Health

Utah Citizens' Counsel Health Committee

Article 4. All Utahns have the right to comprehensive, quality health care at reasonable cost, and responsible societal efforts to help them achieve and maintain optimal well-being, with appropriate initiatives that encourage and facilitate healthy living and the prevention of disease, disability, and injury."

Introduction

U.S. economic strength is hobbled by health care costs nearly twice those of economically comparable OECD nations.[1] The extra cost equals a tax of 6-8% on all income, increasing costs of living and decreasing international competitiveness. This cost does not buy better quality of life or international reputation. Health in the U.S. falls below that in most comparable nations. Utah does better than the U.S. as a whole, but not as well as many nations. Utah has room to improve health while releasing funds for such critical needs as education. It already provides models to improve the quality and cost of U.S. health care, and can do more.

The next few years will test whether costs can be better controlled and at the same time health can improve. Will changes in health policy and health care decrease or increase costs? Will cost controls improve or harm health? How will Utah be shaped by, or shape, these changes?[2]

Last year's report referenced the *Health Field Concept,*[3] which enlarged the study of social and economic "determinants" (for example, pollution) of individual well-being and population health, to go beyond medical care. Consistent with this broader scope of health policy, the Citizens' Counsel this year amended Article 4 of its *Declaration of Utah Human Rights* to include other determinants of health. Our report this year expands the study of health determinants to broaden the tools used to improve health. Success requires connecting health improvement to other human rights[4] as well as understanding conflicts arising among them.[5]

A second theme this year concerns how those responsible for better health are influenced by the incentives of market forces, regulations, and evaluations. Among the most serious challenges to better quality and lower costs of good health are dysfunctional incentives that focus professional or institutional concerns too narrowly and that discourage care for patients most needing it.

A final theme is Utah's senseless failure to accept new federal funding of Medicaid. That failure unfairly treats disadvantaged people and does not intelligently manage Utah's financial health.

The Situation

This report last year included many rankings and indicators measuring costs,[6] access,[7] and quality.[8] This year we concentrate on two well-developed summative rankings. First, **Utah ranks among the very healthiest states, being among the top seven states for 25 years in the United Health Foundation's *America's Health Rankings*. Utah most commonly ranked first during the 90s and 5th to 7th in this decade, being 7th in the latest report.**[9] The ranking focuses upon measures of health, rather than measures of health systems--the professionals, hospitals, insurers, and others directly providing health care. A second ranking, focusing on state health system performance, comes from **the Commonwealth Fund's *Scorecard on State Health***

System Performance,[10] now in its fourth year, which compiles 42 indicators. The most recent *Scorecard* was the first that could "measure the effects of the Affordable Care Act's 2014 coverage expansions." It found "broad based improvements. On most of the 42 indicators, more states improved than worsened."[11] The ranking **placed Utah 18th nationally, though Utah was 12th in preceding years**. The scoring ranks Utah in the top five for lifestyle and avoidable use, and cost; about average for equity, prevention, and treatment; and 36th for access.

Utah's failure to immediately expand Medicaid lost a great opportunity. Leaders in Utah's House of Representatives refused to allow a floor vote on a 2015 bill for full expansion proposed by Governor Gary Herbert, passed by the Senate, and broadly supported by the public. Utah's uninsured rate of 10.5% is down from 14.6% in 2013[12] but is no longer lower than the national rate, which is now at 9.4%. Utah's ranking moved from 25th to 36th as other states used Medicaid expansion to expand coverage. What passed in 2016, needing federal approval, is incomplete yet extravagantly expensive, using traditional, rather than enhanced, federal financial support.[13] It requires more than half the state funding for full expansion but covers only a quarter as many citizens. It fails to address unfairness for the uninsured: Government already subsidizes everyone else, through direct subsidies or tax advantages, for their health insurance.[14] Besides extending coverage, Medicaid expansion improves cost management and total population health.[15]

Measuring health, outcomes of health care, and costs can guide improvements. But selection, calculation, and uses of measures deserve care. Utah's high ranking for healthy lives is no surprise, reflecting our life style, low poverty rate, and education. It is a credit to our people, to be built upon for a place to live and to do business. But such measurements of health may be misused by creating incentives for providers to improve their measures of costs and outcomes by selecting patients or enrollees on the basis of their health.

Problems with indicators as incentives increase with emphasis on transparency and competition in health care. Comparing healthcare systems by per-person costs and per-patient outcomes creates incentives to avoid paying for the care of those whose health is most vulnerable (the strongest determinant of insurers' financial success) and to avoid treating difficult cases (a determinant of quality outcomes). Other incentives affecting health care may help or hurt costs and quality. For example, is the establishment of quick and confidential exchanges of patient clinical records discouraged to protect competitive advantages of electronic-health-record vendors and/or hospitals? Is that in the interests of patients, the general public, or providers?[16] **Appropriate measures, including determinants of health other than medical care, can improve the use and guidance of health care.**

The health field concept[17] looks beyond medical care.[18] A study of health in England, over the last two centuries, found that changes in food supply, sanitation, and family size did more to improve well-being than did medical care.[19] Such comparisons raise useful questions. What costs should be included in comparing programs and determinants?[20] To what extent do the cost and quality of health reflect superior health care? What credit and improvement efforts should go to life style, environment, socioeconomic conditions, or public health?[21] Will improved patient-provider engagement build shared responsibility to manage cost and quality?[22]

J. Michael McGinnis et al.[23] and others[24] **expanded the determinants to five domains, concluding that "the health of the population is the product of the intersecting influences from the different domains**, influences that are dynamic and that vary in their impact

depending upon when in the course of life they occur and upon the effects of preceding and subsequent factors."[25] Each domain is briefly described below, showing McGinnis' estimated proportion of preventable deaths attributable to each domain,[26] though "more important than these proportions are [sic]the nature of the influences in play where the domains intersect."[27]

Genetics (30%) establish "predispositions to health or disease [taking] form at conception" to shape many things, from what we look like, to what diseases we might experience, and to our life expectancies.[28] Research for personalized medicine, for example, studies the genome for better interventions and specificity for individual vulnerabilities and treatments.[29]

Social Circumstances (15%) of our birth and lives shape educational attainment, employment, income disparities, poverty, housing, crime, and social cohesion. Arguably, the most consistent predictor of the likelihood of death in any given year is the level of education.[30]

Environmental Conditions (5%) include hazards that can directly impact our health and well-being: toxic agents, microbial agents, air and water pollution, hazardous waste, radiation, "chemical contaminants of food," safety related to buildings and roadways, "worksite conditions, and home hazards."[31]

Behavioral Choices (40%) are life styles directly impacting health and well-being and may be the most significant domain in terms of early deaths.[32] These choices relate to diet, physical exercise, sexual prudence, substance abuse, attitudes about safety; and stress management.[33]

Medical Care (10%) includes the work of physicians, nurses, dentists, other providers of health care, hospitals, extended care homes, rehabilitation facilities, and surgical centers.[34] "John Bunker . . . estimated that since 1950 our system of medical care accounted for about three of the seven years by which life expectancy has increased."[35] A growing emphasis upon patient engagement in health care takes on new dimensions if patients connect medical care to such other determinants of health as the environment.

More attention to these domains can guide improvements in cost analyses and comparisons. Utah's personal health expenditures per capita are only 73% of national rates. This is commendable, but who or what is to be commended: Utah life-style, management of Utah's health institutions, or what? From 2000 to 2014 the percentage never varied more than 3% from the 73% that marked both the beginning and end of this period, as expenditures for both Utah and the U.S. increased by 94% over these 15 years.[36] Medicare reimbursements, adjusted for age, sex, race, and local prices, show geographic variations large enough to study the determinants. In Utah's hospital referral regions, costs per person per year are: Ogden: $8,731; Provo: $9,397; Salt Lake: $8,480; the U.S. is $9,687.[37] Utah's "All Payer Claims Data Base," now in geographic detail, time series, and comparability, adds opportunity to identify determinants.[38]

Health costs are prompting a growing search for reforms, with Utah playing significant roles.[39] For example: (1) The *Harvard Business Review* used leaders from Intermountain Healthcare (reflecting the international standing of Brent James) and Harvard faculty[40] to compare "capitated payment" (payment per patient per month to emphasize efficiency of care coordination) and "bundled payment" (cost of all providers per incident to emphasize efficiency of specialization) as reforms to replace "fee-for-service billing" by procedure and provider.[41] (2) The University of Utah is expanding research and assessments in genetics, medicine, public

health, and dentistry to reduce costs and improve outcomes.[42] Cost accounting in a new application to three clinical projects (total hip and knee joint replacement, hospitalist laboratory utilization, and sepsis management) prompted changes in performance that appear to account for cost savings in the range of 10%.[43] An editorial reflection in *JAMA* concluded "The study . . . is an impressive and important step forward, not just for the University . . . but for the rest of US health care and other health care systems around the world that are focused on value. The findings offer proof of concept that improving value by patient condition can lead to lower costs and better quality—at the same time."[44]

Commendations

- Utah continues to be **among the top five states for healthy lifestyles and avoidable use, and cost of health care**.
- Utah **contributes to national innovations** to manage costs and quality.
- Utah's **capabilities of health-related research, to improve the economy and health of the state and nation**, are growing in depth of data and capacity for research at health departments, universities, and health institutions.
- In Utah, though perhaps more so in the U.S., there is new **recognition of the variety of human conditions and programs that influence, and are influenced by, health**.

Recommendations

- That the Utah Department of Health lead an **evaluation of incentives and engage the cooperation** of providers, payers, and the public to exercise responsibility, **as a community, to manage costs and improve health**.
- That **for Medicaid**[45] **and other health needs of those with low-income, Utah not defer action while Congress debates**. That Utah seize the day to do what can be done now, to prepare for what might become possible, and to improve other determinants of health to help those, mostly poor, who are not now eligible for subsidies given all others.[46]
- That Utah's health care community **establish a state-wide clinical-health-information-network**.
- That Utah's health care community **improve the measures of**:
  • costs, to include assessment of determinants,
  • costs, quality, and access, by hospital referral region,[47] not just by institution,
  • patient/physician engagement that is two-way and meaningful.
- That Utah's health care community apply a **broader range of determinants to**:
  • manage costs and improve health;
  • support public health programs;
  • encourage work-place involvement in employee and customer health;
  • improve connections of education and health.
- That to improve health, **implement the recommendations in the Environmental Health, Public Education, and Social Support sections of this report**.

Endnotes for Article 4 (Health)

[1] Comparing the economically advanced members of the Organization for Economic Co-operation and Development (OECD).

[2] Morone, a primary historian of the politics of health policy, described recent difficulties: "Partisan politics snarled both the passage and the implementation of the Affordable Care Act . . . Partisanship itself has been essential for American democracy, but American institutions were not designed to handle its current form—ideologically pure, racially sorted, closely matched parties playing by 'Gingrich rules' before a partisan media. The new partisanship injects three far-reaching changes into national health policy: an unprecedented lack of closure, a decline in the traditional political arts of compromise and bargaining, and a failure to define and debate alternative health policies." He further explained with two quotes:

> Let me warn you in the most solemn manner against the baneful effects of the spirit of party. . . . The disorders and miseries which result . . . always distract the public councils and enfeeble the public administration.
>
> George Washington, "Farewell Address," September 1796
>
> If we are able to stop Obama on this, it will be his Waterloo. It will break him.
>
> Senator Jim DeMint, July 2009

James A. Morone, "Partisanship, Dysfunction, and Racial Fears: The New Normal in Health Care Policy?" *Journal of Health Politics, Policy and Law* 41 (no.4) (2016), 827-46, accessed August 2016, doi:10.1215/03616878-3620965.

[3] Marc Lalonde, "*A New Perspective on the Health of Canadians: A Working Document*" (Ottawa, Department of National Health and Welfare, 1974).

[4] Examples this year include: education (management of health costs should be a major determinant of public and private financial resources to support education, and education is a primary correlate of healthy life styles); governance (campaign finance reform may be crucial for the correction of dysfunctional incentives affecting health care and health); personal security (public safety is a crucial and sought-after determinant of health); environment (disease prevention provides a primary justification for the priorities given to reducing air and water pollution and even for city planning [e.g., *Village of Euclid v. Ambler Realty Co.,* 272 U.S. 365 (1926)], accessed November 2016, https://en.wikipedia.org/wiki/Village_of_Euclid_v._Ambler_Realty_Co.); social services (health is a primary determinant of the need for economic and social safety nets, while poverty and behavioral health difficulties are important determinants of poor physical and behavioral health [James S. House, "Social Determinants and Disparities in Health: Their Crucifixion, Resurrection, and Ultimate Triumph(?) in Health Policy," *Journal of Health Politics, Policy and Law*, 41 (no. 4) (2016), 599-626, accessed August 2016, doi:10.1215/03616878-3620845.

[5] Sarah Marchand, Daniel Wikler, and Bruce Landesman, "Class, Health, and Justice," *The Milbank Quarterly* 76, (no.3) (1998), 449-468. The authors raise the question of whether socioeconomic disparities constitute injustice because (1) social inequality fails to maximize total community health, (2) unequal health is itself unfair, (3) justice requires emphasizing improvement of the health of the least advantaged group, and (4) justice requires giving priority to the sickest individuals.

[6] "Health," in *Standing Up for Utah's Needs 2015,* Utah Citizens' Counsel, 26, accessed October 2016, http://www.utahcitizenscounsel.org/.

[7] Ibid., 27.

[8] Ibid., 27-28

[9] "America's Health Rankings," accessed October 2016, http://www.americashealthrankings.org/explore/2015-annual-report/measure/Overall/state/UT.

[10] Douglas McCarthy et al., "Aiming Higher: Results from a Scorecard on State Health System Performance, 2015 Edition," *The Commonwealth Fund*, accessed December 2015, http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/dec/2015_scorecard_v5.pdf, Appendix Exhibit B1, 26.

[11] Ibid., 2.

[12] Ibid., 27.

[13] Some members of the Utah Legislature expressed concern that the enhanced financing provided under the ACA (Affordable Care Act, also referred to as "ObamaCare") for the Medicaid expansion population will be withdrawn.

However, there is no precedent for such a reduction in federal financial participation under the Medicaid or CHIP programs. Many states, however, are conditioning their coverage expansions on a continuation of the 90% federal financing. While the UCC agrees that it is very difficult to cut or eliminate Medicaid programs after an eligibility expansion, these are the hard decisions that the citizens of the state expect our political leaders to address. If such an automatic elimination of the expansion were required by a federal funding reduction, it would be up to a future legislature to decide through typical legislative processes the fate of the program, considering other state priorities and available state dollars,.

The financial benefits of expansions are coming more into focus as states gain more experience. Legislatures and governors have sponsored studies of the expansion, and other independent studies have been undertaken. Even though enrollment is higher than expected in many states, these studies still generally show positive economic benefits to the states. State experiences differ because states differ in program and implementation. We suggest that topics to which Utah should give further consideration are how changes in base programs could save state dollars and how the infusions of additional federal money for full Medicaid expansion compare with the economic development of other state programs. A discussion by Sven Wilson of the potential multiplier effects concludes, while "highly skeptical of (large) multipliers (commonly used, in) a full cost-benefit framework where the *direct* benefits of spending on health insurance is [sic]so high, these *indirect* benefits are hardly needed to tip the balance in favor of Medicaid expansion." Sven E. Wilson, "Economic Perspectives on Utah Medicaid Reform under the ACA,"28-9, accessed December, 2016, "https://medicaid.utah.gov/Documents/pdfs/MedExpansionOption/EconomicPerspectives.pdf, 28-9.

[14] Michael Stapley, "My View: Because We're All Dependent, Utah Should Pass Health Care Reform," *Deseret News,* July 19, 2015, accessed November 20, 2015, http://www.deseretnews.com/article/865632894/Because-were-all-dependent-Utah-should-pass-health-care-reform.html.

[15] McCarthy et al, "Aiming Higher," 6.

[16] Jordan Everson and Julia Adler-Milstein, "Engagement in Hospital Health Information Exchange Is Associated with Vendor Marketplace Dominance," *Health Affairs* 35 (no.7) (2016), 1286-293, accessed August 2016, doi:10.1377/hlthaff.2015.1215.

[17] "Health," in *Standing Up for Utah's Needs 2015*, Utah Citizens' Counsel (2015), endnotes 25, 34. This builds upon Lalonde, *A New Perspective on the Health of Canadians* (Ottawa, Minister of Supply and Services, 1974).The concept has ancient roots and various components of emphasis, such as the socioeconomic environment (House, "Social Determinants and Disparities in Health," accessed December 2016, doi:10.1215/03616878-3620845. The importance to health of socioeconomic conditions and disparities has a continuing though so-far relatively quiet exposition in the past half century. It is a concern of Lalonde's 1971 health field concept. As House reports, it was more specifically addressed in Britain in the "Black Report" commissioned by the Labor government and when completed delivered to the new Conservative government of Margaret Thatcher "which issued 250 copies on a bank holiday with a preface by the secretary of health that essentially said that the new administration was not sure it believed the commission's findings, and, even if it did, it could do nothing about them. Reissued by Penguin Press, the report became a sensation in social epidemiology in the United Kingdom and internationally." House, "Social Determinants," 608-09. It took on extended life in Europe in the 1990s as Margaret Whitehead and others reconfirmed and extended the findings, and was taken up in the U.S at a University of Utah conference that became the substance of an issue of *The Milbank Quarterly, A Journal of Public Health and Health Care Policy* 76 (no.3) (1998). By 2009 the report of the Robert Wood Johnson Foundation's Commission to Build a Healthier America could be summarized by House (above) as "the conditions in which people 'live, work, and play' shape their health far more than access to and utilization of modern medical care." House's 2016 article is part of a special issue of the *Journal of Health Politics, Policy and Law:* "Bringing the Social Sciences to Health Policy: An Appreciation of David Mechanic," 41(no.4) (2016).

[18] Laura McGovern et al., "The Relative Contribution of Multiple Determinants to Health," *Health Policy Brief* August 21, 2014, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=123.

[19] Thomas McKeown, "The Role of Medicine: Dream, Mirage, or Nemesis?" *Nuffield Provincial Hospitals Trust* (London, 1976) 178, accessed November 26, 2016, http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/The_Role_of_Medicine.pdf.

[20] Such measurements raise many questions of what to include. This increases the importance and difficulty of transparency about these choices and about the methods of measurement. The measurement of the value of good health carried to extreme could be the Gross Domestic Product, though even that would not include household and family efforts, voluntary unpaid work, or the beauty of healthy children and adults.

[21] McGovern et al., "The Relative Contribution."

[22] We believe there has been significant improvement in patient-provider communication and involvement. It is an active element of health care change. See for example Paul D. Cleary, "Evolving Concepts of Patient-Centered Care and the Assessment of Patient Care Experiences: Optimism and Opposition," *Journal of Health Politics, Policy and Law* 41 (no.4) (2016), 675-96, accessed December 2016, doi:10.1215/03616878-3620881. In Utah, a major effort to improve transparency and engagement is underway by HealthInsight.

[23] J.M. McGinnis et al., "The Case for More Active Policy Attention to Health Promotion." *Health Affairs* 21(no. 2) (2002) 78-93, accessed December 2016, doi:10.1377/hlthaff.21.2.78. McGinnis is a senior scholar at the Institute of Medicine and the executive director of its Roundtable on Value & Science-Driven Health Care. His career is summarized on Wikipedia, accessed October 31, 2016, https://en.wikipedia.org/wiki/Talk:J._Michael_McGinnis. See also McGovern et al. This brief points out that "While the five categories of determinants of health are generally accepted as the major contributors to health, recent research has suggested that other factors have a strong and unique impact on health and might be considered as possible mechanisms linking direct and indirect determinants, or as determinants in their own right. . . For example, stress appears to have a direct effect on health outcomes and may influence the way in which a person responds to other determinants." Some important efforts in the expansion of health determinants to include social determinants are:

World Health Organization, "Social Determinants of Health: The Solid Facts," 2003, accessed October 12, 2016, http://www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf?ua=1.

Robert Wood Johnson Foundation, "Beyond Health Care: New Directions to a Healthier America," April 2009, accessed October 12, 2016, http://www.rwjf.org/content/dam/farm/reports/reports/2009/rwjf40483.

Atul Gawande, "The Hot Spotters: Can We Lower Medical Costs by Giving the Neediest Patients Better Care?" *The New Yorker*, January 24, 2011, 41-51.

Paul Tough, "The Poverty Clinic," *The New Yorker*, March 21, 2011, 25-32.

A. Solar and E. Scali, "Social Determinants of Health 1," *WHO Paper Series,* 2010, accessed October 12, 2016, http://www.who.int/social_determinants/corner/SDHDP1.pdf?ua=1

A. Solar, and A. Irwin. "Social Determinants of Health 2," *WHO Paper Series,* 2010, accessed October 12, 2016, http://www.who.int/social_determinants/corner/SDHDP2.pdf?ua=1.

The growing attention given determinants is evidenced in the recent issue of *JAMA,* "Addressing Social Determinants of Health and Health Inequalities," 316 (no.16) (October 25, 2016).

[24] "The Relative Contributions of Multiple Determinants of Health Outcomes," *Health Affairs,* Health Policy Brief, August 21, 2014, accessed October 5, 2016, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=123.

[25] Institute of Medicine, Health and Behavior, *The Interplay of Biological, Behavioral, and Societal Influences* (Washington: National Academy Press, 2001).

[26] J.M. McGinnis et al., "The Case for More Active Policy Attention to Health Promotion," *Health Affairs* 21 (no. 2) (2002), 78-93, accessed December 2016, doi:10.1377/hlthaff.21.2.78.

[27] Ibid.

[28] Ibid.

[29] This is a focus of a program at the University of Utah, in a collaborative partnership with Intermountain Healthcare that, interestingly, is highly multidisciplinary: http://healthsciences.utah.edu/phc/.

[30] McGinnis et al., "The Case for More Active Policy."

[31] Ibid.

[32] Ibid.

[33] Ibid.

[34] McKeown, "The Role of Medicine."

[35] J. P. Bunker et al., "The Role of Medical Care in Determining Health: Creating an Inventory of Benefits," in *Society and Health*, B.C. Amick III et al. eds. (New York: Oxford University Press, 1995), 305-41.

[36] The Centers of Medicare and Medicaid Services, December 03, 2015, accessed October 11, 2016, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. Utah's 2010-14 values were estimated based on the national growth rates.

[37] "Total Medicare Reimbursement per Enrollee, by Adjustment Type" (data are for 2012), *The Dartmouth Atlas of Health Care*, accessed October 11, 2016, http://www.dartmouthatlas.org/data/table.aspx?loc=46&loct 2&ind=225.

[38] Data being collected and assembled by the Utah Department of Health. Further information available from Norman Thurston, the Office of Health Care Statistics, Utah Department of Health, Salt Lake City, http://stats.health.utah.gov/.

[39] For examples, see:
Robert Wood Johnson Foundation, accessed December. 2016, http://www.rwjf.org/;
Kaiser Family Foundation, accessed December 2016, http://www.kff.org;
Commonwealth Fund, , accessed December 2016, http://www.commonwealthfund.org;
Journal of Health Politics, Policy and Law, accessed December 2016, http://jhppl.dukejournals.org, such as August 2016;
Health Affairs, accessed December 2016, http://www.healthaffairs.org/, such as July 2016;
Brookings Institution, accessed December. 2016, http://www.brookings.edu/topic/health-care-industry/;
American Enterprise Institute, accessed December 2016, http://www.aei.org/policy/health-care/.

[40] David Leonhardt, "Making Health Care Better," *New York Times Magazine,* November 3, 2009*,* accessed November 29, 2016, http://www.nytimes.com/2009/11/08/magazine/08Healthcare-t.html.

[41] Brent C. James and Gregory P. Poulsen, "The Case for Capitation," *Harvard Business Review*, July-August 2016, 102-11; Michael E. Porter and Robert S. Kaplan, "How to Pay for Health Care," *Harvard Business Review*, July-August 2016, 88-100.

[42] The University of Utah has established a Health Policy & Health Economics interdisciplinary faculty cluster, accessed December 2016, http://www.utah.edu/faculty/hphe/, and in Health Sciences a related section on Health Economics in the Center for Clinical & Translational Science, accessed December 2016, http://medicine.utah.edu/ccts/population-health/health-economics/index.php.

[43] Vivian S. Lee et al., "Implementation of a Value-Driven Outcomes Program to Identify High Variability in Clinical Costs and Outcomes and Association with Reduced Cost and Improved Quality," *JAMA* 316 (no. 2) (September 13, 2016), 1061.

[44] Michael E. Porter and Thomas H. Lee, "From Volume to Value in Health Care: The Work Begins," *JAMA*, 316 (no. 2) (September 13, 2016), 1048. Significance also reviewed by Elizabeth Whitman, "Utah Program Shows Promise in Improving Healthcare Quality While Trimming Costs," *Modern Health Care,* September 13, 2016, accessed October 11, 2016, http://www.modernhealthcare.com/article/20160913/NEWS/160919972.

[45] This should not be a partisan issue; the full expansion will build Utah's economy, increase fairness, and improve health. These are solid reasons to expand, if expansion remains possible, with positive benefits being verified through the experience of other states. These include:

- Basic fairness in availability of coverage to tens of thousands of individuals who cannot otherwise obtain coverage and the benefits of access to care, financial solvency, and enhanced life choices.
- Improved access and use of healthcare.
- Positive economic impacts on the state economy with the influx of hundreds of millions of new dollars into the state--the same impacts seen with the federal dollars received from Hill Air Force Base, transportation funds, as well as the estimates for increased economic growth for large private businesses that choose to locate in Utah.
- Reductions in the amount of hospital and physician uncompensated care.
- The elimination of the work disincentives existing in the current coverage structure. The current program results in total loss of coverage for parents when income exceeds approximately 55% of the federal poverty level (FPL). Coverage cannot be obtained through the health insurance exchange until income reaches 100% of the FPL. This is a significant gap which is only partially addressed by the current proposed Medicaid demonstration application. This creates a significant disincentive to accept incremental increases in income; a relatively modest increase in income is likely to result in the complete loss of insurance coverage potentially worth thousands of dollars and tangible financial and health security. This is a far greater disincentive than the possible disincentive to increase income above the 133% threshold under expanded Medicaid where the individual becomes eligible for relatively affordable coverage with significant cost sharing reductions available through the Health Insurance Exchange, or where it becomes more likely that employer-based coverage will be available. It is tragically ironic that the current Medicaid demonstration proposal aggravates the current structural work disincentives by requiring the newly eligible

individual to have what amounts to zero income in order to qualify for critical treatment for individuals with severe health conditions. This approach requires people to quit work in order to access the benefits.

- Strengthening the safety net delivery system.
- Likely positive impacts to the health care state budget.

Literature on the impacts of Medicaid expansion has been summarized by the Kaiser Family Foundation: Larisa Antonisse et al, "The Effects of Medicaid Expansion under the ACA: Findings from a Literature Review," The *Kaiser Commission on Medicaid and the Uninsured*, June 20, 2016, accessed July 26, 2016, http://kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-findings-from-a-literature-review-issue-brief/). The report reviews findings from 61 studies of the impact of state Medicaid expansions under the ACA, concluding that:

> …a large body of literature analyzing the effects of expansion has developed. In general, this research suggests that expansion has had largely positive impacts on coverage, access to care and utilization, as well as economic outcomes, including impacts on state budgets, the payer mix for hospitals and clinics, and employment and the labor market. Yet, some studies do not find significant impacts and some point to challenges following expansion, such as provider shortages in some areas. These challenges may make it difficult to meet the increased demand for care among the newly-eligible Medicaid population.

A report from the Commonwealth Fund documents that low-income adults in two Medicaid expansion states, Kentucky and Arkansas (the former with coverage through Medicaid and the latter through private insurance) realized significantly higher declines in the rate of the uninsured, received more primary and preventive care, made fewer emergency department visits, and reported better quality of care and health than low-income adults in Texas, which did not expand Medicaid. Benjamin D. Summers et al, "Changes in Utilization and Health Among Low-Income Adults after Medicaid Expansion or Expanded Private Insurance," *The Commonwealth Fund*, August 8, 2016, accessed August 16, 2016, http://www.commonwealthfund.org/publications/in-the-literature/2016/aug/changes-utilization-health-low-income. Since the Kaiser publication, there has been a procession of new publications documenting various positive aspects of medical program and Medicaid expansions:

- **Positive link between CHIP expansion and entrepreneurship (small business formation)**
  Gareth Olds, "Entrepreneurship and Public Health Insurance," *Harvard Business School Working Paper*, June 2016, 16-144, accessed October 17, 2016, http://www.hbs.edu/faculty/Pages/profile.aspx?facId=738736.
- **Positive impacts on uncompensated care**
  Fredric Blavin, "Association Between the 2014 Medicaid Expansion and US Hospital Finances," *JAMA,* 2016, 316 (no. 14), 1475-1483, accessed December 2016, doi:10.1001/jama.2016.14765, October 11, 2016.
- **Positive impacts on state savings**
  Jesse Cross-Call, "Medicaid Expansion Producing State Savings and Connecting Vulnerable Groups to Care," *Center on Budget and Policy Priorities (CBPP)*, June 15, 2016, accessed December 2016, http://www.cbpp.org/research/health/medicaid-expansion-producing-state-savings-and-connecting-vulnerable-groups-to-care.
- **Positive impacts on proper utilization of services**:
  Benjamin D. Summers, Robert J. Blendon, Arnold M. Epstein, and E. John Oray, "Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance," *The Commonwealth Fund*, August 8, 2016, accessed August 16, 2016, http://www.commonwealthfund.org/publications/in-the-literature/2016/aug/changes-utilization-health-low-income accessed 8/16/16.
- **Positive impact on marketplace commercial premiums:**
  Aditi P. Sen and Thomas DeLeire, "The Effect of Medicaid Expansion on Marketplace Premiums," Assistant Secretary of Planning and Evaluation, Dep't of HHS, Issue Brief, August 25, 2016, accessed August 26, 2016, https://aspe.hhs.gov/pdf-report/effect-medicaid-expansion-marketplace-premiums.
- **Positive impact on providers**
  Adam Searing and Jack Hoadley, "Beyond the Reduction in Uncompensated Care: Medicaid Expansion Is Having a Positive Impact on Safety Net Hospitals and Clinics," *Georgetown University Center for Children and Families and, Georgetown University Health Policy Institute*, June 2016, accessed October 17, 2016,

http://www.khi.org/assets/uploads/news/14412/medicaid_hospitals-clinics-june-2016.pdf. There are multiple benefits outlined, including the reduction in uncompensated care: increased ability to fill system gaps by having the resources to open new clinics, buy new equipment, and hire new staff; and greater ability to integrate and improve the care they deliver, while those in non-expansion states are more likely to report "status quo" in their systems. One quote from the report sums this up: "Medicaid expansion has had a profound impact on our ability to deliver care—it is like night and day in our ability to provide care. I talk to my colleagues in other states that have not expanded and they simply cannot deliver care like we can."

[46] What might be done now?

- Expand Medicaid, which may or may not be possible during an interim period between the inauguration of the new president and the adoption of a new health program.
- Enroll persons already eligible for Medicaid but who might now want to be enrolled because of the ACA penalty for being uninsured, because of better information provided such persons, and because of greater awareness of enrollment possibilities and benefits.
- Build public understanding of health insurance, including how it operates, the need for it, and the choices available.
- Increase the use and effectiveness of programs, education, and incentives for healthy and safe life styles.

What might be done in Utah to prepare for what might become possible?

- Monitor the congressional debate, to prepare for possible new law.
- Use Utah's experience and needs to help shape new federal law, for example, the Utah experiences with alternative payment systems.
- Form a task force to monitor fiscal and program impact.

What might be done to better engage other determinants of health?

- Develop understanding that strengths and weaknesses of social and economic environments are especially important to the health of the least advantaged, and that the improvement of these environments, for example, pollution and education, deserve appropriate priority.
- Develop better ways for educators and health care providers to guide students and patients to healthy lifestyles and environments.
- Develop neighborhood-level health and environment programs, making use of the rapidly increasing data for comparisons and guidance between neighborhoods and across time.

[47] There are multiple problems of applying measures of costs and quality at the institutional level. A previously described problem is that they become incentives to compete by avoiding serving persons needing care. An additional problem is that these incentives to avoid care, while reducing expenditures by health-care institutions, substantially increase administrative costs for insurers and providers. They expand extensive paper-work, time-consuming approval processes, and complicated schedules of patient and procedure eligibilities. Further problems come from the expectation that the transparency created by the measures will create healthy competition through informed choice. But this expectation inadequately recognizes that insurance enrollees have very limited means to predict their medical needs, are highly dependent upon the professional judgement of providers who have conflicting financial interests, are making decisions under pressures and uncertainties of health emergencies, and are overwhelmed by legal and medical jargon.

These problems do not justify eliminating institutional-level measures of cost and quality. Instead, they call for careful design and use of the measures and for attending to similar measures for the community or hospital-referral areas, which account for the costs and health of persons underserved or left out of the health care system. Such measures of total community populations provide assessments, and hence incentives, if actively used, for payers and providers to be committed to the whole community. Such a commitment is appropriate for the ethical standards of the institutions and professions, as well as the special obligation of those institutions that are partly supported by charity, tax exemptions, or direct public financing.

These problems and their management are among those that raise arguments for restructuring the insurance market, which can be done in various ways that are not, and are not drifting toward, nationalized health care such as in the British health system. There are tested possibilities of insurance markets that more clearly avoid financial incentives to limit responsibility for health care, yet maintain private delivery of health care. These include expansion of

Medicare eligibility as well as higher regulation of private insurers to prohibit them from discriminating on an actuarial basis (somewhat similar to the regulation of utilities in the U. S.), as exist in

- *Germany:* "Healthcare in Germany," *WikipediA,"* https://en.wikipedia.org/wiki/Healthcare_in_Germany https://en.wikipedia.org/wiki/Healthcare_in_Germany
- *Holland* :"Healthcare in the Netherlands," *WikipediA,,* https://en.wikipedia.org/wiki/Healthcare_in_the_Netherlands, or
- *Switzerland* :"Healthcare in Switzerland," *WikipediA,* https://en.wikipedia.org/wiki/Healthcare_in_Switzerland.

Although this may be considered a question of national, rather than state policy, Utah might at least reduce the problems of the current insurance market structure by careful and expanded use of its regulation of the health insurance market, by encouraging private sector cooperation for community efforts, for which Utah is already known, and by energetic use of cost, quality, and access measures for the community or hospital-referral areas.