Backgrounder

Published by The Heritage Foundation

No. 2453
August 19, 2010

Consumer Power: Five Lessons from Utah's Health Care Reform

Gregg Girvan

Abstract: *Obamacare is on the march, and state policymakers must decide by 2014 how they will respond to this encroachment on states' rights to control their own health insurance markets. The state of Utah has been on the reform path since 2005. With its system of defined* contributions *(as opposed to the standard defined* benefits*), a functioning health insurance exchange, and appropriate risk-adjustment mechanisms, Utah has given its workers the freedom to choose among many health plans with different levels of benefits, instead of remaining tied to the one-size-fits-all approach dictated by Washington. The Heritage Foundation has discerned five distinct lessons that the other 49 states can learn from Utah's experience. The time for learning—and for action—is now.*

Ready or not, governors and state legislators will soon have to make some big decisions about how they will respond to the Patient Protection and Affordable Care Act (PPACA), signed into law by President Obama on March 23, 2010.

The new federal health legislation is deeply unpopular, highly disruptive, unaffordable, and subject to extensive and growing litigation. As a result, it might be repealed or substantially altered by a future Congress.[1] The fact that the most significant provisions of the law do not take effect until 2014 means that the titanic battle over the shape and direction of America's health system has not reached a definitive conclusion but shifted into a new, and even more protracted, phase.

Talking Points

- State policymakers will soon have to make some big decisions about how to respond to the Patient Protection and Affordable Care Act (PPACA), signed into law by President Obama on March 23, 2010.
- The fact that the most significant provisions of Obamacare do not take effect until 2014 means that the titanic battle over America's health system has not reached a definitive conclusion, but shifted into a new, and even more protracted, phase.
- The state of Utah has tackled various areas of reform, including creation of the defined-contribution health insurance market (in contrast to the defined-benefit system), which allows businesses to offer workers the option of making a specified contribution in order to purchase health insurance of their choice.
- State lawmakers who want to maintain the independence of their state's health care system and fiscal future should consider Utah's recent experiences carefully and act accordingly.

This paper, in its entirety, can be found at:
http://report.heritage.org/bg2453

Produced by the Center for Health Policy Studies

Published by The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002–4999
(202) 546-4400 • heritage.org

The Heritage Foundation
LEADERSHIP FOR AMERICA

State insurance markets and Medicaid programs are at the center of much of this battle. How state officials respond to this challenge, within the limited window of the next few years, will not only determine how their constituents are affected, but also shape the terrain on which the next phase of the battle will be fought. Understandably, governors and state legislators may be uncertain about how to proceed.

One approach is to simply await further guidance and instructions from federal officials. But taking that approach would be tantamount to handing over their constituents' health care coverage and their state budgets to federal officials.

The alternative approach is for governors and state legislators to define the terms and conditions of health care reform within the borders of their states and force the federal officials implementing Congress's misguided, poorly designed, and badly written health legislation to respond to new facts on the ground. State lawmakers who take this alternative approach will likely be able to protect more of their constituents from the numerous adverse effects of Obamacare, while also increasing pressure on the next Congress to fix the large and complex problems its predecessor created.

State lawmakers who want to maintain the independence of their states' health care system and fiscal future in the wake of the new federal law should consider Utah's recent experience with health care reform. What makes Utah worth a closer look are not merely its specific policy solutions, but also the broader lessons that can be drawn from how Utah has conducted its health reform process.

Compared to most state health reform efforts, Utah's process is broader in scope, longer in duration, and more systematic in approach.

The Utah Approach

In 2005, Utah policymakers began to reform the medical malpractice system, expand electronic medical records and, most important, allow consumers, especially small-business employees, to purchase their own insurance within a health insurance exchange, all with little cost to the state. So Utah's reforms are more likely to put downward pressure on health care costs while empowering consumers to make their own health care decisions. Federal officials will have to confront this fact and acknowledge that their imposition of mandates and restrictive rules are likely to increase insurance costs for state residents while disrupting existing insurance markets. Mandates and restrictions almost certainly also reduce consumers' health plan choices and quality of care, especially if they are Medicaid patients.

Utah's specific model could yield positive results in other states, but states should adapt Utah's broader approach to their own individual markets and conditions. Utah's reform agenda provides a blueprint to empower health care consumers through conservative principles of free enterprise and consumerism. Utah's experience provides general lessons for every state about how to establish an affordable quality health care system.

Lesson #1: Take the Initiative

Utah started tackling health policy problems well before they reached crisis levels. The state's reform of its health care system is testimony to that foresight.

Then-Governor Jon Huntsman first called for major health care reform in 2005. At that time, Utah's economy was booming and health care costs remained the lowest of any state.[2] In the previous year, Utah's rate of uninsured was 10.2 percent—a low rate by national standards.[3] But it was unacceptable by Utah's standards.

By 2007, Huntsman tasked cabinet officials to explore health policy reform proposals in consultation with local and national experts. Because of this foresight, Utah will be ready to open its own health

1. Robert E. Moffit, "The Prospects for Ending Obamacare: Learning from Health Policy History," Heritage Foundation *Backgrounder* No. 2424, June 21, 2010, at *http://www.heritage.org/Research/Reports/2010/06/The-Prospects-for-Ending-Obamacare-Learning-from-Health-Policy-History#_ftn1*.
2. Office of the Actuary, Centers for Medicare and Medicaid Services, "US State Estimates by State of Residence—Personal Health Care," September 2007, at *http://www.cms.gov/NationalHealthExpendData/downloads/res-us.pdf* (August 9, 2010).

insurance exchange to *all* employers on January 1, 2012. Thus, Utah is far ahead of virtually every other state, increasing employer eligibility to participate in its own version of a market-based health insurance exchange.

Utah had time to enact health reform. With the enactment of the PPACA, other states have a small window of opportunity to pursue far-reaching changes. Most states will have up to two legislative sessions to enact their own health reform measures. States that press ahead with their own proposals now are far more likely to retain them, especially if they are prepared to resist federal encroachments on their legitimate authority when the federal health law is fully implemented. For those states that delay, the danger is that federal regulators will seize that opportunity to fill in the fine print with rules that are almost certain to stifle any state-led innovation, and thus any departure, from Washington's latest interpretation of what is or is not acceptable under the new law. Staying ahead of PPACA deadlines is absolutely critical if the states want to exercise any real measure of control over their health care systems.

State officials should challenge any rule they consider a violation of their traditional prerogatives under the Constitution, and force federal officials to justify their actions through open hearings, if necessary, while encouraging their congressional representatives to support their petitions in Washington.[4] In addition to joining the multi-state lawsuit challenging the constitutionality of the PPACA, Utah continues to press ahead with its reform measures. Utah lawmakers recognize they are not powerless against the federal government, and that they can deal with Utah's unique health problems better than Washington can, with its top-down one-size-fits-all approach. Utah's health reform demonstrates how other states can create a process for enacting consumer-based health reform of their own.

Utah began health reform with certain advantages. A key advantage was that it had the lowest health care costs per capita of any state. Another was a feature of its political culture: a civic inclination to solve emerging problems before real crises develop. State officials recognized a growing rate in the number of uninsured. There was still an opportunity to improve health care coverage for roughly 300,000 residents as well as further contain costs.

Lesson #2: Assess a State's Unique Needs and Circumstances

Utah lawmakers relied on data gathered by state officials in order to identify areas for improvement. Identifying the problems and key demographic groups to target for health reform took over six months. Cabinet agencies and senior staff in the governor's office saw the data-gathering and analysis stage as the critical first stage in developing targeted reform measures.

While the state's rate of the uninsured was below national levels, roughly 15 percent of the American population, Utah officials recognized that more than one of every 10 individuals in the state was uninsured and that that number was growing. Likewise, even though health care costs were still low by national standards, they were rising. State legislators also realized that if these trends were to continue, just like everywhere else in America, heavy health care bills could crush struggling families and businesses and cost increases would have a universally negative impact on the residents of the state.[5]

In the discovery phase, state officials found that the majority of the uninsured were families with at least one working adult. They also realized that the

3. Utah Department of Health, "Estimated Number and Percentage of Utahns Without Health Insurance Coverage," June 1, 2010, at *http://health.utah.gov/opha/publications/2009brfss/Cheatsheet_2009.pdf* (August 9, 2010). The estimate of uninsured in the Utah Healthcare Access Survey is considered to be more accurate than the Current Population Survey from the U.S. Census, in part because of a larger sample size.
4. Robert E. Moffit, "Revitalizing Federalism: The High Road Back to Health Care Independence," Heritage Foundation *Backgrounder* No. 2432, June 30, 2010, at *http://www.heritage.org/Research/Reports/2010/06/Revitalizing-Federalism-The-High-Road-Back-to-Health-Care-Independence*.
5. Utah Department of Health, "Utah Health Status Update: Enteric Diseases," May 2008, at *http://health.utah.gov/opha/publications/hsu/08May_EntericDis.pdf* (August 10, 2010).

growth rate in the number of uninsured was heavily correlated with employment in small businesses. In addition to the burden of health benefits management on business owners, rising premium costs priced many small businesses out of the small group health insurance market. Also, Utah's uninsured often lost coverage because of changes in employment status. Another large group of uninsured included healthy young adults; many were working part-time while in school or raising children.[6]

Once the state clearly identified the needs among its residents, the state's legislative and executive bodies outlined a vision for health system reform. Utah focused on the area of greatest need, the small-business community, and set out to help that group based on a traditional small government, patient-centered philosophy. In other words, its specific health care reform measures reflected the general political culture. Ideally every state should be able to do likewise; no two states are the same.

Lesson #3: Take a Collaborative Approach

Utah's vision depended on stakeholder engagement and investment.[7] Legislators relied on the expertise of physicians, hospital administrators, insurance carriers, and business owners. In addition, other groups, such as the United Way and the Salt Lake Chamber of Commerce brought relevant parties together to build consensus. Based on recommendations from these sources, policymakers crafted legislative language needed to address health insurance coverage gaps and other market inefficiencies.

Because change is often difficult, efforts to involve stakeholders presented challenges. Insurers, for example, expressed concerns about taking on an increased number of uninsured. After all, insurance premiums were likely to increase dramatically if a large proportion of the newly insured were sicker because of previously inadequate health care coverage. However, the state-specific data and analysis gathered by the state's executive branch and policymakers suggested that the uninsured were mostly young small-business employees that were healthy, part of the so-called "young immortals" demographic. The risk pools were likely to get healthier, if they were to change at all.

In addition to molding the state's health reform measures, Utah's effort to involve stakeholders extended the state's reform message to the electorate. If the medical and business communities supported the state's reform vision, they could educate patients and employees on the state's positive reform efforts. This general spirit of cooperation gave health reform traction in Utah.

The Utah legislature's enactment of health care reform was distinctive for several reasons. First, legislators from both parties were involved in multiple steps in the process and the final legislation was approved by overwhelming bipartisan majorities. Although Republicans dominate the legislature, lawmakers approved the 2008 Health System Reform bill 72 to 0 in the House and 26 to 0 in the Senate, while 21 of 22 Democrats in the House voted in favor of the 2010 health system reform amendments legislation.[8] Second, the legislators knew that health care reform would come over a series of many bills over many years, rather than in one monstrous bill. Third, the task force held regular hearings with business and industry leaders to gain valuable input. Considering the sequence of highly partisan maneuvers leading to passage of the PPACA in Congress, Utah had an exceptionally different experience.

6. Laura Summers, "Is Utah *Really* a Low-Wage State?" Utah Foundation *Research Brief*, June 5, 2008, at *http://www.utahfoundation.org/reports/?page_id=298#_edn2* (August 10, 2010).
7. Hearings, "Learning from the States: Individual State Experiences with Health Care Reform Coverage Initiatives in the Context of National Reform," Committee on Health, Education, Labor, and Pensions, U.S. Senate, 111th Congress, 1st Sess., April 28, 2009, at *http://help.senate.gov/imo/media/doc/Clark.pdf* (July 12, 2010). Information on this hearing can be found at *http://help.senate.gov/hearings/hearing/?id=0344d510-ca5d-d6b0-1be3-b9a8c9e2f845* (August 17, 2010).
8. H.B. 133 Second Substitute Health System Reform (Clark, D.), at *http://le.utah.gov/~2008/status/hbillsta/hb0133s02.htm* (August 17, 2010), and Health System Reform Amendments (Clark, D.), at *http://le.utah.gov/~2010/status/hbillsta/hb0294.htm* (August 17, 2010).

Lesson #4: Be the Driving Force to Reach Consensus

At first, Utah organized working groups of physicians, hospitals, insurers, and community groups to assist the state in health care reform legislation and implementation. When the groups submitted recommendations, it became apparent that each group saw another group as the cause of problems in the health care system. State leaders found a solution to lessen future gridlock. In 2009, a cross-section of stakeholders participated in one of three working groups with a specific task: (1) affordability and access; (2) transparency, quality, and infrastructure; and (3) oversight and implementation. Each health care sector worked together to provide sound recommendations in its assigned task area. Led by Utah Speaker of the House David Clark, task force leadership encouraged stakeholders to answer each question with the phrase "Yes, if…" rather than "No, because…."[9]

In spearheading the health system reform initiative, Speaker Clark insisted that the process be an educational one, aimed at securing a thorough understanding of, not just a superficial acquaintance with, the complex issues among legislators, state officials, and members of the health care community. This process was an essential ingredient of successful reform. Utah forged consensus toward a coherent health reform policy in large measure because a serious group of state legislators were willing to be educated about health reform and to engage stakeholders in a real give and take over the proposals and their trade-offs.

Utah created the Health System Reform Task Force in the 2008 legislative session. Its job was to draft proposals for major reform, chiefly in the health insurance market. The task force consisted of a bipartisan panel of state legislators and senior executive staff that met regularly during the year's interim session to prepare additional legislation.

The effectiveness of the task force was enhanced by two key provisions:

First, the task force was allowed to include only those legislators who focused on the target demographics in the whole state rather than specific constituent interests. While this task force did not contain stakeholder representatives, legislators requested groups, such as physicians, hospitals, insurance brokers, and insurance carriers, to participate in other meaningful ways.

Second, the reform legislation included a special clause that repeals the task force each November, before the commencement of the following year's legislative session. In other words, the task force must be reauthorized each year by legislation, which creates a strong incentive for the task force to do its job effectively and quickly. If deliberation were to drag on in the task force, the state could refuse to reauthorize the task force for the following year.

Using recommendations of the Health System Reform Task Force, Utah crafted the bill language necessary to implement comprehensive health insurance market reform, as well as provisions for medical malpractice reform and administrative simplification.

Other states could benefit from assembling a strong legislative leadership committed to a multi-year process, no matter how they decided to organize it.

Lesson #5: Health Reform Must Be Incremental and Specific

Since late 2007, Utah has focused on insurance market reform by increments. In 2008, this meant creating the Utah Health Exchange, a one-stop shop for health plans in the state, similar to the functions of the travel Web site Travelocity, as well as authorizing the Health System Reform Task Force.

Then in 2009, legislation created the pivotal defined-contribution health insurance market (in contrast to the defined-benefit system), which allows businesses to offer workers the option of making a specified contribution in order to purchase health insurance on their own, rather than providing workers with a single and specified benefit level of health insurance. At this point, Utah worked to implement the legislation and hoped to test the defined-contribution market

9. *Ibid.*

within the Utah Health Exchange by the end of the year.

Finally, the 2010 legislative session showed Utah policymakers' consistent commitment to reforming the health care system. Legislators passed legislation authorizing specific corrections to address inefficiencies in risk adjustment of health insurance plans in the defined-contribution market.

Real health reform is an incremental process that requires patience and a willingness to adjust to changing conditions.

Direction of Utah's health reform implementation is from a variety of agencies, from the state's insurance commission to the state's department of health. With only two state officials, the Utah Office of Consumer Health Services is responsible for the administration of the exchange. Utah health reform measures have undergone testing phases in order to discover potential weaknesses before full implementation.

As a key component of Utah health reform, the Utah Health Exchange operates as an Internet portal for employers, employees, and insurers to meet together in a health insurance marketplace. The state rigorously tests the portal for functionality. In August 2009, the Utah Health Exchange's "limited launch" gave officials valuable feedback from over 100 small-business companies.

As a result of the limited launch, officials discovered a significant problem facing the defined-contribution health insurance market: irregular premium rates. Compared to insurance plans outside the exchange, some premiums were higher while others were lower. Such variation in premiums suggested possible adverse selection problems. If left unaddressed, inefficiencies in the market could allow a single dominant insurer to force other carriers out of the exchange, or cause the exchange to fail altogether. Additionally, officials found that the universal insurance application was too complicated for many respondents.

After further study, the tests revealed different risk-rating practices for plans inside the exchange than outside the exchange. In addition, employers that previously provided workers with a defined-benefit plan were considered a new employer group when attempting to switch to the defined-contribution market; such a rating subjects employees to premium rate increases. The 2010 health system reform legislation addressed and corrected many of these structural problems in the exchange's defined-contribution health insurance market.

The state will conduct more tests of the health insurance system and the exchange. At the request of larger businesses, the exchange will also administer a pilot opening for large employers. Following the large-employer pilot program, the exchange will open to all small businesses. Finally, all large employers not included in the pilot are eligible to enroll in the exchange beginning in January 2012.

While the Utah Health Exchange begins open enrollment for small businesses in 2011, Utah will continue testing the exchange's functionality as well as the effectiveness of the defined-contribution health insurance market. In other words, Utah officials are willing to adjust the system as often as needed to ensure health system reform is a reality for all Utahns. Utah's approach is a great example to both the federal and state governments: real health reform is an incremental process that requires patience and a willingness to adjust to changing conditions.

As the Utah state government continues to authorize the Health System Reform Task Force and seeks input from the business community and health care shareholders, state legislators will gain more information, and will implement and test policy options vigorously, building consensus in a step-by-step approach to patient-centered reform.

Reform Results: Power to Patients and Consumers

As Utah legislators and stakeholders worked together, they formulated a set of ideas in accordance with Utah's consumer-centered vision. These ideas included defined-contribution health insurance markets, where employers contribute monetary funds toward the employee's choice of health plan; premium aggregation, where employees can combine multiple funds toward premiums; and

The Heritage Foundation LEADERSHIP FOR AMERICA

sound risk-adjustment principles, which limit adverse selection and maintain stable premium rates. Reforms such as these, tailored to the specific needs of the specific state, can build on positive aspects of health care systems while correcting inefficiencies stacked against consumers. Pursuant to Utah's vision of a consumer-controlled health system, Utah chose to empower private businesses to implement a variety of reform proposals.

At the heart of the Utah health system reform is transformative reform of the health insurance market, which works alongside the traditional insurance market rather than disrupting it. This includes introduction of the defined-contribution health insurance market, and the development of the Utah Health Exchange.

The insurance market reform proposals are then strengthened by introducing a premium aggregator, set to combine contributions from multiple employers, and an enhanced risk adjustment system, designed to reduce adverse selection problems and stabilize premium prices in and out of the exchange.

At the heart of the Utah health system reform is transformative reform of the health insurance market, which works alongside the traditional insurance market.

Utah gives consumers more choices by allowing them to purchase their own plans and take those plans from one job to the next. By owning the plan, consumers can make health care decisions with their doctors, rather than allowing a third-party government payer to sully the doctor–patient relationship through antiquated and often inadequate payment reimbursement. The enhanced competition between insurance carriers in the Utah Health Exchange puts downward pressure on the cost of insurance premiums. These points underscore Utah's philosophy that consumer engagement is the best way to create an efficient health care system.

Using Defined Contributions. Offering additional health insurance options is the foundation of Utah's health system reform. Current federal law treats the value of employer-sponsored health insurance as tax-free income to workers. As a result, most American workers obtain health benefits through an employer, and most of these benefits are offered as defined-benefit health insurance: The employer specifies the benefits package and determines the level of premiums that workers pay.

For employees, there are drawbacks to the traditional health benefits package. Employees often do not have a choice of benefits. In fact, 86 percent of firms offer only a single plan.[10] Additionally, the employer owns the plan, requiring the employee to consider coverage options offered by prospective future employers should the employee desire to change jobs.

For most businesses, especially those with 50 or fewer employees, defined-benefit health insurance has become too costly and unpredictable. Employers must also deal with the hassle of offering and administering benefits.

Uncertainty is the bane of business. Every business wants to know how much operations will cost in the short and long term. Many small businesses, including Utah's, are finding it harder to predict the rising cost of health benefits. Therefore, they face a set of unsavory options, including: paying excess costs with funds that would otherwise increase wages, requiring employees to pay a larger share of premiums or co-payments, or dropping health insurance benefits altogether. If there was a way for companies to provide health insurance benefits with cost predictability, more companies would participate in health benefit programs in order to recruit talented employees.

Defined-contribution health insurance is designed to correct these inefficiencies that commonly plague state health insurance markets. The employer and employee agree to a predetermined amount the

10. Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits 2009 Annual Survey," September 15, 2009, Exhibit 4.1, "Among Firms Offering Health Benefits, Percentage of Firms that Offer One, Two, or Three or More Plan Types, by Firm Size, 2009," at *http://ehbs.kff.org/?page=charts&id=2&sn=19&ch=1048* (August 10, 2010).

employer will contribute to the employee's health insurance benefit. The employee is then free to purchase a health insurance plan in the defined-contribution market that fits his or her needs.

Utah's defined-contribution health insurance market meets the needs of its diverse workforce. Employees and their families retain flexibility in health coverage choice, including the option to switch plans as the need arises. Employees who desire more generous benefits for themselves and their families can spend more out of pocket to make up the difference. Alternatively, they may choose a high-deductible plan with most or all of the premium costs paid by the employer contribution. These plans are more likely to attract young, healthy workers between the ages of 18 and 34, who accounted for 45.9 percent of Utah's uninsured in 2008.[11]

Utah designed the defined-contribution market to be transparent; as a natural consequence of the market's design, consumers know how much insurance plans cost because they have to make the final health insurance purchase. Utah law also requires insurance brokers to disclose their commissions and compensation associated with each plan purchase.[12]

With Utah's defined-contribution arrangement, employers have a stress-free way of providing health coverage because they no longer have to search for health plans. Eventually, employers will be able to offer part-time or seasonal workers the option of a prorated monetary contribution. In any case, the businesses will be able to predict health benefit costs each year.

The defined-contribution market is a great example of consumer-focused reform because the worker becomes the owner of the health plan he chooses. As more employers participate in the new market, employees will be able to take their health plans with them from job to job. The insurance-plan administrators will no longer be hampered by government demands, especially in deciding whether a particular procedure or test is permitted due to cost. As the direct purchaser, the consumer is in a better position to know what terms and conditions are satisfactory. This means that all health care decisions are made within a private contract with insurers, and beyond that, within the doctor–patient relationship.

In sharp contrast to Washington's passion for centralized control, reinforced by new federal regulations, uniform benefit designs, and employer coverage mandates, Utah's defined-contribution option empowers consumers by accomplishing three goals: (1) it increases the number of insured with premium assistance from employers, (2) it increases health plan portability, and (3) it improves the quality of medical care by strengthening the doctor–patient relationship.

Expanding the Utah Health Exchange. As the state's new online health information portal, the Utah Health Exchange serves three purposes:

1. Provide consumers with information on health care financing;
2. Provide a means to compare and purchase health insurance policies; and
3. Provide a standardized enrollment system, facilitated by a universal insurance application.

The exchange will be the central clearinghouse for health insurance in the state, from traditional defined-benefit plans to new defined-contribution plans, from traditional benefits packages to high-deductible plans with health savings accounts. This fall, the exchange's defined-contribution market will feature five insurance carriers, with an anticipated offering of more than 100 unique plans.

Since consumers search out the plans that fit them best, insurers are forced to compete for every consumer rather than negotiating with employers. Not only is there more pressure to keep premium prices low, there is also an incentive to offer more attractive benefits. The goal is to provide better

11. Utah Department of Health, "2008 Utah Healthcare Access Survey Overview Tables," December 2009, Table 3a, "Percentage of Persons With No Health Insurance Coverage by Selected Demographic Characteristics, Utah Residents, 2008," at *http://health.utah.gov/opha/publications/2008uhas/Overview_State_2008.pdf* (August 10, 2010).
12. Utah State Legislature, "H.B. 188: Health System Reform—Insurance Market," 2009 General Session, at *http://le.utah.gov/~2009/bills/hbillenr/hb0188.htm* (August 10, 2010).

value to consumers, not simply lower premium costs. The Utah Health Exchange is a promising reform idea for other states looking to increase insurance plan value and choice for consumers.

Although the PPACA also gives states the option to establish health insurance exchanges, the exchanges envisioned by Congress increase federal control over the health insurance system and funnel people onto Medicaid rolls. Obamacare would impose premium regulations on health insurance, reducing competition among insurers as many of them drop out of the business, resulting in even greater market consolidation. None of the federal measures will reduce insurance costs or provide better value for consumers. If they value choice and consumer value, states must choose an exchange model closer to Utah's model than to the congressional version embodied in Section 1311 of the PPACA. This does not mean that states must adopt the same design. Each state should follow Utah's lead by designing health reforms based on its specific needs and conditions.

The Premium Aggregator. The defined-contribution market within the Utah Health Exchange presented Utah with other opportunities to increase consumer value according to the state's unique workforce.

Utah ranks second nationally in the percentage of part-time workers (Minnesota is first), and is also second in the number of workers per household (Alaska is first).[13] This means that while many Utahns have multiple income streams and earn more in the aggregate than the national average, often they are not eligible for health benefits reserved for full-time workers. Many states will find that they have similar inefficiencies that could be solved by a premium aggregator function.

The premium aggregator greatly lowers insurance costs and increases insurance coverage in households with non-traditional employment situations. A couple, for instance, could combine the husband's employer contribution with the contribution obtained from the wife's employer, allowing the couple to pay less out of pocket, or to increase benefits. Each contribution amount is entered online in the exchange to simplify the premium payment process. Similarly, households with part-time income streams could combine contributions from multiple jobs.

The Utah Health Exchange is a promising reform idea for other states looking to increase insurance plan value and choice for consumers.

As Utah's new one-stop shop for health insurance, the exchange is a great central location to collect premiums. The ability to collect contributions from more than one employer is effective in making insurance more affordable for consumers. To accomplish this task, Utah contracted HealthEquity, Inc., to administer a "premium aggregator" function in the exchange. States desiring a premium aggregator may consider banks, health plan administrators, or payroll service companies to accomplish the same task.

The premium aggregator is especially effective in purchasing a defined-contribution plan. With traditional defined-benefit plans, the couple is normally faced with a difficult decision to choose one spouse's employer benefits plan or the other. Such a wasted opportunity can be avoided in a defined-contribution market with a premium aggregator. Premium aggregator functions increase plan affordability and coverage for nontraditional employment situations, benefiting consumers beyond the strengths of defined-contribution markets.

Risk Adjustment. The results from the Utah Health Exchange's 2009 limited launch revealed areas where the defined-contribution market can be improved, especially to correct selection effects precipitated by variance in premium rates when compared to the traditional defined-benefit market. Businesses considering enrollment in the new market complained that premium quotes for plans in the exchange were often higher than equivalent plans in the existing defined-benefit market.

Insurers returned differing premium quotes mainly for two reasons, both of which are attribut-

13. Summers, "Is Utah *Really* a Low-Wage State?"

able to inadequate risk-adjustment mechanisms. First, the insurance carriers evaluated many businesses as new employer groups entering the insurance market, even though they had existing traditional health insurance packages before registering with the exchange. If the employers instead were treated as renewing groups, they would receive more favorable risk ratings. Second, the carriers assigned different risk ratings to defined-contribution plans in the exchange when compared to the traditional defined-benefit market outside the exchange.

This problem is not unique to Utah. Other states, such as California and Texas, experienced similar variation in premiums when a parallel market was created.[14] The eventual collapse of those health reform initiatives resulted from adverse selection behaviors because rules governing the parallel health insurance markets were not uniform.

Normally, risk-adjustment mechanisms are adequate to mitigate pricing disparities within the same market. These previous experiences, however, show the need for the same health insurance rules between markets. Utah's 2010 Health System Reform legislation sought to harmonize underwriting rules for both the defined-contribution and the traditional defined-benefit markets to maximize the risk adjustor's intended effect.[15]

Lawmakers deferred the design of the risk adjustment mechanism to those with specialized expertise, such as insurance regulators and actuaries. Such experts are familiar with the health status of Utah residents and whether an insurance carrier has more or fewer persons of risk than the average. Currently, Utah adjusts risk on plans within the exchange both prospectively and retrospectively. This means that the adjustor assesses the potential risk of each insurer's pool before and after an individual enters the market, and then compensates the insurer accordingly.[16]

Utah's risk-adjustment method may change as it is applied to all health insurance markets. Defined-benefit plans may work best if adjusted retrospectively because the chance of acquiring a high-risk individual in the pool depends more on whether the company hires the employee, and is therefore enrolled in the defined-benefit plan. Prospective risk-adjustment may work better in the defined-contribution health insurance market because the chance of acquiring a high-risk individual in the insurer's pool depends on the employee's choice of the plan.[17]

More generally, insurers feel confident in a system with robust risk adjustment because they can focus more on managing risk rather than avoiding it. Utah's corrections to the risk-adjustment mechanism will therefore empower insurers to experiment with health plan offerings. With improved risk-adjustment mechanisms, Utah's consumers stand to benefit from greater choice and stable premium costs.

Conversely, adverse selection is all but certain under the new federal health care law, the PPACA. In the new health law, Congress wrote the rules in such a way as to invite massive gaming of the system. Because insurers will be required to accept any person regardless of health status, premiums will increase dramatically across the board. Those who typically opt out of health coverage, such as the young and healthy, will forgo coverage in greater numbers because premium costs will be higher than the mandate's penalty. As this group drops out of the health insurance market, the pool risk and expense will grow. Naturally, these selection deci-

14. Cappy McGarr, "A Texas-Sized Health Care Failure," *The New York Times*, October 5, 2009, at *http://www.nytimes.com/2009/10/06/opinion/06mcgarr.html?_r=1* (August 13, 2010).
15. Utah State Legislature, "H.B. 294: Health System Reform Amendments," 2010 General Session, at *http://le.utah.gov/~2010/bills/hbillenr/hb0294.htm* (August 10, 2010).
16. Edmund F. Haislmaier, "State Health Care Reform: An Update on Utah's Reform," Heritage Foundation *Backgrounder* No. 2399, April 9, 2010, at *http://www.heritage.org/Research/Reports/2010/04/State-Health-Care-Reform-An-Update-on-Utahs-Reform.*
17. Edmund F. Haislmaier, "State Health Care Reform: A Brief Guide to Risk Adjustment in Consumer-Driven Health Insurance Markets," Heritage Foundation *Backgrounder* No. 2166, July 28, 2008, at *http://www.heritage.org/Research/Reports/2008/07/State-Health-Care-Reform-A-Brief-Guide-to-Risk-Adjustment-in-ConsumerDriven-Health-Insurance-Markets.*

sions, precipitated by *de facto* price controls and mandates, will increase premium costs while decreasing plan choice.[18]

Individual states are better equipped than the federal government to create stable health insurance markets. States must assert their rights to control their own health insurance markets, including risk-adjustment mechanisms. States must do so before the federal government takes over, irrespective of the methods each state decides to employ. If not, the PPACA will cause each state's health insurance market to kill jobs and produce rampant adverse selection.

A Call to Action

With the enactment of the massive Patient Protection and Affordable Care Act, Americans can soon expect a storm of regulations and mandates. State officials are not powerless. But they must start to make tough choices in enacting meaningful health care reform, and outline an alternative to the federal government's top-down system of command and control.

Officials in different states should also cooperate with each other, sharing information and acting in concert to protect their common interests; this is the true spirit of federalism. The Department of Health and Human Services is poised to issue a litany of implementation instructions to the states over the next year. A bloc of states embracing customized, state-specific reforms have a better chance of pressing Health and Human Services to accept states' market-based designs for health system reform.

States must assert their rights to control their own health insurance markets, including risk-adjustment mechanisms.

Utah pursued a sound blueprint for health care reform—it is consumer-based, bipartisan, and adheres to the principles of individual freedom and prosperity. States can save time and effort by following a similar process, crafting a state-tailored health care system that increases insurance competition, coverage, portability, and value that serve the needs of each state's unique constituencies.

—Gregg Girvan is a Graduate Health Policy Fellow in the Center for Health Policy Studies at The Heritage Foundation.

18. Michael Cannon, "How Will Obamacare Affect Young Adults?" Cato Institute Summer Liberty Series Video Presentation, June 24, 2010, at *http://www.catooncampus.org/videos#/cat=summer-liberty-series&vid=how-will-obamacare-affect-young-adults* (August 10, 2010).