

Utah Health Status Update:

Medicaid Asset Limit Study

October 2005

Utah Department of Health

A recent study by the Division of Health Care Financing examines the potential impact of raising or removing the asset limits used for determining Medicaid eligibility on enrollment and costs. There are a variety of Medicaid programs for different populations, each with its own set of eligibility criteria. Some programs have limits on the amount of qualified assets a household can have and still be eligible.

Researchers at the Utah Department of Health used nonparametric statistics to estimate the size of the interested population that would become eligible if various asset limits were raised or removed. This technique uses information about the distribution of assets within the current Medicaid population to estimate the size of the unobserved population that would potentially be interested and eligible.

Figure 1 shows the basic approach. The shaded area represents the distribution of assets within the current program participants. By assuming that the distribution of assets is symmetric, researchers can estimate the distribution of assets for those that are above the current asset limit by reflecting the distribution across the median.

Researchers validated the assumption of symmetry by looking at data from the CHIP program, which does not have an asset limit. The total difference between the actual and predicted enrollment was less than 2%.

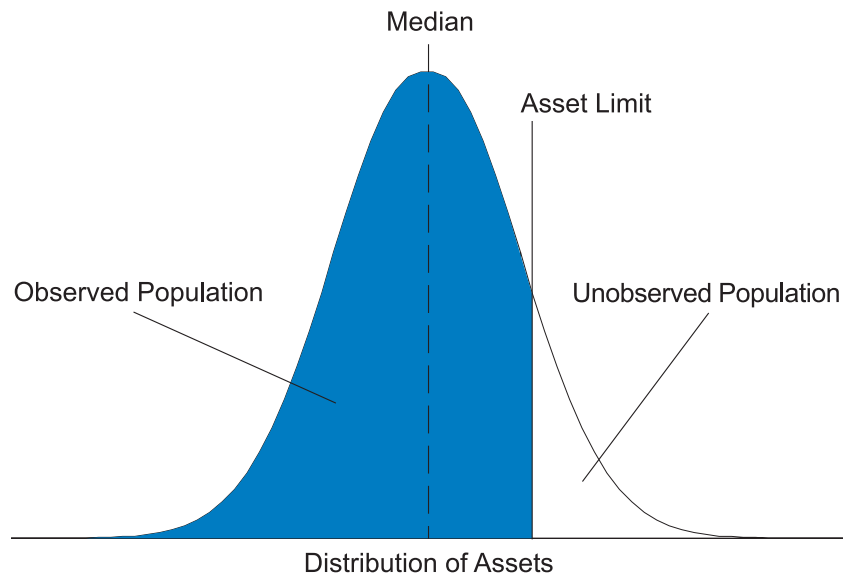
Enrollment Results

There are three main groups of interest: pregnant women, non-pregnant adults, and children.

1. *Pregnant Women*—97.5% of pregnant women on Medicaid are in the Family Medicaid (FM) or Prenatal (PN) programs. The FM Program has a relatively low income threshold and an asset limit of \$2000 for one person or \$3000 for two. Figure 2 compares the actual and predicted asset distributions. The estimated increase in enrollment from

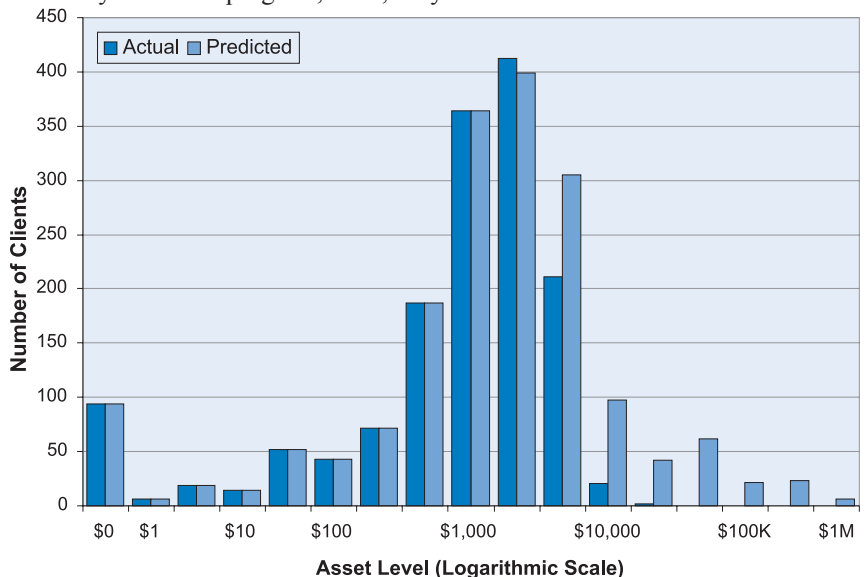
Hypothetical Distribution

Figure 1. Explanation of the methodology behind the Asset Limit Study.



Pregnant Adults in Family Medicaid Program

Figure 2. Asset distribution (actual* and predicted) of clients (pregnant adults) in Family Medicaid program, Utah, May 2005



* Actual assets may include some amounts that are not considered for Medicaid eligibility.

removing the asset limit on the FM program for pregnant women (as shown in Table 1) is 310 women.

2. *Non-pregnant Adults*—About half of the non-pregnant adults are on the FM program. Another quarter are on one of the Aged (AM), Blind (BM), or Disabled (DM) programs. All of these programs have an

asset limit of \$2000 for one person or \$3000 for two. Estimated additional enrollees on these programs are given in Table 1. Figures 3 and 4 compare the actual and predicted asset distributions for these programs.

3. *Children*—The Newborn Plus (NB+) program is available to children ages 6-18 and has an asset limit of \$3000 for two people. Any child who would qualify for this program except for the asset limit would meet the income guidelines for CHIP eligibility. The major impact of raising the asset limit for children would be to move children from CHIP onto Medicaid. Currently, there are around 7,300 children on CHIP that could potentially qualify for Medicaid if the asset test were eliminated. There may also be children who are not eligible for CHIP because they already have insurance through another source and might become eligible for Medicaid if asset limits were removed. We have found no good way to estimate this number precisely, but have historically assumed that it would add about 10% (730) to the increase in enrollment.

Costs

Removing the asset test is estimated to cost (in total dollars):

- \$3 million for pregnant women
- \$20 million for Family Medicaid non-pregnant adults
- \$25 million for aged, blind, or disabled non-pregnant adults
- \$2-\$4 million for children, depending on whether the CHIP slots are backfilled

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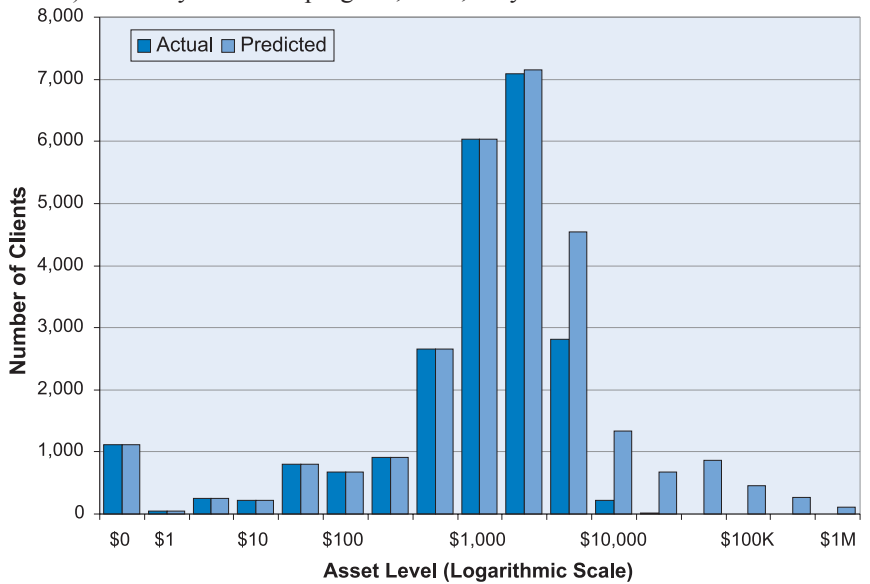
Impact of Removing Asset Limits

Table 1. Estimated additional enrollees due to changes in asset limits by enrollee group.

Change in Asset Limits	Estimated Additional Enrollees		
	Pregnant Women	Family Medicaid	Non-Pregnant Adults Aged, Blind, or Disabled
50% Increase	80	1,800	800
100% Increase	110	2,400	1,200
300% Increase	160	2,900	1,500
No Asset Limit	310	5,300	2,900

Adults in Family Medicaid Program

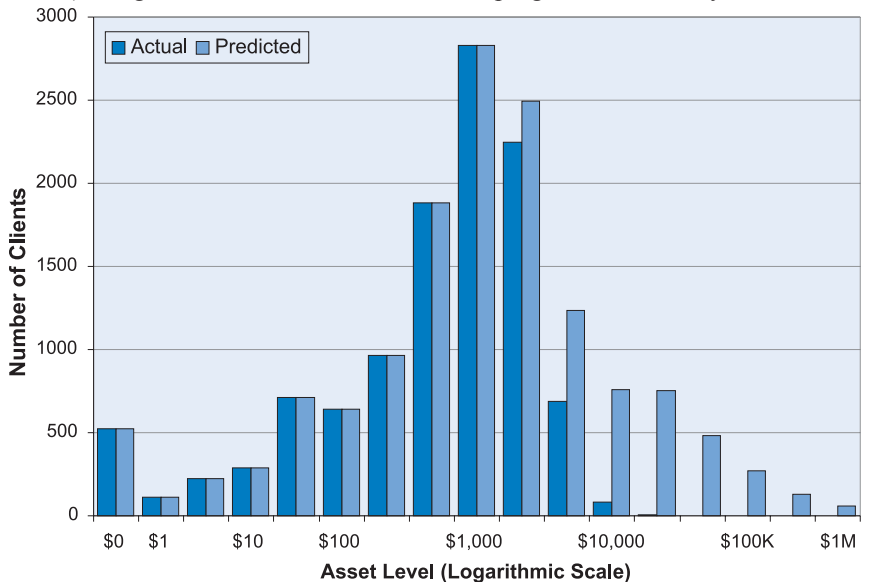
Figure 3. Asset distribution (actual* and predicted) of clients (non-pregnant adults) in Family Medicaid program, Utah, May 2005



* Actual assets may include some amounts that are not considered for Medicaid eligibility.

Adults in Aged, Blind, or Disabled Medicaid Programs

Figure 4. Asset distribution (actual* and predicted) of clients (non-pregnant adults) in Aged, Blind, or Disabled Medicaid programs, Utah, May 2005



* Actual assets may include some amounts that are not considered for Medicaid eligibility.

Breaking News, September 2005

Utah's first West Nile virus (WNV) associated death was reported by TriCounty Health Department. This person was over 65 years of age and was a resident of Uintah County.

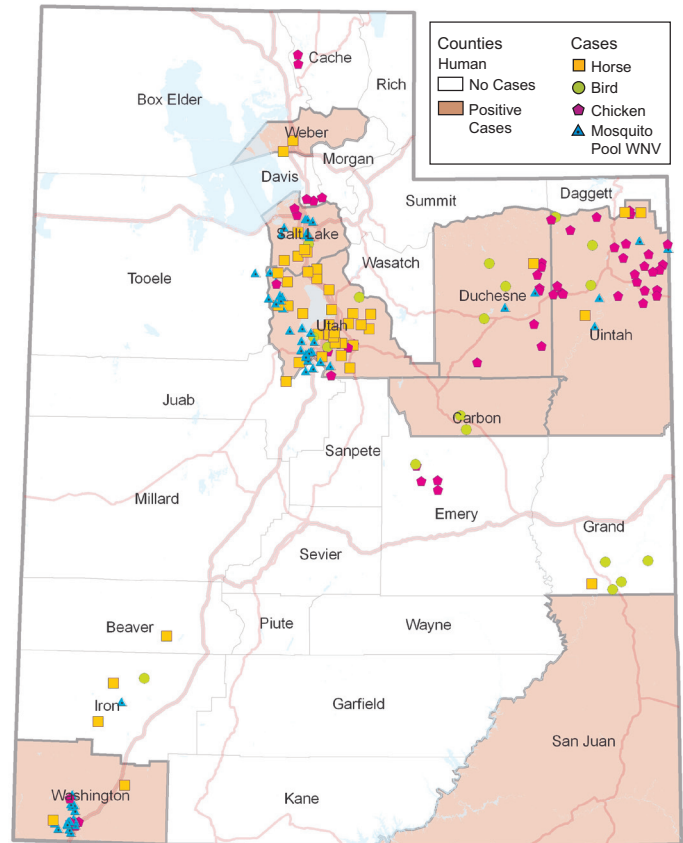
As of September 23, 38 human WNV cases have been reported to the Utah Department of Health. Human WNV infections were reported from the following counties:

- 11 Uintah
- 7 Duchesne
- 1 San Juan
- 1 Weber
- 11 Utah
- 5 Salt Lake
- 1 Carbon
- 1 Washington

Additionally, two potential blood donors were found to have WNV infection. These blood donations were destroyed to prevent them from entering Utah's blood supply.

As of September 23, WNV infection has been reported in 53 horses, 17 birds, 66 sentinel chickens and 79 mosquito pools. So far in 2005, 16 Utah counties have reported WNV activity.

WNV risk will decrease with onset of fall and cool weather, but may continue longer in Southern Utah.



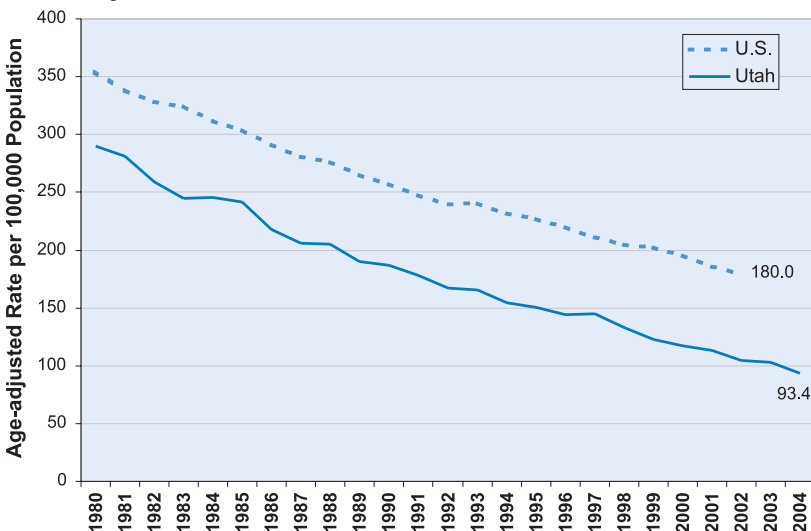
Community Health Indicators Spotlight, September 2005

Coronary Heart Disease

Heart disease continues to be the leading cause of death in Utah and the U.S., and coronary heart disease (CHD) contributes greatly. CHD results from blockage of the arteries that provide blood to heart muscle. Deaths due to CHD have declined steadily since 1980. The state's age-adjusted CHD death rate decreased 210.5% from 1980 to 2004, including a 10% decrease last year alone, from 102.8 per 100,000 persons in 2003 to 93.4 per 100,000 persons in 2004.

Utah ranks among the states with the lowest CHD death rates in the nation and has maintained this status for years. In 2002 the U.S. CHD death rate was 180.0 per 100,000 persons. Perhaps Utah's lower rates are due to residents using less tobacco and having a more active lifestyle. The national obesity epidemic, now also evident in Utah, threatens to reverse this trend.

Coronary Heart Disease Deaths, Utah and U.S., 1980-2004



Utah data from 2004 show that men have higher mortality rates from CHD (126.7 per 100,000 persons) than women (67.0). A decrease in CHD death rates has been observed in every age group except the 85 years and over age group, where a slight increase has been observed since 1999. Combined data (2001–2003) show that Farmington/Centerville is the area with the highest CHD death rate and the Salt Lake City/Avenues area has the lowest rate.

Although the CHD death rate continues to decrease, heart disease is still the number one killer in the U.S. and Utah. If we do not take steps to address the obesity epidemic we might reverse the trend and observe higher CHD death rates occurring in younger ages. Prevention is the key to reducing mortality from coronary heart disease.

Monthly Health Indicators Report for August 2005

Monthly Report of Notifiable Diseases, August 2005		# Cases	# Expected Cases (5-year average)	# Cases YTD	# Expected YTD (5-year average)	YTD Standard Morbidity Ratio (obs/exp)	
Campylobacteriosis (Campylobacter)		27	42	240	223	1.1	
Escherichia coli (E. coli) 0157:H7		3	14	31	65	0.5	
Hepatitis A (infectious hepatitis)		1	5	20	43	0.5	
Hepatitis B (serum hepatitis)		2	2	34	29	1.2	
Influenza		1	2	3274	416	7.9	
Measles (Rubeola, Hard Measles)		0	0	1	1	1.3	
Meningococcal Diseases		0	0	10	5	1.9	
Norovirus		4	0*	27	4*	7.7	
Pertussis (Whooping Cough)		71	18	437	82	5.3	
Salmonellosis (Salmonella)		33	30	340	219	1.6	
Shigella		2	5	37	18	2.1	
Varicella (Chickenpox)		26	30*	415	339*	1.2	
Viral Meningitis		48	33	195	88	2.2	
West Nile (Human cases / Equine cases)		26 / 33	3* / 12*	38 / 56	6* / 16*	6.3 / 3.6	
Notifiable Diseases Reported Quarterly, 2nd Qtr 2005		# Cases	# Expected Cases (5-year average)	# Cases YTD	# Expected YTD (5-year average)	YTD Standard Morbidity Ratio (obs/exp)	
HIV		22	17	42	30	1.4	
AIDS		11	14	21	29	0.7	
Chlamydia		1,105	818	2,164	1,356	1.6	
Gonorrhea		157	92	326	148	2.2	
Tuberculosis		11	9	14	17	0.8	
Program Enrollment for the Month of August 2005		Current Month	Previous Month	% Change From Previous Month	1 Year Ago	% Change From 1 Year Ago	
Medicaid		192,570	192,939	-1.2%	189,668	+0.5%	
PCN (Primary Care Network)		16,819	17,594	-4.4%	15,277	+10.1%	
CHIP (Children's Health Ins. Plan)		31,929	31,703	+0.7%	28,427	+12.3%	
Program Expenditures for the Month of August 2005		Monthly	Expected/ Budgeted for Month	YTD	Budgeted YTD	Variance - over (under) budget	
Ambulatory and Other Care		\$ 587,639	\$ 587,640	\$ 4,516,099	\$ 4,305,110	\$ 210,989	
Fee for Service Hospital Inpatient		\$ 14,348,893	\$ 14,348,890	\$ 120,639,099	\$ 126,733,391	(\$ 6,094,292)	
Long Term Care		\$ 14,276,795	\$ 14,276,790	\$ 122,899,786	\$ 130,301,501	(\$ 7,401,714)	
Pharmacy		\$ 16,426,498	\$ 16,426,500	\$ 145,489,995	\$ 148,779,410	(\$ 3,289,415)	
Health Care System Measures		Current Data Year	Number of Events	Percentage of Utah Population	% Change From Previous Year	Total Charges in Millions	% Change From Previous Year
Overall Hospitalizations		2004	266,195	10.1%	-0.3%	\$ 3,225.0	+11.1%
Non-maternity Hospitalizations		2004	160,302	5.9%	0.0%	\$ 2,692.5	+12.0%
Emergency Department Encounters		2003	638,478	25.2%	+1.0%	\$ 397.8	+18.3%
Outpatient Surgery		2003	279,874	11.1%	+5.6%	\$ 731.2	+17.4%
Annual Community Health Measures		Current Data Year	Population at Risk	Number Affected	Percentage/Rate	Previous Year Rate	% Change From Previous Year
Overweight and Obesity (Adults 18+)		2004	1,698,118	957,739	56.4%	54.7%	+3.1%
Cigarette Smoking (Adults 18+)		2004	1,698,118	178,302	10.5%	11.9%	-11.8%
Influenza Immunization (Adults 65+)		2004	207,920	156,980	75.5%	74.8%	+0.9%
Health Insurance Coverage (Uninsured)		2004	2,469,230	251,861	10.2%	9.11%	+12.0%
Motor Vehicle Crash Injury Deaths		2004	2,469,230	298	12.1 / 100,000	11.6 / 100,000	+4.3%
Suicide Deaths		2004	2,469,230	377	15.3 / 100,000	13.9 / 100,000	+10.1%
Diabetes Prevalence		2004	2,469,230	93,831	3.8%	3.7%	+2.7%
Coronary Heart Disease Deaths		2004	2,469,230	1,603	64.9 / 100,000	70.6 / 100,000	-8.1%
All Cancer Deaths		2004	2,469,230	2,442	98.9 / 100,000	100.9 / 100,000	-2.0%
Births to Adolescents (Ages 15-17)		2004	57,505	854	14.9 / 1,000	16.0 / 1,000	-6.9%
Early Prenatal Care		2004	50,653	39,521	78.0%	78.0%	0.0%
Infant Mortality		2004	50,653	262	5.2 / 1,000	5.0 / 1,000	+4.0%
Childhood Immunization (4:3:1:3:3)		2004	48,619	34,665	71.3%	78.8%	-9.5%

* Due to limited historical data, the average is based upon 2 years of data for norovirus, varicella, and West Nile virus.

Note: % Change could be due to random variation