

OFFICE OF THE
LEGISLATIVE
FISCAL
ANALYST

JONATHAN C. BALL
DIRECTOR

MEMORANDUM FOR EXECUTIVE APPROPRIATIONS COMMITTEE

FROM: Russell Frandsen, Fiscal Analyst
DATE: June 22, 2010
SUBJECT: Follow up to Legislative Questions on May 2010
EAC Presentation on Federal Health Care Reform

The Executive Appropriations Committee heard presentations about federal health care reform at its May 18, 2010 meeting. There were several unanswered questions posed by legislators which are listed below in the order that they were asked:

1. How much money does Medicaid currently spend on the top 5 killers? What will be the projected savings from the preventative money provided?
2. What are the currently eligible but not enrolled on Medicaid doing to maintain their health?
3. What is the specific plan/timeline to get grandfathered plan status for PEHP?
4. Can Medicaid now offer PEHP-level coverage? What will be the impact of that?
5. What are the administrative needs and costs for State agencies to handle 110,000 new Medicaid enrollees? (Health, Workforce Services, Human Services)

Attached are the questions as well as the responses from agencies.

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1. *How much money does Medicaid currently spend on the top 5 killers? What will be the projected savings from the preventative money provided?*

Response from the Department of Health via email on May 24, 2010:

During the last Executive Appropriations Committee, you asked if 'we' know how much is spent on the top five diseases effecting Utahn's- heart disease, cancer, stroke, chronic respiratory disease and diabetes. You asked this question during the discussion of the impacts of health reform in Utah.

Great question, which of course has led us to further questions, so that we can provide an answer for you. Do you mean how much is spent in Utah to treat these conditions in the health care system? Or do you mean how much public health funding is spent to prevent/manage them? Or, both?

We have access to estimates about this information from the CDC through a software program they provide to the state health department and through our 'all payer data base'. Once we are clear on the information you are seeking, it will take us a couple of weeks to provide that information to you.

Thanks so much for your interest~

Best regards,

Teresa

Teresa Garrett, RN MS
Deputy Director, Public Health Practice
and
Chief Public Health Nursing Officer
Executive Nurse Fellow Alumni
Robert Wood Johnson Foundation

2. *What are the currently eligible but not enrolled on Medicaid doing to maintain their health?*

Response from Michael Hales, Medicaid Director with the Department Health via email on June 12, 2010:

Since the individuals are not enrolled in Medicaid, the Department does not have any information about their usage of health care services. However, it is reasonable to assume that some may pay directly or arrange payment plans for some urgent health services. Others may use money from extended family, church groups or other non-profit organizations to pay for some health services. They may receive some preventive services, like immunizations, through local health departments. Since they do not have coverage, they are also likely to defer many health maintenance activities.

3. What is the specific plan/timeline to get grandfathered plan status for PEHP?

Response from PEHP via email on May 25, 2010:

At last week's Executive Appropriations Committee meeting you asked whether PEHP had received official acknowledgement from Health and Human Services (HHS) that our plans were considered "grandfathered". Our reading of the legislation indicates that such status is self-declared based on the broad guidelines set out in the legislation. The HHS Secretary may issue rules regarding "grandfather" status, in which case, PEHP may have to take some formal action. Until then, we are self-declaring our plans "grandfathered".

We believe any plans PEHP develops to participate in the Utah Health Insurance Exchange will not be "grandfathered" and will, thus, be subject to many more of the provisions contained in the federal legislation. (We continue to explore ways to be a participating carrier in the Exchange -- the legal form to take and capitalizing the entity seem to be the biggest challenges at this time.)

Please let me know if you have any questions. Thanks.

Jeff Jensen
Director, Public Employees Health Program of Utah
560 E 200 S
Salt Lake City, UT 84102
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Fax (801) 245-7508

4. Can Medicaid now offer PEHP-level coverage? What will be the impact of that?

Response from Michael Hales, Medicaid Director with the Department Health via email on June 12, 2010:

The Department can offer coverage to Medicaid enrollees through a benchmark plan. The benchmark can be set against the highest enrollment commercial plan, the state employee benefit plan or the federal employee benefit plan. If the benchmark plan were to be offered, the State would still have to guarantee the cost sharing protections that Medicaid requires for the populations that are under the federal poverty level, children and pregnant women. That is essentially the entire Medicaid population covered in the State of Utah. There would not be any cost savings because of the cost sharing protection provisions.

5. What are the administrative needs and costs for State agencies to handle 110,000 new Medicaid enrollees? (Health, Workforce Services, Human Services)

Response from Michael Hales, Medicaid Director with the Department Health via email on June 12, 2010:

Right now, I would estimate about \$1 million in ongoing general fund for increased staff to support the increased enrollment. That would be about a 10 percent increase in admin staff to support enrollment-driven functions such as claims payment, prior authorizations and health plan enrollment.

Response from the Department of Human Services via email on May 27, 2010:

The Office of Recovery Services provides cost recovery and cost avoidance for Medicaid. New Medicaid enrollees would increase the legal demand for these functions. To meet the demands of the additional enrollees at current collection standards would require an additional 15 collection agents at a cost of approximately \$900,000, including \$450,000 General Fund. However, the savings from cost recoveries and cost avoidance would exceed these amounts.

Cherie W. Root
Budget Director
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195 N. 1950 W.
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Response from the Department of Workforce Services via email on June 17, 2010:

Below are the responses to yesterday's request for information.

The LFA request was based on Medicaid caseloads increasing by 100,000+ and attached estimates are based on an average DWS employee caseload of 350. The first document is a staffing summary and the second is the costs for the phone system, a critical component of eligibility services.

In general:

- 285 additional personnel would need to be hired
- 19 additional supervisors would need to be hired (average span of control 15)
- 6 additional Managers would need to be hired (average span of control 90- 100)
- 18 additional support staff would need to be hired (program specialists & PRT)
- 328 - equipment needs (computers, etc)
- Space for staff to work (rent)

- Phone costs which include supervisor licenses, switches, etc.

Total \$32,480,288

There may be a few minor expenses missed, but the big ticket items are captured on these documents. Other items to consider include the costs to train new staff and DTS support for additional staff.

Please let me know if you need further information or clarification.

Thanks,

Ally Isom
Government Affairs Director

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