

Virtual Mentor

Ethics Journal of the American Medical Association
July 2005, Volume 7, Number 7

Policy Forum

Utah's Primary Care Network: States Can Do Better

by Judi Hilman, MA

States have taken a variety of approaches to managing rising Medicaid costs, some of which include more restrictions on eligibility and fewer services. Utah's broad, if somewhat paradoxical, solution to controlling Medicaid costs while serving more of the uninsured is the Primary Care Network (PCN). Proponents and critics alike agree that the PCN is not a total solution. Yet, as states look for ways to cover their uninsured while curtailing escalating Medicaid costs, some are exploring options like Utah's PCN.

A single mother of a 15-month old boy, Molly was enrolled in the PCN from June to December 2003. When she applied, Molly thought the \$50 enrollment fee was reasonable. She later dropped PCN because the program was not helping her with the medical tests she needed for her gastrointestinal distress.

What is the PCN?

For a \$50 annual enrollment fee and stiff cost-sharing requirements (eg, copays for prescription drugs and physician visits), the PCN provides prevention-oriented primary care to uninsured adults who earn less than 150 percent of the federal poverty level in annual income [1]. This benefit package, however, is far below Medicaid standards. Through Section 1115 of the Social Security Act, states can seek a waiver—or exception—to federal Medicaid standards to test a new concept for health care delivery. The waivers permit states to undertake extensive changes in their Medicaid programs if they can demonstrate that their plan advances the Social Security Act's broad objectives. Historically, most Medicaid 1115 waivers have been used to expand comprehensive medical coverage for low-income adults, such as parents with incomes above the regular Medicaid eligibility limits or childless adults, a group that typically falls through the cracks of the Medicaid program.

The PCN, however, is a unique Section 1115 waiver in several respects: it is the first general 1115 waiver that has *not* covered specialty care or inpatient services, focusing instead on prevention-oriented primary care. The PCN was intended to replace the Utah Medical Assistance Program (UMAP), a disappointing state-funded program for chronically ill childless adults with incomes less than 38 percent of the poverty level. The PCN allocates 16 000 slots for low-income parents and 9000 slots for childless adults (who are usually the more medically needy and thus more costly of the traditional waiver target group), covering up to 8 percent of Utah's estimated 300 000 uninsured.

As of March 2005 the PCN had 20 120 enrollees: 60 percent were parents, and 40 percent were childless adults. Of the childless, 81 percent had incomes below the poverty level; among the parents, nearly 60 percent were living under the poverty level. Hispanics were underenrolled, making up only 8 percent of total enrollees but accounting for 29 percent of the state's overall uninsured [2].

What is Covered at Work (CAW)?

When Tommy Thompson, then Health and Human Services Secretary, presented the Bush Administration's new Health Insurance Flexibility and Accountability (HIFA) guidelines for waivers, states were encouraged to build premium assistance programs into their waiver designs, that is, programs to help low-income workers with employer-based insurance plans make their share of the premium payments [3]. Less than 1 year after implementing the PCN, the Utah Department of Health (DOH) submitted an amendment to Secretary Thompson outlining a premium assistance program called "Covered at Work" (CAW) which was swiftly approved.

For each worker-participant, CAW allocates \$50 per month—the estimated market value of the PCN benefit package—toward the worker's share of the premium for employer-based coverage, as long as the employer covers at least half of the premium. Utah is able to offer the CAW program to a maximum of 6000 low-income workers.

Advocates were optimistic at first about CAW's promise of leveraging employer contributions to build a more comprehensive benefit package. However, these hopes were all but dashed when the day arrived to implement the program. On that day—August 1, 2003—only 1 person signed up. As of May 2005, Covered at Work has enrolled only 79 workers. This experience has only confirmed what we already knew from research on premium assistance programs: that \$50 per month is not enough to make employer-based coverage affordable for low-income workers because their share of the monthly premium is usually significantly higher than \$50 [4].

Meanwhile the PCN enrollment is now closed—give or take a few open enrollment periods and the 6000 slots being held for the disappointing CAW program.

The PCN and Cost Sharing

Evidence that the \$50 annual enrollment fee presents a barrier for applicants is substantial: 23 percent of application denials are related to failure to pay the fee [5]. A recent report on disenrollment from the PCN found that 29 percent of those who did not re-enroll listed "finance" as a reason for dropping PCN. A report on application denials also shows a sizeable number of applications categorized as "incomplete." Some of these applicants might be failing to complete the application because of the fee [6].

PCN's Reliance on the Charitable Sector for Specialty Care

When Molly enrolled in the PCN she was not aware that a case manager could work to get specialty care donated. At her orientation Molly was simply told that specialty care and inpatient services were not covered by the PCN and she was given a list of other services that were not covered.

From the start, a major concern about the primary-care-only approach of the PCN has been that it created the potential for a cruel medical paradox. A low-income person might be diagnosed with a serious disease—such as cancer, chronic obstructive pulmonary disease, HIV, or severe mental illness—and then be unable to access the specialty or inpatient hospital care needed to treat the disease.

The PCN benefit package has undeniable value for younger, healthier enrollees. Covering up to 4 prescriptions a month, the pharmacy benefit alone can compensate for any hardship caused by the \$50 enrollment fee. However, the typical former UMAP client has copious and ongoing health care needs, particularly for mental health and substance abuse services and case management. The DOH has acknowledged some of the problems of not covering specialty care and has developed an informal network of physicians who will do some charity work, but the reality is that this donated care is not enough to fill the significant gaps in PCN coverage.

Casey, a young woman suffering from manic depression, was interviewed by a caseworker close to the time she was supposed to renew her PCN coverage. She laughed when asked whether she intended to renew. "Heck, just about everything I needed wasn't covered!" Her PCN-covered doctor did help her qualify and apply for Disability ("Traditional") Medicaid.

For Casey and other chronically ill individuals, prevention-oriented coverage without *guaranteed* access to specialty care or inpatient hospital coverage is virtually useless. After the first 6 months of PCN, former UMAP recipients comprised 15 percent of PCN enrollees. As of March 2005, only 3 percent of PCN enrollees were former UMAP recipients [2, 7]. Clearly, the PCN does not speak to their needs.

After the PCN refused to cover another visit to the ER, Molly developed what turned out to be gallstones: "I was in so much pain but didn't go to the ER because I knew the PCN would not cover the visit." When she had several suspicious moles removed at a local community health center, it was billed to the PCN; again, no payment. "The doctor had no idea it would not be covered, and he was not familiar with the process for getting donated care."

Anecdotal evidence shows serious flaws in programmatic arrangements for securing donated specialty and inpatient care. To this day PCN staffers give out inconsistent information about what is covered. Until recently, little effort was made to educate providers about the referral process. Primary care professionals have their own concerns about liability in the event they are faced with diagnosing serious conditions requiring specialty care that they know cannot be obtained. The hospitals have so far been willing to donate the \$10 million worth of inpatient care per year that was assumed in the original waiver design. They have also been cooperating with local health departments to make sure that more hospitals across the state shoulder the burden of charity care, but they have grown increasingly disgruntled with this arrangement. Together hospitals and health departments have tracked \$13 million worth of inpatient care provided to PCN clients over the last year, \$3 million over the amount requested. As a result, Utah hospitals are the most vocal critics of the PCN.

A recent DOH-sponsored health outcome evaluation found that, while most enrollees were able to get more needed care than before by using the Primary Care Network, former UMAP recipients had more trouble seeing specialists under the Primary Care Network than under UMAP. Moreover, the survey found minimal change in enrollees' physical health status over the first 12 months of enrollment in the PCN [8]. The Kaiser Commission on Medicaid and the Uninsured has initiated a research study to examine the extent to which PCN meets the needs of its beneficiaries, and the results, which should be available soon, ought to offer more evidence about the adequacy of Utah's waiver program [8].

Robbing Petrina to Pay Paul

As a Medicaid 1115 waiver demonstration program, the PCN must be revenue neutral to the federal government, meaning that the federal government will not have to pay more for Medicaid after the "expansion" is implemented than it would have before the waiver. To meet this fundamental requirement, Utah reduced the benefit package and raised the cost sharing for a portion of Medicaid participants—the parents—while leaving benefits and cost sharing the same for the rest of adult Medicaid enrollees. Then, to maintain the distinction between the 2 groups, the DOH renamed Parent's Medicaid "Non Traditional." Other states often financed their Section 1115 expansions of comprehensive medical care by making Medicaid more efficient through shifting to capitated managed care. Utah was the first state to use reductions in benefits and increases in cost-sharing for existing beneficiaries to finance partial care for an expansion group, members of which often earned higher incomes than the existing Medicaid beneficiaries.

The group of very low-income parents who are essentially financing the limited PCN coverage have considerable health and financial needs. This population includes parents receiving welfare and those who have recently left the welfare system.

Recent studies have underscored the unique health care needs of parents in transition out of the welfare system. In their interviews with "welfare leavers," the University of Utah-based Social Research Institute found that 2 to 5 months after leaving the welfare system, the majority (63 percent) remained unemployed and 47 percent had been uninsured at some point since losing their cash benefits; 55 percent currently had physical health problems, and 42 percent rated their mental health as poor [9]. Low-income parents' need for cost-effective preventive care cannot be overemphasized, but some evidence suggests that higher copays reduce parents' utilization of otherwise cost-effective preventive services [10].

Now that PCN is having an open enrollment, Molly decides to re-enroll: "Only because there's nothing else out there. At least it will pay for 4 of the most expensive medications I now need."

We can do better.

For young adults in reasonably good health, the benefits of the PCN are undeniable, though the participants cannot be considered adequately insured. For the program in general, the risks of providing limited or illusory coverage to a small slice of the neediest group probably outweigh the benefits. There are better ways for states to

cover the uninsured than approaches like the PCN [11], just as there are also proven ways to design Bush-era waivers that do not involve cutting services or raising cost sharing for vulnerable populations like working parents [12]. When political options are limited, as they are in Utah, the PCN might make sense as a temporary solution at best, but diligent efforts for a more permanent solution must continue. Other states have done, and clearly can do, better.

References

1. Betit R. *Background on Utah's New Medicaid Waiver*. Salt Lake City, Utah: Utah Department of Health. 2002.
2. Utah Department of Health. *Access Initiatives. Primary Care Network and Covered at Work Enrollment as of March 12, 2005*. Salt Lake City, Utah: Utah Department of Health; 2005.
3. Kaiser Commission on Medicaid and the Uninsured. *The New Medicaid and CHIP Waivers*. Washington, DC: Kaiser Family Foundation; 2002b.
4. Kaiser Commission on Medicaid and the Uninsured. *Serving Low-Income Families Through Premium Assistance: A Look at Recent State Activity*. Washington, DC: Kaiser Family Foundation; 2003b.
5. Utah Department of Health. *Access Initiatives*. Salt Lake City, Utah: Utah Department of Health; 2004.
6. Office of Health Care Statistics. *Utah PCN Disenrollment Report*. Salt Lake City, Utah: Utah Department of Health; 2004.
7. Utah Department of Health. *Access Initiatives. Primary Care Network and Covered at Work Enrollment as of December 2002*. Salt Lake City, Utah: Utah Department of Health; 2002.
8. Xu W, Martin M. *Health Outcome Evaluation of Utah's Primary Care Network*. Paper presented at: the Academy Health Annual Research Conference; June 6-8, 2004; San Diego, Calif.
9. Vogel-Ferguson MB. *TANF Review Study: Health Data (unpublished raw data)*. Salt Lake City, Utah. Social Research Institute, University of Utah. 2005.
10. Ku L, Deschamps E, Hilman J. *The Effects of Nominal Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program*. Available at: http://www.cbpp.org/11-2-04health.htm#_ftn1. Accessed June 21, 2005.
11. Holahan J, Pohl MB. *States as Innovators in Low-Income Health Coverage*. Available at: http://www.urban.org/UploadedPDF/310519_DP0208.pdf. Accessed June 21, 2005.
12. Kaiser Commission on Medicaid and the Uninsured. *Assessing the Role of Recent Waivers in Providing New Coverage*. Washington, DC: Kaiser Family Foundation; 2003a.

Judi Hilman, MA, is the health policy director at Utah Issues, Center for Poverty Research and Action. Her work covers a wide range of policy issues impacting the uninsured, low-income medically underserved, people with disabilities, and ethnic and cultural minorities.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Copyright 2005 American Medical Association. All rights reserved.