My name is David Clark and I am Speaker of the Utah House of Representatives. Senator Kennedy and Senator Bingaman, thank you for inviting me to testify before you today on a number of issues related to state health system reform.

Utah is arguably the healthiest state in the union and is often recognized as having the most efficient health care delivery system. Not coincidentally, Utah also enjoys the lowest per-capita health spending in the nation.[1] However, in spite of our enviable circumstances, Utah state officials recognized the dysfunction of our health system and, in 2005, began serious efforts aimed at reform. Lawmakers in both parties agreed that the status quo was unacceptable and that the current system, characterized by misplaced competition and misaligned incentives, could no longer be tolerated and should be replaced by one characterized by efficiency and value.

In 2008 and 2009, the Utah State Legislature passed landmark legislation setting into motion dramatic changes in the health system. The legislative Health System Reform Task Force met numerous times in 2008 and relied heavily on input and ideas from a broad base of Utah stakeholders, including health care providers, insurers, businesses, and community members. Through a process involving extensive research, public input, and consensus building, the Task Force advanced a number of measures representing critical steps in moving our health system reform efforts forward.

Utah's reform efforts have been and will continue to be designed to address our state's unique circumstances; however, there are certainly elements of our approach that may be broadly applied.

For instance, Utah and Massachusetts both pursued consumer focused health reforms, albeit in different fashion and with a different priority order for the common components. Both states also achieved a broad, bipartisan consensus supporting the basic reform elements. Dissimilarly, however, Utah began by implementing private market reforms first-- creating a defined contribution health insurance option for employers and their workers, with public sector reforms likely to follow. Massachusetts, on the other hand, acted first on the public sector reform piece, shifting tax dollars from paying hospitals for treating the uninsured to buying insurance coverage for the low-income uninsured, and is now rolling out private insurance market reforms.

If two states with such widely differing cultural, political, and systemic backgrounds as Utah and Massachusetts can pursue similar reforms, then other states can do the same, provided they are given the ability and the tools necessary to make adjustments and adaptations to the same basic model in order to accommodate unique circumstances. As we proceed in developing a national health reform policy, we would propose that the best way for the federal government to be involved is to respect the starting points of individual states—their distinct systems, institutions, values, and attitudes—by allowing significant flexibility to implement reforms and systemic changes consistent with local circumstances.

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[1] This and other comparative state-level data may be found at http://www.statehealthfacts.org/

A key lesson in our experience was the importance of cultivating awareness and understanding of the issues at hand. State officials engaged in a multi-year process of discussion and education among lawmakers and stakeholders leading up to enactment of reform. That process resulted in near unanimous approval of the reform legislation in both houses of the Utah State Legislature. An up-front investment in education and consensus building is essential to achieving truly transformative health system changes. While that requires more time and effort, the results are more satisfactory than the alternatives of simply trying to carve out a niche with special rules for some favored product, or patch or expand the current, sub-optimal system.

Effective communication with stakeholders is essential. In Utah, we made it clear at the onset that the status quo simply wouldn't do and that we were committed to enacting meaningful reform. "Real change requires real change" was our clarion call. We also made a decisive effort to clearly define our expectations to stakeholders, making them aware that our vision of reform would require serious engagement and an element of sacrifice by all involved. We encouraged providers, insurers, business leaders, and members of the community to be innovative, and even courageous, in thinking about health system reform. Early and often, my message to stakeholders was, "I don't want to hear 'No, because….' I want to hear, 'Yes, if…'"

While all of the Utah reform provisions (see Appendix for detailed list) are critical, perhaps the two with the most immediate impact on the health system is the establishment of a new defined contribution market for health insurance and the creation of the Utah Health Exchange. A defined contribution approach to health insurance puts the consumer directly in control of their health benefit, while preserving all of the federal tax advantages that are currently only available through an employer-sponsored arrangement. This approach is analogous to the movement from a defined benefit pension program for retirement to employer's defined contributions to an employee's retirement through contributions to a 401(k) or similar retirement account.

Instead of promising or providing a certain level of health benefit, the employer provides a pre-determined level of funding that the employee then controls and uses to purchase their choice of health insurance. The advantage to the employer is that in this simplified system, their only decision is how much to contribute toward the employee's health benefit each year. They are no longer responsible for choosing the benefit structure, insurance company, or provider network. However, the employer is still required to have 75% employee participation in the defined contribution market. This feature is designed to encourage appropriate funding of the employees' benefit plan. Both the choice and the accountability are moved from the employer side of the equation to the employee.

Employees benefit because they now can choose the health benefit that meets their needs, adding additional funding of their own if they so desire. This could have a major impact on the health care system. As consumers are given the opportunity to engage in informed choices, competition will increase. Health plans will have to respond directly to consumer needs and demands. Ultimately, having consumers more engaged in the process will lead to more efficient health care and better health.

The Utah Health Exchange is another critical component. In order for a defined contribution system to function efficiently, consumers need a single shopping point where they can evaluate their options and execute an informed purchasing decision. For a consumer-based market to succeed, individuals must have access to reliable information to allow consumers to make side-by-side comparisons of their options.

The Utah Health Exchange is an internet-based information portal with three core functions: 1) provide consumers with helpful information about their health care and health care financing, 2) provide a mechanism for consumers to compare and choose a health insurance policy that meets their needs, and 3) provide a standardized electronic application and enrollment system. In addition, a feature completely unique to the Utah Health Exchange will allow for premium aggregation from multiple sources (for example, premiums from multiple employers for an individual, from multiple employers for different family members, or from state premium assistance programs) for a single policy.

In addition to these two key operational features, a critical component of the Utah approach was the underlying reliance on market-based principles. We feel confident that the invisible hand of the marketplace, rather than the heavy hand of government, is the most effective means whereby reform may take place. The state must be involved in shaping reform, but the government's role should be limited to simply facilitating the necessary changes.

Perhaps the most difficult aspect of our reform efforts involved overcoming federal regulatory barriers including the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Budget Reconciliation Act (COBRA) and the Health Insurance Portability and Accountability Act (HIPAA). These federal regulations seriously limit the scope of the market affected by state reforms. Moreover, states are unable to aggressively pursue a number of programs, such as many of those involving wellness initiatives or personal responsibility elements. This issue might be largely overcome if states were granted broad authority to initiate demonstration projects determined to promote the intended objectives of the federal statute.

This concludes my prepared remarks. I will be glad to answer any questions you may have. Thank you.

APPENDIX

UTAH'S APPROACH TO HEALTH SYSTEM REFORM

2008 LEGISLATION

The 2008 legislative session was the proving ground for the innovation and determination of state leaders in reforming our health system. Their efforts resulted in a number of measures that established a foundation for health system reform in several ways.

- **Provider Transparency -** The All Payer Database (APD) was created to provide state-wide quality and cost measures for episodes of care.
- **Patient Transparency –** The Utah Department of Health was authorized to adopt standards for the electronic exchange of medical records by the creation of the Clinical Health Information Exchange (cHIE).
- **Internet Portal –** Legislation created the Office of Consumer Health Services (OCHS) to be housed under the control of the Governor's Office of Economic Development. This office was charged with the task of creating an Internet portal that promotes a consumer oriented health care system by making information available to consumers, allowing them to make more informed decisions.
- **CHIP open enrollment and outreach** – Legislation ensured that Utah's Children Health Insurance Program (CHIP) will cover all eligible children who apply. It also required the state departments of Education, Health and Workforce Services to promote enrollment of eligible children in CHIP and Medicaid.
- **State Tax Credit** – The legislation established a nonrefundable state income tax credit of up to 5% for individuals paying for health insurance with post-tax dollars.
- **Waiver Amendments –** Required state programs to work with the U.S. Department of Health and Human Services to help more people get insurance through private programs and to make public programs and subsidies available to more people in difficult circumstances.
- **Legislative Task Force** – Legislation also provided for an eleven-member Task Force to study health system reform. Members of the Task Force formed five working groups representing various stakeholders who dedicated immeasurable time and effort discussing and exploring reform options and strategies.

2009 LEGISLATION

Through a process of extensive research, public input, and consensus building, the Task Force advanced four bills in the 2009 session. These bills represent critical steps in moving Utah's Health System Reform forward. Among the many ambitious and bold accomplishments in these bills:

H.B. 188 –Representative David Clark, House Speaker, Sponsor
Health System Reform – Insurance Market

- **Creation of a Defined Contribution Market** – This legislation increases the availability of consumer information, choice, and power in the health insurance market. The defined contribution system will be operational for the small group market by January 1, 2010. In this market, employees will be able to choose any plan in the market on a guaranteed issue basis using pre-tax dollars. Rating and underwriting in this market will be based only on the employee's age and their

employer's group risk factor. The newly established Risk Adjuster Board will guide technical issues related to keeping the market vibrant and functional. Furthermore, the defined contribution system allows individuals and families to aggregate premium payments from multiple employer or government sources.

- **Expanding the Role of the Internet Portal** – This bill clarifies and expands the role of the internet portal in making information available to consumers to make informed decisions in the small group and individual markets, as well as the new defined contribution market. The internet portal will be a one-stop information, shopping and comparison tool for health care consumers. The portal will provide the technology backbone where the defined contribution market can operate.
- **Enhanced Transparency** – While several efforts to enhance transparency were initiated by the 2008 legislation, this bill contains several additional provisions to increase the transparency of the marketplace and to allow consumers improved access to information so they can make better choices. The bill also requires insurance producers to disclose commissions and compensation to their clients.
- **Lower Cost Products** – The bill creates new, lower cost alternatives in several markets. The bill establishes the new lower cost NetCare health benefit plan, allowing the exclusion of certain state mandated benefits. NetCare will be available as an alternative to employees in the Utah mini-COBRA, COBRA, and conversion markets. This bill also establishes a new product that blends PPO and HMO products and eliminates some of the mandates related to insurer networks.
- **Task Force Re-authorization** – This bill reauthorized the Health System Reform Task Force for an additional year and further required stakeholders to continue efforts for state health system reform..

H.B. 331 –Representative James A. Dunnigan, Sponsor
Health Reform – Health Insurance Coverage In State Contracts

- **Level Playing Field for Contractors** – Contractors bidding for state projects will no longer be advantaged if they do not provide health insurance for their employees. This legislation establishes a requirement that companies contracting with the State for projects exceeding a specified dollar amount provide a basic level of health insurance for their employees. The legislation establishes enforcement and penalties for a contractor who does not maintain an offer of qualified health insurance coverage for employees during the duration of the contract.

H.B. 165 – Representative Merlynn T. Newbold, Sponsor
Health Reform – Administrative Simplification

- **Administrative Simplification** – This bill requires providers and insurers to work together to simplify the billing, coordination of benefits, prior authorization, notification, and eligibility determination processes. This bill also moves the state toward card swipe technology for insurance cards so that a health care provider and patient can determine eligibility and what insurance requirements must be met for services such as deductibles, copayments and insurance status in real time.
- **Demonstration Projects** – The legislation starts the process for health care payment and delivery reform to realign incentives in the health care system. The bill creates a system wide, broad based demonstration project involving health care payers and health care providers for innovating the payment and delivery of health care in the state.

S.B. 79 Health Reform – Senator Peter C. Knudson, Sponsor
Health System Reform – Medical Malpractice Amendments

- **Tort Reform** – This legislation addresses the unique circumstances of receiving health care in an emergency room where health care providers are required, under federal law, to treat any person who comes into an emergency room. Most times, emergency room physicians must treat with no knowledge of the patient and sometimes with an inability to communicate with a patient to determine past medical history. The legislation establishes a standard of proof for emergency room care in medical malpractice actions based on clear and convincing evidence.