Updated Interim Report
Utah State Planning Grant

Utah Department of Health

Prepared for:
Secretary Tommy G. Thompson, U.S. Department of Health and Human Services

March 28, 2002

Supported by a grant from the Health Resources and Services Administration (HRSA),
U.S. Department of Health and Human Services

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Executive Summary

This interim report describes activities undertaken by Utah's Covering the Uninsured 2002 (CU2002) HRSA State Planning Grant through the first 12 months of the project. The report has been updated to reflect completion of the 2001 Utah Health Status Survey and Discrete Choice Analysis of health coverage proposals. Under the guidance of our CU2002 Steering Committee and in partnership with stakeholders throughout the state, we are continuing a number of data collection and policy planning activities through a one-year extension of the HRSA State Planning Grant. These activities continue to reflect the original goals of the project:

- Gain a greater understanding of the uninsurance problem in the state of Utah
- Develop proposals for addressing the problem of the uninsured
- Develop recommendations for Federal action to support State efforts to provide health insurance for the uninsured

Data Collection Activities. We have recently completed a survey of 7,520 Utah households to obtain detailed health coverage information on 24,088 individuals. The 2001 Health Status Survey was completed in November 2001, and results of this survey are included in this interim report.

A survey of Utah employers is nearing completion. Businesses operating in predominately rural or urban areas with 1-9, 10-49, 50-99, or more than 100 employee were surveyed to provide previously unavailable information comparing the characteristics of those companies presently offering coverage to those companies that do not offer health care coverage to their employees. This survey will also provide valuable information about the factors affecting an employer's decision to offer health care coverage. Results of this survey are expected to be available by the end of June 2002.

Policy Planning Activities. The project has organized a number of efforts to develop viable policy options for the state of Utah. The project steering committee has played a key role in this process by authoring the CU2002's guiding principles. The project's guiding principles are:

Make Health Care Accessible to the Most People Possible, under 200%FPL

- Achieve Political and Fiscal Viability
- Cover Greatest Need First
- Preserve private sector investment in the financing of health care
- Promote individual responsibility for the cost of health care
- Solutions are workable and acceptable to target population

Workgroups, comprising community representatives were formed to explore public, private, and cost-sharing approaches to expanding coverage. These workgroups were charged with developing viable proposals that were brought before, and evaluated by, the steering committee. A number of options were explored, including a primary care network, CHIP expansion to parents, Medicaid expansion to parents, and employer cost-sharing model.

Proposals to expand CHIP coverage to parents earning up to 200% of FPL (1115 waiver) or to expand Medicaid coverage to parents earning up to 100% of FPL (1931 waiver) continues under discussion. The most significant barrier to these two proposals is funding.

We also examined the cost-sharing model currently in use by Muskegon County Michigan as a possible adjunct to our PCN proposal. That cost sharing model uses an equally distributed three-way cost share between state, employer and employees to bring insurance coverage to within the reach of businesses that employee a disproportionate number of low income workers. Community leaders and stakeholders took part in a 2-day workshop/discussion with the director of Muskegon County's program, Vondie Woodbury in Salt Lake City in November 2001.

On February 9, 2002, Health and Human Services (HHS) Secretary Tommy G. Thompson formally approved Utah's request for a federal 1115 Medicaid demonstration waiver to expand benefits for primary care and preventive services to about 25,000 residents who otherwise would not have access to health coverage. This waiver allows Utah's Medicaid program to provide a limited medical package (Primary Care Network or PCN) to working adults whose income is less than 150 percent of the federal poverty level. The PCN model is akin to a "family physician" model, which provides basic and general health care services to people seeking assistance for screenings to identify or prevent illness and disease or needing treatment for common illness or injury. It will also provide care for the management of chronic disease. The PCN is scheduled for implementation on July 1, 2002.

In connection with the waiver, Governor Michael O. Leavitt signed into law House Bill 122 enabling even more uninsured working Utahns to obtain health coverage similar to the new Medicaid waiver through a partnership with employers and the private insurance market. Information from CU2002's focus groups and key informant interviews will be used to inform and guide development of this partnership.

We conducted a discrete choice survey of individuals and employers to gauge enthusiasm for the various health coverage options under consideration. Discrete choice analysis uses advanced modeling techniques to provide a better understanding of the values and preferences of a target population. This research method employs sophisticated mathematics, theories in human choice behavior, and scientific design technologies. It involves collecting data from a carefully controlled sample to examine the influence that various factors have on the choices people make. The information is then used to build simulations that identify target groups who react differently to changes in various insurance product packages and predict how changes in key factors (i.e. benefit packages, cost sharing, provider availability, etc.) will influence future choices (uptake rates).

The product packages included in our discrete choice survey described these proposals for providing health care to the presently uninsured. Individual respondents were stratified and grouped by income level, employment status, rural versus urban residence, health status, and parental status. Employer respondents were stratified and grouped by number of employees, urban or rural location, and industry. Respondents were asked to choose among various health insurance options with varying levels of benefit and cost attributes. The results of this project will help us to identify key factors affecting the decision to take up a specific benefits package

across a range of price points. These findings will also guide the development of proposals and recommendations designed to minimize “crowd-out” by identifying how insured respondents might "choose" between their present coverage and several proposed options.

Results of the discrete choice analysis indicated:

? The demand for new plans is strong but highly sensitive to the specific configuration of the plans available. Customers compare and switch between plans based on the features of a plan and how that plan looks in comparison to other plans. Changes in one plan can have a large impact on the demand for other plans.
? A PCN plan with limited benefits, low costs, and service provided through community health centers should form the basis of any suite of health plans offered to the market. This plan should be widely advertised but targeted with messages directed at individuals who place a limited value on extra benefits and who currently don’t carry insurance. A PCN plan should increase health coverage among these groups without encroaching on markets for other health coverage options (new or traditional). In addition, offering a basic PCN plan places other plans (in particular the Cost-Sharing plan) in a more positive context among individuals and employers alike.
? A PCN plan should be complimented with one or more Employer Cost-Sharing plans with service available from approved providers. Employer monthly premiums should be kept to a minimum and benefits kept at moderate levels. Individuals may elect to pay additional amounts to get access to additional benefits.
? Dental benefits and hearing and vision care appear to be the most attractive additional benefits to most individuals. Mental health care is generally less important and sometimes seen as a negative option.
? Waiver plans appear to be generally less successful unless offered through an employer at which time they attract share from the Employer Cost-Sharing plans. In addition, employers prefer Cost-Sharing plans to Waiver plans in part because the Cost-Sharing plans have generally lower Employer premiums but also because Employers are attracted to plans where employees’ pick up at least some of the cost of health care – whether that be contributions toward the premium or higher payments toward inpatient medical expenses.

Regarding Federal action to support state efforts to provide health insurance for the uninsured, recommendations will be included as part of our Final project report. These recommendations will be more specific and meaningful after we have had an opportunity to more fully develop our proposals and to review the data we are presently collecting.

Section 1. Summary of Findings: Uninsured Individuals and Families

Source of information Section 1.1 through 1.3: The 2001 Utah Health Status Survey (UHSS).

The most precise, up to date information on Utahns comes from the UHSS. The survey has been conducted every five years since 1986, and has a much larger sample size than national surveys on the subject. The 2001 UHSS was a telephone survey of 7,520 households throughout the state and included detailed health status information on 24,088 individual Utahns living in those households. In comparison, the 2001 Current Population Survey (CPS) included only 604 Utah households. The information gathered on individuals included in the survey was provided by the adult (age 18 or older) of the household who had the most recent birthday. Data collection was conducted between May 15, 2001 and November 15, 2001. Some notes on the 2001 HSS:

- The 2001 HSS collected information on the type of coverage for every person in the household.
- We used CPS-type classification for type of insurance (e.g., private/employer, Medicaid, Medicare).
- We recorded all types of insurance coverage for each person (not just primary type of coverage).
- We asked specifically about CHIP, and include a question "preamble" that says that CHIP is a government-sponsored program for children of low-income working parents.
- We asked two verification questions (insurance card size and frequency of card replacement) to correctly classify whether persons are covered by Medicaid.
- We asked whether the insurance plan(s) covering persons in the household cover ONLY special conditions, such as diabetes or breast cancer. This is done to distinguish these plans from more comprehensive plans, and get a better measure of overall health insurance coverage.
- For those who responded "no" to the insurance screener question, indicating that they did not have insurance, we asked a follow-up question that lists all possible sources of insurance, and verifies that none of them is relevant in the household.
- For those who lacked health insurance, we asked about each of several reasons why they may not be covered. That is, instead of reciting the list and asking for the primary reason, we asked each reason separately, for each person in the household, and asked whether that reason applied to them.
- Several questions have been added that improve our ability to measure 1) access to medical, mental health, and dental care, 2) employment status, 3) employee take up of insurance plans offered at work, 4) ability to afford prescription medicines, and 5) fear that seeking health care or government assistance would jeopardize US residency status.
- Finally, our measure of household income has been improved in three ways that will improve (decrease) measurement error for poverty status: 1) smaller income categories, 2) an additional question about whether income was steady over the past year, and 3) an additional follow-up question about last month's income for persons whose annual income is not steady over the course of the year.

1.1 What is the overall level of uninsurance in your State?

? **1.1(a) Overall Level of Uninsurance:** The best current estimate of the overall level of uninsurance in Utah is **8.67%** of the population or **197,962 individuals**.

? **1.1(b) Uninsured Children in Utah :** The best current estimate of the overall level of uninsurance among children (age 0 – 18) in Utah is **6.51%** or **50,638 individuals**.

1.2 Characteristics of Utah's Uninsured Population

? **1.2(a) Income:** The highest rate of uninsurance is among individuals living in households earning **less than $15,000** annually (**24%**). Individuals in households earning **between $15,000 and $25,000** annually represent **23%** of the uninsured.

2001 Uninsured by Annual Household Income		
Annual Household Income	Percent Who Are Uninsured	Distribution of Uninsured
Under $15,000	24.04%	13.29%
15,000 - 25,000	20.53%	22.56%
25,000 - 35,000	12.90%	20.05%
35,000 - 45,000	8.45%	13.93%
45,000 - 55,000	8.29%	12.08%
Over $55,000	3.43%	18.09%
Total	8.67%	100%

? Of 50,638 uninsured children (0 – 18 years) in Utah, **35, 645** live in households with annual incomes **at or below 200% of Federal Poverty Level (FPL)**.

Poverty Level of Child's Household	Total, All Children Age 0-18	Percentage of Children Who Lacked Insurance Coverage
At or Below 200% of Poverty	38.38% (298,537)	11.94% (35,645)
201% or Above	61.62% (479,307)	3.24% (15,530)
Total, All Children Age 0-18	100% (777,844)	6.51% (50,638)

? **1.2(b) Age:** Individuals in the **18-34 years** age group have the highest rate of uninsurance **(13.8%)**. This group represents **45%** of all the uninsured individuals in Utah.

2001 Uninsured by Age		
Age range	Percent Who Are Uninsured	Distribution of Uninsured
Under 18	6.8%	24.8%
18-34	13.8%	45.9%
35-49	9.2%	20.0%
50-64	6.6%	8.6%
Over 64	0.7%	0.7%
Totals	8.7%	100%

? **1.2 (c) Gender:** Utah males were somewhat more likely to be uninsured than females.

2001 Uninsured by Gender		
Gender	Percent Who Are Uninsured	Distribution of Uninsured
Male	9.1%	54.2%
Female	8.3%	47.6%
Totals	8.7%	100.0%

? **1.2 (d) Family composition:**

Individual adults who had "Never Married" were most likely to be uninsured (15.2%), followed by those who were "Divorced, Separated, Widowed" (12.2%). Respondents who were "Married, living as married" were the least likely to be uninsured (7.6%). However, because of the large percentage of people belonging to the "Married, living as married" category, this group accounts for 55.4% of all the uninsured in the state.

2001 Uninsured by Marital Status of Utah Adults		
Marital Status (age 18 and over)	Percent Who Are Uninsured	Distribution of Uninsured
Married, living as married	7.62%	55.35%
Divorced, Separated, Widowed	12.20%	16.05%
Never Married	15.23%	28.60%
Totals, Utah Adults	9.56%	100.0%

? **1.2 (e) Health status**: Individuals in "Fair/Poor" health were more likely to be uninsured (9.3%) than those reporting to be in "Good/Very Good/Excellent" health (8.6%).

2001 Uninsured by Health Status		
Health Status	Percent Who Are Uninsured	Distribution of Uninsured
Fair/Poor	9.32%	9.70%
Good/Very Good/Excellent	8.60%	90.30%
Totals	8.67%	100.0%

? **1.2 (f) Employment status**: "Unemployed/Other" adults were the most likely to be uninsured (15.7%). Students (14.7%), part-time workers (12.2% uninsured) and homemakers (10.9% uninsured) were the next most likely to be uninsured, followed by fulltime workers (9.5%). Retirees were the least likely to be uninsured (1.6%). Because of the large percentage of people working full time, this group accounted for 57.5% of all the uninsured in the state.

2001 Uninsured by Employment Status, Utah Adults Age 18+		
Employment Status	Percent Who Are Uninsured	Distribution of Uninsured
Full Time	9.5%	57.5%
Part Time	12.2%	17.6%
Retired	1.6%	2.2%
Keeping House	10.9%	10.8%
Student	14.7%	4.1%
Unemployed/Other	15.7%	8.0%
Total, Adults 18+	9.6%	100.0%

? **1.2(g) Availability of private coverage**: This information is in the process of being collected.

? **1.2 (h) Availability of public coverage:** Approximately 10.3% of all Utah residents receive their health insurance coverage through the State Medicaid program. The current number of enrollees is about 223,800 people under age 65. In general, Medicaid coverage is available to pregnant women (133% FPL), children under 6 (133% FPL), children 6-18 (100% FPL) the disabled (100% FPL), and the Medically Needy (spenddown allowed to $382/mo. per individual). Medicare covers approximately 14.53% ? 1.29% of Utahns. The Children's Health Insurance Plan (S-CHIP) currently has 22,700 children enrolled and determines eligibility at 100-200% FPL. Due to recent budget cuts in the state, CHIP has had to instate an enrollment cap. The Utah Department of Health administers the Utah Medical Assistance Program (UMAP) that provides care for adults with acute, life-threatening or

infectious diseases who earn up to $347 per month. UMAP serves approximately 6,500 individuals each year.

? **1.2 (i) Race/ethnicity:** Data from the 2001 HSS shows Hispanic residents are more than twice as likely to be uninsured (25.84%) than Non-Hispanic residents of the state (7.19%).

2001 Percentage of Persons Who Were Uninsured By Hispanic Status			
	Percent of Utah Population	Percent Who Are Uninsured	Distribution of Uninsured
Hispanic	8.99%	25.84%	23.80%
Non-Hispanic	91.01%	7.19%	76.20%
Total	100%	8.67%	100%

? **1.2 (j) Immigration status**: This information has not yet been summarized.

? **1.2 (k) Geographic location** (as defined by State -- urban/suburban/rural, county-level, etc.): 76.25% of the population of Utah lives along the Wasatch Front. The Wasatch Front is a 100-mile corridor comprised of several urban areas including Salt Lake City, Ogden, Orem, and Provo.

Sampling methods used in the CPS do not permit sub-state estimates. The most recent evidence we have for urban and rural differences comes from the 2001 Utah Health Status Survey. The Utah Health Status Survey found the highest percentages of persons without health insurance coverage in frontier areas of the state.

Number and Percentage of Uninsured Persons by Local Health District, 2001 Utah Health Status Survey

Health District	Total Population	Insured Persons	Uninsured Persons	% Without Health Insurance Coverage
Urban Districts				
Davis County	244,844	235,246	9,598	3.92%
Salt Lake	918,279	833,011	85,268	9.29%
Utah County	385,690	357,848	27,842	7.22%
Weber-Morgan	207,864	187,028	20,836	10.02%
Rural Districts				
Bear River	138,600	129,742	8,858	6.39%
Central	67,207	59,162	8,045	11.97%
Southeast	52,817	45,697	7,120	13.48%
Southwest	147,370	128,911	18,459	12.53%
Summit	31,279	28,935	2,344	7.50%
Tooele	44,430	41,860	2,570	8.04%
TriCounty	41,640	35,920	5,720	13.74%
Wasatch	15,947	14,645	1,302	8.18%
State Total	2,295,967	2,098,005	197,962	8.67%

Utahns living along the more urban Wasatch Front were less likely to be uninsured (8.20%) compared to Utahns living in the more rural areas of Utah (10.15%).

2001 Percentage of Persons Who Were Uninsured By Residence in Wasatch Front Counties			
	Percent of Utah Population	Percent Who Are Uninsured	Distribution of Uninsured
Wasatch Front (Urban)	76.25%	8.20%	71.99%
Non-Wasatch Front (Rural)	23.75%	10.15%	28.01%
Total	100%	8.67%	100%

? **1.2 (l) Duration Uninsured**: Data from the 2001 UHSS indicates that the majority of uninsured in Utah fall into two categories, those that have been uninsured for less than six months (23.9%) and those that have been without insurance for four years or longer (37.4%).

Duration Uninsured	
Duration Uninsured	Percentage Distribution of Persons with No Health Insurance Coverage
< 6 Months	23.9%
6 months - < 1 year	9.2%
1 year - < 2 years	15.9%
2 years - < 3 years	7.2%
3 years - < 4 years	6.4%
>= 4 years	37.4%
Totals	100%

? **1.3 Summarizing the information provided above, what population groupings were particularly important for your State in developing targeted coverage expansion options?**

Based on the 2001 HSS, sub-populations with higher percentages of people without health insurance were:

1. Young adults age 18-34 years old (15 percent without health insurance)
2. Adults without a high school education (26 percent)
3. Persons in households with incomes less than $15,000 a year (24 percent)
4. Unemployed adults (19 percent)
5. Persons of Hispanic ethnicity (21 percent)[1]
6. Persons living outside the urban Wasatch Front (12 percent)
7. Residents of several more rural health districts (e.g., Tricounty and Southwest Utah Health Districts, 17 and 16 percent, respectively)
8. Persons who reported fair or poor health status (12 percent)

? Questions **1.4** through **1.12** are being addressed through focus groups and key informant interviews. This data collection has not been completed.

? **1.13 How should underinsured be defined? How many of those defined as "insured" are underinsured?**

This is a question that is currently being debated by our steering committee. Input is also being sought from community advocates and providers.

Section 2. Summary of Findings: Employer-based Coverage

? **2.1 What are the characteristics of firms that do not offer coverage, as compared to firms that do?**

In addition to information regarding whether or not the company offers healthcare coverage, our employer survey will allow a comparison of companies that offer insurance versus those that do not by the following background information:

- ? How long the company has been in business
- ? Gross payroll amount
- ? Percent of employees on the job for: < 1 year; 1-5 years; 6-10 years; >10 years
- ? Employee profile by age
- ? Whether or not the company offers a range of other benefits including Disability coverage, Retirement plans, Flexible Spending Accounts for health care, paid sick leave, paid vacations, Wellness Programs or exercise facilities, Term Life Insurance, and Medicare Supplemental coverage.
- ? Number/percentage of full-time, part-time, and seasonal or temporary workers:
- ? Industry sector (by SIC code and through self report)
- ? Employee wages
- ? Geographic location (urban versus rural)

? **2.1 (a) Cost of policies**:

Companies offering employee health care coverage are asked to provide information for up to three company plans. Companies with more than three plans are asked to provide information for the three with the highest employee enrollment.

The employer survey asks the following questions:

What is the total premium for an employee with employee-only coverage?
What is the total premium for an employee with family (employee, spouse, and dependents) coverage?

? **2.1 (b) Level of contribution:**

Employers are also asked to report the following:

How much of the total premium for employee-only coverage is paid for by the employee?
How much of the total premium for family coverage is paid for by the employee?

? **2.1 c Percentage of employees offered coverage who participate**:

The following items on the employer survey address the question of employee participation in employer offered plans:

How many employees are currently **eligible** for this plan?

Full-time employees	_____
Part-time employees	_____
Temporary or seasonal employees	_____
COBRA	_____
Retirees age 65 and over	_____
Retirees under age 65	_____

How many employees are currently **enrolled** in this plan?

Full-time employees	_____
Part-time employees	_____
Temporary or seasonal employees	_____
COBRA	_____
Retirees age 65 and over	_____
Retirees under age 65	_____

? **2.2 What influences the employer's decision about whether or not to offer coverage? What are the primary reasons employers give for electing not to provide coverage?**

Information addressing the factors influencing employers' decisions to offer coverage is being collected through our employer focus groups, and the following items on our employer survey.

- ? Approximately how many of your competitors offer healthcare coverage for their workers?
- ? On a scale of 1 to 7 where 1 is not important and 7 is extremely important, how important do you think is it for all working Utahns and their families to have healthcare coverage?
- ? In your opinion, what percentage of a worker's health insurance premiums should be paid by the employer?
- ? In your opinion, what percentage of a worker's health insurance premiums should be paid by the individual worker?
- ? For each of the following statements, indicate whether you strongly agree, somewhat agree, are unsure, somewhat disagree, or strongly disagree:
    - o Providing health insurance to more Utahns would make financial sense overall.
    - o Businesses pay in other ways if they don't provide healthcare coverage for their employees.
    - o Employees see healthcare coverage as part of their compensation.
    - o Uninsured workers get the same quality of healthcare as those with healthcare coverage.
    - o The benefits of early intervention and better management of chronic and acute health problems outweigh the costs of health insurance.
    - o In general, health insurance is not a good value for what it costs.
    - o Workers without healthcare coverage have more absenteeism and are less productive than those who have health care coverage.
    - o Money spent on health coverage for employees reduces other costs.
    - o Employers would be more likely to offer employee health benefits if they had some control over costs.

Employers who do not offer healthcare coverage are asked to indicate how each of the following are reflected in the decision not to offer coverage:

- o Setting up a plan is too complicated and time consuming

- Revenue is too uncertain to commit to a plan
- Employees cannot afford it
- Employees are healthy and do not need it
- Employees have coverage elsewhere
- Employees prefer wages and/or other benefits
- My/our business does not need to offer health insurance in order to recruit and retain good workers
- A large portion of my/our workers are seasonal, part–time, or high turnover
- The company has had an adverse experience with employee healthcare coverage
- Administration?
- The company was denied coverage
- Don't have enough information to make a decision about benefits
- Costs of employee health benefits are too difficult to control
- Other reason why your business does not offer a health plan

Questions **2.2** through **2.7** will be addressed in our employer focus groups and key informant interviews and summarized for the final report.

Section 3. Summary of Findings: Health Care Marketplace

? **3.1 How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions?**

Publicly Insured (Medicaid/CHIP/Medicare)

? Based on the definition of adequate, public insurance products are adequate for the insureds' needs, provider reimbursements (with the exception of dental provider reimbursement), and insurance profits.
? The public system's major breakdown happens when the insured does not understand the playing field and is not able to maneuver within the system.
? Preexisting conditions are accepted as covered, reimbursable, and allowable benefits and costs within the public system.

No Insurance (Safety Net)

? Without insurance or public coverage, individuals primarily rely on the Federal government for health care options. The Community Health Centers (i.e., FQHCs) provide adequate primary care for those already in this public system. For those outside this system, there is not a public safety net that provides reliable or adequate health coverage.
? Secondary or tertiary care is not adequate for this population. Diagnosed problems which cannot be resolved within the safety net require the uninsured's limited disposable and non-disposable income to pay for the high cost treatment(s).

Privately Insured

? Private insurance products are generally adequate. The cost of private products, however, prohibit lower-income families (under 200% FPL) to afford coverage.

? **3.2 What is the variation in benefits among non-group, small group, large group and self-insured plans?**

? **3.3 How prevalent are self-insured firms in your State? What impact does that have in the State's marketplace?**

We are presently collecting this information with the aid of the Utah Department of Labor. The Utah Department of Insurance provided a "very gross estimate" of the percentage of employer group plans that are self-funded at 50 percent.

Data on the *impact* of self-funded employer group plans is not presently available, but will be addressed in our actuarial analysis.

Information on items **3.4-3.6** is being evaluated in our actuarial analysis.

? **3.7 How did the planning process take safety net providers into account**?

Safety net providers have been heavily involved in all aspects of the grant activities. A range of safety net providers are presently represented on the project steering committee, the project workgroups, and in the project "Consultation Teams" as described in section five. The project staff has compiled a comprehensive directory of all safety net providers in Utah

? **3.8 How would utilization change with universal coverage?**

Our contracted actuary is evaluating this issue

? **3.9 Did you consider the experience of other States with regard to**:

Expansions of public coverage?:
Public/private partnerships?:
Incentives for employers to offer coverage?:
Regulation of the marketplace?:

The project's four original workgroups were presented with a large amount of data on all aspects of other states' experience. We compiled a library of information on all topics related to the uninsured that is accessible through our web-site (http://168.179.113.242/resources.html). Workgroup participants were also encouraged to supplement our database with any additional relevant information. Elements of programs currently being offered in other states are evident in many of the proposals presented by the workgroups to our project steering committee.

Section 4. Options for expanding coverage

? **4.1 Which coverage expansion options were selected by the State** (e.g., family coverage through SCHIP, Medicaid Section 1115, Medicaid Section 1931, employer buy-in programs, tax credits for employers or individuals, etc.)?

The study had originally planned to have the workgroups develop four competing proposals that would them be reviewed by the project steering committee who would select three of the four proposals for inclusion in the project's final report.

In all, the workgroups presented a total of ten proposals to the steering committee, many of which contained similar or "overlapping features". Most of these proposals were targeted at specific sub-groups within the overall population of uninsured Utahns. After listening to the workgroup chairpersons present their proposals, studying papers prepared by the workgroups for the steering committee, and two steering committee meetings, the committee recommended that the project focus on a combination of proposals that could be implemented in a graduated manner.

There was broad support for two of the proposals with some key caveats. First, there was general agreement that the **Primary Care Network (PCN) model (the 1115 waiver)**, as proposed by the Utah Department of Health, would provide coverage to a significant portion of the target population under 200% of the FPL. However, concerns were voiced in three areas: 1) the ability of the current safety net of primary care providers to absorb the increased demands that the PCN would likely create; 2) the absence of a more formalized system for providing access to inpatient hospital and specialty care; and 3) the lack of an employer component.

The second "proposal" receiving broad support was actually **a combination of a 1931 expansion and an 1115 CHIP waiver for parents**. Either of these two options, combined with the DOH's PCN could provide coverage for a large segment of the target population.

Many steering committee members stressed the need to maximize employer participation. Several of the proposals dealt directly with this type of coverage. However, there was general agreement that none of these proposals on their own could be fashioned in a manner that would provide coverage for a significant percentage of the unemployed and lower wage uninsured (below 125-150% FPL). The steering committee recommended that the project **continue to investigate the cost-sharing model (Muskegon County's Access Health Program) and the viability of a CHIP buy-in program for employers.**

Prior to being awarded this State Planning Grant, the Utah Department of Health had worked for a significant period of time with the office of Health and Human Services Secretary Tommy G. Thompson to develop the Primary Care Network (PCN) proposal.

As described in section five of this report, the project steering committee studied this proposal and two of the workgroups adopted variations of the proposal, commenting upon the strengths and weaknesses of the PCN as they perceived them. The decision of the project steering

committee to further pursue the PCN as a possible proposal to be presented in the project's final report was a recognition of the PCN proposal's strengths (offering coverage to a broad group of people who presently had no coverage) and the need for a more formalized mechanism by which the community could comment upon and effect the final form of the PCN.

Many of the details of the proposal remain to be worked out; however, the following is a description of the key elements of the PCN proposal as it stands at this time.

PRIMARY CARE NETWORK PROPOSAL (PCN) 1115 WAIVER

? **4.2a What is the target eligibility group under the expansion**?

The proposal would target a new eligible population of adults up to 150% of the FPL who do not qualify for Medicaid.

? **4.3a How will the program be administered?**

The Utah Department of Health will administer the program, upon receipt of federal approvals that are required.

? **4.4a How will outreach and enrollment be conducted?**

The core element will be the Utah Department of Health's eligibility staff who are stationed in various community sites throughout the state, including co-location with the Department of Workforce Services, Community Health Centers, Local Health Departments, Local Health Departments, as well as other areas.

? **4.5a What will the enrollee (and/or employer) premium-sharing requirements be?**

There will be a $50 annual enrollment fee with cost-sharing requirements for services. There will be no premium-sharing requirements. There will be no cost-sharing requirements for American Indians who use HIS or Tribal delivery systems.

? **4.6a What will the benefits structure be (including co-payments and other cost-sharing)?**

Benefit design will be a primary care package focusing on prevention. Specific services will include: physician, pharmacy, lab and x-ray, supplies, emergency services, health education, transportation required for patient care, management of chronic disease, and preventative dental. Pharmacy will be set up similar to Utah's SCHIP program with higher co-pays for non-generic drugs and other expensive alternatives to less costly equivalent drugs. Some inpatient services will be donated by Utah's hospitals based on a capped aggregate value on the contribution of services.

Cost sharing will be equivalent to approximately one-half of what is required under the State employees health plan to reflect the lower income status of this group.

? **4.7a What is the projected cost of the coverage expansion? How was this estimate was reached? (Include the estimated public and private cost of providing coverage.)**

We estimate that we can capture $18 million annually in revenues to fund this waiver plus $8 million of on-going free hospital care donated by Utah's hospitals for a total of $26 million. We estimate that since we will be paying for actual services used, rather than prepaying "actuarial use" as an insurance product, the cost will be relatively low. The cost would be about $50 per person per month.

The estimate was reached based on our experience in providing primary care through grants to community based organizations. We expect to have to cap enrollment based on the funds available for the program.

? **4.8a How will the program be financed**?

The PCN will be financed through Medicaid dollars that will be generated by modifying the Medicaid benefits for non-aged, non-disabled, non-institutionalized Medicaid adults (1931 adults) to that comparable to what Utah State employees receive, and in recognition of their low income status imposing cost-sharing at approximately 50% of the level required by the State employee plan. We would also roll the State-funded program for non-categorical adults into the waiver program.

? **4.9a What strategies to contain costs will be used**?

To begin with, there is a limited benefit package with reasonable cost sharing, which should help direct enrollees to the most cost beneficial service. Additionally, enrollment will be capped based on the availability of funds.

? **4.10a How will services be delivered under the expansion**?

The delivery network will consist of a state-wide coalition of private providers. Members of the network must guarantee a level of capacity to meet the needs of this new population.

? **4.11a What methods for ensuring quality will be used?**

We will review utilization patterns, conduct periodic review of claims, do select medical audits, monitor complaints, and conduct satisfaction surveys.

? **4.12a How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?**

We will use the same eligibility staff who administer Medicaid and are aware of other coverage resources. If eligible for Medicaid, the individual will be enrolled in that program. We are still working out the interaction with commercial plans. We had planned on using this program to

demonstrate the need for a commercial primary care product for low-income adults in small businesses. There is an interest on the part of some legislators and industry to accelerate this, so we can coordinate the program with small employer plans. There is some discussion of providing a voucher to an eligible person, allowing them to buy into employer based coverage.

? **4.13a How will crowd-out will be avoided and monitored**?

Coverage will be denied to those who have access to health insurance, and enrollment will be denied if the individual voluntarily terminated other coverage within 6 months.

? **4.14a What enrollment data and other information will be collected by the program and how will the data be collected and audited**?

At a minimum we will track enrollment and utilization data through our eligibility and MMIS system. We will be tracking disenrollments that result from the enrollment fee.

? **4.15a How (and how often) will the program be evaluated**?

Evaluation will be on-going and annual reports will be provided to CMS.

? **4.16a For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the State to consensus on each of these approaches?**

Financial and political feasibility given the economic condition of the state, and concerns over a large expansion, which have had questionable results in other states and difficulty in being sustained. We have been having our own problems being able to maintain the state's Medical Assistance Program and needed to restructure it within current funding constraints - a commitment we made to the state legislature.

? **4.17a What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed), and the remaining challenges.**

On February 9, 2002, Health and Human Services (HHS) Secretary Tommy G. Thompson formally approved Utah's request for a federal 1115 Medicaid demonstration waiver to expand benefits for primary care and preventive services to about 25,000 residents who otherwise would not have access to health coverage. This waiver allows Utah's Medicaid program to provide a limited medical package (Primary Care Network or PCN) to working adults whose income is less than 150 percent of the federal poverty level. The PCN model is akin to a "family physician" model that provides basic and general health care services to people seeking assistance for screenings to identify or prevent illness and disease or needing treatment for common illness or injury. It will also provide care for the management of chronic disease. The PCN is scheduled for implementation on July 1, 2002.

In connection with the waiver, Governor Michael O. Leavitt signed into law House Bill 122 enabling even more uninsured working Utahns to obtain health coverage similar to the new Medicaid waiver through a partnership with employers and the private insurance market. Information from CU2002's focus groups and key informant interviews will be used to inform and guide development of this partnership.

COST-SHARING MODEL

? **4.2b What is the target eligibility group under the expansion?**

Working uninsured that earn either a certain dollar per hour wage or have incomes at a certain percentage of the Federal Poverty Level. It has not been determined whether the individual or the employer would qualify. Based on data from Muskegon County, Michigan, we would need to get a waiver in order to qualify the business. New Mexico's attempt to implement a three-share model was easier when they chose to qualify the individual instead.

? **4.3d How will the program be administered?**

This hasn't been decided upon, but ideas include setting up a non-profit organization, using county governmental entities, or using the Department of Health to administer the program.

? **4.4b How will outreach and enrollment be conducted?**

To be determined.

? **4.5b What will the enrollee (and/or employer) premium-sharing requirements be?**

Premium-sharing would be three-share. The employer would contribute 30%, the employee 30%, and the community 40%.

? **4.6b What will the benefits structure be (including co-payments and other cost-sharing)?**

The benefits structure would be determined by the community (county, tri-county, etc.) that implements the program. Co-payments and other cost-sharing amounts have not been determined.

? **4.7b What is the projected cost of the coverage expansion? How was this estimate reached? (Include the estimated public and private cost of providing coverage.)**

Awaiting actuarial analysis.

? **4.8b How will the program be financed?**

60% of financing would come from employer and employee contributions. The remaining 40% in community funds has yet to be determined. Other states have chosen Upper Payment Limit, DSH dollars, and surplus CHIP dollars to fund the community portion. None of these options is currently feasible in Utah, and we are exploring other potential sources of financing.

? **4.9b What strategies to contain costs will be used?**

One recommendation was to wait until enrollment had created a large enough risk pool before allowing the self-employed to qualify, as they tend to impose higher costs. Other cost containment strategies, such as a look-back period and exclusion of catastrophic coverage have been considered. Utah has not yet determined exactly how costs would be contained.

? **4.10b How will services be delivered under the expansion?**

Services would be delivered through a network of physicians that contract with the cost-sharing program.

? **4.11b What methods for ensuring quality will be used?**

To be determined.

? **4.12b How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?**

To be evaluated.

? **4.13b How will crowd-out will be avoided and monitored?**

If qualification is made through businesses, they must not have been providing coverage or at least 12 months. If qualification is through individuals then they will need to have been without coverage for either 6 to 12 months.

? **4.14b What enrollment data and other information will be collected by the program and how will the data be collected and audited?**

To be determined.

? **4.15b How (and how often) will the program be evaluated?**

To be determined.

? **4.16b For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the State to consensus on each of these approaches?**

Although the state has not reached consensus on this option, there was strong support for some sort of a cost-sharing program. Considerations that worked in favor of such a program include: employer participation bringing in new private dollars; having employee participation and responsibility with premium contributions (no "free ride" concept); helps small businesses to provide affordable coverage to their employees; it's a program for the working uninsured; and involves the entire community in the cost and administering of health care.

? **4.17b What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed), and the remaining challenges.**

No formal implemental action has been taken. We held a two-day conference with community constituents and Vondie Woodbury of the Muskegon County program to discuss the potential for such a program in Utah. There was a general show of support, but many funding and administration challenges remained.

? **4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)?**

The following options were proposed and considered by our workgroup participants, but for one reason or another, they did not receive the detailed attention like our previous proposals.

? Employers provide a basic primary care package or low-cost insurance
? Allow employers to buy-in to CHC care
? Expand and strengthen CHCs and the safety-net in general as it exists today
? Implement clinics next to Emergency Rooms in order to divert the high cost of non-emergency care
? Develop/expand a mobile clinic system for rural areas
? Adding an employer catastrophic component to the PCN
? Increasing education and outreach with a Community Health Worker component
? Restructure Medicaid spend-down
? Home health mid-level provider network
? Single Payer System
? Vouchers for individuals to buy insurance through employers
? Expand options with MSAs
? Employer Mandates (public or private)
? Individual Mandates (public or private)

? Tax Credits (private – non-employer based or to employers)
? Vouchers (income based)
? Premium Assistance (individual or employer)
? Waive basic minimum coverage requirements
? Small employer purchasing pool (what happened?)
? Catastrophic coverage through employer
? Outreach and education to insured and noninsured about proper use of health care system

? **4.19 How will your State address the eligible but unenrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.**

Existing programs include the Children's Health Insurance Program, Medicaid and the Utah Medical Assistance Program (UMAP). A combined strategy is used to target individuals eligible for these programs – primarily by placing outreach workers in health facilities throughout the state. In addition, the Utah Department of Health is working to identify potential clients via a number of strategies, including:

? Coordinating with allied agencies to distribute information and provide presentations on eligibility determination;
? Identification of clients through church groups in every major religious denomination in the state;
? Identification through schools;
? General press coverage of the existing outreach network;
? Development of advertising material for a number of State health programs with links to Medicaid and CHIP;
? Collaboration with Early Intervention Programs.

In addition to the strategies listed above, Utah has recently simplified enrollment into Medicaid by shortening the length of the application and implementing policies to prevent "over verification." Because of funding shortages, aggressive efforts to increase CHIP enrollment have temporarily ceased.

Upon implementation of Utah's new Primary Care Network, enrollment strategies will be integrated into existing efforts. The Final State Report will provide further details.

The Utah Department of Health maintains ongoing collaboration with a number of partners throughout the state including:

? School and education sites, such as school clinics, in-school social workers, etc.;
? Homeless Adult and Youth Centers;
? Ethnic populations, particularly Hispanic and Native American groups;
? Child care centers and associations;
? County health departments.

Concerning Medicaid and CHIP enrollment, the Department awarded approximately $200,000 to various agencies with the goal of providing improved health access to the medically underserved. Partners in this endeavor included Utah Issues Center for Poverty Research and Action, and the Association for Community Health.

In addition, as the Department of Health has moved forward with implementation of the Primary Care Network, Medicaid and CU 2002 staff have worked with staff on Salt Lake County's Community Access Project Grant to help ensure a coordinated effort that best serves the county's low-income population.

Section 5. Consensus building strategy

? **5.1 What was the governance structure used in the planning process and how effective was it as a decision-making structure? How were key State agencies identified and involved? How were key constituencies (e.g., providers, employers, and advocacy groups) incorporated into the governance design? How were key State officials in the executive and legislative branches involved in the process?**

The project was governed by a Steering Committee composed of twelve community leaders representing the following groups and agencies:

? Rural Health Providers
? Utah Department of Health
? Ethnic Health Agencies
? Utah Health Insurance Association
? National Federation of Independent Business (representing small employers)
? Utah Issues (advocates for Utah's low-income population)
? Utah Medical Association
? University of Utah Center for Health Policy
? Local Health Departments/Utah County Health Department
? Utah Hospital Association
? Native American Tribes

The Utah Department of health served as the lead agency, which provided staff and a project team manager to oversee and coordinate activities for the grant. During the first six months, the Steering committee met monthly and then on an intermittent basis thereafter. The Steering Committee had two primary functions. First, early in the planning process, the committee created the project's guiding principles. Second, the Steering Committee evaluated proposals developed by the four workgroups.

Because of the Steering Committee's diversity, this process proved to be a valuable component in the decision-making structure – particularly for the two functions aforementioned. Although considerable time was spent to reach consensus on the guiding principles, they provided a strong framework for the work ahead. As proposals were being reviewed and discussed by the Steering Committee, common decisions among this diverse group could usually

be attained. After being presented with appropriate data, and the options created by the workgroups and staff, the Steering Committee was able to make sound recommendations based on the original guiding principles.

? **5.1 (a) How were key state agencies identified and involved?**

The primary state agency involved was the Department of Health's CHIP/Access Initiatives division. The Utah Department of Health Executive Director identified potential steering committee members and invited their participation. The goal was to bring together individuals representing those affected most by health access issues, as well as those dedicated to studying the policy and public health implications of access.

Other agencies were involved initially via invitation to an all-day CU 2002 Summit meeting (details are included in Section 5.2). An all-inclusive mailing compiled from lists provided by steering committee members and the Utah Department of Health, was used to identify agencies throughout the state and invite then to participate in the process. Again, the goal was to involve agencies representing a wide range of constituencies. During the first half of the Summit meeting, an overview of the project was given, as well as background data on Utah's uninsured. In the afternoon, breakout sessions were held. The sessions were designed to begin brainstorming possibilities for expanding health access to low-income populations. Participants could choose the breakout group they wanted to attend. CU 2002 staff collected contact information to inform them of upcoming Proposal Team meetings. More than half of those attending the Summit meeting continued to participate in at least one Proposal Team meeting.

? **5.1 (b) How were key constituencies incorporated into the governance design?**

Key constituencies included in the workgroups reported to the Steering Committee. As mentioned, the Steering Committee itself included groups and agencies necessary for success of the grant. While proposals were being developed, consistent communication was maintained between the workgroup members and

? **5.1 c) How were key state officials in the executive and legislative branches involved in the process?**

The Insurance Commissioner's office, legislators and legislative staff was invited to the initial CU 2002 Summit. The few legislators that attended actively participated in the break out sessions and some of the follow-up work group meetings. State officials were also invited to a two-day session on Three-Share Programs. The co-chair of a legislative task force on health care attended and took a significant interest in exploring ways to make the program work in Utah. Finally, the CU 2002 staff has begun to conduct interviews with legislators to acquire a better perspective of what key decision makers think about health care access, and what the role of government can be to ensure adequate access.
The primary governance structure of our project is the project steering committee. The steering committee is composed of community leaders who have volunteered to representing the following organizations:

Organization

- Rural Health Providers
- Utah Department of Health
- Ethnic Health Agencies
- Utah Health Insurance Association
- Small Employers - Natl. Federation of Independent Business
- Utah Issues - Low Income Advocates
- Utah Medical Association
- University Health Policy Center
- Local Health Departments / Utah County Health Department
- University of Utah Health Sciences Center
- Utah Hospital Association
- Native American Health

The steering committee has two primary functions. First, the steering committee created the project's guiding principles. The guiding principles are listed below:

- Make Health Care Accessible to the Most People Possible, under 200%FPL
- Achieve Political and Fiscal Viability
- Cover Greatest Need First
- Preserve private sector investment in the financing of health care
- Promote individual responsibility for the cost of health care
- Solutions are workable and acceptable to target population

The second primary function of the steering committee is to evaluate the proposals that were developed and presented by the project workgroups. Proposal evaluation includes commenting upon specific aspects of the proposals and select proposals for continued review.

- **5.2 What methods were used to obtain input from the public and key constituencies (e.g., town hall meetings, policy forums, focus groups, or citizen surveys)?**

Early in the project (June 18, 2001), a "Partnership Summit" was held for all interested parties. Invitations were mailed to over 600 people representing a wide range organizations and interests. In addition, many groups were encouraged to invite their members as well as any other interested parties.

The first half of the summit agenda included the following:

- An Overview of the HRSA Grant
- A review of Health Insurance Coverage in Utah
- An overview of Utah's Safety Net
- Structure of *Covering the Uninsured 2002* Project (timeline and guiding principles)
- An overview of the workgroup's role

The second half of the summit consisted of the summit attendees organizing into four workgroups according to their own interests. Workgroups were charged with developing proposals for covering the uninsured that would be presented to the project steering committee after a period of about eight weeks. Workgroups elected their own chairperson at the Partnership Summit.

Workgroups were originally structured as follows:

Public workgroup

- ? Expansion Programs
  - Chip (present program in Utah is not solely public)
  - Medicaid (present program in Utah is not solely public)
- ? Single Payer
- ? "Direct" provision of care

Private workgroup

- ? Employer Based
- ? Tax Incentives
- ? Subsidies
- ? Medical Savings Account
- ? Reinsurance/stop loss

Public/Private workgroup

- ? Expansion Programs
  - Chip
  - Medicaid
- ? High Risk Pool

Community-wide workgroup

- ? Combine elements from other workgroups to provide coverage

Small "Consultation Teams" have been formed as mechanisms for community advocates, providers, employers, and health care industry interests to provide input to the grant.

? **5.3 What other activities were conducted to build public awareness and support (e.g., advertising, brochures, Web site development)?**

We have developed a web-site where many of our grant activities are posted (http://www.health.state.ut.us). We have included meeting schedules and minutes on the web-site as well as a "med-line" style database containing a searchable database of health care coverage related literature.

Utah's request for a Section 1115 Waiver to develop their Primary Care Network created many questions within the community. To address concerns, the CU 2002 staff held a two-hour

information meeting open to the public. Attendance included about 40 individuals from various organizations and advocacy groups.

During November, 2001 the CU 2002 staff partnered with ***The Matheson Center For Health Care Studies*** at the University of Utah to host a two day conference on the appropriateness of a cost-sharing model approach (similar to the program presently offered in Muskegon County Michigan[2]) for Utah. We invited Vondie Woodbury, Director of the Muskegon Community Health Project to present at this conference. Break out sessions are planned for members of Utah's Legislative Task force for Access to Health Care, employers, insurance industry representatives, community advocates, providers, and our steering committee. The conference concluded with a roundtable/lunch where community representatives discussed the strengths and weaknesses of such a model for Utah.

We have developed a web-site where many of our grant activities are posted (http://www.health.state.ut.us). We have included meeting schedules and minutes on the web-site as well as a "med-line" style database containing a searchable database of health care coverage related literature.

? **5.4 How has this planning effort affected the policy environment? Describe the current policy environment in the State and the likelihood that the coverage expansion proposals will be undertaken in full.**

The impact of the planning effort has yet to become fully apparent. Having a wide range of community members work on this project appears to have had the effect of generating a broader sense of understanding amongst all parties with regard to the obstacles that exist to providing access to health care for all Utahns.

Section 6. Lessons Learned and recommendations to States

This section will be completed for our final (end of project) report.

Section 7. Recommendations to the Federal Government

? **7.1 What coverage expansion options selected require Federal waiver authority or other changes in Federal law (e.g., SCHIP regulations, ERISA)?**

The PCN proposal would require waivers in the following areas:

1. Restricting Benefit Package
2. Eliminating Categorical Requirements
3. Co-payments/Premiums
4. No Retroactive Eligibility for New Primary Care Network Enrollees
5. Enrollment Cap
6. Eliminate Current Cost Based Reimbursement Methodology for New Primary Care Network Enrollees
7. Comparability

An 1115 waiver would also be needed to expand CHIP coverage to parents earning up to 200% of FPL.

The necessity of other Federal waivers or changes in federal law are being investigated. Implementation of a single payer plan would likely require the most significant changes in Federal law. A detailed list of the required changes is being compiled at this time.

Questions **7.2-7.4** await input from Utah Issues (contracted to study these issues for CU2002).

Appendix I: Baseline Information

Please provide the following baseline information about your State (if possible). Also include any additional baseline information especially relevant to your coverage expansion strategies:

Population:

According to the 2000 U.S. census, the population of Utah is 2,233,169

Number and percentage of uninsured (current and trend):

As mentioned in section one, the 1996 Utah Health Status Survey estimated that 9.5 percent of the Utah population was without any kind of health insurance. The 1991 and 1996 versions of the UHSS showed no change in coverage rates between these years. In addition, the CPS showed no significant change in the rate of uninsurance from 1998 through 2000. Assuming that the UHSS more accurately reflects the rate of uninsurance in Utah and that rate of uninsurance has remained relatively close to 9.5%, there would have been 212,251 Utahns without health insurance in 2000.

It should be noted that Current Population Survey (CPS) data for the year 2000 estimates Utah's uninsured population at 13.4%. More importantly, CPS data from the last three years shows that the percentage of Utah residents without health insurance has remained relatively stable (three year average of 13.2%).

Average age of population:

Average age is not an appropriate measure of central tendency for this state. Median age is 27.1 years, with 36.3% of the population 19 years or younger and 8.5% of the population 65 years or older.

Percent of population living in poverty (<100% FPL):

9.1% of the state's residents live at or below 100% FPL

Primary industries:

Industry type	Number of employees	Annual payroll
Manufacturing	119,140	3,726,130
Retail trade	114,474	1,856,875
Accommodation/Food Service	74,481	650,041
Administrative / Support / Waste management / Remediation Services	68,232	1,147,169
Construction	55,801	1,578,334
Healthcare/Social Assistance	46,989	1,226,744
Wholesale trade	44,312	1,420,376
Finance/Insurance	39,603	1,228,769

Number and percent of employers offering coverage:
Number and percent of self-insured firms:
Payer mix:
Provider competition:

With assistance from the Utah Department of Insurance, the Utah Department of Labor and through the use of our employer survey, we are presently attempting to collect information on the percentage of employers offering coverage, the prevalence of self-insured firms, payer mix, and provider competition.

Insurance market reforms:

We are presently attempting to collect that information with the assistance of the DOI.

Eligibility for existing coverage programs (Medicaid/SCHIP/other):

The following table represents the primary categories of Medicaid coverage in Utah:

	Incoming Eligibility (percent FPL)	Other Criteria:
People with disabilities	100.0% - non-working 250% - working	SSI criteria or 12 months total actual or projected by M.D.
Pregnant Women	133.0%	
Blind	72.0%	
Aged	100.0%	
Medically Needy	53.4%	Does not meet income criteria but qualifies via "spend down". Must be categorically eligible.
Adult Parents	53.4%	
Transitional Medicaid	185.0 %	If income increased due to employment, extended for 12 months. If income increased due to child support payment, extended for 4 months.
Children under 6	133.0%	
Children 6 - 18 years of age	100.0%	

The following is a detailed summary of the medical assistance programs in Utah:

MEDICAID PROGRAMS

1931 Family Medicaid (FM-O)

1931 Family Medicaid provides coverage for low income families with dependent children. Families must meet a deprivation of support requirement. This means the children must be deprived of parental support due to the death, absence, or incapacity or a parent. Families in which the primary wage earner parent is unemployed or employed less than 100 hours per month also meet the deprivation of support requirement. The household must pass two specific income tests. 1931 FM-O households may qualify for a 12 month earned income disregard when the earned income of a parent exceeds the income limit. Additionally 1931 households may qualify for 4 or 12 month Transitional Medicaid when they loose eligibility for 1931FM-O due to child support collections or earnings of a parent.

Family Size	First Test	Second Test
1	$623.00	$382.00
2	$866.00	$468.00
3	$1,079.00	$583.00
4	$1,262.00	$682.00
5	$1,437.00	$777.00
6	$1,584.00	$857.00

Deductions: No deductions are allowed in the first income test. Second test, $90.00 work allowance, a $30 and 1/3 disregard*, child care ($200 maximum

	per child under age two, $175 over age two), some medical bills, from earned income. *****Each individual with the earned income must meet certain requirements to qualify for the $30 and 1/3 disregard.
Spend down:	Not allowed.
Asset Limit:	1 person - $2,000 2 people - $3,000 Each additional person add $25
Retroactive coverage:	Allowed.

Regular Family Medicaid

This program provides Medicaid coverage to low income families who do not qualify for 1931 FM-O because of income or other household circumstances. A household must meet the same deprivation of support requirement as the 1931 FM-O program described above. The difference between 1931 FM-O and regular FM program is that regular FM households do not have to meet the gross income test, and they may spend down to the income limit to be eligible. Regular FM households may also voluntarily choose to leave children out of the coverage that do not meet deprivation of support or when they do not want to count the child's income in determining eligibility.

Household Size	Income Limits	Household Size	Income Limits
1	$382.00	4	$682.00
2	468.00	5	777.00
3	583.00	6	857.00

Deductions:	$90.00 work allowance, a $30 and 1/3 disregard*****, child care ($200 maximum per child under age two, $175 over age two), some medical bills, from earned income. *****Each individual with the earned income must meet certain requirements to qualify for the $30 and 1/3 disregard.
Spend down:	Allowed.
Asset Limit:	1 person - $2,000 2 people - $3,000 Each additional person add $25
Retroactive coverage:	Allowed.

Transitional Medicaid

Families who become ineligible for Family Employment Program (FEP) cash assistance or 1931 Family Medicaid, may receive additional months of Medicaid coverage depending on the reason they became ineligible. Families who are no longer eligible for FEP or 1931 Family Medicaid because of child support can receive Medicaid for 4 additional months. Families who are no longer eligible for 1931 Family Medicaid because of earnings or hours of employment of the parent or non-parent specified relative, or because of the loss of 1931 Family Medicaid time limited income disregards can receive up to 12 months of continued Medicaid coverage. Families who are no longer eligible for FEP because of earnings of the parent or non-parent specified relative can receive up to 12 months of continued Medicaid coverage. A household must meet certain income and reporting requirements to qualify for transitional Medicaid.

Non-Parent Caretaker Relative (FM)

An adult who is caring for a relative child, but who is not the parent of the child may qualify to receive Medicaid. The adult must meet the Family Medicaid eligibility criteria except for deprivation. The caretaker relative's spouse and dependent children cannot be included on the program unless they meet deprivation. Income and assets of the excluded spouse of a caretaker relative must be counted. A different income calculation is used to determine countable income. Spenddown is allowed.

Prenatal Program (PN)

The Prenatal program provides full Medicaid coverage to pregnant women. The income limit for this program is 133% of the Federal Poverty Level for the household size. The program covers the mother from application through 60 days after the birth. Once eligible, the woman remains eligible for the entire period. The mother does not have comply with Duty of Support requirements while she is pregnant or for the 60 day postpartum period. **Children born to women on this program can receive Medicaid through the month of their first birthday under the Postnatal program**.

Household Size	Prenatal Income Limits	Household Size	Prenatal Income Limits
1	$ 953.00	4	$1,957.00
2	1,287.00	5	2,291.00
3	1,622.00	6	2,626.00

Deductions: Same as Family Medicaid. Thirty and one-third disregard from earned income may be allowed only if a client received Diversion or 1931 Medicaid in one of the previous four months.

Asset limits: $5,000 for free coverage. Household's whose assets exceed $5,000 limit may pay a co-payment equal to 4% of the **total** assets. Maximum co-payment is $3,367.

Retroactive coverage: Allowed.

Pregnant Women (PG)

A Medicaid program for pregnant women who do not meet the income limits for the Prenatal program. The advantage of the PG program is that a woman may pay a spend down and receive the coverage. Eligibility follows the regular FM program except that the household does not have to meet deprivation of support requirements.

The woman may receive 60 day postpartum coverage if she applies for benefits before the birth of the child. The spenddown must be met for each month of coverage including the 60 day postpartum period. The mother does not have to comply with Duty of Support requirements while she is pregnant or for the 60 postpartum period. The child will qualify for Medicaid for the first year under the Postnatal program with no spenddown.

Postnatal (PN+)

This program covers the newborn from birth to twelve months and the mother for the 60 day postpartum period. If the mother qualifies for the PN program, the 60 day postpartum coverage for the mother and child is automatic. Mothers who were not on Medicaid when the baby was born may receive the 60

postpartum coverage and the baby may receive the year's coverage if the mother qualifies for the PN program in a retroactive month that covers the date of the birth.

At the end of the 60 day postpartum period, the household must provide verification of the birth and information about any possible insurance coverage. Application for a Social Security card will be requested, but isn't required.

A child can only receive Postnatal coverage if the mother was eligible for Medicaid for the month of birth. If the mother did not qualify for Medicaid for the month of birth, the child may be eligible for the Newborn program.

Newborn Medicaid (NB)

This program provides Medicaid coverage for children from birth through age 5. Children do not have to be deprived of parental support as in the 1931 FM and regular FM programs. A child does not have to reside with the birth mother or other relative to receive coverage.

Income Limit: 133% of the Fedearl Poverty Level.
Deductions: Same as Family Medicaid.
Spend down: Not allowed.
Asset limits: None.
Retroactive coverage: Allowed.

Newborn Plus Medicaid (NB+)

Medicaid coverage for children from age 6 through 19*. Children do not have to be deprived of parental support and do not have to reside a specified relative to receive coverage.

Household Size	Income Limits (100% of Poverty)	Household Size	Income Limits (100% of Poverty)
1	$ 716.00	4	$1,471.00
2	968.00	5	1,723.00
3	1,220.00	6	1,975.00

*Children who turned 18 prior to October 1, 2001 are eligible only through the month of their 18th birthday.

Deductions: Same as Family Medicaid.
Spend down: Not allowed.
Asset limits: Same as FM.
Retroactive coverage: Allowed.

Medically Needy Child (CM)

Households who do not meet the FM deprivation of support requirements and whose income exceeds the NB Medicaid limit, may be eligible for CM Medicaid for children under age 18 or for children between age 18 and 19 who are in school and will graduate before turning 19. Children do not have to be living with a specified relative and the income and assets of adult household members who are not the parents of

the child are not counted. All other eligibility factors follow the guidelines under the regular Family Medicaid program. Spend down is allowed.

Refugee Medical Assistance (RMA)

Refugees entering the United States are eligible to apply for Medicaid for 8 months after their date of entry. The same income and resource standards apply as for FM Medicaid. Refugee Financial Assistance automatically provides eligibility for RMA.

Medicaid Cancer Program

The Medicaid Cancer Program provides full Medicaid benefits to uninsured women under age 65 who are identified through CDC (Center for Disease Control) providers and are in need of treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer. The UCCP (Utah Cancer Control Program) is the CDC provider that will complete screening. If a woman has another type of cancer but the primary cancer is breast or cervical cancer, they may still meet the requirement.

A woman must meet the general Medicaid requirements along with the following requirements:

- ? Screened by the CDC
- ? Need treatment for breast or cervical cancer
- ? Cannot have coverage under a group health plan or other health insurance coverage plan which would cover the treatments needed for breast or cervical cancer
- ? Must be under the age of 65

Income: There are no income limits after meeting the screening by CDC.
Asset limits: None.
Retroactive coverage: Allowed, but not before July 1, 2001.

Aged, Blind, Disabled Medical (A, B, D)

Provides a Medicaid card for individuals who are Aged (65+), Blind, or Disabled. People who want to qualify on the basis of disability must meet the Social Security criteria for being disabled. If disability is denied by Social Security due to Substantial Gainful Activity (SGA), the Medicaid Medical Review Board may still look at disability without considering SGA.

Receipt of SSI or SSA disability benefits meets the criteria for disability. If the person receives SSI, we do not count income of a spouse or parent; assets of a spouse or parent will be counted. The SSI person's income doesn't count toward the income limit except for nursing home or Home and Community Based Waiver clients. Some individuals who lose their SSI payments may still qualify without a spenddown under a protected group.

Household Size	Income Limits
1	$382.00
2	468.00

Deductions: $20.00 general income exclusion, health insurance premiums, $65.00 and ½ of the remaining gross earned income, impairment related work expenses, medical bills.
Spend down: Allowed.
Asset limits: 1 person - $2,000 2 people - $3,000 Each additional person add $25
Retroactive coverage: Allowed.

Aged and Disabled Poverty Level Medical (A, D)

Provides a medical card for people 65 years of age or older, or disabled according to Social Security disability criteria, who have income at or below 100% of the federal poverty limit. People who qualify under this coverage group do not have to pay for their medical card. Income of a spouse or parent is countable to the eligible person. This coverage group is not available to person's whose only impairment is legal blindness.

Household Size	Net Income Limit (100% of poverty)
1	$716
2	$968

Resource Limit: 1 person - $2,000 2 people - $3,000
Deductions: $20.00 general income disregard. $65.00 of earned income and one-half of the remaining earned income is not counted. **No** deductions for health insurance premiums or medical bills.
Spenddown: Not allowed
Retroactive coverage: Allowed.

Medicaid Work Incentive Program (DM)

A Medicaid program for disabled individuals with earned income. The household income limit is 250% of the federal poverty level. If household net income does not exceed 100% of poverty, the individual will not have any cost sharing responsibilities (buy-in premium). If household net income is above 100% of poverty but below the 250% income limit, the individual will pay a buy-in premium equal to 20% of their net countable income.

Basic Qualifying Factors:
Income limits and household size:
The following people will be counted in the household size: the client, a spouse living in the home, parents of a minor child, minor children and children up to age 21 who are full-time students, and siblings (up to age 21 who are full-time students) of a minor client. Only the income of the client, a spouse living in the home and income of parents of a minor client will be counted and compared to the 250% of poverty limit.

HH Size	250% Poverty
1	$1790
2	$2419
3	$3048
4	$3678
5	$4307
6	$4936

Deductions:	$20 General income disregard; the first $65 of earned income and ½ of the remaining; impairment related work expenses. Allocations for children or parents are not allowed. A spouse's income does not have to exceed the allocation to be counted in the 250% test.
Buy-In Premium:	Equal to 20% of the eligible individual's net countable income. Must be paid in cash; medical bills are not allowed to meet the buy-in premium.
Asset Limit:	$15,000 for all household sizes.
Retroactive Coverage:	Allowed (3 months prior to the date of application) but not to start before July 1, 2001. Must meet all eligibility factors each month**.**

MEDICARE COST-SHARING PROGRAMS

There are four related programs available to individuals with Part A Medicare benefits. These programs help cover some of the recipient's costs for Medicare services. They are not Medicaid programs, but a Medicaid recipient who is eligible for Part A Medicare may be eligible for both Medicaid and either QMB or SLMB coverage. Qualifying Individuals (QI) benefits are only available to people who are not receiving Medicaid. Poverty limits change in April of each year.

Qualified Medicare Beneficiaries Program (QMB)

The QMB program picks up costs for low-income **Medicare** recipients which go along with their Medicare cards. People who receive or are eligible to receive Part A Medicare may apply for QMB. QMB pays Medicare Part B premiums and deductibles, the 20% co-payment of Medicare-approved amounts, and co-payments for Medicare-approved, skilled nursing home. It can also pay Part A premiums. It takes about three months after you become eligible for QMB for your Social Security check to increase. You will also be reimbursed by Social Security, at that time, for each month of eligibility. Income from a non-eligible spouse is countable. Coverage begins the first of the month after you are determined eligible. A card will be issued each month. If you do not have Medicaid, the card will read "MEDICARE COST-SHARING ONLY."

Income limits:	100% of poverty. 1 person -$716 2 people -$968
Deductions:	$20.00; $65 of earned income and ½ of remaining earned income is counted.
Spend down:	Not allowed.
Asset limits:	1 person - $4000 2 people - $6000
Retroactive Coverage:	Not allowed.

Specified Low-Income Medicare Beneficiaries (SLMB)

The SLMB program pays the Part B Medicare premium only. Part B Medicare covers a person's physician care, and a variety of out-patient services including out-patient hospital services. The charge is $50.00 per month for 2001. Applicants must pass all the QMB rules, except that their income exceeds 100% of poverty and does not exceed 120% of poverty. The only benefit on this program is the payment of the Part B premium. It takes about three months after you become eligible for SLMB for your Social Security check to increase. You will also be reimbursed by Social Security, at that time, for each month

of eligibility. No card is issued for the SLMB program. An individual may be eligible for both Medicaid and SLMB.

Income limits:	1 person - $859.00	2 people - $1,161.00
Asset limits:	1 person - $4000	2 people - $6000
Retroactive Coverage:	Allowed.	

Qualifying Individuals (QI)

The QI programs pay either all or a part of the Part B Medicare premium. There are two different groups of Qualifying Individuals--Group 1 and Group 2. The criteria is exactly the same as the SLMB program except that the income limits are higher, and the individual **cannot** be eligible for Medicaid coverage. This is not an entitlement program. States have been granted a set amount of federal money to cover the benefits paid by the QI program. When funds have been allocated for a calendar year, no new applicants will receive any benefits. No card is issued for the QI programs.

QI-Group 1
The income limit for QI-Group 1 is from 120% to 135% of poverty. The benefit individuals qualifying under Group 1 will receive is payment of their monthly Part B premium. It takes about three months after you become eligible for QI-Group 1 for your Social Security check to increase. You will also be reimbursed by Social Security, at that time, for each month of eligibility.

QI-Group 2
The income limit for QI-Group 2 is from 135% to 175% of poverty. Individuals who qualify under Group 2 will only have a small portion of their Part B premium paid. The amount of the monthly benefit is $3.09 in 2001. This amount will be multiplied by the number of months a person is eligible during a year and will be paid to Group 2 recipients in the form of a 'refund' check from the Department of Health after the end of the calendar year.

Funding is limited for these groups. When funds are used up, new applicants will be denied coverage. Eligibility in future calendar years is not guaranteed.

Income limits:	Group 1 individuals--1 person = $ 967; 2 persons = $1,307.
	Group 2 individuals--1 person = $1,307; 2 persons = $1,694.
Asset limits:	1 person - $4000 2 people - $6000
Retroactive Coverage:	Allowed.

MEDICAID FOR LONG-TERM CARE

To get Medicaid to pay for long term care people must be financially and medically eligible. The individual may enter a medical facility such as a nursing home, or in some cases may be able to receive care in his or her own home under one of the home and community based waivers.

Nursing Home (NH)

Nursing home Medicaid will pay for nursing home and other medical costs. Some different income and asset rules apply for married couples. The patients doctor and the nursing home must give facts about how ill the patient is to see if the patient qualifies medically for Medicaid.

Income limits:	Complicated. For single people short term (less than 6 months) eligibility is different than long term stay. The nursing home resident is able to keep $45 of monthly income for personal needs such as a permanent or hair cut. The rest of the money, in most cases, must be paid to the nursing home
Supplemental income:	SSI recipients in nursing homes receiving $30 a month plus a state supplemental payment of $15.
Deductions:	Complex. Under Spousal Impoverishment lae, a spouse at home is allowed to keep a portion of total income for living expenses. Medical insurance is a deduction.
Spend down:	Allowed. It is considered a contribution to care and is paid to the nursing home.
Asset limits:	Complex. Under Spousal Impoverishment law, the nursing home client is allowed $2,000.00. The spouse at home may keep ½ the total amount of countable assets. There are some exceptions. The spouse at home may keep a minimum of $17,400 of the assets the couple owned when the patient entered the nursing home, but no more than a maximum of $87,000. These amounts go up January 1st of each year.
Transfer of Assets:	Transfers of assets for less than the fair market value can result in the person being ineligible (i.e., sanctioned) for nursing home Medicaid services for a period of time. When an application for Medicaid is made, the eligibility worker will request information from the prior 36 months about what the person has done with assets. This is called the look-back period. The look-back period is 60 months for assets in trusts.
Retroactive Coverage:	Allowed for nursing home charges only from the date the patient is determined medically eligible. Ancillary (non nursing home) charges are allowed. For more information request the pamphlet "Nursing Home Information, May we be of service to you" BES PM 969. For Married couples also request, "Assessment of Assets" BES PM 992.

Aging Home and Community Based Waiver

A special program for clients who would be medically appropriate for institutional care. This program offers incentives for clients to remain in their own home. These clients are eligible for medical services that are not generally available to Medicaid recipients, such as day treatment programs, lifeline, and in-home respite care. To be eligible for this program recipients must be at least 65 years old. The referral process begins with the Area Agency on Aging (AAA). A case manager from AAA must complete an evaluation of the individual's appropriateness for the waiver.

Income limits:	100% of poverty (adjusted annually). Only the waiver client's income counts.
Deductions:	$125 earned income deduction, spousal and family allowance, health insurance premiums medical expenses, some shelter costs.
Spend Down:	Allowed
Asset Limits:	Complex. $2000, spousal impoverishment applies.
Transfer of Assets:	Same as Nursing Home. Waiver services will not be paid during a sanction period.

Retroactive coverage: Allowed. Waiver services allowed only back to the date the person met the medical criteria as certified by the AAA worker.

DD/MR Home and Community Based Waiver

A special program which helps severely disabled people of any age remain in their own homes rather than being institutionalized. Space is limited in this program. Applications are taken through the Division of Services for People with Disabilities (DSPD). One advantage of this program is that none of the parent's income or assets are counted towards a minor child's eligibility. Also, an intensive service plan is drawn up for the client. All services are paid for by Medicaid. To be eligible for this program, clients must have been disabled before age twenty-two.

Income limits: 100% of poverty (adjusted annually)
Deductions : $740 earned income deduction, health insurance premiums, medical bills, and deduction for a dependent spouse or children.
Spend down: Allowed.
Asset limits: Complex. $2000, spousal impoverishment applies.
Transfer of Assets: Same as Nursing Home Medicaid. Waiver services will not be paid during a sanction period.
Retroactive Coverage: **A**llowed. Waiver services allowed only back to the date the client met the medical criteria as certified by DSPD.

Technology Dependent Children Waiver

A special program which helps medically fragile children remain in their own homes rather than being institutionalized. Space is limited in this program. Children can qualify for this waiver through the month in which the they turn 21. Recipients 21 and older who are admitted to the waiver prior to their 21st birthday may receive ongoing benefits. Applications are taken through the Division of Family Health Services. One advantage of this program is that none of the parent's income or assets are counted towards the child's eligibility. Also, an intensive service plan is drawn up for the client. Parents receive specialized training to learn how to provide some of the care the child needs. Families usually receive private-duty nursing services due to the complex medical condition of these children. All services are paid for by Medicaid. To be eligible for this program, clients must meet specific medical criteria.

Income limits: 100% of poverty (adjusted annually)
Deductions : $125 earned income deduction, health insurance premiums, medical bills, and deduction for a dependent spouse or children.
Spend down: Allowed.
Asset limits: Complex. $2000, spousal impoverishment applies.
Transfer of Assets: Same as Nursing Home Medicaid. Waiver services will not be paid during a sanction period.
Retroactive Coverage: Allowed. Waiver services allowed only back to the date the client met the medical criteria as certified by the Family Health Services worker.

Brain Injury Waiver

A special program for clients who have a brain injury and would be medically appropriate for institutional care. This program offers incentives for the client to remain in their own home. These clients are eligible for medical services that are not generally available to Medicaid recipients, such as supported employment, day treatment programs, behavioral training, and in-home respite care. Policy follows the institutional policy except that the client is allowed higher income deductions. Applications are taken through the Division of Services for People with Disabilities (DSPD).

Income limits:	100% of poverty (adjusted annually) Only the waiver client's income is counted.
Deductions :	$125 earned income deduction, some shelter expenses, health insurance premiums, medical bills, and deduction for a dependent spouse or children.
Spend down:	Allowed.
Asset limits:	Complex. $2000, spousal impoverishment applies.
Transfer of Assets:	Same as Nursing Home Medicaid. Waiver services will not be paid during a sanction period.
Retroactive Coverage:	Allowed. Waiver services allowed only back to the date the client met the medical criteria as certified by the DSPD worker.

Physical Disabilities Waiver

Clients who are eligible for this waiver would be medically appropriate for institutional care. These clients are eligible for medical services that are not generally available to Medicaid recipients. Additional services available include, personal care assistance, consumer training, and personal emergency response services. Policy follows the institutional policy except that the client is allowed a higher income deduction.

Income limits: 300% of the SSI rate. This rate, which is adjusted annually, is $1,590.00 for 2001. If income exceeds 300% the person must spend down to $382.00 and follow DM income policy. Only the waiver client's income is counted.

Deductions :	All income deducted up to 300% of the SSI rate.
Spend down:	Allowed, If income is over 300% of SSI.
Asset limits:	Complex. $2000, spousal impoverishment applies.
Transfer of Assets:	Same as Nursing Home Medicaid. Waiver services will not be paid during a sanction period.
Retroactive coverage:	Allowed. Waiver services allowed only back to the date the client met the medical criteria as certified by the DSPD worker.

OTHER MEDICAL ASSISTANCE PROGRAMS

Utah Medical Assistance Program (UMAP)

A State sponsored program for adults between age 18 and 65 who need medical attention and do not qualify for any Medicaid program. The individual must meet the same U.S. Citizen or qualified alien

requirements required under the Medicaid program. At application, countable income from the previous 12 months is averaged. If the averaged income is equal to or less than the UMAP income limit then current income is used to determine eligibility. If the averaged income is greater than the UMAP limit, there is no eligibility regardless of current income. The resource and income limits are low compared to other programs. The services are also limited to mostly acute care services.

Household Size	Income Limits	Asset Limit
1	$337.00	1 person - $500
2	413.00	2 or more people - $750
3	516.00	
4	602.00	
5	686.00	
6	756.00	

Spend down: Cash only up to $50.00.
Deductions: Health insurance, taxes on earned income.
Retroactive Coverage: UMAP allows a 4 day grace period.

Children's Health Insurance Program (CHIP)

- 200% of FPL and down (all parental income excluding social security and child support that goes to a child)
- Under 19 years of age
- Child must be Legal resident or US citizen
- Currently not insured (if voluntarily dis-enrolled from previous insurance - 90 day waiting period)

CHIP is administered in two tiers, for those families earning less than 150% FPL, there are reduced co-pays for most services and no co-insurance for labs, x-rays, and hospital visits. Families earning more than 150% FPL are required to pay slightly higher co-pays for most services and up to a 20% co-insurance for hospital visits, labs, x-rays, medical equipment, and supplies.

As of February 2002, CHIP enrollment was 26,788 children. According to Chad Westover, CHIP program Director, the total number of children eligible for CHIP in Utah is estimated at just over 36,000. A projected take up rate of 80% would result in 29,000 children covered by CHIP in Utah.

Use of Federal waivers:

The state of Utah currently has two 1915(b) Freedom of Choice waivers.

THE STATE OF UTAH 1915(b) PROGRAM - Choice of Health Care Delivery Program

Proposal Renewal Approval: July 23, 2001
Proposal Renewal Expiration: July 23, 2003

PROGRAM SUMMARY:

The State of Utah submitted a renewal proposal under Section 1915(b) of the Social Security Act (the Act) authority to provide Medicaid clients managed care services in the urban areas of Weber, Davis, Salt Lake and Utah counties. In the rural areas choosing a primary care provider or MCO is voluntary and Medicaid clients may remain with traditional fee for service.

The waiver operates in the following Counties: Weber, Davis, Salt Lake, and Utah. Since July 1, 1996 96% of Medicaid urban clients have been enrolled in MCOs. The program is administered by the Utah Department of Health, Division of Health Care Financing.

The uniqueness of the waiver is that it requires Medicaid clients living in urban counties to select an MCO that provides , through ongoing patient/physician relationship, primary care services and referral for all necessary specialty services.

In the rural areas of Utah Medicaid clients are offered the selection of a Primary Care Provider (PCP) or MCO, when available; traditional fee for service remains an option, as well. Enrollment is voluntary in the rural areas.

The State arranges for an annual independent, external review of the quality of services delivered under each MCO contract with the State. The entity which provides the annual external quality review is not part of the State government, and is not a managed care organization or an association of managed care organizations. The entity is HealthInsight, the federally-designated Peer Review Organization for Utah.

THE STATE OF UTAH 1915(b) PROGRAM - Utah Non-Emergency Transportation Waiver Program (UT06)

Approval: September 19, 2000
Expiration: September 18, 2002

PROGRAM SUMMARY:

The purpose of the waiver is to control costs through the selection of a Statewide non-emergency transportation broker who will be paid a monthly capitation rate based on the average number of eligibles for each month. The waiver program is operated directly by the state Medicaid agency. The State was and will continue to claim transportation as a service under the waiver.

The waiver was approved under 1915(b)(4) authority to allow the State to utilize a single broker statewide. A waiver of 1902(a)(23) was also granted to allow the State in order to constrain beneficiary freedom of choice to selected providers, in this case to the broker or subcontractors selected by the broker. The single broker will be selected through a competitive request for proposal (RFP) process.

The waiver will cover all Medicaid beneficiaries (TANF, SSI, and related populations) who have no personal transportation, have no access to public transportation, or have access to but cannot reasonably use public transportation due to a precluding disability or medical condition. Enrollment for eligible individuals will be mandatory. Populations excluded from this waiver are

those residing in a nursing facility or an ICF/MR or those who have access to and are capable of using public transportation.

The state of Utah currently has the following 1915(c) Home and Community-Based Services Regular Waivers and 1915(c) Home and Community-Based Services Model Approved Waivers.

Utah Home and Community-Based Services Regular Waivers as of *10/04/2001*

WAIVER	DESCRIPTION	STATUS	EFFECTIVE DATE
0158.90.R2	Provides Intermediate care facility for the mentally retarded, services include support coordination, community living, personal assistance, PERS, environmental accessibility adaptations, Chore and homemaker, supported employment, site and non-site-based day, senior supports, transportation, latch key, family assistance and support, respite, self-directed, educational, spec. medical equipment/supplies/assistive tech., and specialized supports. (Replaces 0158.90.R1 which expires 6/30/00)	Approved 6/30/00	07/01/2000
0158.90.R2.01	Waiver mod to 0158.90.R2 to accommodate the dual diagnosis pilot project.	Pending 6/29/01	
0158.90.R2.02	Waiver mod to 0158.90.R2 to decrease factor C for FY2002 from 3,755 to 3,564.	Pending 7/19/01	
0247.90.R1	To provide case management, homemaker, in-home respite, supportive maintenance, adult day care, PERS, non-medical transportation, home delivered meals and companion services. (Replaces 0247.90 which expires 6/30/00)	Approved 6/30/00	07/01/2000
0292.90	Provide case management, homemaker, respite, habilitation, supported employment, specialized medical equipment and supplies, PERS, companion, family training, transportation, structured day programming, community supported	Approved 9/30/99	07/01/1999

	living, and counseling to TBI age 18 and over. (Replaces 0292)		
0292.90.01	Waiver mod to 0292.90 to increase factor C from 59 to 82 for FY 2002.	Pending 7/19/01	
0331	To provide attendant care, personal emergency response systems, personal assistance services, and consumer preparation services to individuals with physical disabilities.	Approved 6/1/98	07/01/1998
0331.01	Waiver mod. to 0331 to change effective date and state contact person, amend provider qualifications for consumer prep. services and clarify the divisions which will enter into provider	Approved 4/2/99	07/01/1998
0331.02	Waiver mod to 0331 to add a new waiver service, Local Area Support Coordination Liaison and to amend the waiver's approved plan of care document.	Approved 12/26/00	07/01/2000
0331.90	To provide attendant care, PERS, local area support coordination liaison, consumer prep., nursing facility level of care.	Pending 7/2/01	

Utah Home and Community-Based Services Model Approved Waivers as of *10/04/2001*

WAIVER	DESCRIPTION	STATUS	EFFECTIVE DATE
40183.90	To provide respite, in-home respiratory care, nutritional evaluation and in-home based treatment, in-home family counseling, portable oxygen for non-medical transportation and activities to technology dependent/medically fragile under 21. (Replaces 40183 which expired 6/30/98) 7/15/98	Approved	07/01/1998
40183.90.01	Waiver mod to 40183.90 to change age criteria to over 21 years of age and older who were admitted t the waiver prior to their 21 birthday. 7/6/99	Approved	07/01/1998

40183.90.02	Waiver mod to 40183.90 to increase the number of individuals served for years 3, 4 and 5. 12/5/00	Approved	07/01/2000

Appendix II: Links to Research Findings and Methodologies

Indicate the Web site addresses for any additional sources of information regarding your State's research work, including detailed data spreadsheets, cross-tabs, focus group and key informant interview summary reports, survey instruments, and summaries of research methodology.

This information will be made available once our data collection efforts are complete. Results of the 1996 Utah Health Status Survey along with numerous other Utah Department of Health publications is available at: http://www.health.state.ut.us/action2000/. Results of studies completed by the Utah State Planning Grant will be posted on the project web-site at: http://www.health.state.ut.us/cu2002.

[1]Data were insufficient to estimate insurance coverage for racial and ethnic minorities.
[2] Information about Muskegon county's Access Health program can be found at http://www.access-health.org