UTAH HEALTH CARE AFFORDABILITY:

A CLOSER LOOK

AUGUST 2023

CONTENTS

INTRODUCTION

States play an important role in making health care more affordable for residents. They have the power to pass and implement policies to curb excess prices, expand coverage, and limit cost-sharing for high-value care and can exercise this authority to protect residents from high and rising health care costs in the absence of federal action. In a 2022 Scorecard assembled by the Healthcare Value Hub, Utah scored 32.4 out of 80 possible points (equivalent to an F grade) on health care affordability policies and outcomes, ranking 22 out of 50 states, plus D.C.[1] While Utah has taken a few critical steps to address health care affordability, including establishing an all-payer claims database and creating an insulin savings program, the state generally performs poorly on a suite of measures across many health care affordability domains.

A 2020 nationwide study found that 27% of Utah adults faced a health care affordability burden,[2] and a 2023 state-level survey found even higher rates with 69% of respondents experiencing an affordability burden.[3] In light of residents' serious health care affordability burdens, Utah has much work to do to make health care more affordable for residents. This report describes Utah's performance in addressing high health care costs and affordability for residents and provides recommendations for actions policymakers can take to reduce these burdens.

🏠$ CURB EXCESS PRICES

Health care spending growth in Utah is driven by increases in the *price* of services, not the quantity of services patients are using. Total spending per person in Utah on medical care and prescription drugs increased 19% from 2017 to 2021, going from $4,200 to $5,000 per person. The average price per service increased 27%, while utilization of services increased by 8%.[4] Price growth was largest for hospital inpatient services (+28% increase from 2017 to 2021) and prescription drugs (+26%), with less price growth for outpatient services (+11%) and professional services (+7%).

Within hospital prices, Utah's inpatient and outpatient private payer prices were 197% of Medicare prices.[5] While is it debated whether Medicare prices are too low or too high for different services, they are a common benchmark of how much services should cost, and increasing private prices relative to Medicare prices is a useful indicator of private cost increases over time. Further analysis shows that almost all Utah hospitals receive prices from commercial payers that exceed the payment level required to cover their maximum expenses with no profit, called the commercial breakeven point (see Figure 1).[6] For example, St. Mark's Hospital in the HCA health system which has 246 beds received private commercial prices 297% of Medicare rates while they would need prices 38% of Medicare to break even with no profit. Utah can reduce health care spending as well as the costs passed on to consumers by enacting policies that track and reduce the prices charged for health care services as outlined in this section.

FIGURE 1: HOSPITAL COMMERCIAL BREAKEVEN POINT COMPARED TO PRIVATE PAYER PRICES CHARGED FOR SELECT UTAH HOSPITALS
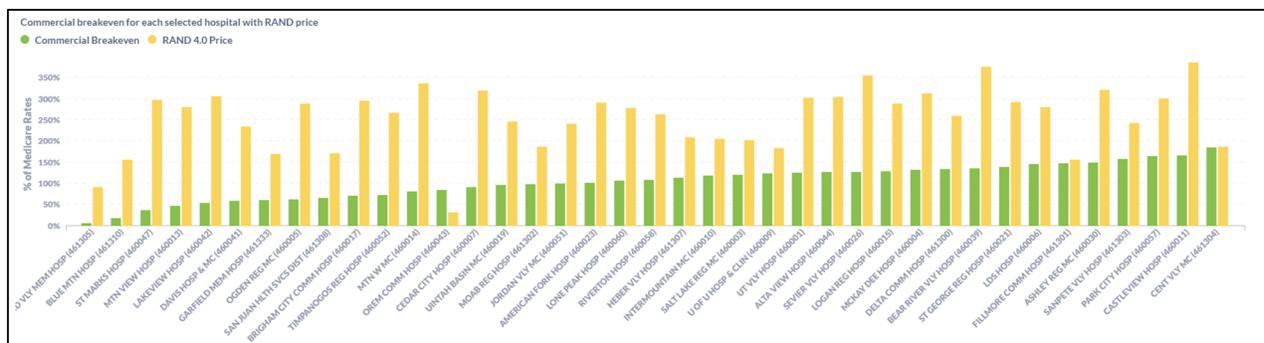
Source: National Academy for State Health Policy's (NASHP) Hospital Cost Tool (HCT), Utah Comparison Among Hospitals, using 2021 data (Accessed May 20, 2023). https://d3g6lgu1zfs2l4.cloudfront.net/

STRENGTHEN THE STATE'S ALL-PAYER-CLAIMS DATABASE

Addressing the rise in private payer prices for health care services is critical for ensuring affordability for both consumers, employers, and state governments. The first step toward understanding payer prices is establishing an all-payer claims database (APCD). All-payer claims databases are large-scale databases typically created by states that contain diverse types of health care data, including claims data from private insurance companies, state employee health benefit programs, and, in some cases, Medicare and Medicaid. APCDs (or their near cousin, multi-payer claims datasets) can provide useful information on payment, utilization, and disease patterns, which can be used by a range of stakeholders to aid health system transformation efforts, including initiatives designed to reduce excess prices.

Utah's all-payer claims database includes information on costs, payment, and medical, pharmacy, and dental claims from Medicaid and some commercial payers, but does not include traditional Medicare claims data.[7,8] In 2022, Utah's APCD captured approximately 90% of the commercially-insured population, 35% of the Medicaid population, 100% of the Children's Health Insurance Program (CHIP) population, and 92% of the Medicare Advantage population in Utah (roughly one third of the state's Medicare population).[9] It also contains some data on uninsured residents who receive care at federally qualified health centers.[10] Traditional Medicare and self-funded employer coverage are not typically included in the APCD, however self-funded plans may choose to voluntarily submit their claims data.[11]

The Utah Health Data Committee manages APCD data collection and has generated one-time reports on topics such as primary care spending[12] and price variation of colonoscopies.[13] However, these reports do not recommend policy interventions to reduce health care price variation once it is identified. Detailed data is available for external groups upon request.[14]

> **POLICY IN ACTION**
>
> **Colorado's** APCD is administered by the nonprofit Center for Improving Value in Health Care (CIVHC),[15] which regularly releases data on key issues, including primary care spending and commercial payments to specific hospitals compared to Medicare rates through dashboard and recurring reports.[16] In addition, the state offers pre-made reports for employers, including a "Cost Driver Analysis" report to determine which services are driving highest healthcare cost among employees, and design benefits that incentivize employees to use high-quality, low-cost facilities, as well as with providers, as well as a report on "Medicare Reference-Based Pricing" to help negotiate lower rates.[17] Publishing

this data regularly and making it available to groups with the power to negotiate prices has had a concrete impact: a local hospital in Summit County, CO was being paid 500% of what Medicare pays for outpatient care, and over 800% of Medicare rates for emergency care. In response, Peak Health Alliance—a health care purchasing cooperative, which is a regional consumer group that shops for insurance plans on behalf of a large group of people—negotiated a lower price on behalf of their members. As a result, they saved roughly $2 million dollars on premiums for 4,500 people in Summit County.[18]

Recommendations:

▲ **Require Ongoing Reports on Priority Issues:** Beyond one-time publications on issues of interest, the state should also publish quarterly or annual reports on key issues related to spending, utilization, and pricing. This could be executed by the Utah Health Data Committee or by the nonprofit One Utah Health Collaborative, as Colorado has done (outlined further in the section below on health spending oversight entities).

▲ **Offer Custom Reports Targeted at Price Negotiators:** Utah should also consider offering custom reports targeted at stakeholders who have the power to negotiate lower prices for consumers, such as insurers, providers, employers, and purchasing cooperatives as Colorado has done. The One Utah Health Collaborative is well-positioned to work with these diverse stakeholders to determine what types of reports would be useful and how they might use them to negotiate lower sustainable prices between providers and insurers.

▲ **Encourage Data Submission from Medicaid, Medicare, and Employers with Self-Insured Plans:** Without complete claims from all insurers, Utah's APCD may only capture a partial view of service utilization and price variation within the state. To further improve the utility of the APCD, Utah could require all Medicaid plans to submit claims data through legislative action or encourage submission by building relationships between the Utah Health Data Committee or Utah Payers Advisory Subcommittee and Medicaid Accountable Care Organizations as a starting point. In addition, the state could access traditional Medicare Fee-for-Service claims through Qualified Entity Certification Program, as Colorado does.[19] For commercial claims, if the state suspects there are pricing outliers in the remaining 10% of commercially-insured claims not already captured, it might consider encouraging more employers with self-funded plans to submit data voluntarily through relationship-building with the Utah Payers Advisory Subcommittee.[20] However if no outliers are suspected, it may not be worth the effort required.

ESTABLISH A HEALTH SPENDING OVERSIGHT ENTITY

Once an all-payer claims database is established, curbing excess prices requires a comprehensive, inter-agency, multi-payer plan to focus on the health care segment of their economies. To systematically address the health care affordability burdens of state residents, states need an entity empowered to look across various types of health and social spending and inform health system transformation efforts. This entity should be responsible for identifying opportunities for improvement in terms of value for each dollar spent, quality shortcomings, and affordability problems for residents—a permanently convened, health spending oversight entity.

As of 2022, nine states have established comprehensive oversight entities that target all health care spending (Colorado, Connecticut, Delaware, Massachusetts, Nevada, New Jersey, Oregon, Vermont, and Washington) and seven states have established entities that target narrow forms of spending, such as hospital or drug spending (Maine, Maryland, New Hampshire, New York, Ohio, Pennsylvania, and Rhode Island).

Utah does not have a permanently convened health spending oversight entity. Rather than creating a state regulatory entity, in 2022 Governor Cox launched the One Utah Health Collaborative, an independent nonprofit organization intended to convene community leaders and stakeholders to address health care affordability and other issues across the health care industry. Their goals include ensuring residents have access to affordable health care by addressing underlying costs, prices, and other factors that impact affordability, equity, and access to care.[21,22,23] The Collaborative makes recommendations based on the work of its community and innovation boards, although it is not currently clear whether they will be making formal recommendations to the legislature.

Recommendations:

▲ **Empower the One Utah Health Collaborative to Act as a Health Spending Oversight Entity:** Utah should consider empowering the One Utah Health Collaborative to act as a permanent health spending oversight entity that targets all forms of health spending and issues regular reports on key utilization and pricing issues. First, the state could allow the One Utah Health Collaborative to have broad access to APCD data, including guidance and technical assistance from the Utah Health Data Committee. The Collaborative could then take responsibility for generating ongoing reports on key topics such as price variation and outliers and be empowered to recommend policy interventions to the legislature.

POLICY IN ACTION

Maryland's Health Services Cost Review Commission monitors the efficiency and effectiveness of hospitals using financial data (revenue, expenditures and utilization) to inform Commission recommendations on global hospital spending targets, uncompensated care and community benefits.

Colorado's Office of Saving People Money on Health Care works with the Department of Health Care Policy & Financing (HCPF) to reduce patient costs for hospital stays and expenses, improve price transparency, lower the price of prescription drugs and make health insurance more affordable. HCPF is issues reports on hospital spending and prices, including "Hospital Cost, Price & Profit Review" in 2021. In 2021, Colorado established a Prescription Drug Affordability Board tasked with setting upper payment limits to reduce prescription drug costs.

Vermont's Green Mountain Care Board is empowered to: monitor spending and quality of care across sectors; operate the state's all-payer claims database; review health insurance rates and identify drivers of rate increases; oversee pilots and innovations; align activity across payers; and make legislative recommendations.

EXPLORE A HEALTH CARE COST GROWTH BENCHMARK

Utah does not have a cost growth benchmark, although the One Utah Health Collaborative has pledged to include a health care spending or cost growth target into their work.[24] Health care cost growth benchmarks seek to constrain annual health care spending growth across sectors. Benchmarks can target different types of health spending and may be accompanied by quality benchmarks (e.g., Delaware) and/or spending minimums for high-value services like primary care (e.g., Connecticut) to ensure that reductions in spending growth do not sacrifice health care quality. Several states have implemented spending benchmarks with varying degrees of enforcement. Some states do not have an enforcement mechanism, relying on public displays of performance to incentivize cooperation, while others (like Massachusetts and Oregon) require entities that exceed the benchmark to complete a performance improvement plan to address excessive price growth and have the power to fine entities for exceeding the benchmark.[25]

POLICY IN ACTION

Massachusetts boasts the longest running benchmark in the country. However, spending within the state has varied significantly over the years—cost growth has been below the benchmark for four of the eight years with data available. Prior to the coronavirus pandemic, spending was on an upward trajectory above the 3.1% benchmark, growing 3.6% in 2018 and 4.1% in 2019. Spending declined 2.3% in 2020 due to a reduction in care during the pandemic, followed by a 9% growth in spending in 2021 as people sought previously delayed care.[26] When looking closer at the data during this volatile period, the annualized rate of spending growth between 2019 and 2021 is 3.2%— closer in line to the state's 3.1% benchmark. Moreover, spending growth in Massachusetts has been lower than the spending growth rate nationally—while the benchmark is not solely responsible for this, it does factor into Massachusetts' health care landscape. 2022 was the first year that the Massachusetts Health Policy Commission—the entity that oversees the benchmark—voted to require the hospital system with the highest prices in the state to implement a Performance Improvement Plan. [27]

Connecticut's benchmarking approach is novel in that it uses the state's Healthcare Affordability Index to estimate the policy's impact on the number of Connecticut households that will have access to quality health care coverage and be able to meet their basic economic needs.[28] An initial study conducted prior to implementation found that adherence to a cost growth benchmark would grant more than 14,000 additional households access to affordable health care (a six percent increase compared to the number of households with adequate income to afford health care expenses in 2019). The impact of the cost growth benchmark is projected to be even greater among households that purchase coverage through the Marketplace, with the amount of households that do not have adequate income to afford health care halving.[29]

Notably, Connecticut's benchmark includes targets for increased primary care spending as part of its strategy.[30] The goal of this initiative is to divert more resources towards primary care and avoid the need for costly and complex care resulting from unmet needs. In 2021, the statewide primary care spending met the five percent target (spending 5.1%), but on their own, commercial payers fell short, spending less than four percent.[31]

Recommendations:

▲ **Establish a Cost Growth Benchmark:** When establishing a cost growth benchmark, the One Utah Health Collaborative should publish reports on how health care spending has changed over the years, within different sectors of the health care system, and among specific providers and hospital systems to identify which groups have the largest spending increases. Without legislative authority, the Collaborative can publicly highlight which entities are charging the highest prices and driving healthcare spending to pressure them into reducing costs and/or prices. From there, the legislature could establish an enforcement mechanism behind the benchmark, such as financial penalties tied to Performance Improvement Plans as Massachusetts has done. Quality benchmarks can also help ensure that efforts to reduce health care cost growth do not negatively impact health outcomes.

▲ **Establish an Affordability Index:** Additionally, policymakers should consider establishing an affordability index for Utah households, as Connecticut has. Doing so will enable policymakers to evaluate the effects of various health care policies and reforms (including, but not limited to, a cost growth benchmark) on Utah households' ability to maintain quality health care coverage along with meeting their basic economic needs.

STRENGTHEN THE STATE'S PRICE TRANSPARENCY TOOL

It is well established that prices for the same health care service can differ significantly across providers and even within the same geographic area, but it is difficult to get reliable information about this pricing landscape.[32] Contrary to popular belief, transparency tools have generally not been successful at incentivizing consumers to compare services and shop for the best price.[33] This is in part because some consumers don't view health care as a "shoppable" commodity and many health care services are not "shoppable" at all, such as emergency services and in geographic areas with limited treatments or providers to choose from.[34]

While "shopping" by patients is unlikely to drive down excess prices, transparent pricing data can be used by researchers, payers, regulators, and legislators to identify outliers and embrace targeted solutions such as reference pricing, strategic network construction, and rate setting, though success will depend on the level of provider competition in the market. For maximum impact, health care price transparency tools should be: free; publicly available; reflect negotiated rates; and display prices that are treatment- and provider-specific.[35]

The Utah Office of the State Auditor's Utah Health Cost Compare tool provides the median amounts paid for many procedures by provider and facility using claims data from the state's APCD.[36] The state auditor is required to maintain a health care price transparency tool that is accessible by the public[37] and the Department of Health is required to publish certain health care cost information and make certain information from the APCD available to the public.[38, 39]

Recommendations:

▲ **Publish Negotiated Price Range Across Insurers:** Utah's price transparency tool provides median prices for specific procedures across all insurers. Including the *range* of prices charged to different insurers for the same services could help consumers more accurately estimate their potential expenses and aide stakeholders in identifying hospitals with substantial price variation for certain services or pricing outliers, that is, hospitals with higher negotiated rate agreements for certain insurers.

POLICY IN ACTION

New Hampshire's price transparency tool—NHHealthCost—was instrumental in driving down prices charged by a major hospital within the state. Prior to 2010, payments to the state's most expensive hospital exceeded those of its competitors by nearly 50%. The state's largest insurer had been unable to decrease prices due to the hospital's prominent reputation and loyal patient base, however, evidence of excessive prices—made public on the state's price transparency website—enabled the insurer to brand the hospital as a pricing outlier, garner public support, and negotiate lower prices. Market observers testified that, despite limited public awareness of the price transparency tool, publicly identifying high-priced providers shifted the balance of power towards the state's insurers and narrowed price variation over time.[40]

# EXTEND COVERAGE TO ALL RESIDENTS

Uninsured people face significant barriers to accessing health care: the high cost of paying out-of-pocket often keeps people from getting preventative care and treatment for chronic conditions. This in turn generates uncompensated care costs for hospitals when uninsured residents use costly emergency services as a last resort but cannot afford to pay the resulting medical bills. Nine percent of Utah residents were uninsured as of 2021, or roughly 288,116 people.

It is important to understand the composition of the state's uninsured population to enroll them in coverage and reduce disparities. Roughly two-thirds of Utah's uninsured, nonelderly population are eligible for Medicaid or a marketplace plan subsidy but remain uninsured (see Figure 3).[41] Utah can reduce its uninsured population by determining why these individuals are not enrolled in Medicaid or a subsidized marketplace plan and enact policies that make these programs more attractive and/or affordable as outlined later in this section.

Another 20% are ineligible because because they have an offer of other coverage through the marketplace or through an employer that is deemed "affordable" by federal standards—but may not be affordable for individuals in reality. In 2023, the federal government fixed the so-called "family glitch," which expands subsidy access to more families and reducing the share of uninsured residents.[42] Finally, Utah can reduce uninsurance rates among those ineligible due to citizenship status by extending coverage options to immigrant populations as outlined later in this section. Looking further, nearly half of Utah's nonelderly, uninsured population earn below 200% of the Federal Poverty Level (FPL), and another 40% earn 200 – 399% FPL (see Figure 4).[43] Utah can reduce its uninsured population by enacting policies that serve residents in these income brackets.

In addition to reducing the overall uninsured population, reducing *disparities* in uninsurance rates requires looking at which populations have the highest uninsurance rates. By income, Utah residents earning under 200% FPL have the highest uninsurance rates (see Figure 5).[44] By race/ethnicity, the state's non-white populations have higher uninsured rates than the white population, particularly residents who are American Indian or Alaska Native or Hispanic or Latino (see Figure 6).[45] Utah can reduce disparities in uninsurance by focusing Medicaid and marketplace plan outreach in these communities to increase enrollment among eligible residents.

FIGURE 3: DISTRIBUTION OF ELIGIBILITY FOR STATE-SPONSORED COVERAGE AMONG UTAH UNINSURED POPULATION (2021)
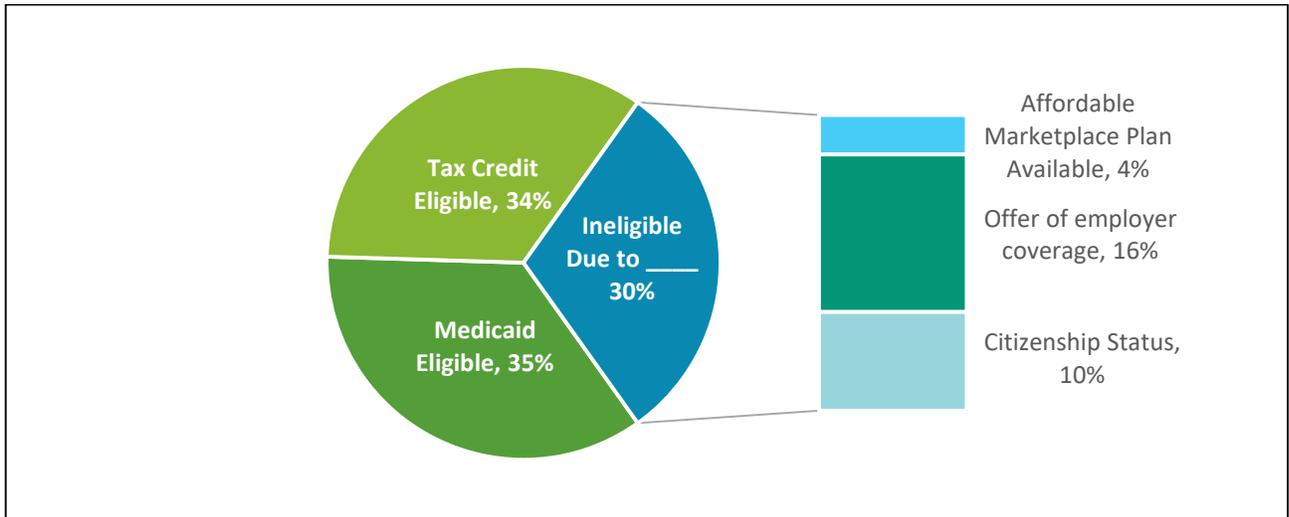
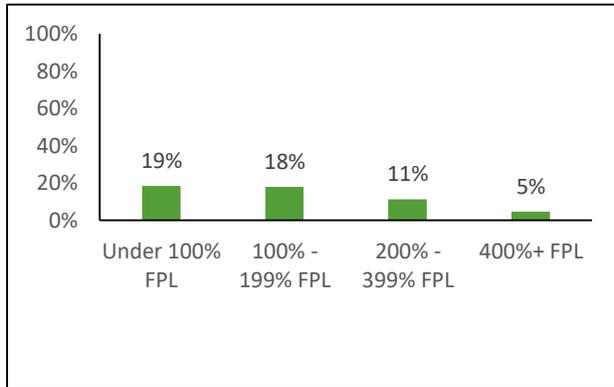*Source: Kaiser Family Foundation, Distribution of Eligibility for ACA Health Coverage Among the Remaining Uninsured 2021 Time Period, Washington, D.C. (Accessed May 4, 2023).*

## FIGURE 4: UTAH DISTRIBUTION OF NONELDERLY UNINSURED POPULATION BY FEDERAL POVERTY LEVEL (2021)
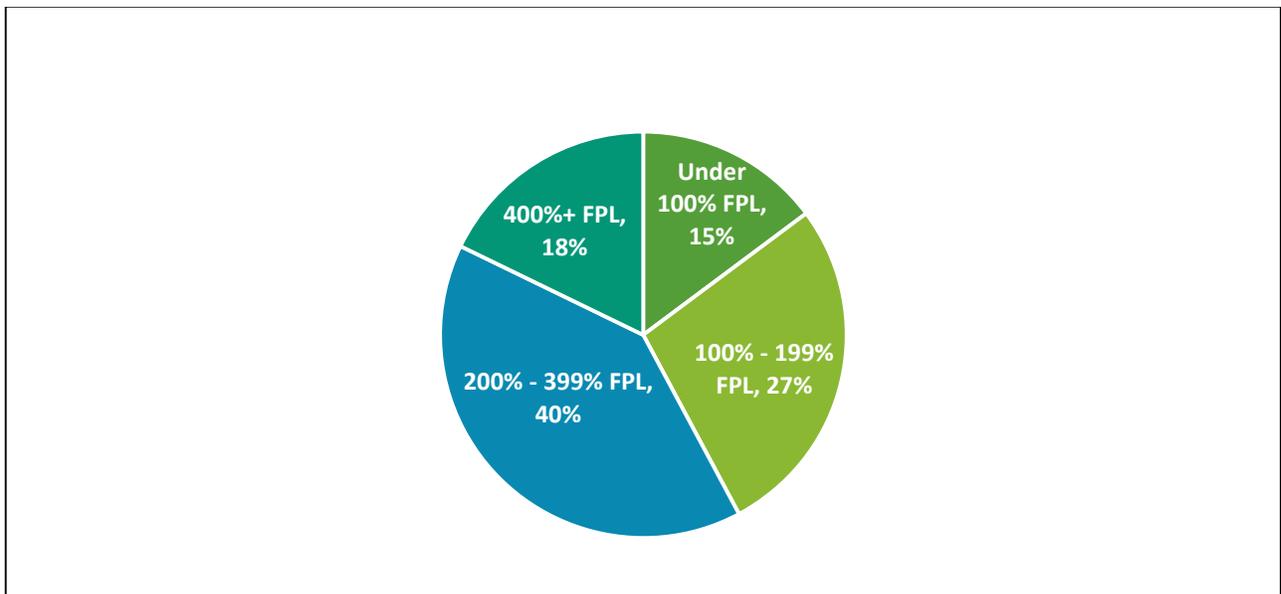
Source: Kaiser Family Foundation, Distribution of the Nonelderly Uninsured by Federal Poverty Level (FPL) 2021 Time Period, Washington, D.C. (Accessed on May 4, 2023).

FIGURE 5: UTAH NONLDERLY UNINSURANCE RATES BY FEDERAL POVERTY LEVEL (2021)

Source: Kaiser Family Foundation, Uninsured Rates for the Nonelderly by Federal Poverty Level (FPL) Time Frame 2021, Washington, D.C. (Accessed May 9, 2023)

FIGURE 6: UTAH UNINSURANCE RATES BY RACE AND ETHNICITY (2021)
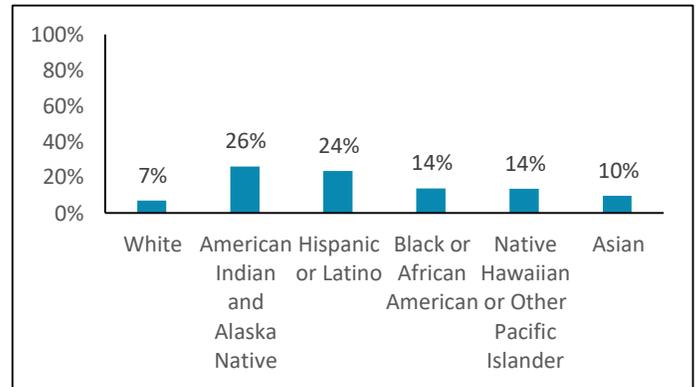
Source: U.S. Census Bureau; American Community Survey, 2021 American Community Survey 5-Year Estimates, Table S2701; generated by Alexandra Allen; using data.census.gov; < https://data.census.gov/table > (May 4, 2023).

INCREASE MEDICAID ENROLLMENT THROUGH CONTINUOUS ELIGIBILITY AND EDUCATION

Utah expanded Medicaid to cover low-income adults with incomes up to 138% of the FPL in January 2020. Notably, voters originally approved a ballot initiative to expand to 138% FPL in 2018, however the process was blocked at the time and was eventually replaced by a 2019 waiver that started at 100% FPL income limit and later expanded to the current 138% FPL. The waiver originally included a work requirement, but it was suspended and later revoked by the Biden administration, so there are currently no work requirement.[46]

While Medicaid expansion has many benefits, roughly one-third of Utah's uninsured residents are eligible for Medicaid but remain uninsured (see Figure 3).[47] Low Medicaid enrollment among low-income residents may be in part due to the halting expansion process and mixed messaging,[48] or the coverage may be undesirable for other reasons. Utah can reduce its uninsured population by increasing Medicaid enrollment as described in the recommendations below.

Utah can also increase Medicaid's reach by ensuring people maintain coverage once enrolled. Many states have reported issues with churn (the process of enrollees repeatedly losing and regaining Medicaid coverage), which can disrupt care, resulting in unnecessary

administrative costs for states and delaying or foregoing care among patients due to coverage disruptions which may increase health costs in the long run.[49] Unfortunately, Utah has been excluded from multiple studies of churn due to incomplete data, so it is difficult to assess the prevalence and scope of the issue.[50,51] Continuous eligibility is one method that can reduce churn by allowing people to verify their income once a year rather than once a month. Utah has enacted continuous eligibility only for children with CHIP coverage (not Medicaid) and for adults with incomes between 0-5% FPL who are experiencing homelessness, substance use disorder, or a mental health disorder.[52]

Recommendations:

▲ **Adopt 12-month Continuous Medicaid Eligibility to All Children and Adults:** Utah should consider enacting continuous Medicaid eligibility for all children with Medicaid through a state plan amendment and for all adults with Medicaid through a 1115 waiver.[53] Continuous eligibility was temporarily adopted for the duration of the COVID-19 pandemic, with enrollment steadily increasing since the beginning of 2020, however it expired on March 31, 2023.[54] Although adopting permanent continuous eligibility does come with increased costs from additional coverage months and initial implementation, reductions in health care costs over time and administrative savings can help offset these costs.[55] See this resource from [Georgetown Center for Children and Families (CCF)](#) for a comprehensive guide to improving Medicaid retention.

▲ **Fund a Medicaid Education and Enrollment Campaign:** Utah can increase Medicaid enrollment among eligible residents is funding a public education and enrollment campaign focused on geographic areas with the [highest uninsurance rates](#).[56] This would include distributing materials that explain the Medicaid program and who is eligible, and providing funding to pay health insurance navigators to do community outreach and enroll residents.

PROVIDE ADDITIONAL COVERAGE OPTIONS FOR PEOPLE ABOVE THE MEDICAID ELIGIBILITY THRESHOLD

While Utah's Medicaid expansion is essential to ensuring affordable health care for low-income residents, over half of Utah's uninsured residents earn incomes above the eligibility limit, and Utah does not offer any additional subsidies or coverage options for middle and higher-income residents.[57] Overall, 34% of uninsured Utah residents are eligible for tax credits to purchase a Marketplace plan but remain uninsured. The state can

start by determining why these individuals are not enrolling in subsidized marketplace plan and enact policies that make these programs more attractive and/or affordable.

Recommendations:

▲ **Provide Additional Premium Subsidies for Residents with Federal Marketplace Plans:** One solution that Utah could pursue without a state-based marketplace is providing premium subsidies directly to consumers purchasing plans on the federally managed Marketplace. Illinois nonprofit DuPage Health Coalition's Silver Access program pays up to $150 in premium subsidies per member per month directly to an enrollee's health insurance carrier.[58] Utah could circumvent the need for a state-based Marketplace by partnering with a 501(c)3 nonprofit to administer additional subsidies, potentially with partial funding from the state government. The state should start by conducting outreach and verifying whether high premiums are the primary barrier to purchasing Marketplace plans for residents, or if there are other barriers.

▲ **Pursue a Medicaid Buy-In Program or Basic Health Plan:** To provide additional coverage options for those above the Medicaid eligibility threshold, Utah should explore establishing a Medicaid Buy-In program or a Basic Health Plan.[59] This can provide sliding scale costs for residents across the income spectrum, and it can be targeted for certain populations or other groups who have difficulty accessing affordable coverage, such as individuals who may not be eligible for Medicaid or CHIP. For example, Vermont allows families with children whose household income is below 312% FPL to purchase Medicaid coverage for $15-$60 per month.[60]

▲ **Reinsurance:** Seventeen states have established a reinsurance program through a 1332 waiver[61] to decrease premiums for those earning too much to receive subsidies, however the federal government temporarily increased Marketplace subsidies during the COVID-19 pandemic, rendering reinsurance programs less effective than in the past. A state reinsurance program should be reevaluated if the federal government lets the additional subsidies expire.[62,63]

PROVIDE COVERAGE OPTIONS FOR IMMIGRANTS

Roughly 10% of Utah's uninsured population is ineligible for state-based coverage due to citizenship status.[64] Noncitizens are more likely to be uninsured, face increased barriers to accessing care, and use less health care than citizens.[65] Noncitizens are also often unable to access private coverage since they are more likely to work in low-wage jobs and in industries that don't offer employer-sponsored coverage, and those ineligible for state-

based coverage can only receive Emergency Medicaid coverage for limited services. In the case of pregnant immigrants living in Utah, this only includes services at the time of delivery and does not cover prenatal or postpartum care.[66] Offering comprehensive coverage options for undocumented adults will help Utah achieve 100% insurance coverage among its residents, improving their health care access and quality of life and reducing uncompensated care costs currently paid by state and local governments.

Utah has made some progress in covering immigrant children: The state currently offers Medicaid coverage to lawfully residing immigrant children without a 5-year wait and beginning January 2024, and expands health coverage to undocumented kids through the Children's Health Insurance Program in January 2024 with a $4.5 million budget cap, data review requirements, and a sunset clause.[67,68] However, the state does not allow legally residing pregnant people to access Medicaid without a 5-year wait and prohibits undocumented pregnant women or adults from accessing Medicaid and CHIP and from purchasing Marketplace plans. Overall, uninsurance due to immigration status causes a lack of preventative care and treatment for chronic conditions that negatively impacts the health and wellbeing of state residents. A 2019 survey found that immigrant families in Utah that were unable to get insurance for their children owed medical bills ranging from $300 to $5,000.

Recommendations:

▲ **Remove the 5-Year Bar for Lawfully Residing Pregnant People:** Utah should adopt the Immigrant Children's Health Improvement Act (ICHIA) option allowing lawfully residing immigrant pregnant people to access Medicaid without a 5-year wait. Several other states have adopted this measure, including Arkansas, Nebraska, North Carolina, and Ohio.[69]

▲ **Use CHIP's Unborn Child Option to Provide Prenatal Care to Pregnant People Regardless of Citizenship Status:** Utah should adopt CHIP's "unborn child" option to provide comprehensive services for pregnant people, regardless of immigration status. Several other states have adopted this measure including Oklahoma, Louisiana, and Missouri.[70]

▲ **Offer Coverage Options for Certain Adults Regardless of Citizenship Status:** To gradually reduce the uninsured adult immigrant population, Utah could state-funded coverage for undocumented adults in select age groups. For example, Illinois created a program to cover adults ages 65+ with income under 100% FPL, including assets, regardless of citizenship status, and later expanded to additional age groups.[71]

INCORPORATE AFFORDABILITY INTO PREMIUM RATE REVIEW CRITERIA

Utah has "effective" rate review as classified by the federal government in which regulators review premium proposals and determine if the rates are reasonable, however the criteria do not include the affordability of premiums. Rate review is the process by which insurance regulators review health carriers' proposed insurance premiums to ensure they are based on accurate, verifiable data and realistic projections of health care costs and utilization. Using a rigorous review process with input from the public and consumer advocates has been shown to lower rates for consumers. Utah's rate proposals are published online.[72,73] The state has the power to deny rate increases: from June 2022 to January 2023, rate increases ranging from +0.91% to +13.25% were accepted, with only one rejection for a +10.0% increase.[74] Additional details on the rate review criteria can be found here.[75]

Recommendations:

▲ **Incorporate Affordability Criteria into the State's Rate Review Process:** Utah should develop affordability standards that evaluate whether premium increases are affordable for residents and incorporate them into the rate review criteria. If a premium increase is deemed unaffordable for residents, the department of insurance can reject the increase and compel insurance carriers to reconfigure their plans with lower premiums. See the NASHP rate review toolkit for model legislation and examples of rate review affordability standards, including specific calculations, as well as an advocacy example from Illinois.[76,77]

POLICY IN ACTION

Rhode Island's affordability standards include four criteria that insurers must meet in order to have their rates approved: increased spending on primary care; adoption of the patient-centered medical home model; supporting the state's health information exchange; and working towards comprehensive payment reform, which include a cap of inflation, plus 1%, in insurers' negotiated prices with hospitals. This rate review process applies to large group market plans as well as the individual and small group markets. A 2019 study found a net reduction in spending by an average of $55 per enrollee.[78]


MAKE OUT-OF-POCKET COSTS AFFORDABLE

High out-of-pocket costs are a principal driver of affordability burdens. As of 2021, median family medical out-of-pocket spending in Utah, including premiums, for people with employer coverage totaled $3,920 per year, over $420 more than the national median.[79] While there are many contributing factors, these high costs cause Utah residents to go without needed health care.

A 2020 nationwide study found that 27% of Utah adults faced a health care affordability burden such as not getting needed care due to cost (9%), delaying care due to cost (10%), changing medication due to cost (12%), or problems paying medical bills (12%) or being uninsured due to cost.[80] However, a 2023 state-level survey found even higher rates, with 69% of respondents having experienced an affordability burden, including delaying or foregoing care due to cost (62%), struggling to pay their medical bills (45%), and being uninsured due to cost (51% of uninsured respondents) (see Figure 7).[81]

FIGURE 7: AFFORDABILITY BURDENS AMONG UTAH RESIDENTS (2018)
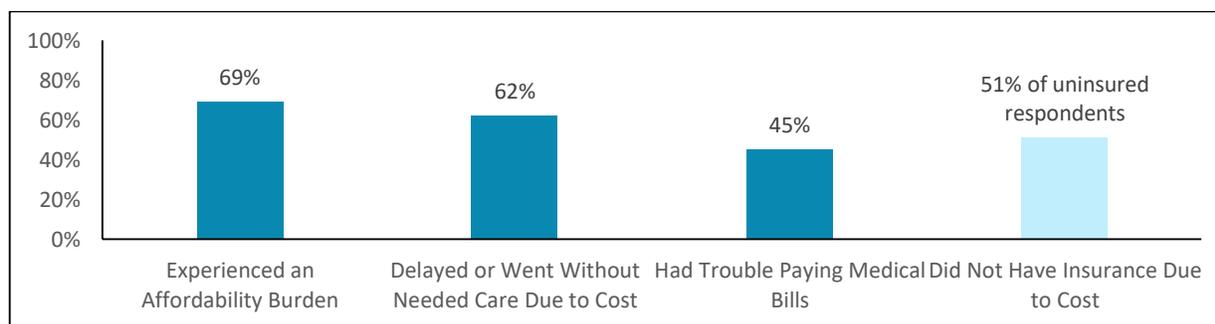
Source: Select results from 2023 Utah Consumer Healthcare Experience State Survey (CHESS) released before official publication, Altarum Healthcare Value Hub

WAIVE OR REDUCE COST-SHARING FOR HIGH-VALUE SERVICES

Failure to receive high-value care like flu vaccines, cancer screenings, and rationing prescription drugs for chronic conditions worsen health outcomes and result in higher spending on medical care in the future.[82,83] Reducing financial barriers by waiving or reducing cost-sharing for specific high-value services is one-way states can encourage the utilization of high-value care and protect against higher spending.

Utah has enacted several innovative policies in this area. In 2020 the state set an insulin price cap of $30 per month for state-regulated plans, however it does not apply to the majority of residents with employer-sponsored coverage.[84] To address this gap in state legislative authority, Utah established the Insulin Savings Program in 2020 and the Epinephrine Savings Program in 2021, which allow any Utah resident to register and purchase insulin at discounted wholesale prices through the state and public employee plan using a member card.[85,86] Since then, insulin price caps have been established for Medicare plans and nationwide insulin manufacturers have announced $25-35 per month price caps for uninsured patients and those with commercial insurance.[87]

Beyond insulin and EpiPens, Utah also passed HB24 in 2023 which allows the public employee insurance program to add additional drugs to the prescription discount program. Additional drugs must not have a generic substitute, must qualify for a substantial rebate, and cannot result in financial losses to the state risk pool if sold as part of the discount program.[88]

Recommendations:

▲ **Add New High-Value Drugs to the Prescription Discount Program:** Building on HB24, the state legislature or the employee benefits plan should add additional high-value drugs to the discount program. Start by commissioning a study to identify high-value prescription medications as candidates for addition to the savings program. The study could consider a variety of factors, including rates of rationing common medications due to cost, medications whose rationing results in disproportionate emergency room spending for consumers and hospitals, and surveys of Utah residents to determine whether the wholesale cash prices would be affordable for residents.

PROTECT PATIENTS FROM SURPRISE OUT-OF-NETWORK MEDICAL BILLS

Surprise medical bills (SMBs)—any medical bill for which a health insurer paid less than the patient expected—are alarmingly common within the American health care system. SMBs, also known as balance bills, can create significant financial burdens for patients, leading to debt and financial insecurity. The federal No Surprises Act (NSA) prohibits balance billing in most insurance plans nationwide beginning in January 2022. The NSA protects consumers from cost-sharing beyond the normal in-network amount when a patient receives emergency services by an out-of-network facility or provider (including air

ambulances) or when out-of-network providers at in-network facilities provide nonemergency services.[89] However, the NSA does not protect consumers from all balance billing, leaving loopholes like ground ambulance rides that are still susceptible.

Utah has no SMB protections (as defined by The Commonwealth Fund),[90] and residents are still vulnerable to some surprise bills that are not covered by federal law. For example, a 2021 study found that 69% of ground ambulance rides in Utah charged to commercial insurance plans had the potential for a surprise medical bill.[91]

Recommendations:

▲ **Broaden Surprise Medical Bill Protections to Cover No Surprises Act Loopholes:** Utah should pass legislation expanding its SMB protections to include ground ambulance services, non-emergency services provided by out-of-network professionals at in-network facilities (such as lab work), and services provided at facilities that are not covered by the NSA (such as urgent care centers, hospice facilities, and addiction treatment facilities).

PROTECT AGAINST SHORT-TERM, LIMITED-DURATION HEALTH PLANS

In response to rising insurance costs, some people turn to Short-Term, Limited-Duration (STLD) health plans, which offer lower monthly premiums compared to Affordable Care Act-compliant plans. However, these policies offer poor coverage, can discriminate against people with pre-existing conditions and pose significant financial risks for consumers. In July 2023, the Biden Administration proposed rules to limit STLD plans, however, federal rules regulating these types of plans have changed with different administrations. State action can ensure STLD plan regulations are consistent and include consumer protections.[92]

Utah allows temporary health insurance plans to follow federal duration limits, with initial terms up to 364 days and the option to renew for a total duration of up to 36 months. Although the state requires short-term plans to have benefit caps of at least $1 million, coinsurance of no more than 50%, and some services that must be covered, many services such as mental health care, maternity care, and outpatient prescription drugs are not required to be covered and are often excluded on short-term health plans. There were at least five insurers selling short-term health insurance plans in Utah in 2023.[93]

Recommendations:

▲ **Restrict STLD Plans:** There are a variety of restrictions that Utah could place on STLD health plans that would protect consumers from their risks without an outright ban on their sale and regardless of federal rule changes, including:

- o Expanding the list of required services to align with ACA essential health benefits more closely, including mental health care, maternity care, and prescription drugs, and requiring the state insurance commissioner to review the forms prior to the sale of the plans to ensure all plans have the mandated benefits.
- o Decreasing the allowed duration of the plans to less than one year.
- o Prohibiting gender rating (i.e., rejecting women or charging them higher premiums) and denial for pre-existing conditions.[94]

CONCLUSION

Utah has taken a few steps to improve health care affordability for its residents but has opportunities to improve. Health care affordability is a multi-faceted issue, and interventions will ultimately be needed across multiple affordability domains—including curbing excess prices, expanding coverage, and reducing out-of-pocket costs—in order to eliminate health care affordability problems for all. Policymakers should consider the recommended strategies in light of this growing burden.

HEALTHCARE VALUE HUB

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