THE UTAH HEALTH COOPERATIVE

A Financially Sustainable Plan for Universal Health Care Coverage in Utah

The Utah Health Cooperative *is the Utah Health Policy Project's bold proposal for financing health care for all Utah residents. This 'states' rights' proposal is fiscally responsible, business friendly, and patient-centered while at the same time preserving fee-for-service medicine and Utah's strong nonprofit traditions.*

We invite input from the community…

The Utah Health Cooperative proposal has been many years in the making. However, it raises a number of issues that are probably best addressed through community discussion. Sprinkled throughout the draft are discussion questions and unresolved issues, indicated by ? , for which we seek comment and fresh ideas from community members. Since every one of us has a personal stake in the health care system, we must actively engage in the development of a solution. To share input or comments, visit the Utah Health Cooperative blog: www.healthpolicyproject.org/blog

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Quality Health Care Coverage for All Utahns

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Acknowledgements

A big thanks to Lisa M. Diamond, Ph.D. for helpful editing, to Lauren O. Florence, MD, for substantive input (and encouragement) on earlier versions of the proposal, to Jim Killian for a fabulous logo design, Andrew Riggle for thoughtful input on the Medicaid discussion, to Joanna Kahn for raising important questions, and finally to Lincoln Nehring for further editing and proofreading.

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A Plan for Universal Health Care Coverage

I. Introduction

For more than a decade health care policy in Utah has languished under misguided principles. The result? A decade of increasing costs, diminishing quality, and rapidly rising numbers of uninsured. As time goes on Utahns are less and less able to obtain the services they need to manage their health. Businesses, too, are feeling the pinch. Health benefit costs are increasing by double digits each year, making it nearly impossible for Utah businesses to compete in a global economy while providing coverage for their employees. The time for bold, forthright solutions to rising health care costs has undoubtedly arrived.

The Utah Health Policy Project is a non-profit organization devoted to making quality, comprehensive health care coverage a reality for all Utahns. This proposal represents the centerpiece of our efforts. We call our plan the "Utah Health Cooperative" because it is based on a *cooperative and sustainable*—rather than competitive and inefficient—approach to financing all medically necessary care for every resident of the state.

In this briefing paper we begin by providing some background on how we have reached the current state of affairs and just how dire the situation is. We then demonstrate how our plan can fix our inefficient, financially unsustainable health care system through a set of inherently conservative policy solutions. In its adherence to core conservative principles, our plan is a genuine Utah product.

1) **Our proposal is fiscally responsible**. No net increase in per capita revenues will be required to make the transition to a state-based, universal health care financing system. State and federal investments in Medicaid and other publicly financed health care programs will be bolstered by including beneficiaries in a universal risk pool.

2) **Our proposal is business friendly**. By relieving Utah businesses of the double digit annual increases in the cost of health benefits, our plan will invigorate Utah's economy.

3) **Our proposal is patient-centered and emphasizes personal responsibility**. The plan guarantees access to all medically necessary care and ensures unrestricted choice of physicians. By including groundbreaking new tools such as electronic medical records and by reliably financing preventive interventions and supporting best practices in service delivery, it empowers Utahns to be responsible for their personal health.

4) **Our proposal affirms states' rights.** The Utah Health Cooperative is fundamentally a states' rights health care reform proposal; Utah health care policy should be fashioned in Salt Lake City, not Washington DC;

5) **Our proposal builds on Utah's nonprofit, evidence-based, integrated health care delivery systems.** Utah already has a strong network of health care delivery systems which is based on published evidence of medical benefit. Our plan builds upon this foundation.

6) **Our proposal provides for timely access to care.** By using traditional fee-for-service systems based on uniform and reliable methods of payment, The Utah Health Cooperative will leave providers with more time and energy for patient care.

II. The Context which Gave Rise to the Utah Health Cooperative

A. Governor Mike Leavitt's *HealthPrint*

Over the past 13 years, the health policy framework of Utah state government has followed the dictates of former Governor Mike Leavitt's blueprint for health reform, *HealthPrint*. *HealthPrint* has been described as "a flexible, market-oriented master plan that outlines a realistic approach…to increase access to health care, contain cost, and improve the quality of health care for all Utahns."[1] *HealthPrint* was designed to incrementally reform health care in Utah through mostly private and small group market reforms, thereby providing affordable health care coverage for all Utahns. The plan not only failed to deliver on its most ambitious goals but it reinforced the free market bias that has stymied systemic health reform ever since.

In 1994 the Utah Health Policy Commission was established by then Governor Mike Leavitt and the Utah Legislature to carry out the goals of *HealthPrint*. *HealthPrint* employed three strategies to increase access to care:

1) Insurance and small group reforms
2) Medicaid expansions
3) The creation of purchasing cooperatives

Cost containment was pursued through other strategies:

1) Enhancing competition
2) Endorsing managed care and greater use of capitation
3) Increasing efficiency and quality through regular data collection, analysis, and reporting

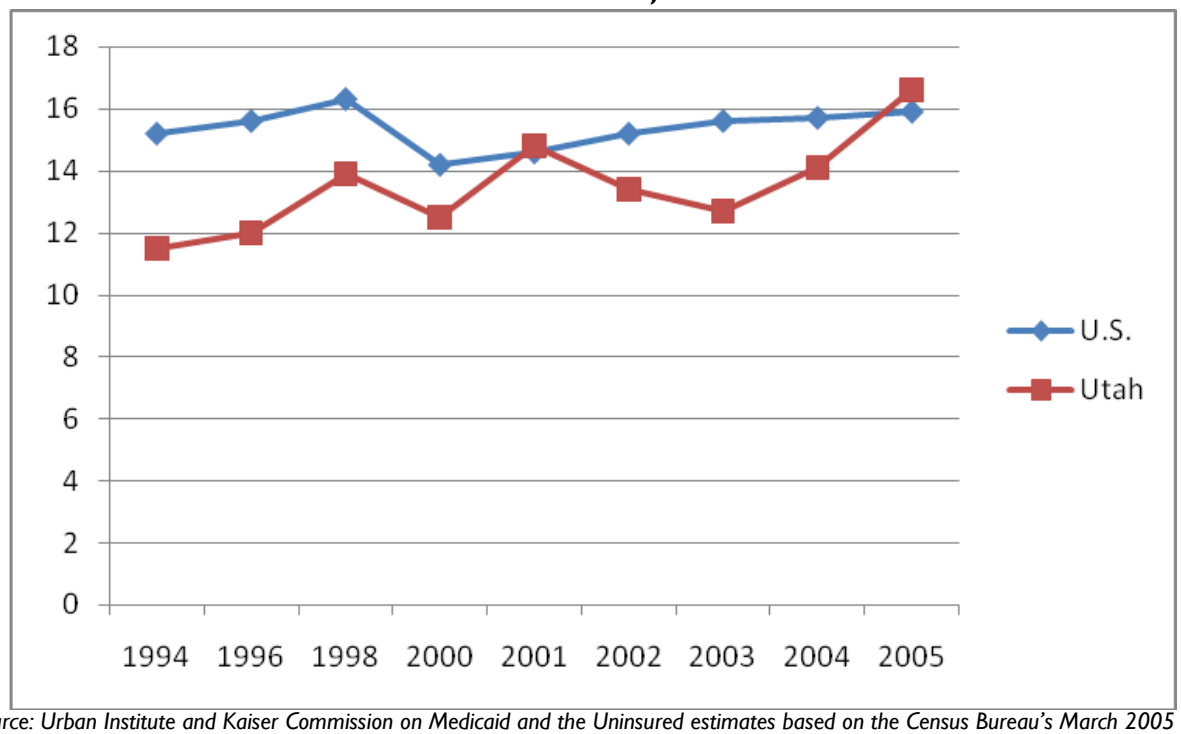
After a flurry of legislative activity and modest reforms, the Health Policy Commission was abruptly decommissioned on June 30, 2000.

[1] Utah Health Policy Commission. "Utah *HealthPrint*: A Blueprint for Market-oriented Health Care." May 1997 Edition, 1st Printing.

After all was said and done, few of the broader goals of *HealthPrint* were achieved. In 1994, 11.5% of Utahns were uninsured, while in 2002 this figure had risen to13.4%.[2] Today it is 16.6%, for the first time surpassing the average national rate.

Figure 1

Uninsured 1994-2005, U.S. vs.Utah



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2005 and 2006 Current Population Survey. www.statehealthfacts.org.

HealthPrint's results with respect to cost containment were likewise disappointing. In 1997, the state government had total health expenditures of $856,500,000, of which $524,100,000 were federal funds.[3] By 2002, total state government expenditures for health in Utah had grown to $1,391,000,000, of which $819,300,000 were federal funds.[4] This represents a 62.4% growth in total state and Federal government expenditures for Utah's health programs in just 5 years—clearly an unsustainable pattern. Spending growth for the U.S. over the same period was less at 58.8%. One might think that with all this increased public spending Utahns would be enjoying greater access to coverage. But in fact, they have enjoyed less and less.

Is this an accurate assessment of HealthPrint and its implications for health policy on the uninsured today? What would you add to (or subtract from) our analysis? To respond to this and other questions, visit www.healthpolicyproject.org/blog

[2] US Census Bureau.
[3] Millbank Memorial Fund. "1997 State Health Expenditure Report." 1999.
[4] Millbank Memorial Fund. "2002-2003 State Health Expenditure Report." April 2004.

B. The Specific Failures of *HealthPrint: Summary*

- **Heath care costs went up.** During 2004 Utah employers saw an increase in employee health benefit costs of approximately 16%, more than the average increase for the nation.[5]

- **The cost containment strategy failed because it was based on false premises.** One prominent University of Utah economist charged that *HealthPrint's* central proposals for increasing Medicaid access rested on faulty assumptions.[6] Under *HealthPrint*, it was postulated that Medicaid rolls could be expanded – without increasing costs – because money would be saved by converting to managed care. But as it turned out, these savings were meager at best; then they dried up completely.

- **Quality of care did not noticeably improve as a result of HealthPrint.** There is no evidence that *HealthPrint's* efforts at data collection and analysis had any impact on the quality (or cost) of health care in Utah. Though a good bit of data was collected, and numerous health quality initiatives launched, these do not appear to have had any appreciable effect.

In summary, the market-oriented paradigm of *HealthPrint* has utterly failed to address Utah's health care crisis. Hundreds of thousands of Utahns continue to lack access to needed care; others fall into financial ruin and bankruptcy as a result of the spiraling costs associated with even a *single* illness and injury; and Utah businesses are forced to make painful financial choices between offering coverage for their employees and competing in a global economy.

Despite *HealthPrint's* disappointing results, the free-market bias seems to carry the day in health policy circles in Utah (consider the current enthusiasm for Health Savings Accounts). How can we counter this bias?

III. A NEW DAY for UTAH HEALTH POLICY

Utahns deserve a better, more financially sustainable solution. Utah Governor Jon Huntsman, Jr. clearly shares this general goal, but old formulas and flawed assumptions continue to stand in the way of real progress. Organizations and corporations with vested financial interests in the health care status quo must be kept at arms length so that the people of Utah can objectively examine the issues and identify the best way forward. A new day for Utah health policy therefore starts with the right set of facts and assumptions.

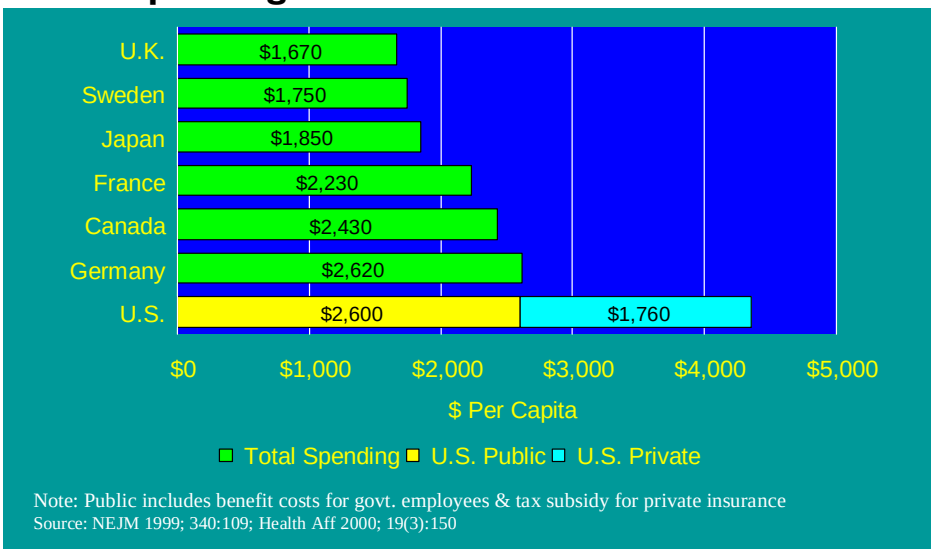
[5] Bob Mims. "Cost of Utahns' health insurance to soar in 2004." The Salt Lake Tribune, 12/8/03.
[6] Norman J. Waitzman. "SmallPrint: Why *HealthPrint's* Goals for Access to Care Have Translated into Little Achievement." Poverty Issues Monograph 1997-01, August 1997.

A. KEY FACTS AND ASSUMPTIONS

1) Utah's health care situation must be viewed in the context of the United States as a whole. Many politicians trumpet the fact that Utah has lower per capita health care spending than the national average. Yet this is less cause for celebration in view of the fact that Americans on the whole are paying nearly *twice as much* for health care per capita than every other country. Figure 2 demonstrates this fact. Note, as well, that this overspending includes both public and private dollars. Not only do Americans spend more tax dollars on health care than other countries (represented by the bottom left bar), but we fork over an additional 40% in private spending (represented by the bottom right bar). About half of this additional 40% is paid out of pocket by private citizens for premiums, co-payments, deductibles, and point of service costs. The other half is paid by private employers subsidizing employee health benefits. This threatens our global competitiveness, since US businesses—but not our international competitors—are forced to channel so many resources into health care costs. Quite simply, no other country in the world relies so heavily on private dollars—from businesses and individuals—to subsidize the health care of its citizens.

Figure 2

U.S. Public Spending Per Capita for Health is Greater than Total Public Spending in Other First-World Nations



A note on this figure: This figure purposely does not illustrate the (minimal) private spending that occurs in the other first-world nations.

2) For all this additional spending, one might think that Americans enjoy the highest quality care in the world. After all, one hears this cliché repeated over and over. But it's a myth. Despite the fact that Americans pay more for health care than any other industrialized nation, the *quality of our care ranks lowest of all industrialized nations (Table 1, next page)*

How would you rate Utah's health care system(s) in terms of quality? Are you pleased with the level of quality you and your family receive?

Table 1

International Health Rankings and National Health Expenditures

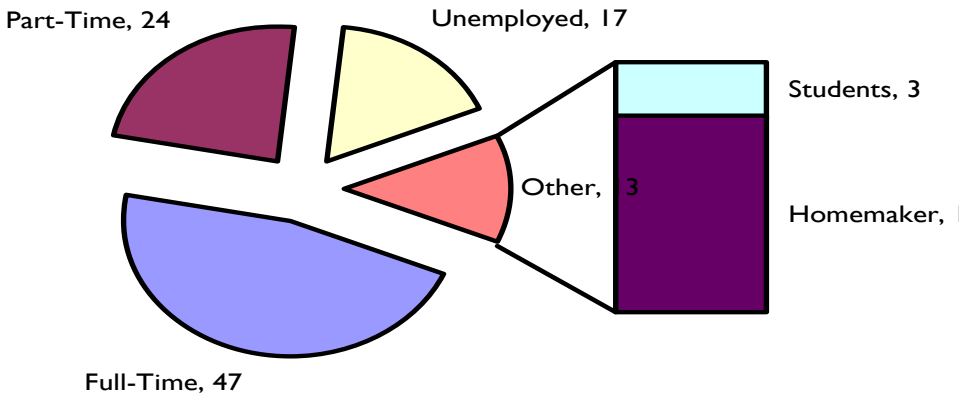
	AUS	CAN	GER	NZ	UK	US
Overall Ranking	4	5	1	2	3	6
Patient Safety	4	5	2	3	1	6
Effectiveness	4	2	3	6	5	1
Patient-Centeredness	3	5	1	2	4	6
Timeliness	4	6	1	2	5	3
Efficiency	4	5	1	2	3	6
Equity	2	4	5	3	1	6
Health Expenditures per Capita*	$2,903	$3,003	$2,996	$1,886	$2,231	$5,635

Note: 1=highest ranking, 6=lowest ranking
* Health expenditures per capita figures are adjusted for differences in cost of living. Source: B.K. Frogner and G.F. Anderson, "Multinational Comparisons of Health Systems Data, 2005," (New York: The Commonwealth Fund, November 2005). Health expenditures data are from 2003, except UK data (2002).

The United States' extravagant health care expenditures not only fail to buy its citizens higher quality care, but they also leave more citizens *uninsured* than any other nation: over 15% of the total population (over 16% of Utahns). Given that our system relies so heavily on employer-based coverage, it is tempting to conclude that the high number of uninsured Americans simply reflects high rates of unemployment. But this is not the case. The majority of uninsured Americans (and Utahns) *are members of working households,* as shown in Figure 3.

Figure 3

Who Are Utah's Uninsured?



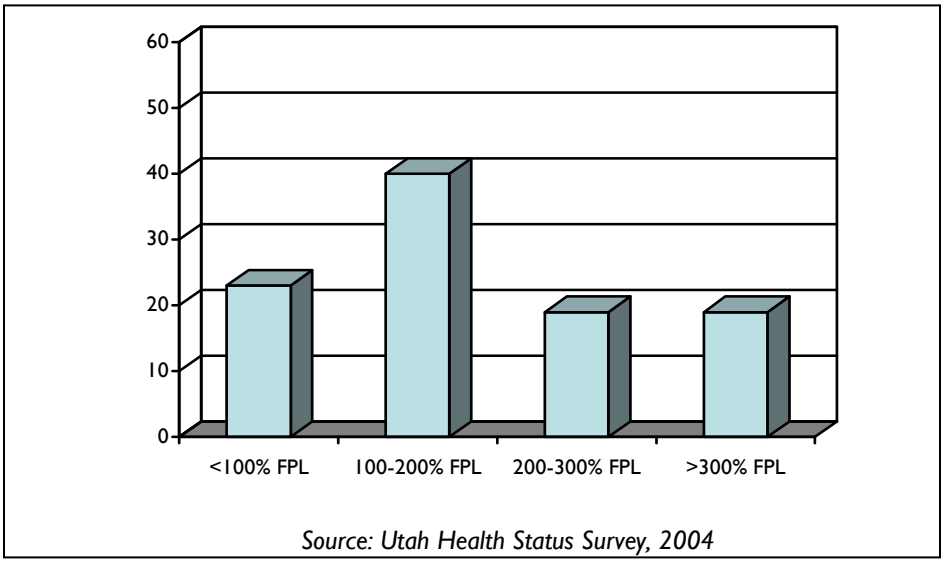
Source: Utah Health Status Survey, 2004

Thus, they are contributing their hard-earned tax dollars to a health care system that is leaving them behind. This might well be the most unfair tax policy in our society. Furthermore, these are individuals who simply cannot afford to pay for health care costs out of pocket. The vast

majority of Utah's uninsured live in low or moderate-income households (*Figure 4*). By failing to provide these individuals with affordable financing solutions, we are basically throwing them away. Every year more than 18,000 American adults die for lack of health care coverage (*Table 2*), a shameful figure that has no equal in any other developed country. In Utah alone, about two adults die every week because of a lack of access to health care.

Figure 4

Utah's Working Uninsured by Income Level



Source: Utah Health Status Survey, 2004

Table 2

18,314 Adult Deaths Per Year Due to Uninsurance

Age Group	Deaths
25-34	1,930
35-44	3,431
45-54	4,734
55-64	8,219
Total	18,314

Source: Care Without Coverage. Institute of Medicine, 2002

3) So if Americans don't have better care or broader coverage, then where does all the extra money go? The answer is simple: Bureaucracy and insurance industry profits

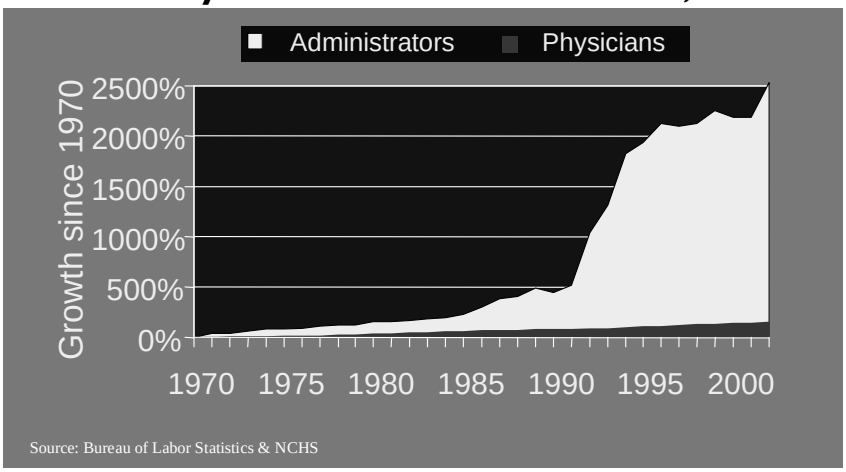
driving higher prices for health services and products. American health care costs are twice the median per capita spending of other developed nations not because Americans receive more hospital care, visit physicians more often, or use more high-tech medical devices; it is because America leads the world in health care bureaucracy.

Where *does* all the money go? While we're at it, are there other areas of excessive spending or waste we should go after?

Over the last thirty years of the 20th century, the number of physicians doubled in the US (darker sliver) while the number of health care bureaucrats increased 2500% (lighter wedge). These bureaucrats are largely in the private sector, staffing the benefit denial activities of health insurance and managed care companies, or the billing departments of hospitals and doctors offices.

Figure 5

Growth of Physicians and Administrators, 1970-2002



B. MOST UTAHNS FAVOR UNIVERSAL HEALTH INSURANCE

Utahns have begun to "wake up" to the insanity of this situation and are increasingly demanding wholesale change. Contrary to the stereotype that Utahns are not willing to make the necessary changes to achieve universal coverage, recent polls suggest the opposite is true. A public opinion poll conducted in Utah for the non-partisan Robert Wood Johnson Foundation found:

1) 91 percent of Utahns said that passing laws to help the uninsured receive health care coverage should be a priority;

2) 70 percent of Utahns favor making sure that all families have access to affordable health insurance, even if it costs more; and
3) 63 percent of Utahns would be willing to pay $50 more per year to assure all residents have health insurance coverage.[7]

The Utah Medical Association and virtually all other health professional organizations agree that health care financing should cover all Utahns.

Utahns seem to favor universal financing of health care for everyone. If health care is not a right (it's not), can we all agree that it is infrastructure necessary for living and working in the 21st century?

C. BUSINESSES LARGE & SMALL NEED HEALTH CARE REFORM

Less than a year ago, while preparing for another round of labor negotiations dominated by health care issues, William Clay Ford Jr., chairman of Ford Motor Company, said that the rising cost of health benefits is among the biggest problems facing American businesses. "Health care is just out of control," he remarked. "It's a system that's broke."[8] This broken system has hit the automobile industry particularly hard: Health care costs eat up such a huge proportion of the budgets of the Big Three automakers that Wall Street analysts have begun to refer to them as "HMOs with wheels." Ford warned that unless America solves this growing crisis, all North American cars may someday be manufactured in Canada, where labor costs are significantly cheaper because health care financing is more efficient.[9]

The problems that Ford identified have a particularly detrimental impact on Utah because our economy is dominated by small businesses, which simply cannot absorb the relentless increases in health care costs. Over the last 5 years alone, costs have been rising at *double digit* rates, *every single year*. Small business owners have responded by passing on higher premiums to workers, reducing benefit packages, or eliminating coverage altogether. No wonder, then, that last year the increase in Utah's uninsured rate was *seven times* the national rate of increase. Among the Utahns who *do* still have coverage, the employee portion of premiums is rising drastically, at a rate that is 50% faster than the rest of the nation. Utah's entrepreneurs should not be forced to choose between covering their workers and competing in a global economy.

Table 3

Utah Premiums *Paid by Workers* Rising 5x Faster than Wages (2000-2004)

	Change in average insurance premium	Change in Average Earnings
Utah	66.3%	13.2%
U.S.	35.9%	12.4%

Source: The Lewin Group for Families USA, 2004

[7] Jill Vicory. "Utah: Profile on the Uninsured." The Alliance for Health Reform. December 18, 2000.
[8] Morris, K. "Ford: Health costs 'out of control'". The Detroit News and Free Press. May 31, 2003.
[9] Joint letter on publicly funded health care to the Canadian Government, from the Canadian CEOs of Ford, GM, and Daimler-Chrysler and the National President of CAW, November 2002.

D. ACTION ON HEALTH CARE SHOULD BE AT THE STATE LEVEL

The time to act is now: The question is whether we have the will and the authority. Some reformers have argued that we should work toward a *federal* solution instead of a state-by-state approach. We maintain, instead, that state-based approaches will provide a better "fit" for each state's unique challenges and advantages. Utah, for example, has a particularly large number of small businesses, and this must be taken into account when devising a workable state health plan. Also, Utahns are generally younger and thus healthier than the residents of other states, and most of our health care corporations are non-profit: These factors have kept our health care costs somewhat below the national average. *Let's keep it that way.*

Should we wait for a Federal solution to the problem of the uninsured and rising health care costs? Or, are we better off with a home-grown solution?

If we prefer to design a plan tailored to Utah, federal health laws and regulations will continue to stand in our way. How do we make it happen?

What is needed is an act of Congress granting exemptions from federal laws and regulations to states with good faith plans for health care reform, while retaining full federal funding for Medicare, Medicaid, CHIP, and other federal health revenues. Two proposed bills in Congress entitled "The Health Partnership Act" could fulfill this need (*see details in Appendix A*). Starting *next* year (*next* year because CHIP will need at least $50 billion when it is re-authorized by Congress this year), Utah citizens should encourage members of their congressional delegation to co-sponsor this bill or something like it. Without it, our hands our tied. Utahns should not have to sit idly by as our citizens and businesses crumble under the staggering costs of an inefficient, broken system. By following the *Six Principles of Health Care Reform in Utah* outlined below, we can reach our goal of universal, high quality, affordable health care for all Utahns.

IV. THE SIX PRINCIPLES OF HEALTH CARE REFORM IN UTAH

1st Principle: Finance medically necessary care for all Utah residents.

The fundamental importance of *universal coverage with sustainable financing* is no longer in dispute. This goal is shared by health professional organizations (like the Utah Medical Association), policy bodies (like Sen. Hatch's Citizen's Health Care Workgroup), and 4 out of 5 American citizens. This consensus exists because we all know the devastating consequences which occur when people cannot afford health care. A Harvard Law School study estimated

that nearly half of all personal bankruptcies are caused by the costs associated with illness or injury in the family.[10]

As we have already noted, these costs also have a devastating effect on large and small businesses. Even church and community charities suffer, their meager coffers depleted by medical welfare needs. The only solution is to guarantee financing for all medically necessary services.

2nd Principle: Patients should have an unrestricted choice of any willing provider.

There are plenty of stereotypes about universal coverage, and one of the most pernicious is that states have to "choose" between offering universal coverage and offering citizens the right to select their own doctor. This is a false choice. Both can – and should – be preserved. We maintain that unrestricted choice of physicians is *critical* to effective health care, because it facilitates the trust between patient and doctor which is necessary for effective diagnosis and treatment. The intimate doctor-patient relationship is the cornerstone of quality health care delivery, and our first priority should be to protect it from invasion and distortion by for-profit corporate interests.

Right now, the doctor-patient relationship is in jeopardy. Among industrialized nations, Americans are *least* able to maintain long term continuity with their chosen physicians. Business interests increasingly rob the patient of unrestricted choice of doctor, while doctors find themselves subject to contractual constraints which force them to deliver care in an assembly-line manner, devoting smaller and smaller amounts of time to larger and larger numbers of patients, and restricting their ability to make needed referrals. These growing bureaucratic hassles fundamentally undermine the delivery of *quality health care*. Utahns should face no barriers in selecting a physician, and the two of them together should face no barriers in seeking necessary opinions, referrals, and treatment options.

The phrase 'any willing provider' elicits strong reactions, from melancholy longing to outrage. To what extent do current financing arrangements (or lack thereof) interfere with the provider-patient relationships? Many Utahns lack a 'medical home' or 'primary care home.' What can be done to ensure that all patients have access to, and make prudent use of, cost-effective primary care?

3rd Principle: Finance all medically necessary care without increasing per capita health care expenditures.

But surely financing for all medically necessary care will raise costs even further, right? Wrong. Health care reform in Utah can and should be budget neutral. We already spend more than

[10] Norton's Bankruptcy Advisor, May 2000.

enough money to have a high quality health care system, we simply need to allocate our spending more efficiently. Right now, Americans spend nearly $7000 a year per person for health care; this makes us the world's leaders in health care expenditures by a wide margin. It certainly cannot be argued that inadequate coverage and quality are due to stinginess—except perhaps with respect to spending on poor people, (Utah ranks among the lowest in per capita Medicaid spending). Quite simply, there is no "revenue problem" in our health care system; we already are paying enough to fund universal care of high quality with unlimited choice of provider. The problem has to do with *what we spend that money on*, as highlighted below.

The last time Utah explored a budget neutral approach to covering the uninsured, the result was the Primary Care Network, a most unsatisfying coverage solution for working poor adults (PCN covers prevention-oriented primary care, and yet its enrollees are counted among the insured). How can we ensure that the proposed leap to budget neutrality is not at the expense of our most vulnerable?

How could the Utah Health Cooperative Integrate Medicaid?

Medicaid supplies two crucial pieces of the puzzle that is the Utah Health Cooperative:

1) funding and
2) a broad definition of medically necessary services.

Utah Medicaid currently has a total budget of over $1 billion. Around 70% of that is paid for by the federal government. Thoughtful incorporation, maintenance, and expansion of this funding partnership are fundamental to the success of the Utah Health Cooperative. Medicaid also provides an impressive array of services across the lifespan, from comprehensive prenatal care to preventive care to community-based long-term care support for the elderly and people with disabilities. If it is our goal not only to increase the economic productivity and self-sufficiency of individuals and families, but also to enhance their well-being and quality of life. The Utah Health Cooperative must therefore cover a similarly wide range of services.

The relationship between the Utah Health Cooperative and Medicaid must be carefully considered. If a state receives federal Medicaid funds, it must comply with guidelines concerning the types of services and how they are provided. Two possible approaches would be for the Cooperative to cover all Medicaid services or to use Medicaid as a wraparound for those services unavailable through the Cooperative.

What is the best strategy for ensuring the inclusion of low-income individuals and families who cannot afford to contribute to the system?

4th Principle: Finance universal care by reducing administrative waste.

Though politicians are fond of saying so, Americans on average do not have the best health care in the world; however, we *do* have the most expenses. Where does the money go? To support our byzantine bureaucracy and to provide profits to investors. Increasingly, our health care institutions, many originally built with Hill-Burton tax funds or through the generosity of donations, are being bought and sold by investors like so many widgets. The for-profit motive in health care contributes to the crisis of rising cost and ever diminishing quality of care.

Up to 30% of the premium dollar given to U.S. health insurance companies is not used on patient care. It goes directly toward administrative costs, which are 2.5 times higher in the private sector than in the public sector. This waste is not a significant problem from the perspective of investors seeking to make money from the health-care system. From their perspective, the fact that health-care companies provide actual health care seems to be beside the point. This is exemplified by the fact that the industry term for the portion of the insurance dollar that is devoted to patient care is called "medical loss ratio." Think about that -- *it's a tolerable loss, rather than the entire point of the system.* It doesn't need to be this way. Many studies of the US health care system have documented that vast administrative savings *are* legitimately available. One study published in the New England Journal of Medicine documented nearly $300 billion in available cost savings in the US, with $1.6 billion in administrative savings achievable in Utah.

5th Principle: Health care is best delivered when hospitals, doctors, health departments, and other institutions cooperate together to serve patients.

One reason that the United States has the most expensive, least efficient health care sector in the developed world is that its fierce competition is being channeled in the wrong directions. Instead of competing to provide the best, most cost-efficient care, providers become ensnared in what we call *the medical arms race*, whose goal is to provide the widest possible range of technologically sophisticated, rarely utilized "Cadillac" services. Hospitals are vying to be all things to all patients, even in catchment areas not large enough to sustain a single high-level intensive care unit. The result is that plenty of fancy equipment lays idle 80% of the time while overall prices continue to rise and many individuals lack access to cost-effective services.

A related side effect of this competition in health care is the now nauseatingly frequent use of advertising to promote health care products and services. What community health benefit is achieved by a hospital repeatedly claiming pre-eminence in heart care, or by a pharmaceutical firm broadcasting the wonders of the purple pill? The rationale behind this mis-investment in advertising demonstrates the fundamental failing of treating healthcare like any other commodity bought and sold in a market economy. Unlike other commodities, demand for health services is not elastic with respect to price. People do not decide to have heart surgery because it is on sale this week. Nor do the parents of a leukemic child forgo needed chemotherapy because they cannot afford it. The ultimate users of these services are not shoppers, *they are patients*. They do not have the special knowledge to be customers in a health

care market, nor do they have the time, energy, or judgment to find the lowest price or best value. *In health care, the buyer cannot beware.*

Furthermore, unlike typical commodities, the decisions that individuals make regarding their health care end up influencing their entire community. These are not, altogether "private" decisions. Each case of communicable disease that goes undetected represents a risk to others. Each baby born without adequate prenatal care entails a significant cost to society in the form of long-term developmental and educational services and poor lifetime productivity. Any health care reform proposal which begins by affirming free-market competition is ignoring the last decade of market based health reform efforts and their failure to register a significant improvement in cost, access, or quality. The only substantial improvement in health care access in the last dozen years has been the Children's Health Insurance Program (CHIP), a taxpayer-financed governmental response to the crisis of uninsured children.

6th Principle: What is needed is a coordinated, streamlined system which allows public funding of health care and private sector health care delivery.

Public funding of health care is essentially already occurring; most health care revenues are tax dollars. What would we do differently? We would create a non-profit trust fund to manage and spend public sector revenues intended for health care in Utah; the fund would be administered by a private board in a publicly accountable manner. Health care *delivery* would remain in the private sector, but its administrative management would be squarely located in the more efficient public sector.

How would doctors be paid? Through conventional fee-for-service arrangements. A panel representing more than 50% of the doctors of Utah would negotiate compensation, fee schedules and contract terms (such as billing, payment, length of contract, grievances, arbitration, termination, dispute resolution, utilization review, and how modifications are handled) with the representatives on the administrative board of the private, non-profit trust fund.

Would doctors and other providers prefer to be paid on a fee-for-service basis? Utah has a shortage of primary care providers and obstetricians…how should the Utah Health Cooperative address this growing problem? *Doctors and other providers are encouraged to comment.*

How would hospitals be funded? Through two methods:

1) an operating budget for each institution could be negotiated reflecting the true costs of hospital function, with payments made at regular intervals; expensive and wasteful hospital billing practices would be eliminated;

2) a capital budget could be held in reserve for use in maintaining pace with developing technology and population shifts; the medical arms race would be over.

V. IMPLEMENTING THE UTAH HEALTH COOPERATIVE

A. Step-By-Step

Step 1 Resolution or Referendum

Pass a resolution or a referendum declaring the intent of the citizens of Utah to cover all residents of Utah without increasing revenues for health care. This will notify Congress of our intent to redirect Utah's health care financing into the Utah Health Cooperative.

Step 2 Pursue the Health Partnership Act or Similar Super-Waiver Mechanism

Starting next year, urge Utah's Congressional delegation to sponsor and actively pursue passage of the Health Partnership Act (*details in Appendix B*) or a similar super-waiver mechanism. The bipartisan HPA bills would give up to 10 states the incentives and flexibility they would need to develop their own plans for comprehensive health care coverage. These plans could include a proposal along the lines of the Utah Health Cooperative.

Step 3 Phase Out For-Profit Health Care Operations and Acquire Assets

Acquire the assets of the state's largest public and nonprofit health plans and hospital systems. Today the vast majority of Utah residents with health insurance are members of non-profit plans. These plans all have a similar mission; they are organized and operated "exclusively for charitable, educational or scientific purposes" (quoted from the IHC articles of incorporation). Thus, there will be no altered sense of mission—or displaced investors—for these organizations as they are merged into the Utah Health Cooperative.

…yes, we did suggest phasing out for-profit health care operations and acquiring the assets…is this a realistic expectation?

Step 4 Merge current public programs into the Utah Health Cooperative.

Many Utahns, including government employees and Medicaid beneficiaries, have financing for health care through government programs. These Utahns are already paying into the system with their own tax dollars, thus they deserve the level of quality that can be achieved through the Utah Health Cooperative. A legislative initiative or referendum could simply declare that all uninsured Utahns and all Utahns receiving health insurance from government programs or non-profit entities will, as of a certain date, receive their health insurance from the Utah Health Cooperative.

B. What Can Be Done *Right Now* to Prepare for the Utah Health Cooperative

1. Protect and sustain current public financing for health care and coverage.

During the time it takes to fine tune and implement the Utah Health Cooperative, vulnerable populations such as children must be protected. Moreover, along the way to financially sustainable health care coverage for all, it would make sense to cover *all* children with the current coverage tools. Why? Because children are typically healthy and therefore less expensive to cover. Also, Utah children are losing coverage at an alarming rate, and this is because small businesses can no longer afford to offer family coverage. Thus, covering *all* children would give Utah's small businesses immediate relief. Utah's investment in public programs like Medicaid and the Children's Health Insurance Program is very modest as it is. To serve as the foundation for the Utah Health Cooperative, this investment must be protected or enhanced through efficiencies like bulk purchasing of pharmaceuticals or changes in the state's contracting arrangements.

But the task of protecting public programs like Medicaid seems never-ending and all-consuming… How can we make headway on the case for universal coverage when Medicaid is in so much trouble?

2. Improve quality of care in current publicly financed coverage systems and expand public and private sector efforts to eliminate health disparities.

Quality initiatives like disease, care, and case management are known to boost health outcomes while bringing down costs. These efforts should be enhanced and perfected for use in the Utah Health Cooperative. Efforts to reduce health disparities and improve health outcomes for Utah's communities of color must be intensified. Robust solutions to today's financing and coverage challenges (like the Utah Health Cooperative) will go a long way to reducing health disparities; but they will not get at the complex, multifaceted factors underlying health disparities. We know this because health disparities persist in European countries. Systemic health reform proposals should therefore be developed in conjunction with statewide efforts to eliminate health disparities.

3. Show the deficiencies of current "solutions" like Primary Care Network (PCN).

Entities working to develop solutions have yet to count the PCN population as part of the population in need of health coverage, yet the PCN only provides access to prevention-oriented primary care.

4. Combat false solutions like Health Savings Accounts and insurance mandates.

Make it clear that only comprehensive and systemic reform, such as the Utah Health Cooperative, can stem the alarming tide of escalating costs.

VI. CONCLUSION: ADVANTAGES OF THE UTAH HEALTH COOPERATIVE

The Utah Health Cooperative is consistent with the core conservative principles that have long characterized Utah: it is budget neutral, requiring no additional expenditures. It preserves the private sector in health care delivery, allowing patients to freely choose their doctors, and doctors to freely choose what and where to practice. It re-establishes the federal-state balance in health policy anticipated by the Constitution. It fulfills the societal obligation of caring for the sick and injured. And, most of all, it will energize Utah's economy.

This proposal demonstrates how a budget neutral plan can make health care accessible to all Utahns, whatever their income level. It is a fiscally responsible plan because it offers a means to provide health insurance for all Utahns without an increase in revenue. The Utah Health Cooperative *covers all needs at the same time, leaving no one behind*. It is, in our view, the single best way forward for Utah.

Appendix A

THE UTAH HEALTH COOPERATIVE
Frequently Asked Questions

WHAT IS THE UTAH HEALTH COOPERATIVE?

The Utah Health Cooperative is a proposed statewide, non-profit health insurance plan covering every Utahn for all medically-necessary services including: acute, rehabilitative, long term and home care, mental health, dental services, occupational health care, prescription drugs and supplies, and preventive and public health measures. By including all Utahns, it revives the original purpose of health insurance, which is to share risk. Boards of expert and community representatives would assess which services are unnecessary or ineffective, and exclude them from coverage. Low-income patients could receive wrap-around services through Medicaid or CHIP. Patient co-payments and deductibles would be eliminated or kept at manageable levels.

HOW WOULD THE UTAH HEALTH COOPERATIVE BE FUNDED?

Government expenditures, including both federal and state sources, already account for nearly 60% of total health spending in Utah. These resources will be diverted to the Utah Health Cooperative. The remainder of health care funding will be derived in equal portions from citizens and private employers in the form of progressive taxation (instead of escalating premiums, which is how individuals and businesses *currently* pour ever-larger amounts of money into the health care system). Importantly, the Cooperative will be budget neutral, meaning that on average Utah's citizens and businesses would pay no more for health care after the creation of the Utah Health Cooperative than they pay now (low-income individuals could have a subsidy through Medicaid or CHIP to cover their out-of-pocket costs). And yet we will be getting more for every dollar, since every single Utahn would be covered.

HOW CAN A BUDGET NEUTRAL PLAN COVER ALL UTAHNS?

The problem with current health care systems is not that we don't spend enough money, it is that we are spending it on the wrong things. The best way to achieve cost containment is to eliminate the current multiple and wasteful payment mechanisms (and payers) for health care. Non-profit administration of health funds by a single, publicly responsive entity (like the Utah Health Cooperative) would have saved $1.6 billion in Utah in 2003. The administrative savings available through a plan like the Utah Health Cooperative have been studied by the Congressional Budget Office, the US General Accounting Office, and numerous others. The Lewin Group, for example, studied the impact of a cooperative system in Massachusetts and concluded that insurance overhead could be reduced to 1.4% (from current levels above 10%); hospital administrative costs could be reduced 14%; and physician administrative costs could be reduced 26%. Here in Utah, actuarial findings suggest that a cooperative plan would have saved

approximately 50% of the administrative burden of a multiple payer system due to non-duplication of administrative functions and elimination of marketing costs.

HOW WOULD THE HEALTH COOPERATIVE PAY FOR HOSPITAL SERVICES?

The Utah Health Cooperative would pay each hospital a monthly lump sum to cover all operating expenses—that is, a global budget. Hospitals would not bill patients or the Cooperative for services covered by the Cooperative. The hospitals and the Utah Health Cooperative would negotiate the amount of the monthly payment on an annual basis, based on past expenditures, previous financial and clinical performance, projected changes in levels of services, wages and input costs, and program innovations. Hospitals could not use any of their operating budget for expansion, profit, excessive executives' incomes, marketing, or major capital purchases or leases. Major capital expenditures would come from the cooperative fund, but would be appropriated separately based upon community needs. Investor-owned hospitals would be converted to not-for-profit status, and their owners compensated for past investment.

HOW WOULD THE UTAH HEALTH COOPERATIVE PAY FOR PHYSICIAN SERVICES AND OUTPATIENT CARE?

Physicians would be paid on a negotiated fee-for-service basis. A panel representing the different provider groups would negotiate compensation, fee schedules and contract terms (such as billing, payment, length of contract, grievances, arbitration, termination, dispute resolution, utilization review, and how modifications are handled) with the administrative board of the Utah Health Cooperative. Physicians and other providers would submit bills to the Utah Health Cooperative electronically and would receive extra payment for any bill not paid within 30 days. Provider payments would cover only the work of providers and their support staff, and would exclude reimbursement for costly office-based capital expenditures for such items as MRI scanners. Allocations for such items would be based on community needs.

HOW WOULD THE HEALTH COOPERATIVE COVER LONG TERM CARE?

The Utah Health Cooperative would cover Utahns with disabilities for all necessary home and community-based, and institutional care, where appropriate. State policy on long-term care is currently undergoing a paradigm shift away from an institutional bias to home and community-based services. Further details on the disposition of long-term care in the Utah Health Cooperative will be developed in conjunction with the state's Aging Commission, which was just renewed by the Utah Legislature.

Meanwhile, the Utah Health Cooperative proposes the following general guidelines for long-term care:

- Anyone unable to perform any of the recognized seven activities of daily living would be eligible for services.
- The local Area Agencies on Aging (AAA) would determine eligibility and coordinate care in conjunction with the State Division of Aging.
- Each AAA would receive a single budgetary allotment to cover the full array of long term care services in its jurisdiction. The Utah Health Cooperative would pay long term care facilities and home care agencies a global budget to cover all operating expenses. For-profit nursing homes and home care agencies would be transformed to not-for-profit status. Doctors, nurses, therapists, and other individual long term care providers would be paid on a fee-for-service basis. Family members and friends who currently provide 70% of all long term care would be assisted through training, respite services, and in some cases financial support.
- The AAAs would contract with long term care providers for the full range of needed services, eliminating the perverse incentives in the current system that often pay for expensive institutional care but not the home-based services that most patients prefer.

HOW WOULD THE UTAH HEALTH COOPERATIVE PROVIDE FOR CAPITAL ALLOCATION, HEALTH PLANNING, AND PROFIT?

Funds for the construction or renovation of health facilities, and for major equipment purchases, would be appropriated from the Utah Health Cooperative budget. A Utah State Health Planning Board consisting of both experts and community representatives would allocate these capital funds. Major capital projects funded from private donations would require approval by the health planning board if they entailed an increase in future operating expenses.

The Utah Health Cooperative would pay owners of current for-profit hospitals, nursing homes and clinics a reasonable fixed rate of return on existing equity. For-profit HMOs and insurance plans would receive similar compensation for their clinical facilities and other administrative facilities needed to manage the Utah Health Cooperative. They would not be reimbursed for loss of business opportunities or for administrative capacity not used by the Utah Health Cooperative.

HOW WOULD THE UTAH HEALTH COOPERATIVE PAY FOR PRESCRIPTION DRUGS AND SUPPLIES?

The Utah Health Cooperative would pay for all medically necessary prescription drugs and medical supplies, based upon a preferred drug list established by a committee of experts. The Utah Health Cooperative would negotiate drug and equipment prices with manufacturers, based on their costs. Where therapeutically equivalent drugs are available, the preferred drug list would specify use of the lowest cost medication, with exceptions available in case of medical necessity. Suppliers would bill the Utah Health Cooperative directly for the negotiated

wholesale price plus a reasonable dispensing fee for any item on the PDL that is prescribed by a licensed practitioner.

HOW WOULD THE UTAH HEALTH COOPERATIVE BE EXPERIENCED BY THE CITIZENS OF UTAH?

Each citizen of Utah would receive a Utah Health Cooperative card entitling the bearer to care with nominal co-payments and no deductibles. Patients would be given a free choice of providers and delivery systems. Instead of ever-escalating premiums and deductibles, Utahns would pay a simple tax to cover their contribution to the overall system. For the first time Utahns would experience *health care security*—the fear of losing one's coverage in the event of job losses/change or becoming vulnerable to devastating personal bankruptcy as a result of a single illness, would disappear.

HOW WOULD THE UTAH HEALTH COOPERATIVE BE EXPERIENCED BY THE PRACTITIONERS OF UTAH?

Physicians will be able to concentrate on what they do best: practicing medicine. Treatment of patients would no longer be constrained by insurance status or bureaucratic dictum. Payment would be prompt. Costs would be contained by limiting entrepreneurial incentives and obviating the need for detailed administrative oversight which is characteristic of multiple payer systems.

HOW WOULD THE UTAH HEALTH COOPERATIVE AFFECT OTHER HEALTH CARE WORKERS?

Nurses and other personnel would enjoy a more humane and efficient working environment. The burdens of paperwork associated with billing would be lightened. The jobs of many administrative and insurance employees would disappear, necessitating a major effort at job placement and retraining. Many of these displaced workers might be deployed in expanded programs of public health, health promotion and education, home care, and as support personnel to free up nurses for clinical tasks. Nursing salaries would rise, increasing interest in nursing jobs and decreasing the current nursing shortage.

HOW WOULD THE UTAH HEALTH COOPERATIVE IMPACT HOSPITALS?

The Utah Health Cooperative would induce hospitals to return to their roots as non-profit providers of needed services cooperating with each other and with the community. Gone would be the profit incentive which leads to overbuilding, litigation, vertical and horizontal growth and domination, and competitive market strategies. Responsiveness to community needs, quality of care, efficiency and innovation would replace financial performance based on

the "bottom line." As the premier academic medical center in the state, the University of Utah Hospital would be properly financed for its multiple missions of care, research, and teaching.

HOW WOULD THE UTAH HEALTH COOPERATIVE AFFECT THE UTAH BUSINESS COMMUNITY?

Utah businesses will realize immediate savings because their tax contribution to the Utah Health Cooperative will be far more manageable—and predictable from one year to the next—than their current health care costs. Health care inflation would be reined in, relieving business leaders of the onerous tasks of constantly monitoring health policy just so that they can keep their budgets in line. These changes will greatly enhance the competitiveness of Utah businesses. Also, because Utahns will no longer be dependent upon employers to cover the cost of care, they will be freer to change jobs, making the entire labor market more mobile. All of these changes will enhance the competitiveness of the Utah economy.

Readers are invited to comment further or provide alternative responses to the Frequently Asked Questions listed above. The UHPP would also welcome additional FAQs.

Appendix B

The Health Partnership Act

Summary

To help the growing number of states tackling the problem of the uninsured and rising health care costs, a bipartisan group of senators and representatives have introduced bold legislation aimed at covering the uninsured in financially sustainable ways. The House (HR506, the preferred vehicle) and Senate (S325) "Health Partnership" bills will provide the states with federal funding and flexibility to expand coverage, control prices, and improve quality of care in ways that are responsive to the unique political climate of each individual state.

The Health Partnership Act initiatives could not be more timely for Utah. Given the parameters of our health care crisis, Utah is in desperate need of robust, sustainable solutions…

- Small businesses dominate Utah's economy, and small business employees are especially likely to be uninsured. This is partly why the increase in the state's uninsured rate between 2004 and 2005 was 7 times greater than that for the rest of the nation;
- Between 2000-04 Utah businesses saw premium increases that were 5 times the increase in earnings;
- To compete in a global economic environment, Utah's businesses will need a dependably healthy workforce at a controllable cost;

The good news is that, given certain advantages related to the state's demographics and efficiencies in Utah's health care delivery systems, Utah should have an easier time than other states in covering the uninsured. A super waiver mechanism like the HPA would provide the incentive and necessary flexibility to build on the relative strengths and efficiencies of Utah's health care delivery systems.

Frequently Asked Questions

How would the Health Partnership Act (HPA) work?

Under the Senate's version of the HPA, states can apply for 5-year *State Health Care Expansion and Improvement Grants*. Proposals which meet certain minimum standards will be selected by a bipartisan State Health Innovation Commission. To compete for grants, states commit to specific goals in reducing the number of uninsured and seeking other improvements in the quality and cost of care for those currently insured.

What types of coverage solutions could be supported under the HPA?

Both the House and Senate versions of the HPA anticipate a broad range of proposed approaches to covering the uninsured. The grants program thus has two complementary purposes:

1. To help states control costs and cover their uninsured in the best, most expedient way possible.
2. To create 'laboratories' and an information exchange for all states to learn about what solutions work best.

How will Utah benefit from the HPA if the state's grant proposal is *not* accepted?

Over time the grants program will produce a "toolkit" of reform options, such as tax credit incentives, Health Savings Accounts, single-payer systems, public program expansions, and pay-or-play mechanisms. Utah could learn from other states' experiences or lead out on innovative solutions.

THE UTAH HEALTH COOPERATIVE

A Financially Sustainable Plan for
Universal Health Care Coverage in Utah

Now it's your turn…

We will be the first to acknowledge that our proposal for the Utah Health Cooperative is bold and ambitious. But we are putting our plan 'on the table' because it is our sense that Utahns are ready for fundamental change in how we finance health care.

From other states' and other nations' experience, we know that it takes a good deal of input and expertise to craft a viable solution to the problem of rising health care costs. Thus we invite input and fresh ideas from community members on our proposal.

Options for Giving Input on the Utah Health Cooperative Proposal

1. Visit the Utah Health Cooperative blog: www.healthpolicyproject.org/blog. Specific questions posed in the draft will be posted there for comment. 'Bloggers' can also share general reflections.
2. Simply send an email to judi@healthpolicyproject.org
3. Respond to a structured Survey Monkey survey (email invitation coming soon!).
4. Attend one of several 'Town Hall Meetings': watch *Health Matters* (UHPP's E-Newsletter) for announcements.

NOTE: *In your blog entries please demonstrate decorum, civility, and respect for those with opinions different from your own. We reserve the right to delete entries that are profane, disrespectful, or completely irrelevant.*

About the Utah Health Policy Project…

The UHPP is focused on the economics of health care as it impacts family self sufficiency, business viability, and the quality of care. For more information or to get involved visit www.healthpolicyproject.org or call 801-433-2299.