

CONTROLLING HEALTHCARE COSTS

PART TWO: ANALYSIS OF FIVE REFORM CONCEPTS

HIGHLIGHTS

- The use of best practice guidelines in medicine can reduce overutilization of healthcare while improving quality. A shield from malpractice liability for those who adhere to guidelines could promote wider adoption of best practices.
- Tort reforms, including stricter limits on noneconomic damage awards, have been shown to reduce medical costs and improve the supply of physicians in national studies.
- A “no-fault” compensation system for medical injuries could provide compensation to a wider group of injured patients for about the same cost as the current tort system.
- State benefit mandates increase the cost of commercially purchased health insurance and can lead to fewer individuals being covered.
- Stronger financial incentives for employers to provide wellness programs and for individuals to live healthy lifestyles could reduce the growing costs of obesity, smoking, and other unhealthy lifestyle choices.
- Employer tax credits can make provision of health insurance more affordable and promote greater coverage in group plans. A modest credit is estimated to cost \$38 to \$88 million, depending on the types of firms to qualify.

The mission of Utah Foundation is to promote a thriving economy, a well-prepared workforce, and a high quality of life for Utahns by performing thorough, well-supported research that helps policymakers, business and community leaders, and citizens better understand complex issues and providing practical, well-reasoned recommendations for policy change.

Alan K. Allred, President
Reed T. Searle, Vice President
Stephen J. Kroes, Executive Director

10 West Broadway, Suite 307
Salt Lake City, UT 84101
(801) 355-1400 • www.utahfoundation.org

A group of business leaders asked Utah Foundation to examine healthcare inflation and Utah’s healthcare situation, including conducting focus groups with healthcare stakeholders to better understand cost issues facing Utah. After reviewing the findings of that process, the employer group requested analysis on five potential reforms for making health insurance more affordable. This report provides that analysis.

The information that follows is not an endorsement by Utah Foundation of these reform ideas but an attempt to analyze the current situation in Utah, options for implementing these concepts, trends and developments in state or national policies related to each reform, and experience with similar policies in other states or nationally. By understanding more about these reforms, the Employers Healthcare Coalition can decide which options it desires to pursue with policymakers. The reforms examined are:

1. **Practice guidelines.** Encourage the use of practice guidelines and evidence-based medicine in order to decrease healthcare costs while improving quality.
2. **Tort Reform.** Decrease the costs of malpractice litigation by reforming aspects of malpractice tort law.
3. **State Mandates.** Decrease the number of state mandates in order to make health coverage more flexible and affordable for employers and individuals who purchase commercial insurance.
4. **Wellness Incentives.** Promote healthy lifestyle choices and participation in wellness programs through financial incentives for individuals and employers.
5. **Tax Credits.** Provide tax credits to small business owners who offer health insurance to their employees in order to increase the number of employees with employer-based insurance, thereby decreasing the number of uninsured.

The following sections describe each of these reform concepts in detail, providing information that should allow the coalition to assess feasibility and desirability of each option.

PRACTICE GUIDELINES

Evidence-based medicine means using the best available research to support objective medical decision-making, rather than healthcare providers choosing treatments based on their own experience with similar patients, anecdotes, and personal medical knowledge. Although science, experience, and intuition continue to play vital roles in medicine, healthcare professionals can also now rely more on evidence from clinical research studies when making treatment decisions.

Practice guidelines¹ enable healthcare providers to use evidenced-based medicine in a clinical setting. According to the Institute of Medicine, evidence-based guidelines are “systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances.”² Guidelines generally focus on a target population or a specific clinical problem. Specialty societies, state and federal agencies, health plans, provider groups, payers, and other organizations develop practice guidelines according to formal, accepted processes. Nonetheless, researchers have found tremendous variation in the rigor of these processes.

Guidelines are most credible and objective when they are “explicitly derived from high-quality evidence, when they are developed with input from relevant stakeholders and specialists, when they address the implications of their recommendations, and when developers cannot be influenced by the funding organization.”³ High-quality evidence includes meta-analyses, systemic reviews, and high-quality clinical trials. When high-quality evidence is not available, developers may have to rely on lower-quality evidence, including expert opinion. Many guidelines make the quality of their recommendations transparent to the user by grading the recommendations according to the strength of the supporting evidence.

Proponents believe that the use of practice guidelines based on evidence-based medicine has the potential to greatly improve quality and cost-effectiveness in healthcare. Practice guidelines promote evidence-based clinical decision-making by distilling research evidence into a form usable by busy healthcare providers. The use of practice guidelines in combination with enhanced health information technology also could facilitate greater transparency in quality and pricing by allowing consumers to evaluate the performance of different healthcare providers relative to a consistent standard. Critics of practice guidelines, such as the Citizens’ Council on Healthcare (a Minnesota organization), argue that there are no one-size-fits-all treatment regimens, and that bias will influence choice of directives. They assert that practice guidelines are a means of shifting power away from the medical profession and that their use will result in rigid standards of care imposed on patients, the rationing of healthcare services, the politicization of medicine, and eventually government-run healthcare.⁴

Current Use of Best Practice Guidelines in Utah

Utahns already benefit from a strong presence of best practice guidelines in local healthcare systems. A prominent example is Intermountain Healthcare, which has been integrating into its clinical settings best practice standards from nationally recognized specialty societies and peer-reviewed clinical research. Two examples highlight how this has changed medical practice among Intermountain’s physicians.

Heart Disease Example

National studies showed that the single most important predictor of whether a patient experiencing a heart problem (or “heart event”) would survive the following year was whether the patient left the hospital with the correct medications prescribed in the correct dosages. It is important for the patient to actually receive the drugs before leaving, rather than planning to follow through later with prescriptions and instructions. National studies showed that 40 percent of heart patients did not receive the proper medications and instructions before leaving the hospital, leading to significant risks.

To change this pattern, Intermountain Healthcare changed the programming of computer systems in its hospitals so that a heart patient could not be discharged unless a medical professional certified on the computer that the proper medications had been given to the patient. The computer system also advises the physician on what to prescribe, based on factors input about the patient’s condition. Now, 98 percent of heart patients leaving Intermountain’s hospitals go home with the correct medications (they believe the other two percent have other factors present making it appropriate to deviate from the standard). Intermountain believes that this change is saving 300 lives a year in its hospitals.

Obstetrics Example

The American College of Obstetricians recommends against inducing birth before 39 weeks of gestational age. This is based on reviews of national statistics and the incidence of neonatal intensive care unit (NICU) admissions for early births. Intermountain Healthcare found that one-third of elective inductions were occurring before 39 weeks in Utah and that the odds of admission to a NICU doubled when birth was induced at 38 weeks compared to 39 weeks. At 37 weeks, the risk doubled again. Because any given obstetrician may not see the impacts within his or her limited pool of patients, these statewide statistics were revealing and convincing that practices needed to change. Intermountain Healthcare established a standard of care among its physicians to not induce birth before 39 weeks unless medical necessity called for it. The standard was justified by showing the data on NICU admissions, and doctors were convinced to abide by the standard. Now, elective inductions before 39 weeks occur in only two percent of cases, rather than one-third.

Implementation of a wide variety of best practice standards is not likely to be feasible without data system support. The large

number of medical advances occurring each year makes it nearly impossible for an individual physician to keep up with best practices for each condition he or she treats. An information system that guides physicians' decisions at the point of care would allow better implementation of a large number of care standards. Intermountain Healthcare is developing such a system with a major information technology contractor. Its goal is to have a computer in each of its physicians' examination rooms within the next five years, and these computers will provide guidance on the expected care to provide for a range of illnesses and conditions.

Health Information Technology

Compared to other states, Utah already has some advantages in health information technology (health IT), and thus could potentially become a leader in the use of best practices guidelines. The Agency for Healthcare Research and Quality (AHRQ) under the federal Department of Health and Human Services (HHS) has awarded contracts to six states totaling \$34.7 million to help them lead the way in regional health information exchange and collaboration. Utah is one of these six states and was awarded \$8 million to help fund projects such as Utah Health Information Network (UHIN).⁵ UHIN is a public/private collaboration to reduce healthcare administrative costs through data standardization and electronic commerce. Using AHRQ funding, UHIN will transform into a Regional Health Information Organization by building upon its systems for the exchange of claims data to support the exchange of clinical data.

In addition, it is estimated that about 25 percent of physicians in Utah currently use electronic medical records, and Medicaid has applied for a grant from the Centers for Medicare and Medicaid Services (CMS) to introduce electronic medical records into long-term care settings.⁶ Utah, along with 32 other states, is also participating in the Health Information Security and Privacy Collaboration. This project, funded by AHRQ and the Office of the National Coordinator for Health Information Technology and led by RTI International (a scientific research and development institute) in collaboration with the National Governors Association, will work to insure that electronic exchange of health information occurs under uniform standards of security and privacy.⁷

Utah is also using funding by the Robert Wood Johnson Foundation (RWJF) "to develop a business plan for ongoing, statewide public health participation in electronic exchange of clinical health information."⁸ In addition, Utah is home to industry leaders in health information technology, including 3M Health Information Systems (established in Salt Lake City in 1983) and DigitalBridge, a leading provider of technology that empowers digital transactions between government and business entities while ensuring privacy and security.⁹ Dr. David Sundwall, executive director of the Utah Department of Health, has said, "We are taking advantage of every opportunity available to promote eHealth in Utah."¹⁰

Options for Implementation

- Grant doctors some type of shield from liability if they adhere to best practice guidelines.
- Mandate that all state-financed healthcare providers use best practice guidelines for specific health problems.
- Provide additional state funding to facilitate the development of health information technology and greater use of best practice guidelines or evidenced-based medicine.

Trends and Developments in State and National Policies

Minnesota Legislature

During the last several years, the Minnesota legislature has proposed various bills designed to promote the development and use of best practice guidelines, sometimes in combination with malpractice tort reform. Some of these bills were greatly influenced by the work of the Minnesota Medical Association Healthcare Reform Task Force. In some instances, the Minnesota Medical Association (MMA) helped draft the legislation. In January of 2005, the MMA published a report based on the work of its Healthcare Reform Task Force entitled "Physicians' Plan for a Healthy Minnesota." The report proposed a model built on four key features, including "systems that fully support the delivery of high-quality care." Recommendations related to this feature included support for physician-developed guidelines and support for expansion of an improved information infrastructure.

Dave Renner, who lobbies at the Minnesota legislature for the MMA, stated that legislation based on the MMA's report had no realistic possibility of being enacted, but was intended to start a discussion about healthcare reform.¹¹ Senator Sheila Kiscaden, who sponsored one of the healthcare reforms based on the MMA report, stated that they were "ideas before their time." Her bill was not debated, did not receive a vote, and received little media coverage.¹² Now the MMA has joined efforts with numerous stakeholders, in addition to physicians, to create Healthy Minnesota: a Partnership for Reform. This organization has a steering committee and four subgroups that are investigating how to best implement the recommendations of the Healthcare Reform Task Force's report.

During the 2005-2006 legislative session, the Minnesota legislature considered a bill (SF 2131) that would have allowed doctors to use evidence of "adherence to a best practice guideline" as an "absolute defense" in malpractice suits. The guidelines could be approved by "recognized specialty organizations" or "an organization established for the purpose of developing community-based clinical practice guidelines."

Dave Renner, of the Minnesota Medical Association, stated that doctors were ambivalent about the connection of best practice guidelines with immunity from malpractice litigation. While doctors generally favor malpractice reform, there was concern that under the measure the guidelines would essentially become standards for care, which would perhaps create liability issues for physicians who chose

to depart from the guidelines for legitimate reasons. In addition, Renner noted that tort reform is hard to sell in Minnesota because the malpractice climate in the state is relatively good, and it is hard to argue that Minnesota is in a malpractice “crisis.”¹³

Like Utah, Minnesota is actively developing its health information technology (health IT), which facilitates the use of practice guidelines. The AHRQ funds many health IT projects in the state. The University of Minnesota is one of AHRQ’s thirteen evidence-based practice centers.¹⁴ The legislature recently passed an e-Health initiative proposed by the Governor that provides \$1.5 million to promote electronic health records.¹⁵ However, Senator Kiscaden stated that the emphasis in Minnesota is on using health IT to reduce medical errors that harm patients and to facilitate the development of pay-for-performance incentives for physicians. She explained that the enhancement of health IT is generally not promoted as a method of facilitating the creation of evidence-based guidelines, since guidelines currently do not enjoy broad political support.¹⁶

Introduced State Legislation

Medical malpractice law is a type of tort law based on negligence. To succeed in medical malpractice cases, the plaintiffs must demonstrate that they were injured because they received substandard medical care, or because their medical provider departed from the “standard of care” that caused them injury. Standard of care here signifies the standard that would be exercised by the reasonably prudent medical practitioner, and essentially means what a competent doctor would do under the same circumstances. The term “standard of care” in tort law does not refer to a written guideline, and is thus dependent on expert opinion and open to interpretation. In some states, doctors are held to a community standard of care, meaning that they must perform as well as other doctors practicing in their home community. In other states, physicians are held to a national standard, meaning that they must practice medicine as well as the average specialist in the same field.¹⁷ Several states have statutes regarding expert witness standards, or pre-trial requirements (such as an affidavit) that refer to standards of care.¹⁸ Because standards of care are generally custom-based, they are not as definitive or clear-cut as practice guidelines.

Several state legislatures, in addition to Minnesota, are beginning to consider the use of practice guidelines in malpractice litigation. A 2005 Connecticut House bill provided for a committee to evaluate the feasibility of reviewing complaints against physicians according to evidence-based standards. Also in 2005, the Minnesota House and Senate introduced a bill that would have made the best practice guideline the standard of proof in malpractice cases. New Jersey proposed a similar bill in 2006. A Vermont statute proposed in 2006 states that practice guidelines are admissible in medical malpractice actions to determine standard of care. In 2005, a proposed Connecticut law called for healthcare facilities to develop surgery protocols to be reported to the Department of Public Health.¹⁹

According to the Government Accountability Office (GAO), Maine temporarily used clinical practice guidelines to provide physicians

with an “affirmative defense” in a claim for professional negligence. The five-year medical liability demonstration project was established in 1990 by the Maine legislature. The law specified that the Board of Registration in Medicine and specialty advisory committees would develop practice parameters and risk management protocols that could be used as a defense against potential malpractice lawsuits by physicians within the medical specialty areas of anesthesiology, emergency medicine, and obstetrics and gynecology.²⁰

Federal and State Healthcare Standards

On August 22, 2006, President Bush signed an executive order regarding healthcare in federally financed programs. The stated purpose of the executive order is to promote quality and efficiency through “health information technology, transparency in pricing and quality, and better incentives for consumers and providers.” The order directs federal agencies that administer or sponsor federal health insurance programs to:

- Increase Transparency in Pricing
- Increase Transparency in Quality
- Encourage Adoption of Health Information Standards
- Provide Options that Promote Quality and Efficiency in Healthcare

As part of the second function (increase transparency in quality), agencies will measure the quality of services based upon standards established by multi-stakeholder entities.²¹

HHS Secretary Michael Leavitt explained that the President wanted to standardize information technology systems with respect to registering patients, reporting lab results, writing prescriptions, and establishing secure communication channels between patients and doctors and among healthcare providers. Secretary Leavitt had previously announced that President Bush would be signing an executive order that sets healthcare standards for all providers of federally financed healthcare at the National Governors Association’s annual meeting on August 6, 2006. At the meeting, Leavitt urged governors to sign up groups that take care of state employees and Medicaid recipients.²²

Expanding health IT is a key component of President Bush’s healthcare agenda. The Administration asserts that increasing the use of health IT will increase efficiency, reduce errors, and improve quality, while protecting patients’ privacy.²³ In 2004, President Bush launched an initiative to make electronic health records available to most Americans within the next ten years. The Administration has also promoted the expansion of health IT by establishing the position of the National Coordinator for Health Information Technology within HHS, providing support for health IT projects, and establishing the American Health Information Community (AHIC). AHIC is allowing CMS, the Department of Veterans Affairs, and the Department of Defense to work with private stakeholders towards a common framework for implementing a nationwide electronic health records system.²⁴ As part of the

government's effort to promote the development of health IT, the University of Massachusetts is conducting an investigation (funded by AHRQ) into how Medicaid can help advance health IT. In addition, CMS is pushing states toward a standards-based, modern IT architecture (called MITA – Medicaid IT Architecture) that can link data from a variety of sources.²⁵

As efforts are undertaken to expand health IT, care must be exercised to promote standardization to ensure systems can communicate with other systems. The use of electronic medical records is growing, but many of these systems use proprietary data schematics and coding of symptoms and indicators. Some experts say there are upwards of 400,000 codes that need to be identified and standardized to allow electronic medical records to be capable tools for diagnosing illness and communicating with other systems. State and federal agencies can foster a more effective and rational adoption of electronic medical records and clinical guidance systems by promoting the development of data standards that all sectors of the medical field can agree to use. Without such standards, a world of competing medical records formats could lead to serious shortcomings in diagnosing problems and a “Tower of Babel” scenario where systems cannot “speak the same language” and exchange information with other systems that need the information to ensure patient health.

Experience with Policies and Evidence of Effectiveness

National Guideline Clearinghouse

In order to implement a law involving best practice guidelines, a state would need to designate an organization that would determine which existing guidelines should be used and possibly prioritize conditions for which guidelines should be developed and adopted. Many clinical practice guidelines are already available for implementation. The National Guideline Clearinghouse (NGC) was created by AHRQ in partnership with the American Medical Association (AMA) and the American Association of Health Plans (now America's Health Insurance Plans). NGC is a comprehensive database of evidence-based clinical practice guidelines and related documents. The Clearinghouse includes summaries about guidelines and their development, links to full-text guidelines, guideline comparisons, and an electronic forum for exchanging information on clinical practice guidelines, their development, implementation and use.²⁶ Many other entities, such as the American Association of Pediatricians, the American College of Physicians, and the University of California, San Francisco have made sets of guidelines available on the Internet. The United Kingdom and the Netherlands also have organizations that develop and promulgate best practice guidelines.

Veterans' Health Administration

The Veterans' Health Administration (VHA) employs a model integrated health information system called VistA (Veterans Health Information Systems & Technology Architecture) which has allowed the Veterans' Administration (VA) to reduce costs and errors, increase safety and efficiency, and improve patient satisfaction. The VA utilizes a system-wide computer network of patient records, which exists

in only three percent of private hospitals. Another VA innovation is a bar-code system for patients and medication that has virtually eliminated medication errors. Using a hand-held laser reader, a nurse scans the bar code on the patient's wristband and then scans the barcode on the bottle of medication. This bar-code system is used in less than five percent of private hospitals, despite the fact that the Institute of Medicine estimates that 1.5 million patients are harmed annually by medication errors.²⁷

A 2005 RAND study that compared the medical records of VA patients with a national sample found that VA patients were more likely to receive recommended care. VA facilities performed consistently better across the spectrum of care, including screening, diagnosis, treatment, and follow-up. Significantly, researchers found that the magnitude of improved performance between the VA and the national sample was greater in those areas where the VA was actively measuring performance. In other words, measuring seemed to improve performance. RAND concludes that this study “provides strong evidence that, if one tracks quality, it will improve not only in the area tracked but overall as well.”²⁸ VA has led private-sector healthcare in the University of Michigan's American Customer Satisfaction Index for six years.²⁹ In 2003, the New England Journal of Medicine found that veterans health facilities were “significantly better” than fee-for-service Medicare on all 11 measures used in the study. VA has also outperformed the highest rated non-VHA hospitals in rankings by the National Committee for Quality Assurance.³⁰

In addition to improving quality, the VA has held down costs. While the cost of private care has increased about 40 percent over the last decade, the VA's cost per patient has remained steady.³¹ Part of VistA's innovation is its linkage with standardized, consistent performance measurement. The clinical reminders system alerts healthcare providers when an intervention is due or a test is required and also allows the VA to compare providers and facilities using benchmark preventive performance measures.³² Through VistA, healthcare providers receive patient-specific comprehensive clinical decision support that encourages evidence-based medicine.³³

Agency for Healthcare Research and Quality (U.S. Dept. of Health and Human Services)

AHRQ promotes enhanced health IT in order to improve healthcare quality while increasing cost-effectiveness. AHRQ argues that health IT improvements are crucial for improving the quality, safety, and effectiveness of healthcare. Information specific to the patient and available at the point of care will result in better treatment decisions and fewer medical errors. Health IT would also rapidly add to the body of evidence-based medical knowledge and enable evidence-based findings about best practices to be put into effect quickly. In addition, AHRQ has concluded that dissemination of information is not enough. A 1999 report on outcomes research concluded that “research and experience have demonstrated that development and dissemination of even high quality, highly credible information is often insufficient to alter practices. Enhanced knowledge must be

linked with supportive practice environments and incentives for change.”³⁴

Risk-management initiatives

In response to rapidly rising malpractice premiums and publicity about apparently preventable anesthesia mishaps, the American Society of Anesthesiologists adopted national anesthesiology standards in the 1980s. Many hospitals mandated that their doctors follow these “standards of practice.” These standards are generally, though not universally, believed to have decreased malpractice premiums and to have reduced injuries and deaths.³⁵

California Workers’ Compensation

Workers’ compensation systems provide medical care and wage-replacement benefits to injured workers. Employers provide no-fault insurance against workplace injuries to pay for the benefits and in return are not subject to lawsuits from workers injured on the job. In recent years, California workers’ compensation has been characterized by “rising medical costs, evidence of inappropriate utilization of medical care (overuse), and concerns about quality and satisfaction.” Medical costs increased by 111 percent between 1997 and 2002. In 2002 alone, medical benefit payments increased 26.3 percent, nearly three times the national average. Medical care payments per 100,000 workers were more than twice the national average.³⁶ By 2000, the overall premium and claims costs in California were the highest in the nation. Twenty-eight insurance companies insuring employers for workers’ compensation in California failed. Many interest groups perceived the state of the system as a “serious threat to the economic climate in California.”³⁷ A study performed by the Workers’ Compensation Research Institute concluded that California’s higher medical costs were due primarily to high utilization.³⁸

The California legislature passed a series of reforms in 2002 (AB 749), 2003 (SB 228), and 2004 (SSB 899) in order to reduce inappropriate medical care utilization and control escalating medical costs. The reforms centered on the use of medical treatment guidelines. Prior to these reforms, individual physicians’ treatment plans were legally presumed to be correct. The legislation required the Commission on Health and Safety and Workers’ Compensation (CHSWC) to conduct a survey and evaluation of “evidence-based, peer-reviewed, nationally recognized standards of care.”

Following the study, the Administrative Director (AD) in consultation with the CHSWC was to adopt a “medical treatment utilization schedule” that incorporated the standards of care recommended by CHSWC and that addressed the “frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers’ compensation cases.” The legislation mandated that the guidelines of the American College of Occupational and Environmental Medicine (ACOEM) would be used as the temporary guidelines until the AD and the Division of Workers’ Compensation chose to replace them. The medical treatment guidelines are “presumptively correct,” and determine the burden of proof required in legal situations. In addition, employers were required to establish

written Utilization Review policies and procedures in harmony with the utilization schedule or guideline adopted by the state.³⁹

In accordance with the provisions of SB 899, the Department of Industrial Relations contracted with Bickmore Risk Services (BRS) to prepare a report for the Administrative Director of the Division of Workers’ Compensation on the effects of the legislative reforms on insurance rates. The study, published in January 2006, concludes that the insurance rates had decreased by 46 percent from July 2003 to January 2006 (from \$4.81 to \$2.59 per \$100 of payroll). BRS projected that the 2006 rates were actually 60 percent less than they would have been absent reforms. BRS mid-range estimates of claims cost savings from the reforms were \$8.1 billion in comparison to 2003 costs, and \$15.0 billion in comparison to projected 2006 costs (absent reforms). The report attributed 27 percent of savings to the reforms related to evidence-based medicine, and noted that the provision of utilization review services in conjunction with evidence-based medicine guidelines, notably those of the ACOEM, “helped the insurance community effectively manage the cost of medical treatment in a manner that is also generally responsive to the treatment needs of injured workers.” BRS also found that the California insurance market had become much more competitive since the reforms, and that many employers were now able to obtain multiple bids for their insurance policies.⁴⁰

TORT REFORM

States have implemented tort reforms to improve the affordability and availability of malpractice insurance by helping to contain costs associated with medical malpractice. Tort reformers hope to reduce malpractice claims and payouts, thereby reducing insurers’ losses. Holding down insurers’ costs in turn reduces the malpractice premiums that insurers charge physicians. Advocates of tort reform also hope to decrease healthcare costs and increase consumers’ access to healthcare by reducing the practice of defensive medicine.

Figure 1: Nine Common Malpractice Tort Reforms in the Mountain States, October 2005

Reform	AZ	CO	ID	NV	NM	UT	WY
Limits on Damage Awards	U	X	X	X	X	X	
Limits on Attorney Fees	CR			X		X	X
Expert Witness Standards	X	X	X		X		
Affidavits or Certificates of Merit	X			X			
Pre-trial Screening or Alternative Dispute Resolution	X	X	X	X	X	X	X
Statutes of Limitation	X	X	X	X	X	X	X
Limits on Joint & Several Liability	X	X	X	X	X	X	X
Compensation or Stabilization Fund		NI		X	X		X
Doctor Apologies	X	X				X	X

U – Unconstitutional
 CR – Courts review attorneys’ fees for reasonableness
 NI – Not Implemented

Source: National Conference of State Legislatures (NCSL).

Defensive medicine has been defined as “the ordering of tests, procedures, and visits, or avoidance of certain procedures or patients, due to concern about malpractice liability risk.”⁴¹ Proponents of tort reform also argue that the transaction costs (particularly attorneys’ fees) of litigation are excessive, that punitive and noneconomic (pain and suffering) damages awards are often arbitrary and thus do not improve safety, and that fair compensation is limited by frivolous lawsuits and excessive awards. Opponents of tort reform argue that reforms favor insurance companies and physicians and infringe upon the rights of individual patients. They argue that tort laws deter malpractice and protect patients against an unsafe medical system. In addition, they assert that malpractice insurance prices are driven by investment income and the insurance cycle, rather than legal trends.

Malpractice Tort Reform in Utah

Like many other states, Utah began enacting malpractice tort reforms in the 1970s in response to a rising number of suits and claims for damages, rising amount of judgments and settlements related to healthcare, and increases in malpractice insurance premiums. The Utah legislature found that these trends were resulting in rising healthcare costs for patients as doctors passed on the cost of the premium and as doctors practiced defensive medicine.⁴² During the last three decades, Utah has enacted many common malpractice tort reforms, including a limit on noneconomic damage awards, a statute of limitations, limits on joint and several liability, limits on attorney fees, pre-trial screenings and voluntary arbitration. In addition, several years ago, Utah was considered as a possible location for a pilot project involving no-fault compensation as an alternative to malpractice litigation. The no-fault compensation system was never implemented, however.

Figure 1 shows how Utah compares to the other mountain states with respect to nine common malpractice tort reforms. The first five reforms listed will be discussed in greater detail below as possible options for implementing further tort reforms in Utah. All of the six mountain states have statutes of limitation. In addition, all mountain states have limits on joint and several liability, meaning that defendants are proportionally liable according to percentage of fault for damages awarded. Four mountain states have statutes that enable the utilization of a compensation or stabilization fund, which provides additional payments to injured patients above a specific amount. These funds limit the liability of individual physicians without limiting total payment amounts to injured patients. Generally, physicians are responsible up to a certain amount of damages (regardless of the amount of damages awarded by the jury), with the rest of the award coming from the compensation or stabilization fund. States may use physician surcharges, general revenues or other means to generate revenues for the funds.⁴³ Utah does not have this legislation. Three mountain states do not allow a doctor’s apology or expression of sympathy to be used as evidence in a malpractice claim. Utah passed this statute in 2006, but its legality has been questioned.

Figure 2: Malpractice Claims Payments by State, 2005

State	State Rank by Average Claims Payments	Average Claims Payments	Total Dollars in Paid Claims	Total Dollars in Paid Claims Per Capita
Connecticut	1	\$731,695	\$103,900,750	\$29.60
Hawaii	2	572,829	10,883,750	8.53
Alaska	3	559,926	9,518,750	14.34
Illinois	4	513,682	207,014,000	16.22
Delaware	5	481,153	14,915,750	17.68
Massachusetts	6	473,166	123,023,250	19.23
Minnesota	7	465,390	33,973,500	6.62
New York	8	378,783	669,687,850	34.78
Wisconsin	9	376,791	32,027,250	5.79
New Jersey	10	361,225	251,412,500	28.84
Maryland	11	358,802	83,242,000	14.86
Virginia	12	357,926	54,404,750	7.19
New Hampshire	13	355,731	18,853,750	14.39
Pennsylvania	14	344,323	365,671,000	29.42
Rhode Island	15	341,000	13,299,000	12.36
Georgia	16	336,118	90,079,750	9.93
Oregon	17	323,351	24,251,300	6.66
Washington	18	318,282	53,153,050	8.45
Arkansas	19	309,411	23,515,250	8.46
North Carolina	20	307,036	59,872,000	6.90
Arizona	21	306,410	84,875,500	14.29
Missouri	22	305,008	66,186,650	11.41
Ohio	23	302,722	125,629,750	10.96
South Dakota	24	296,129	9,180,000	11.83
Wyoming	25	293,611	7,927,500	15.57
Indiana	26	279,230	51,936,750	8.28
Alabama	27	278,689	11,426,250	2.51
North Dakota	28	272,308	7,080,000	11.12
Idaho	29	261,611	7,063,500	4.94
Colorado	30	255,943	32,760,750	7.02
Maine	31	251,910	9,068,750	6.86
Tennessee	32	251,256	39,447,250	6.62
Montana	33	246,089	10,335,750	11.05
Nevada	34	242,799	25,979,500	10.76
Oklahoma	35	242,249	41,909,000	11.81
Florida	36	234,358	256,856,000	14.44
West Virginia	37	232,744	18,386,750	10.12
New Mexico	38	226,974	30,641,500	15.89
Kentucky	39	224,083	35,629,250	8.54
Mississippi	40	204,325	17,776,250	6.09
California	41	204,218	228,724,700	6.33
Iowa	42	194,765	20,060,750	6.76
Louisiana	43	185,386	55,615,750	12.29
Texas	44	182,795	186,085,500	8.14
Vermont	45	169,483	2,542,250	4.08
South Carolina	46	161,092	27,546,750	6.47
Utah	47	158,944	15,576,500	6.31
Kansas	48	150,661	23,352,500	8.51
Michigan	49	130,412	58,816,000	5.81
Nebraska	50	97,381	18,892,000	10.74
United States		\$290,984	\$4,082,217,800	\$13.77

Source: Kaiser State Health Facts.

Currently Utah ranks near the bottom of the states (47th) in terms of the average claims payments, but ranks 15th highest for the number of claims per 1,000 physicians (see Figures 2 and 3). The average claims payment for Utah is \$158,944, which is below the average claims payment for all of the other mountain states and only 55 percent of the national average (\$290,984). Of the seven mountain states, only Arizona and Wyoming have an average claims payment above the national average.⁴⁴ On the other hand, the number of claims per 1,000 physicians in Utah is 19.1, compared to a national average of 17.1. Four of the mountain states (New Mexico, Wyoming, Nevada, Arizona) have a higher number of claims per 1,000 physicians.⁴⁵

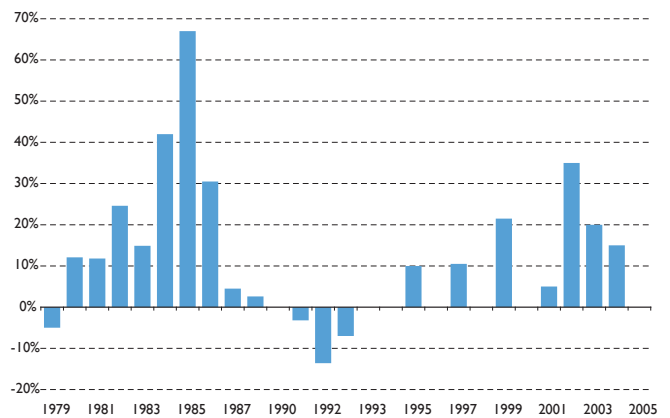
In 1978, the Utah State Medical Association facilitated the creation of the Utah Medical Insurance Association (UMIA), in order to provide a source of stable liability coverage in the wake of a nationwide withdrawal of commercial medical liability insurers.⁴⁶ UMIA is now the primary malpractice insurer in Utah, covering about 2,400 physicians, or almost all physicians who are not directly employed by either Intermountain Healthcare or the University of Utah. Figure 4 illustrates the rate changes of malpractice premiums for Utah physicians insured by UMIA since 1979. Five of the last ten years have double-digit growth rates for malpractice

premiums. Between 1996 and 2006, UMIA premiums nearly doubled (increasing 96 percent) after adjusting for inflation.

Options for Implementation

- Lower non-economic damages cap.
- Total damages cap (as in CO, IN, LA, NE, NM).
- Sliding scale for attorney fees.
- Expert witness standards.
- Certificates of merit.
- Allow court to order arbitration, require arbitration for medical claims under a given amount, or allow either party to request nonbinding arbitration.
- Allow pre-trial screening panels to deny claims without merit from going to trial.
- Adherence to best practice guidelines as a shield from liability.
- No-fault compensation system.

Figure 4: Utah Malpractice Premium Rate Changes 1979-2005



Note: The method of measuring the rate of growth changed in 1985. Therefore, the growth rates for the years before and after 1985 are not directly comparable.
Source: Utah Medical Insurance Association (UMIA).

Trends and Developments in State and National Policies

According to the National Conference of State Legislatures, 48 state legislatures introduced over 400 bills addressing aspects of medical malpractice in 2005. During the 2005 legislative session, 32 states enacted medical malpractice reform legislation into law. As of May 2006, 36 states were considering medical malpractice legislation, and nine states had already enacted bills during 2006. State legislation in 2005 mainly focused on traditional tort reform issues such as limits to damage awards, attorney fees, expert witness standards, and the inadmissibility of doctors' apologies in malpractice suits. 2006 legislation addresses these issues as well as alternatives to litigation and greater accountability for insurance companies.⁴⁷ The Bush administration continues to push federal medical liability reform, including a \$250,000 limit on noneconomic damages, limits on punitive damages, limits on attorney fees, periodic payments for future damages, liability proportional to fault, and the disclosure of collateral source benefits.⁴⁸

Figure 5 illustrates the prevalence of nine commonly adopted tort reforms. Limits on damage awards, limits on attorney fees, expert witness standards, affidavits, and pre-trial alternative dispute resolution (including screening panels and arbitration) will all be explored in detail below as options for implementation. Several of these reforms involve building upon existing reforms already in place in Utah. For example, Utah already has limits on attorney fees, but the limits could be stronger. As mentioned above, Utah already has enacted statutes of limitation, limits on joint and several liability, and a liability shield for doctor's apologies. Utah does not have a compensation fund. See Appendix A for information regarding the tort reforms that have been enacted as of 2005 for each of the fifty states.

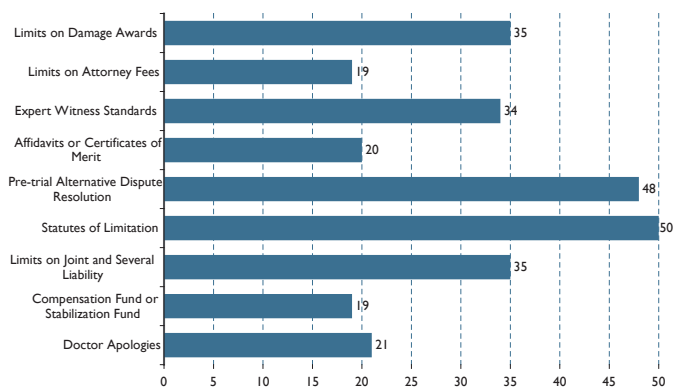
For the following sections, data regarding the enactment of individual tort reforms by states is based on data collected by the National Conference of State Legislatures unless otherwise noted.⁴⁹

Figure 3: Number of Paid Malpractice Claims, 2005

State	State Rank by Number of Paid Claims Per 1,000 Physicians	Number of Paid Claims Per 1,000 Active, Non-Federal Physicians
Nebraska	1	45.8
New Mexico	2	29.7
Wyoming	3	28
Pennsylvania	4	25.8
Louisiana	5	25.4
Florida	6	24.4
Kansas	7	24.1
New Jersey	8	24
Oklahoma	9	23.9
Nevada	10	23.4
New York	11	22.9
Arizona	12	21.4
Texas	13	20.7
Montana	14	20.3
Utah	15	19.1
South Dakota	16	18.6
South Carolina	17	17.7
West Virginia	18	17.2
North Dakota	19	16.8
Kentucky	20	16.5
Mississippi	21	16.4
Iowa	22	16
Michigan	23	15.5
New Hampshire	24	15.3
Missouri	25	14.1
Georgia	26	13.8
Delaware	27	13.7
Arkansas	28	13.5
Indiana	28	13.5
Ohio	30	12.5
Alaska	31	11.9
California	31	11.9
Illinois	33	11.1
Connecticut	34	11
Idaho	34	11
Maryland	36	10.7
Colorado	37	10.4
Tennessee	38	10.2
Washington	39	10.1
Rhode Island	40	10
North Carolina	41	9.1
Maine	42	9
Massachusetts	42	9
Oregon	44	7.8
Virginia	45	7.7
Vermont	46	6.6
Wisconsin	47	5.9
Minnesota	48	5.1
Hawaii	49	5
Alabama	50	4.2
United States		17.1

Source: Kaiser State Health Facts.

Figure 5: Number of States Enacting Nine Common Tort Reforms, October 2005



Source: NCSL.

Limits on Damage Awards

As of October 2005, 35 states had some type of statute addressing damage awards (not necessarily a monetary cap). These statutes may place limits on or provide guidelines for determining economic, noneconomic, punitive, or total damages, or some combination of these. In several states, damage awards are determined by the court or subject to judicial review. The most contentious type of damage awards is noneconomic (pain and suffering) damage awards. Determining how much money to compensate a plaintiff for the loss of a spouse or a disfiguring injury is highly subjective. The fact that award amounts awarded by different juries for similar injuries can vary substantially often raises the criticism that noneconomic damage awards are arbitrary and unfair. Noneconomic damage awards are often the focus of statutory award limits. In some states noneconomic limits or caps are absolute, while in others the amount the plaintiff may recover varies according to the plaintiff's injury or the defendant's conduct.⁵⁰

According to a Robert Wood Johnson Foundation (RWJF) report on medical malpractice, 30 states have a limit or cap on noneconomic or total damages awards. Of those states, four have a total damages cap, four have a noneconomic damages cap of \$250,000, eighteen have a noneconomic damages cap between \$250,000 and \$500,000, and four states have a noneconomic damages cap above \$500,000 (see Figure 6).⁵¹ Five states (Colorado, Indiana, Louisiana, Nebraska, and New Mexico) have a cap on total damages.⁵² In seven states, the State Supreme Court has declared a state's statutory limit on damage awards to be unconstitutional.⁵³

Utah law currently limits noneconomic (pain and suffering) damages to \$460,000 (as of July 1, 2006), to be adjusted annually by the Administrative Office of Courts. Idaho, Colorado, and Nevada all have lower noneconomic damages caps. New Mexico and Colorado both have total limits on all damages (\$600,000 and \$1 million, respectively). In Wyoming and Arizona, limits are constitutionally prohibited.

Attorney Fees

Attorney compensation has generated considerable controversy. Usually lawyers representing patients have a "contingent fee" arrangement, meaning that they only receive a fee if their client wins the case. In addition, under this arrangement the fee depends on the size of the award, not on a set amount or hourly fee. The contingent fee arrangement means that lawyers must take a large share of the damages when they win in order to offset the losing suits for which they receive no compensation. Typically, when limits are not in place, the lawyer will take 33 to 50 percent of the total award.⁵⁴ Utah law states that an attorney's contingency fee cannot exceed one-third of an award. Of the other mountain states, two have sliding scales, one uses court review, and the other three have no limitations. The American Tort Reform Association recommends a sliding scale for attorney fees. Nationally (as of October 2005), six states have a flat proportional limit on attorney fees (like Utah's limit), while 13 states use a sliding scale. In seven states, attorney fees are determined by the court or subject to judicial review. 24 states have no limits on attorney fees.

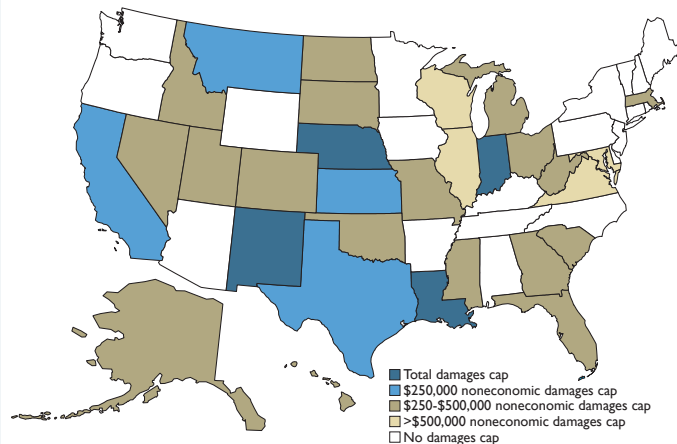
Expert Witness Standards

Expert witness standards define the conditions under which a medical professional may testify as an expert witness in a medical malpractice trial. Utah currently has no provision regarding expert witness qualifications. As of October 2005, 34 states had a law regarding expert witness standards (usually regarding licensure, training, specialty, or clinical activity). Four mountain states have this provision.

Affidavits or Certificates of Merit

Affidavits and certificates of merit seek to reduce the number of claims by creating barriers to filing a claim (in an effort to weed out so-called "frivolous" lawsuits). Like expert witness standards, these provisions also seek to address the way in which negligence is determined by defining standards for who can testify about the required standard of care. Twenty states require an affidavit or certificate of merit from a medical expert to be submitted by a claimant when a malpractice

Figure 6: Caps on Noneconomic and Total Damages



Note: Maine and Oregon have caps that only apply in cases of wrongful death; Alaska, Florida, Massachusetts and Ohio have caps that increase or can be waived in severe cases.
Source: Mello (Robert Wood Johnson Foundation).

complaint is filed. Utah does not have this provision. Of the other mountain states, only Nevada requires an affidavit or certificate of merit. Arizona requires an affidavit only if expert testimony is required to prove liability in the claim. Some states apply the expert witness standards to the medical expert who provides the affidavit or certificate of merit.

Alternative Dispute Resolution

Thirty-seven states use alternative dispute resolution, arbitration, or mediation as options for resolution prior to filing a lawsuit or going to trial. States vary regarding whether the alternative to litigation is required or the associated decisions are binding. In 15 states, arbitration or mediation is mandatory in all cases, or in those cases referred to arbitration or mediation by the court, or if requested by either party (usually the physician). In six states, the results of the alternative dispute resolution are binding. Utah law allows for voluntary arbitration, with a binding decision upon written agreement by all parties. Alternative dispute resolution seeks to bypass the high defense and underwriting costs of formal legal proceedings.

Pre-trial Screening and Review Panels

These provisions provide for panels that conduct preliminary hearings prior to a malpractice trial in order to determine the validity of the complaint. Pre-trial screening and Review Panels seek to reduce the number of claims by erecting barriers to reaching trial. Screening panels are usually intended to weed out claims that lack merit before they go to trial, although plaintiffs are generally not precluded from pursuing a court trial regardless of the panel's finding. Eighteen states provide for some type of review panel prior to trial. Submission of a claim to a panel can be mandatory in all cases, mandatory if requested by at least one party (usually the physician), or voluntary (only used if agreed to by all parties). State provisions also vary as to whether the proceedings during the panel are allowed into evidence if there is a subsequent trial.

Utah's law requires a pre-litigation panel as a condition of litigation, but a plaintiff may pursue a claim in court regardless of the panel's decision. The panel's decision is non-binding and evidence of the proceedings is inadmissible in a court trial. The pre-litigation hearings are intended to convince plaintiffs with nonmeritorious cases to drop their claims or to encourage defendants to settle when there is strong evidence of malpractice. The panel thus allows plaintiffs and defendants to avoid the costly litigation of a full trial. All other mountain states except Colorado also have some type of pre-trial screening process. Arizona's hearing determines if basis exists to go to trial.

Best Practice Guidelines

Some states have proposed legislation that would allow medical providers to use adherence to practice guidelines as a shield from liability. No states have enacted this legislation. For more information about this tort reform, see the Practice Guidelines (Trends and Developments in State and National Policies) section.

Experience with Policies and Evidence of Effectiveness

Malpractice Claims and Damages Awards

In June 2004, the Congressional Budget Office (CBO) published a paper entitled "The Effects of Tort Reform: Evidence from the States." The paper reviewed the major recent studies that addressed the impact of state-level tort reforms. Five of the seven major studies reviewed in the paper examined medical malpractice liability (three studied malpractice liability exclusively, while two studied both general and medical malpractice).

One of these, a 2001 study by Albert Yoon, found evidence that caps reduce damages awards. Yoon studied the amounts recovered by plaintiffs in medical malpractice litigation in Alabama from 1987 to 1999. Yoon found that plaintiffs recovered an average of \$23,000 less per claim in Alabama courts relative to neighboring states without caps. In a 2000 study, Daniel P. Kessler and Mark B. McClellan found that capped awards led to fewer medical malpractice claims. Other reforms such as caps on attorneys' fees, however, tended to have the opposite effect.⁵⁵

Insurers' Profitability and Malpractice Insurance Premiums

In March 2003, the CBO published a cost estimate of H.R. 5, a national tort reform modeled after California's MICRA tort reforms (including reforms such as caps on awards and attorney fees). CBO estimated that, under the tort reform bill, "premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent lower than what they would be under current law." CBO's cost estimate did not include savings from a reduction in the practice of defensive medicine, because estimates at the time were mostly speculative and lacking in empirical evidence.⁵⁶

The 2004 CBO report on tort reform reviewed three studies that addressed malpractice insurers' profitability and physicians' malpractice premiums. W. Kip Viscusi and others found in a 1993 study on 1980s tort reform legislation that limits on noneconomic damages reduced the amount an insurance company pays on a claim by about 14.7 percent. They also concluded that the package of reforms (including modifications to joint-and-several liability, caps on awards, establishing immunities from prosecution, and others) enacted in 1985 and 1986 led to an average reduction of 13.4 percent in medical malpractice premiums.

A 1998 study by Patricia Born and W. Kip Viscusi found that damage caps and other reforms during the mid-1980s reduced insurance companies' costs, reduced insurance premiums, and increased profitability of insurance companies. A 2004 study by Kenneth Thorpe examined state-level trends in insurance premiums earned and insurers' loss ratios for 1985 to 2001.⁵⁷ Thorpe found that states with a noneconomic damages cap had loss ratios that were 11.7 percent lower and overall premiums that were 17.1 percent lower than states without the cap. Thorpe found no association between the adoption of attorney fee caps and the loss ratio or premiums.

The 2004 CBO paper concludes that a number of the empirical studies “found that state-level tort reforms have decreased the number of lawsuits filed, lowered the value of insurance claims and damage awards, and increased insurers’ profitability as measured by payouts relative to premiums in the short run.” However, the paper also argues that the results are not conclusive and “should be interpreted cautiously” because of data availability and quality issues, as well the difficulty in distinguishing the effects of particular reforms when most are enacted in packages at the state level. Randall R. Bovbjerg and Robert A. Berenson, writing for the Urban Institute, assert that caps are “well documented” to reduce malpractice claims and payouts, but argue that whether they continue to achieve savings depends on whether courts and juries apply them as binding limits or attempt to work around them.⁵⁸

Defensive Medicine

In a report entitled “The Factors Fueling Rising Healthcare Costs 2006,” PricewaterhouseCoopers (PwC) concludes that the cost of malpractice litigation and the practice of defensive medicine account for 10 percent of the costs of medical services. The report attributes nine percent of health insurance premiums increases (from 2004 to 2005) to more intensive diagnostic testing, and explains that defensive medicine contributes to these increases in diagnostic testing. Based on a 2002 study on the costs of poor quality, PwC also reports that eight percent of healthcare costs are due to defensive medicine and two percent are due to malpractice litigation.⁵⁹

The 2004 CBO report on tort reform also evaluated studies that addressed the practice of defensive medicine. Studies in 1996 and 2002 by Kessler and McClellan presented evidence that “direct” reform of medical malpractice law led to decreased spending with no significant increase in adverse healthcare outcomes, or, in other words, a reduction in unnecessary medical expenditures. Direct reforms included laws that specified limits on or reductions in malpractice awards. However, these studies depended on a very restricted sample of patients (Medicare patients with acute myocardial infarction or ischemic heart disease), and CBO warns that the results cannot be generalized to the population as a whole. In fact, CBO has found “no evidence that tort reforms reduced medical spending when it applied the same methods used by Kessler and McClellan to a broader set of ailments.” The Government Accountability Office (GAO) also warns against generalizations from the Kessler and McClellan study based on their failure to consider the range of factors that can influence medical spending.

In a 2003 report called “Medical Malpractice: Implications of Rising Premiums on Access to Healthcare,” GAO reviewed studies that addressed the prevalence and costs of defensive medicine practices as well as the potential for tort reform to mitigate defensive medicine costs.⁶⁰ In surveys (such as a 2003 survey by the AMA and a 2002 survey by the American Academy of Orthopaedic Surgeons), physicians report practicing defensive medicine, but GAO cautions that the surveys have limitations, such as low response rates and imprecise measurements of the frequency and prevalence

of physicians’ use of defensive medicine. These limitations preclude generalizations about all physicians’ behavior based upon the surveys. Officials from the AMA and medical, hospital, and nursing home associations told GAO that defensive medicine exists but is difficult to measure, and that other factors (such as revenue-enhancing motives and managed care) also affect utilization rates of procedures.

In a 2006 Robert Wood Johnson Foundation (RWJF) report on medical malpractice, Mello discusses a “well-designed” study of high-risk specialists in Pennsylvania by Studdert and others. This 2003 study found that 93 percent of the high-risk specialists reported that they sometimes or often engaged in at least one of six behaviors associated with defensive medicine. More specifically, “59 percent reported often ordering more diagnostic tests than were medically indicated; 52 percent often made unnecessary referrals to specialists; 33 percent prescribed more medications than were medically indicated; and 32 percent suggested unnecessary invasive procedures such as biopsies to confirm diagnoses.” The study also found that physicians who lacked confidence in the adequacy of their liability coverage or who believed their insurance premiums were burdensome were significantly more likely to report these behaviors.⁶¹

The GAO report also concluded that research suggests that defensive medicine may be practiced in certain specific clinical situations (such as the management of head injuries in ERs and cesarean deliveries in childbirth), but that the findings cannot be generalized to estimate the nationwide costs of defensive medicine because the studies focused on specific clinical circumstances and populations.

D.A. Katz and others published a study in the *Annals of Emergency Medicine* in 2005 that concluded that malpractice fear is associated with increased hospitalization of low-risk patients and increased use of diagnostic tests. The study used surveys of emergency physicians to evaluate the association between physicians’ fear of malpractice and the treatment patterns of patients with a specific heart condition.⁶²

Supply of Physicians

In its 2003 report on medical malpractice, GAO concluded that “actions taken by healthcare providers in response to rising malpractice premiums have contributed to reduced access to specific services on a localized basis” in five states with reported malpractice-related problems. GAO confirmed examples of decreased access to emergency surgery services and newborn deliveries due to malpractice pressures in each of the five states, often in rural areas. In most cases providers identified other factors, besides malpractice concerns, that affected the availability of services. GAO also determined that some of the reported physician actions and service reductions were not substantiated or did not widely impact access to healthcare.

According to a 2005 study by William Encinosa and Fred Hellinger (senior economists with the Agency for Healthcare Research and Quality (AHRQ)), state caps on malpractice awards have increased the supply of physicians, particularly in rural counties.⁶³ The study examined the impact of the size of the caps on the physician supply,

the differential impact of caps on physician supply in rural versus urban areas, and also the impact on surgeons and OB-GYNs, physicians with particularly high medical malpractice premiums. Using county-level data from all fifty states from 1985 to 2000, Encinosa and Hellinger estimated that counties in states with a cap on noneconomic damages had 2.2 percent more physicians per capita because of the cap. The effect was larger in rural counties (3.2 percent more physicians per capita as a result of the cap). In addition, rural counties with a \$250,000 cap had 5.4 percent more OB-GYNs and 5.5 percent more surgical specialists per capita than did rural counties with a cap above \$250,000. For all counties (rural and urban combined), the \$250,000 cap had a significant impact on the supply of surgical specialists (relative to a cap above \$250,000), but not on the supply of OB-GYNs. The caps above \$250,000 did not affect the supply of either specialist, relative to counties with no caps. The effects mainly occurred several years after the cap had been in place.

A study by Kessler and others, published in the *Journal of the American Medical Association* in 2005, also concluded that tort reform increased physician supply. They found that three years after the adoption of “direct” malpractice reforms (such as caps on damages) physician supply had increased by 3.3 percent. Direct reforms had a larger effect on specialties with high malpractice insurance premiums and on states with high levels of managed care.⁶⁴ Two other recent studies (Biacher & Chandra 2005, Matsa 2005), which were identified in the RWJF report as being strong methodologically, did not find a significant association between the malpractice environment and physician supply. Biacher and Chandra found that neither premiums nor payments were significantly associated with overall physician supply. Matsa found that caps on damages were not significantly related to overall physician supply. However, Matsa did find that caps increased the supply of specialists in extremely rural areas by 10 to 12 percent from 1970 to 2000.⁶⁵

In the RWJF report, Mello also points out that the malpractice environment may have longer-term effects on physician supply, such as dissuading college students from entering medical school, deterring medical students from entering particular specialties, or deterring residents from practicing in the same state where they performed their residency. A 2005 study by Mello and Hemenway suggested that “residents who trained in Pennsylvania during the malpractice crisis were much less likely to stay in the state after residency than residents who trained there when the liability climate was calmer.” Mello concludes that “longer-term effects on physician supply may occur that have not been documented.”⁶⁶

Arguments Against Tort Reform

Opponents of tort reform argue that reforms favor insurance companies and physicians and infringe upon the rights of individual patients. Some states have declared any type of cap on damages awards to be unconstitutional. Bovbjerg and Berenson of the Urban Institute point out that caps succeed by “unfairly reducing the recoveries of the most severely injured claimants.”⁶⁷ In addition, while

many studies have demonstrated that the majority of malpractice claims are not valid (meaning that the plaintiff did not experience an adverse medical event due to physician negligence), these studies also show that most patients that receive negligent care never file a claim. For example, the 1993 Harvard Medical Malpractice Study found that for every eight medical injuries due to negligence, only one malpractice claim was filed.⁶⁸ Given that so many patients who suffer from medical negligence are never compensated, opponents of tort reform argue that we must consider whether it is appropriate or desirable to deter consumers from filing a malpractice claim through tort reform.

No-Fault Compensation

No-fault compensation systems, which are an alternative to malpractice litigation, are discussed here separately from the other tort reforms because reforms involving no-fault systems represent an effort to replace rather than modify the existing malpractice litigation system. The above tort reforms are designed to reduce litigation costs, but not to decrease the incidence of medical error (which experts have estimated to be responsible for 44,000 to 98,000 deaths per year in the U.S.⁶⁹) and adverse events. Many healthcare reformers believe that the tort reform battle obscures real problems, and that policymakers should instead focus on the larger problems of the medical liability system, including “its inefficiency, low rate of compensating injured patients, inequity in awarding compensation and lack of deterrence of medical errors.”⁷⁰

Many researchers have concluded that medical malpractice litigation does not serve either of its two main purposes because it fails to deter malpractice or to compensate victims. As stated before, a large body of evidence demonstrates that most adverse outcomes resulting from medical negligence never result in a claim. Based on the Harvard Medical Practice Study (based on 1984 data on hospitalized patients in New York State), Localio and others conclude that only 1.53 percent of patients who suffered adverse events caused by medical negligence filed malpractice claims.⁷¹ Research based on 1992 data from Utah and Colorado showed that only 2.5 percent of patients who suffered adverse events caused by medical negligence filed malpractice claims.⁷² Based on this evidence, the vast majority of patients who suffer negligent injury are never compensated. In addition, health insurance and other non-liability coverage pay almost all compensation because few injured patients sue and still fewer collect.⁷³

Conversely, many malpractice lawsuits are brought to trial, and even won, by patients even though expert reviewers can identify no evidence of negligent care. For the 1992 data from Utah and Colorado, only 22 percent of claims examined actually involved a negligent injury.⁷⁴ Using the 1984 New York data, researchers concluded that only 17.6 percent (about one-sixth) of all claims filed actually involved an adverse event due to negligence, while 25.5 percent of claims filed involved an adverse event but no negligence, and 47.1 percent (nearly half) of all claims involved no adverse event.⁷⁵ Of the claims involving negligence, nearly half (44.4 percent)

resulted in a payoff to the plaintiff. On the other hand, 46.2 percent of claims with an adverse event but no negligence resulted in an award, with a mean payment of about \$98,000, and 41.7 percent of claims with no adverse event resulted in an award, with a mean payment of about \$29,000. In a statistical analysis, negligence was not a significant predictor of the outcome of the malpractice trial. Instead, the most important driver of damages was the severity of the patient's injury. Malpractice litigation therefore cannot act as a deterrent to negligence because negligent providers are unlikely to be sued, and providers who have not acted negligently may be sued anyway. In addition, malpractice insurance means that providers would not bear the true burden of their negligent acts, even if claim success and damages awards were more closely aligned to actual incidents of negligence.

The malpractice tort system is also extremely inefficient. Patients sometimes have to wait years for their case to be decided, and researchers have estimated that only about 40 percent of dollars spent on malpractice insurance go to injured patients, with over half of resources going to administrative costs (such as lawyers' fees).⁷⁶ In 2003, the average plaintiff waited four and a half years for the physician payout.⁷⁷

Critics of the medical malpractice system assert that the malpractice liability system is at odds with efforts to improve patient safety, since tort law creates a strong disincentive to participate in processes that are likely to improve patient safety (such as voluntary reporting of adverse outcomes). In other words, health providers currently have an incentive to not share information about medical errors and adverse outcomes for fear of facing litigation. Experts on medical error and patient safety, such as Troy Brennan, have suggested that we could better synchronize medical error prevention and compensation through a no-fault liability system based on compensable events. Under a no-fault compensation system with mandatory reporting of errors, health professionals could develop a database to determine the root cause of adverse outcomes in order to decrease the number of medical errors and improve patient safety.

On the other hand, critics of no-fault compensation systems argue that no-fault systems will lead to much higher compensation costs (even accounting for savings in administrative costs), since a greater proportion of injured patients would end up receiving compensation. Opponents of no-fault also argue that no-fault systems reduce the incentives for precaution by healthcare providers and increase medical injuries. In addition, supporters of the current malpractice tort system believe that injured patients have a right to a jury trial, and that an administrative system could possibly favor powerful corporations over individual citizens.

No-fault Compensation in Utah

In the 1990s, the RWJF provided funding to help develop no-fault malpractice compensation systems in Colorado and Utah. The main focus of the research was to estimate the rate of adverse events (injuries caused by medical treatment) in Colorado and Utah in order to

estimate the cost of a no-fault system (the statistics cited earlier in this section based on 1992 Utah and Colorado data are from this project). Under the no-fault administrative system (named Experiment in Patient Injury Compensation or EPIC), courts would play only a limited role, on appeal of decisions, while a quasi-governmental entity determined compensation amounts through speedy nonadversarial adjudication. EPIC made hospital entities responsible for paying compensation (a system known as enterprise liability), in order to give healthcare organizations a strong incentive to provide high-quality care and improve patient safety.

A study of the proposed programs concluded that compensation of all adverse events "would substantially exceed the money currently spent on the medical malpractice systems." However, researchers also concluded that the administrative system would have similar costs to the existing malpractice tort system if compensation were restricted to injuries that meet the Swedish "avoidability" criteria – even with noneconomic damages awards and even though a much greater number of patients would receive compensation than under the no-fault system than under the existing tort system. Under the Swedish system, if adjudicators determine that the injury resulted from treatment, and that either the treatment in question was not medically justified or that the outcome was avoidable, then the claimant receives compensation. The Swedish system also has a threshold (at least 10 days in the hospital or more than 30 sick days) to eliminate minor claims. Proponents of no-fault system argue that focusing on the concept of avoidability standard (based on the idea of error reduction through changes in systems of care) rather than negligence (based on the idea that errors can be reduced by greater diligence by individuals) leads to a more open exchange about circumstances that lead to errors.

Despite these promising efforts, the no-fault compensation system was never implemented in Utah or Colorado. Researchers concluded that the effort failed in Utah for a number of reasons, including the stabilization of malpractice premiums, projected costs of the new system, and the fact that the dominant hospital chain declined to commit the use of its Salt Lake City hospital as a demonstration site.⁷⁸

In addition to Sweden, there are several other international precedents for the no-fault system, including Denmark, Finland and New Zealand. Canada's health council recently considered the pros and cons of the New Zealand no-fault model. New Zealand officials reported that their program "supports a culture of openness" and also delivers 90 percent of costs to the patient (a much more efficient system than malpractice litigation, in which only 40 percent of all resources go to the plaintiff).⁷⁹

Other experiences with no-fault compensation in the United States include two state-based administrative compensation systems (which function much like Workers' Compensation). Virginia and Florida both enacted no-fault compensation programs for birth-related neurological injuries in the late 1980s. Under these systems, the

injured party did not have to prove negligence and compensation was decided administratively rather than by courts. Using grant money from the Robert Wood Johnson Foundation, the Duke University Medical Center evaluated the Florida and Virginia systems from June 1995 to November 1997. Evaluators concluded that the no-fault system was more efficient (delivering similar benefits to tort, but more quickly and with lower administrative costs), that no-fault claimants were generally satisfied with the program, and that a much larger portion of payments went to patients (only three percent went to lawyers under no-fault, versus 39 percent under tort). Researchers also concluded that, just as in the tort system, only a small portion of potential claimants seeks compensation under no-fault, possibly due to the continued use of the tort system for cases covered by no-fault and a lack of outreach education about the program.⁸⁰ In addition, evaluators reported that the programs were too limited in scope to achieve broader access to compensation and prevention of medical injuries, two of the principal goals of the no-fault system.⁸¹

Federal legislation has recently focused national attention on alternatives to malpractice litigation. In 2005, U.S. Senators Baucus and Enzi introduced The Fair and Reliable Medical Justice Act (S 1337), which authorizes grants to fund state pilots of alternatives to medical tort liability systems (such as administrative determination of compensation). A 2002 report by the Institute of Medicine, which suggested such state-based demonstrations, helped shape the act.⁸²

STATE MANDATES

A health insurance mandate is a legislative requirement that an insurance company or health plan cover (or offer coverage for) certain healthcare providers, benefits, and patient populations. For example, a mandate may require that health plans cover providers such as chiropractors, or benefits such as mammograms, or patient populations such as adult children enrolled in college. States can require health insurers and health plans to either cover the benefit in all of their policies (whether the buyer wants the benefit or not) or to simply offer the coverage in at least one policy. Mandated coverage spreads the costs of the additional benefits over the entire insured population, while the mandated offer simply makes the coverage available at an increased cost to those who desire it. Only a small fraction (around nine percent according to one estimate⁸³) of state mandate laws are mandated offering; the great majority are mandated coverage.

Mandates make health insurance more comprehensive, but also more expensive. State mandates affect only the commercial health insurance market: small employers (private group plans) and individual policy holders (usually the self-employed). Some state mandates apply only to private group plans and not individually purchased policies. The Utah Department of Insurance estimated that in 2004 32.2 percent of Utah residents had commercial health insurance coverage: 26.8 percent with private group plans and 5.5 percent with individual plans.⁸⁴ Researchers estimate that nationally about 42 percent of a state's population is insured under commercial

health insurance policies: 33 percent with private group plans and nine percent with individual plans.⁸⁵ Thus, state mandates affect less than half of a state's population. Individuals who have public coverage (Medicare, Medicaid) or no coverage (uninsured) are not affected by state mandates. Larger companies and organizations are usually self-insured, which means they are governed by the federal Employee Retirement Income Security Act (ERISA) but are generally not subject to state mandates.⁸⁶ All companies, even those operating under ERISA, are subject to federal health insurance mandates.

Advantages of Mandates

Proponents view mandates as a way to provide more comprehensive health insurance to consumers. They argue that mandates correct for inefficiencies or inequities in the healthcare market. For example, proponents have suggested that mandates may help solve the problem of adverse selection. Adverse selection is when the people who are most likely to need healthcare are also the most likely to obtain comprehensive health insurance coverage. If healthy people opt for minimal insurance, while unhealthy people seek comprehensive coverage, the comprehensive coverage will become more and more expensive (perhaps prohibitively costly) because the insurance pool is full of unhealthy people, who are expensive to cover. Because of this fact, employers and insurers may have an incentive to offer inadequate benefits in order to deter unhealthy individuals from joining their insurance pools.

Mandates that require all insurance plans to cover certain costly illnesses spread the risk (and cost) of treatment across a large number of insurers. Some proponents also argue that mandates help prevent discrimination against individuals with particularly costly conditions.

In addition, proponents of mandates generally argue that the cost of an individual mandate is relatively low, and may even lead to an overall reduction in health plan costs if the mandated benefits help prevent future medical costs. If mandates improve overall health of workers, mandates may also improve worker productivity. Partnership for Prevention, an organization that promotes policies to prevent disease and improve health, argues that mandating recommended preventive services can "improve health, prevent disease and disability, and potentially lower some health costs." They recommend that policymakers use mandates to reduce barriers to accessing preventive services.⁸⁷

Since mandates generally apply only to employees of smaller businesses, another rationale for mandates is that they protect small business employees from inadequate coverage. Proponents of state mandates argue that insurance is worthless if it does not cover basic medical care and protect against financial disaster. Organizations such as The Foundation for Taxpayer & Consumer Rights highlight the plight of families who incur huge amounts of medical expenses despite the fact that they had health insurance because of the limited coverage of their plans.⁸⁸

Disadvantages of Mandates

Opponents, such as the National Center for Policy Analysis and the Council for Affordable Health Insurance (CAHI), assert that mandates drive up the cost of health insurance premiums and contribute to a higher uninsured rate. If insurers are forced to cover benefits that they previously were not covering, claims costs and therefore premium amounts will rise. Although proponents of mandates claim that the cost of any one mandate is relatively small, opponents argue that collectively mandates are very costly. When health insurance premiums increase, some employers may drop coverage or consumers may decline coverage, which results in greater numbers of uninsured persons. Those opposed to mandates often assert that some coverage is better than no coverage.

Opponents argue that employers should be able to determine what type of coverage meets their financial and personnel needs. They also argue that mandates put small business owners at a disadvantage, since larger self-insured employers have the flexibility to determine what type of coverage best serves their needs, while small businesses must choose either to cover all mandated benefits or to offer no coverage at all.

Opponents often portray mandates as attempts by special interest groups to personally benefit from laws that further their private interests. Opponents point out that within the healthcare field, provider groups have been the main proponents of legislation.⁸⁹ They argue that mandates are often based on anecdotes, instead of medical science or an analysis of the costs and benefits of the treatment. Opponents also argue that there is no proof that health insurance markets are inefficient. They assert that there is no empirical evidence that consumers demand insufficient health insurance, or that government intervention would improve the efficiency of health insurance plans.

In their analysis, Laugesen and others posit that “mandates became a de facto reform effort that imposed no public finance costs, and therefore played to demands for lower taxes and healthcare reform.” Mandates may also be popular because they deliver a substantial benefit to a relatively small group while spreading costs across a broad majority. Thus, proponents of mandates have more to gain from political activity than opponents, and so are more likely to promote their interests through political support for sympathetic legislators.⁹⁰

Utah’s Health Insurance Mandates

As part of its 2005 Health Insurance Market Report, the Utah Department of Insurance listed the following state health insurance mandates in Utah (Utah Code section in parentheses):

Coverage Mandates

- Standardization and simplification of terms and coverages of individual and group health insurance policies to facilitate public understanding and comparison in purchasing. (31A-22-605)

- Dependent coverage to age 26. (31A-22-610.5)
- Extension of policy for a dependent child with a disability. (31A-22-611)
- Conversion privileges for an insured former spouse. This means that upon divorce, a former spouse (formerly covered under his or her spouse’s insurance policy) can convert to an individual policy and continue coverage with the same insurer. (31A-22-612)
- Mini-COBRA benefits for employees of employer with less than 20 employees (expansion of federal COBRA requirements). (31A-22-722)

Benefit Mandates

- \$4,000 minimum adoption indemnity benefit. This mandate specifies that if a person with maternity coverage adopts a newborn, the insurance company must reimburse that individual for at least \$4,000 of the adoption costs. (31A-22-610.1)
- Special dietary products for individuals with inborn metabolic errors. (31A-22-623)
- Catastrophic coverage of mental health conditions (expansion of federal statute). (31-22-625)
- Diabetes coverage. This mandate requires coverage of diabetes equal to that of other illnesses and conditions, as well as coverage of self-management education and diabetes treatment equipment and supplies. (31A-22-626)
- Standing referral to a specialist. This statute requires that, for policies that restrict direct access to specialists, insurers have a procedure in place that enables the primary care physician to provide a standing referral to a specialist if the insured needs continuing care from the specialist. (31A-22-628)
- Basic Healthcare Plan in individual market. This plan includes coverage of several types of preventive services. (31A-22-613.5 and 31A-30-109)

Provider Mandates

- Preferred provider contract provisions, including 75 percent reimbursement provision for non-preferred providers, quality assurance program, nondiscrimination, and grievance process. (31A-22-617)
- HMO payments to noncontracting providers in rural areas. (31A-8-501)

These mandates apply to commercial insurance only. Large businesses can self-insure, and when they do, they are exempt from state mandates under ERISA.

In its 2006 report, CAHI estimates that Utah’s current insurance mandates increase the cost of basic health coverage by 13 to 47 percent. By CAHI’s calculations, then, for an individual policy in Utah with an annual premium of \$3,000, the cost of the annual premium if there were no mandates would be anywhere between \$2,041 and \$2,655 (or \$345 to \$959 less). For a family policy with an annual premium of \$10,000, the premium would cost between

\$6,803 and \$8,850 without the state mandates (\$1,150 to \$3197 less annually). According to the Council for Affordable Health Insurance's (CAHI) framework, only Alaska, Idaho and the District of Columbia have fewer mandates than does Utah. It should be noted, however, that CAHI's analysis does not include the prevalence or cost of Any Willing Provider mandates. Any Willing Provider (AWP) laws require managed care companies to include any provider in their network that is willing to participate in the plan according to their terms. Thus, their estimate for Utah does not include Utah's Any Willing Provider provisions (the two provider mandates listed above) for rural providers by HMOs and for non-preferred providers (with 75 percent reimbursement) by PPOs.⁹¹

Options for Implementation

- Remove some or all state mandates.
- Allow employers to choose a "mandate-lite" health plan.

Trends and Developments in State and National Policies

According to CAHI, state mandates have increased from less than ten in 1965 to 1,843 in 2006.⁹² In a comparative analysis of mandated benefit laws from 1949 to 2002, Laugesen and others concluded that there was a large increase in the number of mandated laws during the 1990s, "during a period of HMO enrollment growth and public anxiety regarding managed care practices." The public was fearful that HMOs would deny them benefits or treatments even if clinicians felt they were necessary, and legislation often attempted to override any such restrictions. Subsequent research has found little evidence of the behaviors that such mandates were attempting to prevent.

Laugesen and others demonstrate that the purposes of state mandates have changed and broadened substantially over the last several decades. Initially a way for nonmedical providers (e.g., social workers) and alternative providers (e.g., acupuncturists) to receive insurance reimbursement, mandated benefit laws today focus on how, where, and when services will be provided. Mandated benefit laws are also now used to support medical research (coverage of clinical trials) and to encourage greater use of preventive care such as screening services.

Some mandates are adopted in virtually every state, while others are adopted in only a few. According to CAHI's 2006 report, the most popular benefit mandates address minimum hospital stay following childbirth, mammograms, breast reconstruction following mastectomy, diabetic supplies, treatment of alcoholism, emergency services, and mental health benefits. The most popular provider mandates include chiropractors, psychologists, and optometrists. The most common covered-persons mandates involve newborns, adopted children, continuation of benefits for dependents and former employees, and conversion to non-group insurance once group coverage ends. Each of these mandates has been adopted by at least 40 states.⁹³ CAHI identified the following trends in 2006 for mandate legislation that seems to be "catching on":⁹⁴

- An increase from 22 to 27 states with a diabetic self-management mandate.
- The introduction of legislation in 20 states to increase the dependent eligibility age regardless of student status (the so-called "slacker" mandate); Utah already has a "slacker" law that mandates dependent coverage to age 26.
- Seven states now have an autism specific mandate, separate from the general mental health benefit legislation. 40 states have state mental health benefit mandates and 42 have state mental health parity laws. Mental health parity laws require that insurers who cover mental health conditions provide equivalent benefits and restrictions in insurance coverage for mental health services and for other health services.

On the other hand, CAHI also notes that states are slowing the pace at which they adopt mandates, requiring mandated benefit studies, and allowing "mandate-lite" policies. At the conclusion of the 2006 legislative sessions, most states had the same total number of mandates as before or only one more. Some states, including Utah, were highlighted for dropping mandates. CAHI reported that between 2003 and 2005, Utah dropped 15 of its 36 provider mandates. In addition, 28 states now require mandated benefits studies.⁹⁵ Utah statute requires that mandated benefits be reviewed with respect to coverage, benefits, and providers after five to 10 years of enactment to determine if the mandate should be continued, modified, or repealed. So far, Utah's Department of Insurance has published reports on three state mandates. Finally, at least 10 states allow some individuals to purchase a policy with fewer mandates, or a so-called "mandate-lite" policy. For example, in 2001, Arkansas and North Dakota enacted legislation that "gives consumers the option of purchasing individual or group health plans that comply with all, some, or none of the state-imposed health benefits."⁹⁶

All types of health insurance policies, including those offered under ERISA by self-funded or self-insured employers, must comply with federal mandates. The first federal mandates were passed by Congress in 1996. Federally-mandated benefits include reconstructive breast surgery for women after covered mastectomies, minimal hospital stays after birth, and portability and pre-existing condition issues. Many of the most common state mandates are also federal mandates. In addition, federal law mandates that if an insurer or plan offers mental health benefits, the benefits offered must be same as those offered for other health benefits (often called mental health parity). Although there has clearly been an interaction between the adoption of federal and state mandates, it is difficult to specify the direction of the interaction, or whether there are simply common causes affecting the adoption of a given mandate at both the state and federal levels.⁹⁷ When federal and state laws regulate the same benefits, state law sometimes takes precedence over the federal law.

Small businesses sometimes avoid being subject to state mandates by self-funding health insurance for their employees through an association. Utah allows small businesses to obtain insurance through an association health plan (AHP) as long as the association

is formed for a legitimate purpose, and not simply in order to purchase health insurance collectively. If the business association chooses to self-fund, rather than purchase commercial insurance, then the association is like an ERISA employer and is not subject to state mandates.

Some policymakers interested in making health insurance more affordable for small business owners have also proposed allowing small businesses to form AHPs across state lines, which would allow any small business in any state to self-insure and act like an ERISA employer, thus exempting the small business from state mandates. Since at least 1999, Congress has considered enacting this type of legislation. Most recently, Senator Michael Enzi (R-Wyoming) proposed S. 1955: Health Insurance Marketplace Modernization and Affordability Act of 2006. The bill amends ERISA and the Public Health Service Act to “expand healthcare access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace.” The bill has been considered in committee, and the committee has recommended that it be considered by the entire Senate. The House companion bill, HR 525, passed in July 2005 with 100 percent Republican and 20 percent Democratic support.

Experience with Policies and Evidence of Effectiveness

Costs of Mandates as a Share of Claims and Premiums

Evidence from both public and private sectors supports the claim that federal and state mandates have contributed to increasing health insurance costs and uninsured rates.

Researchers in several states have calculated the share of insurance claims associated with mandates using data on insurance claims. A 1996 General Accountability Office (GAO) report summarized the findings of studies conducted in several states between 1987 and 1993 that estimated the claims costs associated with mandated benefits.⁹⁸ A 1988 study concluded that Maryland’s mandates accounted for 22 percent of claims costs. At the time of the study, Maryland had the most mandated benefits of any state. The Virginia State Corporation Commission estimated in 1993 that the state’s mandates accounted for 12 percent of group health insurance claims.

A 1987 study in Iowa estimated that the potential cost of several commonly mandated benefits would be about five percent of claims costs. Estimates for Massachusetts, Oregon, and Wisconsin lay between the extremes of Maryland and Iowa. GAO attributed part of the differences in cost estimates to the number of mandated benefits included in each state, since studies that reported the highest estimated costs were in states with high numbers of mandates.

A 2003 GAO report on health coverage also reported on more current findings regarding the cost of state mandates.⁹⁹ A 2000 study by Milliman & Robertson for Texas estimated that 13 specific mandates accounted for 6.3 percent of the average small group premium. A 2000 study in Virginia concluded that the mandates “represented

26.87 percent and 29.28 percent of the overall premiums for individual and family group policies, respectively.”

The Utah Department of Insurance has studied three state mandates. A 2003 report found that the diabetes mandate did not “appear to have increased comprehensive claim costs more than 0.1 percent.”¹⁰⁰ A 2004 report found that the catastrophic mental health statute did not “appear to have increased comprehensive claim costs more than 1.0 percent.”¹⁰¹ Both of these estimates were consistent with other states’ studies of the mandates, and with estimates of premium cost increases previously conducted by the Legislative Fiscal Analyst. A 2003 report on the adoption indemnity mandate predicted that increasing the indemnity benefit from \$3,155 to \$4,000 would result in a 0.03 percent increase in average healthcare costs per member per year.¹⁰²

Marginal Costs of Mandates

However, because some of the benefits likely would have been provided anyway, it is not appropriate to attribute the full share of claims to the state mandates. Instead, it is more appropriate to focus on the marginal cost of the mandates, or the additional cost imposed by the mandate. A report by Gregory Acs and others, published in 1992 by the U.S. Department of Labor, concluded that premiums were four to 13 percent higher as a direct result of state mandates among firms that offered health insurance.¹⁰³ As part of its annual evaluation of the costs of its mandates, Maryland estimates a marginal cost of state mandates. In 2001, the marginal cost of mandates in the small group market represented 3.4 percent of premiums (the total cost accounted for 14.1 percent). In 2000, the Congressional Budget Office (CBO) concluded that the marginal cost of five state mandates (alcoholism, drug abuse, and mental illness treatment, chiropractic services, and mandated continuation of health insurance for terminated employees and their dependents) was between 0.28 and 1.15 percent. Benefit mandates generally might increase premiums by about five percent, according to the CBO.¹⁰⁴

Although employers and managed healthcare plans had expressed concern about the potentially high costs associated with Any Willing Provider (AWP) laws, GAO estimated in 1996 that the actual cost impact of these laws as they were enacted was likely to be limited, and that studies provided “no definitive measure of actual costs of the laws that have been implemented.” In contrast, a 2004 publication by the Federal Trade Commission (FTC) reported unintended and adverse consequences as a result of AWP and Freedom of Choice (FOC) Legislation.¹⁰⁵ FOC laws require plans to reimburse for care that consumers obtain from a qualified out-of-network provider. FOC laws are similar to AWP laws except that they are directed at consumers instead of providers. The FTC staff argues that empirical evaluations of AWP and FOC laws indicate that these policies lead to higher healthcare expenditures (two percent higher expenditures in states with such provisions compared to those without). FTC staff also assert that AWP and FOC laws are more likely to appear in states with limited managed care penetration, suggesting that the provisions are used to protect providers (by preempting competition) rather

than to protect patients. The FTC recommended that governments consider that mandates “are likely to reduce competition, restrict consumer choice, raise the cost of health insurance, and increase the number of uninsured Americans.”

Percent Increase in Premium

The cost of mandated health insurance laws depends on the cost per person benefiting as well as the number of people affected. Some services, such as mandated coverage for special formulas for infants with metabolic disorders, have very high costs per person who uses the coverage, but are not used by many people. Other services, such as maternal length of stay mandates, have a small cost per person, but are used frequently or by many people. In addition, if most people already have a given type of benefit coverage, then mandating that coverage will not significantly affect costs, since few new people will be covered as a result of the mandate.

A study conducted for the American Association of Health Plans by PricewaterhouseCoopers (PwC) in 2002 concluded that government mandates and regulation accounted for 15 percent of the total increase in premiums between 2001 and 2002.¹⁰⁶ A 2006 report by PwC attributes part of the decrease in premium growth rates in recent years to a decline in the passage of new mandates as a result of heightened attention being paid to the cost of mandates.¹⁰⁷ CAHI estimates that “mandated benefits currently increase the cost of basic health coverage from a little less than 20 percent to more than 50 percent, depending on the state.” This estimate is based on the cost assessment of each mandate by CAHI’s Actuarial Working Group on State Mandated Benefits, which provides cost-range estimates based on analysis of company data and their experience. The estimated cost level given is considered typical but not applicable to all variations in legislation. CAHI emphasizes that some mandates have a much greater impact on the cost of health insurance than others. According to CAHI, the most expensive mandates are mental health parity and prescription drugs, which typically increase premiums by five to 10 percent each.¹⁰⁸ GAO reported in its 1996 report on health insurance regulation that obstetrical care and mental healthcare were cited in studies as among the most expensive mandates.¹⁰⁹

Prior to implementation, the Legislative Fiscal Analyst estimated that the diabetes mandate would result in premium costs increasing by no more than 0.17 percent. The Legislative Fiscal Analyst also predicted that the premium impact of the catastrophic mental health mandate would range between a 2.0 percent savings and a 7.0 percent increase.¹¹⁰

Uninsured

In their 1999 study, Jensen and Morrissey attributed “1/5 to 1/4 [of] the uninsured problem” to the presence of state mandates. Frank Sloan and Christopher Conover concluded that 20 to 25 percent of the uninsured lacked coverage because of the cost of state benefit mandates in a 1998 study using data from 1989 to 1994.¹¹¹ In 1998, the Urban Institute found a correlation between mandates for alcohol or drug abuse treatments and reduced private coverage as well as

increased overall uninsured rates.¹¹² An earlier study in 1987 by John Goodman and Gerald Musgrave estimated that 14 percent of the uninsured nationwide lacked coverage because of mandates.¹¹³

Scientific Basis

Laugesen and others point out that mandates can encourage the adoption of ineffective technology, such as ABMT (Autologous Bone Marrow Transplantation). After many states had mandated this controversial coverage, the National Cancer Institute reported in 1999 that studies involving randomized clinical trials showed the lack of benefit and occasional harm associated with this treatment. Some healthcare professionals insist that mandates are ineffective because the legislative process is too slow to keep up with technological and scientific advances, and that mandated treatments can quickly become obsolete. In fact, Laugesen and others explain how political factors sometimes seem to outweigh scientific factors in determining whether a mandate becomes enacted or not. For example, maternal length-of-stay mandates spread rapidly and were adopted in all 50 states and DC, despite the lack of scientific consensus supporting the legislation. At the time the legislation passed, there was no evidence that shorter stays were harmful. Subsequent research has not demonstrated improved health outcomes as a result of the mandates. Mental health parity legislation, in contrast, was passed in only 31 states, despite general professional agreement that mental health illness is under treated and that treatment is beneficial. Laugesen and others suggest that further study is necessary to determine when mandates facilitate or impede technological diffusion.

In a 2002 report, Partnership for Prevention asserts that “states are not adopting mandates based on evidence.”¹¹⁴ Researchers analyzed current clinical preventive services mandates throughout the U.S. compared to services recommended by the U.S. Preventive Services Task Force (USPSTF), an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services. USPSTF is sponsored by the Agency for Healthcare Research and Quality (AHRQ), which is part of HHS. Researchers found that four of the recommended USPSTF services were not mandated by any state, but that three services that were not recommended by USPSTF (due to insufficient evidence) were still mandated for coverage. One of the services not recommended by USPSTF was mandated in 27 states. The other two services were mandated in 12 states each. The report noted that “required coverage of these services is inconsistent with evidence and may pose a burden on health plans and result in poor investment of health dollars.” In addition, the report concluded that many of the preventive services which best protected health and were most cost-effective were recommended by few or no states.

Utah currently does not mandate coverage for any preventive services (see section above: Utah’s Health Insurance Mandates). However, Utah does mandate that insurers offer a Basic Healthcare Plan in the individual market, and this plan includes coverage for several types of preventive services for children and adults.

WELLNESS INCENTIVES

Healthcare costs are a major concern for both commercially insured and self-insured employers. Since self-insured businesses use their own funds to pay for employees' healthcare, employees' healthcare costs directly impact company finances. For small businesses, which are usually commercially insured, employees with costly health conditions can result in much higher premiums. In most states, insurers can use certain characteristics of a group of employees to set premium amounts for a business. A small business with an employee who has a very costly condition may have much higher premiums than another small business covered by the same insurer. Some states restrict the amount that premiums may vary among small businesses or the characteristics that may be used to set premiums. State restrictions on premium variability affect how much an employee's healthcare costs will affect the premium for a given small business. For both small and large Utah businesses, then, employees with high healthcare costs significantly impact the cost of healthcare for the company.

Throughout the nation, rapidly rising healthcare costs and the prevalence of avoidable threats to health (such as smoking, obesity, and poor nutrition) have motivated many businesses to become involved in promoting healthier lifestyle choices among their employees through wellness programs. Health promotion and disease prevention programs include health risk assessments, smoking cessation, stress management, exercise and fitness, nutrition guidance and weight control, as well as cholesterol and blood pressure screenings. In addition to making wellness programs available to employees, some employers provide financial incentives for participation and for employees who attain health goals, or refuse to cover employees with unhealthy lifestyle choices. The most controversial practice is refusing to hire or even firing existing employees who engage in certain behaviors that negatively impact health.

Defenders of wellness incentives argue that such practices are legitimate methods for controlling escalating healthcare costs, costs that are partly determined by personal choices. They also argue that employers and employees who make healthier choices should not have to bear the cost of other employees' unhealthy behaviors. Proponents of incentives for healthy choices claim that there is extensive evidence that certain behaviors pose a significant economic burden to companies in the form of significantly higher healthcare costs. Wellness programs, along with high-deductible insurance plans and health savings accounts, are part of a broader movement to shift greater responsibility onto individuals for healthcare costs. Proponents also argue that wellness programs not only control medical costs, but also improve worker productivity and quality of life.

Critics assert that employers' regulation of legal activities outside the workplace violates employees' privacy and civil liberties and should be illegal. They point out that almost every lifestyle choice individuals make is health-related. Opponents suggest that if

employers are permitted to regulate employee behavior based on economic considerations, then employers may eventually attempt to regulate diet, hobbies, sleep habits, recreational activities, and even childbearing. Where, critics ask, should the line be drawn? Opponents also claim that such practices are rarely based on actuarial data from insurers and show no evidence of saving employers money. The American Civil Liberties Union (ACLU) has stated that penalties for unhealthy lifestyle choices (or rewards for healthy choices) may not be wrong "in principle," but that employers should be able to justify penalties for unhealthy lifestyle choices with actuarial data. In addition, the ACLU argues that the employer should be able to demonstrate that the penalties do not disproportionately impact groups protected from discrimination, such as racial minorities.¹¹⁵

Utah's Current Wellness Incentives Situation

State Law Affecting Wellness Promotion Efforts

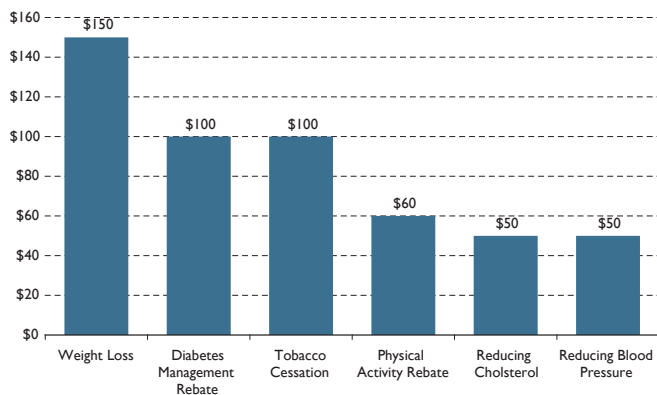
Utah has no "lifestyle discrimination" laws. No laws explicitly protect employees against discrimination based on legal off-duty behavior, such as smoking or drinking alcohol. In fact, Utah is one of many so-called "at-will employment" states, which means that an employee can be fired for almost any reason, as long as the employer is not engaging in discrimination on the basis of race, gender or disability (prohibited by federal law). Arizona, Colorado, Nevada, New Mexico, and Wyoming all have some type of statute prohibiting discrimination against employees based on lifestyle choices. Of the mountain states, only Utah and Idaho do not have this type of anti-discrimination statute.¹¹⁶

In Utah, insurers may consider age, gender, family composition, and risk characteristics when setting the premium for a major medical product for small-group (50 or fewer employees) or individual plans. Risk characteristics include such health-related factors as weight, smoking status, and health conditions such as diabetes or cancer. Employee participation in wellness programs is not considered a risk characteristic, and thus cannot be factored into premium amounts. Utah law does restrict how much premiums can vary according to risk characteristics. Utah insurance code states that for similar coverage and for similarly situated individuals, the premium cannot vary by more than 30 percent of the index rate. This means that the most expensive premium (1.3 times the index rate) cannot cost more than 186 percent of the lowest premium (0.7 times the index rate) for similarly situated individuals (same age, gender, family composition). This means that if the cheapest premium for a given type of coverage is \$10,000 for a family of four, the most expensive premium can cost no more than \$18,600 for another family of four (with individuals who match with respect to age and gender, and other non-health-related characteristics), regardless of risk characteristics.¹¹⁷ All the other mountain states except Colorado also use a rating band type of premium-setting requirement. Colorado uses a modified community rating requirement.¹¹⁸

Wellness Programs for Medicaid Recipients

Since 2001, Medicaid has partnered with the Utah Department

Figure 7: Healthy Utah Annual Rebate Amounts



Source: Utah Department of Health.

of Health's Tobacco Prevention and Control Program (TPCP) to help Medicaid recipients quit smoking; their smoking rates are almost triple those of the Utah average. The tobacco cessation program includes Utah Tobacco Quit Line services (counseling, information, referrals to classes, nicotine replacement therapy) and pharmacotherapies (use of prescription drugs, such as Zyban). The services, which originally targeted pregnant women, are now available to all Medicaid adults. In 2004 the program expanded to offer these programs to Primary Care Network (PCN) participants. PCN offers minimal coverage for individuals who have incomes just above the cut-off for Medicaid. In addition, the Utah Department of Health offers some tobacco cessation services, such as information and counseling through the Utah Tobacco Quit Line, to all Utahns. Medicaid does not cover other typical wellness programs, such as weight loss, nutrition, or physical activity programs, although it does cover many preventive services, particularly for children. Utah's Medicaid program does not use any financial incentives to encourage healthier behaviors.¹¹⁹

Wellness Programs for State Employees

Utah promotes health and wellness among state employees through its Healthy Utah program. Healthy Utah is an employee health and wellness program available to agencies that have elected to offer a Public Employees Health Program (PEHP) plan that includes this benefit. At this time, employees and their covered spouses, but not dependents, are eligible to participate. Approximately 55,000 PEHP members currently participate in the Healthy Utah program. Through this wellness program, employees and their covered spouses can earn rebates of \$60 to \$150 annually for physical activity, tobacco cessation, weight loss, reduced cholesterol, reduced blood pressure, or diabetes control (see Figure 7). Healthy Utah also helps cover the cost of tobacco cessation courses and weight loss classes. All participants are eligible for the physical activity rebate, but only persons who exhibit the relevant high-risk factor (such as smoking or a cholesterol level above 200 mg/dL) are eligible for the other rebates. The Healthy Utah program also includes health education through a website and wellness seminars, free testing sessions (to check cholesterol, blood pressure, body fat composition, weight, and blood glucose), one-on-one counseling for individuals with

elevated test results, as well as \$500 mini-grants to help establish Wellness Councils and wellness programs at individual worksites.¹²⁰ Kathy Paras, program manager of Healthy Utah, reports that PEHP spends about \$800,000 annually on the Healthy Utah wellness program. The Healthy Utah wellness program is funded by PEHP and administered through the Utah Department of Health.¹²¹

In reviewing claims data, PEHP concluded that, compared to non-obese patients, medical costs for obese patients were 36 percent higher for hospital and outpatient care and 77 percent higher for medication costs. In 2003, based on an assessment of obese members' interest in weight loss services, PEHP developed an innovative pilot program for members with a BMI (body mass index) over 35. Participants in the program, which is now about to enter its third year, receive reimbursements of up to \$60 per month for gym memberships and nutritional counseling, such as the Weight Watchers program.

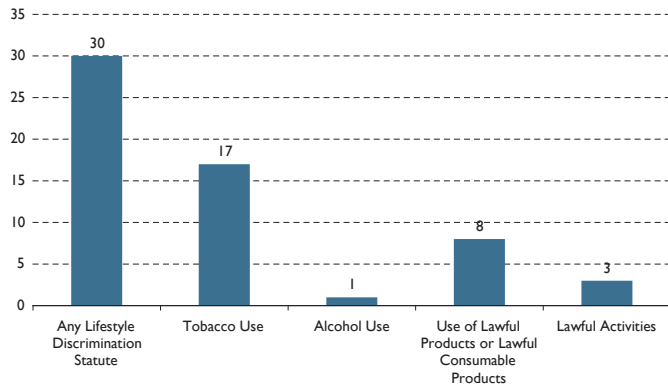
During the first year of the program (2004-2005), the average weight loss per person was nine pounds. For the second year (2005-2006), participants lost an average of 20 pounds for a total of about 7,000 pounds lost. The program now has over 600 participants. If all participants took full advantage of the reimbursement, PEHP would spend about \$430,000 on the program this year, but only about one-fourth of participants receive the full reimbursement by participating in both the exercise and nutritional programs. The majority of participants only take advantage of reimbursement for either the gym membership or nutritional counseling. Since many participants do not utilize the full \$60 per month allotted to them, the actual cost of the program is significantly less than \$430,000 for PEHP. The program is evaluated on an annual basis. Savings in medical claims will probably be measured after the program has been in effect for four or five years. Based on the evaluation of the program, including the degree to which the program helps participants lose weight and increase their quality of life, PEHP will determine the weight loss services that it can offer all members in the future.¹²²

Options for implementation

- Allow insurers and self-funded employers to consider tobacco use and wellness program usage as a rating factor in developing premiums.
- Allow commercial insurers and commercially insured employers to provide financial incentives (lower premiums, lower copayments, rebates) for healthy behaviors, including participation in a wellness program.
- Expand funding for wellness programs for state employees and Medicaid recipients, especially smoking cessation programs.
- Provide state employees and Medicaid recipients with financial incentives (discounts on premiums and copayments) for healthy behaviors.

Wider adoption of wellness programs does not necessarily require a change in law or policy. However, policymakers could facilitate the promotion of healthier behaviors among individuals by implementing

Figure 8: Number of States with Lifestyle Discrimination Statutes, By Behavior Explicitly Protected, 2004



Source: National Workrights Institute.

reforms, such as those listed above, that enable greater use of financial incentives for both employers and individuals.

Trends and developments in state and national policies

State and Federal Lifestyle Discrimination Laws

According to a 2006 report on “Lifestyle Discrimination” by the National Workrights Institute (founded in 1988 by the American Civil Liberties Union), 30 states have some type of statute that bars discrimination on the basis of legal lifestyle choices (see Figure 8). These statutes typically protect the use of tobacco and/or alcohol, or any lawful product. A few statutes prohibit discrimination against an employee for engaging in any “lawful activity.” Some opponents of lifestyle discrimination claim that federal anti-discrimination laws (which prohibit discrimination on the basis of race, gender or disability) may also apply to lifestyle discrimination.¹²³

State and Federal Regulation of Premium Variability

The nondiscrimination provision of HIPAA (Health Insurance Portability and Accountability Act of 1996) prohibits all businesses from differing premiums for similarly situated individuals on the basis of health-related factors. These requirements apply to both self-insured and commercially insured businesses. HIPAA specifies that health-related factors include health status, medical condition, claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability, and disability. HIPAA does

not prohibit varying premiums among employees for other reasons, such as employment status (part-time versus full-time) or geographic location. Federal requirements under HIPAA do not prohibit insurers or self-funding employers from considering the health of employees and their dependents when setting a group’s premium, but they do prohibit variation in the premium employees pay based on this health information. State requirements that limit premium variation among small businesses apply only to insurers, and therefore do not affect self-insured employers.¹²⁴

GAO reports that in 2003 nearly all states (47) had some restrictions on variability in premiums (set by insurers) for different small employers purchasing the same coverage. However, these state requirements vary widely in the extent to which they restrict the premium variability and in the group characteristics that may be considered when setting premiums. GAO reports that “whether and how factors such as age, gender, and health status are considered can affect the extent to which small businesses with employees having higher risk factors pay more for coverage.”

According to GAO, states tend to adopt one of three different types of premium-setting requirements in order to restrict the variation in the premiums for small businesses of the same size purchasing the same coverage: pure community rating, modified community rating, or rating bands. Pure community rating requirements are usually the most restrictive and allow insurers to vary premiums according to geographic area and family size only. Modified community rating requirements allow some variation based on age and gender, in addition to geographic area and family size, but prohibit variation based on health. Rating bands allow insurers to vary premiums on the basis of employees’ and dependents’ health, as well as many other factors (age, type of business, size of group), but set some restriction on the amount of variation allowed. The most common approach is ratings bands (see Figure 9).¹²⁵ However, GAO explains that many states’ premium-setting requirements include aspects of two or more types of the three main types outlined above. All seven mountain states use the rating band type of premium-setting requirement.

To illustrate the impact of different state regulations, GAO explained that while in Texas a small business with older, higher-risk employees and dependents could be charged a premium nearly four times as much as a small business with younger, healthier employees and dependents, in New York the two small businesses would have to be charged the same premium. In 2002, 45 states (including all seven mountain states) also had restrictions on adjustment of premiums at renewal, but not on the frequency of adjustment.

In Alabama in 2004, managers of insurance plans for government workers recommended cost-saving ideas to Governor Bob Riley’s task force on state employee health insurance. Among their recommendations were that obese employees and employees who smoke be required to pay higher health insurance premiums. The cost of health insurance for Alabama’s government workers increased from \$320 million in 1998 to more than \$970 million in 2004.

Figure 9: Number of States with Premium-Setting Requirements for the Small Group Market, by Type of Rating, 2005

Type of rating	Number of states	Description of requirements
Pure community rating	2	Prohibits use of health status and other factors such as age, group size, and gender. Premiums can vary among small businesses only for geographic area and family size.
Modified community rating	8	Prohibits use of health status. Premiums can vary among small businesses for geographic area and family size and for other factors within limits, such as age and gender.
Rating bands	37	Premiums can vary among small businesses for health and other factors, such as age, group size, and industry, within limits.
No restrictions	3	No limits on factors that can be used or amount premiums can vary among small businesses.

Source: Figure based on table from GAO, with updated data from Kaiser State Health Facts.

Governor Riley has argued that healthcare costs could cripple the state budget, and appointed the task force to consider ways to handle the increasing costs.¹²⁶ In November 2004, the Alabama Legislature enacted legislation (Act 2004-646) that requires the State Employees' Insurance Board to charge tobacco users a higher premium for their health insurance plan. Effective October 1, 2005, all active and retired employees were charged \$20 more per month on their health insurance premiums, but employees and retirees could obtain a \$20 discount off their monthly premium by certifying that they (and their spouse, if covered) had not used tobacco products within the last 12 months. In effect, health insurance premiums increased by \$20 per month only for smokers and users of tobacco products. The legislation did not address obesity.¹²⁷

A Florida law, enacted in July 2004 and finalized in state rules in February 2005, "forces most private insurers and HMOs in the state to send rebate checks to employers when their workers adopt a healthier lifestyle," such as losing weight, exercising regularly, or quitting smoking. Employers can decide whether or not to pass on the savings to workers. Proposed rebates range from half of a percent to three percent, with incentives for specific programs as high as ten percent. However, the new requirement has raised questions of privacy.¹²⁸

Massachusetts' landmark new healthcare law contains several provisions designed to promote healthy behavior. Previously in Massachusetts, commercial health insurers were not allowed to vary premium amounts based on smoking status. State regulation also restricted discounts for residents who completed wellness goals to no more than five percent. The new law allows insurers to charge higher premiums for smokers than nonsmokers and also eliminates the cap on discounts for residents who complete wellness goals such as weight-loss programs and enrollment in exercise classes. Insurers can now consider tobacco use and wellness program participation as factors when developing premium amounts for small group and individual markets. State regulators still restrict the total variation that can exist between premiums.

In addition to changes in the state regulation of premium variability, the new law gives Medicaid recipients discounts on premiums and copayments if they quit smoking, complete screenings, or complete other wellness goals. The state will also spend \$7 million annually for two years to offer smoking-cessation classes for Medicaid recipients. Medicaid recipients have a far higher rate of smoking than the general population (39 percent vs. 17 percent), and legislative staff have estimated that smoking-related medical costs for Medicaid recipients total \$700 million annually. The \$14 million spent over the two-year period will allow the state to offer the classes to nearly every Medicaid recipient who smokes. In April 2006, at least two other states (Iowa and Michigan) were offering discounts to Medicaid recipients for healthy behaviors.¹²⁹ West Virginia has enacted a reform that provides Medicaid recipients with an expanded group of benefits if they comply with all recommended medical treatment and wellness behaviors.¹³⁰

Other states, such as Maine, also allow premiums to vary (within limits) among small businesses according to smoking status and participation in wellness programs.¹³¹ The federal government has also begun to invest in prevention. For example, Medicare has initiated some anti-smoking and anti-obesity education programs, as well as disease management projects for chronic conditions.¹³²

Incentives for Employees by Employers

Employers use many different methods to encourage workers to make healthier choices. Employers may cover part or all of the cost of smoking-cessation, weight-loss, nutrition and exercise classes, as well as screenings and flu vaccinations. Some companies' cafeteria menus feature healthy entrees, sometimes priced lower than regular meals. Many firms now offer a price break for nonsmokers, such as a 15 percent discount on out-of-pocket insurance costs.

Instead of giving out rewards and penalties according to health-related choices, some employers restrict access to coverage and even employment based on workers' health-related behaviors. Firms may refuse coverage to employees and their dependents unless they participate in a wellness program. Several companies now have official policies against hiring smokers, and other companies are threatening to fire employees unless they quit smoking. Companies with incentives for healthy choices may also help attract healthier applicants for jobs (workers who already exercise, eat well, and don't smoke), which could further control health costs for employers.

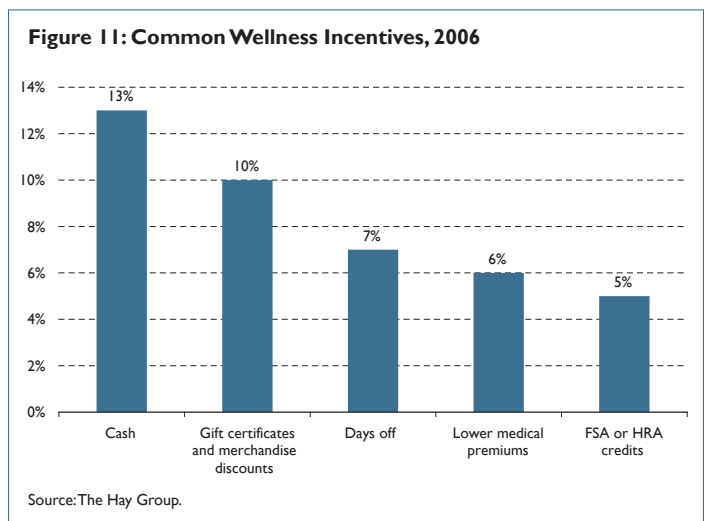
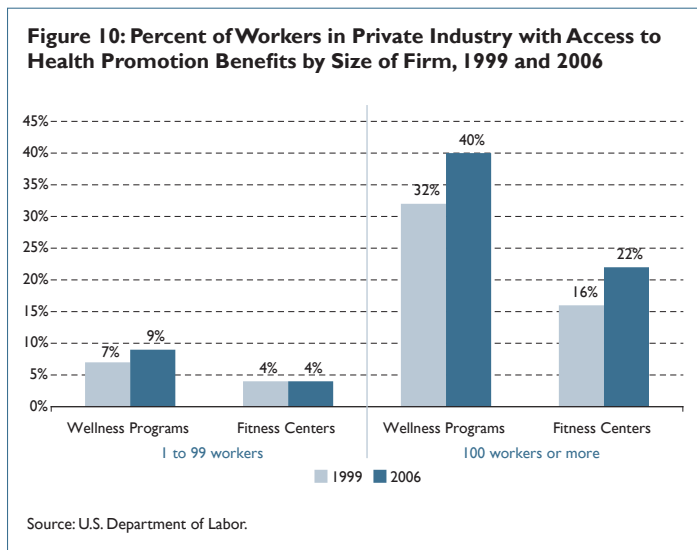
The media has highlighted the methods of several businesses who are taking aggressive measures to encourage workers to adopt healthier lifestyles. Weyco, a health-benefits-management company in Michigan with 200 employees, was one of the first companies to receive widespread media attention for its controversial efforts to reduce healthcare costs. The company offered employees financial incentives for meeting with a private trainer and accomplishing exercise goals, subsidized health club costs, and offered fitness classes and an office walking trail. Weyco also charged smokers higher premiums, provided smoking cessation classes and a smoking counselor, and warned workers that they had 15 months to stop smoking or face termination. In January 2005, Weyco began randomly testing workers for nicotine. Twenty of the 24 employees who smoked had successfully quit smoking. Four employees who continued to smoke were fired when they refused to take the test. A lawsuit against Weyco and its CEO has since been filed.¹³³

Scotts Miracle-Gro Company in Ohio has pursued similar tactics. Although currently 30 percent of Scotts Miracle-Gro's 5,300 U.S. employees smoke, CEO James Hagedorn is taking steps to create a totally smoke-free staff. Scotts offers free smoking-cessation classes, but by October employees could lose their jobs if they continue smoking and fail a random test. Scotts also offers free weight-loss and nutrition classes, healthy alternatives on its cafeteria menu, and access to a fitness center with personal trainers and a medical staff. Healthcare costs are currently \$25 million a year at Scotts.¹³⁴

Many other corporations, such as Union Pacific Railroad and Alaska Airlines have stopped hiring smokers in states where it is legal to do so. Investors Property Management in Seattle does not hire smokers and does not offer medical insurance through the company to smokers hired before the ban. General Mills charges a \$20 per month “smokers’ surcharge” on smokers’ health premiums. In 2005, Gannett Co. Inc. (publisher of 99 daily newspapers nationwide with 40,000 U.S. employees) instituted a \$50 monthly fee for smokers unless they enroll in a cessation program. State employees in Kentucky, West Virginia, Alabama and Georgia who smoke also pay a health insurance surcharge. When the Society for Human Resource Management in Arlington, Virginia, surveyed 270 human resource managers nationally in 2004, only one had a formal policy against hiring smokers, but four percent said they preferred not to hire smokers, and nearly five percent said they charge smokers higher premiums for health insurance. PricewaterhouseCoopers’ Health Research Institute reported in 2005 that more than 6,000 companies nationwide do not hire smokers at all.¹³⁵

In 2005 in Pennsylvania, the Lancaster Chamber of Commerce and Industry, along with partnering providers and insurers, announced a plan with significant rewards and penalties to encourage participation in wellness programs. If employers convince two-thirds of employees to sign up, employees can save up to 20 percent on their premiums and their co-pays when using partnering facilities. But to qualify for the discount, employees and their dependents must complete a health-risk assessment and annual BMI calculations, show progress towards reducing BMI when necessary, promise to exercise three times a week, eat healthy foods most of the time, and attend smoking cessation classes if they smoke. The program is designed to get people to change their unhealthy choices. Other local firms are watching to see how the program works.

HHS reports that employer wellness programs differ considerably in comprehensiveness, intensity, duration, and the extent to which they are integrated with other programs and benefits. HHS also states that small businesses face much greater financial and practical challenges



in implementing wellness programs, and that public policy should address the special needs of small employers.

The U.S. Department of Labor (DOL) data demonstrate an upward trend in wellness programs, as well as a discrepancy in the opportunity to participate in wellness programs by size of employer. From 1999 to 2006, the percent of all workers (insured and uninsured) in private industry with access to wellness programs has increased from 17 to 23 percent. DOL defines wellness programs as programs that provide employees with help in areas such as stress management, nutrition education, and smoking cessation. The percent of workers with access to fitness centers (onsite fitness centers or subsidized fitness club membership) has increased from nine to 13 percent during the same period. However, in 2006, just nine percent of workers in small firms (defined as firms with one to 99 workers) had access to wellness programs compared to 40 percent of workers in larger firms (defined as firms with 100 workers or more) (see Figure 10). In 1998 (latest data available), 35 percent of full-time state and local government employees were eligible for wellness plans and 14 percent were eligible for subsidized fitness.¹³⁶

A 1999 survey of over 1,500 work sites conducted by the Association for Worksite Health Promotion, Mercer, and HHS also found that smaller employers were less likely to offer health promotion activities. The survey found that 50 percent of employers with 750 or more employees offered a comprehensive employer-sponsored health promotion program compared to 33 percent of employers with 50 to 99 employees.¹³⁷

Other survey sources, such as Hewitt Associates, the Society for Human Resource Managements, Mercer Health & Benefits LLC, and the Hay Group confirm an upward trend in employers’ use of wellness programs.¹³⁸ Based on a survey of more than 500 major employers, Hewitt Associates reported that the percent of employers who offer incentives for participation in wellness programs increased from 21 percent in 2004 to 30 percent in 2005.¹³⁹ The Hay Group’s 2006 survey of 435 employers found that the most common rewards for participation in wellness programs include cash (used by 13 percent of companies), gift certificates and merchandise discounts

(10 percent), days off (seven percent), lower medical premiums (six percent), and Flexible Spending Account (FSA) or Health Reimbursement Account (HRA) credits (five percent). According to the survey, three percent of employers increased the amount of their financial incentive for wellness programs.¹⁴⁰

According to research conducted by PricewaterhouseCoopers' Health Research Institute, employer support for wellness programs is widespread and growing. The 2005 survey revealed that 84 percent of 150 CEOs at large US multi-national companies believe that they could reduce healthcare costs "somewhat" or "a great deal" by providing financial incentives for employees who participate in healthy lifestyle programs. In addition, 48 percent of executives agreed that their organizations should require employees who smoke or are obese to pay a larger share of their health benefit costs.¹⁴¹

Incentives for Employers by Insurers

Beginning October 2006, Blue Care Network of Michigan (BCN) will offer a healthcare product called Healthy Blue Living that rewards both employers and employees for employees' adoption of healthy lifestyles. Blue Care Network of Michigan has more than 450,000 members, award-winning disease management programs, and is the HMO affiliate of Blue Cross Blue Shield of Michigan. The new program is possible now that the governor of Michigan has signed a new law amending the insurance code (Bill 848) that allows healthcare carriers to provide a rebate or reduction in premiums, copayments, coinsurance, or deductibles (not to exceed 10 percent of paid premiums) for participation in wellness programs offered by the employer. Such financial incentives for wellness programs were previously banned under the state's community rating law regulating commercial health insurance premiums.¹⁴² Some self-insured employers had already been offering incentives for several years. Healthy Blue Living, which is designed to lower premiums and increase employee accountability, will save employers an average of 10 percent in premiums and will charge employees lower copays and deductibles if people commit to healthier lifestyles. Employers will be required to offer a smoke-free work environment and will be encouraged to promote both physical activity and healthy food choices at work.

To qualify for the "enhanced" benefit level, employees and spouses must commit to healthy lifestyles, complete a health risk appraisal, fill out a member qualification form with their primary care physicians, and agree to follow the care plan of their physician. The care plan is based on the results of the member qualification form, which assesses alcohol use, blood pressure, blood sugar, cholesterol, smoking status, and weight, the leading causes of chronic illness and costs that can be controlled. Enrollees will also have access to care management programs and services, such as free smoking cessation and weight loss programs, health education, and health coaches at work. BCN will conduct random audits to be sure the program is working appropriately. Throughout the process, the employer will not see completed member qualification forms or know the benefit level ("enhanced" or "standard") of employees, thus preserving

confidentiality. BCN developed Healthy Blue Living in response to demand from small businesses and the Detroit Regional Chamber of Commerce. BCN expects to enroll 5,000 to 10,000 members in the plan in the first year.¹⁴³

Legal Issues

Wal-Mart received heavy (negative) media coverage in 2005 when an internal memo to Wal-Mart's board of directors was leaked to Wal-Mart Watch, a nonprofit group allied with labor unions. The memo proposed recommendations to control healthcare costs by discouraging unhealthy people from working at Wal-Mart. Wal-Mart's benefit costs had increased from \$2.8 billion in 2001 to \$4.2 billion in 2004 (Wal-Mart earned \$10.5 billion on sales in 2004). The memo, which noted that Wal-Mart workers were "getting sicker than the national population, particularly in obesity-related diseases," stated that "it will be far easier to attract and retain a healthier work force than it will be to change behavior in an existing one."¹⁴⁴

Wal-Mart's experience demonstrates that attempting to contain health costs by increasing the overall health of the workforce can be a delicate matter for employers. Mark Rothstein, a bio-ethics professor at the University of Louisville, questions whether people can trust in the confidentiality of the health questionnaires they complete. He points out that if an employee's health information filtered back to the company, the employee could be adversely treated, since employers have a strong financial incentive to eliminate high-cost employees.¹⁴⁵

Emile A. Des Roches of Mercer Health & Benefits LLC, says that companies will have to "steer their way through complex statutes, case law and regulations regarding discrimination and disabilities" in order to implement programs that promote healthy lifestyles.¹⁴⁶ Wellness programs potentially may conflict with the Americans with Disabilities Act (ADA) and the Employee Retirement Income Security Act (ERISA), as amended by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA prohibits discrimination in health coverage based on health status. Although the nondiscrimination provision does not prevent insurers or employers from giving discounts or rebates for participation in health promotion programs, businesses should ensure that their programs constitute a "bona fide wellness program," as defined by a regulation based on HIPAA that was proposed by the U.S. Department of Labor, the IRS and HHS. A "bona fide wellness program" is reasonably designed to promote health or prevent disease, limits the total reward an individual can receive, makes the reward available to all similarly situated individuals, and provides an alternative standard for persons with a medical condition that makes it unreasonably difficult or inadvisable to meet the wellness program standard.¹⁴⁷

Employers can minimize potential conflicts with federal regulations by focusing on employee behavior rather than on health standards, by keeping medical records confidential and separate from personnel records, and by ensuring that their wellness program is truly voluntary.

Few court decisions have tested employer restrictions on employees' health-related behaviors or hiring policies that exclude smokers. Nonetheless, employers may face legal challenges regarding their wellness programs. Employees may argue that financial incentives are inherently coercive. Smokers may claim that because they are addicted to nicotine they are protected under the ADA. State statutes that protect against "lifestyle discrimination" may provide a basis for challenging even the existence of wellness programs.¹⁴⁸

Experience with Policies and Evidence of Effectiveness

In a 2006 report called "The Factors Fueling Rising Healthcare Costs," PricewaterhouseCoopers (PwC) found that increased utilization of healthcare services was the most important factor in the 8.8 percent increase in premiums between 2004 and 2005. PwC concluded that increased utilization accounted for 43 percent of the overall increase and that lifestyle challenges, including obesity, smoking, drug abuse, and physical inactivity, contributed to increased utilization.¹⁴⁹

According to HHS, persons with chronic diseases account for 75 percent of the nation's medical costs. In a 2003 report called "Prevention Makes Common 'Cents,'" HHS explains that there is clear evidence that major chronic conditions, and the enormous direct and indirect costs associated with them, are "in large part preventable, and that to a considerable degree they stem from, and are exacerbated by, individual behaviors. In particular, overweight and obesity, lack of physical activity, and smoking greatly increase the risk of developing the most serious chronic disorders." The report argues that more healthcare expenditures should be focused on prevention strategies that reduce the prevalence and cost of preventable diseases.¹⁵⁰

The Costs of Obesity

HHS considers the increasing prevalence of obesity as one of the top threats to the health of the nation. While obesity is partly determined by genetics, HHS has stated that "much, if not most, of the recent increase in prevalence of obesity in the US population stems from changes in people's diets and the level of their physical activity." Rates of obesity have doubled in the US since 1980. HHS estimates that approximately two-thirds of the adult population is overweight or obese. In 2003, only one-third of adults 18 and over engaged in regular leisure-time physical activity. More than 38 percent of adults were classified as inactive, meaning that they reported no sessions of light or vigorous leisure-time activity of at least 10 minutes duration within a week.¹⁵¹ In 2005, more than half of Utah adults (55.2%) were overweight or obese. Since 1989, the proportion of obese adults in Utah has increased 112 percent. In addition, the number of overweight Utah children increased dramatically from 1993 to 2002. In 2002, an estimated 25.5 percent of grade K-8 students in Utah were overweight or at risk of becoming overweight.¹⁵² Although estimates of obesity vary somewhat, all studies reveal dramatic increases in the prevalence of overweight and obesity.

Overweight and obesity are risk factors for numerous chronic diseases including type-two diabetes, congestive heart failure, stroke, hypertension, poor reproductive health, and many types of cancer. Research has demonstrated that healthcare utilization and costs increase as body mass increases. Obesity may be more costly than smoking, problem drinking, or aging 20 years. Estimates of the total (direct and indirect) costs of overweight and obesity for the U.S. range from \$69 billion to \$117 billion annually. Researchers estimate that overweight and obesity represent 4.3 to 9.1 percent of total healthcare expenditures, with Medicare and Medicaid financing as much as half of these costs. Using data from 1996 to 1998, researchers found that Medicare spending was 15 percent higher for overweight individuals and 37 percent higher for obese individuals. According to Eric Finkelstein, health economist with the Research Triangle Institute, "the average taxpayer contributes about \$180 per year to obesity-related treatments through Medicare and Medicaid." Finkelstein also suggests that although the medical expenses of obese and overweight workers exceed those of healthy workers in their early 30s, most of the costs occur after age 65, when their medical conditions will likely be covered by Medicare. Thus, employers may not have a strong incentive to invest in weight-loss programs, since government bears a large portion of the economic burden of obesity.¹⁵³

Businesses bear a significant portion of the costs associated with treating obesity-related conditions. Overweight and obese individuals cost employers more not only in terms of health insurance costs, but also in terms of disability insurance costs and lost productivity. HHS reports that the cost to US business of obesity-related health problems in 1994 was nearly \$13 billion: about \$8 billion in health insurance expenditures, \$2.4 billion for sick leave, \$1.8 billion for life insurance, and almost \$1 billion for disability insurance. Based on his research, Finkelstein concluded that extremely obese workers (nine percent of full-time employees) cost employers on average \$2,200 annually in medical expenses, and miss about a week more of work than healthy co-workers.

The Costs of Smoking

The 2003 HHS report estimated that over 46 million (about 23.5 percent) of American adults smoked every day or almost every day. Although the proportion of adults who smoke cigarettes has been declining since the first Surgeon General's report in 1964, the rate of decrease in cigarette smoking has slowed in recent years.¹⁵⁴ Tobacco use is a risk factor for many chronic conditions, such as chronic lung disease, heart disease, stroke, and several forms of cancer. The harmful effects of smoking extend to nonsmokers who are exposed to secondhand smoke. The National Institute on Drug Abuse estimates that the total (direct and indirect) costs of smoking equal \$138 billion annually. Solid evidence indicates that smoking accounts for six to 14 percent of personal healthcare expenditures, that smokers have higher lifetime medical costs, and that smokers are more costly than nonsmokers to employers. Researchers estimate that the economic costs of smoking equal almost \$3,400 per smoker per year. Smoking-related illnesses account for approximately

14 percent of all Medicaid expenditures and more than \$20 billion of Medicare expenditures each year. Although the percentage of Utah adult smokers is low (below 12 percent) compared to other states, the Utah economy loses \$530 million annually to smoking-attributable medical and productivity costs, according to the Utah Department of Health.¹⁵⁵ According to HHS, each of the billions of packs of cigarettes sold in the U.S. costs society about \$7.18 in medical costs and lost productivity. A book published in 2004 by Duke health economists estimates that the total social cost per pack over a lifetime, including both private costs and societal costs such as second-hand smoke and Medicare, equals nearly \$40.¹⁵⁶

Cost-benefit of Wellness Promotion

Some researchers, like James Romeis, a professor of health services research at St. Louis University's School of Public Health, are skeptical of the impact of wellness programs, due to the role of genetics in smoking and weight problems.¹⁵⁷ Opponents of "lifestyle discrimination" such as the National Workrights Institute point out that the Bureau of National Affairs reported that 95 percent of companies banning smoking reported no financial savings, and that the U.S. Chamber of Commerce found no connection between smoking and absenteeism.¹⁵⁸ Nonetheless, many studies have shown that worksite health promotion programs have a positive impact on employee health status, medical care costs, and business efficiency measures such as absenteeism.¹⁵⁹

According to HHS, a number of comprehensive reviews that have analyzed findings across large numbers of studies provide a "strong indication that many health promotion and disease prevention programs do work and do result in significant cost savings." One review of the health promotion and disease management programs for nine large employers found a significant return on investment (ROI) for the programs, ranging from \$1.49 to \$4.91 in benefits per \$1.00 spent on the program, with a median of \$3.14. Relatively little research has been conducted on the long-term effects of wellness programs. In its 2003 report, HHS highlights the successes of several businesses with exemplary health promotion and disease prevention programs:

- Motorola saves \$3.93 for every \$1 invested in wellness benefits. The company saves \$6.5 million annually in medical expenses for lifestyle-related diagnoses.
- In 1997 DaimlerChrysler estimated that it saved \$200.35 per year for each employee who completed a health risk assessment and participated in an additional wellness activity.
- Union Pacific estimated a 10 percent decrease in healthcare costs due to lifestyle-related factors as a result of its wellness program which includes health risk assessments and follow-up intervention programs.
- "High-risk" employees who participated in Caterpillar's Healthy Balance Program reduced doctor office visits by 17 percent and hospital days by 28 percent.
- Northeast Utilities documented a 1.6 ROI in the first two years of its wellness program which targets lifestyle-related health risks.

- Pfizer's fitness centers program had an ROI of 4.29, with over 41 percent of the total population participating.
- CIGNA's smoking cessation program has an ROI of 9.5. The program, which combines behavioral counseling and pharmacologic treatment, helped 67 percent of participants to quit smoking after 12 months.
- The State of California estimates that their statewide tobacco prevention program saved \$3.62 in direct medical costs for every \$1 spent, with an overall cost savings of \$8.4 billion from 1990-1998.

HHS has created a framework for prevention for the nation called Healthy People 2010. One of the national health objectives of this framework is to increase to 75 percent the proportion of worksites (of all sizes) that offer a comprehensive employee health promotion program to their employees by 2010.¹⁶⁰ Michael Carter of the Hay Group, a global management consultancy that publishes an annual report on benefits, argues that "Disease Management and wellness programs, which lower costs by improving employees' health, currently are the best long-term strategies for controlling costs."¹⁶¹

HEALTH INSURANCE TAX CREDITS

Employer-sponsored health insurance came into popularity in the 1940s as a method of increasing employee compensation during a tight wartime labor market. At the time, federal law limited wage and price increases but allowed companies to provide health insurance benefits without reporting the benefits as taxable income for an employee.¹⁶²

Today, in most cases, the Internal Revenue Service considers fringe benefits as taxable income to an employee unless Congress has enacted a specific exemption.¹⁶³ Such an exemption has been provided since the 1940s for employer-sponsored insurance, allowing premiums paid on behalf of employees to be exempt from federal income taxes as well as from Social Security and Medicare payroll taxes. States have conformed to this federal tax law, allowing the exemption from state income taxes as well. These exemptions provide a significant tax subsidy to employees, and the subsidy is more apparent at higher income levels which are taxed at higher rates.

For employers' own tax liabilities, health insurance premiums are simply treated as a cost of doing business and no special tax law is required to make these costs exempt from business income taxes.

A number of proposals have been made in recent years to enact tax credits to encourage more businesses to offer health insurance to employees or to encourage more employees or individuals to obtain health insurance. Most of the discussion on tax credits has focused on the federal tax system. For example, during the 2004 presidential election campaign, President George W. Bush proposed a \$3,000 refundable tax credit for low-income families to purchase health insurance. He also proposed a tax credit for small employers equal to \$500 per employee family to fund health savings account

contributions by those employers. His opponent in the 2004 presidential race, Senator John Kerry, proposed a range of credits for individuals to help them purchase health insurance from the Congressional Health Plan. He also proposed a small-employer tax credit of up to 50 percent of premiums for companies providing insurance to low-income employees.¹⁶⁴

Other proposals have been made in Congress in recent years, including several in 2005 and 2006. Many of these proposals have also included expanding the ability for small employers to pool their health insurance purchasing through association health plans or other means.

Utah's Current Tax Credit Situation

Utah is like most (perhaps all) states in conforming to federal tax law that allows employer-paid health insurance benefits to be excluded from individual income taxes. Utah does have a very limited employer tax credit for health insurance, and it is very similar to a law in Colorado. Utah's law provides a \$200 per employee credit to small firms expanding or locating in an enterprise zone and paying at least 50 percent of health insurance premiums for employees. The credit is only available for two years, and Utah's credit can be claimed for no more than 30 employees. Enterprise zones are limited geographical areas designated for specific tax benefits to spur economic development. In Utah, enterprise zones are located in rural counties.

Options for implementation

Tax credits designed to subsidize health insurance premiums may be applied in three primary ways:

1. Credits to individuals to help them afford individual insurance policies.
2. Credits to employers to reduce the costs of employer-paid insurance premiums.
3. Credits to employees to offset their costs of participating in employer-sponsored health insurance plans.

In each of these cases, the credit may be designed to either cover all who qualify, regardless of whether they would have purchased insurance without the subsidy or it may be made available only to those who have not purchased health insurance for a specified period to try to focus the incentive on those currently uninsured. Obviously, the broader coverage can be very expensive because many employers already provide health insurance to employees.

A 2003 study for the California HealthCare Foundation used an economic model to predict the impacts of three health insurance tax credit concepts like those stated above.¹⁶⁵ The model assumed that each credit was aimed at lower-income individuals and small employers, phasing out each credit at higher incomes or employer sizes. Even with those limitations, the credits would be very expensive. Figure 12 shows highlights of the study. Of the three options, the

Figure 12: Modeling of Health Insurance Tax Credits in California

	Individual Tax Credit	Employer Tax Credit	Employee Tax Credit
Credit for employee with single coverage*	\$1,000	\$1,500	\$350
Credit for employee with family coverage*	\$2,500	\$3,500	\$800
California state costs, net of savings	\$1.6 billion	\$1.9 billion	\$1.6 billion
Number of people taking up subsidy	2.01 million	3.07 million	8.52 million
Change in uninsured population	-640,000 (-10%)	-780,000 (-13%)	-390,000 (-6%)

*These are maximum credits for small firms with low-income employees. The credit would phase out as firm size and employee wages increase.
Source: California Healthcare Foundation.

credit to employers would produce the largest reduction in the number of uninsured individuals. The credit to individuals to help them afford nongroup insurance policies would be a close second in covering the uninsured. The credit to employees would cover more people in total but would have a much smaller impact on the uninsured.

Those estimates are derived from a complicated econometric model, estimating the dynamics of how many individuals would move among individual and employer group insurance markets, Medicaid, and the ranks of the uninsured. Because some would leave the Medicaid program, the state would realize some financial savings. For the employer credit option, it was estimated that \$158 million in savings would be realized from Medicaid, and that figure is deducted from the fiscal costs. In this example, the Medicaid savings were estimated at about 13 percent of the gross fiscal cost.

In crafting an employer tax credit, several options would be available regarding how the credit impacts tax liabilities:

1. Credits that only offset current tax liabilities – if the credit were larger than the taxpayer's current annual tax liability, and excess credit would be forgone.
2. Credits that are refundable to those without enough current tax liability (the state would write a check to pay the taxpayer if the credit were larger than the current tax liability).
3. Credits that may be carried forward to offset future tax liabilities.

Many small businesses have small profit margins and therefore low tax liabilities. If these employers cannot carry the credits forward or receive refunds or payments for credits that exceed their tax liability, the credits may not provide much incentive for purchasing insurance, since they would not provide enough of a subsidy.

To create an individual tax credit, policymakers would also need to determine how the credit would impact an individual's tax liability. Many individuals, especially those at low incomes, do not have a high enough state income tax liability for a non-refundable credit to provide much subsidy impact. To ensure that the tax subsidy is an effective incentive for individuals, the credit would probably need to be refundable. This means a taxpayer would receive cash from the state in the amount that the credit exceeds his or her tax liability for the year.

To understand how an employer tax credit might impact Utah's tax system, Utah Foundation has created the following rough model. This is not as extensive as a legislative fiscal note would be, but it provides a "ballpark" figure that may be useful in considering this policy option.

This rough model is based on a fully refundable tax credit of \$500 per employee choosing single coverage health insurance, \$750 per employee choosing employee-plus-one coverage, and \$1,000 per employee choosing family coverage. The model uses MEPS-IC data to calculate how many employees choose family coverage, employee-plus-one coverage, or single coverage. It assumes that when previously uninsured employees receive health insurance, they will sign up for these coverage options in the same proportion as existing employees; for example, 54-56 percent will choose family coverage, depending on the size of firm.

This example provides two options: providing the credit to all firms with fewer than 10 employees, or to all firms with fewer than 50 employees. We did not attempt to limit the credit to only employees with low incomes or to firms that do not already provide health insurance, although those options could be chosen to limit its fiscal impact. However, surveys are showing a decline in the number of firms offering insurance, especially small firms. The decline in employer-sponsored coverage appears to be correlated with rising costs, and limiting the credit to only firms that have not provided insurance would forgo the opportunity to encourage the continuation of existing employer-sponsored insurance.

Using data from the Agency for Healthcare Research and Quality (AHRQ), it is fairly simple to show how many employees are currently covered by employer-sponsored insurance at small firms. Credits for these employees' firms would constitute the bulk of the fiscal impact, costing about \$27 million for firms with less than 10 employees or nearly \$66 million for firms with less than 50 employees. The difficult part of the estimate is calculating how many of the uninsured would receive coverage as a result of this incentive. If provision of these credits resulted in 30 percent of the uninsured who work at small firms becoming insured, the total costs would be around \$38 million for the smallest firms, those with less than 10 employees. If the credits were available to firms with less than 50 employees, the costs could be around \$89 million per year.

There could be some offset to these costs if firms claiming the credit were no longer allowed to deduct health insurance as a normal business expense. However, credits in these amounts would equal about 12-16 percent of actual premiums, based on 2004 averages, and those percentages will decline as premiums continue to rise. If the credit is much lower than in this example, it will not be a much stronger incentive than simply deducting insurance costs as a business expense. It may be worth allowing companies to claim the deduction and the credit to ensure the credit carries sufficient impact.

Figure 13: Potential Utah Fiscal Impact of a Broad Employer Tax Credit for Small Firms, Based on 2004 figures from MEPS-IC*

	Option 1: Firms Under 10	Option 2: Firms Under 50
Employee coverages by firm size		
Employees by size of firm	141,905	286,089
Employees at firms that offer insurance, percent	39.5%	54.6%
Employees at firms that offer insurance, number	56,052	156,205
Employees insured as percent of those at firms that offer insurance	58.5%	53.0%
Employees insured by their employer, number	32,791	82,788
Employees not insured by their employer, number	109,114	203,301
Employees not insured by any source, percent**	33%	33%
Employees not insured by any source, number	46,829	94,409
Average Insurance Premiums		
Family premium, annual average	\$8,654	\$8,654
Tax credit for employer, per employee choosing this coverage	\$1,000	\$1,000
Percent of employees choosing family coverage	56.0%	54.3%
Employee-plus-one premium, annual average	\$6,059	\$6,059
Tax credit for employer, per employee choosing this coverage	\$750	\$750
Percent of employees choosing employee-plus-one coverage	11.8%	10.2%
Single coverage premium, annual average	\$3,034	\$3,034
Tax credit for employer, per employee choosing this coverage	\$500	\$500
Percent of employees choosing single coverage	32.2%	35.5%
Costs of Tax Credit		
Tax credit cost for those already covered	\$26,544,070	\$65,982,383
Additional cost if 10% of uninsured received coverage	\$3,790,779	\$7,524,427
Additional cost if 20% of uninsured received coverage	\$7,581,558	\$15,048,854
Additional cost if 30% of uninsured received coverage	\$11,372,338	\$22,573,280
Total cost for those already covered +10% of uninsured gaining coverage	\$30,334,849	\$73,506,809
Total cost for those already covered +20% of uninsured gaining coverage	\$34,125,628	\$81,031,236
Total cost for those already covered +30% of uninsured gaining coverage	\$37,916,408	\$88,555,663

* Medical Expenditure Panel Survey - Insurance Component, AHRQ, 2004.
 ** Kaiser Family Foundation estimated the number of uninsured working for firms under 10 at 33% of those firms' employees. A ratio for employees at firms under 50 is not available; therefore, the 33% figure is used for that column as well, although its accuracy is uncertain.
 Source: Utah Foundation based on data cited.

Another offset to these costs would be savings in the Medicaid program. The model for California described above estimated that Medicaid costs would be reduced by about 13 percent through an employer tax credit. It is not certain that Utah's proportion of Medicaid leavers would be similar but if it were, the state could save about \$40 million from its share of Medicaid costs.

In addition, any reduction in the uninsured or underinsured population would reduce the effects of cost shifting by hospitals and practitioners, making insurance for the remaining population more affordable. This would be difficult to quantify but would be a real benefit to others in the Utah economy.

Passage of such a credit may be difficult. Income taxes are earmarked for public and higher education in Utah, and the credits referenced above would reduce income tax revenues. If the employer health insurance tax credit needed to be pared down from the broad example in this model, it could be limited by any of the following actions, either alone or in combination:

- Eliminate refundability so only those with a tax liability would receive the credit.
- Limit the credit to firms with a specified percentage of low-wage workers.
- Limit the credit to only those firms with fewer than 10 employees.
- Limit the credit to only firms that did not provide health insurance to employees in the previous two years (or some other period).

- Cap the credit at a lower dollar amount per employee or eliminate the larger credits for dependent coverage.
- Appropriate funding for a limited pool of credits and allow employers to participate on a first-come, first-served basis.

Eliminating refundability would lower the fiscal estimate since many small firms would not have enough tax liability to receive the full credit. But for companies with little or no tax liability, this would remove the incentive and limit its effectiveness in promoting coverage.

Limiting the credit to firms with more low-wage workers could be very effective. These are likely to be the firms with the greatest need and the lowest rate of offering health insurance. This would focus the credits incentives on firms that need it most, and since more of these firms do not currently provide insurance, this would greatly reduce the cost of subsidizing those who already provide insurance.

Providing credits only to firms that have not provided insurance in recent years removes the largest portion of the fiscal impact, since 70 to 90 percent of the impact shown in Figure 13 is from credits for those already insured. A decision would be needed on how many years a firm would receive the credit after newly insuring its employees, otherwise each firm that receives the credit would soon become ineligible (because it would be currently insuring its employees) and many would likely cancel coverage.

Capping the credit at a lower dollar amount or eliminating the larger credits for dependent coverage would still provide an incentive for firms to cover employees, but it could leave many dependents uninsured. Companies may still offer family coverage, but doing so would be more costly for the company or the employee.

Creating a limited pool of credits would allow for more predictable fiscal impacts but would create a disadvantage for new firms and others that were not fast enough to get into the pool before it closed. This kind of policy can be acceptable for pilot projects but is not very equitable for broad public policy reforms.

The most promising alternative would be limiting eligibility for the credits to firms with a certain level of low-wage workers. Eliminating refundability, limiting eligibility to the smallest firms, or capping the credit dollar amount would also be workable but could do significant harm to the effectiveness of the policy.

Trends and Developments in State and National Policies

Perhaps because these can be expensive proposals, not much has been done at the state level. In 1988, California enacted a broad small-business health insurance tax credit (SB 2260, Statutes 1988, Ch. 1521), but the credit was to be implemented at a later date and was repealed before becoming effective. A more recent proposal in California for a 50 percent tax credit for small employers and self-employed individuals was estimated to cost more than \$1 billion annually.¹⁶⁶ The proposal was not enacted.

Montana and Tennessee have both recently enacted programs to subsidize employer-sponsored insurance. Tennessee's law was signed this summer and is in the implementation phase now, while Montana began implementation in 2005.

Montana's "Insure Montana" initiative provides a tax credit to small employers of \$100 per insured employee per month plus \$100 for spouse coverage and \$40 for dependent coverage. These credits are only available for firms with two to nine employees. With limited funding, the state took the first firms to apply until funding was exhausted and created a waiting list of firms desiring to receive the credit.

The other component of the program created a purchasing pool and a subsidy for firms of two to nine employees not previously offering coverage. This pool also has a waiting list because of limited funding. This purchasing pool offers two insurance policies with moderately high deductibles (\$500 or \$1,000) and co-pay rates of 20 percent or 30 percent. To ensure the high deductible does not discourage preventive care, enrollees are provided two annual doctor visits with 100 percent coverage. Dental coverage is included. The state provides a subsidy of \$146 per enrolled employee (no additional amount is provided for dependents). Employees may receive assistance for their share of the premiums, based on a sliding scale of income levels. The net result is that employers pay about 25 percent of the premium for a single employee. The state asked insurers to bid on providing this coverage, and BlueCross BlueShield won the bid.

The Insure Montana program was allocated \$13 million for the first two years, 40 percent of which is used for the tax credits. Funding was created through a \$1 per pack increase in cigarette taxes. The program is still early in implementation, having begun in early 2006.

Tennessee's "Cover Tennessee" program was signed into law in June 2006. The governor expects the program to become operative by January 2007. The program was enacted as part of a package that includes enhancements of state-federal children's health insurance, the state pool for uninsurable adults, a pharmacy benefit for low-income individuals, and a diabetes treatment and prevention program. Cover Tennessee will not provide tax credits but will offer assistance for the employer share of health insurance premiums for low-income workers. The program's assistance is only available to those purchasing a low-cost, limited insurance policy developed by insurers for the state. The goal is an individual premium of \$150 per month, with enrollees, the state, and the employer each paying one-third of the cost. To avoid discouraging preventive care, these policies will not have high deductibles. The policy would be portable when an employee changes jobs.

Experience with policies and evidence of effectiveness

There is little experience with tax credits or other employer subsidies among the states. The programs in Montana and Tennessee will provide some insight into feasibility and effectiveness over the next several years.

In Montana, as of early August, 4,650 individuals were insured. That figure amounts to only three percent of Montana's uninsured population, but the program is very limited, amounting to less than one-half percent of state general fund spending.

EFFORTS OF OTHERS ON HEALTHCARE REFORM

The Employers Healthcare Coalition decided to focus on reforms that would decrease healthcare costs and increase coverage by expanding employer-based coverage. Many other public and private organizations in Utah are also studying healthcare reform. Governor Huntsman has sponsored an initiative called "Health Insurance Coverage for Utah's Uninsured Citizens." This group has formed several proposals designed to provide health insurance for all Utah children and to make health insurance more attainable for small business employees and individuals. The Governor's Office of Economic Development is also studying how to increase small businesses' access to health insurance.

In July 2006, the Utah Department of Insurance published its annual report on the health insurance market. This report included eight recommendations for legislative action to improve Utah's health insurance market. Three of the recommendations are similar to reforms proposed in this report: encourage the development of and require the use of electronic data interchange standards (related to Practice Guidelines), replacement of the medical malpractice system with a no-fault dispute resolution system modeled after workers' compensation insurance (related to Tort Reform), and removal of state mandated coverage (instead requiring only mandated offering) for groups 2-50 (related to State Mandates). The Utah Health Department, the Utah Legislature, and non-profit organizations such as the Utah Health Policy Project are also searching for ways to increase access to healthcare and decrease the number of uninsured.

CONCLUSION

Rapidly increasing healthcare costs strain the budgets of families, businesses and the government. As the growth rate of healthcare costs continues to outpace both the inflation rate and the growth rate of workers' wages, society faces an ever-growing problem. As healthcare costs rise, employers drop coverage or shift more costs to employees in order to remain competitive in an increasingly global economy. Increasingly, employees may not be offered insurance through their jobs or may be unable to afford enrolling in job-based insurance even when coverage is offered. Less job-based coverage results in higher numbers of uninsured or publicly insured persons. Since the healthcare costs of the uninsured are generally uncompensated and public healthcare programs generally undercompensate providers, this shift away from private coverage results in greater cost-shifting to private insurance.

Adding to the problem is the fact that as the price of health insurance rises, the youngest and healthiest persons in society are the most likely to choose not to purchase insurance, believing that their risk of

health problems is too low to merit the payment of costly premiums. As the young and healthy bypass the insurance pool, healthcare costs are spread across a smaller unhealthier group of people, and insurers face higher average costs per individual and must therefore charge higher premiums.

Since more expensive health insurance premiums increase the number of uninsured, and greater numbers of uninsured result in more expensive insurance premiums, Utah faces a potential downward spiral in both health insurance coverage and affordability as healthcare costs continue to rise.

The five reforms analyzed in this report would be useful in addressing some of the root causes of rising healthcare costs. National and state data, researchers, and Utah healthcare stakeholders agree that rapidly advancing medical technology costs, unchecked consumer demand, providers' fear of malpractice litigation, individuals' unhealthy behaviors, and cost-shifting all drive up the cost of healthcare. Greater use of practice guidelines and health information technology can curb overutilization while improving the overall quality of healthcare. Tort reform decreases the costs of litigation, diminishing the motivation to practice defensive medicine. The removal of mandated coverage laws and providing tax credits for small businesses who offer coverage to employees both may increase the number of privately insured persons by making employer-based insurance more affordable for small businesses. Promoting stronger wellness incentives would address obesity and other conditions that contribute to expensive health problems.

Appendix A: Nine Common Malpractice Tort Reforms in U.S. States, October 2005

State	Limits on Damage Awards	Limits on Attorney Fees	Expert Witness Standards	Affidavits or Certificates of Merit	Pre-trial Screening or Alternative		Limits on Joint and Several Liability	Compensation or Stabilization Fund	Doctor Apologies	Total
					Dispute Resolution	Statutes of Limitation				
Alabama	Unconstitutional		x	x	x	x				4
Alaska	x		x		x	x	x			5
Arizona	Unconstitutional	Court review	x	x	x	x	x		x	6
Arkansas	x		x		x	x	x			5
California	x	x	x		x	x	x			6
Colorado	x		x		x	x	x	Not Implemented	x	6
Connecticut		x	x	x	x	x	x		x	7
Delaware	x	x	x	x	x	x		x		7
Florida	x	x	x	x	x	x	x	Not Implemented	x	8
Georgia	x		x	x	x	x	x	x	x	8
Hawaii	x	Court review			x	x	x			4
Idaho	x		x		x	x	x			5
Illinois	x	x	x	x	x	x			x	7
Indiana	x	x	x		x	x		x		6
Iowa		Court review	x		x	x	x			4
Kansas	x	Court review	x		x	x		x		5
Kentucky					x	x	x			3
Louisiana	x		x		x	x	x	x	x	7
Maine	x	x			x	x			x	5
Maryland	x		x	x	x	x		x	x	7
Massachusetts	x	x			x	x			x	5
Michigan	x	x	x	x	x	x	x			7
Minnesota	Court review		x	x	x	x	x			5
Mississippi	x		x	x	x	x	x			6
Missouri	x			x		x	x	x	x	6
Montana	x		x		x	x	x	x	x	7
Nebraska	x	Court review			x	x	x	x		5
Nevada	x	x		x	x	x	x	x		7
New Hampshire	Unconstitutional	x	x		x	x	x		x	6
New Jersey	x	x	x		x	x	x			6
New Mexico	x		x		x	x	x	x		6
New York		x		x	x	x	x			5
North Carolina	x		x		x	x			x	5
North Dakota	x			x	x	x	x	Not Implemented		5
Ohio	x	Court review	x		x	x	x		x	6
Oklahoma	x	x	x	x		x	x	x	x	8
Oregon	Unconstitutional	x			x	x	x	x	x	6
Pennsylvania	Unconstitutional		x		x	x	Unconstitutional	x		4
Rhode Island			x		x	x				3
South Carolina	x		x	x	x	x		x		6
South Dakota	x				x	x	x		x	5
Tennessee		x	x		x	x	Unconstitutional			4
Texas	x		x	x	x	x	x			6
Utah	x	x			x	x	x		x	5
Vermont					x	x				2
Virginia	x		x	x	x	x		x	x	7
Washington	x	Court review			x	x	x			4
West Virginia	x		x	x	x	x	x	x	x	8
Wisconsin	Unconstitutional	x			x	x	x	x		5
Wyoming	Unconstitutional	x			x	x	x	x	x	6
Total	35	19	34	20	48	50	35	19	21	

Source: NCSL.

ENDNOTES

1 Practice guidelines are also called evidence-based guidelines, best practice guidelines, clinical practice guidelines, practice parameters, protocols and standards of care.

2 Teryl K. Nuckols and others, *Evaluating Medical Treatment Guideline Sets for Injured Workers in California*, (Santa Monica, California: RAND Corporation, 2005).

3 Nuckols and others, 14

4 Twila Brase, "How Technocrats are Taking Over the Practice of Medicine," *Citizens' Council on Healthcare*, January 2005, <http://www.cchconline.org/pdfreport/EBM_Report_-_Ex_Summary.pdf> (9 October 2006).

5 Agency for Healthcare Research and Quality, "AHRQ and Health IT," <http://healthit.ahrq.gov/portal/server.pt?open=512&objID=562&&PageID=5663&mode=2&in_hi_userid=3882&cached=true> (9 October 2006).

6 Dr. David Sundwall, "The eHealth Strategy of the Utah Department of Health," October 2006.

7 Agency for Healthcare Research and Quality, "Welcome to the Privacy and Security Project," <<http://healthit.ahrq.gov/>> (11 October 2006).

8 Utah Department of Health, "About UNIFY," 2006, <<http://www.health.utah.gov/unify/>> (11 October 2006).

9 Sundwall; DigitalBridge, <<http://www.digitalbridge.com>> (11 October 2006).

10 Agency for Healthcare Research and Quality, "Welcome to the Privacy and Security Project."

11 David Renner, phone interview by author, 19 September 2006.

12 Senator Sheila Kiscaden, interview by author, 18 September 2006.

13 Renner.

14 Agency for Healthcare Research and Quality, "Evidence-based Practice Centers," February 2006, <<http://www.ahrq.gov/clinic/epc/>> (9 October 2006).

15 Minnesota Department of Health, "News Release," 27 June 2006, <<http://www.health.state.mn.us/news/pressrel/ehealth062706.html>> (9 October 2006).

16 Kiscaden.

17 Peter P. Budetti and Teresa M. Waters, "Medical Malpractice Law in the United States," Kaiser Family Foundation, May 2005. <<http://www.kff.org/insurance/upload/Medical-Malpractice-Law-in-the-United-States-Report.pdf>> (9 October 2006).

18 National Conference of State Legislatures, "Medical Malpractice Tort Reform," 1 May 2006, <<http://www.ncsl.org/standcomm/sclaw/medmaloverview.htm>> (9 October 2006).

19 National Conference of State Legislatures, "Medical Malpractice Tort Reform."

20 Government Accountability Office, "Medical Malpractice: Implications of Rising Premiums on Access to Health Care," August 2003, <<http://www.gao.gov/new.items/d03836.pdf>> (9 October 2006), 11; American Tort Reform Association, "Medical Liability Reform," 2005, <<http://www.atra.org/issues/index.php?issue=7338>> (9 October 2006).

21 The White House, "Fact Sheet: Healthcare Transparency: Empowering Consumers to Save on Quality Care," 22 August 2006, <<http://www.whitehouse.gov/news/releases/2006/08/20060822.html>> (9 October 2006); The White House, "Executive Order: Promoting Quality and Efficient Healthcare in Federal Government Administered or Sponsored Healthcare Programs," <<http://www.whitehouse.gov/news/releases/2006/08/20060822-2.html>> (9 October 2006).

22 David S. Broder, "Administration Aims to Set Health-Care Standards," *Washington Post*, 7 August 2006, <<http://www.washingtonpost.com>> (7 August 2006).

23 The White House, "Fact Sheet: Healthcare Transparency: Empowering Consumers to Save on Quality Care."

24 The White House, "Reforming Health Care for the 21st Century," 2006, <<http://www.whitehouse.gov/stateoftheunion/2006/healthcare/index.html#section11>> (9 October 2006).

25 Nancy Ferris, "An e-prescription for Medicaid," *Government Health IT*, 14 August 2006, <<http://www.govhealthit.com/article95606-08-14-06>> (9 October 2006).

26 National Guidelines Clearinghouse, "About NGC," 9 October 2006,

<<http://www.guideline.gov/about/about.aspx>> (9 October 2006).

27 Douglas Waller, "How VA Hospitals Became The Best," *Time Magazine*, 27 August 2006, <<http://www.time.com/time/magazine/article/0,9171,1376238,00.html>> (9 October 2006).

28 RAND Health, "Improving Quality of Care: How the VA Outpaces Other Systems in Delivering Patient Care," 2005, <http://www.rand.org/pubs/research_briefs/RB9100/RAND_RB9100.pdf> (9 October 2006).

29 Department of Veterans Affairs, "VistA Fact Sheet," July 2006, <<http://www.innovations.va.gov/innovations/docs/InnovationFactSheet.pdf>> (30 October 2006).

30 Philip Longman, "The Best Care Anywhere," *Washington Monthly*, January/ February 2005, <<http://www.washingtonmonthly.com/features/2005/0501.longman.html>> (9 October 2006).

31 Waller.

32 Department of Veterans Affairs, "VistA Frequently Asked Questions," July 2006, <<http://www.innovations.va.gov/innovations/docs/InnovationsVistAFAQPublic.pdf>> (9 October 2006).

33 Department of Veterans Affairs, "VistA Fact Sheet," 2006, <<http://www.innovations.va.gov/innovations/docs/InnovationFactSheet.pdf>> (9 October 2006).

34 The Outcome of Outcomes Research at AHCPR: Final Report (Agency for Healthcare Policy and Research, Rockville, MD, 1999), <<http://www.ahrq.gov/clinic/outcosum.htm>> (9 October 2006).

35 Randall R. Bovbjerg and Robert A. Berenson, "Surmounting Myths and Mindsets in Medical Malpractice," *The Urban Institute*, October 2005, <http://www.urban.org/UploadedPDF/411227_medical_malpractice.pdf> (9 October 2006).

36 Teryl K. Nuckols and others.

37 Bickmore Risk Services, "A Study of the Effects of Legislative Reforms on California Workers' Compensation Insurance Rates: Executive Summary," Prepared for California Department of Industrial Relations and Division of Workers' Compensation, January 2006, <http://www.dir.ca.gov/DWC/Study_legislativeReformsCaWCInsuranceRates/DWCExecSummary.pdf> (9 October 2006), 2.

38 Teryl K. Nuckols and others.

39 Teryl K. Nuckols and others.

40 Bickmore Risk Services.

41 Congressional Budget Office, "The Effects of Tort Reform: Evidence from the States," June 2004, <<http://www.cbo.gov/ftpdocs/55xx/doc5549/Report.pdf>> (9 October 2006).

42 See Utah Code 78-14-2, "Legislative findings and declarations -- Purpose of act."

43 Peter P. Budetti and Teresa M. Waters, "Medical Malpractice Law in the United States," Kaiser Family Foundation, May 2005. <<http://www.kff.org/insurance/upload/Medical-Malpractice-Law-in-the-United-States-Report.pdf>> (9 October 2006).

44 The Kaiser Family Foundation, "Number of Paid Medical Malpractice Claims, 2005," Kaiser State Health Facts, 2006, <www.statehealthfacts.org> (9 October 2006).

45 The Kaiser Family Foundation, "Payments on Medical Malpractice Claims, 2005," Kaiser State Health Facts, 2006, <www.statehealthfacts.org> (9 October 2006).

46 Utah Medical Insurance Association, "History of UMIA," 21 June 2006, <<http://www.umia.com/history.html>> (30 October 2006).

47 National Conference of State Legislatures, "Medical Malpractice Tort Reform," 1 May 2006, <<http://www.ncsl.org/standcomm/sclaw/medmaloverview.htm>> (9 October 2006).

48 The White House, "Fact Sheet: President Calls for Medical Liability Reform," 16 January 2006, <<http://www.whitehouse.gov/news/releases/2006/01/20060116.html>> (9 October 2006).

49 National Conference of State Legislatures, "Medical Malpractice Tort Reform."

50 Budetti and Waters.

51 Michelle M. Mello, "Medical malpractice: Impact of the crisis and effect of state tort reforms," Robert Wood Johnson Foundation, The Synthesis Project, May 2006, <http://www.rwjf.org/publications/synthesis/reports_and_briefs/pdf/no10_researchreport.pdf> (12 October 2006).

52 The RWJF report does not classify Colorado as a state with a total damages

cap, perhaps because the court can award amounts above the cap if it finds that applying the limit would be unfair (see Colorado Revised Statute § 13-64-302).

53 In Wisconsin, the Supreme Court ruled in July 2005 that the existing damage award limit was unconstitutional. The legislature has since reestablished a limit on noneconomic damage awards by enacting a bill with a higher limit on damages than the overturned bill.

54 Budetti and Waters.

55 Congressional Budget Office, "The Effects of Tort Reform: Evidence from the States."

56 Congressional Budget Office, "Cost Estimate of H.R. 5: Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003," 10 March 2003, <<http://www.cbo.gov/ftpdocs/40xx/doc4091/hr5.pdf>> (9 October 2006).

57 Loss ratios equal the losses incurred (including the costs of adjusting claims) on policies written in a given year divided by the amount of premiums collected in that same year.

58 Randall R. Bovbjerg and Robert A. Berenson. "Surmounting Myths and Mindsets in Medical Malpractice," The Urban Institute, October 2005, <http://www.urban.org/UploadedPDF/411227_medical_malpractice.pdf> (9 October 2006).

59 PricewaterhouseCoopers, "The Factors Fueling Rising Healthcare Costs 2006," Prepared for America's Health Insurance Plans, January 2006, <[http://www.pwc.com/extweb/pwcpublishings.nsf/docid/E4C0FC004429297A852571090065A70B/\\$File/ahip-factors_fueling_rising_hc-costs.pdf](http://www.pwc.com/extweb/pwcpublishings.nsf/docid/E4C0FC004429297A852571090065A70B/$File/ahip-factors_fueling_rising_hc-costs.pdf)> (9 October 2006).

60 Government Accountability Office, "Medical Malpractice: Implications of Rising Premiums on Access to Health Care," August 2003, <<http://www.gao.gov/new.items/d03836.pdf>> (9 October 2006).

61 Michelle M. Mello, "Medical malpractice: Impact of the crisis and effect of state tort reforms."

62 David A. Katz, Geoffrey C. Williams, Roger L. Brown, and others, "Emergency physicians' fear of malpractice in evaluating patients with possible acute cardiac ischemia," *Annals of Emergency Medicine* 46, no. 6 (December 2005): 525-533.

63 William E. Encinosa and Fred J. Hellinger, "Have State caps on malpractice awards increased the supply of physicians?" *Health Affairs—Web Exclusive* (31 May 2005): 250-258.

64 Daniel P. Kessler, William M. Sage and David J. Becker, "Impact of Malpractice Reforms on the Supply of Physician Services," *Journal of the American Medical Association* 293, no. 21 (1 June 2005): 2618-2625.

65 Michelle M. Mello, "Medical malpractice: Impact of the crisis and effect of state tort reforms."

66 Michelle M. Mello, "Medical malpractice: Impact of the crisis and effect of state tort reforms."

67 Randall R. Bovbjerg and Robert A. Berenson. "Surmounting Myths and Mindsets in Medical Malpractice."

68 Kenneth E. Thorpe, "The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms," *Health Affairs—Web Exclusive* (January 21, 2004), <<http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.20v1.pdf>> (9 October 2006).

69 Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, editors, Committee on Quality of Health Care in America, Institute of Medicine, *To Err Is Human: Building a Safer Health System* (Washington, D.C.: National Academy Press, 2000).

70 Michelle M. Mello, "Medical malpractice: Impact of the crisis and effect of state tort reforms."

71 A.R. Localio and others, "Relation between malpractice claims and adverse events due to negligence. Results of the Harvard Medical Practice Study III," *The New England Journal of Medicine* 325, no. 4 (25 July 1995): 245-251.

72 Michelle M. Mello, "Malpractice Liability and Medical Error Prevention: Strange Bedfellows?" Prepared for the Council on Health Economics and Policy Conference on Medical Malpractice Practice in Crisis: Health Policy Options, March 2003, <<http://council.brandeis.edu/pubs/Malpractice/MalpracticeAndErrors-Mello.pdf>> (12 October 2006).

73 Bovbjerg and Berenson.

74 Michelle M. Mello, "Malpractice Liability and Medical Error Prevention: Strange Bedfellows?"

75 T.A. Brennan, C.M. Cox and H.R. Burstin, "Relation between negligent

adverse events and the outcomes of medical-malpractice litigation," *New England Journal of Medicine* 335, no. 26 (26 December 1996): 1963-1967.

76 Claudia H. Williams and Michelle M. Mello, "Medical malpractice: Impact of the crisis and effect of state tort reforms," Robert Wood Johnson Foundation, Policy Brief no. 10, May 2006, <http://www.rwjf.org/publications/synthesis/reports_and_briefs/pdf/no10_policybrief.pdf> (12 October 2006).

77 Bovbjerg and Berenson.

78 David M. Studdert, Troyen A. Brennan and Eric J. Thomas, "Beyond dead reckoning: measures of medical injury burden, malpractice litigation, and alternative compensation models in Utah and Colorado," *Indiana Law Review* 33, no. 4 (2000): 1643-1687; Michal H. Brown, "Improving Malpractice Prevention and Compensation Systems," Robert Wood Johnson Foundation, September 2002, <<http://www.rwjf.org/reports/npreports/impacs.htm>> (12 October 2006); "No-Fault Compensation for Medical Injury Proposed as Incentive for Reporting and Correcting Hospital Error, Improving Patient Safety," Harvard School of Public Health, 10 July 2001, <<http://www.hsph.harvard.edu/press/releases/press07102001.html>> (12 October 2006); Mello, *Strange Bedfellows*.

79 Kevin Bissett, "Health Council examines no-fault insurance for medical errors," the Canadian Press, 27 September 2006, <<http://ca.news.yahoo.com>> (12 October 2006).

80 Although the no-fault system was intended to be the exclusive remedy for qualifying claims, Florida courts allowed claimants to simultaneously pursue their claim in both the tort and no-fault systems.

81 Michael H. Brown, "Can the No-Fault Approach Contain Malpractice Insurance Costs?" Robert Wood Johnson Foundation, September 2002, <<http://www.rwjf.org/reports/grr/027070.htm>> (12 October 2006).

82 "Baucus, Enzi Introduce Bill to Promote State Alternatives To Medical Tort Liability System," Committee on Finance, U.S. Senate, 29 June 2005, <<http://finance.senate.gov/press/Bpress/2005press/prb062905.pdf>> (12 October 2006).

83 Miriam J. Laugesen, Rebecca R. Paul, Harold S. Luft, Wade Aubry and Theodore G. Ganiats, "A Comparative Analysis of Mandated Benefit Laws, 1949-2002," *Health Services Research* 41, no. 3 (June 2006): 1081-1103.

84 Jeffrey E. Hawley, "2005 Health Insurance Market Report," Utah Department of Insurance, 10 July 2006, <<http://www.insurance.utah.gov/2005%20Health%20Ins%20Report.pdf>> (9 October 2006).

85 Gail A. Jensen and Michael A. Morrissey, "Mandated Benefit Laws and Employer-Sponsored Health Insurance," Health Insurance Association of America, January 1999, <<http://membership.hiaa.org/pdfs/jensenrpt.pdf>> (9 October 2006).

86 There is some precedent for states to regulate aspects of self-insured employer plans (in 2003 the U.S. Supreme Court upheld Kentucky's Any Willing Provider laws, which apply to all insurers in the state).

87 Partnership for Prevention, "Preventive Services: Helping States Improve Mandates," 2002, <http://prevent.org/images/stories/Files/publications/Preventive_Services_State_Mandate_Brief_FINAL.pdf> (9 October 2006)

88 The Foundation for Taxpayer & Consumer Rights, "Junk Health Insurance," 2006, <<http://www.consumerwatchdog.org/healthcare/AHP/>> (9 October 2006).

89 Jensen and Morrissey.

90 Laugesen and others.

91 Council for Affordable Health Insurance, "Health Insurance Mandates in the States," 2006, <<http://www.cahi.org>> (9 October 2006).

92 Council for Affordable Health Insurance, "Health Insurance Mandates in the States."

93 Council for Affordable Health Insurance, "Health Insurance Mandates in the States."

94 Council for Affordable Health Insurance, "Trends in State Mandated Benefits, 2006," May 2006, <http://www.cahi.org/cahi_contents/resources/pdf/TrendsEndsMay2006.pdf> (9 October 2006).

95 Council for Affordable Health Insurance, "Trends in State Mandated Benefits, 2006."

96 Juliette Cubanski and Helen H. Schauffer, "Mandated Health Insurance Benefits: Tradeoffs Among Benefits, Coverage, and Costs," California Health Policy Roundtable, July 2002, <<http://www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13995>> (9 October 2006).

97 Laugesen and others.

- 98 Government Accountability Office, "Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance," August 1996, <<http://www.gao.gov/archive/1996/he96161.pdf>> (9 October 2006).
- 99 Government Accountability Office, "Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses," September 2003, <<http://www.gao.gov/new.items/d031133.pdf>> (9 October 2006).
- 100 Jeffrey E. Hawley, "2003 Diabetes Mandate Report," Utah Department of Insurance, 28 October 2003, <<http://www.insurance.utah.gov/2003DiabetesRpt.pdf>> (9 October 2006).
- 101 Jeffrey E. Hawley, "2004 Catastrophic Mental Health Report," Utah Department of Insurance, 27 February 2004, <<http://www.insurance.utah.gov/2004MentalHlthRpt.pdf>> (9 October 2006).
- 102 Jeffrey E. Hawley, "2003 Adoption Indemnity Report," Utah Department of Insurance, 25 July 2003, <<http://insurance.utah.gov/2003AdoptionRpt.pdf>> (9 October 2006).
- 103 Government Accountability Office, "Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance."
- 104 Government Accountability Office, "Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses."
- 105 Federal Trade Commission and the Department of Justice, "Improving Health Care: A Dose of Competition," July 2004, <<http://www.ftc.gov>> (9 October 2006).
- 106 PricewaterhouseCoopers, "The Factors Fueling Rising Healthcare Costs," Prepared for America's Health Insurance Plans, April 2002, <<http://www.heartland.org/pdf/14621.pdf>> (9 October 2006).
- 107 PricewaterhouseCoopers, "The Factors Fueling Rising Healthcare Costs 2006," Prepared for America's Health Insurance Plans, January 2006, <[http://www.pwc.com/extweb/pwcpublishations.nsf/docid/E4C0FC004429297A852571090065A70B/\\$File/ahip-factors_fueling_rising_hc-costs.pdf](http://www.pwc.com/extweb/pwcpublishations.nsf/docid/E4C0FC004429297A852571090065A70B/$File/ahip-factors_fueling_rising_hc-costs.pdf)> (9 October 2006).
- 108 Council for Affordable Health Insurance, "Health Insurance Mandates in the States."
- 109 Government Accountability Office, "Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance."
- 110 Jeffrey E. Hawley, "2003 Diabetes Mandate Report"; Jeffrey E. Hawley, "2004 Catastrophic Mental Health Report."
- 111 Jensen and Morrisey.
- 112 Cubanski and Schaffler.
- 113 Jensen and Morrisey.
- 114 Preventive Services.
- 115 The American Civil Liberties Union, "Lifestyle Discrimination in the Workplace: Your Right to Privacy Under Attack," 31 December 1998, <<http://www.aclu.org/workplacerrights/gen/13384res19981231.html>> (10 October 2006).
- 116 National Workrights' Institute, "Lifestyle Discrimination: Employer control of legal off duty employee activities," 2006, <http://www.workrights.org/issue_lifestyle/ldbrie2.pdf> (10 October 2006).
- 117 Information on premium setting in Utah provided by Ms. Tanji Northrup, Rate and Form Analyst for Utah's Health Insurance Division & Office of Consumer Health Assistance (OCHA). See also Utah code section 31A-30-106 (subsections 1h and 1b) for information on premium setting by commercial insurers.
- 118 GAO, 2003, Small Business Health Coverage Requirements
- 119 Utah Department of Health, Utah Tobacco Prevention and Control Program, "Tobacco Programs for Medicaid and PCN Clients," 28 June 2005, <<http://www.tobaccofreeutah.org/healthcare-medicaid&pcnprograms.html>> (25 October 2006).
- 120 Utah Department of Health, Healthy Utah website, <<http://www.healthutah.org/>> (10 October 2006).
- 121 Kathy Paras, phone interview by author, 10 October 2006.
- 122 Utah Public Employees Health Program, "PEHP Launches Weight Management Program," 2006, <http://www.pehp.org/UPS_GenApp/do/timelyTopics/weightManagement> (30 October 2006); Amy Keate (Member Representative -- Weight Management Coach), phone interview by lead author, 30 October 2006.
- 123 National Workrights' Institute, "Lifestyle Discrimination: Employer control of legal off duty employee activities."
- 124 Government Accountability Office, "Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses," September 2003, <<http://www.gao.gov/new.items/d031133.pdf>> (9 October 2006).
- 125 Government Accountability Office, "Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses"; The Kaiser Family Foundation, "Small Group Health Insurance Market Rate Restrictions, 2005," Kaiser State Health Facts, May 2005, <<http://www.statehealthfacts.org>> (9 October 2006).
- 126 Brett J. Blackledge, "State urged to link behavior, insurance," The Birmingham News, 22 April 2004.
- 127 Alabama State Employees' Insurance Board, "State Employees' Insurance Board Tobacco User Policy," <http://www.alseib.org/v1.0.0/healthinsurance/sehip/pdf/tobacco_policy.pdf> (11 October 2006).
- 128 "State: healthier lifestyle should mean cheaper health insurance," The Associated Press, 2 February 2005.
- 129 Liz Kowalczyk, "Bay state's nonsmokers could save; health law can reward lifestyle gains," The Boston Globe, 16 April 2006.
- 130 U.S. Department of Health and Human Services, "HHS Approves Innovative Medicaid Reform In West Virginia," 3 May 2006, <<http://www.hhs.gov/news/press/2006pres/20060503.html>> (24 October 2006).
- 131 Government Accountability Office, "Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses."
- 132 Martin Sipkoff, "Employers' Stock in Wellness Rises With No End in Sight," Managed Care, July 2006, <<http://www.managedcaremag.com/archives/0607/0607.wellness.html>> (10 October 2006).
- 133 National Workrights' Institute, "Lifestyle Discrimination: Employer control of legal off duty employee activities"; Kathy Barks Hoffman, "Quit smoking or you're fired," Tennessean.com, 9 February 2005, <http://www.tennessean.com/business/archives/05/01/65409839.shtml?Element_ID=65409839> (10 October 2006); "Whose Life Is It Anyway?" CBS News, 16 July 2006, <<http://www.cbsnews.com/stories/2005/10/28/60minutes/main990617.shtml>> (10 October 2006).
- 134 Alison Grant, "Off-duty? Not so fast; Some employers try to regulate workers' outside activities," Plain Dealer, 10 April 2006.
- 135 Kathy Barks Hoffman, "Quit smoking or you're fired," Tennessean.com, 9 February 2005; PricewaterhouseCoopers, "Looking at Issues Facing Healthcare Executives," 2005, <<http://www.pwc.com>> (10 October 2006).
- 136 U.S. Department of Labor, Bureau of Labor Statistics Data, <<http://www.bls.gov/>> (27 September 2006).
- 137 U.S. Department of Health and Human Services, "Educational and Community-Based Programs," Healthy People 2010, November 2000, <http://www.healthypeople.gov/document/HTML/Volume1/07Ed.htm#_Toc490550857> (30 October 2006).
- 138 Francis P. Alvarez, "Preventive medicine: employee wellness programs are prone to legal maladies that require careful monitoring," HR Magazine, January 2006; Repps Hudson, "Insurance strategy turns to incentives for healthier habits," St. Louis Post-Dispatch, 30 July 2006; Leah Carlson Shepherd, "Employers increase wellness push with new programs, incentives," Employee Benefit News, 1 July 2006.
- 139 Maurissa Kanter and JoAnne Laffey, "Hewitt Study Shows Employers Seeking to Attach Root Causes of Health Care Cost Inflation," Hewitt Associates, 10 January 2005, <<http://www.hewittassociates.com/Intl/NA/en-US/AboutHewitt/Newsroom/PressReleaseDetail.aspx?cid=2037>> (10 October 2006).
- 140 Shepherd.
- 141 PricewaterhouseCoopers, "Looking at Issues Facing Healthcare Executives."
- 142 Gloria Gonzalez, "New Michigan law promotes wellness programs," Business Insurance, 4 October 2006, <<http://www.businessinsurance.com/cgi-bin/news.pl?newsId=8507>> (11 October 2006).
- 143 "New Blue Care Network product seeks to reward healthy lifestyles," Business and Management Practices, 15 May 2006; Katie Merx, "HMO will tie rates to users' health: Blue Care Network to reduce costs for low-risk patients," Detroit Free Press, 10 July 2006.
- 144 Steven Greenhouse and Michael Barbaro, "Wal-Mart Memo Suggests Ways to Cut Employee Benefit Costs," The New York Times, 26 October 2005, <<http://www.nytimes.com>> (20 September 2006).
- 145 "Whose Life Is It Anyway?" CBS News.

- 146 Hudson.
- 147 Alvarez.
- 148 Alvarez.
- 149 PricewaterhouseCoopers, "The Factors Fueling Rising Healthcare Costs 2006," Prepared for America's Health Insurance Plans, January 2006, <[http://www.pwc.com/extweb/pwcpublishations.nsf/docid/E4C0FC004429297A852571090065A70B/\\$File/ahip-factors_fueling_rising_hc-costs.pdf](http://www.pwc.com/extweb/pwcpublishations.nsf/docid/E4C0FC004429297A852571090065A70B/$File/ahip-factors_fueling_rising_hc-costs.pdf)> (9 October 2006).
- 150 U.S. Department of Health and Human Services, "Prevention Makes Common 'Cents,'" September 2003, <<http://aspe.hhs.gov/health/prevention/>> (11 October 2006).
- 151 Centers for Disease Control and Prevention, National Center for Health Statistics, "Table 72. Leisure-time physical activity among adults 18 years of age and over, according to selected characteristics: United States, selected years 1998–2003," Health, United States, 2005, <<http://www.cdc.gov/nchs/data/hus/hus05.pdf#summary>> (24 October 2006).
- 152 Utah Department of Health, "Obesity in Utah: Data and the Problem," <http://health.utah.gov/obesity/data.html>
- 153 Alison Lapp, "RTI economist cites costs of obesity; Both taxpayers, employers paying for overweight," The Herald-Sun, Business C1, 30 June 2005.
- 154 Centers for Disease Control and Prevention, National Center for Health Statistics, "Executive Summary," Health, United States, 2005, <<http://www.cdc.gov/nchs/data/hus/hus05.pdf#summary>> (24 October 2006).
- 155 Utah Department of Health, Tobacco Prevention and Control Program, "Tobacco Prevention and Control in Utah, Sixth Annual Report: Make Your Life a Little Easier," August 2006, <http://www.tobaccofreeutah.org/tppfy06report.pdf> (19 October 2006).
- 156 The MIT Press, "The Price of Smoking," 2006, <<http://mitpress.mit.edu/catalog/item/default.asp?tid=10298&ttype=2>> (11 October 2006).
- 157 Hudson.
- 158 National Workrights' Institute, "Lifestyle Discrimination: Employer control of legal off duty employee activities."
- 159 Employee Benefit Research Institute, "Fundamentals of Employee Benefit Programs. Part Three: Health Benefits," 2005, <<http://www.ebri.org/pdf/publications/books/fundamentals/Fnd05.Prt03.Chp24.pdf>> (11 October 2006).
- 160 U.S. Department of Health and Human Services, "Healthy People 2010," November 2000, <<http://www.healthypeople.gov/document/tableofcontents.htm>> (11 October 2006).
- 161 The Hay Group, "Six Years of Double-digit Medical Rate Increases Has Had a Significant Impact on Employers and Employees," 3 March 2005, <http://www.haygroup.com/us/media/press_release.asp?PageID=1130> (11 October 2006).
- 162 Melissa Thomasson, "Health Insurance in the United States," 2003, <eh.net/encyclopedia/article/thomasson.insurance.health.us> (30 October 2006).
- 163 Internal Revenue Service, "Taxable Fringe Benefit Guide: Training Provided by the Internal Revenue Service," January 2006, <www.irs.gov/pub/irstegee/fringe_bnft_flgsg.pdf> (30 October 2006).
- 164 Kaiser Family Foundation, "Health Care & the 2004 Elections," 2004, <www.kff.org/Content/elections2004.cfm> (30 October 2006).
- 165 Karl Polzer and Jonathan Gruber, "Assessing the Impact of State Tax Credits for Health Insurance Coverage," prepared for California HealthCare Foundation, June 2003.
- 166 AB 39 (Thomson and Campbell), 2001.

Utah Foundation thanks the members of the Employers Healthcare Coalition Steering Committee for guidance on this project: Robin Riggs, Salt Lake Chamber; Greg Freddo, Merit Medical Systems; Aaron Bludworth, Modern Display; Dennis Lloyd, Workers Compensation Fund; Stan Lockhart, Micron; Colleen Brenton, IM Flash Technologies; and Kelly Atkinson, Utah Health Insurance Association. For more information on the Employers Healthcare Coalition, please contact Robin Riggs at the Salt Lake Chamber at (801) 328-5080.

FUNDING FOR THIS REPORT PROVIDED BY:
Merit Medical Systems and the Salt Lake Chamber

MAJOR SUPPORTERS OF UTAH FOUNDATION

PLATINUM

Rocky Mountain Power/Pacificorp
Intermountain Power Agency

GOLD

Questar Gas
Kennecott Utah Copper

SILVER

Altius Health Plans
Energy Solutions
Intermountain Healthcare
Kennecott Land
Merit Medical Systems
O.C. Tanner

Regence BlueCross BlueShield
Wells Fargo Utah
Wheeler Machinery
Utah Transit Authority
Zions Bancorporation

BRONZE

Chase Financial
Garbett Homes
Ivory Development
Key Bank

MountainStar Healthcare
Sandy City
US Bank

This research report was written by Research Analyst Elizabeth Escandon and Executive Director Stephen Kroes. Ms. Escandon and Mr. Kroes may be reached for comment at (801) 355-1400. They may also be contacted by email at: betsy@utahfoundation.org or steve@utahfoundation.org. For more information about Utah Foundation, please visit our website: www.utahfoundation.org.

The mission of Utah Foundation is to promote a thriving economy, a well-prepared workforce, and a high quality of life for Utahns by performing thorough, well-supported research that helps policymakers, business and community leaders, and citizens better understand complex issues and providing practical, well-reasoned recommendations for policy change. For more information, please visit www.utahfoundation.org, or call us at (801) 355-1400.

NON PROFIT ORG. U.S. POSTAGE PAID PERMIT NO. 6418	_____

