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COVERAGE AND COSTS

What's Driving Medicaid Spending in Utah?

UTAH HEALTH COST SERIES: PART 3

MAY 2018

COVERAGE AND COSTS

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INTRODUCTION

In 2010, the Affordable Care Act marked a major milestone for the Medicaid program. The law significantly changed national health care policy by expanding Medicaid coverage eligibility to a broader population. Since then, there have been several proposed changes to the program both nationally and in Utah. There are probably more to come.

This report addresses Utah's Medicaid program, the factors driving Medicaid costs, and both recent and proposed changes.

This is the third in a series of Utah Foundation reports analyzing the cost of health care in Utah. Part 1 examined the total cost of health care in Utah and the factors driving the cost of medical care. Part 2 estimated the affordability of health insurance for Utah individuals and families.

BACKGROUND

Medicaid is a publicly funded federal-state health insurance program for low-income populations. The program covers one in five Americans, reaching low-income children, adults, seniors and people with disabilities.¹ Nationally, it is the single largest source of health care coverage.² The significance of Medicaid reaches beyond immediate beneficiaries. A survey by the Henry J. Kaiser Family Foundation found that six out of 10 Americans reported that Medicaid is personally important for them and their family.³



KEY FINDINGS OF THIS REPORT

- In 2016, per capita Medicaid spending in Utah was the lowest in the nation at \$703. At the other end of the spectrum, Medicaid spending in New York was \$3,169 per capita.
- In 2014, Utah spent \$5,326 per enrollee (in combined state and federal funds), one of the lowest expenditure levels in the nation. North Dakota spent \$10,721, the highest in the nation.
- National Medicaid spending is expected to grow at an average annual rate of 5.8% through 2026 – slower than Medicare, but faster than private insurance and far faster than the rate of inflation.
- The federal government pays for 70% of qualifying Medicaid programs in Utah, the ninth highest reimbursement rate in the nation. Reimbursement levels are determined in large part by each state's per capita income, and Utah's is among the lowest in the nation because of the state's high proportion of children.
- While Utah's Medicaid spending increased in 2017, there was a slight decrease in enrollment. This is due in part to an increase in the average enrollment of older Utahns and individuals with disabilities, who are more expensive to care for.
- Although children make up 63% of Utah's Medicaid enrollment, they account for less than one-third of total spending.
- In Utah, individuals with disabilities make up less than 15% of enrollment, but account for nearly half of all spending.
- In 2016, Medicaid accounted for 18.7% of Utah's overall state budget, the eighth lowest in the nation.
- The primary factors driving Medicaid spending growth include increases in health care and prescription drug costs, increases in overall enrollment, increases in enrollees who are older or have disabilities, and downturns in the economy.

However, many policymakers worry about the program’s cost. In 2016, Medicaid accounted for \$576 billion in combined federal and state spending – roughly \$1,711 per capita and \$7,680 per enrollee nationwide.⁴ Medicaid spending per capita in Utah is much lower, about \$703. This is the lowest in the nation and a fraction of the highest-spending state’s (New York) per capita Medicaid expenditures of \$3,169.⁵ This is in part explained by Utah’s relatively low enrollment rate. It can also in part be explained by Utah’s relatively low proportion of enrollees over 65 or who have a disability – groups that come with high costs.

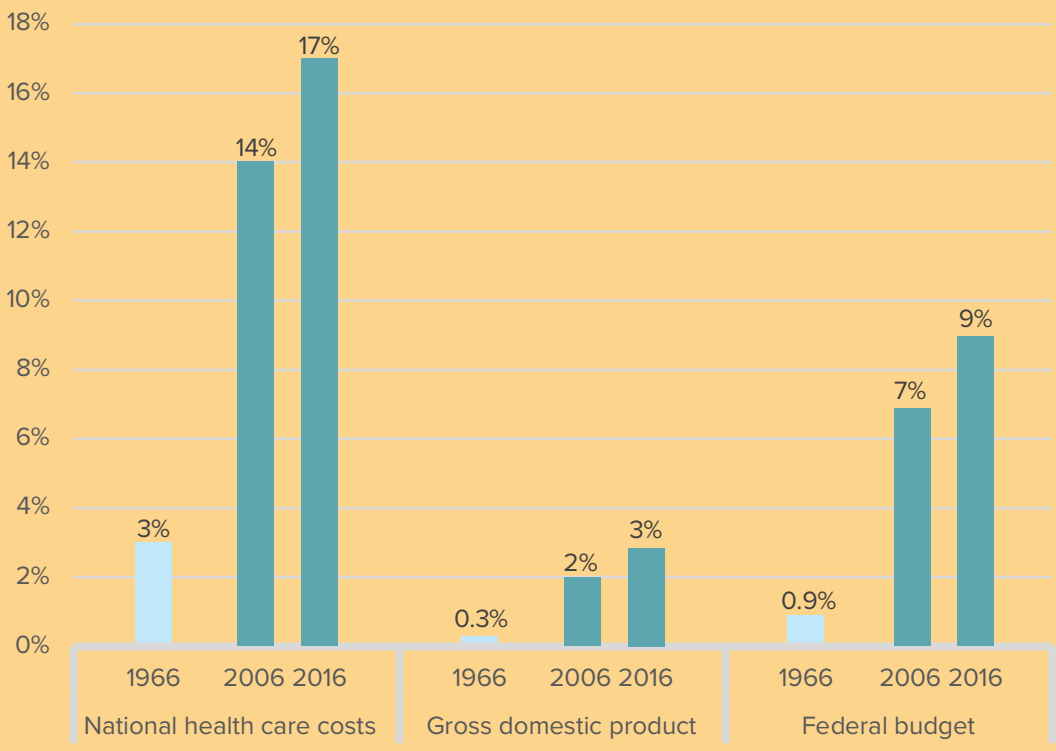
Utah is the 10th lowest-spending state per enrollee. In 2014 (the most recent year for which data are available), Utah spent \$5,326 per enrollee. Nevada spent \$4,003, the lowest in the nation. North Dakota, at the other end of the spectrum, spent the most – \$10,721 per enrollee.⁶

For some health care needs, Medicaid provides more funding than any other source of insurance. Nationally, it funds more than half of all long-term care service costs and pays more for behavioral health services (mental health and substance abuse services) than any other source of health insurance.⁷

There are widespread concerns that Medicaid’s overall spending growth is on an unsustainable path. In 1966, the first year Medicaid was implemented, it accounted for less than 3% of total health care costs. In 2016, Medicaid accounted for nearly 17% of total U.S. health care spending. Medicaid spending also increased as a share of the overall economy, from 0.3% of total spending in 1966 to 3% in 2016. A third measure of Medicaid’s spending growth is demonstrated in its share of the overall federal budget, which increased from 0.9% of federal spending in 1966 to 9% in 2016. (See Figure 1.)

The cost impact of Medicaid has grown significantly over time and continues to grow.

Figure 1: U.S. Medicaid Cost Increases as a Percentage of Three Separate Measures



Sources: Centers for Medicare & Medicaid Services, Medicaid and CHIP Payment and Access Commission, Congressional Budget Office, U.S. Government Publishing Office, U.S. Office of Management and Budget.



METHODOLOGY, SCOPE AND LIMITATIONS

This report analyzes Medicaid cost trends both nationally and in Utah. It examines populations currently enrolled and eligibility policies in Utah. It provides an overview of state and national Medicaid cost trends and the financial landscape, both in the state and nationally. Finally, the report analyzes possible policy changes that are currently underway in Utah.

The report examines the cost of Utah's Children's Health Insurance Program separately. CHIP in Utah is separate from Utah's Medicaid program. Children enrolled in CHIP are up to 19 years old and in families that make between 138% and 205% of the federal poverty level.

To prepare this report, Utah Foundation interviewed experts in the medical field, community health organizations and government, as well as other stakeholders. The report draws on research reports and scholarly literature from the Utah Department of Health, the Utah Division of Medicaid and Health Financing, the Utah Office of the Legislative Fiscal Analyst and the Utah Medical Care Advisory Committee. It also draws on data from the Centers for Medicare & Medicaid Services, the Henry J. Kaiser Family Foundation, the Commonwealth Fund, Pew Research Center and the State Health Access Data Assistance Center.

The Centers for Medicare & Medicaid Services project Medicaid spending to grow at an average annual rate of 5.8% through 2026. While alarming, this is slower than the projected rate of 7.4% for Medicare. By contrast, total national expenditures for private insurance are expected to decelerate during this period, averaging 4.7%. This is in part a result of the ongoing shift of the baby-boom generation, leaving private insurance for Medicare and Medicaid.⁸ The projected Medicaid cost increase contrasts sharply with projections closer to 2% for the overall rate of inflation and 2% for GDP growth.⁹

PAYING FOR MEDICAID

States and the federal government share the cost of Medicaid. To receive federal funding, states must cover certain mandatory services. These include services for core groups, such as poor children and pregnant women, as well as core benefits, such as inpatient and outpatient hospital services. Outside of those core groups and services, states have a great degree of flexibility in designing Medicaid. States may choose to cover optional services. This may include insuring additional groups of people or offering other benefits (such as prescription drugs and physical therapy), which must receive federal approval for federal funding.



MEDICAID ENROLLEE POPULATION DEFINITIONS

This report identifies Medicaid enrollees in five categories: children, adults, individuals with disabilities, older Utahns and the Primary Care Network. Utah's Medicaid program insures **children** up to 19 years old in families that make less than 138% of the federal poverty level. There are some classifications that insure children between birth and five years old in families up to 144% of the federal poverty level. **Adults** in the program include pregnant women, caretakers, refugees, and women with breast and cervical cancer between 19 and 64 years old. **Individuals with disabilities** include people under the age 65 who are enrolled in a Medicaid program based on their disability status. **Older Utahns** include people who are over the age of 65. The **Primary Care Network** is a separate program that enrolls adults without children, and parents or caretaker relatives, yet it is funded with Medicaid dollars.

Although the program is optional, all 50 states, the District of Columbia, and U.S. territories participate and receive federal funding. However, because of the flexibility encouraged by national policy, each state has a unique Medicaid program.

How is it Funded?

The federal government guarantees matching funds for mandatory services and approved optional services. The matching rate is determined by a federal formula designed to account for income variation across the states by using per capita income as the main variable. Utah's matching rate of 70% is one of the highest in the nation, largely because Utah's per capita income is among the lowest in the nation (due to Utah's high proportion of children).¹⁰ For every \$1 spent by the state, the federal government spends \$2.36. No state can receive a rate lower than 50% (an equal match of \$1 by the federal government for every \$1 spent by the state) and no higher than 83% (whereby the federal government pays \$4.88 for every \$1 spent by the state.)¹¹ In 2018, 14 states received the minimum 50% rate. Mississippi received the highest match rate of 75.7%. The average federal share of Medicaid expenses increased from 57% before the Affordable Care Act to 63% in 2016.¹²



RECENT NATIONAL MEDICAID REFORM PROPOSALS

In 2017, the U.S. House of Representatives passed the American Health Care Act as a replacement for the Affordable Care Act, popularly known as "Obamacare." The bill was passed on to the Senate for review. The Senate's version of the bill was titled the Better Care Reconciliation Act of 2017. Both versions of the bill proposed two cost growth reforms that would have drastically changed the way Medicaid is financed. Had the bill passed, states could have chosen between a Medicaid block grant or a per capita allotment.

With a block grant, the federal government provides an annual lump sum payment to states to use for Medicaid expenditures. The formula used to determine the annual block grant would have been tied to the CPI-U (the urban consumer price index, a common measure of inflation). In other words, the federal contribution would grow at a preset formula, rather than in response to the size of the population in need of Medicaid or the growing cost of care.

Under a per capita allotment approach, the federal government provides a fixed amount of money per Medicaid enrollee. The formula for annual per capita funding would have been tied to the medical care component of the CPI-U for most enrollees. For people with disabilities and people over 65 years old, the per capita growth rate would have been tied to the medical care component of the CPI-U plus one percentage point.

Both proposals are meant to reduce federal spending by creating fixed-funding formulas, and effectively shift more of the cost burden to states. Had the bill passed, the Congressional Budget Office and the Joint Committee on Taxation estimated the legislation would reduce federal deficits by \$420 billion between 2017 and 2026.

However, these proposals raised concerns because medical care inflation in the U.S. has consistently risen faster than general inflation since 1948 and using the CPI-U to track inflation could result in funding shortfalls in the future. Multiple analyses also predicted that the changes would encourage states to scale back Medicaid enrollment and benefits to avoid budget shortfalls, increasing the number of uninsured. The Congressional Budget Office estimated there would be an increase of 22 million uninsured by 2026, largely among low-income Americans.

For more information on medical cost inflation, see *Bills of Health: What's Driving Medical Service Costs in Utah?* at www.utahfoundation.org/reports/bills-health-whats-driving-medical-service-costs-utah/.

Sources: Health Reform Tracker. The Commonwealth Fund. Congressional Budget Office. Congressional Research Office. The JAMA Forum.

Medicaid spending can vary year-to-year because it has an open-ended financing structure. In other words, there is no financial cap on spending except in U.S. territories. If a state spends more on a program, the federal government guarantees the matched rate for increased spending. The open-ended financing system allows federal funds to assist states based on actual costs and needs as economic circumstances change. The open-ended financing structure, however, also makes Medicaid spending difficult to forecast.

This piece of Medicaid policy is frequently a target for national reform policy, which can have a significant impact on the way states pay for Medicaid. One recurring proposal is to move to a block grant approach, which gives each state an annual lump sum for the Medicaid program. Another option is a per capita allotment, where each state receives a fixed amount of federal funding per Medicaid enrollee. (See the sidebar.)

Medicaid Cost Growth Trends

In 1966, state and federal Medicaid spending totaled just \$1 billion. By 1971, Medicaid spending reached \$6.5 billion, more than double the initial projections.¹³ This was because analysts underestimated the extent to which states would extend coverage for optional groups and services, which greatly exceeded enrollment expectations.¹⁴

Although Medicaid enrollment declined in the second half of the 1970s, spending continued to increase. This was largely due to high price inflation throughout the economy, with an annual rate peaking at nearly 15% in 1980, as well as inflation in medical costs.¹⁵ The tremendous growth in Medicaid spending from 1970 to 1980 (averaging 17% per year) motivated Congress to look for ways to reduce the cost of the program.

In 1981, Congress passed the Omnibus Budget Reconciliation Act, which instituted a three-year reduction in federal financial participation toward program costs. It reduced eligibility for welfare benefits, making it more difficult to qualify for Medicaid. The act also gave states much more flexibility in program development. Many states began to implement alternative health care delivery and reimbursement systems. These changes helped reduce average annual spending increases and helped keep enrollment stable.

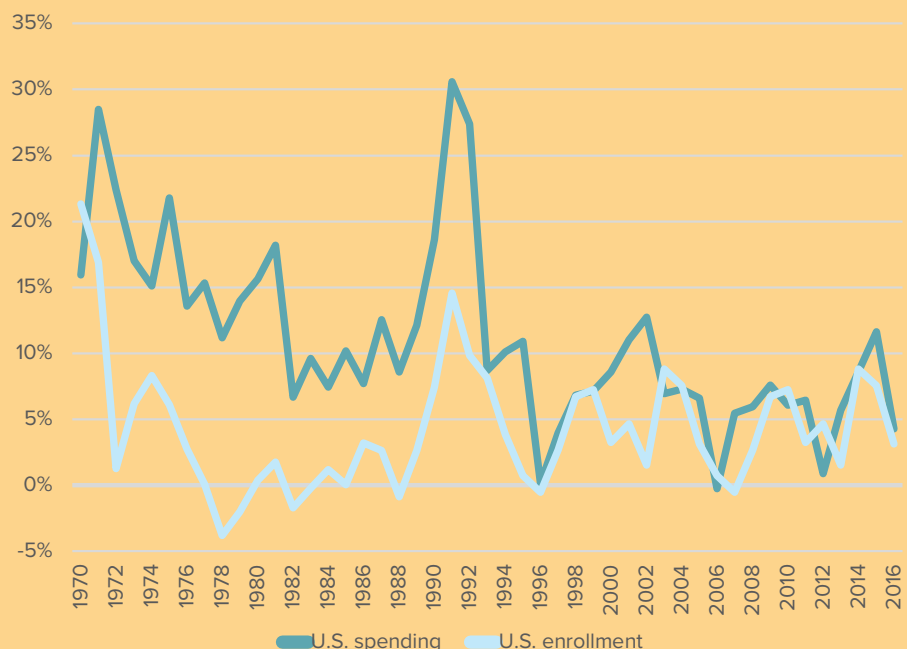
By the late 1980s, policymakers worried that the 1981 act had been too severe. As a result, the federal government expanded eligibility by weakening Medicaid's link to cash assistance programs and more closely aligned program eligibility with the federal poverty level. The eligibility expansion, coupled with the recession in 1991, caused the greatest increase in Medicaid spending in the history of the program, increasing nearly 27% nationally (Figure 2) and 36% in Utah.

The remainder of the 1990s saw substantial decreases in both spending growth and enrollment, largely due to an improving economy and federal policies that gave states more flexibility to design their programs. The Balanced Budget Act of 1997 implemented provisions to Medicaid that encouraged the use of managed care (see

The biggest spikes in Medicaid spending and enrollment occurred in 1991.

Figure 2: Annual Percentage Change, Spending Growth and Enrollment, U.S., 1970-2016

Source: Centers for Medicare & Medicaid Services, Office of the Chief Actuary, Medicaid and CHIP Payment and Access Commission.





KEY TERMS AND CONCEPTS FOR MEDICAID DELIVERY AND PAYMENT REFORM

Historically, most state Medicaid programs delivered and paid for health care services on a **fee-for-service** basis. Under this payment model, Medicaid pays participating physicians, clinics, hospitals and other providers for each service provided. This model is the most expensive as it inherently rewards volume, as opposed to patient outcomes or quality of care. Fee for service can also be fragmented and can lack coordination among providers, which can result in redundancy and waste. As a way of reducing costs and increasing efficiency, state Medicaid programs have expanded implementation of alternatives to fee for service in both service delivery and payment systems. These alternative models are together generally referred to as **managed care**.

There is wide variation in the approach to managed care among states, as they design and combine service delivery and payment systems depending on their reform goals, the needs of their enrollee populations and overall budgetary limitations. The Kaiser Family Foundation identified seven of the most common alternative delivery systems and nine payment models.

Utah overhauled its Medicaid fee-for-service model with **accountable care organizations**, which are health plans that deliver services to, and coordinate the care of, their Medicaid members. In addition to changing the way care is delivered to Medicaid beneficiaries, Utah also changed the way it paid providers. All contracts Utah has with accountable care organizations are **full-risk capitated care**. Capitated payments are a fixed per member per month rate that state Medicaid agencies pay managed care organizations. Managed care organizations assume the full risk for all health care costs enrollees incur, giving them an incentive to increase positive patient outcomes. Utah's Division of Medicaid and Health Financing contracts with an actuarial firm to set the capitated rates.

Sources: The Henry J. Kaiser Family Foundation. Utah Division of Medicaid and Health Financing.

sidebar for definitions), which Utah now uses. In 1990, only two states had waivers approved by the federal government to implement Medicaid managed care. By 1999, 34 states had a managed care plan. The percentage of Medicaid enrollees in managed care increased from 10% in 1990 to 55% in 1999.¹⁶

Increases in Medicaid enrollment, and spending, frequently follow downturns in the national economy. National increases in 2014, by contrast, were a result of the eligibility expansion implemented under the Affordable Care Act.

NATIONAL HEALTH POLICY CHANGES

The Affordable Care Act became law in 2010, bringing major changes to Medicaid. The most well-known change expanded eligibility to all people who earn up to 138% of the federal poverty level – making income, rather than specific program parameters, the only requirement for this new group to qualify. This provision is most significant for childless adults. Prior to the Affordable Care Act, childless adults were eligible for coverage only if the state in which they resided received approval from the federal government for funding or it was funded entirely by the state. Few states had federal permission to offer coverage to this population, and those that did had strict eligibility requirements or capped enrollment. As of 2016 (the most recent year for which data are available), the expansion increased Medicaid enrollment by nearly 12 million more people nationwide, roughly 4% of the U.S. population.¹⁷ The Affordable Care Act fully funded the newly eligible population from 2014 to 2017, with the federal funding matching rate

phasing down to 90% from 2020 onward. This is a significantly higher match than states receive for traditional Medicaid.

Some states fought the change in national policy. In 2011, 26 states sued the federal government over the constitutionality of the Affordable Care Act's expansion provision. The U.S. Supreme Court ruled in favor of the states in 2012. The court found that the Medicaid expansion was unconstitutionally coercive, holding that the states were not provided enough time to voluntarily consent to the change in policy. The court also found, however, that this was remedied by making Medicaid expansion optional. There are 18 states that have not adopted full Medicaid expansion, including Utah. In this, Utah is joined by neighboring Idaho and Wyoming, along with several Great Plains states and most Southern states.



MEDICAID ORIGINS

Before enacting Medicaid, the federal government made limited medical payments to states for cash welfare recipients. This led to the Kerr-Mills Act. The Kerr-Mills legislation extended eligibility for medical benefits to people 65 and older who were not receiving cash assistance, but who would otherwise be reduced to poverty by medical costs.

State and local officials were eager to replace the legislation, arguing it was failing to meet its objectives. National advocacy groups echoed these concerns. The elderly population was growing, health care costs were rising and there was no affordable health insurance for those who were retired or unable to work. At the same time, President Lyndon B. Johnson vowed to wage a “War on Poverty” by means of major national efforts in health insurance, education, job training and increased safety net protections for low-income Americans.

At the time Medicaid was enacted alongside Medicare, there was little pushback. In fact, while Medicare stole the spotlight, Medicaid was perceived less as a groundbreaking program, but rather as a modified version of Kerr-Mills.

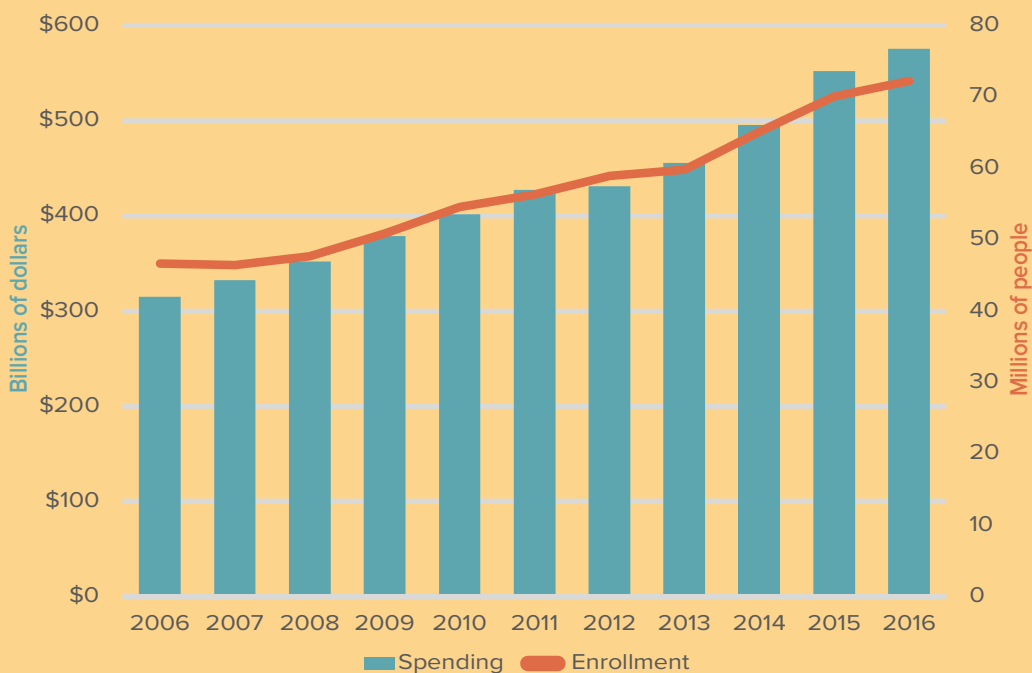
Source: Centers for Medicare & Medicaid Services.

Spending and Enrollment Trends

In 2015, the first full year of the Medicaid expansion, national spending increased 10.5%, largely due to an enrollment increase of 13.2%.¹⁸ The following year saw much smaller increases. Enrollment in 2016 increased 3.9%, while total spending increased 3.5%. (See Figure 3.) Nationally, enrollment growth is projected to continue to slow in 2018 due in part to a stable economy and the slowing of new enrollment under the Affordable Care Act.

Increases in Medicaid spending generally follow increases in Medicaid enrollment.

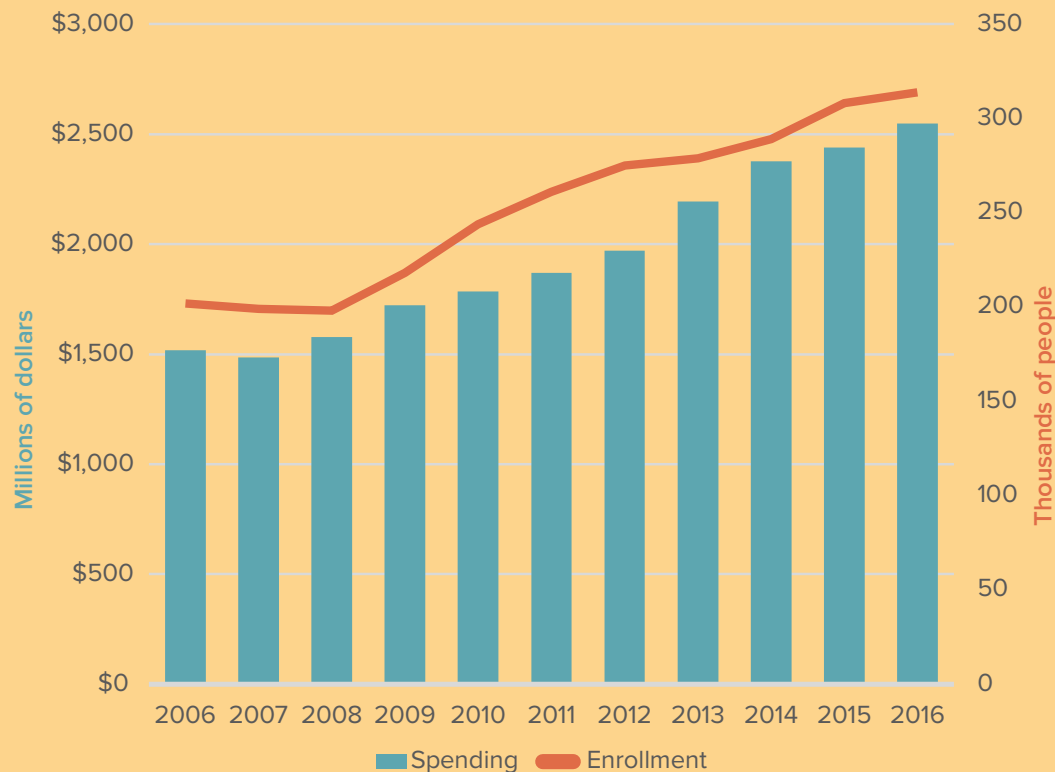
Figure 3: National Enrollment and Spending Growth, 2006 to 2016



Source: Centers for Medicare & Medicaid Services. Medicaid and CHIP Payment and Access Commission.

Increases in Utah's Medicaid spending roughly follow increases in Medicaid enrollment.

Figure 4: Utah Enrollment and Spending Growth, 2006 to 2016



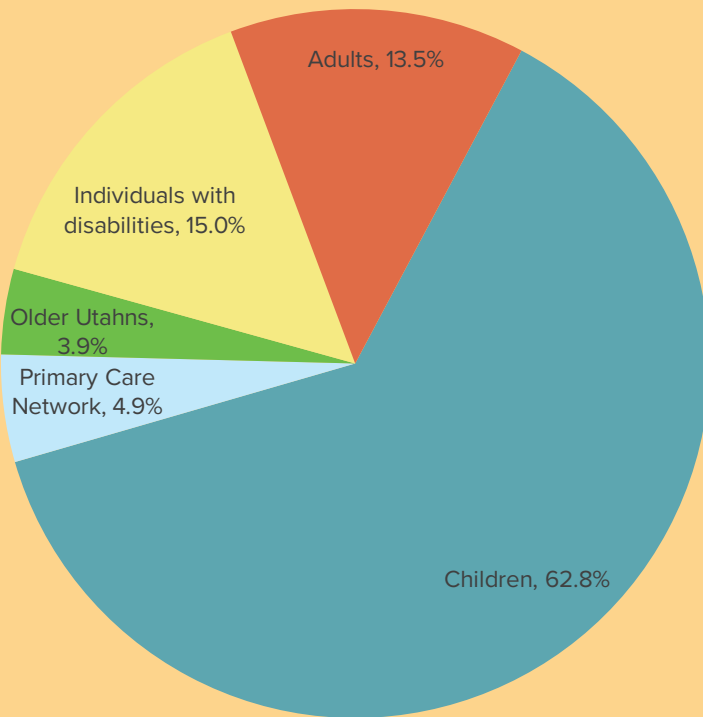
Source: Utah Department of Health.

Utah's enrollment and growth pattern is similar to that of the nation at large. (See Figure 4.) However, Utah began saving money in 2014 as a result of the Legislature's passage of Senate Bill 180, Medicaid Reform, during Utah's 2011 general session. SB 180 called for a four-pronged approach to cost reduction: replace fee-for-service plans with accountable care organizations; pay providers for packages of services delivered over an entire episode of illness, rather than piecemeal; bring the rate of growth in Medicaid more in line with the overall growth of the general fund; and add incentives for beneficiaries to maintain and improve their health status.¹⁹ In 2014, Utah's Medicaid budget had a \$50 million surplus from the previous year, due in large part to the reforms implemented under SB 180.²⁰

After two years of deliberations with the Centers for Medicare & Medicaid Services, Utah provided for four accountable care organizations: HealthChoice Utah, Healthy U, Molina Healthcare of Utah and SelectHealth Community Care. The Utah Division of Medicaid and Health Financing requires Medicaid enrollees living in 13 of Utah's 29 counties to enroll in a managed care plan.²¹ The counties required to enroll are largely along the Wasatch Front and have the greatest access to multiple options for a managed care health plan. In all other counties, beneficiaries have the option of enrolling in a managed care plan or a fee-for-service plan. In 2017, about 93% of Utah's Medicaid beneficiaries were enrolled in an accountable care organization.²²

Children make up nearly 63% of the total Medicaid population.

Figure 5: Utah Medicaid Enrollment by Population Categories, 2017



Source: Utah Department of Health, 2017 Medicaid & CHIP Annual Report.

UTAH'S EXPANSION PROPOSALS

In Utah, the Department of Workforce Services primarily determines eligibility for Medicaid, with a limited number of cases completed by the Department of Human Services. There are more than 30 types of Medicaid classifications in the state. Each classification imposes unique eligibility requirements. Household income and financial assets are a primary consideration for eligibility for all classifications. Beneficiaries must be U.S. citizens, legal immigrants or permanent residents of the U.S. They must also be residents of Utah. Additionally, beneficiaries must qualify each month for continued coverage.

About 10% of Utah's population has health insurance coverage through Medicaid. Figure 5 shows the percent of enrollees broken down into five broad categories.

Children make up the largest percentage of the Medicaid program by far. Individuals with disabilities and the adult population are the second and third largest groups.

Targeted Adult Population Expansion

In November 2017, a limited Medicaid expansion for adults took effect in Utah. The targeted adult population qualifies only under specific conditions. The expansion provides Medicaid coverage for adults who earn up to 5% of the federal poverty level. Income up to 5% of the federal poverty is equivalent to no more than \$50.25 per month for a household size of one, and \$67.70 per month for a household of two.



AFFORDABLE CARE ACT MEDICAID POLICY CHANGES

The Affordable Care Act implemented several other policy provisions in addition to the expansion. The law included provisions to improve the delivery of community-based long-term services and improve the overall quality of care. The law also provided funding to states to upgrade Medicaid enrollment systems. It provided funding to streamline the application process for Medicaid, the Children's Health Insurance Program and health insurance subsidies on the federal health insurance exchange. Funding and resources were also dedicated to simplifying the enrollment and renewal processes.

Prior to the Affordable Care Act, people had to apply for Medicaid in person, fill out paperwork and asset test requirements, wait up to several weeks (or in some cases months) for an eligibility determination and repeat this process when renewing their enrollment. The Affordable Care Act simplified the process by allowing individuals to apply in person, by mail, over the phone or online. There is an electronic verification process with a real-time eligibility determination and an annual automated renewal process.

The law also created a new office within the Centers for Medicare & Medicaid Services to coordinate care between beneficiaries who are eligible for both Medicare and Medicaid. Other provisions in the law addressed areas where the program could enhance transparency and improve anti-fraud and abuse measures.

Sources: Medicaid.gov, The Henry J. Kaiser Family Foundation.

The expansion identifies three priority groups: the chronically homeless; those involved in the justice system through probation or parole and in need of substance abuse or mental health treatment; and those in need of substance abuse or mental health treatment without a criminal justice component. As of 2018, only the first two categories are open for enrollment in Utah. The third category is closed indefinitely as the Utah Department of Health monitors enrollment and expenditures for the first two categories. The Utah Department of Health estimates that between 4,000 and 6,000 adults could be covered. So far, 1,607 individuals are enrolled.²³

Local community health workers note there are some logistical challenges associated with enrolling homeless people and those with criminal histories and mental health issues. Additionally, the low income limit means few people qualify.

Utah House Bill 472 – Partial Medicaid Expansion

During the 2018 legislative session, the Utah Legislature passed House Bill 472, which calls for the Utah Department of Health to file a waiver with the Centers for Medicare & Medicaid Services requesting a partial Medicaid expansion.

The partial expansion increases the income eligibility for adults up to 100% of the federal poverty level. The bill also requests the increased federal funding match rate of 90%, with a financial safeguard to automatically sunset the program if the federal match ever drops below 90%. The bill also allows for flexibility with enrollment caps and a work requirement component for qualified adults. Services for the expansion population would be provided through a managed care model.

The bill requires approval from the Centers for Medicare & Medicaid Services. As of May 2018, there are 36 states with 44 approved waivers that are currently active and 23 states with pending waivers.²⁴

Once Utah's Department of Health submits the waiver called for under HB 472, Utah will join nine other states that have submitted waivers requesting a work re-



SECTION 1115 DEMONSTRATION WAIVERS

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to waive provisions of major health and welfare programs and allow states to use federal Medicaid dollars in ways otherwise not permitted. States submit waivers to the Centers for Medicare & Medicaid Services for approval, denial or ongoing negotiation. States use Section 1115 waivers for a broad array of requests, including expanding coverage, changing the way health care is provided and paid for, modifying the range of benefits provided, altering cost-sharing requirements from beneficiaries, increasing provider payments, and quickly extending coverage during an emergency.

The current administration has encouraged states to use 1115 waivers. The Centers for Medicare & Medicaid Services has sent a letter to state governors signaling support for states to pursue waivers to implement work requirements for Medicaid eligibility among qualified adults.

Source: The Henry J. Kaiser Family Foundation.

requirement, among which three states (Arkansas, Indiana and Kentucky) have been approved. The remaining six are pending. The sponsor of HB 472 included the work requirement with the intent of encouraging workforce participation and self-sufficiency among beneficiaries.

States are submitting waivers requesting Medicaid work requirements based on guidance from the Centers for Medicare & Medicaid Services. In January 2018, they issued a letter to state Medicaid directors announcing their full support for states seeking to implement a work requirement. Despite backing from the federal administration for work requirements, Utah officials face a difficult political process to get the waiver approved. In 2013, the previous administration explicitly informed states that waivers for partial expansions with the increased federal match rate would not be approved. In 2014, the Centers for Medicare & Medicaid Services approved Wisconsin for a partial expansion for adults up to 100% of the federal poverty level, but denied Wisconsin's request for an increased federal match rate.²⁵

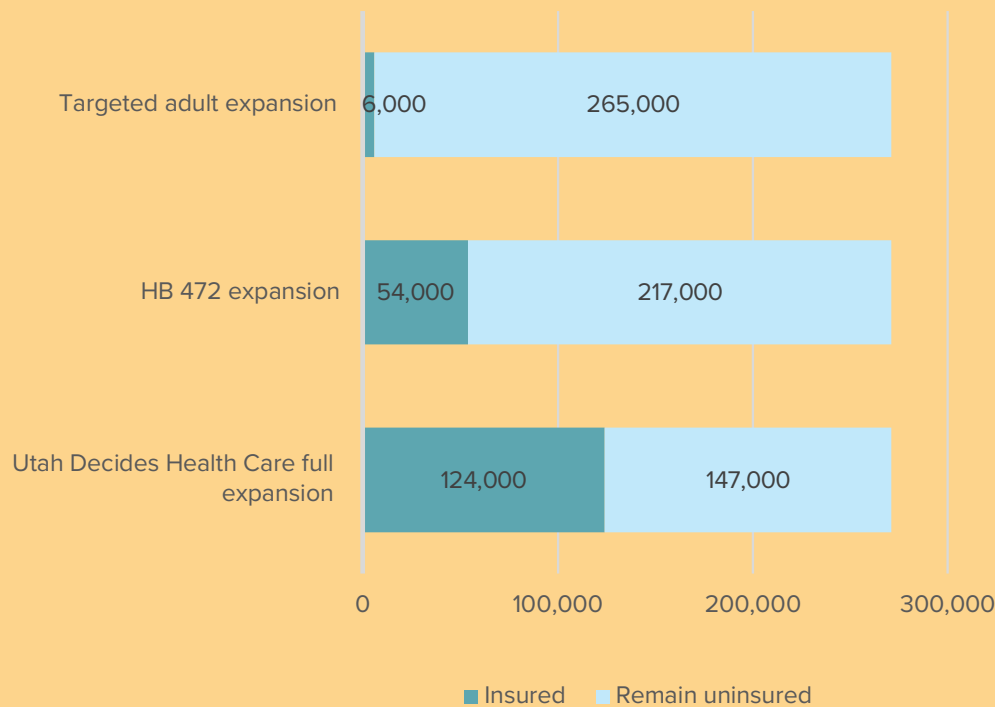
It is unclear how the current administration will respond to Utah's request. In 2018, the Centers for Medicare & Medicaid Services denied Arkansas' waiver request for a partial expansion, after having fully expanded. This was because the state requested a reduction in coverage from 138% of the federal poverty level down to 100%.²⁶

There are other reasons to question whether the current administration will approve Utah's waiver. To begin with, the Affordable Care Act specifically allocates a full federal match rate for an expansion population up to 138% of the federal poverty level. A request for partial expansion with an increased federal funding match rate has not yet been approved by the Centers for Medicare & Medicaid Services for any other state. Furthermore, they may lack the discretionary power under the law to award different states different match rates for the same eligibility group. That said, the change in administration might open the way for approval.

While the bill expands Medicaid coverage to about 54,000 Utahns by 2020, some community health workers and advocacy organizations see the bill as inadequate.²⁷ These groups are advocating for full Medicaid expansion in Utah, which could more than double the number of people eligible for Medicaid coverage.²⁸ (See Figure 6.)

There are substantial differences in coverage outcomes depending on Medicaid expansion.

Figure 6: Possible Reductions in Utah's Uninsured Adult Population, by Expansion Program



Source: U.S. Census Bureau, American Fact Finder. The uninsured number is based on 2016 data. State of Utah House of Representatives. Utah Department of Health. Public Consulting Group. Some people remain uninsured due to finances or other personal preferences even though they have access to health insurance on the federal exchange.

As of April 2018, the Utah Decides Health Care group successfully verified enough signatures to put full Medicaid expansion to voters on the November 2018 ballot.

It should be noted that this population (101% to 138% of the federal poverty level) currently has access to premium subsidies on the federal health insurance exchange. However, premiums and deductibles may be difficult to afford, discouraging people in this population group from obtaining health coverage. Others may remain uninsured for different reasons.

This has consequences for both Utahns and providers. People without insurance are less likely to receive preventive care and services for major health conditions and chronic diseases, which can create a need for costly services in the future.²⁹ In some cases, providers offer charity care for those without insurance, resulting in substantial uncompensated care costs. For instance, in 2016, one of the largest health care providers in Utah absorbed \$420 million in uncompensated care.³⁰ In states that expanded Medicaid as outlined by the Affordable Care Act, uncompensated care costs substantially decreased. Between 2013 and 2015, providers in the 31 states that expanded collectively saved \$6.2 billion in uncompensated care.³¹

Hospitals primarily cover uncompensated care costs. Both the federal and state governments provide partial compensation to hospitals to help offset the cost. In 2017, Utah's Division of Medicaid & Health Financing paid Utah hospitals \$30.6 million for uncompensated care, of which the federal government contributed just over \$8 million.³²

UTAH'S SPENDING ON MEDICAID

In 2017, the total cost of Medicaid in Utah was \$2.6 billion. Since not all programs require the 70-30 match, Utah paid about 35% of this amount (\$928.8 million), with the remainder coming from federal funds. While states have flexibility to determine how to pay for Medicaid, the primary source of funding comes from state general fund appropriations.

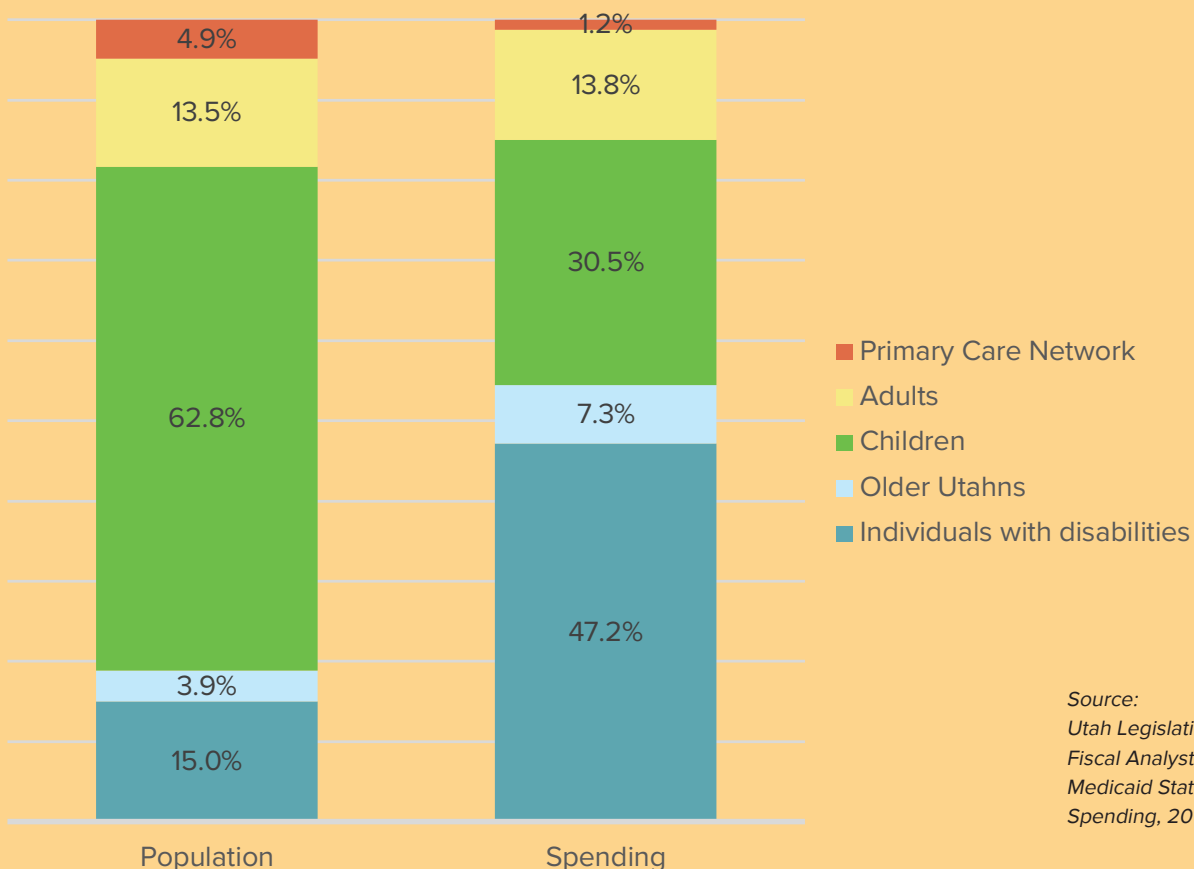
In 2016, Medicaid accounted for 18.7% of Utah's overall budget, the eighth lowest in the nation.³³ Within the eight-state region, only Wyoming saw a smaller share of its state budget going toward Medicaid, at 11.4%, the lowest in the nation.³⁴ Unlike Wyoming, however, Utah's Medicaid program as a share of the overall budget has decreased during the past few years. In 2014, Medicaid accounted for 19.5% of the overall budget, and in 2015 it accounted for 19%.

Cost by Population Group

There are substantial differences in costs among enrollment groups. Individuals with disabilities and older Utahns cost significantly more than adults and children. (See Figure 7.) Although individuals with disabilities account for 15% of the Medicaid population, they account for nearly half of all Medicaid spending.

More than half of all Medicaid costs are spent on older Utahns and individuals with disabilities.

Figure 7: Percentage of Medicaid Enrollment Populations by Percentage of Total Spending, Utah, 2016



Source:
Utah Legislative
Fiscal Analyst,
Medicaid Statewide
Spending, 2016.

a third of total spending. Utah's annual per enrollee cost for a child is substantially less than for an individual with a disability, \$2,483 compared to \$19,510.³⁵ Compared to the national average, Utah spends slightly less for children but slightly more for individuals with disabilities.

Cost of Eligibility Expansion

Under the 2017 expansion, enrollees with incomes up to 5% of the federal poverty level have an estimated cost of about \$100 million annually. About \$16 million will be paid for by the state and Utah hospitals have agreed to contribute \$13.6 million.

HB 472, which would expand eligibility up to 100% of the federal poverty line, is designed without any new state funds.³⁶ The bill is designed to use state money appropriated for the existing targeted adult expansion, as HB 472 would absorb that population. It also calls for the enhanced federal match rate of 90%, as opposed to the traditional 70-30 match. In addition, Utah hospitals agreed to increase their financial contribution to the program over time if necessary. Providers have an incentive to expand Medicaid because of the potential savings in uncompensated care costs. As a safeguard, the bill has a cap on state funding to control costs. However, this provision could potentially prevent individuals from getting Medicaid even if they qualify.

Looking Ahead: A Proposal for Full Medicaid Expansion

The Utah Decides Health Care ballot initiative proposes to pay for the full expansion with a 0.15% increase in the state sales tax rate on all non-food items. The increase would generate an estimated \$91 million in new revenue. The expansion currently qualifies for the 90% federal match rate promised under the Affordable Care Act. If approved, the federal government will be responsible for \$804 million to pay for Utah's newly eligible Medicaid enrollees.³⁷

Utah Foundation takes no position on the matter, and analysis of the Utah Decides Health Care proposal is beyond the scope of this report. However, a few general observations from a national perspective are in order.

Since the enactment of the Affordable Care Act, a large body of research has been produced on the effects of full Medicaid expansion in states.³⁸ A recent review of literature by the Kaiser Family Foundation showed states that enacted full expansion significantly increased the number of individuals with health insurance coverage, improving the financial security of low-income populations. Some studies found increased coverage also reduced uncompensated care costs for hospitals and clinics.³⁹

Expanding Medicaid may also reduce premiums on the online federal health insurance exchange. One study found that premiums on exchange in non-expansion states were 7% higher than states that had fully expanded.⁴⁰ This difference depends in part on the risk pool. If adults in poor health move from the federally subsidized Marketplace to Medicaid, it improves the risk profile of the Marketplace pool, easing price pressure on premiums.

However, uncontrollable future Medicaid costs remain a matter of concern. Expenditures for the program often balloon precisely when states are least prepared to pay for it, such as recessionary periods.⁴¹



Furthermore, annual upticks in state spending are projected through 2020 as the enhanced federal match slowly phases out from 100% to 90%. Additionally, overall Medicaid spending is projected to far outpace inflation at an average annual rate of 5.8% through 2026.⁴²

Still, it is unclear to what extent these costs would be offset by savings on uncompensated care, savings on state-funded behavioral and mental health programs, increased tax and fee revenue from accountable care organizations, and increased tax revenues from economic activity.

MEDICAID COST DRIVERS

There are several factors that cause spending growth in Medicaid expenditures. These factors help explain historical and projected spending growth.

Rising Health Care Costs

Parts 1 and 2 of Utah Foundation's Health Cost Series found that medical technology and prescription drugs are among the main drivers of increased health care spending. While the U.S. government sets reimbursement rates paid to providers for fee-for-service Medicaid, they regularly increase to help account for the increasing cost of care.⁴³ Between 2016 and 2017, 46 states increased the reimbursement rate for some type of provider (inpatient hospital, outpatient hospital, physician rate).⁴⁴ Utah increased rates for dental providers, nursing care facilities and accountable care organizations, which reimburse physicians, hospitals and all other medical providers of care.⁴⁵ In Utah, accountable care organizations negotiate reimbursement rates with providers.

THE QUESTION OF IMPROPER PAYMENTS

Since 2003, the U.S. Government Accountability Office has classified Medicaid as a high-risk program from a fiscal oversight standpoint. Medicaid's size, growth and program diversity make adequate fiscal oversight at the state and federal levels difficult. Every two years, the office releases a report identifying agencies and programs that are vulnerable to fraud, waste, abuse and mismanagement, or are most in need of organizational transformation. The office measures this based on the "improper payment rate." Payments are considered improper when: federal funds go to the wrong recipients; recipients receive the incorrect amount of funds; sufficient documentation is not available during review to discern that a payment was proper; or recipients use federal funds in a way that was not accounted for.

Not all improper payments represent fraud, nor do they necessarily represent a financial loss to governments. Nationally, the two top causes for improper payments in 2017 were the inability of state Medicaid agencies to authenticate eligibility through proper documentation and administrative or process errors made by state or local agencies. From 2013 to 2017, the Medicaid improper payment rate increased from 5.8% to 10.1%. This was due in large part to the challenges associated with the new compliance requirements outlined under the Affordable Care Act. The Centers for Medicare & Medicaid Services note that it is common for improper payment rates to increase following the implementation of new regulations.

The U.S. Government Accountability Office identified four program issues where states can focus to improve improper payment rates: enrollment verification processes, oversight of state Medicaid managed care organizations, screening procedures for provider participation in Medicaid, and coordination between Medicaid and the federal health insurance exchange to ensure individuals do not have duplicate coverage.

In 2016, the Centers for Medicare & Medicaid Services conducted an on-site visit of Utah's Medicaid program and accountable care organizations. The Centers found Utah could improve oversight of the state's managed care organizations. Specifically, the report recommended the following: the state should ensure all accountable care organizations have a case tracking management system, so all Medicaid fraud investigations can be accurately reported and tracked; the state should ensure accountable care organizations are allocating sufficient resources to the prevention, detection, investigation and referrals of suspected fraud; and the state should improve procedures that enhance the relationship between accountable care organizations and Utah's Office of Inspector General of Medicaid Services.

It should be noted that the Affordable Care Act implemented several tools to increase the amount of money the federal government recovers from fraud through Medicaid, Medicare and CHIP. The enhanced fraud recovery provisions may be working. The total amount of overall money recovered by the federal government from fraud cases has been consistently higher in years after implementation of the Affordable Care Act compared to years prior. For instance, in 2009 (the year before the Affordable Care Act was passed) the federal government recovered \$1.6 billion. In 2011, the federal government recovered \$2.5 billion. In 2017, the federal government recovered \$2.4 billion.

Source: Payment Accuracy. Project on Government Oversight. U.S. Governmental Accountability Office. Centers for Medicare & Medicaid Services.

There are also several demographic factors that contribute to growth in Medicaid spending. Both nationally and in Utah, as the population ages, more enrollees are shifting out of private health insurance and into public health insurance programs, like Medicaid and Medicare.

It should be noted that most Medicaid dollars are spent on medical services, as opposed to overhead expenses. Only about 5% of Medicaid dollars are spent on administration, with the remainder spent on medical services.⁴⁶ By comparison, the Center for Economic and Policy Research found private health insurance companies spend at least 12% of their overall costs on overhead expenses.⁴⁷

Eligibility Expansions

Historically, as enrollment increases in Medicaid, so does spending. As demonstrated earlier, this was true in both the U.S. and Utah. The Affordable Care Act Medicaid expansion greatly increased enrollment by extending eligibility to those previously ineligible. Since the implementation of this law, most states have expanded. Additionally, the Affordable Care Act expanded the mandatory benefits such as preventive services and essential health benefits. While some of those benefits may result in higher short-term costs, they may also yield long-term savings from avoided costs.

Demographic Factors

There are also several demographic factors that contribute to growth in Medicaid spending. Both nationally and in Utah, as the population ages, more enrollees are shifting out of private health insurance and into public health insurance programs, like Medicaid and Medicare. Spending growth can in part be explained by an increasing share of older beneficiaries and individuals with disabilities enrolling in the program.⁴⁸

For instance, in 2017, Utah saw increases in the number of both older people and individuals with disabilities; they are more expensive to care for than children and pregnant women. In Utah from 2016 to 2017, the average monthly enrollment among older Utahns increased 4.1%; among individuals with disabilities it increased 1.3%. Child enrollees, however, decreased by 1.9% and pregnant women decreased by 5.1%.⁴⁹ This trend will drive up costs.

Economic Conditions

The health of the economy is a notable cause for Medicaid spending growth. Economic conditions can have a significant impact on enrollment. Because Medicaid eligibility is predominantly based on income, downturns in the national or state economy can increase the number of individuals eligible for the program. During recessionary periods, an increase in the number of unemployed individuals or a decrease in income can result in increased enrollment.

THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

The Children's Health Insurance Program was created under the federal Balanced Budget Act of 1997 to extend coverage to children in families who made too much to qualify for Medicaid, but too little to afford private coverage through an employer or to directly purchase from an insurance company. States can administer the program through Medicaid, as an entirely separate program, or as a combination of the two. Utah joins 38 other states with a combination design. This is in part because CHIP has a different financing structure and eligibility requirements than Medicaid.

Historically, federal law required that all states offer Medicaid to children up to six years old in families with incomes below 138% of the federal poverty level.⁵⁰ Beyond six years old, states had flexibility in determining the income eligibility level. For instance, in 2013 (the year before the Affordable Care Act implemented provisions to CHIP), four states had an income eligibility threshold of 300% of the federal poverty level (Hawaii, Maryland, New Hampshire and Vermont). That year, Utah kids in families with incomes below 100% of the federal poverty level qualified for CHIP. Utah has since increased the threshold to 200% of the federal poverty level.

In 2014, the Affordable Care Act implemented provisions that changed how low- and moderate-income children are covered. It required that all children up to 19 years old in families with incomes up to 138% of the federal poverty level be covered under Medicaid, as opposed to CHIP. Federal officials assumed all states would expand Medicaid to adults with incomes up to 138% of the federal poverty level. The administration argued that families would be best served if they were covered under the same insurance plan.⁵¹

Additionally, benefits through Medicaid are usually more generous. While state officials must meet minimum requirements, states have broad flexibility to charge families a premium and copayments for coverage. Utah charges up to \$75 in premiums every four months (depending on family income) to maintain CHIP enrollment. The Utah Department of Health also charges a \$15 late fee if families fail to pay the premium on time. Most families paid copayments in addition to premiums. Utah families are not required to pay more than 5% of their family's annual gross income on premiums, co-payments and other out of pocket costs.⁵²

The Affordable Care Act also increased the federal government's match rate for CHIP. Like Medicaid, CHIP is financed by a federal-state partnership. Before the Affordable Care Act, Utah had an 80-20 match rate. For 2015 to 2019, the federal match rate increased by 23 percentage points, but not to exceed a 100% match rate. Utah, along with 11 other states, receives a 100% match rate, meaning the federal government covers all costs.⁵³ The Affordable Care Act allows states to use federal funds from the enhanced match rate for kids that transferred from CHIP to Medicaid and for a separate CHIP program.

Unlike Medicaid, CHIP funds are capped at the federal level and for each state. The funding is determined by a federal formula that uses a state's annual disbursement of CHIP funds and adjusts for health care inflation and child population growth.⁵⁴ In 2017, total CHIP spending in Utah was about \$137 million, which amounted to an estimated \$2,143 per child for the year.⁵⁵

The cost and scope of Medicaid in Utah will likely be at the forefront of Utah health policy for the remainder of 2018, and perhaps years to come. In the background is the ongoing tension between concerns about fiscal sustainability and a desire to bring health coverage to a broader population of Utahns.

CONCLUSION

Medicaid is a large component of health insurance coverage in the U.S., covering one in five Americans. Since its inception, enrollment in the program has steadily increased, along with the cost. The cost of Medicaid has also steadily increased in Utah. The primary cost drivers behind Medicaid include: enrollment, particularly during economic downturns; increases in the cost of health care services and prescription drugs; and an increasing proportion of individuals over 65 years old and individuals with disabilities.

Nationally, the cost of Medicaid is expected to grow at an average annual rate of 5.8% through 2026. This is in part because of significant policy changes to the program. The most notable change is the eligibility expansion for adults who earn up to 138% of the federal poverty level, a provision in the Affordable Care Act. Utah has chosen not to implement the full expansion. However, Utah's eligibility expansion is in a state of flux.

In 2017, Utah expanded eligibility to a limited adult population who earn up to 5% of the federal poverty level. Now the state is seeking approval from the Centers for Medicare & Medicaid Services to expand eligibility to adults who earn up to 100% of the federal poverty level, but with work-related requirements for qualifying beneficiaries. The outlook for approval is unclear. If approved, supporters of the bill assert that no new state funding will be needed to finance the expansion.

At the same time, health advocates have succeeded in getting a full Medicaid expansion initiative on the ballot in November 2018, putting the matter directly to Utah voters.

In short, the cost and scope of Medicaid in Utah will likely be at the forefront of Utah health policy for the remainder of 2018, and perhaps years to come. In the background is the ongoing tension between concerns about fiscal sustainability and a desire to bring health coverage to a broader population of Utahns.

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