Health Policy Update

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UTAH CHAPTER OF ACP: HEALTH AND PUBLIC POLICY COMMITTEE CHAIR
Disclosures

No financial disclosures

Views are my own, and do not reflect the views of the University of Utah or American College of Physicians, except when referencing official positions of the American of College of Physicians
Outline

Surprise billing
Status of the Patient Protection and Affordable Care Act in 2020
Medicaid Expansion
Surprise Billing
Surprise Billing

**What is it?**

Unexpectedly high medical bill from care provided by out-of-network provider when expected to be in-network

Different from balanced billing:
- Insurance pays part of bill and the patient is billed the balance
- Can result from out-of-network bills

**Where does it happen?**

Emergency Services
- No option to select facility/provider

Non-emergency services at in-network facility
- Part of the care is provided by out-of-network provider

Medical Transport
Networks of Physicians

IN NETWORK

Insurance companies create networks of physicians
  ◦ Provide care with contracted rates

Incentive to join is based on increased patient volume

Network Adequacy Standards
  ◦ Health plan to deliver the benefits with reasonable access

In Network Rates : ~ 125% of Medicare

OUT OF NETWORK

Some physicians don’t have incentive to join
  ◦ Could charge higher costs out of network

Bargaining power?

Network adequacy
  ◦ Not enough at the time?

Out of Network Rates : ~ 300% of Medicare
Surprise Billing

Ideally a health plan would be able to provide adequate in-network physicians

Surprise Billing = Market Failure:
- Failed negotiations between health insurance companies and physicians
  - Insufficient Network
  - Insufficient Access to In-Network Physicians

*Leaves patients vulnerable to higher costs*
High Patient Costs

Higher out of network co-pay

Balance Billing
  Difference between allowed amount and providers' charge
Incidence of Surprise Billing

Among people with large employer coverage, the share of in-network visits with at least one out-of-network charge, 2017

- 16% of in-network inpatient admissions result in at least one out-of-network charge
- Utah 8%

- 18% of emergency visits result in at least one out-of-network charge
- Utah 16%
Incidence of Surprise Billing

By Type of Admission

- All admissions: 10%
- Surgical: 23%
- Medical: 18%
- Maternity & newborn: 19%
- Mental health and/or substance abuse: 20%

Distribution Across Hospitals

Figure. Incidence of Out-of-Network Billing Across Hospitals, 2010-2016

- Emergency department visits
- Inpatient admissions

Source: KFF analysis of IBM MarketScan Commercial Claims and Encounters Database, 2017

Peterson-KFF Health System Tracker

Assessment of Out-of-Network Billing for Privately Insured Patients Receiving Care in In-Network Hospitals

ECC, Sun, MD, PhD; Michelle M. Millo, JD, PhD; Jason Madingh, MA, MSc; Lawrence C. Baker, PhD
Incidence of Surprise Billing: 2010-2016

Increase in surprise billing from 26.3% in 2010 to 42% in 2016

Table 3. Annual Incidence and Magnitude of Out-of-Network Billing for Inpatient Admissions

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of Admissions$^a$</th>
<th>Admissions With Out-of-Network Bill, No. (%)$^b$</th>
<th>Mean (SD)</th>
<th>10th</th>
<th>25th</th>
<th>50th</th>
<th>75th</th>
<th>90th</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>607 160</td>
<td>159 609 (26.3)</td>
<td>804 (2456)</td>
<td>0</td>
<td>30</td>
<td>285</td>
<td>794</td>
<td>1684</td>
</tr>
<tr>
<td>2011</td>
<td>573 457</td>
<td>175 610 (30.6)</td>
<td>990 (2876)</td>
<td>0</td>
<td>73</td>
<td>389</td>
<td>971</td>
<td>2060</td>
</tr>
<tr>
<td>2012</td>
<td>830 824</td>
<td>301 568 (36.3)</td>
<td>1277 (3899)</td>
<td>0</td>
<td>125</td>
<td>508</td>
<td>1194</td>
<td>2568</td>
</tr>
<tr>
<td>2013</td>
<td>867 523</td>
<td>338 715 (39.0)</td>
<td>1483 (4188)</td>
<td>16</td>
<td>192</td>
<td>653</td>
<td>1428</td>
<td>2950</td>
</tr>
<tr>
<td>2014</td>
<td>803 425</td>
<td>327 676 (40.8)</td>
<td>1731 (4698)</td>
<td>25</td>
<td>244</td>
<td>760</td>
<td>1682</td>
<td>3474</td>
</tr>
<tr>
<td>2015</td>
<td>828 481</td>
<td>319 297 (38.5)</td>
<td>1920 (5157)</td>
<td>35</td>
<td>291</td>
<td>853</td>
<td>1842</td>
<td>3791</td>
</tr>
<tr>
<td>2016</td>
<td>947 111</td>
<td>397 447 (42.0)</td>
<td>2040 (4967)</td>
<td>44</td>
<td>325</td>
<td>984</td>
<td>2084</td>
<td>4112</td>
</tr>
<tr>
<td>Overall</td>
<td>5 457 981</td>
<td>2 019 922 (37.0)</td>
<td>1574 (4382)</td>
<td>8</td>
<td>183</td>
<td>667</td>
<td>1538</td>
<td>3215</td>
</tr>
</tbody>
</table>
Cost of Surprise Billing

Increase in mean potential costs from $804 in 2010 to $2040 in 2016

Table 3. Annual Incidence and Magnitude of Out-of-Network Billing for Inpatient Admissions

<table>
<thead>
<tr>
<th>Year</th>
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<th>Admissions With Out-of-Network Bill, No. (%)</th>
<th>Potential Out-of-Network Responsibility, $</th>
<th>Mean (SD)</th>
<th>10th</th>
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<th>75th</th>
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<td>0</td>
<td>508</td>
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<td>2568</td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>5,457,981</td>
<td>2,019,922 (37.0)</td>
<td>1574 (4382)</td>
<td>0</td>
<td>0</td>
<td>508</td>
<td>1194</td>
<td>2568</td>
<td></td>
</tr>
</tbody>
</table>
### Surprise Billing in Internal Medicine

#### Table 4. Incidence and Magnitude of Out-of-Network Billing for Medical Transport Services and the 10 Most Common Physician Specialties for Inpatient Admissions

<table>
<thead>
<tr>
<th>Specialty</th>
<th>No. of Admissions&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Admissions With Out-of-Network Bill, No. (%)&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Potential Out-of-Network Responsibility, $&lt;sup&gt;c&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean (SD)</td>
<td>10th</td>
</tr>
<tr>
<td>Radiology</td>
<td>3,181,749</td>
<td>267 (759)</td>
<td>15</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>2,132,940</td>
<td>595 (575)</td>
<td>44</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>2,007,554</td>
<td>450 (1,133)</td>
<td>9</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>1,961,192</td>
<td>1,369 (1,807)</td>
<td>0</td>
</tr>
<tr>
<td>Cardiology</td>
<td>1,701,819</td>
<td>328 (1,438)</td>
<td>10</td>
</tr>
<tr>
<td>Unknown</td>
<td>1,115,844</td>
<td>544 (1,489)</td>
<td>29</td>
</tr>
<tr>
<td>Pathology</td>
<td>987,225</td>
<td>297 (542)</td>
<td>16</td>
</tr>
<tr>
<td>Medical transport</td>
<td>947,744</td>
<td>424 (2,176)</td>
<td>0</td>
</tr>
<tr>
<td>Family practice</td>
<td>783,703</td>
<td>384 (1,330)</td>
<td>0</td>
</tr>
<tr>
<td>Obstetrics &amp; gynecology</td>
<td>760,049</td>
<td>1,228 (3,457)</td>
<td>18</td>
</tr>
</tbody>
</table>
How do we fix it?

State and federal regulation

Basis of most proposals:

1.) Hold patients harmless
   - In-network co-pays
   - Prevent balanced billing

2.) Negotiating Insurance and physician payments
   - Benchmarking Physician Payments
     - % Medicare rate
     - % Median in-network rate
     - % of billed charges
   - Dispute resolution:
     - Independent Dispute Resolution (IDR)
     - Binding baseball style arbitration
       - Used by New York
Strong Public Support

Figure 4
Majorities Across Partisans Support Surprise Medical Bill Legislation
Do you support or oppose legislation protecting patients from paying the cost not covered by their insurance when they receive care from a provider or hospital who is not in their network?

<table>
<thead>
<tr>
<th></th>
<th>Support</th>
<th>Oppose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>78%</td>
<td>20%</td>
</tr>
<tr>
<td>Democrats</td>
<td>84%</td>
<td>14%</td>
</tr>
<tr>
<td>Independents</td>
<td>78%</td>
<td>20%</td>
</tr>
<tr>
<td>Republicans</td>
<td>71%</td>
<td>26%</td>
</tr>
</tbody>
</table>

SOURCE: KFF Health Tracking Poll (conducted September 3-8, 2019). See topline for full question wording and response options.
Federal Legislation

- Bipartisan-bicameral legislation to stop Surprise Billing
  - Senate Health, Education, Labor, and Pensions (HELP) Committee
  - House Energy and Commerce Committee
- Incorporated into large spending bills
- Principles
  - Benchmarking at median in-network rate
  - Dispute through binding arbitration
Failed to Pass in 2019

Surprise billing legislation did NOT pass near the end of 2019
  ◦ Despite strong public support

Lobbying against legislation:
  ◦ Doctor Patient Unity - private equity physician staffing companies
  ◦ Also opposed by the Utah Medical Association
Surprise Billing at State Level

- In 2019 – 29 states enacted consumer protection
  - 13 with comprehensive protection
- Utah has NOT enacted legislation on Surprise Billing
Utah- Surprise billing

2019 LEGISLATIVE SESSION

Rep. Jim Dunnigan (District 39- Taylorsville)

Intent to pass legislation to protect patients and prohibit balanced billing

No agreement on payment “fair-agreement” with UMA.

No bill was introduced

2020 LEGISLATIVE SESSION

Utah Medical Association proposed bill for surprise billing for ED visits
Patient Protection and Affordable Care Act

STATUS IN 2020
Patient Protection and Affordable Care Act

Signed into law in 2010 under President Obama

Major provisions enacted in 2014

Changed health care in United States
  ◦ Dramatic reduction in uninsured
  ◦ Increased patient protections

Figure 1
Number of Uninsured and Uninsured Rate Among the Nonelderly Population, 2008-2017

NOTE: Includes nonelderly individuals ages 0 to 64.
## Many Popular Provisions

### Americans’ Opinions Of ACA Provisions

<table>
<thead>
<tr>
<th>Percent who say they have a <strong>Favorable</strong> opinion of each of the following provisions of the law.</th>
<th>Total</th>
<th>Democrats</th>
<th>Independents</th>
<th>Republicans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allows young adults to stay on their parents’ insurance plans until age 26</td>
<td>82%</td>
<td>90%</td>
<td>82%</td>
<td>66%</td>
</tr>
<tr>
<td>Creates health insurance exchanges where small businesses and people can shop for insurance and compare prices and benefits</td>
<td>82</td>
<td>91</td>
<td>78</td>
<td>71</td>
</tr>
<tr>
<td>Provides financial help to low- and moderate-income Americans who don’t get insurance through their jobs to help them purchase coverage</td>
<td>81</td>
<td>92</td>
<td>82</td>
<td>63</td>
</tr>
<tr>
<td>Gradually closes the Medicare prescription drug “doughnut hole” so people on Medicare will no longer be required to pay the full cost of their medications when they reach the gap</td>
<td>81</td>
<td>85</td>
<td>82</td>
<td>80</td>
</tr>
<tr>
<td>Eliminates out-of-pocket costs for many preventive services</td>
<td>79</td>
<td>88</td>
<td>78</td>
<td>68</td>
</tr>
<tr>
<td>Gives states the option of expanding their existing Medicaid program to cover more low-income, uninsured adults</td>
<td>77</td>
<td>91</td>
<td>77</td>
<td>55</td>
</tr>
<tr>
<td>Requires employers with 50 or more employees to pay a fine if they don’t offer health insurance</td>
<td>69</td>
<td>88</td>
<td>61</td>
<td>56</td>
</tr>
<tr>
<td>Prohibits insurance companies from denying coverage because of a person’s medical history</td>
<td>65</td>
<td>70</td>
<td>66</td>
<td>58</td>
</tr>
<tr>
<td>Increases the Medicare payroll tax on earnings for upper-income Americans</td>
<td>65</td>
<td>77</td>
<td>69</td>
<td>42</td>
</tr>
</tbody>
</table>

**Note:** Some items asked of half sample.
**Source:** KFF Health Tracking Poll (conducted November 14-19, 2018). See topline for full question wording and response options.
ACA Repeal Efforts

Concerted effort among Republicans in 2017 to repeal and replace
- House passed American Health Care Act
- Senate: The Better Care Reconciliation Act (BRCA)
- ‘Skinny Repeal’ defeated with decisive vote by the late John McCain

Failed to pass significant repeal and replace legislation

However, changes were made to ACA:
- Reduced funding for outreach and advertising
- Shortened enrollment period
- Eliminated Cost Sharing Reduction payments → silver loading
- Removal of tax for not having health insurance
ACA and the Individual Mandate

ACA required individuals to have health insurance or pay a penalty

Challenged by Supreme Court in 2012
  - *National Federation of Independent Business v Sebelius*
  - Upheld as Congress’ ability to implement a tax

December 2017- Congress passed a tax bill that eliminated financial penalty (tax)
  - Took effect 2019

Twenty State coalition, including Utah Attorney General Sean Reyes, challenged the constitutionality of the Affordable Care Act
  - Without a tax there is no mandate
  - Mandate was “essential” to the ACA
  - ‘Inseverable’ \(\rightarrow\) ACA is unconstitutional

Department of Justice declined to defend the ACA

Another coalition of 16 States defend the law
Texas Judge Strikes Down Obama’s Affordable Care Act as Unconstitutional

Internists: Texas Judge’s Decision to Take Health Care Away from Millions Must be Overturned

Statement attributable to:
Ana María López, MD, MPH, MACP
President, American College of Physicians
DOJ and Democratic Attorneys general appealed

DOJ changed course and agreed with District Court’s decision
  ◦ ACA should be invalidated

December 2019 U.S. 5th Circuit Court of Appeals
  ◦ Agreed mandate with $0 penalty is unconstitutional
  ◦ Sent back to District Judge for more analysis on constitutionality of ACA

Case expected to be heard by Supreme Court
  ◦ After 2020 Presidential Election
What’s at Stake

Medicaid expansion
Dependent coverage up to age 26
Pre-existing condition protection
Preventative services
Essential health benefits
Health insurance subsidies
Annual and lifetime limits
Cap on out-of-pocket cost sharing
Close Medicare “doughnut hole”
Utah Medicaid Expansion

HOW DID WE GET HERE?
Medicaid Expansion

ACA: Medicaid expansion optional starting in 2014

- Non-elderly adults with incomes up to 138% of FPL
  - 2020: $17,236 for an adult, and $35,535 for a family of four
- Majority of cost covered by Federal Govt
  - Federal Share in 2020: 90%
- 15 million Americans have gained health insurance through Medicaid Expansion

As of January 2020:

- 37 states (including DC) expanded Medicaid
- 14 states have not expanded Medicaid
Utah and Medicaid Expansion

2014-2018
- Utah considered several Medicaid Expansion proposals → None Passed

2018
- H.B. 472 Medicaid Waiver Expansion - Passed
  - Expand Medicaid for adults with incomes up to 100% of the federal poverty limit
  - Required Section 1115 waiver
  - Subject to CMS approval
  - Planned implementation Jan 1st, 2019
    - Work requirement
    - Enrollment caps
    - Requires ESI
- H.B. 325 Enhancement Waiver Program - Passed
  - Only if H.B. 472 not approved
  - Enhance the existing Primary Care Network
  - Decrease in benefits for some other populations
Proposition 3: Utah Decides Health Care Act

2018 Ballot Measure – Proposition 3: Utah Decides Health Care

Full Medicaid Expansion
- Provide Medicaid for individuals under the age of 65 AND
- Incomes up to or below 138% of the FPL
- Increase in sales tax of 0.15%

Ballot Measure PASSED with 53% of the vote
Senate Bill 96: Medicaid Expansion Adjustments

Concerns about financial sustainability with Medicaid Expansion

- Projected deficit of $83 million in FY2025

“putting pressure on other core government functions and social programs.” Gov Herbert

S.B. 96 Signed By Gov Herbert signed into law February 2019

- Expands Medicaid to 100% of FPL
- Additional flexibilities in Medicaid through State Waivers
Section 1115 Waivers

Section 1115 of the Social Security Act grants the Secretary of HHS to approve experimental, pilot, or demonstration projects to promote the objectives of the Medicaid Program.

“Core objective of Medicaid is to serve the health and wellness needs of our nation’s vulnerable and low-income individual and families”

Give States more flexibility to design and improve Medicaid programs

◦ Robust evaluation
◦ Budget neutral to federal government
◦ Approved for 5-year period, and can be extended
### Medicaid Expansion: At A Glance

#### July 2019

<table>
<thead>
<tr>
<th>Expansion Plan Provisions</th>
<th>Bridge</th>
<th>Per Capita Cap</th>
<th>Fallback</th>
<th>Full Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Timeline</strong></td>
<td>Effective April 1, 2019</td>
<td>Upon CMS Approval (Submit Waiver to CMS Spring 2019)</td>
<td>Upon CMS Approval (Submit Waiver to CMS by March 15, 2020)</td>
<td>July 1, 2020 (if needed)</td>
</tr>
<tr>
<td><strong>Federal Poverty Level</strong></td>
<td>100%*</td>
<td>100%*</td>
<td>138%</td>
<td>138%</td>
</tr>
<tr>
<td><strong>Authority</strong></td>
<td>Waiver</td>
<td>Waiver</td>
<td>Waiver</td>
<td>State Plan</td>
</tr>
<tr>
<td><strong>Presumptive Eligibility (PE)</strong></td>
<td>Yes</td>
<td>No Hospital PE</td>
<td>No Hospital PE</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Self-Sufficiency Requirement (Work Requirement)</strong></td>
<td>Yes (effective January 1, 2020)</td>
<td>Yes</td>
<td>Yes*</td>
<td>No</td>
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<tr>
<td><strong>Authority to Cap Expansion Enrollment</strong></td>
<td>Yes*</td>
<td>Yes*</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Lock-out for Program Requirements/Violations</strong></td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Require Enrollment in Employer’s Plan with Premium Reimbursement</strong></td>
<td>Yes (effective January 1, 2020)</td>
<td>Yes</td>
<td>Yes*</td>
<td>No</td>
</tr>
<tr>
<td><strong>Funding (% federal/% state)</strong></td>
<td>70/30</td>
<td>90/10**</td>
<td>90/10</td>
<td>90/10</td>
</tr>
</tbody>
</table>

- SB 96 required provisions for implementation
- **90%** federal match available up to per capita cap limit
Fallback Waiver

Utah received approval for the Fallback Waiver effective January 1, 2020

Waiver allows for:
- Expanded eligibility for individuals with incomes up to 138% of FPL
- Coverage for another 45,000 Utahans
- Enhanced federal match rate (90%)
- Community engagement requirement expanded to new Adult Expansion Population
  Requires Employer Sponsored Insurance

Not approved:
- Enrollment caps
- Removal of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for those aged 19 and 20
- Premiums and a charge for non-emergent use of the ED
- Several others

Estimated 120,000 Utah Adults are eligible for the Expansion Program
Utah Medicaid Work Requirements

Applied to individual who qualify through the Adult Expansion Population

Meet an Exemptions:

1. Age 60 or older;
2. Pregnant or up to 60 days postpartum;
3. Physically or mentally unable to meet the requirements as determined by a medical professional or documented through other data sources;
4. A parent or other member of the household with the responsibility to care for a dependent child under age six;
5. Responsible for the care of a person with a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act;
6. A member of a federally recognized tribe;
7. Has applied for and is awaiting an eligibility determination for unemployment insurance benefits, or is currently receiving unemployment insurance benefits, and has registered for work at the Department of Workforce Services (DWS);
8. Participating regularly in a substance use disorder treatment program, including intensive outpatient treatment;
9. Enrolled at least half time in any school (including, but not limited to, college or university) or vocational or apprenticeship program;
10. Participating in refugee employment services offered by the state, which include vocational training and apprenticeship programs, case management, and employment planning;
11. State Family Employment Program (FEP) recipients who are working with an employment counselor;
12. Beneficiaries in compliance with or who are exempt from SNAP and/or TANF employment requirements; or
13. Working at least 30 hours a week, or working and earning at least what would equal the federal minimum wage earned working 30 hours a week.

If no exemption than individuals must:

- Register for work through the state system
- Complete an evaluation of employment training needs
- Complete the job training modules as determined to be relevant to the individual through the assessment of employment training needs
- Applying for employment with at least 48 potential employers

Expecting 6,000-8,000 Individuals to not comply with community engagement requirements
Medicaid Work Requirements — Results from the First Year in Arkansas

Total enrollees who lost coverage in 2018 due to work and reporting requirements = 18,164

Work requirements stopped March 2019 by Federal Court
Status of Work Requirements
January 3rd, 2020
Section 1115 Demonstration Waivers and Other Proposals to Change Medicaid Benefits, Financing and Cost-sharing: Ensuring Access and Affordability Must be Paramount

Joint principles of the following organizations representing front-line physicians:

American Academy of Family Physicians
American Academy of Pediatrics
American College of Obstetricians and Gynecologists
American College of Physicians
American Osteopathic Association
American Psychiatric Association

Limiting Barriers to Eligibility and Coverage: CMS should ensure that waivers and other proposed changes to Medicaid do not impose punitive requirements that individuals be employed, be actively seeking a job, or be enrolled in a job training or job recruitment program and/or impose mandatory drug testing as a condition of eligibility.
Healthy Adult Opportunity

Announced January 30\textsuperscript{th}, 2020

**What:** States must operate within a defined federal budget target
- Aggregate cap (Block Grant)
- Per-enrollee cap
- Rates expected to be below growth in Medicaid Spending

**How:** States can apply using Section 1115 waivers (Not mandatory)

**Who:** Mostly the Adult Medicaid Expansion population

**Why:**
- Gives States flexibilities to change coverage (must cover essential health benefits)
- Change cost-sharing changes e.g. co-pays
- Less federal oversight
Healthy Adult Opportunity

Expecting significant legal challenges
- Changes to Medicaid program without congressional approval
- Expected reduction in coverage and access

Internists Say Changes to Medicaid Program Will Put Health Care at Risk for Vulnerable Patients

Statement attributable to:
Robert McLean, MD, MACP
President, American College of Physicians
Summary

**Surprise Billing:**
- 16% of inpatient admission and 18% of ED visits
- Increases costs for patients
- State and Federal consumer protection bills pending

**Affordable Care Act:**
- Many popular provisions are in jeopardy
- Pending federal court rulings
- Likely be decided by Supreme Court in 2020 (after election)

**Medicaid Expansion:**
- Utah has expanded Medicaid providing thousands of low-income Utahans with healthcare coverage
- Work requirements for Medicaid eligibility approved in Utah
- Healthy Adult Opportunity Program (Block Grants), pending legal challenges, may be policy issue for Utah Medicaid