrictions, and 34 states reduced benefits; and
- 11
- 12 • 20 states imposed new or higher beneficiary co-payments.
- 13

14 The impact of limited or reduced payment rates to physicians and other health care providers will
15 likely continue to have an adverse affect on access to care for Medicaid beneficiaries. When faced
16 with financial constraints, states are likely to reduce payment rates to providers because this
17 strategy can be implemented easily and quickly, without reducing the numbers of Medicaid
18 enrollees. As a result, physicians, especially those who practice in rural and inner-city areas, will
19 be faced with difficult decisions regarding whether to continue to accept Medicaid patients.

20

21 Furthermore, the National Association of State Budget Officers reported earlier this year that for
22 the first time, states will collectively spend more on Medicaid (21.9% of total state spending) than
23 any other program, including K – 12 education (21.5% of total state spending). In 22 states,
24 Medicaid already has surpassed primary education as the largest expense.

25

26 Over the years, some states have developed a variety of strategies to maximize payments under
27 Medicaid using disproportionate share hospital (DSH) payments and upper payment limit (UPL)
28 arrangements. Some of these financing arrangements have resulted in billion of dollars in federal
29 expenditures with little or no state matching funds. The Bush Administration recently suggested
30 that the Medicaid program could save perhaps up to \$60 billion over 10 years by addressing the
31 issues surrounding intergovernmental transfers, reducing what it pays for prescription drugs, and
32 closing the loopholes that allow older Americans to “spend down” to Medicaid eligibility.

33

34 As a result, the nation’s governors are continuing to work with their state legislators, members of
35 Congress, and the Administration to further define the “flexibility” of state Medicaid programs in
36 ways that would minimize the shift to state budgets. Accordingly, many of the state-based
37 programs that are discussed in this report should be viewed in the context of imminent changes to
38 the financing structure of the Medicaid program.

39 Alternative Efforts to Improve Coverage to the Poor

40

41

42 Continuing levels of unemployment, combined with a slow recovery in tax revenues, has made it
43 difficult for many states to initiate new efforts to improve coverage for the poor beyond public
44 sector program expansions or waivers. Nonetheless, a few states have pursued alternative
45 approaches such as partnering with the private sector to contribute to employer-sponsored coverage
46 premiums, developing health-care related ballot initiatives, and even attempting “comprehensive”
47 health care coverage strategies.

1 For example, in West Virginia, the State Coverage Initiatives program provided a \$1.36-million
2 demonstration grant in March 2004. West Virginia passed a new law to create a public/private
3 partnership between the West Virginia Public Employees Insurance Agency and health insurance
4 companies. Small companies with fewer than 50 employees, that have had no coverage for at least
5 a year, are able to access the state purchasing pool if 75% of their eligible employees participate.
6 Participating companies pay 50% of the premium costs. The state estimates that the costs to small
7 businesses will be 20-25% below the usual market rates. After the first year, participating private
8 insurance companies must be able to demonstrate a minimum anticipated medical-loss ratio of 77%
9 to remain eligible (the current requirement is a 73% medical loss ratio).

10
11 The 2004 elections also provided opportunities for states to improve state health care programs
12 through the use of ballot initiatives. Voters in Colorado, Oklahoma, and Montana approved
13 tobacco tax increases to enhance health care efforts in their respective states. In Colorado, for
14 example, voters overwhelmingly approved a \$0.64 sales tax increase on tobacco products that is
15 expected to bring in \$175 million to be used for health programs for the underserved. Forty-six
16 percent of the funds will be used to expand Medicaid and SCHIP, 19% will be used toward
17 improved funding for community health centers, 16% will be used toward cancer, heart, and lung
18 research programs, 16% will go for tobacco prevention and cessation programs, and 3% will be
19 provided to local government entities.

20 21 SELECTED STATE-BASED EFFORTS TO IMPROVE COVERAGE

22
23 Based on the informal survey data received by the state medical associations and the information
24 shared by the national medical specialty society representatives, the Council has decided to
25 highlight state initiatives in Arkansas, Florida, North Carolina, Maine, and Utah as a cross-section
26 of state options to improve health care for the poor. The Council has focused on these states to
27 simply provide a glimpse of some selected strategies for improving health insurance coverage for
28 the poor, and cautions that these efforts by no means encompass the full range of possible
29 approaches being undertaken by the states.

30 31 Arkansas

32
33 In 1992, Arkansas joined with the information-technology consulting firm EDS to simplify the
34 Medicaid process with the hopes that more physicians would be encouraged to treat Medicaid
35 patients. The Arkansas Automated Eligibility Verification and Claims Submission System was
36 created to provide each Medicaid beneficiary with a picture identification card that activates
37 electronic approval of the patient's Medicaid status and submits payment directly from the State to
38 the health care provider. As a result of this technology, Medicaid became the fastest health care
39 payer in Arkansas, leading to a significant increase in the number of physicians who were willing
40 to treat Medicaid recipients.

41
42 ConnectCare/ARKids First A is Arkansas Medicaid's primary care case management program
43 which provided health care services to more than 335,000 Arkansans in FY 2003. The
44 ConnectCare program was designed to capitalize on the increased number of physicians willing to
45 accept Medicaid patients. ConnectCare allows each Medicaid beneficiary to select a primary care
46 provider from a list of participating physicians in the area. The names of primary care physicians
47 who accept Medicaid patients are publicized using a consumer-focused approach (e.g., television
48 and a 24-hour 800 hotline). Such information efforts have empowered Medicaid patients to shift

1 the focus of much of their care from the emergency room to primary care physicians. Medicaid
2 beneficiary use of ConnectCare has resulted in greater continuity of care and enhanced disease
3 management. In 1997, ConnectCare received the Ford Foundation's Innovations in American
4 Government Award.

5
6 A 2003 analysis of the program conducted by the Arkansas Foundation for Medical Care found that
7 more than 79% of respondents said it was not difficult to find a personal physician with whom they
8 were happy; to receive a referral to a specialist; to receive the care that they or their physician
9 believed necessary; or to receive health care services without any delays pending approval from
10 Medicaid/ConnectCare. In addition, previous studies determined that the use of the emergency
11 room for emergency and non-emergency care for Medicaid patients has decreased more than 50%
12 since the program's inception. According to Arkansas medical officials, ConnectCare has created a
13 mean savings of \$30 million over the former Medicaid system by increasing access to primary care
14 providers.

15 16 Florida

17
18 The Florida Health Flex program benefits the low-income population by providing uninsured
19 individuals, whether employed or unemployed, with an affordable health care product. The design
20 of the program provides flexibility for local initiatives by allowing entities other than licensed
21 insurance companies, such as community organizations and local governments, to pool their
22 resources and funding to design and establish programs for low-income individuals. By reducing
23 the reliance on costlier hospital inpatient and emergency services, Health Flex addresses
24 affordability and the issue of rising health care costs. Yet, because the program may have
25 limitations on coverage, those individuals with extensive health care needs may require non-
26 covered services that would contribute to the cost of uncompensated care.

27
28 In June 2004, "The 2004 Affordable Health Care for Floridians Act" was signed into law by
29 Governor Jeb Bush. Among the key provisions in the Act are the following:

- 30
- 31 • Creates the Florida Health Insurance Plan as a high-risk pool for uninsurable medical risks,
32 replacing the Florida Comprehensive Health Care Association; funds the Plan by premiums
33 and general revenue; and provides that the benefits to be offered by the Plan must be the same
34 as for small employer plans, which now includes a Health Savings Account (HSA) option.
35
 - 36 • Expands the Health Flex Program statewide, including an option of a catastrophic plan with
37 health flex plan; requires grievance procedures; requires the Office of Insurance Regulation
38 (OIR) to provide oversight of advertisement and marketing procedures; and retains eligibility
39 requirements.
40
 - 41 • Creates the Small Employers Access Program which establishes purchasing pools for
42 employers of 25 or fewer employees, rural hospitals, and nursing home employers. Policies
43 offered must include an HSA option.
44
 - 45 • Requires the insurance carriers of small employer to offer HSAs or Health Reimbursement
46 Arrangements (HRA) to small employers, and requires the HSA plan to offer the same benefits
47 as the standard health plan.

- 1 • Provides for the licensure of discount medical plan organizations that offer, for a fee, access to
2 providers of medical services at a discount.
3
- 4 • Requires hospitals, insurers, and federally qualified health centers to create emergency room
5 diversion programs.
6
- 7 • Authorizes “rebates” for employers and employees enrolled in a health wellness program
8 approved by the plan.
9

10 In a separate, more recent development, Governor Bush also has unveiled a proposal for Medicaid
11 reform. Proposed in January 2005, “Empowered Care” calls for increased privatization in the
12 program. Under the proposal, state officials would assign each eligible beneficiary with a “risk
13 adjusted” premium amount that would likely be determined by an actuarial firm. Beneficiaries
14 could use the premiums like a voucher to shop for health plans of their choice. Insurance
15 companies would compete to administer coverage. State officials would assist beneficiaries in
16 choosing among managed care organizations, insurance plans, provider service networks or
17 community based care systems to provide their health services. Insurance companies participating
18 in the plan would define the amount and scope of benefits they offer. Flexible accounts would be
19 used to purchase additional coverage. This proposal differs from other state plans by limiting the
20 administration of the Medicaid program, extending the partnership between the state and private
21 sectors, and shifting the responsibility to the individual to seek the best options for their care.
22

23 Maine

24
25 “Dirigo Health,” (Latin for “I lead”), is a comprehensive program that aims to ensure access to
26 coverage for up to 180,000 state residents, starting with small-business employees, the self-
27 employed, and low-income individuals. In addition to improving access by 2009, Dirigo Health
28 aims to decrease health care costs in the state, and is committed to improving quality of care to all
29 citizens.
30

31 Dirigo uses two primary methods to broaden access to care. First, Maine used its existing waiver
32 authority to expand MaineCare, the state’s Medicaid and SCHIP program. Parents with incomes
33 up to 200% of the FPL and childless adults earning less than 125% became eligible. Second, in
34 October 2004, employers could begin to enroll in DirigoChoice, a public/private health plan
35 initially formed to target businesses and municipalities with 50 or fewer employees, self-employed
36 persons, and uninsured individuals with incomes of up to 300% of the FPL. The program,
37 administered by Anthem Blue Cross and Blue Shield of Maine, offers individuals and families a
38 sliding scale of rates based on ability to pay. Employers offering this product to their employees
39 pay at least 60% of its costs, but benefit from lower rates as a result of greater risk pooling.
40

41 To enhance quality and decrease costs, Dirigo includes greater transparency marked by:

- 42
- 43 • Strengthened oversight, review, and approval of small-and large-group insurance rate filings.
44
- 45 • A requirement that hospitals maintain price lists and provide them to patients upon requests.

- 1 • A requirement that health care practitioners notify patients in writing of their charges for
2 common services.

3
4 Many policy-makers are carefully observing Maine's attempt in terms of implementation costs,
5 administration requirements, and information reporting techniques.

6 7 North Carolina

8
9 In 1991, North Carolina began a Primary Care Case Management (PCCM) program called
10 ACCESS under a 1915(b) Medicaid waiver. The goal of the program was to link Medicaid
11 recipients to primary care physicians who would provide preventative and routine care and
12 decrease the inappropriate use of the emergency room, thereby reducing program expenditures.
13 Although the program started in five counties, by 2002, all 100 of the counties in North Carolina
14 offered it. Each Medicaid enrollee is provided with a choice of a primary care physician (PCP) and
15 education about how to appropriately access his or her physician. For example, patients are given
16 instructions to call their PCP before going to any other physician, emergency room, or before
17 seeking specialty care. Once selected, the physician is responsible for managing and assuring each
18 enrollee's care. Physicians are paid a per-member per-month case management fee, and services
19 are paid on a fee-for-service basis.

20
21 In 1998, the program was enhanced with ACCESS II and III, currently referred to as Community
22 Care of North Carolina (CCNC). ACCESS II includes local physician networks that agree to
23 develop systems that integrate developmental screening and surveillance into well-child visits.
24 ACCESS III is similar to ACCESS II, but it utilizes a community-based approach. The
25 enhancement programs were designed to bring together primary care providers, local hospitals,
26 health departments, the Department of Social Services, and other community and county providers
27 to manage health care needs of Medicaid recipients. The community participants are formally
28 linked through a 501(c)(3) non-profit corporation agreement which receives the case management
29 fees and coordinates the services. Each network is responsible for managing the health care of
30 their communities by identifying high-cost health conditions, assisting physicians develop
31 protocols for screening and disease management, helping patients coordinate care, and collecting
32 and reporting program and patient information to the Division of Medical Assistance the North
33 Carolina Medicaid program administrator.

34
35 Physician participants of the ACCESS and CCNC programs are actively involved in program
36 management and refinement, which has consistently been shown to increase physician satisfaction
37 and quality of care. In addition, an analysis of the 2000-2002 time period shows that the CCNC
38 program helped to reduce the overall health care expenditures for individuals with asthma and
39 diabetes (North Carolina Rural Health Research and Policy Analysis Program, Evaluation of
40 Community Care of North Carolina Asthma and Diabetes Management Initiatives: January 2000-
41 December 2002, April 2004).

42 43 Utah

44
45 In 2002, Utah Governor Michael Leavitt (now Secretary of HHS) received approval to implement a
46 Medicaid Section 1115 HIFA waiver called the Primary Care Network (PCN), to help finance an
47 expansion of coverage to adults who lacked health insurance and were previously ineligible for
48 Medicaid. Essentially, the program created a formal entry into the health care delivery system for

1 very low-income individuals. To implement this program, the waiver sought to allow the state to
2 offset the cost of the PCN expansion by increasing cost-sharing and reducing benefits for about
3 17,600 current Medicaid beneficiaries. The eligible populations includes adults aged 19 to 54 who
4 have not had health insurance coverage for six months or more, who have annual family incomes
5 less than 150% of the FPL, and whose employers pay less than 50% of their health care benefits.
6 The PCN program is open to both working and non-working adults. As of May 2003, 43% of
7 those enrolled were employed (Profiles in Coverage: Utah's Primary Care Network, November
8 2003).

9
10 Eligible beneficiaries are able to access physician office visits, immunizations, emergency care,
11 lab, x-ray, medical equipment and supplies, basic dental care, hearing and vision screenings, and
12 prescription drugs. According to the former executive director of the Utah Department of Health,
13 the goal of PCN is to "encourage people to be proactive about getting coverage and enrollment
14 before they need to be hospitalized." Although hospital inpatient care is not covered, beneficiaries
15 can take advantage of hospital and specialty care components donated from the community. A
16 voluntary arrangement was negotiated by the Utah Department of Health and the Utah Hospital
17 Association to provide \$10 million in donated hospital care. Only those people enrolled in PCN
18 are eligible to receive the volunteered hospital inpatient services.

19
20 The Utah Office of Health Care Statistics conducted a reassessment survey after 12 months of
21 enrollment. Survey findings indicated that the new coverage improved access to primary care for
22 PCN enrollees. While the ability to access specialty care was found to be a challenge for a portion
23 of adults enrolled in PCN, researchers concluded that the 12-month evaluation period was too short
24 to demonstrate significant results of the program impact, and that future follow-up studies are
25 needed (Office of Health Care Statistics, Health Outcome Evaluation of Utah's Primary Care
26 Network (PCN): A New Medicaid Waiver, June 2004).

27
28 In August 2003, a waiver amendment known as "Covered at Work" was approved to allow Utah to
29 use Medicaid funds to provide premium assistance to parents and other adults who would be
30 eligible for the PCN, but who have access to employer-sponsored insurance. Eligible adults may
31 receive a monthly subsidy for up to five years (\$50 per individual and \$100 per family for the first
32 two years and then a decreased amount over the remaining three years). Eligibility requirements
33 for Covered at Work are similar to the eligibility requirements for the PCN. However, an adult
34 must have access to coverage and the premium share must exceed 5% of the adult's monthly
35 income. Costs are controlled by limiting the number of participants and benefits allowable. The
36 state can also cap enrollment in Covered at Work based on availability of state funding.

37 38 RELEVANT AMA POLICY

39
40 Over the past 20 years, the House of Delegates has established comprehensive AMA policy to
41 support efforts to improve health insurance coverage for the poor. Consistent with its strong
42 tradition in support of pluralism, the AMA has long recognized incremental coverage for different
43 groups of the uninsured, consistent with finite resources, as a necessary step toward universal
44 access (Policy H-165.882, AMA Policy Database).

45
46 Since the adoption of the recommendations in Council on Medical Service Report 9 (A-98),
47 "Empowering Our Patients: Individually Selected, Purchased and Owned Health Expense
48 Coverage," the Council has prepared numerous reports that have refined the AMA's current

1 proposal to expand health insurance coverage and choice. The AMA proposal includes three key
2 elements: (1) a preference for individual rather than employer ownership and selection of health
3 plans; (2) the use of income-related, refundable, advanceable tax credits toward the purchase of
4 health insurance; and (3) appropriate market regulation based on the recognition that neither free-
5 market mechanisms nor market regulations alone will fully meet the needs of those with expensive
6 medical conditions (Policies H-165.920, H-165.865, and H-165.856). As such, the low-income
7 have always been a core constituency for the AMA's reform proposal. In fact, the AMA
8 specifically supports implementation of refundable, advanceable, individual tax credits for the
9 purchase of health insurance for specific target populations such as low-income workers, low-
10 income individuals, children, and the chronically ill (Policy H-165.851[1]).

11
12 With respect to government-financed health insurance programs for the lowest-income individuals
13 and families, the AMA believes that refundable, advanceable tax credits are preferred over public
14 sector expansions as a means of providing coverage to the uninsured (Policy H-165.920[17]), and
15 that the funding for the expansion of health insurance coverage for presently uninsured children
16 should preferably be used to allow these children, by their parents or legal guardians, to select
17 private insurance rather than being placed in Medicaid programs (Policy H-165.882[1]).

18
19 In the long term, it is the policy of the AMA that the medical care portion of the Medicaid program
20 should be financed with federally issued tax credits or vouchers that are refundable, advanceable,
21 inversely related to income, and administratively simple for patients, to allow acute care patients to
22 purchase coverage individually and through programs modeled after the state employee purchasing
23 pool or the Federal Employee Health Benefits Program (FEHBP), with varying cost-sharing
24 obligations based on income and eligibility under the current Medicaid program as described
25 below:

26
27 (a) Individuals who would otherwise qualify for mandatory Medicaid eligibility groups should
28 receive tax credits or vouchers that are large enough to enable them to purchase coverage with
29 no cost-sharing obligations.

30
31 (b) Individuals who would otherwise qualify in an optional Medicaid eligibility group should
32 receive tax credits or vouchers that are large enough to enable them to purchase coverage with
33 limited cost-sharing (Policy H-165.855[1]).

34
35 In the short term, the AMA has supported greater equity within the Medicaid program through the
36 creation of basic national standards of uniform eligibility for all persons below poverty level
37 income, and the elimination of the existing categorical requirements (Policy H-290.997). The
38 AMA also has advocated that states be required to reinvest savings achieved in Medicaid programs
39 into expanding coverage for additional uninsured individuals, particularly children, through a
40 variety of mechanisms, such as providing premium subsidies or a buy-in for individuals in families
41 with income between their state's Medicaid income eligibility level and a specified percentage of
42 the poverty level, or providing vouchers for recipients to use to choose their own health insurance
43 plans (Policy H-290.982[8]).

44
45 In those states with Medicaid managed care plans, the AMA has established a set of 21 criteria to
46 be used in federal and/or state oversight and evaluation of such plans (Policy H-290.985). As a
47 means of assuring broad access to care under the Medicaid program, the AMA also has advocated
48 for adequate and appropriate payment to physicians (Policies H-290.980 and H-290.997[4]).

1 Long-standing AMA policy encourages physicians to participate in efforts to enroll children in the
2 Medicaid and SCHIP programs through the use of “presumptive eligibility,” and supports a variety
3 of efforts to streamline and simplify the enrollment processes for these programs (Policy
4 H-290.976). The AMA also has significant policy in support of state risk pooling programs
5 (Policies H-165.988, H-165.992[1], and H-165.995[1]; allowing individuals to “buy in” to state
6 employee purchasing pools or the FEHBP (Policy H-165.995[3]); and using increases in sales tax
7 on tobacco products to expand health insurance coverage (Policy H-290.982[9]).
8

9 Most recently, the AMA has advocated that state governments be given the freedom to develop and
10 test different models for improving coverage for patients with low incomes, including combining
11 advance and refundable tax credits to purchase health insurance coverage with converting Medicaid
12 from a categorical eligibility program to one that allows for coverage of additional low-income
13 persons based solely on financial need; and for changes in federal rules and federal financing to
14 support the ability of states to develop and test such alternatives without incurring new and costly
15 unfunded federal mandates or capping federal funds (Policy D-165.966).
16

17 DISCUSSION

18
19 In a frequently cited 2004 essay, noted economists Henry Aaron and Stuart Butler advocate that
20 federally supported state experimentation represents a promising way to make progress in
21 expanding health insurance coverage to the uninsured (Aaron and Butler, *Health Affairs*, 2004).
22 After years of national efforts for which there has been little progress, the authors argue that states
23 should be allowed to “try widely differing solutions with federal financial support under legislated
24 guidelines.” Under this type of strategy, states would be able to pilot-test a variety of approaches
25 that have been proposed at the national level, such as allowing Medicaid and SCHIP to cover
26 additional populations, with greatly enhanced federal matching payments; providing vouchers to
27 individuals to mimic a comprehensive system of refundable tax credits; making FEHBP-type
28 coverage available to a broader population within a state; and establishing association health plans
29 and other group purchasing arrangements.
30

31 With the adoption of Resolution 118 (A-04), the AMA supports a strategy that, in part, is similar to
32 that proposed by Aaron and Butler. As previously noted, the AMA believes that state governments
33 should be given the freedom to develop and test different models for improving coverage for
34 patients with low incomes, and supports changes in federal rules and federal financing to support
35 the ability of states to develop and test such alternatives without incurring new and costly unfunded
36 federal mandates or capping federal funds.
37

38 Given competing priorities at the national level, combined with a still struggling economy, the
39 Council on Medical Service believes that a state-based approach continues to be the most
40 politically viable strategy at this time for achieving some level of progress in improving health
41 insurance coverage for the poor. As the Council discussed in its Report 4 (I-04), growth in U.S.
42 health care spending and health insurance premiums continues to outpace overall economic growth
43 and inflation. In 2002, the U.S. returned to deficit spending, with expenditures exceeding revenues
44 by close to \$500 billion in 2004 (U.S. Office of Management and Budget, February 2004). In
45 2003, the latest year for which data are available, the number of uninsured rose to 45 million, or
46 15.6% of the non-elderly population (U.S. Census Bureau, 2004). The biggest driver of the
47 increase in the uninsured has been the loss of employment-based coverage, which arose from a
48 combination of factors: job losses, rising premiums, fewer employers offering coverage (including

1 retiree coverage), and more employees declining coverage. Furthermore, during a period of
2 widespread state budget crises, enrollment in public programs only partially offset losses in private
3 coverage.

4
5 Despite these challenges, a number of states have been proactive in developing strategies and
6 programs to expand health insurance coverage. Similar to education and welfare, the states have
7 shown that they increasingly are the principal innovators in identifying and implementing solutions
8 to improve coverage for the poor. The state-based initiatives highlighted in this report are intended
9 to provide a snapshot of the variety of approaches that have been proposed and/or implemented.
10 As the Council describes, some of these programs have been successful in improving coverage and
11 access to care, while containing costs. Other programs are still too recent to have provided
12 definitive results or conclusions.

13
14 From the five initiatives highlighted in this report, the Council believes that there are several
15 notable elements that states may want to consider replicating, including: facilitating relationships
16 between public and private sectors; providing Medicaid enrollees with choices of primary care
17 physicians along with education about how to appropriately access their Medicare provider; and
18 speeding Medicaid reimbursement to physicians using automated eligibility and claims submission
19 technology. Some analysts suggest that state officials could establish information centers or
20 clearinghouse for individuals, families, and small businesses seeking comparative information on
21 health insurance (The Heritage Foundation, March 2003). Currently, the U.S. Office of Personnel
22 and Management and the personnel offices of all federal agencies provide comparative information
23 of available health plans, including premium costs, co-payments, the level of benefits, and solid
24 comparative information on health plan performance.

25
26 In addition, several of these state-based initiatives to improve coverage contain components that
27 are similar to, or consistent with, AMA policy. For example, many aspects of Florida's "Enhanced
28 Care" Medicaid proposal are consistent with Policy H-165.855[1] which advocates that the medical
29 care portion of the Medicaid program should be financed with federally issued tax credits or
30 vouchers. Approval and implementation of this program would provide an ideal way of testing the
31 viability of this type of approach.

32
33 However, the Council believes that perhaps the most important issue is that real progress continue
34 to be made in trying as many approaches as possible to expand health insurance coverage – even if
35 some initiatives are not entirely consistent with the AMA's preferred approaches. Overarching
36 AMA policy supports free market competition and pluralism of health care delivery systems and
37 financing mechanisms (Policies H-165.985[1] and H-165.920[1]). The Council believes that the
38 AMA and members of the Federation should continue to advocate that states be provided with as
39 many opportunities as possible to implement programs that will actually extend health insurance
40 coverage at the local and regional levels, and may provide information to guide further policy-
41 making decisions at the national level. At the same time, consistent with long-standing Policy
42 H-290.982[3], the Council believes that it is important to encourage states to ensure that a variety
43 of approaches to health care financing delivery remain within their respective Medicaid programs.

44
45 As Aaron and Butler conclude in their essay, "by actually testing competing approaches to reach
46 common goals, rather than endlessly debating them, the U.S. is far more likely to find the solution
47 to the perplexing and seemingly intractable problem of uninsurance." The Council plans to

1 continue to study and evaluate state-based approaches to improving health insurance coverage for
2 the poor, and will continue to report to the House of Delegates on future findings.

3
4 RECOMMENDATIONS

5
6 The Council on Medical Service recommends that the following be adopted and the remainder of
7 the report be filed:

- 8
9 1. That the American Medical Association (AMA) reaffirm Policy D-165.966[2], which
10 advocates for changes in federal rules and federal financing to support the ability of states to
11 develop and test different models for improving health insurance coverage for patients with
12 low incomes without incurring new and costly unfunded federal mandates or capping federal
13 funds. (Reaffirm HOD Policy)
14
15 2. That the AMA urge national medical specialty societies, state medical associations, and county
16 medical societies to become actively involved in and support state-based demonstration
17 projects to expand health insurance coverage to low-income persons. (Directive to Take
18 Action)
19
20 3. That the AMA reaffirm Policy H-290.982[3], which encourages states to ensure that within
21 their Medicaid programs there is a pluralistic approach to health care financing delivery.
22 (Reaffirm HOD Policy)
23
24 4. That the AMA encourage state governments to maintain an inventory of private health plans
25 and design an easily accessible, consumer-friendly information clearinghouse for individuals,
26 families, and small businesses on available plans for expanding health insurance coverage.
27 (Directive to Take Action)
28
29 5. That the AMA reaffirm Policy H-290.980, which advocates for adequate and appropriate
30 payment to physicians under the Medicaid program. (Reaffirm HOD Policy)

References for the reports are available from the AMA Division of Socioeconomic Policy
Development.

Fiscal Note: Advocate to the Federation and state governments at an estimated total cost of \$1,002.