Utah FOUNDATION Executive Summary

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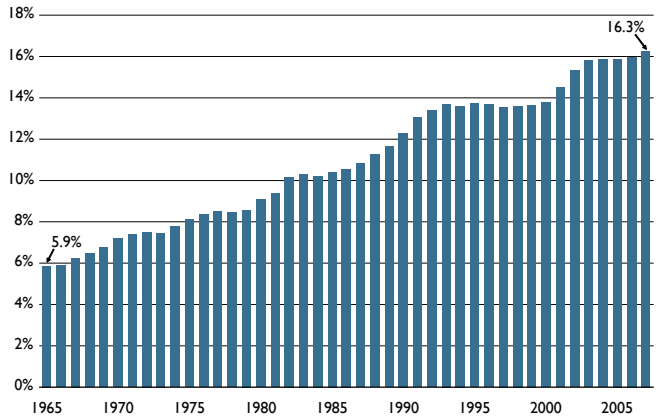
UTAH'S HEALTH SYSTEM REFORM
KEY ISSUES TO RESOLVE

Utah voters ranked healthcare as the fourth most important issue of concern on Utah Foundation's 2008 Utah Priorities Project survey. The high ranking of healthcare in the top ten issues reflects Utah voters' concerns with the current health system.

Our nation spends more on healthcare per capita than any other country and national spending on healthcare as a percentage of GDP has been steadily increasing since 1965 (Figure 1).[1] The trajectory of rising healthcare costs has significantly outpaced growth in motor fuel, housing, food, and apparel, and had led to increasing numbers of uninsured.

UDOH estimates there were 287,200 uninsured people living in Utah in 2007.[2] This equals 10.6% of the population, representing a 1.3 percentage point decrease from the 2006 uninsured rate. Although survey results indicate the uninsured rate fell in 2007, historical data reveal a significant upward trend in the uninsured rate in Utah. Between 2001 and 2007, the number of uninsured in Utah grew at an average annual rate of 6.3%, compared with 2.7% for the state's overall population growth rate.

Figure 1: U.S. Health Expenditures as a Percent of GDP, 1965-2007



Sources: Centers for Medicare & Medicaid Services (CMS); Bureau of Economic Analysis (BEA). Calculations by Utah Foundation.

Being uninsured not only represents a risk to the uninsured, but it creates a negative externality for society in terms of the receipt of uncompensated care. Because federal law requires all people have access to emergency care, even if they do not have the means to pay for it, physicians and hospitals frequently receive no compensation for emergency care provided to the uninsured.[3] It is estimated that up to 12% of the money spent on uncompensated care is cost-shifted onto private health insurance premiums.[4]

From 2003 to 2007, the average health insurance premium for a family of four increased 18.5% (Figure 2). During this same period, the employers' contribution to the family premium fell to 72.9% from 75.1% of the total.[5] Increasing premiums not only force employers to reduce their share of the total cost, but restricts many employers from being able to provide employees with insurance at all. The percent of Utah firms with 100 employees or less that offer health insurance has decreased since 2004, implying that these employees are either purchasing their own insurance, going without insurance, or receiving some sort of public or private assistance (Figure 3). The use of government-based insurance has increased for almost all age groups as the use of private insurance has declined.

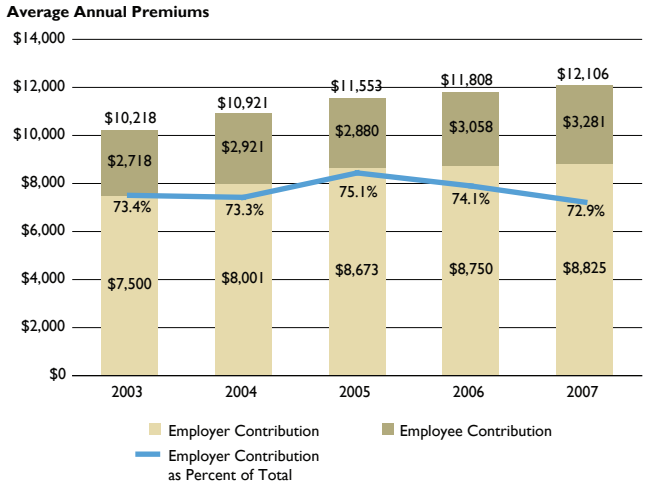
The increasing number of uninsured is one contributor to rising healthcare costs. However, several other factors contribute to this inflation as well. These factors include, but are not limited to: 1) increased hospital, physician, and clinical costs due to delivering more technologically advanced care; 2) increased hospital costs due to provider consolidation and less competition; 3) significant growth in prescription drug expenditures; and 4) the persistent overuse, misuse, and waste of healthcare.[6]

UTAH'S REFORM: HB 133

Health System Reform (HB 133) requires the Department of Health, the Insurance Department, and the Governor's Office of Economic Development (GOED) to work with the Legislature to develop the

For the complete report on this topic and other reports, please visit our website at www.utahfoundation.org

Figure 2: Average Annual Premiums for Family Coverage, 2003-2007



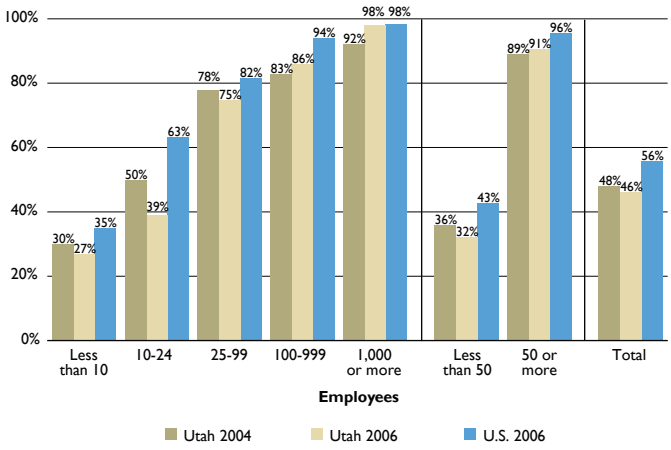
Coverage is for a family of four. Premium amounts are in 2007 inflation-adjusted dollars.
Sources: Regence Blue Cross/Blue Shield; Bureau of Labor Statistics (BLS). Calculations by Utah Foundation.

state's strategic plan.[7] HB 133 uses a 1-3-6-10 approach to reform. During the first year, the Legislature will establish a foundation for reform by developing a task force. Over the next three years, the Legislature is to develop and implement a plan to address six areas of need, recognizing that it may take as long as ten years for full reform. More information on the task force, the six areas of need, and other aspects of HB 133 are included in the full report.

SIX ISSUES TO ADDRESS FOR REAL SYSTEMIC REFORM

HB 133 is an important first step to state health system reform, but there are many issues that need to be addressed before real systemic reform can take place at the state level. In order to identify some of these issues, Utah Foundation interviewed representatives from six different stakeholder groups of the health system industry. These groups include the government, insurers, hospitals, providers, businesses, and consumers. During these interviews common themes began to emerge, and based on these themes, Utah Foundation identified six overarching issues that need to be addressed before real systemic reform can take place at the state level. Utah Foundation does not attempt to present solutions to these issues in this report, but provides background information and an understanding of the issues.

Figure 3: Percent of Private-Sector Establishments that Offer Health Insurance by Firm Size (2004 and 2006)



Source: Agency for Healthcare Research and Quality (AHRQ), Medical Expenditure Panel Survey (MEPS).

1. Navigating the Federal System

The past three decades have seen an increase in standards, regulations and oversight requirements that must be met by private insurers, employers, hospitals, and doctors. Federal laws such as ERISA, COBRA, HIPAA, and the Internal Revenue Code are examples of legislation that contain requirements pertaining to private health insurance that can displace state statutes. Of these federal regulations, one of the largest obstacles to state healthcare reform is the Employee Retirement Income Security Act (ERISA). Intending to streamline benefit packages, minimize administrative burdens, and protect benefits from mismanagement, ERISA removed competing state laws on insurers and employees focusing on benefit plan administration.

States seeking health system reform frequently encounter challenges with ERISA's "preemptive clause" which states that ERISA "supersedes any and all State laws insofar as they relate to any employee benefit plan."[8] As such, any state reforms that attempt to regulate plan providers and benefits can be challenged and nullified under ERISA. For example, Maryland's Fair Share Health Care Fund Act (which required large employers to spend at least 8% of their payroll on health benefits or pay into a state fund for low income individuals) was nullified in U.S. Court of Appeals under ERISA as singling out Wal-Mart for special health spending requirements.

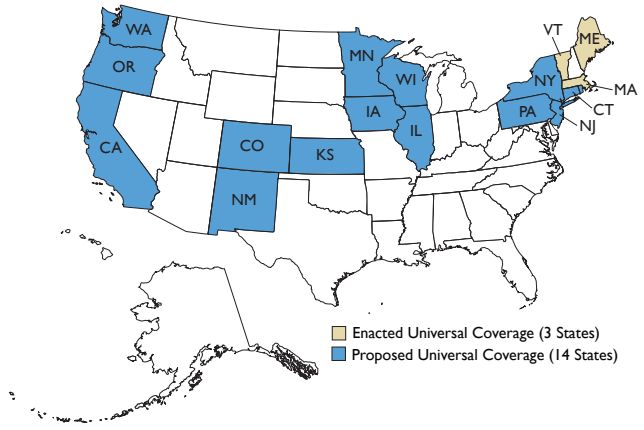
Despite numerous federal regulations that can hamper state level health system reforms, there are multiple areas that can be addressed at the state level. These include such issues as insuring unemployed individuals, providing reliable access to health information on costs, and working to make insurance affordable to individuals outside of ERISA regulations. As of August 2008, three states have enacted and are implementing health system reforms aimed at universal coverage (Figure 4). An additional 19 states are moving towards more comprehensive reforms with the introduction of health reform bills or the establishment of health reform commissions. The reform efforts of these states are discussed in the full report.

2. Incentives in the Health System Industry

The second most common issue discussed by stakeholders is how market-based reform can align the incentives of the different stakeholders in the health system industry. Each stakeholder operates through a unique set of incentives, with little consideration of how their actions may affect the other groups. The current goal of Utah's health system reform task force is to realign the incentives of healthcare stakeholders using market-based reform. In order for stakeholders' incentives to be truly aligned, however, the representatives interviewed felt several shifts in the system must occur. A few of the major changes are outlined below.

Insurance companies have an inherent incentive to maximize profit by reducing the risk of paying for expensive medical procedures by insuring large risk pools, pricing individuals out of the market, or denying coverage. This, however, increases the number of uninsured persons receiving uncompensated care, creating a socially suboptimal outcome. Avoiding risk may save insurance companies money in the short run, but society pays for those without insurance in the

Figure 4: U.S. States Moving Toward Comprehensive Health Care Reform



Source: Kaiser Family Foundation.

long run. Some of the representatives interviewed believe increasing access by lessening medical underwriting would lower the indirect costs that arise from uncompensated care.

The most commonly cited misaligned incentive of providers and hospitals was their potential to promote the overutilization of costly medical services. For instance, there are almost three times as many MRI scanners in the United States as the OECD average.[9] Almost all of the representatives interviewed felt that medical providers and hospitals need to counsel their patients about the best options for care, rather than hedge risk by simply ordering tests. This will in turn reduce overutilization within the system and help reduce the amount of money spent on medical technology. It is also felt that providers and hospitals can manage costs by engaging in "best practices" and using more comprehensive electronic information exchange to lower administrative costs.

Current incentives of consumers also create problems in the health system. When employers began providing health insurance as a way to compete for employees, they also began excluding the consumer from the market. This created a system of asymmetric information and moral hazard in which consumers have little incentive to understand the costs that occur from unnecessary medical treatments. It is felt that consumers need to engage in preventive care, eat well, exercise, and refrain from risky behavior. Consumers also need to be aware of the costs and benefits of treatments and engage in greater dialogue with their physician and insurer.

3. Improving on the Market System

The third most common issue discussed by representatives of the stakeholder groups is how to enact health system reforms with a focus on market-based solutions. While the model for state market-based reform is still in the early stages of development, there remains a question as to how the market can align the incentives in a way that is beneficial to everyone. A few of the stakeholders interviewed felt ethical issues related to the healthcare system may prevent the health system from moving to a true market system. These ethical issues include dilemmas about expensive care for the very ill or elderly that may not be equitably resolved by market forces.

4. Affordability

Another theme that arose from the stakeholder discussions was the concept of affordability. It is not affordable for small businesses to provide insurance, it is not affordable for individuals to purchase their own insurance, and it is not affordable for states to handle the increasing number of persons utilizing government-based insurance programs. The two largest insured groups are those who have employer-based coverage or utilize government programs. Both of these groups receive a subsidy and most people on these plans could not afford health insurance without the subsidy. The community input workgroup suggests that an independent commission conduct an affordability study for Utah to determine the percentage of household income that can be reasonably devoted to healthcare.[10]

5. Potential Tradeoffs Among Cost, Quality, and Access

An overarching goal of state health system reform is to address the three pillars of reform: cost, quality, and access. While it is argued that some strategies to improve quality and expand access will decrease the cost of healthcare by improving efficiency, many stakeholders acknowledge that there are some potential tradeoffs among the three pillars. One potential tradeoff that was mentioned by both the hospital and the insurance representatives is how to encourage new medical innovation while keeping down costs. Insulating patients and providers from the direct cost of health services guarantees medical services are consumed in quantities that generate marginal costs greater than the marginal benefits they provide. However, these improvements also save lives and improve the quality of medicine. How can reform reduce health system costs in a way that prevents the overutilization of medical technology, but doesn't hinder the availability of life-saving medical advancements? A detailed analysis of this and other tradeoffs is in the full report.

6. The Process

A final issue of concern that was mentioned by the stakeholders had to do with the health system reform process. Stakeholders are concerned that HB 133 doesn't provide the necessary mechanisms to keep the process moving after the task force finishes its work in November. They are also concerned about how Utah would find the political will to do what needs to be done. It is one thing to acknowledge what needs to be done to change the system, and it is another to acknowledge what politically can be done. The final concern that was mentioned about the process is how the current preference for handling small changes in the health system is keeping those involved in the reform process from focusing on bigger challenges.

CONCLUSION

Health system reform is not an easy task to undertake. It requires making changes that could disrupt the financial interests of major industries. Real systemic reform calls for the involvement and participation of insurers, providers, hospitals, consumers, employers, and the government. These stakeholders are involved in the reform discussion taking place at the state level, and after interviewing representatives of each group it is clear that there are still many issues to be addressed before real systemic reform can take place. Whether or not these issues will be addressed in the next three or ten years is yet to be seen, but there is a consensus they must be addressed for reform to take place.

ENDNOTES

1 "Controlling Healthcare Costs Part One: Understanding the factors driving Healthcare Inflation," *Utah Foundation* (October 2006).

2 Utah Department of Health (August 2008).

3 The Emergency Medical Treatment and Active Labor Act (EMTALA) is a federal statute prevents hospitals from rejecting patients, refusing to treat them, or transferring them to other hospitals because they are unable to pay or are covered under the Medicare or Medicaid programs.

4 Geoff Colvin, "We all Pay for the Uninsured," *Fortune* (May 1, 2008).

5 Regence Blue Cross/Blue Shield.

6 For more information see "Controlling Healthcare Costs Part One: Understanding the factors driving Healthcare Inflation," Utah Foundation (October 2006).

7 Health System Reform, H.B. 133, State of Utah General Session (2008).

8 For complete ERISA text, see http://caselaw.lp.findlaw.com/scripts/getcase.pl?court=fl&vol=99-00041.2&invol=1.

9 Ezekiel J. Emanuel and Victor R. Fuchs, "The Perfect Storm of Overutilization," *Journal of American Medical Association* 299:23 (June 2008): 2789-2791.

10 "Health System Reform Community Workgroup Proposal for Reform" *Community Input Group Discussion Draft* (September 16, 2008).

This research report was written by Utah Foundation Research Analyst Laura Summers with assistance from independent researcher Holly Farnsworth Anzalone and President Stephen Kroes. Ms. Summers or Mr. Kroes may be reached for comment at (801) 355-1400. For more information about Utah Foundation, please visit our website: www.utahfoundation.org.

The mission of Utah Foundation is to promote a thriving economy, a well-prepared workforce, and a high quality of life for Utahns by performing thorough, well supported research that helps policymakers, business and community leaders, and citizens better understand complex issues and providing practical, well-reasoned recommendations for policy change.

Utah FOUNDATION
10 West Broadway, Suite 307
Salt Lake City, UT 84101