COMMENTS OF UTAH REPRESENTATIVE DAVID CLARK
BEFORE THE U.S. SENATE COMMITTEE ON
HEALTH EDUCATION LABOR AND PENSIONS
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Senator Harkin, Senator Enzi, and other Honorable Members of this Distinguished Committee.

Two years ago, I appeared before you to report how Utah's health reform efforts might inform the national health care debate. Since then, Utah has been moving forward to develop a health insurance exchange that is part of an overall strategy to inject elements of consumerism — information, choice, and accountability — into health care, all with the goal of improving health status by increasing the availability of high-quality, affordable health insurance. I would like to report quickly on this effort and suggest some additional lessons you might consider as implementation of the Affordable Care Act unfolds.

As you know, Utah created the second of only two operating exchanges in the nation. We are indebted to our friends in Massachusetts who created the first exchange and were willing to teach us from their experience. I commend Congress for attempting to learn from both states. I am confident, however, that there is still much to learn as all 50 states and the federal government work to implement the ACA. We are moving into unchartered territory.

Next week will mark one full year since the Patient Protection and Affordable Care Act (PPACA) was signed into law.[1] During the past year, states, led by officials from both sides of the aisle, have implored members of Congress and the Obama administration to allow significant state flexibility on issues ranging from public programs to state health insurance exchanges.

Although the language of the ACA is quite prescriptive, it does not specify everything. My plea to you today is for help to ensure that as the ACA is implemented, the U.S. Department of Health and Human Services uses a light touch and resists the temptation to fill in too many of the missing details. Those missing details provide policy space for flexibility — the kind of flexibility that will allow for the iterative innovation so very necessary to accomplish the legislation's laudable, but complex goals

[1] The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010.

Urging states to experiment with competing approaches to solve the nation's coverage problems, building on the considerable state innovation already under way, is far more likely to lead to real improvement than the one-size-fits-all approach represented by PPACA.

For instance, prior to the advent of PPACA, Utah undertook a number of efforts aimed at reforming the health care system to better respond to our state's unique business and demographic needs. As we gathered data to develop an accurate picture of our uninsured population, we found that most of our uninsured population were employed and most work for small businesses, many of which did not offer health insurance benefits. Like most states, the vast majority of Utah's businesses are small businesses and, only about 44 percent of those small businesses were offering health insurance coverage. In addition, a great number of our uninsured were "young immortals"-- those between the ages of 18-34 who are employed and in general good health but who tend to view traditional health insurance coverage to be either unnecessary or too costly.

It was clear to us early on that, in order to reduce our uninsured population, we needed to find a way to make insurance coverage more accessible and attractive to small employers and employees of small business, even the so-called young immortals. To that end, we pursued changes to our insurance market that would provide more cost predictability for businesses, thereby creating an incentive for those employers currently offering benefits to continue doing so. As well as creating a way for employees who are not offered coverage to access group plans.

As part of our health system reform efforts, Utah small businesses now have the option of using a defined contribution model for their health benefit offerings. A defined health benefit left businesses with unpredictable and ever-escalating costs. Through access to Utah's new defined contribution market, employers can manage and contain their health benefit expenditures. With the creation of the Utah Health Exchange, Utah employees also benefit from expanded access, choice, and control over their health care options. Rather than the traditional one-size-fits-all approach inherent in the defined benefit model, employees can now use the defined contribution from their employers to shop for health insurance tailored to their individual needs and circumstances. The Utah Health Exchange

currently gives Utah small business employees more than 100 plan choices, all of which retain the pre-tax and guaranteed-issue advantages of traditional small group insurance.

After the planning phase in 2009, the demonstration pilot phase in 2010, the Utah Health Exchange is now fully operational. It is worth noting that all the groups who participated in the pilot chose to renew renewed coverage in the exchange for 2011. In addition, when the Utah Health Exchange was fully launched in September of 2010, 31 additional employer groups enrolled for coverage effective January 1, 2010, 17 additional employer groups enrolled for coverage beginning February 1st, and approximately 83 employer groups were getting coverage through the Utah Health Exchange as of April 1st, bringing the total number of individuals covered in the Utah Health Exchange to more than 2,500 in the first four months of effective coverage following the full launch. We are now running a fully-functional exchange for the small employer market after a 15-month pilot and various adjustments. Since the pilot was opened at the end of last year to all small employer groups enrollment of employers and covered lives has grown on average by about 43% per month
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What does the Utah Health Exchange offer that hasn't been offered before?

First, choice. In the Exchange, employees of participating employers have the opportunity to select from many health plans rather than the one, two, or three plans their employers may have previously offered or perhaps not offered at all. Currently, over 100 plans are offered to small employer groups in the Exchange.

Second, a defined contribution arrangement. The Exchange allows health insurance benefits to be provided through a defined contribution model rather than a defined benefit model, much as is now done with many retirement benefits. Employers participating in the Exchange will have to continue funding premiums at levels sufficient to meet existing employee participation requirements.

And third, as we continue to develop the Exchange, it will incorporate some of the features required under the ACA — availability of information necessary for consumers to evaluate the performance of insurers and their plans, and links to public programs.
The Exchange will also allow consumers to aggregate premium contributions from multiple employers. This includes contributions from multiple employers of an individual and employers of multiple individuals within a household.

Bear in mind that participation in Utah's exchange is 100% voluntary by both the insurance carriers and the employers. It involved no new mandates, no new regulatory features, and no new assessments against carriers for funding purposes. Perhaps most significantly, our figures indicate that 20 percent of businesses participating in our defined contribution market through the Utah Health Exchange were not previously offering coverage, thus we can safely assume that many of those now covered through the exchange were previously counted among our uninsured population

An intrinsic flaw of the PPACA is that it fails to unleash the potential of states to innovate in designing reforms that respond to their own unique circumstances. Recently, in a response to the unyielding call from states for increased flexibility, Senators Ron Wyden (D-OR) and Scott Brown (R-MA) introduced Senate Bill 3958, otherwise known as Wyden-Brown. That bill would accelerate, from 2017 to 2014, the date when states may apply to the Secretary of Health and Human Services (HHS) for a waiver as detailed in Section 1332 of the PPACA. If successful, a state would remain eligible to receive federal dollars that would otherwise go to premium and copayment subsidies for plans in the insurance exchanges as well as tax credits for small businesses but, instead, use that money to help fund alternative approaches to reaching the coverage objectives of the PPACA.

Under this provision, the state would have to demonstrate to the Secretary that, under the state alternative, at least as many individuals would be covered as under PPACA, that the coverage was at least as good as that required under the PPACA, and as affordable for individuals. In addition, the state proposed alternative would have to be budget-neutral for the federal government.

While I applaud the efforts of Senators Wyden and Brown, I must point out that the bill is woefully insufficient in terms of granting states meaningful flexibility.

First of all, let me be clear, states were never invited to the table to give input on health care reform as that legislation was being fleshed out. Thus, assuming President Obama is re-elected in 2012, it is frankly difficult for me to imagine that HHS would reverse its course and grant waivers that, in essence, repeal a number of PPACA provisions the current administration

vigorously supports. The Secretary has ultimate waiver authority and it is unrealistic to expect HHS to grant waivers for alternatives of which they disapprove.

Second, states must still guarantee a generous and expensive level of benefits that go well beyond basic benefits. And since the Secretary defines what constitutes "at least as comprehensive" is, a state has no guarantee a waiver would be granted, even if plans in the state-proposed alternative have the same actuarial value as those specified in the PPACA. One way flexibility is, essentially, no flexibility at all. Bear in mind that states, unlike the federal government, must balance their budgets each year.

Third, states would be unable to include other health programs into their waiver request. For instance, provisions associated with Medicaid and the State Children's Health Insurance Program (SCHIP) could not be waived under Wyden-Brown; therefore, state-based alternatives to the enormous Medicaid expansion prescribed under PPACA (a particular source of anguish for governors and legislators alike) could not be addressed under Wyden-Brown.

Finally, Wyden-Brown pits theoretical success against actual achievement. Estimates are, at best, educated guesses; and even the most educated of guesses, can be off. For instance, initial estimates from the Congressional Budget Office indicated the cost to the states for the Medicaid expansion would be about $20 billion. Recently, however, a Joint Congressional Report prepared by the Senate Finance Committee and the House Energy and Commerce Committee[2] estimated that cost at closer to $118 billion. We can only assume the estimates regarding the number of people covered under PPACA and the level of affordability promised are not guaranteed and thus, should not be used as a standard against which state alternatives are measured.

The Wyden–Brown legislation falls short and thus will not allow states sufficient flexibility to make meaningful changes, nor will it neutralize serious state opposition to various parts of the PPACA. To accomplish both through a

[2] Joint Congressional Report by Senate Finance Committee, Orrin Hatch (R-Utah), Ranking Member and House Energy and Commerce Committee, Fred Upton (R-Michigan), Chairman. Medicaid Expansion in the New Health law: Cost to the States. March 1, 2011. <http://energycommerce.house.gov/media/file/PDFs/030111MedicaidReport.pdf>.

waiver approach, the states must be allowed to include state-federal programs such as Medicaid and SCHIP as part of the waiver. This would, of course, require Congress to grant states the option of exempting state reform plans (including those proposing changes to Medicaid) from certain statutory provisions of existing programs. It would also require that HHS not be allowed to reject a waiver simply because it did not square with the partisan goals or ideological leanings of whatever administration happens to occupy the White House.

Rather than trying to impose a national solution, Congress should give strong encouragement to the states to take the lead, allowing them to advance alternative proposals and reward states that achieve the goal of improved health care coverage. This is not a partisan issue or an ideological debate; rather, it is about how to best and most efficiently serve diverse populations and different geographies and about designing state-specific solutions to address state-specific challenges.

In Utah, we have chosen a path of business- and consumer-oriented health system reform which responds to Utah's needs and we are making significant progress. Congress and the Obama administration should recognize this and remove the barriers to increased success for all states.

To reiterate to the point I wish to make today — that in order for true reform to occur the federal government must maximize the policy space available for innovation, let me use an analogy.

Like successful gardening, successful innovation requires fertile soil. The fertile soil of innovation is mutual understanding and cooperation among stakeholders, free of the weeds of restrictive regulations that choke new or untried ideas. This kind of soil has to be cultivated and protected, it doesn't appear by itself. If congress and HHS are not extremely careful, the seeds of federal policymaking sown under the ACA will rather quickly fill in what little policy space has been left to states and choke the innovations envisioned by the ACA and which history suggests are most likely to occur only as the result of experimentation at the state level. These innovations include payment and delivery reform innovations like episode of care payments, accountable care organizations, etc. The federal government, like a wise gardener, should be patient and focus on developing the proper conditions for state-level innovation. It cannot force innovation to grow. Innovation takes cooperation, and cooperation takes time.

Taking the gardening analogy just a bit further, the ACA is recognition that the traditional, heirloom varieties of health care delivery are no longer sufficient for the needs of our country. In their place must be developed new, hybrid varieties that will yield better outcomes at lower cost to more people. Wisdom dictates that states be given enough time to rise to their opportunities, and enough flexibility to experiment in developing these hybrids.

In closing, there are many issues related to the development of exchanges that must be addressed over the next two years—determination of essential benefits packages, establishing risk adjustment and other mechanisms to address the potential for adverse selection, standards for plan participation, determination of initial and ongoing individual eligibility, administration of subsidies, coordination with public coverage programs, governance, etc. Each of these issues should be addressed with the idea that we won't get it 100% right the first time. We are moving into unchartered territory that requires the humility and restraint to allow one another space to incrementally innovate and learn from our experiences. If HHS rushes to figure out too many details up front, rather than allowing ACA to evolve over time with significant state experimentation and feedback, we run the very real risk that many of the misaligned financial incentives that account for so much inappropriate consumption today will only be locked in further and will be that much more difficult to fix in the future.

Thank-you.