Proposed Health Reform Legislation

Critical Overview and Recommendations

A Utah Health Policy Project Issue Brief — January 2009 ***Discussion Draft***

Background

The Health Reform Task Force is wrapping up its work for 2008. After taking input all summer and fall from five workgroups, three draft bills were rolled out on December 16: *Insurance Market Reforms*, *Administrative Simplification*, and *Health Insurance Coverage in State Contracts*. The proposed bills take a few positive steps toward reforming Utah's health care system, however a number of changes could be harmful for Utahns and the overall system.

As a whole, the bills do not represent a comprehensive package for reform, and Speaker David Clark is the first to admit this. Cost, quality and access are addressed to a certain extent, with cost being the main target for year one. Given the strong threads of consensus across three of the five work groups for bold, comprehensive reforms, the end result is disappointing. However, with deficits projected for the foreseeable future and the promise of national reform looming on the horizon, this is an awkward time to initiate comprehensive health reforms at the state level. For these reasons and until legislative leaders embrace the need for bold reforms, the Utah Health Policy Project (UHPP) would prefer to see incremental steps to orient the state's health care delivery systems toward comprehensive reforms and fresh opportunities from the federal level. This issue brief provides a critical overview of the three bills, along with recommendations for what to drop, what to keep, and what to add to prepare Utah's health care systems for comprehensive reforms.

Insurance Market (the main bill)

The largest and most ambitious of the Task Force bills is the *Insurance Market* bill. This legislation aims to expand access, stabilize premiums, and create insurance market flexibility. These are all worthy goals, yet the bill falls short of reaching all of the intended goals. Most worrisome is the proposal for "mandate-lite" benefit packages and the creation of Netcare, a bare-bones benefit package that would be exempt from certain state mandates. While mandates or patient protections do add some cost to premiums, these costs are negligible relative to the overall structural cost benefits. Studies on the cost and benefit of mandates have shown that the overall cost is less than 1%.[i] Research also shows that any needed, high cost benefit *not* covered will likely be cost shifted back to the commercially insured population. In any case, Utah has the third lowest number of

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It depends on who you ask. UHPP co-convened the community workgroup, 1 of 5 formed to give input to the Legislature's Health System Reform Task Force. Through a unique partnership with the Association for Utah Community Health, the workgroup used video technology to engage 13 different Utah communities and over 500 participants in discussions about the future of health care in Utah. Participants included providers, business leaders, uninsured and under-insured individuals, small business owners, advocates, caseworkers, and others. What did we learn from this process? Utah communities are ready for bold, far-reaching health system reforms.

For various reasons, mostly political, but some related to the recession and lack of revenues available to initiate true, comprehensive reforms, the task force is rejecting an 'omnibus' approach in favor of a piecemeal approach. Based on our review of the draft legislation and certain harmful provisions introduced therein, UHPP believes this is for the best. **Utah may not be ready for bold health system reforms.**

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mandated benefits in the nation, which means our mandates add even less cost to premiums. [ii]

In addition to putting the health of consumers at risk, mandate-lite and mandate-free plans are known to undermine current coverage plans. They invite *adverse selection*, whereby the older and unhealthy choose more comprehensive packages and the younger and healthy choose the stripped down, cheaper packages. [iii] As time goes on the comprehensive packages become increasingly expensive and out of reach for the people that need coverage the most. While increasing the number of choices consumers have within a system and bringing the cost of benefits down is a laudable goal, the risks associated with mandate-lite and limited benefit packages are considerable. As a state we *do* want to increase the number of insured, but in the process we do not want to increase the number of people with insurance who still cannot access cost-effective, medically necessary care. Let us not forget: the original purpose of insurance is to share risk and maintain access to affordable health care despite changes in health status.[iv] Policy changes should move us toward this original purpose of insurance, not further away from it. At a minimum the state should only implement these changes on a pilot demonstration basis and study the implications of the changes on Utahns and the overall system.

UHPP organized several summits on health system reform and Medicaid around the state. This one took place at McKay Dee Hospital and included 5 legislators from Davis, Weber, and Box Elder Counties. As with the Community Group video conferences for the Task Force, consensus for bold reform was overwhelming.

To promote consumerism, the bill creates a web base system for consumers to research, shop for, compare, and purchase health insurance—the *portal*. Introduced last year in HB133, the *portal would* now facilitate *defined contribution,* where an employer can provide employees with a set or predictable dollar amount to purchase their own health insurance, and additional transparency within the broker and insurance industry. The leap to a defined contribution system may be premature, and this is one of many changes that should not be attempted in isolation. Several important steps must be taken to support a defined contribution system. Some are included in the bill and some are missing. Since employers do not have to cover a specific percentage of an employee's premium there must be some other mechanism for affordability to make up for the loss of financing. Though the state has applied for a Federal Medicaid waiver to expand its premium assistance program, the Utah Premium Partnership (UPP), the status of Utah's waiver application is uncertain in the transition to a new Presidential administration. Without more slots and financing in UPP, the state will have no way to make up the loss of employer investment in premiums that will occur with the proposed shift to defined contribution. There must also be a standard minimum credible coverage to ensure people can obtain insurance that meets their needs. The mandate-lite and limited benefit plans (discussed above) are therefore at cross-purposes with defined contribution.

For a defined contribution arrangement to work it must be accompanied by several risk adjustment mechanisms or strategies. *The bill includes two essential mechanisms: reinsurance* and *modified community rating.* Reinsurance is a proven approach to smoothing out the spikes in premium increases that small groups experience when an employee gets sick or has an accident. This mechanism also reduces adverse selection for insurers, allowing them to concentrate on keeping enrollees healthy as opposed to avoiding risk. Modified community rating is mainly aimed at the consumer in that it ensures people can access coverage regardless of their health history. This type of rating strategy will allow consumers to effectively shop 'live' for insurance. Under current risk management arrangements, a true cost quote is not accessible until *after* the customer has been fully *underwritten* (evaluated as to risk). Therefore, an individual or small business cannot go onto a website, such as the portal, and obtain a live quote or make real-time comparisons between insurers and products. These mechanisms help ensure the portal can function in the intended fashion.

If the goal is for consumers to shop more effectively, then there must be transparency at every level of the health care delivery system. In moving toward greater transparency within the insurance and broker industries the bill assumes that if consumers understand where and how their money is being spent, they will naturally drive the demand for higher value at the right cost. Unfortunately, studies have not shown this to be true; but perhaps Utah could be the first state to figure out how consumers can actually make effective use of such information.[v] Regardless, transparency throughout the system is an essential component to reform.

Access to health coverage and care is admittedly difficult to tackle in an economic downturn and yet it is important to address as times get tough for families. The Insurance Market bill moves the issue forward by expanding the definition of small group to include groups of one and extending the time an employee is eligible for mini-(state-based) COBRA, a law that allows eligible employees to stay on their employer's health plan for a specific time period. Both changes take steps towards improving access in the private market at a time when expanding access is difficult if not impossible.

Administrative Simplification (Bill Draft)

It's no secret that the health care system is riddled with administrative hurdles—for consumers and providers alike. For consumers it starts with choosing an insurer and provider, making an appointment, then on to the arcane and altogether maddening billing process. Each of these steps has its own set of administrative protocols that add further cost, redundancy, and confusion for all parties. Inefficiencies on the administrative side can add as much as $300 billion to the system.[vi] These administrative inefficiencies also hamper the actual delivery of care.

The draft *Administrative Simplification* bill aims to make the system more efficient for consumers, providers and insurers. The bill establishes a pilot demonstration initiative to realign incentives within the system. This will be a first step to addressing what could easily amount to a 20% decrease in total health care costs![vii] The bill also initiates system efficiencies by addressing consumer billing, payment reforms, coordination of benefits, standardization of health benefit 'swipe' cards, and streamlining payment and pre-authorization processes. The bill is intended to enhance quality within the system and reduce costs in the long run.

The most innovative sections of the bill attempts to tackle one of the biggest problems in the entire health system – misaligned incentives. The bill begins to address the pervasive problem in the delivery of care by allowing for a statewide payment reform demonstration project. Details of the project will be developed by stakeholders at meetings convened by the Office of Consumer Health Services and a neutral, non-biased entity. This section could be strengthened by establishing specific goals and by situating the neutral entity at the Partnership for Value-Driven Health Care which is based at HealthInsight. Language should be added to further specify the goals and outcomes related to incentivizing primary and preventive care and creating payment reforms that support medical homes. Additionally, the entity should be charged with creating a plan that can be implemented statewide within two years.

Health Insurance Coverage in State Contracts

Contracting with entities that do not provide health care coverage for their employees causes taxpayers to not only cover the cost of the contract, but also the costs of uncompensated care and medical assistance utilized by uninsured workers. Over time experienced workers with families are forced to migrate out of construction, which results in a loss of productivity and an increase of a younger, more accident prone workforce. [viii] Requiring state contractors to provide health insurance thus levels the playing field.

The Health Insurance Coverage in State Contracts bill is designed to motivate state contractors for construction and design to provide health insurance. As written, the current bill only applies to prime contracts and subcontracts valued at $500,000 or greater. Unfortunately, such a threshold will have minimal impact on the types of industries that typically employ uninsured workers. The increase in the number of covered employees should be closely

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States with positive reforms, whether proposed or underway, have taken an omnibus approach, and this is not by accident. It turns out that most of the major changes that are needed would fail if attempted in isolation. The tell-tale example is *community rating* (when risk is shared as a community and higher premiums cannot be charged because of health status). Any new market that introduces community rating by itself will naturally attract the oldest and sickest of the uninsured. This phenomenon is called "adverse selection" and it is the kiss of death for private market reform. To prevent adverse selection, the same rating laws must be in place inside and outside the new marketplace. Also, mechanisms to bring the young, healthy uninsured into the new marketplace must be established, usually through premium assistance and a requirement to participate. Lastly, a risk adjustment mechanism is necessary to protect insurer's solvency and keep premium rates down.

It is in the best interest of the state to make quality, cost-effective health care available to every Utah resident. Reforms must therefore be bold and comprehensive, embracing the three pillars of reform: access, cost, and quality. Fortunately, this is the starting point for health reforms at the national level. For the sake of our economic recovery, Utah should take full advantage of these fresh opportunities.

monitored to ensure the bill is meeting its goals of favoring and increasing health coverage through the state contracting process.

Conclusion

Unfortunately, many strategies known to bring cost down and improve access to cost-effective care are not included in the three bills, such as medical homes, and a benefits commission. These are important investments that must be made as soon as revenues become available—if not sooner. All are well tested strategies that help realign incentives for all parties and ensure necessary health care is accessible to all.

Quality, one of the three main items to tackle in reforms, is a minor component of these bills. Given the lack of revenue for any of the necessary 'down payments' on reform, this would be a good year to introduce robust quality initiatives. Transparency definitely adds quality to the system and the bills contain a few half-hearted incentives for insurers to build wellness benefits to their products, yet there are no concrete parameters for designing these incentives.

With the state facing deficits as far as the eye can see, many of the key building blocks for true reform must be postponed to better times. These include: strengthening and expanding public programs, creating more slots in UPP, the state's premium subsidy program, and building the primary care infrastructure (adding new facilities as well as producing and retaining providers). Yet, the state can lay the groundwork for reform now by protecting Utah's current investment in cost-effective programs like Medicaid and CHIP. Given the bare-bones nature of Utah's Medicaid and CHIP programs, any cuts would only add to the problems the Task Force is working to address. UHPP has prepared amendments (available on our website: www.healthpolicyproject.org) that will go a long way to addressing our concerns with the three bills. If most of these are integrated in the bills, then the legislation will be helpful in moving health reform forward. These bills are complex and UHPP will be working to amend these bills so that they benefit Utahns and the overall system.

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[i] McAndrew, Claire. *Limited-Benefit Plans: Expanding Coverage or Holding Your State Back?* Families USA, October 2008, available at: http://www.familiesusa.org/assets/pdfs/limited-benefit-plans.pdf.

[ii] Bunce, Victoria Craig and Wieske, JP. *Health Insurance Mandates in the States 2008.* Alexandria: Council for Affordable Health Insurance, 2008, available at: http://www.cahi.org/cahi_contents/resources/pdf/HealthInsurance Mandates2008.pdf.

[iii] McAndrew, Claire, op. cit.

[iv] Kofman, Mila J.D. and Pollitz, Karen M.P.P. *Health insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change*. Health Policy Institute, Georgetown University. April 2006.

[v] *Integrating Quality into Utah's Health System Reforms*. Utah Health Policy Project and HealthInsight, 2007.

[vi] *Administrative Simplification for Medical Group Practices*. Medical Group Management Association, June 2005, available at: http://www.mgma.com/WorkArea/showcontent.aspx?id=800.

[vii] Healthcare Administrative Simplification Coalition Speakers Tool Kit Power Point, July 2007, available at: http://www.simplifyhealthcare.org/page.cfm/ID/10/SpeakersToolkit.

[viii] Philips, Peter Ph.D. *What will Mandating Health Insurance on Public Construction Cost the Taxpayer & Contractor?* University of Utah Economics Department, 2000.