Backgrounder

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State Health Care Reform: An Update on Utah's Reform

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Abstract: *In sharp contrast to the recently enacted federal health care reform, Utah is taking a targeted approach to expanding coverage while moving the system in a more patient-centered direction. Utah's approach promises to increase the number of employers offering insurance, reduce the number of uninsured, provide true coverage portability, increase competition among insurers and health care providers, and provide better value to patients and consumers. Other states should follow Utah's example by seeking to shield their citizens from the adverse consequences of the federal legislation and by pressing ahead with better reform designs, particularly ones that move their health insurance markets in more consumer-centered or patient-centered directions.*

Utah is emerging as a leader in health care reform. In 2009, the Utah legislature created a new defined contribution option for employer-sponsored health benefits that is administered through an Internet-based health insurance exchange.[1] The objectives are to give employers, particularly smaller firms, an easier way to offer health benefits to their workers and to provide workers and their families with more coverage choices.

The legislation also established a companion risk-adjuster board of stakeholders for the defined contribution option. The board is tasked with determining the rating rules for the plans offered on a defined contribution basis and with designing mechanisms to adjust risk across insurers in the market. The objec-

Talking Points

- Utah continues to make significant progress in implementing true consumer-centered and patient-centered health reforms.
- Utah has enacted further insurance reforms to improve the basic insurance market functions of risk transfer, risk pooling, and risk allocation, and to harmonize market rules for the traditional group coverage segment and the new defined contribution coverage segment of the state's employer-sponsored insurance market.
- State lawmakers should view the uncertainty created by federal health care legislation as an impetus to move further and faster in making state-level reforms to protect their citizens and better position their states for the possibility that the new federal law will be repealed.
- The only way to create better value in health insurance and medical care is to make individual patients and consumers the dominant decision makers in a reformed, market-based system.

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tives are to help consumers to easily compare the benefits and prices of competing plans while enabling insurers to adjust payments among themselves to compensate for selection effects.[2]

In implementing the legislation, Utah officials wisely opted to conduct a test run with an initial group of employers and workers in fall 2009. Based on the results, they are modifying the program before opening it to general enrollment. Many of the issues identified in the test run can be addressed administratively, and the Utah legislature adopted legislation[3] in its 2010 session to address those issues that required legislative action.

Over the past year, Utah has made significant progress in implementing consumer-centered health reform. Similarly, lawmakers in other states should now look to shield their citizens from the adverse consequences of the new federal health care legislation, while pressing ahead with better reform designs, particularly ones that move their health insurance markets in more consumer-centered or patient-centered directions.

Additional Insurance Market Reforms

The initial test run in the fall of 2009 revealed some inefficiencies in risk transfer, risk pooling, and risk allocation—the most basic functions of any insurance market—that threatened to undermine Utah's goal of a consumer-centered, employer-friendly health insurance market. In general, the test run revealed the need to modify the enrollment and plan selection process to make it more user friendly for both employers and workers, as well as the need to make additional changes to ensure a level playing field for insurer and plan competition. Most notably, some significant pricing disparities arose between coverage offered on a defined contribution basis and the same coverage offered on the traditional, defined benefit basis.

The pricing differences were largely attributable to two factors: carriers using different base rates for the two market segments for the same plan and carriers applying new business rating rules to employer groups entering the defined contribution market, when more favorable renewal business rating rules would have yielded better rates for most applicants. Using renewal rating rules would be more appropriate because many employers seeking to offer their workers defined contribution coverage through the exchange already provide traditional group coverage through one of the insurers in the exchange.

Utah's experience has been consistent with those of other state experiments that resulted in parallel markets with differing rules, such as different rules for association plans and single-employer plans or for the individual and group markets for self-employed individuals. While risk adjustment mechanisms can reasonably compensate for selection effects *within* a given market, they cannot be expected to compensate adequately for selection effects *between* parallel markets with different rating rules. The existence of parallel markets with different rules invites additional selection behaviors by both insurers and their customers.[4]

In response, Utah enacted additional insurance market reforms in 2010 to harmonize the rating

1. For additional background on Utah health reform, see Edmund F. Haislmaier, "State Health Reform: The Significance of Utah Health Insurance Reforms," Heritage Foundation *WebMemo* No. 2569, July 29, 2009, at *http://www.heritage.org/Research/Reports/2009/07/State-Health-Reform-The-Significance-of-Utah-Health-Insurance-Reforms*.
2. Selection effects refers to the natural propensity of insurers and their customers to make choices that are in their own interest, which collectively results in the segmentation of risks within the market. Selection effects that result in grouping individuals according to their risk profiles, such as high-risk individuals in one group and low-risk individuals in another, as opposed to a more random or even distribution of risks can disrupt the normal insurance market function of cross-subsidizing risks. However, selection effects can also produce positive benefits if policymakers establish alternative mechanisms for pooling and cross-subsidizing risks across the whole market. For example, a health insurance market in which plans can tailor coverage to the needs of individuals with a particular medical condition can produce better results for those individuals, provided that there is some mechanism for pooling their risk and costs with those of all other individuals in the market.
3. "Health System Reform Amendments," Utah Legislature H.B. 294, at *http://le.utah.gov/~2010/bills/hbillenr/hb0294.htm* (April 6, 2010).

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rules, coverage application forms and processes, and insurer underwriting practices in both the defined benefit and the defined contribution segments of the state's employer-sponsored insurance market.

Specifically, the legislation:

- Requires insurers to use the same base rates for defined contribution coverage and defined benefit coverage. Insurers must also use the same risk factors in both sub-markets when underwriting employer groups. Thus, an insurer can still charge two employer groups with different risk profiles somewhat different premiums for the same coverage, but the employer's rating will be the same for both the defined benefit policies and defined contribution policies.
- Requires insurers to treat employer groups that switch from defined benefit coverage to defined contribution coverage as renewals for rating purposes, not as new business. This is important because existing Utah law allows an insurer to "rate-up" a new employer group by up to 85 percent above the base rate according to the group's risk.[5] However, an insurer can rate-up an employer group renewing coverage by a maximum of 15 percent above the group's current risk rate, subject to the 85 percent maximum above the trend-adjusted base rate. Thus, insurers can annually increase rates across the board to reflect "trend"—a general increase in the cost of coverage in the employer market due to growth in the price and volume of medical care consumed—but cannot increase rates for a particular employer group above 85 percent of the base rate for the particular plan.[6]
- Requires insurers to use the same set of individual rating factors for both defined contribution and defined benefit employer coverage. Aside from modest geographic variation allowed in current law, the rating factors will be family status and age. The legislation sets four family status categories (single adult, one adult plus dependents, couple with no dependents, and couple with dependents), and applies five-year age bands between ages 20 and 65, with a maximum age rating variation of five to one—meaning the rate for someone 65 or older cannot be more than five times the rate for someone 19 or younger.[7]
- Prohibits an insurer from subdividing its employer group insurance business into two or more classes of business for rating purposes without prior approval from the Utah Insurance Department. The legislation also limits each insurer to a maximum of five classes of business and specifies that a carrier may not establish a separate class of business solely for defined contribution policies sold through the Health Insurance Exchange.[8]

4. For a further discussion, see Edmund F. Haislmaier, "State Health Reform: How Pooling Arrangements Can Increase Small-Business Coverage," Heritage Foundation *WebMemo* No. 1563, July 23, 2007, at *http://www.heritage.org/Research/Reports/2007/07/State-Health-Reform-How-Pooling-Arrangements-Can-Increase-Small-Business-Coverage*.
5. Utah law permits insurers to vary group rates by 30 percent above or below the standard rate for new applicants, which translates into a maximum rate-up of 85 percent above the base or lowest rate.
6. For example, a new group of roughly average risk might be charged a 40 percent rate-up above the base rate for the plan in the first year. If general health care costs increased by 5 percent, then all employer groups with that particular plan would see their rates increase by 5 percent the next year to account for the trend. However, if the risk of the particular group in this example also deteriorated during the year because its mix of employees became "sicker," the insurer would only be allowed to increase that group's risk rate by a maximum of 15 percentage points. Thus, in those circumstances the renewal rate for the group could not exceed 20 percent (5 percentage points for the trend plus up to 15 percentage points for the change in the specific group's risk level).
7. Age banding is a way to simplify age rating for both insurers and customers. All individuals who fall within a particular band are treated as being the same age for rating purposes. Thus, five-year age bands means that individuals are grouped by age in five-year increments for age rating purposes, such as 20- to 24-year-olds, 25- to 29-year-olds, and so on.
8. Lawmakers expect that the Insurance Department will continue to permit insurers to establish separate classes of business when there are good reasons to do so, such as when one insurer acquires a book of business from another insurer as the result of a sale, merger, or liquidation of the originating insurer.

- Tasks the Insurance Department with working with the carriers to shorten and simplify the uniform coverage application form, particularly the health history questions used in underwriting group coverage and determining insurer risk adjustments for individuals in the defined contribution market.
- Expands the application of the risk adjuster, making it a statewide mechanism for the entire small group market—both the defined contribution and defined benefit segments—effective in 2013.

Together, these insurance law changes are designed to reinforce other steps the state is taking to create a more consumer-focused health care market with greater transparency of costs and benefits for both health insurance and medical care. The insurance reforms are designed to focus insurer competition on managing risk, instead of avoiding risk.

Unlike some other states and Congress in the recently enacted federal health care legislation, Utah lawmakers have taken a minimalist approach in setting and harmonizing basic insurance market rules.

In the same fashion, Utah's parallel initiatives to create greater pricing and outcomes transparency for medical care are designed to enable patients to make better informed decisions and to focus provider competition on offering better value in health care.

Unlike some other states and Congress in the recently enacted federal health care legislation, Utah lawmakers have taken a minimalist approach in setting and harmonizing basic insurance market rules.[9] Utah policymakers have surgically applied traditional state insurance regulatory tools to harmonize the insurance functions across the employer coverage market as they work toward open participation in the health insurance exchange. In doing so, they remain true to their state's conservative philosophy and tradition of sound fiscal management, while moving Utah toward a more competitive, buyer-focused health insurance market.

Utah's approach is designed to allow easier comparison shopping for consumers, a level playing field for insurers, and lower barriers to market entry for new health insurance plans, while still permitting insurers wide latitude to design and offer different types of coverage and benefit packages. The objective is to allow the market to provide consumers with genuine, meaningful choice among a variety of plan designs and coverage options, while ensuring that the whole market functions smoothly and that customers can make informed choices.

For example, establishing standard categories for the rating factors of family composition and age makes it easier for customers to compare differing coverage offerings on a consistent basis. Yet allowing a five-to-one variation in age rating still gives insurers sufficient scope to price risk appropriately. This variation also enables younger individuals, who are generally healthier, to obtain coverage at reasonable rates in contrast to the more limited three-to-one variation allowed under the recent federal legislation, which will make coverage more expensive for young people. Furthermore, given that young adults tend to earn less than older individuals with more career experience, allowing insurers to charge them less for coverage better matches not only their generally lower risk profile, but also their lower earnings, making young adults more likely to buy coverage. Higher young adult enrollment, in turn, would not only improve the risk pool, but also reduce the number of uninsured, who tend to be disproportionately younger than the general population.

Importance of Risk Adjustment

The same minimalist approach is evident in Utah's approach to establishing a risk adjustment system. While the state is requiring all carriers in the small group market to participate in the system, lawmakers have wisely left the carriers and other relevant stakeholders to determine the design and operational details of the system.[10]

9. Patient Protection and Affordable Care Act, Public Law 111–148.

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Applying the risk adjustment system to all carriers in the market is sound public policy because it helps to reduce barriers to market entry. It makes it easier for new insurers to enter the market and less risky for carriers—both new and incumbent players—to test innovative benefit designs.

It is also good public policy to apply the risk adjustment system to all coverage, whether sold on a defined contribution basis or a defined benefit basis. This spreads more of the risk associated with higher cost individuals across a larger pool, reducing premium volatility for small employer groups, regardless of how the firms choose to offer health benefits. Thus, small employer groups should not face steep premium increases simply because one employee suffers from a major, expensive illness.

Furthermore, by allowing the carriers themselves to design the specifics, the resulting system will more likely focus on only those instances in which selection effects could disrupt the market. This is important because not all medical risks are the same, and insurers need to retain incentives to use other tools to manage risks appropriately.

For example, the risk of expensive trauma cases is largely random, and health insurers have other tools to manage that risk, such as purchasing stop-loss and reinsurance coverage from a commercial reinsurer or, if the injury is the result of an accident or negligence by another party, subrogating claims to applicable property or liability coverage. Thus, carriers might agree to exclude most or even all claims associated with expensive trauma cases from the risk adjustment mechanism.

For individuals with chronic medical conditions, such as diabetes, the risk adjustment mechanism should not try to compensate the insurer for all claims costs. Rather it should focus on adjusting for disparities in the distribution of such individuals. For example, if 10 percent of the population in a given market is diabetic, the risk adjustment mechanism would apply only if an insurer had more or less diabetic enrollees than the norm (10 percent). Carriers might even agree on a normal range of variation, such as 1 percentage point above or below the statistical norm. Thus, in this example, an insurer could only submit claims to the risk adjustment pool for the diabetics that put it above 11 percent, while offsetting payments into the pool would come principally from those carriers with less than 9 percent diabetics in their book of business. Further, the carriers might agree to limit claims against the pool to the historical average per-case cost in order to retain incentives for the insurer ceding the claims to continue to manage case costs. The risk adjustment mechanism can also account for other differences, such as if a particular insurer had a lower-than-average share of diabetic enrollees, but a higher-than-average share of cancer patients.

The timing of risk adjustment is also a consideration. In designing the risk adjuster for Utah's defined contribution market in the fall of 2009, the carriers opted to have much of the adjustment occur prospectively, with the remainder handled retrospectively. However, when the system is expanded under the new legislation to include the defined benefit market, it might make sense to adjust defined benefit plans retrospectively because whether an insurer receives a high cost enrollee in the defined benefit market is more the product of employer hiring decisions than plan selection decisions. Whereas, the reverse is the case in the defined contribution market.

As can be seen from these simplified examples, the wisest approach for lawmakers is to allow the experts and actuaries from the participating insurers to design and operate risk adjustment, under supervision by expert staff from the state's insurance department. The experts and actuaries have the expertise needed to design and operate the system and to determine whether to use consulting actuaries or other vendors or to use off-the-shelf risk adjustment algorithms instead of constructing their own.

10. For a further discussion, see Edmund F. Haislmaier, "State Health Care Reform: A Brief Guide to Risk Adjustment in Consumer-Driven Health Insurance Markets," Heritage Foundation *Backgrounder* No. 2166, July 28, 2008, at *http://www.heritage.org/Research/Reports/2008/07/State-Health-Care-Reform-A-Brief-Guide-to-Risk-Adjustment-in-ConsumerDriven-Health-Insurance-Markets*.

Patient-Centered Reforms

The consistent theme in Utah's approach to health care reform is using traditional state regulatory authority over insurance to shift both health insurance and health care delivery from a seller-focused system to a buyer-focused system. Beyond increasing choice and competition, this approach offers a number of other potential benefits, some of which will likely occur gradually over time.

Potential Benefit #1: More Employers Offering Coverage

Providing employers with a defined contribution option should make it easier for more firms to offer their workers quality health benefits with less risk, uncertainty, and hassle than traditional, one-size-fits-all defined benefit group coverage. Under a defined contribution arrangement, each worker chooses the plan that best suits his or her needs and situation. Employees can reevaluate their decisions each year during the open enrollment period. If the plan that he or she selected the previous year increases its premium, the worker can decide whether the benefits are worth the extra cost or another plan offers a better cost-benefit proposition.

For the employer, the defined contribution option simplifies providing employee health benefits by making it principally a question of financing. The employer decides the amount or percentage of compensation to provide as its base contribution for employee health benefits and then adjusts payroll withholding according to each worker's particular preferences and circumstances. For example, the employer could withhold more salary on a pre-tax basis to pay for an employee's chosen plan or withhold less if the worker is partly buying coverage with a contribution from his or her spouse's employer. The employer could also factor in a coverage subsidy provided by a government program to a worker in a low-income family.

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Thus, the availability of a defined contribution option could eventually lead to almost every employer in the state—even small, start-up firms—offering some type of coverage to its workers. Indeed, such an outcome could be made an explicit goal, and state governments could partner with insurers, brokers, and business groups—such as chambers of commerce or farm bureaus—to inform and educate employers about the new opportunities and benefits of offering coverage to their workers.

Potential Benefit #2: Fewer Uninsured

For state lawmakers, the creation of a defined contribution option for employer-sponsored health benefits opens up three new paths for gradually reducing a state's uninsured population:

1. To the extent that the defined contribution option makes it easier for firms that do not offer coverage to start offering coverage, more uninsured workers and their dependents will gain coverage.
2. As more firms offer coverage, fewer workers will experience coverage gaps when changing jobs, and the incidents of individuals becoming uninsured will likely decrease.
3. State lawmakers will be able to use the payment aggregation mechanism in the defined contribution option to leverage and better target subsidies from existing or new programs to help those who need financial assistance to obtain or keep coverage. This would particularly benefit lower-income workers and the temporarily unemployed.

Potential Benefit #3: True Coverage Portability

Over time, if more employers offer health benefits on a defined contribution basis, then increasing numbers of workers will be able to take their preferred coverage with them from job to job, thus creating true health insurance portability.

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Potential Benefit #4: More Choice, Competition, and Innovation

The Utah defined contribution option for employer-sponsored health benefits lowers barriers to market entry for insurers, thus encouraging competition. Under Utah's design, an insurer can offer one or more plans in the defined contribution market if it is licensed by the state's insurance department, its proposed insurance plans meet the state's coverage and rating requirements, and the insurer participates in the risk adjustor.

As with any market that draws customers to a single place to shop, a defined contribution health insurance market administered through a state insurance exchange makes it easier for sellers to reach willing buyers. It also helps buyers to comparison shop among the different sellers, forcing sellers to compete more sharply for their business. In more competitive markets, sellers soon realize that price is not the only or even the largest competitive advantage. Often, the best way to increase sales is to offer products that better meet consumer needs and preferences. In health insurance, a defined contribution market should stimulate insurers to experiment by offering new and innovative benefit packages and plan designs.

Potential Benefit #5: Better Value for Patients and Consumers

Over the long term, shifting to a more consumer-centered health insurance market will create new incentives to provide better value in health care coverage. The three basic functions of insurance—risk transfer, risk pooling, and risk allocation—are most efficiently accomplished in health insurance when the insured have a direct economic relationship with their insurer. In a defined contribution market, the insurance company's customers are individuals, not their employers. This change in purchasers should prompt a fundamental and desirable shift in how health insurers and purchasers think and operate.

When an employer purchases coverage for its workers through a traditional defined benefit plan, the employer's main concern is cost. In contrast, while individuals purchasing coverage directly for themselves and their families will certainly focus on cost, they will also be much more likely than their employers to evaluate competing plans on the differences in benefits, plan design, and access to health care providers.

By making the individual the decision maker, a defined contribution market encourages insurers to experiment by offering plans with features that individuals might value, but that are not necessarily as attractive to employers.

For example, a plan design that tries to control costs by limiting patient access to care will likely be less popular in a consumer-driven market than a plan that allows patients to see any provider, but imposes lower co-pays for using better value providers. Similarly, employee turnover and employers switching coverage in search of lower rates makes it difficult in traditional group coverage to maintain the continuity needed to successfully implement wellness or disease management programs that take more than one year to show results. However, when workers, not employers, choose their coverage, they are more likely to renew coverage that satisfies their needs and expectations. This gives insurers an opportunity to experiment with offering long-term incentives, such as premium rebates for customers who stay with their plans over a number of years and successfully participate in wellness or disease management programs with measurable, personal outcome goals.

The Right Approach to Health Care Reform

The ongoing national health care debate is rightly seen as a titanic struggle between contending visions of a government-controlled health care system versus a market-based health care system. However, advocates of a government-controlled system inaccurately and somewhat self-servingly portray the debate as a contest between their vision and the status quo.

While some interest groups within the health system are comfortable with the status quo and seek to preserve it, many opponents of a government-controlled system are motivated by an alternative vision of what a market-based system *should* look like. They envision transforming the present market that often puts the interests of sellers ahead of buyers into a market that puts the interests of buyers (i.e., patients and consumers) ahead of the interests of sellers.

From the "patient first" perspective, a government-controlled system is unacceptable because it subordinates the unique needs of the individual to the majority preferences of the collective. Nor is the current market-based system that favors sellers over buyers an acceptable solution.

Utah's health reform experiment offers a tangible example of how lawmakers can exercise traditional state powers to craft policies that make their state's health care system more patient-centered or consumer-centered while treating sellers fairly and accommodating their legitimate business needs. Utah's reforms should help sellers in the system—notably doctors, hospitals, insurers, and insurance brokers—to compete successfully on a level playing field in a consumer-centered market.

The only way to create better value in health insurance and medical care is to make individual patients and consumers the dominant decision makers in a reformed, market-based system. Only when those who use the system also control the funding and make the decisions will incentives in the health system be properly aligned to seek and deliver better value. Because third-party payers, such as employers and governments, are never the users of the system, they can never effectively manage or regulate the system into delivering better value. Nor can the suppliers or sellers—such as doctors, hospitals, and insurers—deliver better value without a direct economic relationship with the recipients of their goods and services. Absent pressure from value-seeking buyers in a competitive market, sellers will naturally tend to avoid risks and to increase profits, irrespective of the best interests of their patients or customers.

The only way to create better value in health insurance and medical care is to make individual patients and consumers the dominant decision makers in a reformed, market-based system.

Utah's reform strategy is important because it reflects a disciplined and systematic philosophy of putting patients and consumers first in the health system. Utah's health insurance reforms are designed to put insurance plans on a level competitive playing field and lower barriers to market entry, reduce the obstacles to small employers offering health insurance coverage, enable individuals to choose the coverage design that they prefer, and ensure that consumers have meaningful information in a consistent format so that they can effectively comparison shop.

In the same way, Utah's efforts to create enhanced provider price and quality transparency are designed to put doctors, hospitals, and other health care providers on a level competitive playing field and to give consumers and their insurance plans the information that they need to determine which providers offer the best results at the best prices.

Similarly, Utah's new defined contribution market will allow insurance brokers to operate as agents for the buyers, shifting from their current role as agents for the sellers. As with a similar shift that recently occurred in the real estate market, buyer agents are compensated for using their knowledge and expertise to help their clients get the best value given the client's personal circumstances and preferences. In contrast, seller agents are compensated for helping their clients maximize revenue.

In its 2009 health insurance reform legislation, Utah took the modest step of requiring brokers to disclose their commissions to buyers. However, during initial implementation the state's business community insisted on going further by having the exchange provide for standard, per-person compensation to brokers for helping individuals choose coverage.

This design aligns broker incentives with the interests of buyers by ensuring that broker compensation does not vary based on which insurer the customer chooses or the level of benefits offered by competing plans. For example, when sellers pay brokers on a percent-of-premium basis, brokers have an incentive to sell more comprehensive coverage plans with higher premiums. In contrast, when buyers pay brokers a standard per-capita fee, brokers have an incentive to recommend the coverage option that best meets each buyer's personal situation, which for some customers might be a lower premium, high-deductible plan coupled with a health savings account (HSA).

At the same time, lawmakers and employers are assured that individuals will be able to rely on the advice of trained and licensed professionals when choosing coverage. While some brokers may balk at the extra effort entailed in operating in a consumer-centered market, the more perceptive brokers will recognize an opportunity to expand their businesses by offering additional products, such as other lines of insurance or financial products, to large numbers of new customers with whom they previously did not have business relationships.

Conclusion

Over the past year, Utah has made significant progress in implementing consumer-centered health reform. As is prudent with any reform effort, Utah lawmakers and officials continue to adjust and improve their design—administratively where possible and legislatively where necessary—based on real world experience and new information. This process will likely continue for some time, and Utah's lawmakers and stakeholders, particularly the business community, have demonstrated a sound understanding that real and meaningful health reform is as much a process as a goal.

Given that Utah starts from a position of lower health care costs and better quality care than most other states, its willingness to tackle the difficult tasks of achieving even better results while expanding coverage should be a model and an inspiration for other states.

The recent enactment of federal health care legislation creates a period of enormous uncertainty for state lawmakers. Many provisions of the new federal law will not take effect for several years. Much of it is unworkable as enacted. Its passage has already aroused such significant public opposition that the impending election of a new Congress could lead to its outright repeal. It could then be replaced with more sensible and limited federal reforms. Furthermore, the federal officials tasked with implementing the new law have very limited expertise or experience in the insurance market and thus will likely look to existing state practices for guidance in developing federal regulations—assuming that they even reach that stage before Congress makes still more changes.

For all of these reasons, the prudent approach for state lawmakers is to look to shield their citizens from the adverse consequences of the federal legislation, while pressing ahead with better reform designs, particularly ones that move their health insurance markets in more consumer-centered or patient-centered directions. They should not simply accept the federal legislation as conclusive.

In a health system reformed along consumer-centered lines, participants will need to adopt new ways of thinking and operating, and change is often unsettling. However, the benefits of improved value, choice, portability, and coverage in health insurance and medical care make the effort and the changes worthwhile. Ultimately, a system in which insurers and medical providers compete and prosper by devising new ways to provide patients and consumers with better results at better prices would benefit everyone. The state of Utah is at the forefront of that effort and continues to make steady progress toward that worthwhile goal.

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