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November 16, 2011

Senator John L. Valentine, Senate Chair
Representative James A. Dunnigan, House Chair
Business and Labor Interim Committee
Utah Legislature

Subject: Preliminary Annual Report of the Health System Reform Task Force

Senator Valentine and Representative Dunnigan,

During the 2011 interim, the Health System Reform Task Force has focused on three key issues:

(1) ongoing implementation of Utah-based health care reform;
(2) how to respond to the federal Patient Protection and Affordable Care Act and the federal Health Care and Education Reconciliation Act of 2010 (both referred to hereafter as the ACA); and
(3) how to constrain growth in health care spending.

This preliminary report summarizes the status of each issue.

I. IMPLEMENTATION OF UTAH-BASED REFORM

Prior to passage of the ACA, the Utah Legislature, state agencies, and private sector stakeholders developed initiatives intended to increase the availability of affordable health care coverage and constrain the rate of health care spending. These initiatives include the Utah Health Exchange, payment and delivery reform demonstration projects, an all payer claims database, and statewide standards for the electronic exchange of clinical health information (cHIE). Following passage of the ACA, the Legislature also initiated the development of a Medicaid waiver designed to realign provider and patient financial incentives and limit the annual rate of growth in state Medicaid expenditures. The status of each of these initiatives is discussed below.

UTAH HEALTH EXCHANGE This year marks the first time small employer groups have been able to purchase health insurance policies through the Utah Health Exchange (policies were available to only a limited number of employers during the 2009–2010 pilot phase of the Exchange). Since December 2010, enrollment has increased steadily from 11 employers and 380 covered lives to 196 employers and 4,893 covered lives (as of November 1). Exchange administrators expect that as many as 50 additional groups may enroll for coverage beginning January 2012.

The executive branch has begun a process of envisioning what the Exchange should do and how it should operate in the future.

PAYMENT AND DELIVERY REFORM DEMONSTRATION PROJECTS The pediatric medical home project is still moving forward, but the diabetes and pregnancy/delivery projects are no longer considered as relevant as they once were and are no longer progressing.

ALL PAYER CLAIMS DATABASE (APCD) Last year, the Utah Department of Health began publishing APCD data on the total cost of care for various health conditions. APCD data will be posted on the Utah Health Exchange beginning in 2012.

ELECTRONIC CLINICAL HEALTH INFORMATION EXCHANGE (cHIE) Standards have been developed for the statewide electronic exchange of clinical health information. Last year, regional cHIE pilots were implemented. Efforts continue to be made to increase the data available to health care providers through cHIE.

MEDICAID REFORM WAIVER The waiver was developed with stakeholder input and submitted to the U.S. Secretary of Health and Human Services July 11, 2011. Although development of the waiver was considered by the Health and Human Services Interim Committee rather than the Task Force, it is included here for completeness.

II. RESPONDING TO THE ACA

HOW UTAH'S EXISTING EXCHANGE FITS IN The ACA requires each state to establish and operate, either separately or together, two health insurance exchanges by January 1, 2014 — an American Health Benefit Exchange (AHBE) and a Small Business Health Option Program (SHOP). States may either create state-operated exchanges certified by the U.S. Secretary of Health and Human Services no later than January 1, 2013, or defer to the federal government to create and operate the exchanges. With minimal modification, the Utah Health Insurance Exchange will probably meet the SHOP requirements (federal rules are yet to be finalized). However, significant modifications will be required if the exchange is used to implement the 16 major functions required of an AHBE.

STATE EFFORTS TO ENSURE FLEXIBILITY Due to the uncertainty of an evolving federal regulatory landscape, states nationwide are struggling to understand the nature and impact of options available under the ACA. On top of regulatory uncertainty, the law is now before the Supreme Court of the United States. In this environment, representatives of Utah's legislative and executive branches, including members of the Task Force, have pressed federal officials repeatedly this year for timely regulatory guidance. They have also responded, both in person and in writing, to proposed federal rules on various topics, and made concrete suggestions that would minimize ACA implementation problems and protect future options for state-based reform.

ESSENTIAL BENEFITS PACKAGE One of the many significant regulatory decisions yet to be made is the definition of an essential benefits package by the U.S. Secretary of Health and Human Services. The package will establish minimum coverage for the ACA Medicaid expansion population (persons with incomes at 100% — 138% of the federal poverty level) and

for persons purchasing coverage through exchanges. If the Secretary implements recommendations by the National Academies' Institute of Medicine, states will have the option, within limits, of defining an essential benefits package. At this point, Utah is waiting to see how its state-mandated benefits (e.g., coverage of foods for inborn metabolic errors) will be treated under the essential benefits definition. If the benefits are adequately covered, the state will not have to take action. If they are not, the state will have to determine whether it is willing to pay for the increased cost of AHBE subsidies attributable to the addition of those benefits.

When the U.S. Secretary of Health and Human Services crafts an essential benefits package, data may be produced that will help states determine whether they wish to add additional benefits to the package. For this reason, and because specifics about the package are entirely unknown, an in-depth analysis of whether to require that any of Utah's mandated benefits be offered in the exchanges should wait for the Secretary's announcement. Meanwhile, the Task Force has received, or will receive today, testimony from persons who would like to see the following benefits covered by policies sold through an AHBE or SHOP: vision care, dental care, spiritual care, foods for inborn metabolic errors, and bariatric treatment,

AREAS OF INFLUENCE State policymakers have the potential to influence many other areas of ACA implementation. Some of these include:

- how the exchanges should be governed;
- whether the individual and small group markets are merged;
- what policies will be offered in the exchanges;
- whether the AHBE should include employers with 51 to 100 employees during 2014 and 2015;
- how market risk adjusters will function;
- how Medicaid eligibility will be determined;
- how the requirement for individual insurance coverage will be enforced; and
- how federal premium subsidies offered through the AHBE will be administered.

III. COST CONTAINMENT

OVERVIEW OF STRATEGIES During the 2011 interim, the Task Force reviewed reports by the National Conference of State Legislatures' on 15 state strategies for constraining growth in health care spending.

ON-SITE HEALTH CARE CLINICS The Salt Lake Chamber of Commerce reported that both self-insured and commercially insured businesses in Utah are starting to utilize on-site health care clinics.

WELLNESS PROGRAMS AND INCENTIVES Public Employees Health Program (PEHP) reported that:

- 68% of its enrollees have two or fewer medical risks and incur an average of $1,345 in annual medical expenses;
- 20% of its enrollees have three or four medical risks and incur an average of $5,497 in annual medical expenses; and
- 12% of its enrollees have five or more medical risks and incur an average of $16,242 in annual medical expenses.

In other words, enrollees with three or four medical risks are four times as expensive as enrollees with two or fewer risks, and enrollees with five or more medical risks are 12 times as expensive as enrollees with two or fewer risks.

PEHP, Regence BlueCross BlueShield of Utah, Educators Mutual Insurance Association, SelectHealth, and Humana reported on their use of employee wellness programs. Humana reported that one study showed use of its Vitality wellness program — which provides non-cash incentives based on the completion of wellness goals verified by electronic monitoring — resulted in a 45 percent reduction in insurance claim increases over a five-year period.

IV. FOR FURTHER INFORMATION

Please contact us or other members of the Task Force if you have questions about this report.

Sincerely,

Sen. Wayne L. Niederhauser
Senate Chair, Health System
Reform Task Force

Rep. James A. Dunnigan
House Chair, Health System
Reform Task force