Utah FOUNDATION Executive Summary

Report Number 678, November 2006

CONTROLLING HEALTHCARE COSTS
PART TWO: ANALYSIS OF FIVE REFORM CONCEPTS

A group of business leaders asked Utah Foundation to examine healthcare inflation and Utah's healthcare situation, including conducting focus groups with healthcare stakeholders to better understand cost issues facing Utah. After reviewing the findings of that process, the employer group requested analysis on five potential reforms for making health insurance more affordable. This report provides that analysis.

This report is not an endorsement by Utah Foundation of these reform ideas but an attempt to analyze the current situation in Utah, options for implementing these concepts, trends and developments in state or national policies related to each reform, and experience with similar policies in other states or nationally.

The reforms examined are: promoting greater use of best-practice guidelines, tort reforms, reducing state mandates on insurers, greater incentives for healthy lifestyles, and tax credits to make insurance more affordable.

PRACTICE GUIDELINES

Practice guidelines facilitate evidence-based clinical decision-making by distilling research evidence into a form usable by busy healthcare providers. Proponents believe that guidelines developed by specialty societies and other organizations have the potential to greatly improve quality and cost-effectiveness in healthcare. Critics worry that practice guidelines will become practice directives. Because of its relatively advanced health information technology, Utah could potentially become a leader in the use of best practices guidelines.

Options for promoting greater use of practice guidelines include:

- Grant practitioners a shield from liability if they adhere to practice guidelines.
- Mandate that all state-financed healthcare providers use practice guidelines for specific health problems.
- Provide additional state funding to facilitate the development of health information technology and greater use of practice guidelines.

By connecting malpractice liability relief to adherence to guidelines, policymakers could create incentives for increased quality while reducing liability costs. Perhaps even more important, such a policy could reduce defensive medicine and overutilization. Numerous states have considered legislation involving practice guidelines. Minnesota and New Jersey both considered bills tying guidelines use to malpractice indemnity.

Several experiences with the use of practice guidelines suggest that they have great potential for increasing healthcare quality while decreasing costs. The Veterans' Health Administration, which uses electronic health records and encourages evidence-based medicine, consistently provides higher quality healthcare at a lower cost than the private sector.[1] Another example involves California's Workers' Compensation system, which had extremely high insurance rates that threatened the state's economic climate. The California Legislature recently instituted reforms that centered on the use of medical treatment guidelines, and workers' compensation insurance rates have since fallen by as much as 60 percent in just three years (a savings of $15 billion).[2]

TORT REFORM

States have implemented tort reforms to improve the affordability and availability of malpractice insurance by helping to contain costs associated with medical malpractice. Proponents of tort reform argue that the transaction costs (particularly attorneys' fees) of litigation are excessive and that damage awards are often arbitrary and thus do not improve safety. Opponents of tort reform argue that tort laws deter malpractice and protect patients against an unsafe medical system. During the last three decades, Utah has enacted many common malpractice tort reforms, including a limit on noneconomic (pain and suffering) damage awards.

Currently Utah ranks near the bottom of the states (47th) in terms of the average claims payments, but ranks 15th highest for the number

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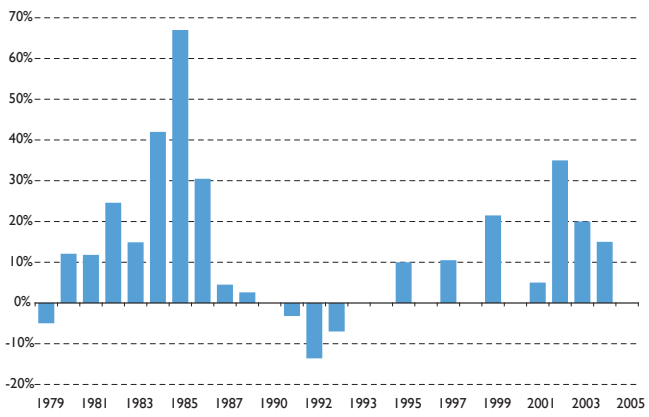
Figure 1: Utah Malpractice Premium Rate Changes 1979-2005



Source: Utah Medical Insurance Association.

of claims per 1,000 physicians.[3] Malpractice premiums for the Utah Medical Insurance Association (the primary malpractice insurer in the state) increased 96 percent (adjusted for inflation) between 1996 and 2005.

Options for implementing tort reform include:

- Lowering the noneconomic damages cap or enacting a total damages cap.
- Stronger screening processes.
- Standards for expert witnesses.
- Strengthening alternatives to litigation.
- Sliding scale for attorney fees.
- Adherence to practice guidelines as a shield from liability.
- No-fault compensation system.

Tort reforms have once again become prominent on state and national legislative agendas. A 2004 Congressional Budget Office (CBO) paper concluded that "state-level tort reforms have decreased the number of lawsuits filed, lowered the value of insurance claims and damage awards, and increased insurers' profitability as measured by payouts relative to premiums in the short run." Research has also found that malpractice pressures may affect the supply of physicians, particularly in high-risk specialties (such as obstetrics) and rural areas. In 2003, CBO estimated that if a national tort reform proposal (including caps on awards and attorney fees) were enacted, "premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent lower than what they would be under current law." This did not include cost savings from a reduction in the practice of defensive medicine.

Some health care reformers believe that the tort reform battle obscures real problems, and that policymakers should instead focus on the larger problems of the medical liability system, including "its inefficiency, low rate of compensating injured patients, inequity in awarding compensation and lack of deterrence of medical errors."[4] Experts on medical error and patient safety have suggested that we could better synchronize medical error prevention and compensation through a no-fault liability system based on compensable events. Critics of no-fault compensation systems argue that no-fault systems will reduce the incentives for physician precaution.

In the 1990s, researchers concluded that a no-fault system in Colorado or Utah would have similar costs to the existing malpractice tort system if compensation were restricted to injuries in which the injury was avoidable, even though many more patients would receive compensation. Other experiences with no-fault compensation in the United States include two state-based administrative compensation systems for birth-related neurological injuries which function much like workers' compensation. Evaluators concluded that the no-fault system was more efficient, delivering similar benefits to tort, but more quickly and with lower administrative costs.[5]

STATE MANDATES

A health insurance mandate is a legislative requirement that an insurance company or health plan offer coverage for certain healthcare providers, benefits, and patient populations. Mandates make health insurance more comprehensive, but also more expensive. State mandates affect only the commercial health insurance market: small employers and individual policy holders. Thus, state mandates affect well below half of Utah's population. Proponents view mandates as a way to provide more comprehensive health insurance to consumers. They argue that mandates correct for inefficiencies or inequities in the healthcare market. Opponents assert that mandates drive up the cost of health insurance premiums, contribute to a higher uninsured rate, and put small business owners at a disadvantage.

Utah's current mandates include such benefits as dependent coverage to age 26 or coverage of adoption expenses. In its 2006 report, the Council for Affordable Health Insurance (CAHI) estimates that Utah's current insurance mandates increase the cost of basic health coverage by 13 to 47 percent.[6]

Options for implementing mandate reform include:

- Remove some or all state mandates.
- Allow employers to choose a "mandate-lite" health plan (a health plan that includes some or none of the state mandates).

According to CAHI, state mandates have increased from less than ten in 1965 to 1,843 in 2006. However, states are slowing the pace at which they adopt mandates, requiring mandated benefit studies, and allowing "mandate-lite" policies. Evidence from both public and private sectors supports the claim that federal and state mandates have contributed to increasing health insurance costs and uninsured rates. One estimate from Maryland in 2001 concluded that the marginal cost of mandates in the small group market represented 3.4 percent of premiums (the total cost accounted for 14.1 percent). Two studies published in the late 1990s attributed 20 to 25 percent of the uninsured problem to the cost of state benefit mandates.[7]

WELLNESS INCENTIVES

Throughout the nation, rapidly rising healthcare costs and the prevalence of avoidable threats to health (such as smoking and obesity) have motivated many businesses to promote healthier lifestyle choices among their employees through wellness programs. Defenders of wellness incentives argue that such practices are legitimate methods for controlling escalating healthcare costs, while critics assert that employers' regulation of legal activities outside the workplace violates employees' civil liberties. Federal law prohibits discrimination in health coverage based on health status, but does not prevent insurers or employers from giving discounts or rebates for participation in health promotion programs.

Utah law regulates premiums in the small-group market using a rating band system that restricts how premiums can vary according

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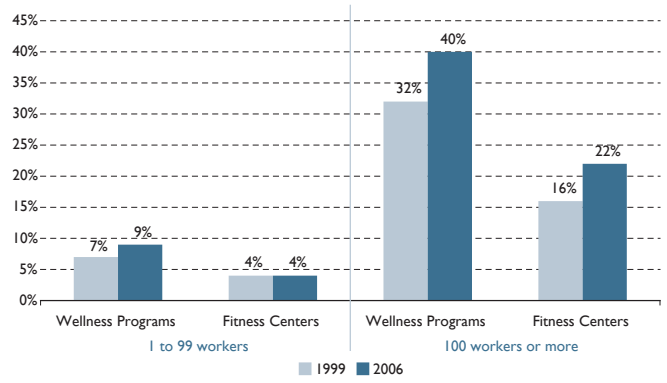
Figure 2: Percent of Workers in Private Industry with Access to Health Promotion Benefits by Size of Firm, 1999 and 2006



Source: U.S. Department of Labor.

to risk characteristics. Employee participation in wellness programs is not considered a risk characteristic. Utah promotes health and wellness within state-funded health programs by giving rebates to state employees for health-improving behaviors, by subsidizing exercise and weight-loss programs for very obese employees and by covering smoking cessation programs for Medicaid recipients.

Options for facilitating wellness incentives include:

- Allow insurers to consider wellness program usage as a rating factor in developing premiums for small-group plans.
- Allow insurers to provide financial incentives to employers and employees for healthy behaviors.
- Invest additional funds in wellness programs for state-funded health programs.
- Provide state employees and Medicaid recipients with stronger financial incentives (discounts on premiums and copayments) for healthy behaviors.

Many states are actively promoting healthier behaviors through policy reforms. Alabama state employees who use tobacco now must pay higher premiums than non-users. A 2005 Florida law requires most insurers to give rebates to employers when their workers adopt healthier lifestyles. In April 2006, at least three states were offering discounts to Medicaid recipients for healthy behaviors. West Virginia now provides Medicaid recipients with an expanded group of benefits if they comply with all recommended medical treatment and wellness behaviors. Michigan has passed reforms to allow health care carriers to provide financial incentives to both employees and employers for participation in wellness programs offered by the employer.

Federal health officials consider the increasing prevalence of obesity as one of the top threats to the health of the nation. The U.S. Department of Health and Human Services reports that overweight and obesity represent 4.3 to 9.1 percent of total healthcare expenditures. The Utah Department of Health estimates that Utah's economy loses $530 million annually to smoking-attributable medical and productivity costs. U.S. Department of Labor data and other sources demonstrate that employers are increasingly using wellness programs but that smaller employers are less likely to offer health promotion activities (see Figure 2). Some healthcare experts assert that wellness programs represent one of the best long-term strategies for controlling costs.

HEALTH INSURANCE TAX CREDITS

A number of proposals have been made in recent years to enact tax credits to encourage more businesses to offer health insurance to employees or to encourage more employees or individuals to obtain health insurance. Most of the discussion on tax credits has focused on the federal tax system.

Tax credits designed to subsidize health insurance premiums may be directed at individuals or employers. A 2003 study for the California HealthCare Foundation found that a credit to employers would produce the largest reduction in the number of uninsured individuals. A credit to individuals who purchase nongroup insurance policies would be a close second in covering the uninsured.

Utah Foundation created a rough fiscal estimate of the tax costs of a small-employer tax credit. This rough model is based on a fully refundable tax credit of $500 per employee choosing single coverage, $750 per employee choosing employee-plus-one coverage, and $1000 per employee choosing family coverage. Figure 3 shows the potential impacts of such a credit for employers with fewer than 10 employees or for firms with less than 50 employees.

Credits for firms that already provide insurance would constitute the bulk of the fiscal impact, but since many firms are dropping health benefits in recent years, providing a credit may help small firms continue to provide insurance. It is difficult to estimate how many uninsured individuals would obtain insurance as a result of the credit, so the model provides a range of impacts depending on how many uninsured gain coverage. If 30% of the uninsured working at small firms (less than 50 employees) gained coverage, about 60,000 workers and their families would benefit.

Passage of such a credit may be difficult, since income taxes are earmarked for public and higher education in Utah. To reduce their fiscal impact, credits could be limited by any of the following actions:

- Eliminate refundability so only those with a tax liability would receive the credit. Alternatively, firms could be allowed to carry the credit forward to years when they have a tax liability.
- Limit the credit to firms with a specified percentage of low-wage workers.
- Limit the credit to only firms that did not provide health insurance to employees in the previous two years (or some other period).
- Cap the credit at a lower dollar amount per employee or eliminate the larger credits for dependent coverage.
- Appropriate funding for a limited pool of credits and allow employers to participate on a first-come, first-served basis.

Figure 3: Potential Fiscal Impacts of a Small-Employer Health Insurance Tax Credit

	Option 1: Firms Under 10	Option 2: Firms Under 50
Tax credit cost for those already covered	$26,544,070	$65,982,383
Additional cost if 10% of uninsured received coverage	3,790,779	7,524,427
Additional cost if 20% of uninsured received coverage	7,581,558	15,048,854
Additional cost if 30% of uninsured received coverage	11,372,338	22,573,280
Total cost for those already covered +10% of uninsured gaining coverage	$30,334,849	$73,506,809
Total cost for those already covered +20% of uninsured gaining coverage	34,125,628	81,031,236
Total cost for those already covered +30% of uninsured gaining coverage	37,916,408	88,555,663

Note: This assumes an annual credit of $1,000 per employee choosing family coverage, $750 per employee choosing employee-plus-spouse coverage, and $500 per employee choosing single coverage.
Source: Utah Foundation, using data from AHRQ (MEPS) and Kaiser Family Foundation.

There is not much experience with health insurance tax credits in other states. Montana and Tennessee have both recently enacted programs to subsidize employer-sponsored insurance, but those programs are too new to assess their fiscal impacts or effectiveness.

Please see the full research report for more detailed information on each of these reform concepts.

ENDNOTES

[1] Douglas Waller, "How VA Hospitals Became The Best," Time Magazine, 27 August 2006; RAND Health, "Improving Quality of Care: How the VA Outpaces Other Systems in Delivering Patient Care," 2005; Philip Longman, "The Best Care Anywhere," Washington Monthly, January/February 2005.

[2] Bickmore Risk Services, "A Study of the Effects of Legislative Reforms on California Workers' Compensation Insurance Rates: Executive Summary," Prepared for California Department of Industrial Relations and Division of Workers' Compensation, January 2006.

[3] The Kaiser Family Foundation, "Number of Paid Medical Malpractice Claims, 2005," Kaiser State Health Facts, 2006; The Kaiser Family Foundation, "Payments on Medical Malpractice Claims, 2005," Kaiser State Health Facts, 2006.

[4] Michelle M. Mello, "Medical malpractice: Impact of the crisis and effect of state tort reforms," Robert Wood Johnson Foundation, The Synthesis Project, May 2006.

[5] Michal H. Brown, "Improving Malpractice Prevention and Compensation Systems," Robert Wood Johnson Foundation, September 2002; Michael H. Brown, "Can the No-Fault Approach Contain Malpractice Insurance Costs?" Robert Wood Johnson Foundation, September 2002.

[6] Council for Affordable Health Insurance, "Health Insurance Mandates in the States," 2006.

[7] Government Accountability Office, "Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses," September 2003; Gail A. Jensen and Michael A. Morrisey, "Mandated Benefit Laws and Employer-Sponsored Health Insurance," Health Insurance Association of America, January 1999.

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This research report was written by Research Analyst Elizabeth Escandon and Executive Director Stephen Kroes. Ms. Escandon and Mr. Kroes may be reached for comment at (801) 355-1400. They may also be contacted by email at: betsy@utahfoundation.org or steve@utahfoundation.org. For more information about Utah Foundation, please visit our website: www.utahfoundation.org.

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Utah FOUNDATION
10 West Broadway, Suite 307
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