The Health Committee Report

Introduction and Summary of Major Positions

Utah is one of the five healthiest states in the nation and first for individual healthy behaviors.[1] Recent Medicaid expansion provided financial access to medical care for an estimated 125,000 individuals. Nevertheless, opportunity for improvement remains. National polls document that health is a major concern to Americans.[2] According to a recent Utah Foundation poll, health care (costs and accessibility) remains the top issue in Utah, and the coronavirus is tightly linked to each of the top five issues identified.[3] Our positions on Utahns' health and well-being include the following, all of which will be described more fully in the subsequent pages:

- **Strengthening public health.** Specific steps should be taken to strengthen the vision, role, and capacity of public health in the State of Utah.
- **Learning from the state's response.** An independent review of the State's response to COVID-19 should determine what was done well and what improvements could have been made, including recommendations for better management of future pandemics.
- **Supporting Medicaid expansion.** Utah should maintain Medicaid coverage for adults up to 138% of the federal poverty level and withdraw the waivers that create barriers to coverage.
- **Improving emotional well-being.** A thorough study should be completed to improve understanding of the causes of Utah's high suicide and depression rates and then develop a plan for improvement, including access to quality prevention and treatment resources.
- **Increasing immunization levels.** The Department of Health should develop a plan to increase immunization levels and to optimize the use of a COVID-19 vaccine.
- **Improving infant mortality.** The Department of Health should work closely with physicians to develop a plan to reduce infant mortality in the State of Utah.
- **Determinants of health.** State efforts to improve health should include reducing poverty, improving education, keeping people safe, and improving the quality of our environment.
- **Guidelines for future health initiatives**:
    - *Equity and Justice for all*
    - *Optimization of financial resources*
    - *Significant expansion of financial access*
    - *Stabilization of health care financing*
    - *Alignment of incentives that encourage appropriate behavior*
    - *Administrative simplification*
    - *Prevention and preparedness*
    - *Uniform distribution of risk sharing*
    - *Subsidies for the financially disadvantaged*

COVID-19 and Population Health

The COVID-19 pandemic has impacted every nation in the world. As of December 1, 2020, there have been 63.4 million cases and 1.47 million deaths worldwide. These include 13.6 million cases and 268,000 deaths in the United States,[4] and 195,707 cases and 671 deaths in Utah, and the spread of the virus and its many consequences is increasing.

The Utah Response to COVID-19. Utah was one of the first states to declare a statewide emergency related to COVID-19,[5] but was among only 12 states that did not issue a statewide stay at home order.[6] The Utah Department of Health and Dr. Angela Dunn, the State Epidemiologist, have provided timely and reliable information on the spread of COVID-19, including case and positivity rates, testing, hospitalization, ICU use, and deaths. The Utah case fatality rate (deaths as a percentage of cases) of 0.59 percent is one of the lowest in the United States,[7] and Utah does have a low mortality rate of 27.5 deaths per 100,000 population, but there are five states with lower rates.[8,] The case fatality and mortality performance is primarily related to Utah's young, heathy population and exceptional health care systems, not the state's management of COVID-19.[9] As of December 1, 2020, Utah had confirmed 6,131 COVID-19 cases per 100,000 population, which is the highest for states in the West and 6th highest in the nation.[10] The case rate is very high for a young, healthy state and not acceptable.[11] Additionally, a high percentage of COVID tests in Utah have been positive (around 19 %), which indicates many unreported cases and a need for more testing.[12] The increasing rate has resulted in some of the highest COVID-19-related ICU bed occupancies since March[13] and will increase the Utah mortality rate. All of this is most likely because of an ineffective plan to maximize compliance with public health guidelines since the emergency declaration, and failure of the Utah Office of Management and Budget to appropriately involve the Utah Department of Health (UDOH).[14] As the State Auditor concluded, "pandemic preparations were not reasonably sufficient; [an] unclear chain of command hindered early emergency response; and the UDOH…had little involvement in decisions to purchase the dashboard and other services."[15] There were also many questionable expensive no-bid contracts[16] for services and supplies, including the *TestUtah* initiative[17] and the *Healthy Together* app.[18]

Adherence to public health guidelines while opening up. Opening up our state safely during a pandemic, and being able to stay open, require a well-designed and executed plan to optimize *compliance with public health standards*.[19] This did not happen, which was a notable cause for higher than expected case rates. For example, the wearing of masks is a proven intervention for controlling the spread of the virus,[20] and Utah experienced significant non-compliance with public health guidelines. Some have argued that requiring masks, restricting large group gatherings, and social distancing infringe on personal liberty; however, reasonable restraints on individual liberty interests are well within the constitutional prerogative of the state when public health interests are implicated. For example, the health consequences of second-hand smoke are well documented.[21] It is estimated that in 2020, there will be 41,000 deaths in the United States

related to second-hand smoke[22]--a fraction of the total projected deaths related to COVID-19--, but smoking in public places is prohibited in Utah, and no one argues that they "have the freedom to choose to blow smoke in your face." Furthermore, the risk of exposure to COVID-19 is substantially more serious since, unlike second-hand smoke, one cannot see or smell the coronavirus.

COVID-19 Testing. Testing serves many purposes: (1) test results confirm a diagnosis; (2) testing populates the important systems that track the spread of the virus; and (3) testing provides the ability to do case tracking, which is a critical tool in managing the spread.[23] Delays between the manifestation of symptoms, obtaining a test, and receiving test results have challenged public health systems before and during the COVID-19 pandemic.[24] And, as concluded by the State Auditor, more consideration should have been given to the contact tracing approach.[25]

Loss of employment. It is estimated that up to 40 million individuals may lose employment resulting in 20 million claims for unemployment benefits.[26] Research from Yale University found that "high unemployment rates increase mortality and low unemployment decreases mortality and increases the sense of well-being in a community."[27] In October 2020, Utah had the fifth lowest unemployment rate in the country at 4.1%.[28] Opening up the economy is an important public policy consideration that should be made *independent of political and ideological considerations* and *with the well-being of the public as the state's number one priority*.

Access to healthcare. Before COVID-19, it was estimated that 30 million people in the United States did not have health insurance and another 44 million were underinsured, [29] and the number is growing.[30] Utah ranked 34th [31] of the 50 states with a 13 percent non-elderly uninsured rate in 2020.[32] According to Kaiser Family Foundation data, there were about 210,000 non-elderly uninsured individuals in Utah in 2018.[33] The United States does not provide universal health insurance coverage;[34] and insurance coverage for a significant number of Americans is linked to employment, creating instability in the continuity of coverage for many individuals and families.[35] It is estimated that 10 million Americans will lose their insurance as a result of COVID-19;[36] and according to a recent poll by the Utah Foundation, "health care (costs and accessibility) remains the top issue [in Utah]…"[37]

Loss of revenue for hospitals and other healthcare providers. Our healthcare systems have experienced a significant loss of revenue due to increased costs for equipment to treat COVID-19 patients, the closing of outpatient departments, and the postponement or cancellation of elective procedures.[38] In addition, job losses and the rise in the number of uninsured patients have increased the impact of uncompensated care.[39] The combination of these factors illustrates the challenges of unreliable and inconsistent revenue sources and the challenge for some hospitals to remain financially viable, Rural hospitals in Utah have been particularly hard hit.[40] COVID-19 essentially stress tested our healthcare system in real time, exposing the need to explore more consistent and reliable methods for financing healthcare.

COVID-19—Health disparities and social justice. The disproportionate impact of the COVID-19 pandemic on vulnerable socio-economic communities and racial and ethnic minorities highlights the inequities in healthcare access and quality of care,[41] as illustrated in the following table. Additionally, adequate testing resources were not available in areas where vulnerable populations are concentrated.[42]

	White alone, not Hispanic	Hispanic or Latino	Native Hawaiian/Pacific Islander	Black/African American	American Indian/Alaska Native	Asian
Percent of Population	78%	14.2%	1.6%	2.1%	2.3%	3.8%
Number of Cases	62,754	32,497	3,868	1,978	1,747	2,511
Percent of Cases*	53.9%	27.9%	3.3%	1.7%	1.5%	2.2%
Cases per 100,000	2,551.1	6,091.0	8,124.5	3,396.5	3,094.6	2,171.4

Source: Coronovirus.utah.gov/case-counts/. As of November 1, 2020

*9.7 percent of cases did not identify race or ethnicity

The relative number of cases and the case rate for Hispanics and Pacific Islanders is exceptionally high. The underlying causes of such health disparities are complex and interrelated, but they include cultural norms, social and structural determinants of health, racism and discrimination, economic and educational disadvantages, healthcare access and quality, individual behavior, and biology.[43]

***Misinformation and disinformation*.** Disinformation and misinformation about COVID-19 has adversely impacted efforts to control the spread of COVID-19.[44] The distribution of complete and reliable information, and the aggressive identification and clarification of misinformation and disinformation should be a significant part of pandemic management.

Important Continuing Issues that Preceded COVID-19

The Cost and Quality of Healthcare. In 2018, the United States spent 16.9 percent of gross domestic product (GDP) on health care--nearly twice as much as the average OECD country, but while spending more on health care, we are not achieving comparable performance. The U.S. has poorer health outcomes, lower life expectancies, higher suicide rates, higher chronic disease burden, and a higher incidence of obesity. In short, "*the U.S. has the highest rate of avoidable mortality because people are not receiving timely, high-quality healthcare.*"[45]

Higher prices are the primary reason the U.S. spends more on health care than any other country.[46] Other reasons include more frequent use of expensive technologies,[47] the volume of health care that has no value in treating or preventing injuries, illness, or disease,[48] and a financing system in the U. S. that is one of the most complicated and costly in the world.[49] Additionally, perverse incentives[50] that cause insurers and providers to avoid high risk patients,[51] and providers and consumers who dispense or consume unnecessary care or fail to seek or provide necessary care also impact both cost and quality.[52,] *To be successful, responsible health system reform must address both cost and quality of health care.*

Medicaid Expansion. The UCC has long supported the full expansion of Medicaid to 138% of the federal poverty level (FPL) and withdrawal of waivers that inhibit access to coverage.[53] Most research related to Medicaid expansion has verified the positive results expansion states have experienced,[54] and much more recent research continues to demonstrate the benefits. [55]

Medicaid and Public Health. The Utah Department of Health (UDOH) was created nearly forty years ago from public health and medical assistance programs within the Department of Social Services. The purpose for which it was created was to expand the state's health policy vision and facilitate working relationships to promote more efficient use of the state resources to improve public health.[56] The UCC believes Utah's recently-expanded Medicaid program is uniquely positioned to help drive public-health-focused responses to many of the shortcomings of our current health care system identified in this report.[57]

Mental Illness, Suicide, and Depression. Utah and other Mountain States have consistently high suicide and depression rates.[58] Using seven indicators of mental health, Mental Health America ranked Utah 41st for youth[59] and 50th for adults (including the District of Columbia).[60] This low ranking indicates both a higher rate of mental illness and less access to quality mental health care.[61] There is a documented relationship between poverty, social welfare policies, and emotional well-being; and a study completed in 2020 specifically documented the relationship between state-level minimum wages, unemployment, and suicide levels.[62] A thorough study of the specific causes of these high depression and suicide rates in Utah should be given high priority, followed by the development of a tailored plan to improve access to quality prevention and treatment resources.

The Level of Immunizations in Utah. Over the last 9 years the Utah immunization rate has declined. For the school year 2009-2010, Utah had the 6th highest immunization rate in the nation for kindergarten children at 97.7%. Mississippi ranked 1st with a rate of 99.7.[63] For the school year 2018-2019, however, Utah dropped to 23rd with a rate of 92.6. Mississippi retained the top spot at 99.2.[64] This trend must be reversed. *The COVID-19 pandemic will continue to be a challenge until a safe and effective vaccine is produced for public use; and an effective public information campaign will be essential to instill confidence in and acceptance of the vaccine.*

Infant Mortality. Infant mortality is used as an overall measure of population health. In 1995 Utah had the 3rd lowest infant mortality rate in the nation but dropped to 17th in 2018, as other states dramatically improved their infant mortality statistics while the Utah rate increased slightly.[65] Similarly, significant improvement has occurred in many countries, as illustrated in the following table. [66]

Year	Utah Rate/1000 Births	Utah Rank	Best State	U.S. Average	Canada	United Kingdom	Spain
1995	5.41	3	5.18 (Mass.)	7.6	6.1	6.2.	5.5
2006	5.12	5	4.7 (Wash.)	6.9	5.3	5.6	4.4
2018	5.5	17	3.6 (NH)	5.9	4.7	3.9	2.7

Note: Utah infant death rates in 2017= 5.9, ranked #25; 2016 =5.4, #16; 2015= 5.1, #14; 2014= 4.9, #13

***Determinants of health*.** The personal, social, economic, and environmental factors that influence health are known as "determinants of health." Because of the failure of national political leaders to implement measures to correct basic problems in the structure and administration of health care, state leaders and members of the health care community in Utah have been shifting their efforts to better address the underlying determinants of health to improve the quality and the cost of good health.[67] UCC is pursuing such opportunities by building connections across our study areas, with particular initial attention to relationships between environmental health, public education, social support services, and equal rights.

Recommendations

1. ***Strengthen public health.*** Specific steps should be taken to strengthen the vision, role and capacity of UDOH, including the establishment of a broad vision of health that incorporates all determinants of health. This should include ensuring that there is high quality medical and public health expertise in the leadership of the Department of Health. Medicaid should be even more strongly integrated into the public health system and used as a tool to implement social change that will have a direct impact on health and well-being and improve management of the COVID-19 pandemic.
2. ***Learn from the state's response.*** There should be an independent review of the State response to COVID-19 to determine what was done well and where improvements could have been made. At a minimum, the analysis should determine why the Utah case rate was so high; whether the mortality rate was disproportionately high, given Utah's young and healthy population; whether public health expertise was appropriately considered in the decision-making process; the propriety of decisions on no-bid contracts and purchases; and how the state response to the needs of its most vulnerable populations could have been improved.

3. ***Improve testing for infectious diseases.*** UDOH should work with the Association of Public Health Laboratories to develop a system to improve case tracking and minimize delays between manifestation of symptoms, testing, and obtaining test results.
4. ***Medicaid expansion and public health.*** Utah should maintain the Medicaid adult expansion that provides coverage to adults up to 138% of the federal poverty level (FPL). Additionally, Utah should withdraw the demonstration waivers that would create barriers to coverage, including the community engagement and premium requirements.[68]
5. ***Improve emotional well-being.*** The Division of Substance Abuse and Mental Health should lead an effort to determine the causes of Utah's high suicide and depression rates and develop a plan to improve mental wellness and increase prevention and treatment resources.
6. ***Improve infant mortality.*** The Department of Health should take the lead in determining why Utah's relative ranking for infant mortality has declined and work with the medical community and public health partners to define and implement a strategy for improvement.
7. ***Increase immunization rates.*** UDOH, in conjunction with local health departments, should work with the health care provider community to develop a plan to improve immunization levels and to optimize the use of a COVID-19 vaccine when it becomes available.
8. ***Determinants of health.*** State efforts to improve health should include reducing poverty, improving education, keeping people safe, and improving the quality of our environment. An increase in the state minimum wage and efforts to manage global warming are examples.
9. ***Guidelines for change.*** The Utah Citizens' Counsel urges policymakers to utilize the following guidelines to evaluate proposals for change:

- *Equity and justice*—Proposals should be designed to reasonably and fairly produce benefits for all—minorities, rich and poor, healthy and infirm, rural and urban.
- *Optimization of available financial resources.* Proposals should take advantage of available financial resources from Federal, State and community sources.
- *Significant expansion of access to health care*—Initiatives should expand access to health care and move our community in the direction of achieving universal coverage.
- *Subsidies for the financially disadvantaged*—Efforts to expand financial access should provide for adequate subsidies for the poor and disadvantaged.
- *Stabilization of the financing of health care*—Reforms should provide options to eliminate erratic funding for providers and ensure continuity of insurance coverage for consumers.
- *Alignment of incentives that encourage appropriate behaviors.* Reform initiatives should incentivize providers, insurers, and consumers to make decisions that eliminate disparities, promote quality care, improve health, and remove waste.
- *Administrative simplification*—Reform proposals should reduce administrative costs and should simplify not complicate the existing system.
- *Prevention and preparedness.* Special consideration should be given to initiatives that prevent illness, disease, and accidents and prepare our communities for future crises.
- *Risk sharing*—Reform initiatives should facilitate a premium structure that promotes the uniform distribution of the cost of disease and injury across all insurance systems.

Endnotes for Health Report

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[8] See "All State Comparison of Testing Efforts," *Johns Hopkins University Corona Virus Resource Center*, accessed November 7, 2020, https://coronavirus.jhu.edu/testing/states-comparison.
[9] Utah is one of the healthiest states in the nation, has the lowest median age (31.1 years) and the smallest population over age 65. It is therefore expected that Utah would experience low mortality.
[10] See "All State Comparison of Testing Efforts," *Johns Hopkins University Coronavirus Resource Center*, accessed November 7, 2020, https://coronavirus.jhu.edu/testing/states-comparison.
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[17] "Silicon Slopes develops a site to help more Utahns get tested for coronavirus, but how widely remains in question," *Salt Lake Tribute*, accessed September 11, 2020, https://www.sltrib.com/news/2020/04/02/silicon-slopes-develops/.
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[23] Mirjam Kretzschmar, et. al. "Impact of delays on effectiveness of contact tracing strategies for COVID-19: a modeling study," *The Lancet* (2020) 5:8, E452-E459, accessed September 11, 2020, https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(20)30157-2/fulltext.

[24] Early in the pandemic, delays in testing results made case tracking impossible. The Department of Health has indicated that there have been significant improvements and that testing delays are generally less that 48 hours.

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[48] William Shrank, Teresa Rogstad, and Natasha Parekh, "Waste in the US Health Care System: Estimated Costs and Potential for Savings," *JAMA* (2019), 322(15), 1501-1509, accessed September 11, 2020, https://jamanetwork.com/journals/jama/article-abstract/2752664. Most experts estimate that about 25 percent of all health care delivered in the U.S. (and Utah) represents waste and has no value in treating or preventing injuries, illness, or disease. There are some that estimate over one-half of health care consumed is wasteful. The cost of this waste was estimated to be $760 to $935 billion.

[49] Uwe E. Reinhardt, *Priced Out: The Economic and Ethical Costs of American Health Care (*Princeton: Princeton University Press, 2019), *25-40.* It is estimated that only 4 of 9 employees in our current system are clinicians while the other five are administrators and consultants. And the number of non-clinicians is growing. From 1990 to 2012, the number of workers in the U.S. health care system grew by 70 percent. Nearly 95 percent of the growth has been in non-doctor roles. And "for every doctor, only 6 of 16 non-doctor workers have clinical roles…and 10 of the 16 non-doctor workers are purely administrative and management staff."

[50] "Why a Hospital Might Shun a Black Patient," *New York Times,* accessed October 31, 2020, *https://www.nytimes.com/2020/10/06/opinion/medical-racism-payment-models.html*.

[51] M Sonal Sekhar and N Vyas, "Defensive Medicine: A Bane to Healthcare," *Ann Med Health Sci Res.* (2013) 3(2), 295–296, accessed September 11, 2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3728884/.

[52] "How perverse incentives are ruining healthcare," *Medical Economics* (2015), accessed September 11, 2020, https://www.medicaleconomics.com/view/how-perverse-incentives-are-ruining-healthcare. "More than half Americans have avoided medical care due to cost," *Health Care Finance News*, accessed September 11, 2020, https://www.healthcarefinancenews.com/news/more-half-americans-have-avoided-medical-care-due-cost. Kenneth Thorpe, et.al., "The Challenges Of High-Deductible Plans For Chronically Ill People," *Health Affairs* (2019), accessed September 11, 2020, https://www.healthaffairs.org/do/10.1377/hblog20190416.47741/full/.

[53] After the 2018 successful Medicaid expansion ballot initiative, the 2019 Legislature passed a complex bill that required the Utah Department of Health (UDOH) to go through a series of demonstration applications in an attempt to add additional conditions to the expansion, including limiting the expansion eligibility income limit to 100% FPL, a community engagement requirement, a cap on the the number of enrollees based on the state appropriations available, addition of a per capita cap on per enrollee expenditures, and a number of other restrictions and program enhancements. While the demonstration application was being developed and making its way through the federal approval process, the Legislature authorized the state to expand Medicaid to adults with incomes under 100% FPL but with the regular Utah federal match of approximately 70%, versus the 90% federal match allowed under most adult expansion programs. This cost the state millions of dollars in lost federal matching revenue dollars each month while Utah worked through the demonstration application process.

The federal Medicaid agency, the Centers for Medicare and Medicaid Services (CMS), denied the state's request for the partial expansion to 100% FPL as well as the request to cap enrollment. At this point, the State also apparently decided it would not pursue the per capita cap approach and developed and submitted a new demonstration application going to the full income limit of 138% FPL ($17,236 for an individual or $35,535 for a family of four) and again requesting the authority to place an enrollment cap on the new adult expansion population. The request also included many of the remaining waivers required under the state statute.

On December 23, 2019, CMS authorized UDOH to implement full Medicaid expansion in the state. The expansion extended Medicaid eligibility to adults with incomes up to 138% FPL. The federal government will cover 90% of the costs of these services, with the state covering the remaining 10%. It is estimated that up to 120,000 Utah adults are eligible for the expansion program. CMS also approved imposing a community engagement requirement on some newly eligible adults to receive Medicaid benefits. However, this requirement has been overturned by federal courts in several other states.

Utah's demonstration application included other components, including premiums and surcharges for those over 100% of the federal poverty level, housing supports, and eligibility penalties for intentional program violations. CMS is still reviewing these requested waivers.

[54] Research data from UCC Health reports prior to 2018 can be accessed at http://www.utahcitizenscounsel.org/. The research cited in endnote 61 includes financial benefits to the states, increased adult coverage, better access to care, better utilization of services, affordability of care, financial security among low-income populations, improved financial support of rural hospitals, and

better employment. While coverage and enhanced access to services and the other areas of improvement continue to be important, three areas need to be highlighted in this UCC Health report, given the UCC focus on the strong interdependencies across our policy areas, and what we are experiencing with the COVID-19 pandemic. Medicaid expansion has:

- helped to reduce disparities in coverage by income, age, marital status, and, in some studies, race/ethnicity.
- reduced medical debt, over-limit credit card spending, and numbers of evictions and bankruptcies. Some research also points to an association between Medicaid expansion and improvements in other measures of financial stability, including food security.
- reportedly made it easier to seek employment or continue working.

[55] "Medicaid Expansion and the Louisiana Economy," *Louisiana Department of Health*, accessed July 21, 2018, http://gov.louisiana.gov/assets/MedicaidExpansion/MedicaidExpansionStudy.pdf. This report has a summary of prior work done for other states around financial benefits. Two of its conclusions are that for Louisiana expansion "The estimated state tax receipts generated by the infusion of federal dollars exceeded the state dollars budgeted for the Medicaid expansion program by over $50 million and this does not include any net budgetary savings from moving participants from one Medicaid program to Medicaid expansion with the higher FMAP" and "The economic impact associated with the Medicaid expansion program is spread across the state and will be sustained as long as Medicaid expansion is sustained."

"Understanding The Relationship Between Medicaid Expansions And Hospital Closures," *Health Affairs*, accessed July 24, 2018, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0976.

"Implications of the ACA Medicaid Expansion: A Look at the Data and Evidence," *Kaiser Family Foundation*, accessed July 21, 2018, https://www.kff.org/medicaid/issue-brief/implications-of-the-aca-medicaid-expansion-a-look-at-the-data-and-evidence/. This has a review of the more current research literature on the impacts of Medicaid expansion. Additionally, see "The Effects Of Medicaid Expansion Under The ACA: A Systematic Review," *Health Affairs*, accessed July 21, 2018, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.1491. "After analyzing seventy-seven published studies, we found that expansion was associated with increases in coverage, service use, quality of care, and Medicaid spending. Furthermore, very few studies reported that Medicaid expansion was associated with negative consequences, such as increased wait times for appointments—and those studies tended to use study designs not suited for determining cause and effect."

"The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review," *Kaiser Family Foundation*, accessed August 2, 2020, https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/.

"How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care," *Commonwealth Fund*, accessed August 31,2020, https://www.commonwealthfund.org/publications/2020/jan/how-ACA-narrowed-racial-ethnic-disparities-access.

"The Impact of the ACA on Insurance Coverage Disparities After Four Years," *National Bureau of Economic Research,* accessed August 31, 2020, https://www.nber.org/papers/w26157.

"The Affordable Care Act Reduced Socioeconomic Disparities In Health Care Access," *Health Affairs*, accessed August 31, 2020, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0083.

"Medicaid Expansion Reduced Unpaid Medical Debt And Increased Financial Satisfaction," *Health Affairs*, accessed August 31, 2020, https://www.healthaffairs.org/do/10.1377/hblog20170724.061160/full/.

"Effect of the Affordable Care Act's Medicaid Expansions on Food Security, 2010–2016," *American Journal of Public Health*, accessed August 31, 2020, https://ajph.aphapublications.org/doi/10.2105/AJPH.2019. 305168.

"The Effects of the ACA Medicaid Expansion on Nationwide Home Evictions and Eviction-Court Initiations: United States, 2000–2016," *Journal of Public Health*, accessed August 31, 2020, https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305230.
"Association of Medicaid Expansion With Enrollee Employment and Student Status in Michigan," *JAMA Network*, accessed August 30, 2020, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2759843.
"Medicaid Expansion as an Employment Incentive Program for People With Disabilities," *American Journal of Public Health*, accessed August 30, 2020, https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2018.304536?journalCode=ajph.
[56] The Utah Commission on Executive Reorganization determined that it would be important to have a broad vision of health that effectively formulates policy to create the greatest potential to improve the well-being of Utahns. They believed that within a short time "health" could become the new great problem of domestic politics. Governor Matheson and the Legislature agreed, and Utah combined health activities, including Medicaid, under one administrative authority and built direct relationships between the highest levels of administrative and political responsibilities.
[57] Medicaid can be an integral community component in redesigning and implementing better approaches to prevention, eliminating heath disparities, tackling the determinants of health, and implementing improved payment approaches for primary care.
[58] "Suicide Mortality by State," *National Center for Health Statistics*, accessed August 11, 2020, https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm.
[59] "Mental Health in America - Youth Data," *Mental Health America*, accessed August 11, 2020, https://www.mhanational.org/issues/mental-health-america-youth-data.
[60] Ibid., https://www.mhanational.org/issues/mental-health-america-adult-data.
[61] "Utah's Mental Health System," *Kem C. Gardner Policy Institute and Utah Hospital Association* (2019), accessed August 11, 2020, https://gardner.utah.edu/wp-content/uploads/MentalHealthReportAug2019.pdf.
[62] J.A. Kaufman et al., "Effects of increased minimum wages by unemployment rate on suicide in the USA," J Epidemiol Community Health (2020), 74:219-224, accessed August 11, 2020, https://jech.bmj.com/content/74/3/219.abstract.
[63]2009-10 through 2018-19 School Year Vaccination Coverage Trend Report, *Centers for Disease Control and Prevention*, accessed August 11, 2020, https://www.cdc.gov/vaccines/imz-managers/coverage/schoolvaxview/data-reports/coverage-trend/index.html.
[64] Ibid., *CDC*, https://www.cdc.gov/vaccines/imz-managers/coverage/schoolvaxview/data-reports/coverage-reports/2009-10.html.

Kindergarten Immunization Rates
Utah and Top Performing States

State	2018-19 Rate	2018-19 Rank	2009—10 Rate	2009-10 Rank
Mississippi	99.2	1	99.7	1
West Virginia	98.8	2	91.2	36
Maryland	97.4	3	97.2	13
New York	97.2	4	97.6	8
Massachusetts	96.9	5	93.0	27
Nebraska	96.9	5	97.5	9

Texas	96.9	5	98.1	5
California	96.5	6	93.6	26
Tennessee	96.5	6	97.4	10
Pennsylvania	96.4	7	86.9	42
South Dakota	96.2	8	96.8	15
New Mexico	96.1	9	97.6	7
Louisiana	95.5	10	96.9	14
Nevada	95.1	11	94.5	22
Wyoming	95.1	11	N/A	N/A
New Jersey	95.0	12	N/A	N/A
Virginia	95.0	12	92.1	32
Utah	92.8	23	97.7	6

[65] "Infant Mortality Rate by State," *National Center for Health Statistics*, accessed August 11, 2020, https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm; "Infant Deaths," *Centers for Disease Control WONDER*, accessed August 11, 2020, https://wonder.cdc.gov/lbd.html.
[66] "Infant Mortality Rates," *OECD*, accessed August 11, 2020, https://data.oecd.org/healthstat /infant-mortality-rates.htm.

Infant Mortality Utah and Top Performing States
Selected OECD Countries, 2018

State/Country	Infant Mortality **2018**	Rank	Infant Mortality Rate **2006**	Rank	Infant Mortality Rate **1995**	Rank
New Hampshire	3.6	1	5.91	15	5.32	2
New Jersey	3.9	2	5.44	8	6.56	15
California	4.2	3	5.04	3	6.3	11
Connecticut	4.2	3	6.17	18	7.13	21
Massachusetts	4.2	3	4.85	2	5.18	1
Oregon	4.2	3	5.38	7	6.12	8
New York	4.3	7	5.64	10	7.68	30
Colorado	4.7	8	5.77	13	6.41	13
Washington	4.7	8	4.7	1	5.79	7

Montana	4.8	10	6	17	7.09	19
Rhode Island	5.0	11	6.22	20	7.12	20
Iowa	5.1	12	5.12	4	8.26	36
Idaho	5.1	12	6.82	26	6.15	9
Minnesota	5.1	12	5.18	6	6.78	16
Wyoming	5.3	15	6.78	25	7.83	33
Maine	5.4	16	6.29	21	6.4	12
North Dakota	5.5	17	5.92	16	7.08	18
Texas	5.5	17	6.19	19	6.52	14
Utah	5.5	17	5.12	5	5.41	3
United States Average	5.9	13*	6.9	26*	7.6	24*
Sweden	2.0	1*	3.4	3*	4.1	2*
Spain	2.7	3*	4.4	9*	5.5	12*
Germany	3.2	7*	4.4	8*	5.3	8*
France	3.8	9*	4.5	10*	4.9	5*
United Kingdom	3.9	10*	5.6	22*	6.2	19*
Canada	4.7	12*	5.3	18*	6.1	16*

*Ranking with OECD Countries

Note: Utah infant death rate in 2017 is 5.9, ranked #25; 2016 - 5.4, #16; 2015 - 5.1, #14; 2014 - 4.9, #13.

[67] "Determinants" are discussed in our previous reports. See, for example, Utah Citizens' Counsel, *Standing Up For Utah's Needs, 2018 Report*, Health chapter. See also *Health Affairs*, which made research articles on health determinants topics of its 2020 February and April issues. In the February issue, Leora I. Horwitz and co-authors report on an extensive search of public announcements by health systems making investments in social determinants: 78 programs in 57 U. S. health systems, involving expenditures of at least $2.5 billion. This is an indication of levels and targets of interest in such programs. See also Leora I. Horwitz et al., "Quantifying Health Systems' Investment in Social Determinants Of Health, By Sector, 2017-19," *Health Affairs*, 39:2 (February 2020), 192-198.

[68] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," accessed August 2, 2020, https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/. Benjamin D. Sommers et al., "Medicaid Work Requirements — Results from the First Year in Arkansas," *The New England Journal of Medicine*, accessed August 2, 2020, https://www.nejm.org/doi/full/10.1056/NEJMsr1901772. The policy underpinnings of helping individuals transition to private coverage and requiring more personal responsibility in beneficiaries have scant research backing. While adopting policy initiatives that align with these principles could help improve beneficiary well-being, approaches that do not result in loss of coverage and reduced financial security are needed.