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THE ECONOMICS OF THE *HEALTHY UTAH* PLAN: A PRELIMINARY ANALYSIS

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1. Overview

Under the Affordable Care Act (ACA), also known as ObamaCare, citizens from every state are paying taxes to fund the expansion of Medicaid, the nation's main program to finance healthcare for the poor. States that have foregone the Medicaid expansion are paying hundreds of millions (or more) in taxes annually to Washington from which they receive no benefit.

The *Healthy Utah* plan, in a nutshell, provides a mechanism to use federal Medicaid dollars to provide private health insurance options for poor and low-income adults who do not qualify either for traditional Medicaid or for subsidies from the Marketplace.[2]

In addition to providing significant health and economic gains, the plan recognizes key political realities. First, even if Republicans make significant gains in the next Congressional election, there is no feasible path for the ACA to be repealed for many years to come,[3] and the Obama Administration will remain in power until 2017.

Second, and more important, *Healthy Utah* appeals to a set of values that have wide support in the state among both Republicans and Democrats, including finding free market solutions to social problems that encourage work, personal responsibility, and accountability. Because of these features, an overwhelming

Healthy Utah—*Essential Features:*

- *Returns federal tax dollars to Utah to help the uninsured.*
- *Fills the "donut hole" (which leaves the poor with no options) created by the Supreme Court.*
- *Channels Medicaid dollars into the private market.*
- *Strengthens Utah's insurance markets, including the market for employer-provided plans.*
- *Creates market-based options for working individuals and families.*
- *Promotes individual responsibility for health care decisions.*
- *Unifies families in the same health insurance plans.*

[2] The "Marketplace" in this brief will refer to federally-operated insurance exchange that individuals access through healthcare.gov.

[3] Repeal would require approval of the Senate, where 60 votes will be required. Not even the most pro-GOP forecaster is expecting the Republicans to gain that level of control in Congress any time soon. It is always possible, of course, that changes could occur because of judicial rulings.

percentage of Utahns support the *Healthy Utah* plan because they are looking for a way to assist people in obtaining health insurance that does not compromise Utah values. A recent scientific poll puts support for the *Healthy Utah* plan at close to 90% of the state. The plan features are particularly popular among the state's conservatives.[4]

These political realities, however, are not the focus of this brief. Politics constrains what is possible, but the economic question is whether the *Healthy Utah* plan improves, on balance, the well-being of state residents. The answer to the economic question is resolutely "yes." Even though there are significant uncertainties ahead, the economic benefits significantly outweigh the likely costs.

In short, the worst economic option for Utahns is to send our tax dollars to Washington and get nothing in return. Governor Herbert's *Healthy Utah* is a reasonable way to avoid that undesirable outcome in a way that makes economic sense and promotes Utah's values.

2. Economic features of Healthy Utah

2.1. Closing the "Donut Hole"

At its conception, the ACA was designed to expand Medicaid to all the nation's poor and low-income families with income up to 133%[5] of the federal poverty level (FPL). Because the benefit and eligibility packages in Medicaid programs differ across the states, this expansion would have had uneven effects across the nation. Utah's Medicaid program is among the least generous in the nation and benefit levels are at or near federal minimums in all required benefit categories. Thus the financial consequences of a Medicaid expansion in Utah would be much greater than in some of the states that have decided to expand.

The central goal of moving all the poor into Medicaid was upended, however, by the US Supreme Court in 2012. The Court ruled that the federal government could not force the states to expand their Medicaid programs. An important consequence of this change is that many of the poorest Americans have no access to affordable health insurance unless they fall into one of the traditional categories for Medicaid coverage. In states with more generous Medicaid policies, this is of little consequence, but thousands of poor Utahns do not qualify for the state's Medicaid program as currently constituted.

[4] See Wilson & Goodliffe, 2014. The Poll was conducted statewide by Dan Jones & Associates and an independent analysis of the data was conducted by analysts at Notalys.

[5] Under Medicaid rules, the first 5% of income is "disregarded," meaning that the effective rate at which coverage applies is 138%.

Furthermore, the ACA does not allow people to receive subsidies to purchase health insurance from the Marketplace unless their income is between 100-400% of FPL. In other words, much of middle-class America is given a substantial subsidy to buy health insurance if they do not have an employer sponsored plan, but the poor cannot participate.

To summarize, the "Donut Hole" (or "Medicaid Gap") in Utah consists of the following two groups of people:

- Childless (and non-pregnant) adults with income less than 100% FPL
- Adults with children with income between 50-100% of FPL.

Congress could eliminate the donut hole in many states by changing just one number in the ACA. If they allowed states to partially expand Medicaid to 100% of the poverty (instead of 133%), it is likely that more states would agree to this partial expansion, eliminating the donut hole. Similarly, the Obama administration could decide unilaterally to allow this change in interpretation, as it has unilaterally made many other significant changes to the law, but they have indicated an unwillingness to grant this option.[6] Barring a dramatic departure from the Administration's stated intentions, a partial expansion is not possible, and Utah has to come up with a practical approach that will be acceptable to the Obama Administration.

Under Healthy Utah*, every Utahn has a pathway to affordable health insurance—no more "Donut Hole"*

Healthy Utah is designed to completely close the donut hole. *All Utahns under 133% of poverty will have access either to:*

- Employer-sponsored insurance plans
- Premium support to purchase a plan through *Healthy Utah*
- Coverage in Traditional Medicaid

Middle-income Utahns between 133-400% of FPL will have still have access to federal insurance subsidies to purchase insurance in the Marketplace (subsidies decline with income).

[6] Whether or not CMS has the legal authority to make such a change is not a topic addressed further here. Clearly Congress does have such authority, but the political prospects of Congress agreeing to make this change are very dim.

2.2. Reliance on the Private Market

The most significant economic feature of *Healthy Utah* plan is the significant reliance it places on market-based solutions rather than government-administered programs. In addition to providing coverage for some of the neediest Utahns, *Healthy Utah* will strengthen the market for private insurance.

The Employer Market

In the US, most Americans purchase health insurance through employer-sponsored plans. As designed, the ACA poses a threat to the employer market because it provides heavy subsidies for purchasing plans in the individual market rather than the employer market, where the subsidies cannot be used. Will the *Healthy Utah* plan make this problem worse, as some[7] have suggested?

The answer to this question comes from understanding why firms offer insurance and why workers buy it. The largest reason firms offer insurance is because they get large tax breaks from doing so. These tax breaks will persist under the ACA and, when the "employer mandate" goes into effect, they will become even stronger, since businesses with over 50 full-time employees will face penalties if they do not provide their employees with insurance.

Second, the market faces pressure from insurers. Insurance companies are better able to manage their risks by offering employer-based group plans rather than selling directly to individuals. Insurance companies gain whenever they can offer plans to large groups of people.

Third, health benefits are part of an overall wage/benefit package that employers use to compete for and retain employees. Business that offer health plans reduce their expensive turnover costs because employees are generally averse to changing their health plans.

Because of rising insurance costs in general, employers have been scaling back coverage for some time. This is likely to continue, given the way the ACA is designed and because health care costs continue to rise. We may see a decrease in employer-sponsored plans because of these larger market forces, but there little reason to conclude that employers would drop their plans in significant numbers because of the existence of funds under *Healthy Utah.* In general, businesses offer insurance because of economic incentives to do so, not because of the availability of other insurance options for employees.

Healthy Utah will put millions of new dollars into the hands of poor and low-income individuals. Those who have the option of purchasing employer plans will now have the funds to do so. People are uninsured for many reasons, but the poor are uninsured largely because the plans

[7] See, for example, Liljenquist, 2014.

offered to them are unaffordable. *Healthy Utah* will change that and pump millions of dollars of new demand into the employer health insurance market.

Healthy Utah will, therefore, take advantage of the existing incentives that push people towards their employer plans without having to pay the full cost of the insurance (as would be the case with Medicaid). As envisioned by the ACA, some of the economic cost of these plans will be shared by employers and some by the employee. On the other side of the ledger, employees gain by having access to insurance, and employers gain because insurance leads to a more stable and healthier work force.

The Individual Market

For those without access to employer provided plans, the next option is to purchase insurance in the private market. The current plan proposed by the Governor is to use the Avenue H exchange, which is Utah's small business health insurance exchange. Avenue H has an existing infrastructure that can be expanded to facilitate the purchase of private market plans. Just as people use a defined contribution from their employer to buy a plan on Avenue H, participants in *Healthy Utah* will use a subsidy to help them pay premiums for the policies on the exchange (though the plans on the SHOP portion of the exchange will face a different set of regulations from the plans purchased with *Healthy Utah* funds).

Avoiding Insurance Crowd-Out

One of the most economically salient features of a Medicaid expansion under the ACA is that many individuals who would otherwise purchase private insurance are pushed into Medicaid (Gruber & Simon, 2008). This may be a less attractive option for them, and it is certainly less attractive to the insurance industry, an important part of the economy. Private insurance crowd-out is one of principle objections that many economists have to Medicaid expansion.

Under a full Medicaid expansion, tens of thousands of Utahns would move from private insurance to Medicaid. Under Healthy Utah, *they stay in the private market.*

In 2012, there were over 57,000 adult Utahns with private insurance who had income less than 100% FPL and an additional 146,000 adults in the 100-138% range. Under a Medicaid expansion, as envisioned by the ACA, all of these people—plus over 100,000 children who were on private insurance—would have to move into Medicaid, where their health care choices are typically much more limited. This exceeds by over 108,000 the number of uninsured adults and children in the state in the same

income groups in 2012.[8] Furthermore, all those who have bought policies on the federal Marketplace in the last few months and have income in the 100-138% FPL range would also have to shift to Medicaid under a Medicaid expansion.

Under *Healthy Utah*, all of these people would receive government funds to buy insurance either from their employer-sponsored plans or on the *Avenue H* exchange.[9] This difference alone indicates that *Healthy Utah* is not just Medicaid expansion by another name, as some critics have charge. It is a different approach entirely.

Healthy Utah does require policy shifting of another kind that should be mentioned. Those who are in the 100-138% FPL range and are buying plans in the Marketplace would have to purchase their plans through *Healthy Utah*. These plans may have better benefits in many cases, but the loss in consumer welfare associated with people being forced to switch plans should not be ignored.

2.3. Consumer Choice and Accountability

One downward force on health care costs is that an increasing portion of healthcare is being paid by consumers through the use of medical savings accounts and high-deductible insurance plans. Participants in these plans have the incentive to shop around for different health care options and to limit their expenditures that are not medically necessary. This is the power of the market. When consumers face the financial consequences of their decisions, they change their behavior. And that behavioral change puts market pressure on the health care industry, lowering both expenditures and health care prices.

Traditional Medicaid has little in the way of consumer accountability. Medicaid co-pays are only a few dollars and total monthly expenses are capped. These "cost-sharing protections" are crucial for the very poor to get the care that they need, but the co-pays do not increase with higher levels of income or assets. Additionally, Medicaid patients have some choice about the providers they can see, but they have no choice in choosing plan features that may be appealing to them and no ability to affect plan features through their purchasing power. The features of the Medicaid plan are determined by federal and state policies. In addition to providing insurance, *Healthy Utah* will give low-income residents market power—their preferences and choices will shape the types of policies offered in the future.

Healthy Utah, if successful, will provide options, the same kinds of options that are available to those purchasing plans in the Marketplace. Moreover, the State is negotiating with CMS the ability to charge premiums and higher co-pays for higher-income participants. These will incentivize consumers to seek more cost-effective care. In the short-run, *Healthy Utah* is able to pay less for these plans because the consumers are paying a higher percentage of the cost,

[8] These numbers are imputed from PCG (2013), p. 20.
[9] The exception are those who are "medically frail," according to the definitions found in the ACA; the medically frail must subscribe to traditional Medical under the *Healthy Utah* plan.

and, in the long-run, they will incentivize consumer accountability will hold down insurance costs.[10]

Finally, even though Medicaid patients can choose providers, many Utah providers will no longer accept Medicaid patients because of, ostensibly, low provider reimbursement rates. Under *Healthy Utah*, providers will negotiate reimbursement rates with insurers in the same manner as they do with other private plans. And many of Utah's health care providers will benefit in another important way: they will no longer need to provide free or reduced-price care to poor adults without insurance. Instead, they can be compensated fairly for the care they provide.

2.4. Family Unification

The burden of making health care decisions is increased when families have to negotiate the different features of multiple insurance plans. Those in the Donut Hole often have children who are on Medicaid or CHIP.

> Healthy Utah *keeps families together—promoting their health and reducing the hassle of multiple policies.*

Healthy Utah will allow people to bring their children along with them into the plans that they choose, with "wraparound" benefits for the children, if necessary. It is hard to put a dollar amount on this feature, but patients are able to make better decisions and providers are able to provide better care when families are treated as a whole, rather than dividing them up among different insurance plans.

2.5. Why is this Analysis "Preliminary?"

Currently, *Healthy Utah* is more of an outline than a detailed plan. Governor Herbert's staff and officials of the Department of Health are negotiating with officials at CMS in advance of submitting a formal waiver request. Thus, the analysis in this brief may be affected by changes to the plan that come out of that negotiation.

The concepts in *Healthy Utah*, however, are specific and clear enough to make broad assessments of their economic impacts, even though assigning dollar estimates to the plan are premature and, as with any new program, projected costs and benefits are always made in the

[10] It should be noted, however, that the cost-sharing in the *Healthy Utah* plans is still likely to be small, especially when compared to cost-sharing in high-deductible plans.

face of significant uncertainties. A full accounting of costs and benefits from any program can only be made after the fact and, even then, it is an imprecise science.

Nonetheless, the general claims made about *Healthy Utah* in this brief do not depend on detailed estimates to be legitimate. The basic economics of the plan are straightforward enough to draw conclusions with a high degree of confidence.

3. Program Impacts

3.1. The Economic Value of Health Care

The most common metric for determining the economic value of any good or service is consumers' willingness to pay for it. Using this as our measuring stick, how much, then, is health care worth to people in the state, especially the poor?

Health Care Expenditures

To begin to answer that question, we must first get a sense of how much is spent on health care by different groups in the state. In our modern, information-heavy economy, it is surprisingly difficult to answer this question. Even for well-tracked groups, such as Medicaid enrollees, precise estimates are hard to come by. Medicaid enrollees sometimes purchase health care that is not covered by Medicaid or they purchase medical care from providers who do not accept Medicaid patients. Estimating expenditures for hard to track groups, such as the uninsured, is even more difficult.

Even with access to emergency and charity care, the uninsured in Utah get much less health care than those on private or public insurance.

In a financial analysis conducted for the Utah Department of Health in the latter part of 2013, analysts from the consulting groups of Leavitt Partners and Notalys estimated that total annual health care expenditures by Medicaid enrollees (assuming there would be no Medicaid expansion) would be $7,890 in 2014.[11] Their corresponding projection for spending by the uninsured is $1,751. This is a difference of over $6,139 per year, per person on an annualized basis. (New enrollees in *Healthy Utah* are likely to spend significantly less than the average because they will be healthier than the average current enrollee on Medicaid.)

[11] This excludes individuals who are dually eligible for Medicaid and Medicare. The estimate is for a person who is on Medicaid for a whole year. See Leavitt Partners & Notalys (2013)

These numbers imply that expenditures for Medicaid recipients is 4.5 times more than spent by the uninsured. Part of this gap may reflect unreported charity care, but that amount is surely a small part of the total. Moreover, the uninsured include some people who are not poor and choose to pay for their care out of pocket; thus expenditures by the *uninsured poor* may be even lower.

Every year the percentage of national income spent on health care rises; today it is over 17%. Despite what pundits say, this is mostly *not* bad news. We spend more than ever primarily because we are richer than ever and we are getting better care. True, a good-sized chunk of increased spending is waste and inefficiency (many countries get much better value for the dollar than the US), but most of it is due to rising consumer value. This includes both better health outcomes and more consumer satisfaction (Cutler & McClellan, 2001; Chernow, Hirth & Cutler, 2003).

Surplus Value

In a competitive marketplace where people voluntarily purchase goods and services, almost all purchases include what is called "surplus value" or "consumer surplus." If a consumer spends a dollar on a piece of fruit but would be willing to spend two dollars, if necessary, then the total economic value of the fruit ($2) exceeds the expenditure by one dollar. That difference between expenditure and willingness to pay is the consumer surplus, which is one dollar in this example.

Understanding the total economic value of health care is extremely complex because health care isn't like a piece of fruit. It is multi-faceted and involves many inputs and many people. Even a routine office visit to the doctor involves the services of a variety of professionals and office staff, as well as variety of medical inputs, including office equipment and supplies. Furthermore, because third-parties often pay for the majority of the cost of healthcare services, consumers seldom know the full cost of what is being expended for their care.

It is clear from research that the demand for health care is, to use economic jargon, relatively inelastic.[12] This implies significant consumer surplus exists in health care. Consequently, to get an idea of the total economic value of health care that privately insured Utahns purchase, we have to add the consumer surplus to the expenditures. No ready estimate of consumer surplus exists, but because of the inelasticity of health care demand, surplus values are likely to be significant.

There are too many wrinkles in this problem to place a firm value on the economic value of health care, but there are strong reasons to conclude that it is very high. To think about this question another way, how much would a typical Utah family be willing to pay for a promising

[12] A good is said to have inelastic demand when an increase in price does not significantly change the quantity purchased. Goods with inelastic demands are associated with high consumer surplus.

medical procedure that might save the life of a dying family member? We focus a lot on the growing costs of health care and sometimes forget that modern medicine also provides tremendous value, a value that is both large and not fully measurable.

In the end, a large estimate of consumer surplus is not necessary to justify the conclusions of this analysis. Indeed, the program makes sense on the basis of expenditures alone. But it is important for policymakers to have a sense that the economic value of health care likely far exceeds what we have to pay for it.

Overspending and Waste

A serious complication with determining the value of health care spending is that people use significantly more medical care than they would on their own because much of the care is paid by a third-party—either their private insurance or government. We have known since the RAND Health Insurance Experiment (Newhouse, 1996) that as the out-of-pocket portion of medical care rises, people consume less care. In colloquial terms, the more people have "skin in the game," the more they limit their spending. The downside of having insurance, from a social perspective, is that it incentivizes consumes to spend more than they would if they had to cover all medical costs out-of-pocket.

The consumer incentives to overspend on health care lead to a lot of waste in the health care economy (Berwick & Hackbarth, 2012; Brownlee, 2008, Welch, 2012). Economists are in widespread agreement that a high percentage of healthcare spending in the US is wasteful or even harmful. A recent review by the Institute of Medicine (2013) puts the total at about 30% of total healthcare spending, with an estimate for 2009 of $765 billion. Factors other than consumer incentives contribute to overspending as well, including administrative waste, medical errors, lack of knowledge about the best quality of care standards, and "defensive medicine" by practitioners.

Why do we as Americans tolerate this overspending? Part of the answer is that what we consider waste when *others* do it is "just being sure" when *we* do it. A test or procedure that is not cost-effective from a social perspective (the costs outweigh the benefits) may still be individually desirable when we make decisions for ourselves and insurance companies or government bear the costs. This is why insurers cannot say yes to every patient or provider request for treatment. It is probably true that we tolerate waste in the system partly because we want a robust set of options when *we* are in need of care.

Another obstacle to reform is that inefficiencies are tied to poorly constructed *incentives* in our health care system. Most health economists support, for instance, moving away from fee-for-service models of payment in favor of value-based reimbursement (where payment is based on people and conditions, rather than treatments); these payment reforms are part of the Accountable Care Organizations (ACOs) that are becoming more prevalent. Eliminating waste is hard because every wasteful dollar spent goes into someone's pocket. It is hard to eliminate inefficiencies because people who gain from inefficiencies are reluctant to change the rules of the game that generate them.

Fortunately, there are many constraints in the system that limit the overspending impulse. Managed care plans and insurance coverage policies, for instance, limit what can be purchased. Employers are becoming increasingly vigilant in demanding true value from the health care plans they pay for. The growth of high-deductible plans incentivizes consumers to limit spending. Under the ACA, significant federal resources are being devoted to studying and implementing treatment and payment reforms that raise the value provided in healthcare spending. Private health care companies, such as Intermountain Healthcare, are making great strides to improve the efficiency of care in Utah. [13]

In sum, there are significant forces working against the incentives to overspend on health care. This means that when thinking about the value of healthcare spending, we should be careful not to overemphasize overspending. In other words, the value of health care to the uninsured should not be dismissed because of waste in the system. Think about it this way: How many *insured* people are willing to give up their health care plans because of waste?

Will covering people in *Healthy Utah* involve wasteful spending? Certainly. Health care spending in the state will continue to involve significant inefficiencies, but the magnitude of these inefficiencies do not negate the high value that access to health care has for the citizens of the state.

Economic Value and Income

So what about the poor? Is it worth it to spend more and more money each year on health care for low income people? Do they deserve it? That is an ethical and political question that cannot be answered by economics. But what can be said with economics is that health care for the poor has a high value *for the poor!* An "average" Utahn on private insurance spends more than $5,000 per year on health care with thousands more (probably *many* thousands) of consumer surplus on top of that. Those in poverty cannot spend that much because, in simplest terms, *they are poor*. The economists' term *willingness* to pay includes as part of the construct an *ability* to pay. Thus, a low willingness to pay among the poor reflects mostly their low income—not the underlying value of health care.

Waste and overspending are hard to eliminate, yet consumers still get significant economic value from health care spending, probably much more than the amount actually spent. The same is true for the uninsured.

[13] Utah has the lowest per-capita health care expenditures in the nation, but, after controlling for age, other demographics, and socioeconomic variables, health care spending in Utah is about at the national average (Leavitt Partners and Notalys, 2013). Therefore, we have many inefficiencies in our system that could still be eliminated.

We do know from a recent study that the willingness to pay for care among the Medicaid population, even with their low income, is not trivial. Krueger and Kuziemko (2013) showed that the Medicaid population (nationally, not in Utah) would be willing to pay, on average, about $1,900 annually to be covered by Medicaid. This is surprisingly close to the number reported earlier that the uninsured are already spending on health care.

But a better question is this: how much would they be willing to pay if they weren't poor? What if they were just average people with average incomes? We do not have an answer to that question, but neither do we have evidence that the answer would be significantly different from what we find among middle-income citizens of the State.

In our political and economic system, people have different perspectives on society's obligation to provide an economic safety net for the poor. This brief does not speak to those moral questions. But, in terms of simple consumer economics, the average Utahn would place a high value—at least $5,000-$10,000 and perhaps much more—on the health care they purchase. If we give the poor equal standing with the rest of the state, what value should be assigned?

3.2. The Value of Health Insurance to the Poor

Insurance companies are able to make profits because the value people place on insurance exceeds the expected (average) cost of their medical care. Insurers pool risks and charge people premiums. Not everyone who can afford insurance buys it (people differ in their desire to bear risk and in their knowledge about the risks they face), but the overwhelming majority of people do—this fact is a fundamental market indicator of the value of insurance. This doesn't mean insurance markets are perfect. What it does mean is that consumers see the value of the products to be at least what they have to pay for them.

As discussed above, the presence of insurance can lead to overspending and inefficiency in health care. This has long been recognized as a key feature in the economic theory of medical insurance (Arrow, 1963, Pauly 1974). In more recent years, a practical feature of insurance has been recognized as significant. Nyman (2003) highlights that an important part of insurance demand is that insurance allows access to treatments that would otherwise be unattainable. This is a rather obvious point long understood by ordinary people that was ignored in much of the theoretical discussion by economists until recently.[14] In the real world, without insurance there are a set of health care services that are simply out of reach by low-income people. Even

[14] In economic theory, insurance allows people to smooth out their consumption over time, rather than getting hit by big "shocks," such as a large medical bill. But in the traditional model, uninsured large shocks are simply absorbed by the consumer. In reality, people without insurance cannot absorb the cost of care and often have to forego needed care.

middle-income and high-income people can face insurmountable medical costs—which is why they almost always have insurance.

The ability to get needed care when health crises strike is the heart of the value of insurance for most people. This fact was lost in some of the commentary following the recent results from the randomized study of Medicaid participation that has been occurring in Oregon (Baiker et al., 2013). This high-quality study showed that access to Medicaid improved basic health measures such as hypertension, cholesterol, and hemoglobin counts, but the improvements were small and statistically insignificant.[15] But significant improvements in average health do not have to result from Medicaid for it to be worth the expense.

The Oregon study showed that Medicaid enrollees had significantly better mental health, were less depressed, and spent much less on health care, including costs for catastrophic events and payment of medical debts. In other words, their quality of life was much higher, as was their self-reported health. Access to health insurance for any group of people (regardless of income or insurance status) is unlikely to have large effects on the baseline health measures of the type looked out in the Oregon study. But this doesn't mean insurance has no value. Insurance is not a cure-all, but it buys a significant amount of peace of mind, of protection against the unforeseeable and sometimes catastrophic events that are part of life. These events are the reason so many people go to great lengths to buy health insurance, even though they may never need it.

Access to insurance not only safeguards health, but it reduces poverty, too.

For the reasons above, the amount that consumers have to pay for insurance, given market prices, is a lower-bound on the economic value gained by consumers. The amount people would be *willing* to pay is much higher. We know this because as insurance prices have skyrocketed in recent decades at a rate much faster than average income, people keep buying insurance at very high rates (though they have moved somewhat, as theory predicts, to lower-cost, high-deductible plans). Surplus values of 2-3 times the actual cost of insurance do not seem unreasonable.

Finally, even if the *health* benefits of insurance were small (which is probably *not* the case when looked at in a more comprehensive fashion), the *economic* benefits to insurance for the poor may be sizable. Partly this is due to the surplus values discussed above. Additionally, people with low income face a host of economic problems. Research shows (Summers & Oellerich, 2013)[16] that Medicaid has significant anti-poverty effects (a fact also confirmed by the Oregon

[15] Statistical insignificance means that that that the estimates are too imprecise to draw firm conclusions, usually because of a small sample size.
[16] They conclude that in 2010 Medicaid kept 2.6 million Americans out of poverty.

study). The life stability provided by insurance also has positive spillover effects on the families and employers of low-income people, important effects that are hard to quantify.

In brief, the state budget will almost surely benefit by adopting Healthy Utah. *Even under a "worst case scenario," the costs to the state budget will be negligible compared to the benefits to residents.*

3.3. Medicaid Reform in Utah

In 2012, the Utah Legislature passed landmark Medicaid reform. The primary feature of this reform was putting most of the state's Medicaid population (those living along the Wasatch Front) into accountable care organizations. ACOs receive a fixed amount per Medicaid enrollee and thus have strong incentives to engage in cost-effective treatment. The ACO movement is gaining ground in Medicaid programs in other states as well as in Medicare (Muhlestein, 2014). It is likely to be successful because rather than mandating an endless list of regulations on care, it creates incentives for the provider to provide low-cost, high-quality care.

The *Healthy Utah* plan does not affect the trajectory of these important reforms. Most low income adults under the plan will receive health care through employers or through the plans they purchase under *Avenue H*. Under *Healthy Utah*, the "medically frail" will go into Medicaid, where most of them will be treated as part of an ACO.

3.4. Program Costs

Because of the ACA, some people who were previously eligible but not enrolled are being channeled in to Medicaid, where the federal match rate in Utah is approximately 70%. This is known as the "woodwork effect." Because of the woodwork effect and the mandatory changes to Medicaid, the state incurs an additional $39 million from 2014-2016, according to PCG. But these costs are mandated by the ACA, and the state is required to pay them regardless of what it chooses to do.

But the "optional expansion" is another story entirely. Under the ACA, ***100%*** of the cost of covering new Medicaid enrollees from 2014-2016 would be paid for by the federal government. After that, the federal portion would decline gradually to 90%. In fact, the PCG consultants estimated that the state would save, during the first three years, $48.8 million in budgetary costs (not including additional revenues from economic expansion).

In short, a full Medicaid expansion has no program costs during the first three years. The details of *Healthy Utah* have not yet been determined, but the costs are likely to be in line with the Medicaid dollars used to fund it. Some aspects will be more expensive (providers on private plans are compensated more than in Medicaid, for instance), but other costs will be lower (enrollees will pay more than they do in traditional Medicaid).

> *The work requirement in* Healthy Utah *is an important force countering the work disincentives associated with public health insurance.*

Furthermore, by filling the donut hole, the state is projected to save $61.3 million in other public assistance costs. County governments will save $18.7 million in public assistance. The budget will also benefit from new state and county taxes generated by the economic expansion. PCG estimates these to be $43.3 million in state and county taxes (though there are reasons to be skeptical of a large economic stimulus).

3.5. Additional Program Benefits

Reduction in Uncompensated Care

A significant portion of the care that low-income Utahns receives comes in the form of uncompensated care. Because the donut hole is closed, the health care industry can recoup these costs and be compensated, for the most part, at the same rates that they receive from private insurance plans. PCG estimated a savings of $181 million over a three year period for uncompensated care.

Incentives to Work

One of the negatives of traditional Medicaid is that people have an incentive not to work because earning more income makes them ineligible for benefits. Some research has shown that these work disincentives are significant (Dague, DeLiere & Leininger, 2014; Mulligan, 2012).

Healthy Utah reduces these disincentives. Those whose income raises them above eligibility for *Healthy Utah* will be eligible to purchase insurance plans in the Marketplace if they do not have access to an employer-sponsored plan. This is particularly important for individuals with children who are below the 50% poverty threshold. Parents can now increase the amount of income they earn without falling into the Donut Hole by working more.

There is a downside, however. Under the status quo, people have strong incentives to climb out of the Donut Hole by earning more than 100% of FPL. If they now have insurance options below 100%, then their work incentive is reduced. Of course the fact that they do not lose

A significant advantage of Healthy Utah *is that it requires no up-front expenditures and no long-term commitments. The program can be abandoned or changed as soon as it proves undesirable. It is completely reversible. In public policy, the value of reversibility is high.*

insurance options as they gain income is a feature of the ACA that reduces the strong work disincentives under traditional Medicaid. Thus, closing the donut hole creates two offsetting effects on work incentives, and it is unknown which will be greater (or if either is significant).

As a protection against work disincentives, Governor Herbert is seeking permission from CMS to have a work requirement as part of the *Healthy Utah* plan. How effective this requirement will be and what enforcement mechanisms are involved are not yet known, but the work requirement provides protection not found in the ACA or the current Medicaid program.
There will certainly be some limitations on the work requirement, and it may take the form of job training for some individuals. A long term path to higher income potential is the best benefit that participants in Healthy Utah could promote.[17]

Increased Economic Activity

Healthy Utah will bring in hundreds of millions of dollars from the federal government over the first three years. In addition to the direct benefits this spending provides, the inflow of spending also has larger economic effects because of economic multipliers. The PCG report used an industry-standard IMPLAN model and estimated that the benefit of the full Medicaid expansion over three years was $652 million.

Regional multipliers are controversial among economists and many are very skeptical of them. However, most economists believe there will be some spillover as people who work for and profit from the healthcare industry spend the inflow of funds on other goods and services in the economy.

Transition to Future Medicaid Changes

Starting in 2017, all states will have the option of applying for permission to re-design their Medicaid program to more closely resemble a block-grant program. Because *Healthy Utah* is taking a big step in that direction already, the state will face considerable advantages of taking advantage of the program re-design option.

[17] Funding for job training is not provided as part of the plan.

Reversibility

Many public policy decisions are challenging because they involve large up-front capital investments or they have consequences that cannot be undone (such as permanent environmental impacts). One of the most attractive features about the Healthy Utah plan is that it is *entirely reversible.*

Sometimes the most well-intentioned plans and most honest projections fail to produce the desired benefits. By committing to *Healthy Utah*, state policymakers are making no binding commitments to future expenditures or participation (the same is true of a Medicaid expansion, of course).

Governor Herbert's approach is very cautious in this regard. His plan is for a three year pilot project. During this time policy makers can observe the effects of the plan and can change direction if needed. Advocates of continuing *Healthy Utah* will have to make their case; otherwise the program goes away.

Public policy in the health care arena is rapidly changing and, therefore, knowledge about the effects of the ACA and other programs such as *Healthy Utah* will be valuable as decisions are made in the future.

3.6. Important Uncertainties

Health System Capacity

Healthy Utah will promote a large and relatively sudden increase in the demand for health care services. As discussed in Wilson (2013), sudden increases in demand can have the following consequences:

- First: excess capacity is used up—this is the *win-win* part, but it does not last forever, and it is limited and localized.
- Second: shortages, delays and lack of availability develop
- Third: Providers and patients respond to those signals; the most important effect is an increase in health care prices
- Fourth: The capacity of the industry begins to expand in response to the above changes; this occurs relatively slowly.
- Fifth: Policies change in response to the industry effects; these changes induce additional market effects.

Relatively little is known about the capacity of the Utah health care sector to absorb a large and sudden increase in demand. Because the health care industry contains so many players, it is hard to understand the overall capacity constraints in the industry. A recent workforce study (Koduri, 2012) of the Utah physician market showed that our current capacity is adequate, but there are warning signs for the future. There are only 178 patient care physicians per 100,000 people, which is below the 290 recommended by the Council on Graduate Medical Education and less than the 319 average in the US (Heisler, 2013). Because it has a younger population than the rest of the country, Utah needs fewer physicians per capita, but currently 50% or more of all primary care specialists report full or nearly full practices.

According to the workforce study, Utah has a need of 332 physicians each year, but Utah trains only 95 physicians in the state. Will Utah continue to attract physicians from out of state as demand for physicians increases nationwide because of the ACA? Evidence suggests that America will experience a growing shortage of physicians in the coming decade (AAMC, 2013). The American Association of Family Physicians claim that there could be a shortage of 40,000 primary care physicians by 2020. A study by the Lewin Group estimates that under the ACA there will be a shortage of 91,500 physicians nationwide by 2020.[18] Recent revelations of physician shortages at Veterans Administration facilities reflects this larger national problem.

One advantage of Healthy Utah is that most of the participants will be on private health insurance plans that should be indistinguishable from the private plans of other state residents, at least from the provider perspective. When capacity is strained, those on Medicaid are likely to feel the greatest pinch because providers are compensated at a lower rate for treating Medicaid patients. Moving people into private plans is a way to level the playing field so that the poor do not face the burdens of a constrained system.[19]

Finally, when Medicaid enrollees have a difficult time obtaining treatment, they sometimes go to emergency rooms for care (as do the uninsured and those with insurance). Having access to private insurance will therefore save on healthcare costs in the state because Healthy Utah participants will have an easier time obtaining urgent care from private providers. [20]

Administrative Capacity

Any new government program will require state administrative resources. These costs should be considered for budgetary planning. However, *Healthy Utah* should be much less expensive to administer than traditional Medicaid because the patients are being transferred through to

[18] Some (Green LV, et al., 2013) argue that physician shortages could be eliminated by structural reform to the industry, including using more non-physicians and through electronic communications. These types of reforms will likely be the result of responses to shortages, but they will take considerable time to implement, whereas the increase in demand happens rapidly.

[19] Of course there are other reasons why poorer Utahns have a harder time accessing health care than other State residents.

[20] Portions of the preceding paragraphs in this sub-section draw upon Wilson (2013).

private insurance plans that will administer the plans. The PCG estimate for administering a full Medicaid expansion was $20.9 million for the first three years, half of which was to be funded through new federal funds. We will have to wait for more detail to estimate the administrative costs of the program, but they are likely to be much smaller than the estimated costs for a full expansion. The costs of administering and enforcing the work requirement (not part of the PCG analysis) have not yet been estimated.

Just as the state has been forward-looking in establishing its own health insurance exchange (Avenue H), which will aid in the administration of *Healthy Utah*, the state has been forward-looking in investing in information technology. For many years, officials at the Department of Health and Department of Workforce Services have been developing a state-of-the art eligibility and enrollment system called *eRep*. This technological advantage not only reduces costs for the state but significantly reduces the burden on citizens to apply for and renew enrollment in state programs.

Unknown Details

State officials have indicated that officials at CMS are willing to consider the new ideas found in *Healthy Utah*. CMS appears to be open to allowing premiums and more cost-sharing than found in Medicaid, but by how much? Ultimately, the budgetary effect of the program will be a function of these questions.

A related question is whether employers in the plan will change their plans due to the fact that subsidies from *Healthy Utah* are available. The subsidy from Healthy Utah will raise the demand among employees for the plans. A likely result will be for employers to try to reduce their contribution, essentially passing some of their costs off to the state. The state may need to enact some regulations to curtail this incentive.

Finally, *Healthy Utah* strengthens the private insurance industry in Utah by providing significant subsidies for what is likely to be a low-risk pool of people. Higher cost groups (the elderly, the medically frail, the disabled, pregnant women, etc.) will not be in the pool, which makes this potential group of enrollees particularly attractive to insurance companies. Nonetheless, these are the people who have traditionally not had access to insurance, so less is known about their health care utilization once they become insured. Initial enrollees will likely be those with higher risk, so plan administrators would be wise to monitor the costs associated with providing coverage to this pool. Outreach to lower-risk people (particularly the "young invincibles," who often fail to seek insurance) is recommended. The individual health insurance mandate in the ACA provides another tool to incentivize people in the target enrollment group that has not existed in the past.

4. A Quick Summary of Costs and Benefits

The discussion of the preceding section raises several important impacts of *Healthy Utah*. The graphic below divides these impacts into those experienced by the state budget and those realized by state residents.

The numbers in the graphs below are approximate. *Healthy Utah* is much different than a Medicaid expansion, but many of the estimates that were made in the PCG report can be applied to estimate the effects of the new plan. The PCG report analyzed 2014-2016, but *Healthy Utah* will not take effect until 2015 and will run through 2017. Dollar values rely principally on the 3-year estimates from Scenario 2 of the PCG report; thus, actual values going forward will differ slightly because the time period is delayed and the effects of moving from Medicaid into the private insurance market.

Impact on State & County Budgets

Benefits:

* *Reduction in public assistance costs ($61 million)*
* *Taxes from economic expansion ($46 million)*

Costs

* ***No** known costs during 2015-2016*
* *Small state contribution in 2017 ($ 10s of millions)*
* *Administrative costs ($ 5-10 million)*

Impact on State Residents & Industries

Benefits:

* *Benefit of health care to the poor (Expenditures: $800 million Surplus values: $ 100s of millions)*
* *Reduction in uncompensated care ($181 million)*
* *Expansion of State Economy ($652 million)*
* *Insurance Industry Profits*

Costs

* *Possible strain on Health Care Industry, including higher health care prices and reduced quality.*

5. Conclusions and recommendations

There is a lot of uncertainty related to the *Healthy Utah* plan. Usually the presence of uncertainty argues for exercising caution. Shouldn't the state exercise caution in moving forward on bold, new plans?

Yes. But caution does not mean inaction. The costs to inaction in this case are millions of dollars in foregone benefits to state residents with each passing week. Those losses are *certain*, and they are not coming back.

The ACA is drastically re-shaping American health care. Most Utahns, according to opinion polls, believe these changes are not for the better. But the state has no power to undo the ACA or to ignore its requirements or the taxes associated with it.

What the state *does* have the power to do is reclaim part of the funds that state residents are already contributing to fund the ACA. The *Healthy Utah* plan may or may not be the ideal option to make that happen, but it clearly brings hundreds of millions of dollars into the state to help low-income residents who have no other means of obtaining health insurance. It does so at minimal risk to state budgets and at considerable gain to the state economy.

The economic case for moving forward with *Healthy Utah* at this time is compelling. Policymakers can move forward with confidence—even with the uncertainty that faces us.

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