Utah FOUNDATION Research Report

Report Number 688, October 2008

UTAH'S HEALTH SYSTEM REFORM
KEY ISSUES TO RESOLVE

HIGHLIGHTS

- Rising healthcare costs create a negative feedback cycle within the market, making health insurance unaffordable. This increases the number of uninsured who then use public programs (increasing state healthcare costs) or go without insurance and receive uncompensated care (increasing healthcare costs and private insurance premiums).
- During this decade, the percentage of people utilizing government-based insurance has increased for almost all age groups as the percentage of people with private insurance has declined.
- Based on common themes from health system stakeholder interviews, six issues that need to be addressed for real systemic reform include: 1) navigating the federal system; 2) re-aligning stakeholder incentives; 3) improving on the market system; 4) defining affordability; 5) dealing with tradeoffs between cost, quality, and access; and 6) improving the reform process.
- Federal laws that contain requirements pertaining to private health insurance can displace state statutes. One of the largest federal obstacles states frequently encounter challenges with is ERISA's "preemptive clause" which maintains that ERISA "supersedes any and all State laws insofar as they relate to any employee benefit plan."

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Utah voters ranked healthcare as the fourth most important issue of concern on Utah Foundation's 2008 Utah Priorities Project survey. Among the top concerns in this area were the cost of healthcare and the quality of health insurance benefits. Survey respondents also expressed significant concern about losing health insurance, covering the uninsured, and the quality of healthcare. The high ranking of healthcare in the top ten issues reflects Utah voters' concerns with the current health system. This research report reviews some of the major problems underlying the current system, summarizes Utah's initial steps for reform, and identifies six issues that need to be addressed for real systemic reform to take place at the state level.

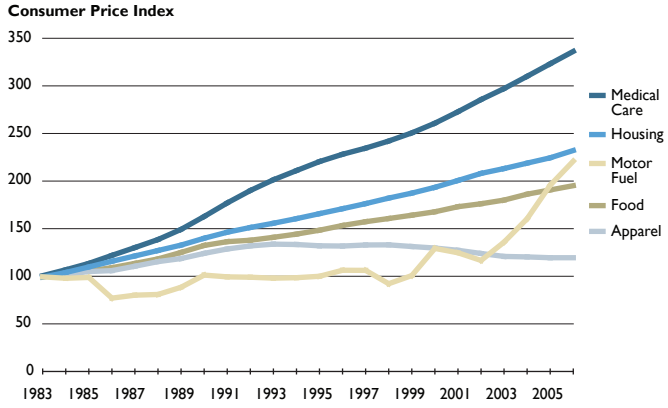
THE PROBLEM

Health system reform has become an increasing important topic at both the state and federal level. The trajectory of rising healthcare costs has significantly outpaced growth in the cost of motor fuel, housing, food, and apparel (Figure 1). More and more employers have been unable to keep up with the rising cost, which has forced many businesses to lay off employees or not provide insurance. This creates a negative feedback cycle within the market; rising healthcare costs increase the number of people who don't have access to insurance and therefore must either utilize public programs (increasing the state's healthcare costs) or go without insurance and receive uncompensated care through emergency room services (increasing healthcare costs and premiums for those insured).

Uninsured

There are several national and state surveys that attempt to estimate the number of uninsured. A few of the major national surveys include the Current Population Survey (CPS), Medical Expenditure Panel Survey (MEPS), Survey of Income and Program Participation (SIPP), and National Health Interview Survey (NHIS). At the state level, the Utah Department of Health (UDOH) uses the Utah Healthcare Access Survey to estimate the number of Utah residents who lack health insurance coverage each year. Although the estimates of each survey

Figure 1: Consumer Price Trends of Medical Care vs. Other Consumer Goods and Services



For consumer price indices, 1982-84 = 100. Medical care includes both commodities and services. Food does not include beverages. Housing is rent of primary resident or owner's equivalent of rent.

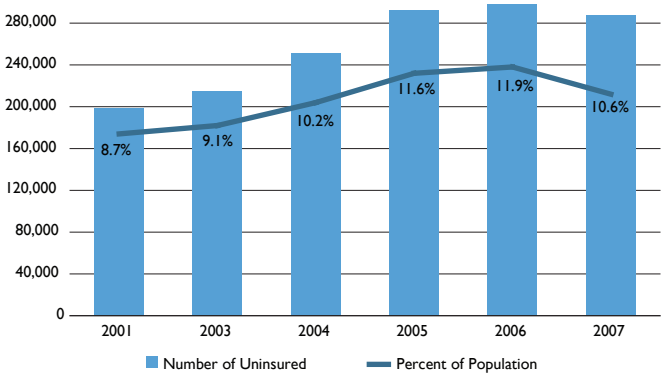
Source: 2007 Economic Report of the President.

vary due to sampling size, survey methodology, definitions of insured, and length of survey, they all provide useful estimates of uninsured individuals during a particular period or point in time.[1] This report presents the uninsured estimates from CPS and UDOH.

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 (Figure 2). Although survey results indicate the uninsured rate fell in 2007, historical data reveal a significant upward trend in percentage of people without insurance in Utah. Between 2001 and 2007, Utah's uninsured population grew at an average annual rate of 6.3%, compared with 2.7% for the state's overall population growth rate.[3] The average annual increase for uninsured children ages 0-17 was even greater; there was a 7.5% average annual growth rate in the number of uninsured children between 2001 and 2007 compared to a 2.3% average annual growth rate in this population.[4]

A recent release by CPS estimates there are 399,000 uninsured persons in Utah.[5] This represents 15.6% of the total population, and ranks Utah above the national average (15.4%) in terms of the percentage of persons without health insurance coverage. While CPS estimates of the uninsured tend to be higher than other surveys, its

Figure 2: Estimated Number and Percent of Utah Residents Who Lack Health Insurance Coverage, 2001-2007



Source: Utah Department of Health (UDOH).

data provide useful national and state-level estimates, allowing one to compare Utah to national trends. The CPS data show the percentage of uninsured persons in Utah ranks 18th highest, just above the national average.[6] Texas has the largest uninsured rate; 24.4% of its population does not have insurance. Massachusetts ranks the lowest with only 8.3% of its population uninsured. The low uninsured rate in Massachusetts is reflective of its 2006 health reform initiative, which included an individual mandate. This initiative increased access and reduced the number of uninsured from 10.3% (2004-2005 average) to 7.9% (2006-2007 average).[7]

Even though the uninsured estimates from UDOH and CPS differ, both surveys confirm the rising number of uninsured persons over the last decade. Being uninsured not only represents a risk to the uninsured person, but it creates a negative externality for society in terms of the receipt of uncompensated care.[8] Because federal law requires all people to have access to emergency care, even if they do not have the means to pay for it; hospitals and physicians frequently receive no compensation for emergency care provided to the uninsured.[9]

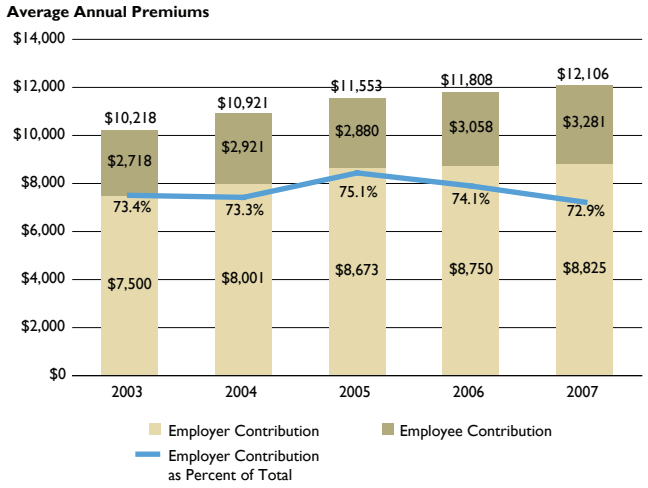
Hospitals are especially affected by uncompensated care, as most physicians are now paid a predetermined stipend for on-call duty at a hospital. Physicians receive this stipend regardless of their patients' ability to pay, placing the burden of providing uncompensated care on the hospitals. The uninsured also generally require more expensive procedures once in the emergency room due to their lack of preventive and primary care visits. Data from UDOH show uninsured Utah residents are less likely to have had a usual source of medical care (66.9% of uninsured vs. 93.3% of those with coverage) or a routine medical visit in the last year (54.4% vs. 71.6%). Utah residents who lack health insurance are also more likely to seek primary care from an emergency department or urgent care center (12.4% vs. 6.7%) which is typically more expensive than care received from a primary care provider.[10] In addition, hospitals and physicians are usually not fully compensated for providing care to those on publicly funded programs such as Medicaid or Medicare.

When hospitals and providers "write off" a significant portion of healthcare services, it increases the cost of private health insurance premiums. Increased premiums in turn, however, price small employers and individuals out of the market, increasing the number of persons who are uninsured and creating a negative feedback cycle within the market. A 2008 study by Professor Jack Hadley at George Mason University estimates people receive about $56 billion in care that is not paid for by individuals or private insurance.[11] While most of this amount is paid for by public programs (like Medicaid and Medicare), it is estimated that 2% is cost-shifted onto private health insurance premiums.[12] Up to 12% of real uncompensated care (costs that are never recouped by hospitals and providers) is cost-shifted onto private health insurance premiums.[13]

Businesses

In 2007, 59.3% of all U.S. residents received insurance through an employment-based system.[14] Employers offer insurance through the workplace in order to promote worker productivity, obtain tax advantages, attract high-quality workers, and because it is a convenient way to pool risks.[15] However, rising healthcare costs result in an increased cost to businesses providing health insurance. From 2003 to 2007, the average health insurance premium for a family of

Figure 3: Average Annual Premiums for Family Coverage, 2003-2007

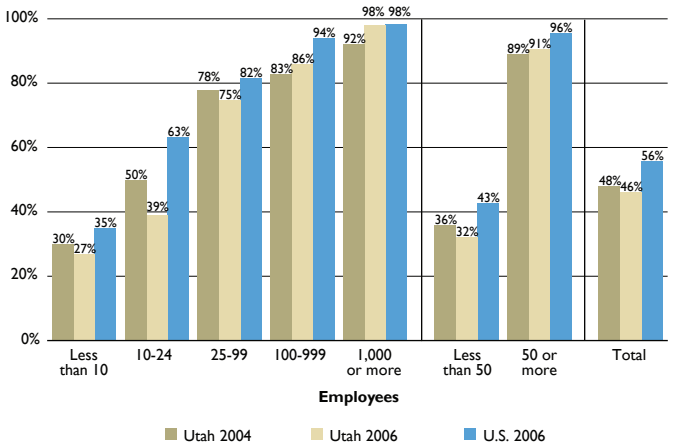


Coverage is for a family of four. Premium amounts are in 2007 inflation-adjusted dollars. Sources: Regence Blue Cross/Blue Shield; Bureau of Labor Statistics (BLS). Calculations by Utah Foundation.

four increased from $10,218 to $12,106 (in 2007 inflation-adjusted dollars). This represents an 18.5% increase in the premium amount in just over four years. During this same period, the employees' contribution to the family premium increased 20.7%, while the employers' contribution increased 17.7%. The slower growth in the employers' share of the contribution is illustrated in Figure 3, which shows that the employers' contribution to the total premium has declined from 75.1% to 72.9% since 2005. This decrease illustrates one consequence of rapidly inflating insurance prices: employers are making employees bear increasingly more of the cost burden, which is slowing the growth in take-home pay for many workers.

Increasing premiums not only force employers to reduce their share of the total cost, but they also restrict many employers from being able to provide employees with insurance at all. Figure 4 shows the percent of all private-sector establishments that offer health insurance by firm size for Utah in 2004 and 2006. While the percent of large firms (with 100 or more employees) that offer health insurance has increased slightly from 2004, the percent of small firms that offer

Figure 4: 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).

health insurance has decreased in every category, implying that these employees are either purchasing their own insurance (and spending up to $10,000 to $12,000 out of pocket on health insurance per year), going without insurance, or receiving some sort of public or private assistance. According to Census, the decline in employment-based coverage "essentially explains the decrease in total private health insurance coverage."[16] The number of Utah residents with employment-based coverage fell from 64.8% in 2004 to 62.8% in 2006.[17] A decade earlier, 71.2% of Utah residents and 61.1% of all Americans had job-related coverage.[18]

Another contributing factor to the number of uninsured is that only some of the employees who work for a firm offering health insurance will actually be eligible for the insurance. The most common reasons for ineligibility include not working enough hours each week or enough weeks in the year to be eligible, having not worked long enough to qualify for benefits, or being employed as a contract or temporary worker.[19] Figure 5 shows that, compared to the national average, Utah employees are less likely to work for companies that offer health insurance, and if they do, then they are less likely to be eligible for employer-sponsored insurance; only 84% of Utah employees work for firms that offer health insurance compared to 87% of employees at the national level.[20] The discrepancy between these two percentages gets larger as the firm size gets smaller.

These statistics may be influenced by Utah's high percentage of part-time workers and large number of small businesses. The high percentage of part-time workers stems from Utah's propensity for seasonal work, young population, and the large number of Utah workers who are enrolled in college or post-secondary training. However, CPS data show the most common reason Utah workers cite as to why they worked part time is because of "other family/personal obligations." Over 55% of Utah's female part-time work force, which is the largest in the nation, listed this as their reason for working part time compared to 39% nationally.[21] Using the U.S. Small Business Administration standards, which considers small companies as those with fewer than 500 employees, 99.6% of companies in Utah are small businesses and 97.7% of those have fewer than 100 employees.[22] However, despite the enormous proportion of small firms in the state, half of Utah employees work for large companies. Of total Utah employees, 34% work for firms with less than 100 employees while 50% of all Utah employees work for firms with more than 1,000 employees (these numbers may include part-time workers).[23]

Having a high percentage of part-time workers and large number of small businesses could lower the number of Utah employees with health insurance because part-time workers typically do not qualify for health insurance benefits and small businesses have a difficult time maintaining affordable insurance due to small risk pools. Many workers reject health insurance even if they are eligible because they cannot afford to pay the employee's portion of the premium.[24] Data from UDOH show that in 2007, 10.8% of all adults (age 19-64) employed full time were uninsured, 13.3% of all adults employed part time were uninsured, and 22.7% of all self-employed adults were uninsured.[25]

Public Programs

A portion of the people who do not receive employer-based health insurance and are unable to afford or have access to individual health insurance may qualify for federal and state insurance programs

Figure 5: Employees and Employer-Sponsored Health Insurance by Size of Firm, 2006

		Less than 10 employees	10-24 employees	25-99 employees	100-999 employees	1,000 or more employees	Less than 50 employees	50 or more employees	All Firms	Total Employees
Employees by Firm Size	Utah	10.9%	10.0%	13.0%	16.5%	49.6%	27.3%	72.7%	100.0%	987,786
	U.S.	11.5%	8.9%	14.0%	18.6%	47.0%	27.5%	72.5%	100.0%	114,690,765
Employees in firms that offer health insurance	Utah	37.6%	49.5%	81.5%	93.5%	98.7%	52.3%	96.0%	84.0%	829,740
	U.S.	43.3%	67.4%	85.0%	95.1%	98.7%	61.2%	96.7%	86.9%	99,666,275
Employees eligible for health insurance at firms that offer health insurance	Utah	82.5%	58.9%	77.7%	73.5%	74.0%	72.3%	74.2%	73.9%	613,178
	U.S.	81.9%	76.3%	73.8%	77.2%	78.2%	77.7%	77.5%	77.5%	77,241,363
Employees who are eligible for health insurance that are enrolled in health insurance	Utah	83.4%	81.6%	70.3%	68.3%	77.0%	78.1%	74.5%	75.1%	460,497
	U.S.	81.3%	76.5%	75.8%	77.1%	79.3%	77.4%	78.6%	78.3%	60,479,987
Employees enrolled in health insurance as a percent of all employees	Utah	25.9%	23.8%	44.5%	46.9%	56.2%	29.5%	53.1%	46.6%	460,497
	U.S.	28.8%	39.3%	47.5%	56.6%	61.2%	36.8%	58.9%	52.7%	60,479,987

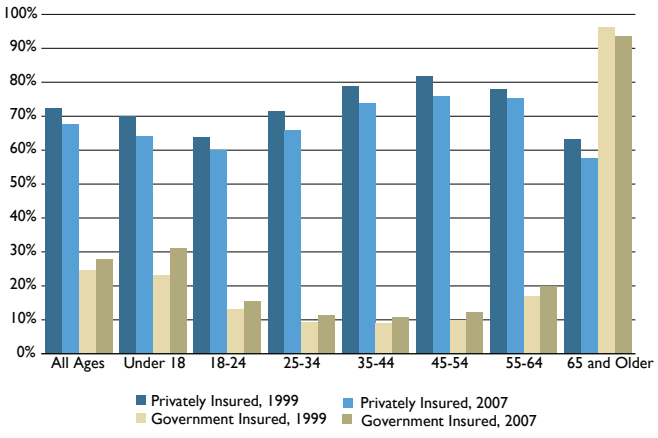
Source: AHRQ, MEPS. Calculations by Utah Foundation.

such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP), Utah's Premium Partnership (UPP), and the Utah Comprehensive Health Insurance Pool (HIPUtah). Utah's Medicaid program pays the medical bills for people who qualify for one of Medicaid's three categories (there are different categories for children, pregnant women, and adults), have low incomes or cannot afford the cost of healthcare, and who have resources under the federal limit for the Medicaid category in which they are applying. The monthly income standard varies between approximately 55% and 133% of the federal poverty level, depending on the category, and an individual must prove qualification every month they are receiving Medicaid assistance. A person whose income exceeds the designated income levels may be considered for the Medically Needy program, which allows a person who is otherwise ineligible to pay excess monthly income to the State of Utah or to accept responsibility for a portion of their monthly medical bills.[26]

Medicare is a federal health insurance program for people age 65 or older, people under age 65 with certain disabilities, and people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). The program provides insurance subsidies for hospital care (including some hospice and home health care), medical care (doctor's services and outpatient care), and prescription drugs. Program participants pay a monthly premium for most of these services.[27] CHIP is a state-sponsored, UDOH-operated health insurance plan for uninsured children whose parents' income is under 200% of the federal poverty level.[28] UPP is a program designed to help low income working Utah families afford health coverage by providing a subsidy for people to purchase employer-sponsored health insurance. UPP will reimburse up to $150 per adult and $100 per child every month for qualifying families.[29] HIPUtah is a state-run program designed for people with serious medical conditions that are unable to get insurance at any price because of they represent a high health risk to insurance companies. HIPUtah is funded by a combination of enrollee premiums and yearly legislative appropriations.[30]

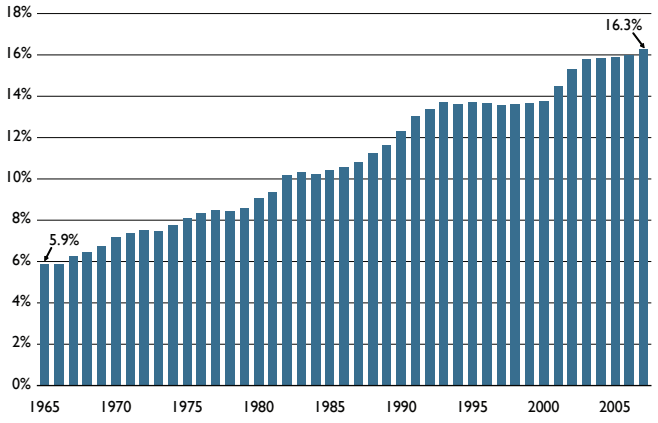
Federal and state public programs provide a necessary safety net for those who legitimately cannot afford health insurance, and increasing numbers of people have enrolled in these programs as the cost of healthcare and health insurance premiums have risen. Figure 6 illustrates how the percentage of people utilizing government-based insurance has increased for almost all age groups as the percentage of people with private insurance has declined. Increasing enrollment numbers in conjunction with increases in health costs has a negative impact on federal and state budgets. Although K-12 education has historically represented the largest share of state spending nationally, in 2003 Medicaid surpassed K-12 education, becoming the largest category of state spending. In 2006, Medicaid spending accounted for 21.5% of total fiscal expenditures, with elementary and secondary education accounting for 21.4%.[31] In Utah, however, K-12 education continues to be the largest spending category, but while public K-12 education spending relative to $1,000 of personal income declined between FY 1991 and FY 2007 at an average annual rate of -1.5%, Utah's portion of Medicaid funding significantly increased at an average annual rate of 4.6%. Between FY 2001 and FY 2007, Utah's CHIP expenditures increased at an average annual rate of 21.6% (CHIP was implemented in Utah in FY 2001).[32]

Figure 6: Percent of Population with Insurance, by Age Group and Type of Insurance, 1999 and 2007



Source: U.S. Census Bureau.

Figure 7: U.S. Health Expenditures as a Percent of GDP, 1965-2007

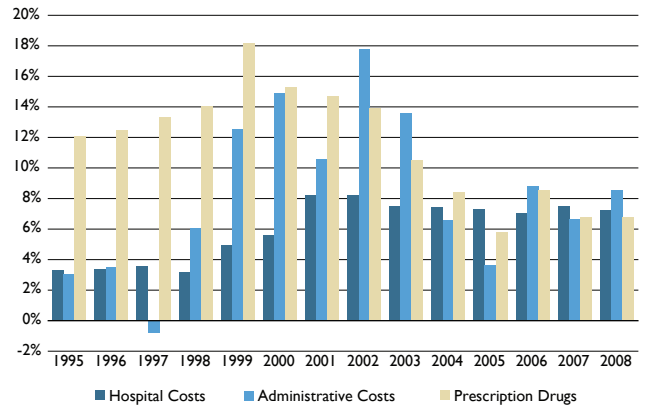


Sources: Centers for Medicare & Medicaid Services (CMS); Bureau of Economic Analysis (BEA). Calculations by Utah Foundation.

Rising Healthcare Costs

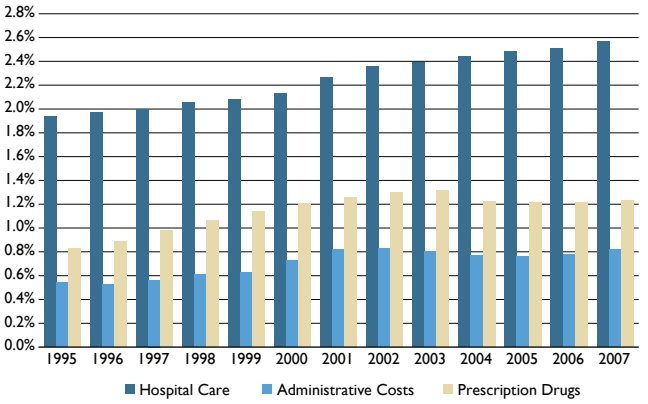
Healthcare is the largest sector of the U.S. economy. Our nation spends more on healthcare per capita than any other country, and national spending on healthcare as a percentage of GDP has been steadily increasing since 1965, when healthcare spending accounted for just 5.9% of GDP (Figure 7).[33] By 2007, healthcare spending represented 16.3% of GDP, and researchers estimate that by 2017 it will account for 19.5% of GDP.[34]

Figure 8: Annual Percent Change in Total U.S. Hospital, Administrative, and Prescription Drug Costs, 1995-2008



Sources: CMS; BEA. Calculations by Utah Foundation.

Figure 9: U.S. Health Expenditures as a Percent of GDP, by Category, 1995-2007



Sources: CMS; BEA. Calculations by Utah Foundation.

As mentioned above, the increasing number of uninsured persons is one contributor to rising healthcare costs. However, several other factors contribute to this inflation as well. A 2006 Utah Foundation report, citing various studies of the American healthcare system, identified several of these factors which include, but are not limited to: 1) increased hospital, physician, and clinical costs due to delivering more technologically advanced care; 2) increased hospital prices due to provider consolidation and less competition; 3) increased provider employment costs due to a considerable nursing shortage within the United States; 4) increased administration costs due to the number of insurance and hospital plans that are available; 5) significant growth in prescription drug expenditures; and 6) the persistent overuse, misuse, and waste of healthcare.[35]

A 2002 study by the Juran Institute and the Midwest Business Group on Health estimated that the cost of poor quality care, as a result of overuse, misuse, and waste, accounted for about 30% of healthcare costs. The study attributed 10% of this to litigation and defensive medicine.[36]

Rising Healthcare Premiums

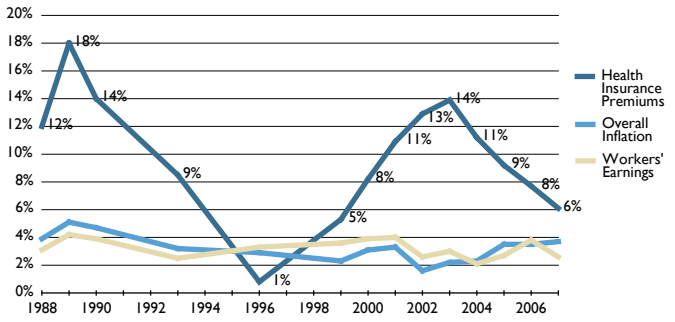
The previously mentioned 2006 Utah Foundation report also analyzed the factors that have contributed to growth in health insurance premiums. Citing research from PricewaterhouseCoopers, the report concluded that one of the primary factors is increased utilization, which accounted for almost half of the inflationary growth experienced between 2004 and 2005.[37] Increased utilization comes from increased consumer demand, use of new treatments, defensive medicine, the aging of the population, and lifestyle choices such as smoking and poor nutrition. The rest of the growth is attributed to general inflation and increases in healthcare prices due to movement to broader-access plans, higher priced technologies, and cost shifting from Medicaid and the uninsured to private payers.

While premiums continue to increase, the rate of increase has moderated in recent years (see Figure 10). From the spring of 2005 to the spring of 2006, premiums rose by 6.1%, down from a 7.7% increase in 2006 and a 9.2% increase in 2005.[38] Nonetheless, premium growth continues to outpace both the rate of inflation and growth in workers' earnings. From 2006 to 2007, the rate of overall inflation was 3.7% and wages grew by 2.6%. While the average premium grew by 6.1% between 2006 and 2007, 10% of covered workers are employed by firms that experienced premium increases greater than 15% and 46% are employed by firms with premium increases of 5% or less. National average annual premiums for employment-based health insurance coverage in 2007 were $4,479 for single coverage (up from $4,242 in 2006) and $12,106 for family coverage (up from $11,480).[39]

UTAH'S REFORM: HB 133

With the support of chief sponsor Representative David Clark, Senate sponsor Sheldon Killpack, and 47 cosponsors, Health System Reform (HB 133) passed both the House and the Senate and was signed by Governor Huntsman on March 19, 2008. The goal of HB 133 is to enhance and preserve the health of all Utah residents and it is lauded as being the first step to real systemic reform at the state level. It

Figure 10: Percent Increase in Employer-Sponsored Health Insurance Premiums Compared to Other Indicators, 1988-2007



Source: Kaiser Family Foundation.

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 state's strategic plan for health system reform.[40]

Real health system reform will not happen quickly or easily; therefore, HB 133 uses what has been referred to as a 1-3-6-10 approach to health system reform. During the first year, the bill calls on the Legislature to enact specific changes to establish a foundation for reform by developing a task force and working to lower costs of insurance premiums. 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 implementation of reform.

Task Force

Steps taken during the first year include establishing a task force consisting of 11 legislative members (four members from Senate and seven members from the House). The purpose of this task force is to review and make recommendations for the state's development and implementation of a strategic plan for health system reform. A report, including proposed legislation, is scheduled to be presented to the Business and Labor Interim Committee before November 30, 2008.[41]

To ensure the task force deals with the real issues of systemic reform, five stakeholder input groups were created that operate under the leadership of the task force and other legislative members. The five input groups are business, hospitals, providers, insurers, and the community. Each of these input groups has an appointed "special master." The job of these legislative "masters" is to facilitate communication between each group and to make certain its ideas are fully represented to the task force. The stakeholder input groups have been meeting separately with their special masters to coordinate ideas and develop proposals. During the regularly scheduled monthly task force meetings, representatives from the input groups present findings and recommendations from their respective groups. After considering the different policy proposals, the task force will develop and prepare its final report.

While all of the input groups are still in the process of developing and finalizing their respective proposals, a few of these groups presented their initial findings at previous task force meetings. The community group, which is comprised of individual citizens, medical providers, business representatives, and policy analysts, recommends Utah's health system reform promote competition based on efficiency, quality, equity, and value through the use of community ratings, reinsurance, and risk adjustment mechanisms. They believe reform should provide incentives for healthy lifestyles and the appropriate use of healthcare through the implementation of health care homes (which is a system wherein primary care providers work with patients, families, and other healthcare professionals to assist patients in accessing all needed medical services) and mandates that individuals obtain insurance (which are essential in a community rated system). This group also recommends optimizing public programs, conducting an independent affordability study, and increasing transparency and value through the creation of a health benefits commission and the use of a market facilitator like the internet portal.

The insurance group, consisting of representatives from major health insurance companies, small carriers, and the broker community, is currently developing legislation that would allow the creation of a health insurance product that provides more options for those leaving their existing insurance plan in an effort to encourage people to stay insured and avoid an individual mandate. It would be available to individuals who have recently left a group or employer plan and would lower the amount of time an employee must be on their previous group plan from six months to three months. They anticipate the product will cost one-third less than the average large group plan, largely because it offers fewer benefits.[42]

In order to control inflationary healthcare costs and promote economic vitality, the business input group recommends implementing health system reform that promotes transparency and the full disclosure of costs by providers and insurers. They want this information to be standardized, easily understandable, and readily accessible. This group also promotes the availability of Health Savings Accounts (HSAs), and supports the use of an insurance internet portal.[43] The other stakeholder input groups are developing proposals as well, and are scheduled to present their findings and proposals in future task force meetings.

Six Areas of Need

Representative Clark identified six areas of need to be addressed by the HB 133 process: [44]

- Ensuring that patients have access to information about the cost and quality of healthcare and that there is a real opportunity for clinical health information exchange by providing tools that help providers and insurers supply this information.

- Creating incentives for patients to assume ownership of their health, health insurance, and healthcare which will, in turn, help the consumer understand how the health system works and make better healthcare choices.

- Optimizing state programs by engaging in educational outreach aimed at identifying and enrolling individuals and children in existing public programs in order to decrease the number of uninsured. This also includes using federal waiver amendments and policy to direct patients toward private health insurance solutions through expanding the scope and accessibility of programs like UPP.

- Making health system reform a collaborative effort by working with community partners to help the uninsured find ways to become enrolled in appropriate public or private insurance plans, as well as working with businesses, insurers, and providers to develop the best approach for establishing real reform at the state level.

- Effectively lowering the cost of health insurance premiums by establishing a non-refundable tax credit for those purchasing health insurance with taxable income.

- Developing a 16-point strategic plan to guide health system reform into the future. HB 133 outlines the 16 measures that must be considered (but not necessarily implemented). These measures include health insurance market reform, development of best practices, promoting personal responsibility (possibly through the use of individual mandates), modifying public programs to support private health insurance, maximizing

tax benefits, and modernizing the Public Employees Health Program (PEHP) by allowing state employees to purchase individually owned policies through a system of defined contributions.

Governor's Office of Economic Development

Included in HB 133 is the enactment of the "Health System Reform Act" which requires GOED to serve as the coordinating entity when working with other executive branch agencies and to report and assist the Legislature with the state's strategic plan for health system reform. An Office of Consumer Health Services (OCHS), under the control of GOED, is also established to coordinate with the Insurance Department, the Department of Health, and the Department of Workforce Services in developing a web portal which provides access to private and government health insurance websites and electronic application forms. The purpose of this web portal is to increase the transparency of the insurance market.[45]

OCHS is also responsible for facilitating a private sector method for the collection of health insurance premium payments made for a single policy by multiple payers (for example, coordinating partial payments from employers, UPP, and the employee and routing them to the insurer). OCHS will also assist employers by creating a free or low-cost method for purchasing health insurance by employees, individuals, and self-insured business owners using pre-tax dollars.

Increasing Private Insurance Utilization

A key aspect of Utah's strategic plan for health system reform is promoting personal responsibility by encouraging people to obtain health insurance. In order to help people obtain health insurance, the Legislature wants to create a system of subsides and Medicaid waiver provisions that bring more people into the private insurance market.[46] Some of the key waiver provisions the state is attempting to implement include expanding UPP to cover people using individual policies, HIPUtah, or COBRA, extending the enrollment waiting period for CHIP and UPP from 90 days to six months for those voluntarily dropping individual coverage, and creating an option that would allow the state to shift some Disproportionate Share Hospital (DSH) funding to UPP if enrollment increased up to current federal cost limits.[47]

The state is also considering whether or not to include a provision that would prohibit children from enrolling in CHIP if their parents qualify for UPP. The purpose of this provision is to keep families on the same healthcare plan and allow children who do not have the UPP option to enroll in CHIP. The problem with this provision is that it potentially violates several federal regulations and the Center for Medicare and Medicaid Services (CMS) has expressed concern about children potentially receiving fewer benefits under UPP than they would under CHIP (this illustrates the general problems associated with moving away from federally sponsored programs when the alternative provides fewer benefits than those federal programs).[48] Since HHS Secretary (and former Utah governor) Michael Leavitt challenged Utah to take the lead in state health system reform, it is felt that Utah will receive support for most of these waiver requests.

SIX ISSUES TO ADDRESS FOR REAL SYSTEMIC REFORM

Regardless of whether they are legislators, businesses, insurers, providers, or consumers of healthcare, it is generally agreed among stakeholders that now is the time for health system reform. Unfortunately, reform is much easier said than done. The current structure of the U.S. healthcare system is like a giant jigsaw puzzle, made up of a million different pieces. Creating a new picture means that some of these pieces will be included and some will not, while other pieces will need to be re-cut to fit into the new picture. The issue of what to do with the leftover pieces needs to be addressed, and because some pieces are left out not everyone will be satisfied with the new picture. The most difficult part of reform, however, is making these decisions when it is still unclear as to what the new picture should look like.

HB 133 is an important first step to state health system reform, but there are many pieces to the puzzle 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.

While the information provided by the different stakeholders was varied and based on their experiences and knowledge of the industry, common themes began to emerge from the different interviews. 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. It is important to note that Utah Foundation does not attempt to present solutions to these issues in this report but provides background information and an understanding of the issues to those who wish to be more involved with state health system reform at a higher level.

The six issues that need to be addressed for real systemic reform include: 1) how to navigate the federal system; 2) how to re-align the current incentives of stakeholders in the health system industry; 3) how to improve on the market system; 4) how to define affordability; 5) how to deal with the potential tradeoffs among cost, quality, and access; and 6) how to improve the current health system reform process.

1. Navigating the Federal System

Overall, the most common issue stakeholders believe needs to be addressed in greater detail is how, and if, state reform can take place within the federal system's laws and regulations. Historically, the federal government has allowed states to actively regulate health and insurance industries. The passage of the 1944 McCarran-Ferguson Act permitted states to regulate insurance companies without federal interference. While states may have regulating authority, this does not preclude the federal government from enacting new legislation or enforcing more commanding federal laws that often conflict with state regulations. Since the 1970s, the federal government has taken a more active role in regulating areas of the healthcare and insurance industries which were previously overseen by states.

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, Americans with Disabilities Act, the Internal Revenue Code, and the Civil Rights Act are examples of legislation containing 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 1974 passage of the Employee Retirement Income Security Act (ERISA), a federal law enacted to protect benefits offered in the workplace. Intending to streamline benefit packages, minimize administrative burdens, and protect benefits from mismanagement, ERISA removed competing state laws on insurers and employers focusing on benefit plan administration. While ERISA was originally created to deal with employee pension issues, it has impacted healthcare regulation by encompassing all employee welfare benefits offered by private employers. Even though there is no federal statute requiring private employers to provide insurance, ERISA does set forth minimum standards for those employers that do offer benefits. Certain standards of conduct by individuals who manage plans, conditions for government reporting, plan participant disclosures, provisions for ensuring the protection of plan funds and that plan participants receive the benefits for which they qualify are some of the requirements under ERISA.

ERISA is ambiguous in nature and its interaction between state and federal statutes is complex and confusing. Specifically, 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."[49] The U.S. Supreme Court has repeatedly upheld ERISA's federal preemptive clause over existing state statutes.[50] As such, any state reforms that attempt to regulate plan providers and benefits can be challenged and nullified under ERISA. For example, a state cannot seek to expand healthcare coverage that is funded through the imposition of tax levies on all employers. Proposals for this type of reform can be blocked by ERISA's preemption clause prohibiting insurance requirements for employers. The state of Maryland and Suffolk County, NY both have had health reform measures challenged under ERISA. Maryland and Suffolk County enacted a "fair share" type of reform targeting large corporations and requiring them to contribute a set amount towards healthcare. Both cases were ruled to be invalid and preempted by ERISA.

Maryland's Fair Share Health Care Fund Act was nullified in U.S. Court of Appeals under ERISA as singling out Wal-Mart for special health spending requirements. The bill required employers with more than 10,000 workers to spend at least 8% of their payroll on health benefits or pay into a health program state fund for low income individuals. Four companies in the state had over 10,000 employees, although Wal-Mart was the only corporation to have an 8% contribution mandate; Johns Hopkins was required to contribute 6%, while the other two companies already met health spending requirements. The Circuit Court of Appeals ruled that ERISA preempted Maryland's program because of its "connection with" an employee sponsored benefit plan and impact on plan administration. It is the first state level "fair share" healthcare reform to be fully adjudicated by the Courts and found to be in violation of ERISA. The effects of this ruling can impact other areas with similar measures, as illustrated in Suffolk County, and the viability of such plans remains to be seen given the absence of a Supreme Court ruling.

In New York, Suffolk County's statute on "fair share" health reform was also overturned following the decision in Maryland. In Suffolk County, large retailers selling groceries were required to contribute a minimum amount to healthcare expenditures. The law was specific in nature and targeted retailers not participating in collective bargaining agreements, earning more than $1 billion in annual revenue, and having 25,000 square feet in retail grocery sales. Based on these requirements the law effectively targeted Wal-Mart, BJ's Wholesale Club, Target, and Kmart. The law was overturned, citing ERISA preemption that the plan would require employers to vary benefits offered to New York employees rather than having uniform, nationwide benefits.

As evidenced from the cases in Maryland and New York, there is considerable power behind ERISA's preemption clause. While specific aspects of these reforms are in violation of federal statutes, proponents of state health reform argue that real reform is hindered by ERISA and a system is needed to allow the federal government to grant waivers in order for states to proceed with changes to the healthcare and insurance industries. There is, however, no system set up to grant or administer such waivers. As ERISA is a federal statute, Congress would need to amend the law in order to grant waivers. The only waiver that Congress has approved since ERISA's inception has been for Hawaii, which received a federal waiver for an employer mandate enacted by the state a few months prior to the passage of ERISA. This waiver, in effect since 1974, for Hawaii's PrePaid Health Care Act, was granted through an amendment to the law, signed by the President, which specifically states the waiver applies to Hawaii.

Despite the lack of waivers, states are able to enact some measures of reform without violating ERISA. Under ERISA, states are able to continue to regulate insurance activities as long as the regulations do not pertain to the coverage in self-funded employer plans. Large corporations often self-fund their own insurance plans—meaning that the employer itself pays the medical claims and essentially acts as the insurer even if an outside agency is hired to administer the plan. By self-funding a plan, an employer does not typically pay premiums for healthcare their employees might receive; rather an employer pays for the actual care received by employees and dependents. This lowers the cost of insurance premiums in exchange for carrying the direct risk and payment for employee claims. It is these types of plans that are subject to federal, not state regulation. States can regulate plans that are operated by state-licensed health insuring groups that provide coverage to a benefit plan set up by employers or a plan sponsor.

ERISA has expanded several times to encompass more health-related issues with the passage of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. COBRA amended ERISA to require employers with 20 or more employees to offer a continuation of healthcare coverage for workers and their beneficiaries for a limited period of time and the right to continue benefit coverage under certain circumstances and events (death, termination, divorce, or legal separation). Plan sponsors are required to notify individuals of their right to continue coverage and address the benefits to be offered, coverage lengths, and premiums they must pay.

HIPAA was created out of concern for the lapse in coverage that occurs when people change or lose their jobs. It is designed to make health insurance more portable, secure and to improve access to health insurance and prohibit discrimination against individuals with certain medical needs. State-licensed health insuring organizations are required to comply with limits on pre-existing medical condition exclusions, to

make health insurance available to small group employers regardless of their claim status and the health status of employees and to allow individuals leaving group coverage to purchase individual coverage regardless of pre-existing conditions and health status. The law prohibits discrimination based on health status for coverage for all types of insurance plans—self funded, group health plans, and individual coverage. HIPAA also provides for administrative simplification by establishing national standards on electronic healthcare transactions, national identifiers for plans, providers and employers, as well as additional compliance measures to protect privacy and maintain the security of health information.

Unlike other aspects of ERISA, HIPAA is clear in the division between federal and state responsibilities. While many portions of HIPAA are implemented through ERISA, the Internal Revenue Code, or the Public Services Health Act, HIPAA does allow more protective state laws to supersede federal standards. It is only when state codes do not meet HIPAA regulations that federal authorities intervene. There are criticisms that enforcement divisions vary with each HIPAA standard—as such, there are many different tests as to whether or not a state standard supersedes a federal standard and this has led to a piecemeal division of responsibility.

Furthermore, HIPAA compliance costs regarding privacy and security requirements can be expensive for both states and care providers. Meeting federal privacy requirements can result in higher costs for healthcare and health insurance as additional information technology and personnel are needed to administer new programs as well as train doctors and staff on new data requirements. These increased cost burdens on hospitals and insurers are typically passed on in the form of higher insurance premiums and higher costs of healthcare.

In addition to the federal requirements listed above, there are many other statutes that pertain to private health coverage that states must recognize when attempting reforms. The Newborns Act, Mental Health Parity Act, The Women's Health and Cancer Rights Act, Age Discrimination Act, Pregnancy Discrimination Act, Americans with Disabilities Act, Family and Medical Leave Act, coverage of adopted children, and pediatric vaccine requirements are all examples of federal standards on private health insurance.

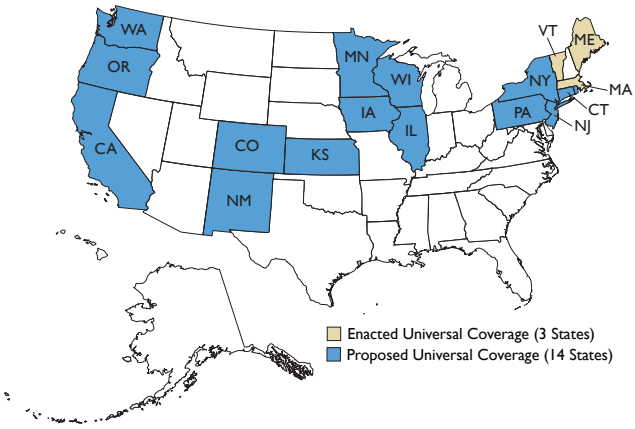
States are also required to comply with federal regulations on Medicaid. Federal changes made earlier this year can restrict eligibility requirements states may place on individuals with modest incomes seeking assistance. Because the federal government pays a large portion of the costs incurred by programs such as Medicaid and State Children's Insurance Programs (SCHIP), compliance with program requirements is necessary if states wish to continue receiving federal assistance. Expansions to coverage levels must be also approved by the federal government. States such as Louisiana, Ohio, and Oklahoma have recently experienced difficulties in their attempts to expand these programs.

States seeking health system reform are also challenged by the question of how to pay for increased and expanded coverage for individuals. Most states face balanced budget requirements through their own state statutes or constitutions and changes to Medicaid, or expansion of other health programs could result in an increased cost to states. If a state faces a budget shortfall in a weakened economy and if existing insurance programs are already strained, any proposed health reforms could be unsuccessful. States that wish to raise money up front, on their own, to offer additional coverage also face challenges—states with lower median incomes tend to have higher uninsured rates and fewer state resources to fund that coverage.

State Reform Efforts

Given the above constraints, several states have successfully enacted meaningful health system reforms. Goals for reforms vary from addressing cost and quality aspects of healthcare, to expanded coverage for children and young adults, to offering universal, or near universal coverage for all residents. As of August 2008, three states, Maine, Vermont, and Massachusetts have enacted and are implementing health system reforms aimed at universal coverage. An additional 19 states are moving towards more comprehensive reforms with the introduction of health reform bills in their 2008-2009 legislative sessions or the establishment of health reform commissions. Of these 19 states, 14 have proposals to establish universal coverage.

Figure 11: U.S. States Moving Toward Comprehensive Health Care Reform



Source: Kaiser Family Foundation.

In order for health reforms to be successful, the Legislature, Governor, general public, and key stakeholders must be in agreement on aspects of the proposed legislation. Even with complete acceptance and successful passing of new reforms, legal challenges—such as ERISA, can still thwart policies. The success of current state reforms in Massachusetts, Vermont, and Maine remains to be seen as several aspects of their plans may be preempted by ERISA. Both Massachusetts and Vermont have "pay or play" laws that force employers to choose between offering health insurance and paying a tax or fee. The taxes and fees collected from businesses that choose to not offer health insurance would generate the revenue necessary to provide a stable financial base for maintaining reform efforts. While Maine does not have an employer-participation requirement in its health reform plan, some aspects of its financing mechanisms are as contentious as "pay or play" laws. As will be discussed below, it is these "pay or play" or "fair play" types of reforms that are the most controversial. The validity of such reforms under ERISA has yet to be fully adjudicated, meaning the U.S. Supreme Court has not yet made a ruling on the issue.

Massachusetts' health reform rests on these basic principles: 1) the state will provide subsidies to offer health insurance on a sliding scale for low income residents and will direct more public funds to hospitals that provide free care for uninsured individuals; 2) the establishment

of the Commonwealth Health Insurance Connector, a purchasing pool that offers individuals choices for insurance; 3) the imposition of penalties for individuals who do not have health coverage in an effort to deter individuals who have the means to pay for insurance but rely on free care; and 4) employers with more than 11 employees must provide health insurance coverage or pay a "fair share" fee of $295 per employee annually.

Vermont has also passed "pay or play" health system reforms similar to Massachusetts. Vermont's reforms are aimed at universal coverage and expanded care for individuals with chronic illnesses through the creation of a health insurance plan for people who do not have access to employer insurance, premium assistance for individuals who do have insurance but are at lower income levels, and an employer required fee of $365 per employee for those who do not have insurance.

Maine does not currently require individual or employee participation in its reforms; however, the state's Dirigo Health plan recently underwent changes to its financing structure. When the plan was originally enacted, financing for the plan was possible through assessments on insurers and third party administrators through "savings offset payments." This allowed the state to collect payments from these groups if it could show that healthcare costs had declined due to greater levels of insurance coverage and cost savings measures from the plan. If the state demonstrated that the Dirigo plan resulted in insurers and administrators saving money, then the insurers and administrators themselves were assessed a fee based on their estimated savings. In April 2008, the Governor signed into law a new bill that changes the financing of the health plan to be funded through increased taxes on beer, wine, and soda along with a flat surcharge on insurers.

The City of San Francisco was the first city in the country to implement healthcare services for all uninsured residents with the creation of the Healthy San Francisco Plan in 2006. Participants share in the cost of the plan along with employers who are required to spend a minimum amount per hour on healthcare. So far, San Francisco is the only city to actually be challenged in court under ERISA for violations of the "pay or play" laws. In 2006, the Golden Gate Restaurant Association sued the City of San Francisco for violating ERISA. In December 2007, a U.S. District Court sided with the Golden Gate Restaurant Association and barred the city from requiring employer contributions. While the case is on appeal, the 9th U.S. Circuit Court of Appeals ruled in January 2008 that the city can continue requiring employers to contribute towards the cost of Healthy San Francisco pending an appeal of the original ruling. This temporary stay was upheld by Justice Anthony Kennedy of the U.S. Supreme Court, and a decision in the matter has yet to be reached.

Whatever outcome is reached, its impact will be far reaching. To date, there have not been any direct challenges to the reforms in Vermont, Massachusetts, and Maine, most likely due to the low cost burdens placed on employers or insurers. However, there is considerable discussion that lawsuits challenging these reforms under ERISA are inevitable as the stakeholders in the process become dissatisfied or if the state considers raising the "fair pay" portion employers are required to contribute. Until a court case is actually presented to the Supreme Court, it is impossible to predict the direction an ERISA preemption challenge could go. The outcome of the San Francisco case can also affect states considering similar measures. In the past two years, 30 states have had bills introduced pertaining to "pay or play" types of reforms, and the outcome in Maryland, Suffolk County, and the future ruling in the San Francisco will be a precursor to the success and survival of other reforms throughout the country.

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 such as insuring unemployed individuals, providing reliable access to health information on costs, and working to make insurance affordable to individuals outside of ERISA regulations. Reform efforts may survive ERISA challenges as long as states are careful to not specifically tax employers. This said, a tax on insurers, employers, or providers may be acceptable as long as states do not specifically target ERISA plans, but rather apply taxation measures through general taxing powers. Implementing broader state taxes on goods or services or other universal assessments to help fund new programs or expand coverage, raising the age of dependent coverage, or offering businesses credits for health benefits are possible avenues to explore in reform efforts.

Other Reform Examples

As of August 2008, 19 states have introduced health reform legislation and 14 states are working towards comprehensive health system reform.[51] Several of these states have created task forces or commissions charged with developing specific reform plans to be evaluated in future legislation sessions, while other states are further in the implementation process. Many of the state reforms seeking universal coverage for all residents have developed timelines for implementation to be reached in the next five years. Iowa has recently passed legislation seeking to provide health insurance to all uninsured children in the state by 2011 and all uninsured adults by 2013. Washington State seeks to provide access to health coverage for all residents by 2012. Wisconsin has also implemented reforms that provide for health insurance coverage for all children of the state—regardless of income levels.

The Illinois Legislature has failed to approve proposed reforms by Governor Blagojevich—and the Governor is seeking to use his executive power to expand health coverage without legislative approval. The Illinois All Kids Program was the first in the nation to provide healthcare for all children in the state and the Governor seeks to expand this program by offering healthcare for all residents through the Illinois Covered Program. An injunction has been issued, however, prohibiting the Governor from continuing program expansion through his own administrative order. Despite the current legislative impasse in Illinois, the state has been successful in reforming other avenues of healthcare—specifically women's health. Illinois is the first state to provide free mammograms, breast exams, pelvic exams, and Pap tests to all uninsured women.

Like Illinois, Oregon has experienced challenges implementing health reforms. Oregon's Healthy Kids Plan seeks to provide coverage for all children in the state—either through program expansion based on income levels or through offering program buy-ins for higher income families. The Healthy Kids Plan's success is contingent upon financing which was originally sought through a ballot initiative raising taxes on tobacco products by 84 cents. However, the tax

increase was not approved by voters in the 2007 November election, and if additional financing methods are not agreed upon, the plan will not be implemented.

Minnesota has enacted several different types of healthcare reform legislation in the past few months that seek to expand coverage levels for low income individuals as well as to improve the use of technology in health decisions. Minnesota passed into law comprehensive health system reform legislation in May 2008 that expands Minnesota Care[52] to 250% of the federal poverty level, reduces sliding scale premiums, requires employers with 11 or more employers to establish a Section 125 plan[53] (and provides funding for them to do so), promotes the use of health care homes for individuals with chronic illnesses, and increases the transparency of healthcare quality. While these reforms do increase coverage levels and help insure affordability of insurance for low income individuals, a large part of Minnesota's reforms are focused on expanding and improving information technology infrastructure for the health industry.

The Minnesota e-Health Initiative is a consortium of consumers, providers, public health agencies, and government officials who are tasked with ensuring the adoption and use of health information technology. A statewide implementation plan is part of the responsibility of the e-Health initiative and sets goals for meeting the following new mandates: by 2011, e-prescribing of all medications must be implemented in order to improve quality, safety, and cost effectiveness in the prescribing process; by 2015, all hospitals and healthcare providers must have interoperable health records systems (and penalties will be created for those who fail to establish such infrastructure); and by 2009, uniform health data standards must be established. Additional reforms were proposed in July 2008 that would allow all residents to access personal health records and compare prescription and health procedure costs online.

Several states have done more than expanding public programs and changing eligibility requirements in their efforts to expand coverage to children and individuals. Massachusetts was the first state to execute an individual mandate requiring all citizens to carry health insurance. Insurance coverage will be verified through state income tax forms and processed through an insurance database. Massachusetts law also has provided for penalties to be placed on individuals not in compliance with the reforms. First-offense penalties begin with a loss of personal exemption status on income tax reforms, increasing to a portion of the costs of premiums an individual would have paid for insurance in following years. Thus far, Massachusetts is the only state with an individual mandate on insurance coverage for all residents. New Jersey signed into law, in July 2008, a bill requiring all children to have public or private health insurance within one year of the bill's enactment. New Mexico has considered a reform requiring all individuals to show proof of insurance coverage (or proof of ability to pay for needed care) by 2010. The bill, however, did not pass in the 2008 legislative session.

As illustrated above, there is increased interest in health system reform at both at the state and federal level. Given rising costs and uninsured rates, there is intense debate surrounding the establishment of a national healthcare plan. In addition to various party and candidate platforms surrounding the issue, over 180 Congressional bills have been introduced in the 2007-2008 Congressional session that will need to be monitored as they relate to state reform proposals.

2. Incentives in the Health System Industry

The second most common issue discussed by the representatives of the stakeholder groups is how market-based reform can align the incentives of the different stakeholders in the health system industry. Each stakeholder in the current healthcare system operates through a unique set of incentives, with little consideration of how their actions may affect other groups. This, in turn, has created a system which leaves millions of American without insurance and millions of others struggling to keep up with rising healthcare costs. The following section uses information from Utah Foundation's interviews to discuss the current incentives of each stakeholder and how the incentives need to change in order for market-based reform to take place at the state level.

Current Incentives

Insurance Companies: Like all businesses, insurance companies have an inherent incentive to maximize profit. In the insurance industry this is done by minimizing the medical loss ratio (the amount of money that is spent on actual medical care compared to total revenues from premiums). In order to minimize the medical loss ratio, insurance companies can reduce their risk of having to pay for expensive medical procedures by maximizing risk pools (providing insurance plans to large groups), pricing individuals out of the market, or denying coverage. This, however, increases the number of uninsured persons using uncompensated care or public programs, creating a socially suboptimal outcome. It also means that those who need the insurance the most are generally those who cannot get coverage.

Health Insurance Brokers: Health insurance brokers also add to the misalignment of incentives in the health system industry. While brokers can provide valuable services to small firms, such as obtaining prices for coverage, explaining benefits to employees, and acting as a liaison to the insurance company and policy holder, brokers earn their money by receiving commissions from insurance companies in exchange for selling their health plan products.[54] Therefore, as the price of health plans rise, so does the amount brokers earn from commission. Brokers can earn anywhere from 2% to 10% commissions; however the average commission is around 6%.[55] In 2003, the average annual premium for family coverage was $10,218 (in 2007 inflation-adjusted dollars). In 2007, the average annual premium was $12,106. If a broker earned the same 6% commission in 2003 as 2007 then the broker's earnings would have increased by 18.5% over the last four years, simply due to inflation in insurance premiums. The average increase in all workers earnings during these years was around 12.1%.[56] This implies that between 2001 and 2003, when health insurance premiums were increasing at double digit annual rates, brokers commissions were increasing at similarly high rates (see Figure 10). Because brokers' commissions rise at the same inflationary rate as insurance premiums, they have no financial incentive to change the current system.

In addition to giving brokers a commission on each policy they sell, health insurance companies may also provide brokers with non-financial incentives for selling their products (such as prepaid vacations, concert tickets, etc.). This creates a potential conflict of interest, in which brokers have an incentive to sell health plans that provide them with the greatest commission or bonus, which may not be the plans that are the most appropriate or cost effective for their

client. However, many brokers would say that if they don't serve their clients interests, they will not be able to keep their business long term. It's not clear how important this potential conflict of interest is in influencing actual behavior.

Providers and Hospitals: The most commonly cited misaligned incentive of providers and hospitals is their potential to promote the overutilization of costly medical services in the United States. For instance, there are almost three times as many magnetic resonance imaging (MRI) scanners in the United States as the OECD average and U.S. patients receive 45% more cardiac revascularization procedures (coronary artery bypass grafts, angioplasties, and stents) than patients in Norway, which has the next highest number. The United States also has the fourth highest per capita consumption of pharmaceuticals and U.S. patients utilize many more "new drugs"—those on the market five years or fewer—than patients in other countries. Greater use of new, more expensive pharmaceuticals, as well as higher prices both for older and newer drugs, explain why the United States spent $752 per capita on pharmaceutical drugs in 2005, whereas France, with the next highest expenditure, spent $559 and Japan just $425.[57]

A study by Ezekiel J. Emanuel, MD, PhD and Victor R. Fuchs, PhD attribute providers' overutilization to four factors. First is the physician culture in which medical doctors are trained to enumerate all possible diagnoses and tests that would confirm or exclude an illness. Meticulousness, not effectiveness is rewarded. Second is the fee-for-service payment system. Because physicians are paid for each test or procedure they perform, rather than a flat salary, they have an inherent financial incentive to run procedures. Physicians are small business owners who worry about revenue flow and profit margins just like any other business. Third, the current system's bias toward paying significantly more for procedures rather than for evaluation and management increases physicians' inclination to order a test rather than to watch, wait, and counsel patients. The current system exacerbates this problem because there are no checks to the number of procedures done. Finally, medical malpractice laws and the resultant defensive medicine are also known to contribute to overutilization.[58] While some argue defensive medicine only contributes a small percentage to rising healthcare costs, representatives from the provider group made the point that theoretically it is much bigger issue. For instance, even if performing a procedure will only change the diagnosis 1% of the time, knowing that missing a diagnosis may lead to a million dollar lawsuit is incentive enough for doctors to perform the procedure.

Businesses and Consumers: Incentives of consumers and businesses also create problems in the current health system. When employers began providing health insurance as a way to compete for talented employees after World War II, they also began excluding the consumer from the market. This created a system of asymmetric information and moral hazard. Moral hazard occurs when a party insulated from risk behaves differently from the way it would if it were fully exposed to the risk and had to bear the full consequence of its actions. In normal markets, demand is modulated by cost. Third-party payments for medical treatment by insurance and employers, however, lessen this effect on consumers. Because consumers are removed from the payment system, they have little incentive to truly understand the costs that occur from unnecessary medical treatments.

Consumers also add to the misalignment of incentives by relying on advanced technology and innovation to relieve discomfort. Across all industries, U.S. consumers embrace technological fixes for problems. In the medical sphere this translates into patients believing more expensive treatments and interventions equate to better care. Direct-to-consumer marketing exacerbates this problem; pharmaceutical companies spend more than an estimated $4 billion annually advertising prescription drugs which drives patients' requests for new and more costly medications.[59]

Realigning Incentives

The current goal of Utah's health system reform task force is to realign the incentives of healthcare stakeholders using market-based reform. This generally implies fixing some of the asymmetric information in the market by ensuring that patients have access to information about the cost and quality of providers and that there is a real opportunity for clinical health information exchange. It also involves creating incentives for patients to take better ownership of their health, health insurance, and healthcare. In order for stakeholders' incentives to be truly aligned, however, representatives from the stakeholder groups believe the following general shifts must occur.

Insurance Companies and Brokers: Representatives from the consumer group, as well as some representatives from the insurer and business group, believe insurers need to stop minimizing risk and start managing their clients' wellness. While some of this can be done through healthy behavior and wellness programs, some of which are already being implemented by major insurance companies within the state, it must also be done through competing on the value of the product they are providing and not on avoiding risk. Currently, federal law guarantees that every critically ill or injured person will be treated in the health system, regardless of whether they have health insurance or not. Because of this guarantee, these representatives believe it is not socially optimal for insurance companies to waste resources trying to identify persons likely to have critical illness in order to save money by excluding these persons through price increases or denial of coverage.

Minimizing the medical loss ratio may save specific insurance companies money in the short run; however, society as a whole pays for those without insurance in the long run. Some representatives believe that while lessening the impact of medical underwriting may result in a temporary cost increase as more people utilize private insurance and enter the risk pool, this cost would decrease in the long run, because more people would be paying directly into the system over time. This lowers the indirect costs that arise from the uncompensated care given to the uninsured or those on public programs. Because not all poor health conditions are a result of choice, punishing people for contracting a terminal illness, or having a family member with a terminal illness, is not in society's best interest.

A few representatives made the point that health insurance brokers also need to start managing their clients' wellness by focusing less on selling plans that provide the greatest commission and bonuses to themselves, and focusing more on selling plans are the most appropriate or cost effective for their client. They argue that selling "Cadillac" type plans to businesses may be useful to the employees in the company who can actually afford high premiums, but these expensive plans force many entry-level and lower-income employees

to opt out of the health insurance plan, even if it is offered to them. Increasing the transparency of brokers' commissions may be one solution to this problem.

Finally, it is argued by most representatives that the insurance industry needs to work with other stakeholders in the health system industry to develop a basic/essential insurance plan. This plan would provide a baseline benefit at a low cost that could be purchased by those seeking only minimal cost-effective coverage. This plan could include essential preventive, primary, and catastrophic care and should be designed in a way that encourages people to access the health system at the right times and the right places in order to stay healthy and avoid unnecessary emergency care visits.

Providers and Hospitals: Representatives from almost all of the groups believe medical providers and hospitals need to be more willing to honestly counsel their patients about the best options for care, rather than hedge risk by simply ordering tests. For instance, while most back pain resolves itself in two weeks, back fusion surgery for uncomplicated degenerative disc disease occurs tens of thousands of times each year even though there is no clinical evidence that the surgery reduces pain or impairment more than nonsurgical care. It is believed that counseling with patients about their diagnosis, and the probability it will change by running extra tests, will in turn reduce overutilization within the system.

These representatives also believe that counseling with patients and reducing the magnitude of procedures will help reduce the amount of money providers and hospitals spend on medical technology—which is recouped through utilization. Because most providers and hospitals are also business owners who worry about profit, they have an inherent incentive to purchase new medical technology as a way to separate themselves from the competition. This leads to several providers and hospitals in the same area owning the same types of machines (MRIs, PET scanners, and lithotripters) when realistically one or two machines in the area would be sufficient for people's needs. For instance, MRI machines cost $1 million to $2 million each, and MRI scans are run at prices of $600 to $1,000. It is estimated that more than five million MRI scans were performed in the nation last year, adding about $5 billion to the nation's health bill.[60] It is argued that if competing providers and hospitals did not purchase these machines themselves, and instead all outsourced patients to one independent agency in the area, then there would be little incentive to overuse this technology.

Representatives from the provider group hope that coming to a consensus about a diagnosis and treatment plan with patients will also eliminate the use of defensive medicine. If patients knowingly agree to their medical treatments and make educated decisions about which tests to undergo the probability of a lawsuit occurring will be lessened. Pre-planned compensation for instances when treatments legitimately go wrong could also reduce this risk. Arguably patients should receive some type of compensation for substandard care; however, this compensation could be set in advance (similar to a workers compensation plan) and not be subject to the randomness of the justice system.

Representatives from the hospital, business, insurer, and government groups believe that engaging in "best practices" through the use of evidence-based medicine can also help providers and hospitals manage costs. As described by the Center for Evidence-Based Medicine, evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.[61] It allows doctors to utilize the best available external clinical evidence from systematic research when developing diagnoses and advising treatments. Providers and hospitals should integrate evidence-based medicine with their own clinical expertise and apply it to their patients' unique biology and circumstances. "Best practices" uses evidence-based medicine to determine the most cost effective way for providers and hospitals to deliver healthcare by helping to eliminate the use of unnecessary tests and procedures when treating patients.

Providers and hospitals should also work to lower their administrative costs through the use of electronic exchange. Representatives from the hospital, provider, and insurer group argue that the amount of paperwork in the current system creates major inefficiencies which could be remedied through the real-time transfer of medical records. Changes also need to be made in the medical system that will encourage more students to go into medicine, particularly primary care. Representatives from both the provider group and the consumer group made that point that the current physician infrastructure is not big enough to handle the number of patients already in the system, much less the increase that would come from lowering the uninsured rate. Even with the University of Utah's Medical School, Utah has been a net importer of physicians for years and the current shortage is only going to get bigger as most physicians in the state are getting ready to retire and the time to train new physicians is lengthy. One solution may be to expand the use and abilities of Nurse Practitioners.

Consumers: One of the keys to increasing personal responsibility in the health system is having consumers be more accountable for their health. Consumers need to engage in preventive care by regularly seeing their doctors for routine checkups. They need to be proactive about monitoring their health and get care early when complications arise. Eating well, exercising often, and refraining from risky behavior can help reduce the possibility of illness or injury in the long run.

Representatives from all groups feel that in order for a market-based system to work, consumers need to be better educated about the health system and play a more active role in their healthcare decisions. They need to be aware of both the costs and benefits of treatments and engage in more open dialogue with their physician and their insurer. This dialogue will allow consumers to be part of their healthcare decisions and decide about whether they really need a procedure or not. While consumers do not always have this choice (like emergency care from an injury) there are numerous occasions when consumers do have the discretion to decide whether they need or want treatment. For instance, consumers should carefully consider alternative options to surgery such as physical therapy and medication. Most of the time the outcomes of these treatments are the same, but many people don't realize that they have a choice because they simply aren't informed about the different outcomes.

Most of these representatives also believe consumers need to have more choice in the insurance policy they use and the physicians they see. In order to make wise choices, consumers need to be educated about the importance of insurance and know what type of insurance is best for their health history. They also need to be educated about the type of doctor they are seeing, what his or her training is in, and

where that training is from. Having people make educated decisions about their healthcare not only benefits the individual, but benefits society because one person's poor health decisions can affect the cost to everyone else.

The goal of consumer choice is that it will lend itself to individual responsibility. The one concern with this theory is that it won't be effective unless it is coupled with an individual mandate. An individual health insurance mandate will ensure that everyone is participating in the healthcare system and avoids the problems associated with providing uncompensated care. While some people are opposed to the term "mandate," a few of the stakeholder representatives feel it is important to recognize that mandates already exist in terms of workers compensation and auto insurance. Many representatives of the input groups felt that without a mandate, or some kind of financial consequence for not having insurance, then there will be little cost savings in the area of uncompensated care.

Employers: While employers also need to be better educated about health insurance and healthcare decisions, representatives question the employers' role in real market-based reform. Several business and government representatives believe removing the employer from the system is beneficial because it puts the consumer in total control of their insurance and healthcare decisions. Purchasing individual insurance also allows insurance plans to be more portable which removes distortions the current insurance system has created in the labor market. About 60% of people currently receive insurance through their employer, meaning people must change insurance plans when they change employment.[62] People with severe illness or injury may be hesitant to change jobs for fear of not being able to get new insurance. This fear is compounded if the person is moving to a smaller company or staring their own business, which significantly reduces the risk pool and increases premiums. It was also pointed out by business representatives that rising insurance premiums also hurt businesses from a global economic perspective. Already having to compete with lower wages, employers are further disadvantaged by having to pay inflating health insurance prices.

Government: It is important to consider the government's role in market-based reform as well. Most stakeholder representatives acknowledge that even in a consumer-driven market system the government will still need to provide a safety net for the segment of the population that will not benefit from market solutions. A market-based system will never be able to lower healthcare costs enough so they are affordable for everyone. While this implies the government's role may not change much from what it is now, representatives feel it is important to acknowledge that market-based solutions may increase the number of people utilizing public programs, and if universal coverage is a primary goal, it may be necessary for the government to expand existing public programs to cover the uninsured so uncompensated care costs are contained.

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 remain questions as to how, exactly, the market can realign the stakeholders' incentives and if the market can align the incentives in a way that is beneficial to everyone. A few of the stakeholders who were interviewed felt ethical issues related to the healthcare system may prevent it from moving to a true market system. For instance, is it fair to let the market determine who can and cannot receive medical treatment? The Agency for Healthcare Research and Quality found that 5% of the population accounts for 49% of total health care expenses.[63] Is it then fair to exclude or limit the use of this 5% in order decrease total costs? Or what about the fact that an enormous amount of healthcare dollars is spent on maintaining a person's last few years of life (it is estimated that about 30% of total Medicare dollars each year are spent on last years of life care).[64] It would be difficult to tell the elderly that in terms of their life value, the benefit of them getting treatment may not be worth the cost. It would be even more difficult to deny care to the chronically ill because their treatments are too expensive and contribute to rising healthcare inflation.

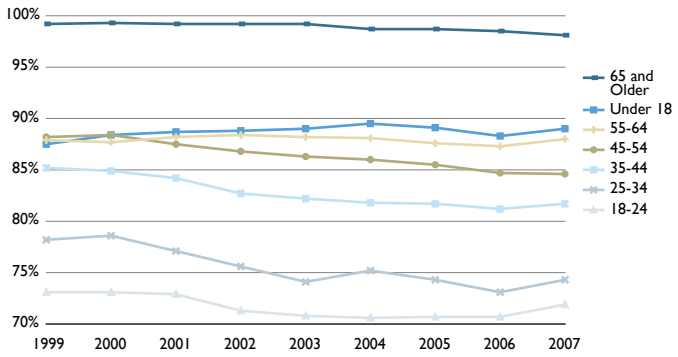
4. Affordability

Another theme that arose from the stakeholder discussions was the concept of affordability. One of the foremost problems with the current health system is that health insurance and healthcare is simply not affordable. It is not affordable for small businesses to provide their employees with 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 question then is—how can coverage become affordable?

Representatives from the consumer group argue that lowering healthcare costs is not the same as making healthcare affordable. While lowering costs may address the crowding out problem for those at the upper end of the income scale, it will take a major a reduction in costs to help those who cannot afford health insurance without some sort of government assistance. If a market system is created that only allows wealthy and healthy people to participate then it will lead to increasing costs in the long run through the continuation of cost shifting. In the current system, the largest group of the insured is those who have employer-based coverage, while the second largest group is those on government-based programs such as Medicaid or Medicare. Both of these groups receive a subsidy (the first through their employer and the second through the government), and most people on these insurance plans would not be able to afford insurance without the subsidy.

About 80% of workers with single coverage and 94% of workers with family coverage contribute to their total insurance premium. The average annual worker contributions for single and family coverage are $694 and $3,281, respectively, and these are about 10% higher than the amounts reported in 2006 ($627 and $2,973).[65] If workers were not receiving a subsidy from their employer then the cost would be much higher. The median family income in Utah is $62,432, while the average total healthcare premium for family coverage is around $11,000.[66] People can't afford to pay around 18% of their income to insurance and still be able to afford rent, food, childcare, etc. Some reform efforts that remove the employer from the system envision the employer increasing workers' pay by the same amount the employer contributes to the health insurance premium. Without other adjustments in the health system industry, however, the growth of health insurance premiums will likely continue to outpace the growth in wages. This means employees will begin to bear larger portions of their premium than in the current system. Without a subsidy, small decreases in insurance costs will do little to fully address the problem

Figure 12: Percent of Population Covered by Private and/or Government Health Insurance, by Age Group, 1999-2007



Source: Census.

of access.

For instance, it is often stated that of those who currently do not have insurance in Utah, one-third are "young immortals" (young, healthy adults who choose not to have insurance because they see no immediate benefit from the cost), one-third are people who can currently utilize government programs but are not enrolled, and one-third are people who are simply cannot afford coverage. Lowering costs may increase access for these "young immortals" and would therefore theoretically increase insurance pools and lower costs for all consumers because "young immortals" use the least amount of medical services. The real question, however, is whether these costs will be reduced enough so that those who truly need insurance, but can't currently afford it or are denied coverage, can get insured.

Without making healthcare truly affordable, the impact of lowering costs may be minimal, especially if the government imposes an individual insurance mandate without appropriately defining affordable coverage. The community input workgroup suggests that an independent commission conduct an affordability study for Utah's market. The study would determine the percentage of household income that can be reasonably devoted to healthcare while still having sufficient income for other basic necessities.[67] It would not only analyze the cost of premiums, but take into account out-of-pocket costs, co-pays, and deductibles. The results of the study will give policymakers a baseline understanding of what is truly affordable and where the proper boundary should be made between private and public programs. The workgroup felt that, without this affordability study, the bar may be set too high and attempts to lower costs would have little effect as people either continue to remain uninsured or an increasing number of people begin to utilize public programs.

5. Potential Tradeoffs Among Cost, Quality, and Access

One of the overarching goals 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, such as practicing evidence-based medicine, will decrease the cost of healthcare by improving efficiency in the health system, many stakeholders acknowledge that, while it is not necessarily a zero-sum game, there are some potential tradeoffs among the three pillars.

Quality vs. Cost

One potential tradeoff that was mentioned by both the hospital and the insurance representatives is how to encourage new innovation, and therefore maintain quality care, while keeping down costs. As mentioned above, one of the major misalignments of the current healthcare system is that it creates a system of moral hazard; relying on health insurance as a payment mechanism tends to induce consumption of services that would not otherwise occur.[68] Insulating patients and providers from the direct cost of health services guarantees that these services will be consumed in excessive quantities that generate marginal costs greater than the marginal benefits they provide. This in turn creates a system which favors cost-increasing technology rather than cost-saving treatments.[69] American medical innovation research and development spending more than doubled during the 1990s and accounted for over 11% of total medical device and diagnostics sales in 2005.[70] However, while many of these improvements are cost-increasing technologies, they are technologies which do save lives and improve the quality of medicine. From 1960 to 2000, average life expectancy increased by seven years, and 3.5 of these years are attributed to improvements in healthcare.[71] The question then remains as to how reform can reduce health system costs in ways that reduce the incentives for overutilization of medical technology, but do not hinder the availability life-saving medical advancements?

Access vs. Cost

A second potential tradeoff that was described by government, hospital, and business representatives is the tradeoff between access and costs. In order to increase access, it may be necessary to expand public programs, which comes at an increased cost to the state. In Massachusetts, for example, imposing an individual mandate resulted in more residents than predicted enrolling in Commonwealth Care—the state's subsidized insurance plan for adults who are not offered employer coverage and don't qualify for Medicaid. As a result, state spending projections have outstripped original funding estimates.[72] The question then remains as to whether there is a way to have universal coverage without an individual mandate, and is it possible to impose a mandate without expanding public programs?

Can Costs be Reduced in an Already Low-Cost State?

This brings up a third, potential but important, tradeoff mentioned by government, employers, and hospital representatives. This tradeoff stems from the idea that reform may actually be harmful to Utah, affecting its reputation as a low cost, high quality provider of healthcare. Data from the Kaiser Family Foundation show Utah has one of the lowest average individual insurance premiums in the nation ($3,849), one of the lowest ratios of state government health spending and total health spending as a percentage of GSP (2% and 12.1% respectively, see Figure 13), as well the lowest healthcare spending per capita ($3,972).[73] Utah is known as having one of the best-managed state governments in the nation. Utah's strict financial management, especially in regard to capital spending and debt service, has helped the state government achieve one of the highest overall performance grades in the nation, according to the 2008 Government Performance Project conducted by the Pew Center on the States.[74] The health system industry in Utah is also currently leading the nation in electronic billing. It is one of five states with an operating state-level health information exchange (HIE).[75] Utah's HIE is run by the Utah Health Information Network (UHIN). UHIN is working toward moving the entire state over to a standardized electronic billing system by 2010, making Utah the one of the first states with this type of system.[76]

Figure 13: State Government and Total Health Spending as a Percent of GSP

State	State Government Health Spending as a percent of GSP	State	Total Health Spending as a percent of GSP
U.S. Average	**3.3%**	**U.S. Average**	**13.3%**
Mississippi	5.9%	West Virginia	20.3%
Maine	5.3%	Maine	19.4%
New York	5.3%	Mississippi	18.1%
West Virginia	4.9%	North Dakota	17.6%
Rhode Island	4.8%	Kentucky	16.9%
Hawaii	4.5%	Montana	16.7%
Louisiana	4.3%	Alabama	16.2%
New Mexico	4.3%	Rhode Island	16.2%
Pennsylvania	4.3%	Vermont	16.2%
South Carolina	4.3%	Pennsylvania	16.1%
Arkansas	4.1%	Missouri	15.7%
Vermont	4.1%	South Carolina	15.7%
Kentucky	4.0%	Florida	15.6%
Tennessee	4.0%	Tennessee	15.6%
Alaska	3.9%	Ohio	15.5%
Missouri	3.9%	Arkansas	15.4%
Alabama	3.8%	Oklahoma	14.8%
Montana	3.7%	Wisconsin	14.8%
North Dakota	3.5%	Nebraska	14.5%
Georgia	3.4%	Indiana	14.4%
North Carolina	3.4%	Kansas	14.4%
Minnesota	3.3%	South Dakota	14.4%
Nebraska	3.3%	Louisiana	14.2%
New Jersey	3.3%	Massachusetts	14.1%
Ohio	3.3%	New York	13.9%
Oklahoma	3.3%	North Carolina	13.8%
Wyoming	3.3%	Iowa	13.7%
Maryland	3.2%	Minnesota	13.7%
Michigan	3.2%	Michigan	13.5%
Oregon	3.2%	New Hampshire	13.5%
Washington	3.2%	Maryland	13.3%
Connecticut	3.1%	Idaho	13.0%
Texas	3.1%	Oregon	13.0%
Arizona	3.0%	New Mexico	12.6%
Kansas	3.0%	Washington	12.6%
Idaho	2.9%	Arizona	12.5%
Delaware	2.8%	Hawaii	12.5%
Florida	2.8%	Georgia	12.2%
New Hampshire	2.8%	Illinois	12.2%
South Dakota	2.8%	Connecticut	12.1%
California	2.7%	**Utah**	**12.1%**
Iowa	2.7%	New Jersey	11.8%
Wisconsin	2.7%	Texas	11.7%
Illinois	2.6%	Alaska	11.6%
Massachusetts	2.6%	Colorado	11.1%
Indiana	2.5%	California	11.0%
Utah	**2.0%**	Nevada	11.0%
Nevada	1.9%	Virginia	10.9%
Colorado	1.8%	Delaware	9.7%
Virginia	1.8%	Wyoming	9.4%

Source: Kaiser Family Foundation.

While many agree that now is the time for reform, a few of the representatives from the stakeholder groups mentioned that they are hesitant to act to quickly, not because they are resistant to change, but because they acknowledge that reform may actually damage Utah's favorable healthcare market. Some argue that Utah is not in the position to start dramatically lowering state healthcare-related costs, because the costs are already so low. The question that needs to be addressed is then whether the state of Utah is willing to undertake additional costs in order to increase access to healthcare? On the other hand, if Utah waits too long, changes could occur at the federal level that would not respect Utah's uniqueness. Because of this, some stakeholder representatives feel the sooner Utah is able to make real changes the more the state will be able to protect its residents', businesses', and health systems' interests.

Quality vs. Consumer Choice

A fourth potential tradeoff mentioned by some of the government, hospital, and community representatives is the tradeoff between consumer involvement and access to quality care. One of the major misalignments in current health system is the fact that consumers' healthcare choices are decoupled from the associated costs by the insurance industry. Removing the employer from the system, and decreasing asymmetric information is one way to get consumers more involved with their healthcare choices, which will hopefully in turn reduce overutilization and decrease costs. The concern with this theory is that once consumers are aware of the costs and have access to their healthcare funds through accounts like HSAs, they may delay care until absolutely necessary in order to save money. Such actions would reduce preventive care and increase emergency room visits, exacerbating the current problem. If people select health insurance plans solely on costs, the immediate cost savings may come as a detriment to their long-term health because they may not receive the benefits they need. Some stakeholders argue that too much shopping around for "bargain deals" could result in disrupted care. While this idea is speculative, it is important to acknowledge that there is a tradeoff between involving consumers with their healthcare and trusting them to make optimal choices.

6. The Process

A final issue of concern that was mentioned by nearly all of the stakeholders had to do with the health system reform process. The first concern about the process is that HB 133 doesn't provide the necessary mechanisms to keep the process moving after the task force is finished. The task force ends its work in November and many wonder who will be the leader of reform after it ends. The leader could be the Governor's Office or an independent commission, but the consensus is that something needs to be in place or there will be a natural tendency for all of the stakeholders to move back to the status quo. Representative Clark envisions health system reform to be a 10-year process, which is an appropriate timeline for reform of this size, but a long timeline makes it easy for the various stakeholders to become detached over time.

The second concern about the process that was mentioned by all of those interviewed is how to get the various stakeholders to change so real reform is possible. There are many people and industries with significant financial ties to the current system and because health system reform has the potential to change people's livelihoods, people are justifiably reluctant to reform. The Utah insurance industry, for instance, employs more than 2,400 people working for direct health and medical insurance carriers alone (this number does not include brokers); these are people whose employment could be drastically affected by health system reform.[77] While the first difficulty is getting people to work together, the second difficulty is combining everyone's ideas into one workable solution that reflects a balance of interests. Some stakeholders believe cross-stakeholder dialogue is enough to solve this problem, while other worry it is impossible to develop a solution that satisfies everyone.

The third concern that was mentioned about the process is where one gets the political will to do what needs to be done. Utah has a conservative legislature that will be resistant to reforms that require increased state funding or expansion of public programs. Stakeholders feel 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. It was also mentioned by some of the stakeholders that bipartisan support is needed for any health system reform to really work.

The final concern stakeholders had about the current process is how to define the big picture. Many stakeholders feel the current sentiment in the reform process is to tackle small items first and then go after the big picture. These stakeholders worry, however, that the preference for handling small changes is keeping those involved in the reform process

from focusing on the bigger challenges. Without the big picture it is difficult to know what reform should look like in the end and difficult to know when reform is successful. Obviously, there is no quick fix to health system reform, but without specific end goals it is difficult to make changes that constitute real reform.

CONCLUSION

Rising healthcare costs are increasing at a trajectory that is detrimental to the economy. Individuals and many employers have been unable to keep up with rising costs, forcing businesses to lay off employees or not provide insurance. This creates a negative feedback cycle as it increases the number of uninsured who then choose to utilize public programs (increasing the cost to the state) or go uninsured and utilize emergency room services (which increases healthcare costs and premiums for those insured). The general consensus of stakeholders in the industry is that the rising costs are unsustainable and now is the time for reform. Utah took its first steps to real systemic reform with HB 133. The goal of this bill is to make healthcare in Utah more accessible and more accountable in order to enhance and preserve the health of all Utah residents. It requires the Department of Health, the Insurance Department, and the Governor's Office of Economic Development to work with the Legislature to develop and implement the state's strategic plan for health system reform in the next ten years.[78]

Health system reform, however, 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 became clear that there are still many issues to be addressed before real systemic reform can take place.

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