# Utah Health Status Update:
## *Health System Reform*

January 2009 — Utah Department of Health

### Background

The 2008 legislature passed House Bill 133 as the centerpiece for guiding health system reform efforts. The bill passed both houses unanimously and was signed by Governor Huntsman on March 19, 2008. Some of the provisions of H.B. 133 that are already in progress include:

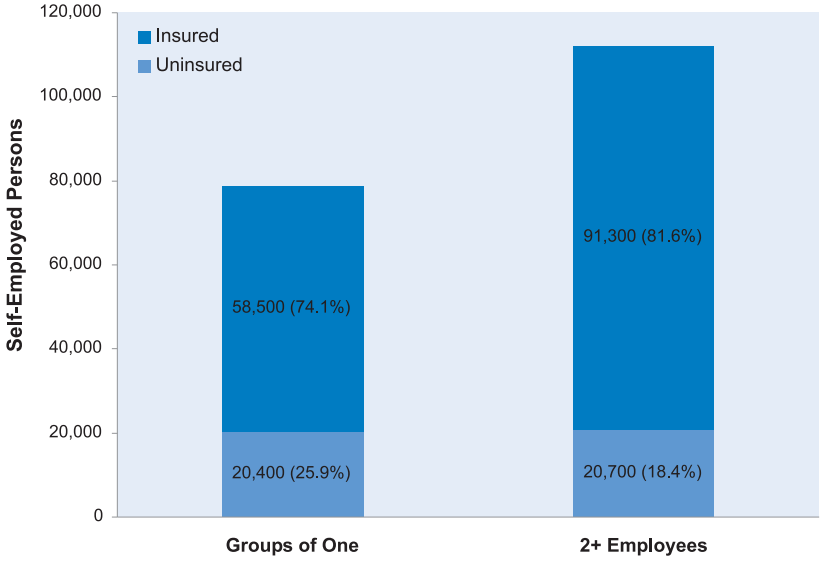
- Directing several executive branch agencies to work with the Legislature to develop a state strategic plan for health system reform
- Developing standards for health insurance applications and electronic submission mechanisms
- Raising the threshold at which an individual can be denied individual health insurance
- Changing the individual market to allow the Utah Premium Partnership (UPP) to be more effective in assisting uninsured low-income Utahns to obtain employer-based health insurance
- Directing the Department of Health to seek federal waivers to make UPP even more effective in supporting individual enrollment in private health insurance

H.B. 133 also laid out the blueprint for continuing reform efforts. The part of H.B. 133 known as the "Health System Reform Act":

- Creates the Office of Consumer Health Services in the Governor's Office of Economic Development and charges them to serve as the coordinating entity for the executive branch's efforts to assist the legislature in health system reform.
- Describes 16 elements that are required to be considered as part of the state's strategic plan for health system reform and establishes a time line for their implementation. These 16 points can be grouped into six areas of critical need.
- Establishes the Health System Reform Legislative Task Force to develop and implement the strategic plan.

### Insurance Coverage Among Self-employed Utahns

*Figure 1.* Health insurance coverage by self-employment status and number of employees, Utah adults aged 19-64, 2007




Source: Utah Healthcare Access Survey

This report gives an update on the activities of the task force as they have worked to develop the state's strategic plan for health system reform.

### Health Care System Reform Task Force

The task force included 11 members from both the Senate and the House from both parties. The task force met formally nine times in 2008 between April and December. However, recognizing that there would be broad interest in health system reform, the task force organized five working groups to consider and refine proposed elements to be included in the strategic plan. Each working group was guided by one or more legislators. Each group met several times and each reported to the task force on their progress at regular meetings.

### Result of the Task Force's Efforts

On December 16, 2008, members of the task force presented three draft bills that represent their legislative approach to health system reform for the upcoming session. This is a summary of the key provisions contained in those bills.

**Six Areas of Need**

**Insurance Reform**
**Transparency & Value**
**Personal Responsibility**
**Optimizing Public Programs**
**Maximizing Tax Advantages**
**Modernizing Governance**

<u>Draft Bill – Health System Reform – Insurance Market</u>: The overall impact of this bill would be to shift more of the responsibility for health care financing decisions to the consumer, while providing them with new tools and resources to be successful. The end goal is to achieve better outcomes through increasing the roles of market s and consumer choice in the industry.

The key elements of reform contained in this bill include:

*Defined Contribution System* – This bill creates a new type of health insurance market where employers will have the option to offer their employees a true defined contribution approach to health insurance benefits. The bill contains provisions that would allow all Utah employers to opt into a defined contribution arrangement. The bill would also require those employers to set up a Section 125 plan so that employees can pay their share of premiums with pre-tax dollars. It requires insurers to accept premium payments from multiple sources, and does not allow them to have employer contribution requirements.

*Portal Implementation* – The health insurance portal is a critical element in helping a defined contribution market to be successful. This bill contains language clarifying the role and giving the insurance commissioner authority to adopt standards for information that insurers will provide to the portal.

*Mitigates Adverse Selection* – Many people worry about how selection issues, where sick people buy in to a particular plan and healthy people do not, could affect changing markets. This bill contains provisions to mitigate this problem. The main provision is the establishment of a re-insurance pool for the small group market. This would help to spread the risk much more broadly. Also, employers participating in a defined contribution market will have to auto-enroll all employees, unless they provide documentation to opt out.

*Mandate Free Plans* – This bill also includes language that allows insurers to offer new types of plans that are much lower in cost than the current marketplace and do not have to include all of the state benefits and coverage mandates. Plans offered under this provision would have to include coverage for certain core medical services, such as inpatient and outpatient care, office visits, diagnostic tests, and pharmacy. Preventive care, including immunizations, would have to be covered without a deductible. The intent of this provision is to encourage insurers to be very aggressive in providing a low-cost health plan that will still appeal to consumers.

*Groups of One* – In the current marketplace, sole proprietors who have no employees do not have access to the small employer group market. This bill contains language that would allow all legitimate small businesses access to the same market, regardless of whether they have employees. As noted in Figure 1, 25.9% of the groups of one in Utah in 2007 were uninsured, representing over 20,000 individuals.

*NetCare* – This bill also contains language that creates a new type of lower cost health plan that would become an alternative to COBRA or mini-COBRA policies, which are often priced above a person's ability to pay. NetCare would also become the state's conversion policy for those exhausting their employer-related benefits, as well as becoming the state's standard for comparison.

*Broker Compensation Disclosure (Conflict of Interest)* – This bill also contains language that would address the inherent conflict of interest that arises when a broker or agent is being paid by the seller of the insurance plan instead of the buyer. The language in this bill would require all broker compensation to be disclosed to their clients before a sale is made.

Draft Bill – Health Reform – Administrative Simplification: This bill aims to get at the heart of the cost issue by getting providers and insurers to work together to achieve productive efficiencies in the health care system. Some key components of this bill include:

*Cooperation* – Insurers and providers will work together to develop standard formats for billing and claims, facilitating provider credentialing, and a meaningful prior authorization process.

*Standardized Insurance Cards* – The bill also contains a provision to speed the development of swipe card technology to provide real-time access to coverage and benefit information to patients and providers.

*Demonstration Projects* – Another cornerstone of the draft legislation is the establishment of a mechanism for providers and insurers to work together to set up large scale demonstration projects to investigate innovative payment systems, such as episodes of care, and health care delivery systems, such as medical homes.

*Other Efficiencies* – The bill also aims to promote and encourage providers and insurers to continue to look for and implement other efficiency-enhancing efforts in the provider-insurer relationship.

Draft Bill – Health Reform – Health Insurance Coverage in State Contracts: The third bill contains language that will require state contractors that provide significant design or construction services to ensure that their employees have health insurance coverage.


## January 2009 Utah Health Status Update

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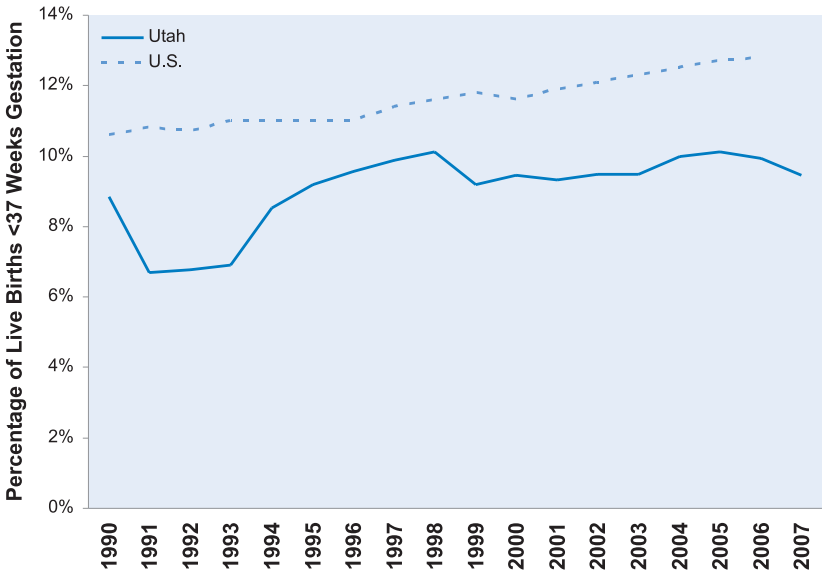
## Breaking News, December 2008

### Increased Rate of Premature Birth

Preterm birth (< 37 weeks gestation) is the leading cause of perinatal death in otherwise normal newborns. Preterm infants have increased risks for long term morbidities and often require intensive care after birth. Average hospital stays for preterm infants without complications are three times longer than a term infant, and for a preterm birth with complications, hospital stays are over eight times longer. The March of Dimes estimates that each preterm birth carries a cost of $51,600 for medical care, early intervention services, and special education.

Approximately half of preterm births in Utah are due to complications of the pregnancy (multiple births, placental problems, fetal distress, and infections) or maternal health factors such as high blood pressure or uterine malformations. The remaining preterm births have unexplained causes.

**Percentage Preterm Births, Utah and U.S., 1990–2007**




In an effort to reduce the preterm birth rate, emphasis is being placed on maternal preconception health to help women achieve optimal health prior to pregnancy by stopping use of tobacco, getting chronic diseases such as diabetes and high blood pressure under control, and being at an optimal prepregnancy weight. Early and continuous prenatal care is encouraged to detect problems that may arise during pregnancy. Standards for assisted reproductive technology should be followed to reduce the frequency of twins or higher order multiple pregnancies. Women should be educated regarding the danger signs of pregnancy and the importance of recognition and treatment for these symptoms. Pregnant women who have had a previous spontaneous preterm birth should be offered 17 hydroxyprogesterone caproate beginning at 16–20 weeks gestation which has been shown to substantially reduce recurrent preterm births. Progesterone supplementation has no beneficial effect in reducing preterm birth in women pregnant with multifetal pregnancies.

## Community Health Indicators Spotlight, December 2008

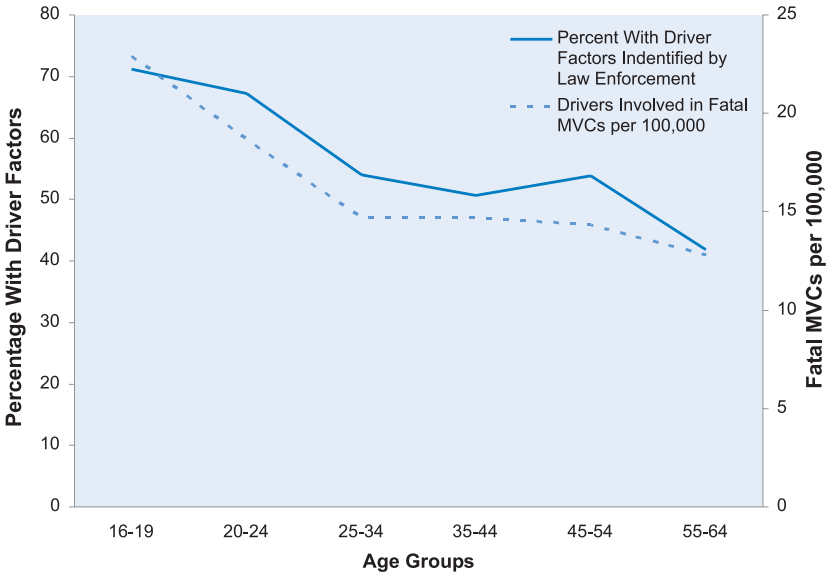
### Utah Teen Drivers Involved in Fatal Motor Vehicle Crashes, 2005–2007

Utah teen drivers aged 16–19 had higher rates of motor vehicle crashes (MVCs) resulting in one or more fatalities than any other age group under 65. There were 22.9 teen drivers involved in fatal MVCs per 100,000 population. For drivers between the ages of 20 and 64, the rate of fatal MVCs was 15.0 per 100,000 population. The 65+ age group was excluded because this group contained a large proportion of non-drivers.

According to law enforcement, drivers aged 16–19 had more driver-related factors/behaviors that contributed to fatal crashes than drivers of any other age group. Over 70% of teen drivers involved in a fatal MVC had an identified driver-related factor/behavior compared to 46.2% among drivers aged 20–64. The most common driver-related factors/behaviors for the teens were: speeding (28.4%), reckless/negligent driving (22.7%), and drowsiness (18.1%).

Visit http://health.utah.gov/vipp for more information on teen driving.

**Utah Drivers Under 65 Involved in Fatal MVCs, 2005–2007 (n=1078)**




Source: Fatality Analysis Reporting System

# Monthly Health Indicators Report

*(Data Through November 2008)*

| Monthly Report of Notifiable Diseases, November 2008 | Current Month # Cases | Current Month # Expected Cases (5-yr average) | # Cases YTD | # Expected YTD (5-yr average) | YTD Standard Morbidity Ratio (obs/exp) |
|---|---|---|---|---|---|
| Campylobacteriosis (Campylobacter) | 17 | 19 | 350 | 281 | 1.2 |
| Enterotoxigenic Escherichia coli (E. coli) | 9 | 6 | 87 | 101 | 0.9 |
| Hepatitis A (infectious hepatitis) | 0 | 1 | 12 | 22 | 0.5 |
| Hepatitis B (serum hepatitis) | 3 | 3 | 31 | 31 | 1.0 |
| Influenza† | Weekly updates at http://health.utah.gov/epi/diseases/flu | | | | |
| Measles (Rubeola, Hard Measles) | 0 | 0 | 0 | 0 | -- |
| Meningococcal Diseases | 0 | 1 | 9 | 7 | 1.2 |
| Norovirus | 0 | 1 | 9 | 12 | 0.7 |
| Pertussis (Whooping Cough) | 0 | 40 | 177 | 396 | 0.4 |
| Salmonellosis (Salmonella) | 39 | 16 | 337 | 270 | 1.2 |
| Shigellosis (Shigella) | 3 | 5 | 38 | 50 | 0.8 |
| Varicella (Chickenpox) | 73 | 81 | 718 | 605 | 1.2 |
| Viral Meningitis | 4 | 10 | 58 | 161 | 0.4 |

| Notifiable Diseases Reported Quarterly, 3rd Qtr 2008 | Current Quarter # Cases | Current Quarter # Expected Cases (5-yr average) | # Cases YTD | # Expected YTD (5-yr average) | YTD Standard Morbidity Ratio (obs/exp) |
|---|---|---|---|---|---|
| HIV | 34 | 21 | 82 | 60 | 1.4 |
| AIDS | 8 | 13 | 28 | 36 | 0.8 |
| Chlamydia | 1,471 | 1,166 | 4,449 | 3,327 | 1.3 |
| Gonorrhea | 111 | 168 | 390 | 491 | 0.8 |
| Tuberculosis | 5 | 10 | 19 | 27 | 0.7 |

| Program Enrollment for the Month of November 2008 | Current Month | Previous Month | % Change§ From Previous Month | 1 Year Ago | % Change§ From 1 Year Ago |
|---|---|---|---|---|---|
| Medicaid | 172,979 | 172,195 | +0.5% | 158,140 | +9.4% |
| PCN (Primary Care Network) | 17,508 | 18,780 | -6.8% | 20,204 | -13.3% |
| CHIP (Children's Health Ins. Plan) | 36,272 | 35,673 | +1.7% | 30,651 | +18.3% |

| Medicaid Expenditures (in Millions) for the Month of November 2008 | Current Month | Expected/ Budgeted for Month | Fiscal YTD | Budgeted Fiscal YTD | Variance - over (under) budget |
|---|---|---|---|---|---|
| Capitated Mental Health | $ 9.5 | $ 8.5 | $ 44.2 | $ 42.3 | $ 1.8 |
| Inpatient Hospital | $ 22.3 | $ 19.9 | $ 89.1 | $ 78.1 | $ 11.0 |
| Outpatient Hospital | $ 8.7 | $ 8.6 | $ 34.0 | $ 33.2 | $ 0.8 |
| Long Term Care | $ 6.2 | $ 15.4 | $ 71.5 | $ 75.7 | ($ 4.2) |
| Pharmacy | $ 11.1 | $ 13.5 | $ 52.7 | $ 60.2 | ($ 7.5) |
| Physician/Osteo Services‡ | $ 7.5 | $ 6.9 | $ 27.9 | $ 26.1 | $ 1.8 |
| TOTAL HCF MEDICAID | $ 131.3 | $ 134.3 | $ 570.2 | $ 580.7 | ($ 10.4) |

| Health Care System Measures | Number of Events | Rate per 100 Population | % Change§ From Previous Year | Total Charges in Millions | % Change§ From Previous Year |
|---|---|---|---|---|---|
| Overall Hospitalizations (2007) | 278,952 | 9.7% | -0.7% | $ 4,265.9 | +10.1% |
| Non-maternity Hospitalizations (2007) | 164,659 | 5.6% | -0.9% | $ 3,554.6 | +9.9% |
| Emergency Department Encounters (2006) | 670,168 | 24.4% | -1.9% | $ 667.2 | +20.6% |
| Outpatient Surgery (2006) | 304,511 | 11.2% | -3.7% | $ 1,020.9 | +7.7% |

| Annual Community Health Measures | Current Data Year | Population at Risk | Number Affected | Percent/ Rate | % Change§ From Previous Year |
|---|---|---|---|---|---|
| Overweight and Obesity (Adults 18+) | 2007 | 1,865,484 | 1,080,100 | 57.9% | +5.5% |
| Cigarette Smoking (Adults 18+) | 2007 | 1,865,484 | 218,300 | 11.7% | +19.4% |
| Influenza Immunization (Adults 65+) | 2007 | 227,890 | 173,700 | 76.2% | +5.7% |
| Health Insurance Coverage (Uninsured) | 2007 | 2,699,554 | 287,200 | 10.6% | -10.4% |
| Motor Vehicle Crash Injury Deaths | 2007 | 2,699,554 | 269 | 10.0 / 100,000 | -12.0% |
| Suicide Deaths | 2007 | 2,699,554 | 368 | 13.6 / 100,000 | -0.1% |
| Diabetes Prevalence | 2007 | 2,699,554 | 127,000 | 4.7% | +15.0% |
| Coronary Heart Disease Deaths | 2007 | 2,699,554 | 1,531 | 56.7 / 100,000 | -5.1% |
| All Cancer Deaths | 2007 | 2,699,554 | 2,547 | 94.3 / 100,000 | -5.1% |
| Births to Adolescents (Ages 15-17) | 2007 | 61,060 | 1,133 | 18.6 / 1,000 | +13.5% |
| Early Prenatal Care | 2007 | 55,063 | 43,728 | 79.4% | +0.5% |
| Infant Mortality | 2007 | 55,063 | 284 | 5.2 / 1,000 | +2.5% |
| Childhood Immunization (4:3:1:3:3:1) | 2007 | 51,449 | 40,200 | 78.1% | +14.7% |

† Influenza activity is sporadic in Utah. Influenza-like illness activity is below baseline statewide. As of December 10, 2008, 16 influenza-associated hospitalizations have been reported to the UDOH. More information can be found at http://health.utah.gov/epi/diseases/flu.

§ % Change could be due to random variation.

‡ Medicaid payments reported under Physician/Osteo Services do not include enhanced physician payments.

Notes: Data for notifiable diseases are preliminary and subject to change upon the completion of ongoing disease investigations. Active surveillance for West Nile virus has ended until the 2009 season.