UTAH HEALTH POLICY PROJECT
Quality Health Care Coverage for All Utahns
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HEALTH SYSTEM REFORM IN UTAH
THE ROAD MAP TO SUCCESS

EXECUTIVE SUMMARY

The Utah Health Policy Project is dedicated to bold health system reforms that result in quality, comprehensive, and affordable health care coverage for all Utahns. Health reform will be at least a three year process, and UHPP looks forward to working with the business community, providers, advocates, consumers and governmental partners over the years on the reforms. As the state moves forward with health reform, we agree with the Governor's Work Group on the Uninsured, that reforms should be as robust as possible and structured to address cost, quality and access. Otherwise, efforts will result in further cost shifting and perpetuation of current inequities and inefficiencies. While UHPP agrees that Utah's health system must be consumer driven, the consumer aspect of the system should be a means toward an end. The *ultimate* aim should reflect the goals of:

1. Expanding ACCESS to affordable, quality coverage
2. Increasing QUALITY and
3. Containing COST

For health system reforms of the magnitude that are needed, the right framework is essential for success. The most significant elements of true health system reform (the need to leverage and make better use of Medicaid and CHIP, an essential basic benefit package, a benefit commission, quality improvement and transparency, guaranteed issue/community rating, and individual and employer requirements) are interdependent, and should not be attempted piecemeal.

Rep. D. Clark's HB133 *Health System Reform* Legislation

Rep. Clark and Senator Killpack sponsored and passed HB133 in the 2008 Legislative Session. This bill establishes a framework for the development and implementation of a strategic plan for health system reform. The passage of HB133 was a crucial step in the multi-year reform process. The bill outlines:

- Topics to be studied,
- Ideas to be integrated into new insurance products, and
- Entities that will be involved in the process.

A legislative task force was created in the bill to lead the efforts. This task force has met once and will meet at least once a month during the summer. For more information on the task force meetings visit:
http://www.le.utah.gov/asp/interim/Commit.asp?Year=2008&Com=TSKHSR

For further details on HB133 see our factsheet on our web site: www.healthpolicyproject.org.

Last fall the United Way Financial Stability Council looked at models from other states and proposed a marketplace facilitator as a mechanism for facilitating portability, uniform risk management and quality standards, transparency, and free market competition. No matter how it is configured, the marketplace facilitator should be the platform for the private market reforms. HB133 creates a similar mechanism called the Office of Consumer Health Services. As the reforms move forward, the functions of this office will need to be evaluated and strengthened to facilitate the goals of reform. Our comments will highlight and expand upon these and other key table-setting measures and offer suggestions to strengthen the overall framework for health system reform.

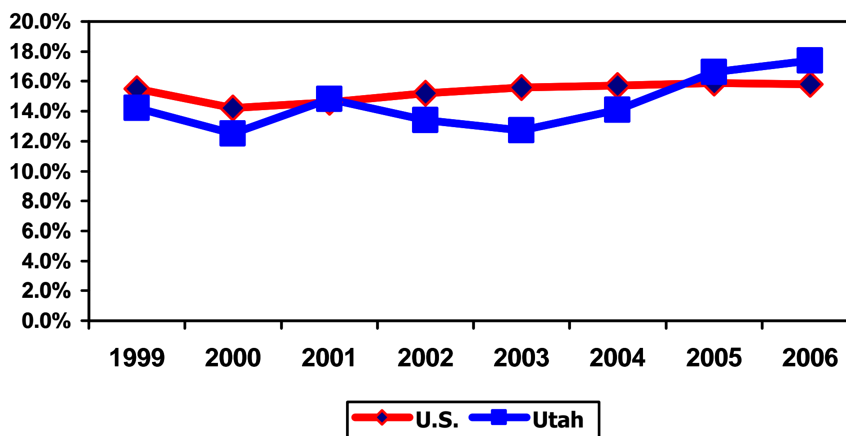
Updated: April 29, 2008

THE PROBLEM

A record number of Utahns are without health coverage. The official Utah Health Status Survey estimate is that 306,000 Utahns are without health insurance, including 89,500 children. National estimates rank Utah as having a higher than average rate of uninsured residents, 17.4% or 442,000 residents, despite having higher than average median annual income, $55,179 (CPS data). This, however, is related to the fact that we have more workforce participation per household.

About one-third of Utah's uninsured are working but are not offered or unable to afford insurance. Another one-third are eligible for Medicaid or CHIP, but haven't signed up. The final one-third are mostly young, probably healthy individuals who apparently choose not to buy insurance because they think they don't need it – the so-called "Young Immortals." All three of these groups need to be brought into the health system for it to work more efficiently.

Utah's Uninsured Rate Surpasses the U.S. Rate for Second Year in a Row



Between 2000 and 2004, workers' share of health premiums increased by 66%, but wages only went up 13%. Premium increases in Utah are nearly double the US average (*The Lewin Group for Families USA, 2004)*. If something is not done, health premium cost increases will surpass the annual household income within 20 years. Utah is also leading the nation in small businesses dropping health insurance coverage for their employees. While nationally 43% of businesses with fewer than 50 employees offer health insurance to employees, only 34% of Utah small businesses offer coverage (*Kaiser Commission on Medicaid and the Uninsured. statehealthfacts.org).* This is especially alarming due to the fact that Utah's economy is dominated by small businesses.

DETAILED RECOMMENDATIONS

AFFORDABILITY AND ACCESS

The goal of reform should be nothing less than to provide every Utah resident with affordable health coverage that facilitates access to comprehensive, quality care. There are a number of strategies that can be utilized to achieve this goal. If an individual mandate is considered, the following steps must be taken first.

1. ***Optimize Existing Programs: Medicaid, CHIP & Utah Premium Partnership (UPP) –*** Implement proven strategies for optimizing enrollment in Medicaid, CHIP and UPP.

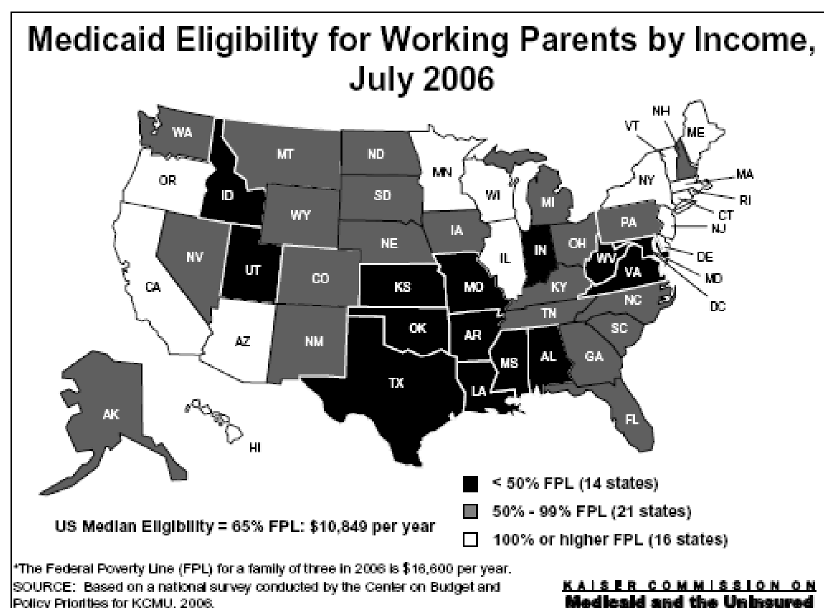
    a. Invest in community organizations that have trust with and knowledge of communities who are eligible for public programs. Legislation (HB131 by Rep. Jen Seelig) was passed in the 2008 legislative session to distribute mini-grants on a competitive basis to community-based organizations with a proven ability to target under-enrolled families and to help them make prudent use of health care resources. If this approach proves effective, additional funding will be beneficial in the future.

    b. Implement "presumptive eligibility" for Medicaid and CHIP. "Presumptive eligibility" permits prospective Medicaid and CHIP enrollees to obtain services during the application period. Many uninsured children and parents have unmet health care needs. However, when they apply for Medicaid and CHIP, they often have to wait for over a month before their application is processed. "Presumptive eligibility" can help children and families get needed care right away. Children can be determined presumptively eligible by people who provide other services to low-income families. Mini-grant recipients (*described above*) could perform this function.

    c. Remove the Medicaid asset test, since it acts as a bureaucratic barrier to eligibility and sends families the wrong message (that they should not try to build assets). Forty-seven states have removed the asset test for children's Medicaid.

    d. Remove barriers to enrolling in the Utah Premium Partnership (UPP) program by adopting best practices in premium assistance programs. One such barrier was eliminated during the 2008 session. Now, eligible individuals do not have to wait for open enrollment; rather UPP eligibility is a *qualifying life event* (like a marriage, divorce, or birth of a child).

2. ***Expand Eligibility for Existing Public Programs*** – For true coverage to be affordable, a prerequisite for participation, Utah will need a significant influx of federal dollars. This can be achieved through current programs, like Medicaid and CHIP, that receive generous federal matching funds.



UHPP

a. Raise eligibility levels for low-income working parents from the current 50% of the federal poverty level (FPL) up to at least 100% FPL (a family of four at 100% FPL makes $21,200 per year). Given Utah's generous 3-to-1 match rate, there is no better way to capture these critical resources. To manage the cost, the benefit package for the newly eligible parents can be scaled back to CHIP levels. Massachusetts raised eligibility for its parents to 300% of the poverty level—yet many (20%) still cannot afford to fulfill the state's individual mandate.

Uninsured Utahns by Income Level

Poverty Level:	0-100%	101-150%	151-200%
Children (0-18)	22,000	31,000	13,000
Adults (19-64) with children	**42,000**	**46,000**	**20,000**
Adults (19-64) without children	8,000	11,000	9,000

Source: Utah Health Status Survey, 2006

The cost of such an expansion would be around $26 million in state funds.

b. Increase the number of slots in Utah Premium Partnership (UPP). As a premium assistance program, UPP is an excellent way to assist families who are working toward financial stability but cannot afford private coverage. UPP allows families to participate in private market coverage.

3. ***Invest in Utah's Primary Care Infrastructure***– If Utah wants to encourage primary and preventive care, the most cost-effective way of providing care, then Utah must invest in the primary care infrastructure. There are several ways to do this:

   a. Increase Medicaid provider reimbursement for primary care providers. Reforms should be designed to incentivize real-time access to preventive and primary care. For this to happen, primary care providers should receive enhanced reimbursements. Primary care providers should be given additional incentives to provide after-hours care. While the Governor's budget recommended a significant $18 million increase in reimbursement rates, unfortunately, legislators did little address the provider rate in the 2008 legislative session. The state provided an additional $8,950,800 in state general fund to address Medicaid provider reimbursement rates. This represents rate increases from 2.0% up to 3.3%, depending on the medical specialty category, barely enough to keep pace with inflation.

   b. Provide incentives for students at medical school and nursing school to stay in Utah or move to Utah and serve in designated "medically underserved areas." This can be achieved through student loan forgiveness programs like the state's Workforce Financial Assistance Program. This program receives Federal matching funds.

   c. Strengthen Utah's primary care capacity by investing in the state's comprehensive primary care delivery sites through capital construction grants. This will allow current providers with a track record of providing comprehensive primary care to expand capacity.

IMPROVE QUALITY

Health care reform is not just about getting "more" health care; it's about making sure that everyone has access to the *right* health care, at the *right* time and place. Improper utilization is generally driven by physician choices, not patient demands. Thus, strategies directed at the physician practice can help to reduce improper utilization. Such strategies include:

1. Creating a **Health Benefits Commission (HBC)**. The Health Benefit Commission should have both rule-making and adjudicatory functions. HBC Commissioners would be responsible for initially identifying and then continually updating the list of medical services included in the basic benefit package. Since their determinations would be based upon clinical effectiveness, the HBC must be supported in their efforts by a public-private partnership of medical scientists serving as the primary resource for establishing evidence-based standards of care. This critical public-private sector partnership between a strong, state-mandated HBC and evidence-driven medical expertise will enable Utah to go after the massive quality-related waste embedded in current insurance and health care delivery systems. Such forthright improvements in *quality* are critical for reducing overall costs and maximizing the benefits we can extend to all Utahns. Quite simply, quality improvement is fundamental for effective, comprehensive reform (for more details on the issue of quality improvement, see UHPP's new report *Integrating Quality into Health System Reforms*.)

2. Developing a '**medical home**' plan for the state. A *medical home* is defined by the American Academy of Pediatrics and the American Academy of Family Practice as an approach to health care characterized by a partnership between patients and their care providers. A medical home is the point of first contact between a family and the health care system that is always accessible, with continuous service over the long term, and where primary care is comprehensive, family-centered, coordinated, compassionate, and culturally effective (American Academy of Pediatrics, 2002).

   There will be some upfront cost associated with implementing 'medical home' access in states like Utah where there is a critical shortage of primary care providers. But the initial expense will pay off later. States with more family practitioners use more effective care and have lower spending, while those with more specialists have higher costs and lower quality of care (Baicker, 2004). Patients with a medical home are more likely to receive appropriate preventive care, less likely to be hospitalized for preventable conditions, and more likely to be diagnosed early for chronic or disabling conditions. Thus better coordination and continuity of medical homes will improve outcomes *and* possibly cut costs over the long term.

3. Expanding the use of **Electronic Medical Records** (EMR). EMRs are known to improve quality by ensuring that providers have all the necessary information when treating a patient. Utah took a great step forward during the 2008 session by passing legislation establishing "Standards for Exchange of Electronic Health Information," expanding the use of EMR, and allocating funds to implement this project.

PROMOTE *FULL* TRANSPARENCY

UHPP is excited to see transparency and efficiency as a major goal of recent reform proposals, as these are generally good vehicles for increasing quality and containing costs. However, we are concerned that there may be an expectation that consumer-driven health care is a panacea for health system woes. The basic idea behind consumer-oriented transparency is that patients and their families could use such tools to shop for value for their health care dollar, and facilities would in turn compete for these dollars by providing better value. While this kind of transparency inherently adds value to the system by keeping more of hospital leaders' attention and resources focused on quality, these tools alone are unlikely to

change patient choices in the current system. In fact, health care systems are inherently at odds with the basic assumptions that drive consumerism in other markets. Consumers generally do not have much control over where they get care. Nor do they have enough medical knowledge or access to sufficient information to make choices about what constitutes a “better value” for different health care needs.

To improve transparency in our health system—without inflating expectations—efforts should include:

1. Expanded data collection on cost of episodes of care. Last year the Legislature passed a bill authorizing the Utah Health Data Committee to make rules and develop an RFP (Request for Proposal) process to collect and report such data. This year the Legislature allocated $615,000 to the new program. While this approach has certain limitations (*noted above*), it should be expanded to include all settings of care.

2. Physician performance measures and reporting to encourage better coordination and collaboration across settings of health care delivery.

3. Health plan performance measures and reporting: To further engage the market and stimulate consumer demand for quality and efficiency, health plans should be compared on critical measures such as administrative efficiency, preventive screenings, and other standard measures of quality. Consumers should have complete cost and quality information on health plans at the point of plan selection. Information about *medical loss ratios* (the insurance industry term for the proportion of the health care dollar that is devoted to patient care) and administrative overhead and denial rates should be published alongside the other cost and quality information.

RISK MANAGEMENT & COMMUNITY RATING

Health insurance or ‘small group’ market reforms are essential to the goals of decreasing cost and increasing access. Without significant insurance market reforms health insurance will not be affordable. Recent proposals include a provision for community rating and risk pooling. In our view, these are indispensable provisions and should be highlighted in the reform process. Modified community rating should require that participating health insurance companies offer the basic benefit package (or better) at the same rate regardless of medical history, gender, occupation, or location. It may be desirable to allow underwriting based on age.

With the following additional safeguards in place, a marketplace facilitator (hereafter “*facilitator*”) can be an effective mechanism for managing risk and controlling cost:

1. Only carriers that meet specific quality and efficiency standards should be permitted to offer products on the *facilitator*. By limiting the *facilitator* to a reasonable number of high-quality carriers, we avoid fragmenting the market into a hodgepodge of risk pools which ultimately defeats the purpose of pooling risk.

2. The reforms should implement uniform rating standards *outside and inside* of the *facilitator*, so that the health risks covered within the *facilitator* are consistent with the rest of the market. These standards should include – at a minimum -- modified community rating (*defined above*).

3. Combine the small and non-group markets in the *facilitator*. This spreads the risk for both groups and will bring down costs for the individual and employer. Competition between insurers will increase since they will be competing for business, and cherry picking and adverse selection will be reduced.

4. **Employers should be required to contribute some portion of the premium for their employees to participate in the *facilitator*.** Yet we must carefully consider how to determine what specific costs should be assumed by different employers after the proposed merging of the small group and non-group markets. In the current system, employers in the small group market have certain advantages, and these must be preserved in order to encourage employers to continue their current financial commitment to coverage. For instance, Utah currently allows insurers to base the premium rates it charges small employers on the ages of the employees in the group; however, employers still enjoy group rates – they cannot charge their older workers more than the younger workers in premiums. This should still be the case for workers participating in the *facilitator*. At the end of the day, our reforms should not undermine the leveraging currently in place to help employers provide group coverage.

5. Health plans participating on the *facilitator* should be able to buy products like pharmaceuticals at a cost-saving group or bulk rate.

6. Information about the cost and quality of health plans and providers should be readily available to all participants in the *facilitator* at the point of plan selection.

7. Brokers and community-based organizations that help individuals to enroll in the proposed *facilitator* should receive a commission for educating people about their options, and giving them the specific information needed to identify the health plan that best meets their needs.

FINANCING THROUGH SHARED RESPONSIBILITY

There is no way around it: true health system reform will cost money. But the long-term payoff in terms of cost containment, economic productivity, and improved health outcomes is worth the initial expense. Financing should be as diversified as possible, ensuring that everyone is sharing the cost. We recommend that Utah review and utilize some of the following funding streams:

1. **Surplus revenues and re-allocation of existing state funds**. A substantial portion of these new dollars should be devoted to drawing down Federal Medicaid matching funds to cover low-income working parents.

2. **Medicaid 1115 waiver**. Continue negotiating changes to the current Medicaid 115 waiver, but include a public input process; make sure the Primary Care Network (PCN) is replaced with comprehensive coverage in these negotiations.

3. **Provider assessments** can be a great way to bring additional funds into the system once there is a clear path towards universal coverage and the remaining components of the reforms are enacted. Until then, it is premature to ask providers to fund health reform. They are already over-burdened by the current tacit mandate to provide uncompensated care.

4. **Affordable Choices waiver**: this type of waiver should be explored carefully. The Bush Administration encourages states to translate DSH (Disproportionate Share Hospital) monies into coverage, but without allocating new Federal dollars. If all or most DSH and uncompensated care dollars are converted to coverage, the hospitals would be left without sufficient resources to care for the remaining uninsured. Making matters worse, Utah has a very low DSH allotment. Utah should therefore seek credit for projected savings from quality improvement initiatives in budget neutrality calculations around the Affordable Choices waiver.

5. **Employer responsibility**. Employers need a level playing field. Employers that do not contribute some minimum amount (for example, 50% of the cost) toward employees' premiums should be assessed a fee. As a first step or table setting measure, employers should be required to set up section 125 plans. These permit employees to pay for health insurance using pre-tax dollars.

6. **State tax credit**. This could include a sales, corporate, or individual income tax credit for individuals who have or employers that provide the essential benefits package.

7. **Tobacco Tax**: Utah is in the bottom third of states in terms of its tobacco tax. Higher tobacco taxes are proven to reduce smoking in youth.

8. **Other taxes** and revenue sources should be considered.

SUMMARY

Health system reform will not be easy, but Utah's families, businesses, and taxpayers cannot afford to stay on the current path. To ensure success, health reform must address cost, quality and access at the same time. Thanks to the health reform framework introduced by Rep. Dave Clark, Utah is now on a multi-year path to bold reform. A series of difficult, inherently complicated policy changes will have to be made to ensure that Utah achieves true health system reform. These include:

- stronger, more accessible public programs;
- shared responsibility for individuals, employers and government;
- community rating;
- a commitment to systemic and continuous quality improvement;
- greater transparency throughout the system; and
- a medical home plan for all Utahns.

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