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Rising health care expenditures, a growing senior population, and a changing demographic profile will impact Utah's future health care needs.

Staying Ahead of the Curve: Utah's Future Health Care Needs

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INFORMED DECISIONS™

Kem C. Gardner Policy Institute and the David Eccles School of Business

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Staying Ahead of the Curve: Utah's Future Health Care Needs

ANALYSIS IN BRIEF

Utah is known as a low-cost, healthy state, but the factors that help us maintain our position as one of the healthiest states in the country are changing. Rising health care expenditures, a growing senior population, and a changing demographic profile will impact Utah's future health care needs. This report provides data and information on Utah's changing demographic profile and evolving demands for health care.

Key points include the following:

- **Utah's health care expenditures are growing at one of the fastest rates in the country.** This increase is likely due to the state's rapid population growth, but could also reflect rising costs of health care and an increase in health care utilization rates.
- **The percent of the population age 65 and older in Utah is expected to double over the next 50 years.** An aging population that is prone to a higher prevalence of chronic conditions will place upward pressure on individual, system, state, and federal-level health care spending and resources.
- **Utah's population is becoming more diverse and the state's changing demographic profile may place new demands on Utah's health care system.** While different population groups have different health care needs, the severity of these needs vary based on individuals' genetics, behaviors, and socioeconomic status.
- **Income levels differ considerably across Utah's population groups and counties.** Key economic indicators and health care outcomes show a clear urban-rural divide.
- **Utah ranked as the fifth healthiest state in 2018.** This is an improvement from eighth in 2016, but lower than the 1990s when Utah consistently ranked first.
- **Increasing mental health needs, substance use disorders, as well as diverging access to health care** are some of the indicators negatively influencing Utah's ranking.

To stay ahead of the curve, Utah decision makers should continue to seek innovative health care policies and proactively develop new approaches to providing health care, improving the health of Utah residents, and lowering health care cost trends.

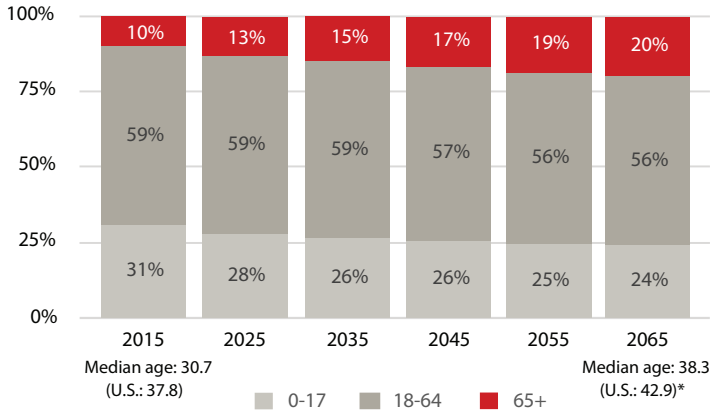
At a Glance

Prevalence of Utah Adults Age 65+ with Chronic Conditions, 2015 vs. 2065

Chronic Conditions	Estimated number of adults age 65+with chronic conditions	
	2015	2065
Alzheimer's*	29,000	112,174
Arthritis	153,552	593,951
Asthma	28,390	109,816
Cancer (skin)	68,992	266,865
Cancer (all others)	50,370	194,835
Chronic Obstructive Pulmonary Disease	26,559	102,731
Diabetes	63,802	246,791
Depressive Disorder	56,170	217,271
Heart Conditions	59,528	230,260
High Blood Pressure	172,174	665,981
Poor Oral Health**	80,592	311,736
Total Population Age 65+	**305,273**	**1,180,818**

Note: The estimated increase is solely a function of population growth and does not account for possible increases or decreases in the prevalence of chronic conditions over time that could result from changes in the health or demographics of the state's population, improvements in medical therapy, or the implementation of state or system-level policies and programs that promote healthy behaviors.
Source: Kem C. Gardner Policy Institute analysis of Utah Behavioral Risk Factor Surveillance System data, Office of Public Health Assessment, Utah Department of Health and Kem C. Gardner Policy Institute 2015-2065 State and County Projections.
*Source: Kem C. Gardner Policy Institute analysis of data from the Alzheimer's Association Report, 2015 Alzheimer's Disease Facts and Figures.
**Source: 2016 prevalence data. Behavioral Risk Factor Surveillance System.

Selected Age Groups as a Percent of Utah's Total Population, 2015–2065



*2060 projection. Source: U.S. Census Bureau 2017 National Population Projection Tables. Source: Kem C. Gardner Policy Institute 2015-2065 State and County Projections. U.S. median age from U.S. Census Bureau, Population Division Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2017.

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Introduction

Utah is known as a low-cost, healthy state. Thanks to our young population and active lifestyles, we have the lowest per capita health care spending in the country and rank high on most measures of healthy behaviors. That said, the factors that help us maintain our reputation as one of the healthiest states in the country are changing.

This report provides data and information on Utah's changing demographic profile and evolving health care needs, highlighting implications for Utah's future health care system.

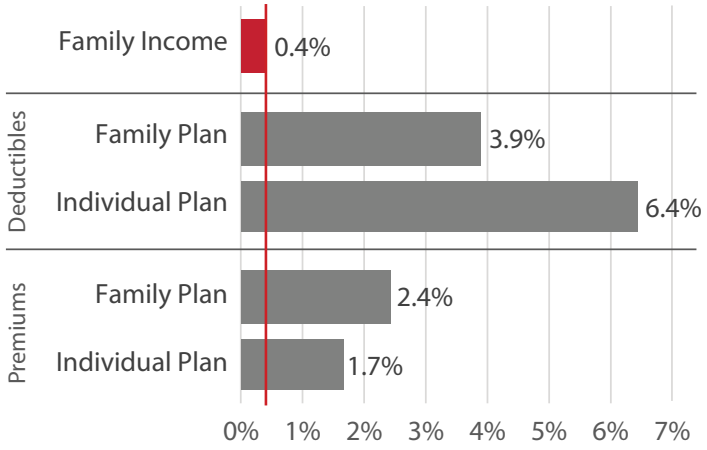
Utah's Spending on Health Care is Rising

Utah's health care expenditures are growing at one of the fastest rates in the country.[1] This increase is likely due to the state's rapid population growth, but could also reflect rising costs of health care and an increase in health care utilization rates. From 1991 to 2014, the fastest growing expenditures in Utah were in home health care and prescription drugs (including medical nondurable products).

In terms of national health care spending, the Centers for Medicare & Medicaid Services (CMS) projects that personal health care spending (which measures spending on medical goods and services provided directly to patients) will grow at an average annual rate of 5.5–5.7 percent from 2019 to 2026.[2] Nationally, growth in the price of medical goods and services contributes to close to half of this increase. Other primary contributors include increases in health care utilization, population growth, and changing demographics.

Figure 2

Average Annual Growth in Utah's Family Income Compared to Health Insurance Costs, 2006–2016



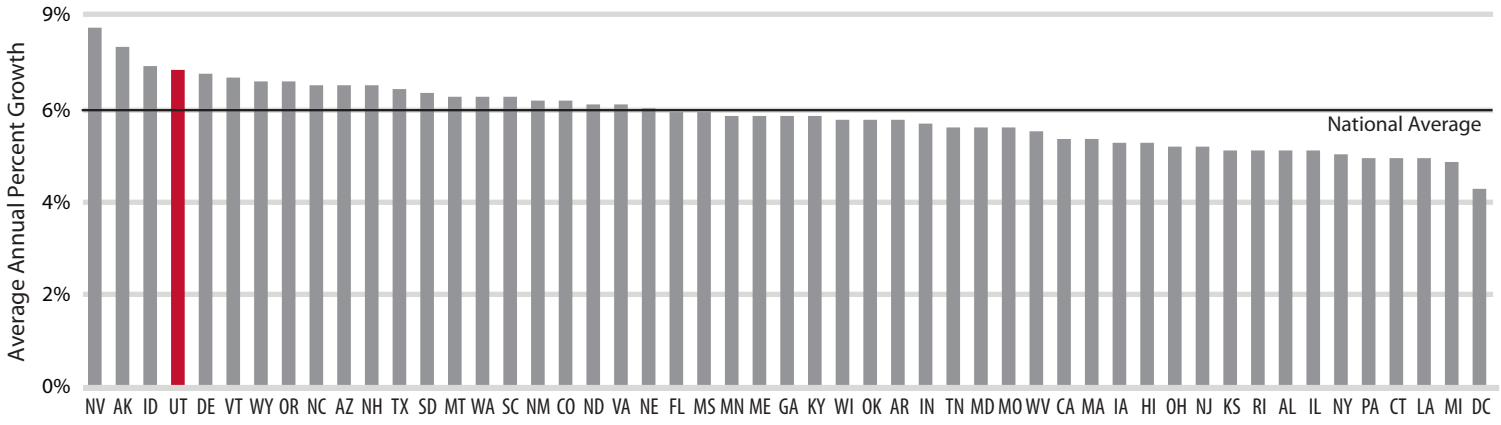
Note: Income is median family income. Premiums and deductibles represent average employee contributions and deductibles for private-sector employees enrolled in single and family coverage. Inflation-adjusted (2016).
Source: Kem C. Gardner Policy Institute analysis of Medical Expenditure Panel Survey data and Census Bureau, Current Population Survey data.

Increasing Insurance Costs

Just as the price of medical goods and services has increased, so has the cost of insurance. Data from the Utah Insurance Department show that Utah, like the rest of the country, experienced increases in the cost of health insurance coverage over the last decade.[3] When adjusting for inflation, Utah's median family income was relatively stagnant between 2006 and 2016 with an average annual growth rate of 0.4 percent. However, the

Figure 1

Average Annual Percent Growth in Total Health Care Expenditures, 1991–2014



Note: Health care expenditures includes spending for all privately and publicly funded personal health care services and products. Data does not indicate it is inflation-adjusted.
Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. National Health Expenditure Data: Health Expenditures by State of Provider, June 2017.

cost of health insurance premiums and deductibles for both family and individual health plans rose at an average annual rate more than three times the rate of family income during this same period (Figure 2).

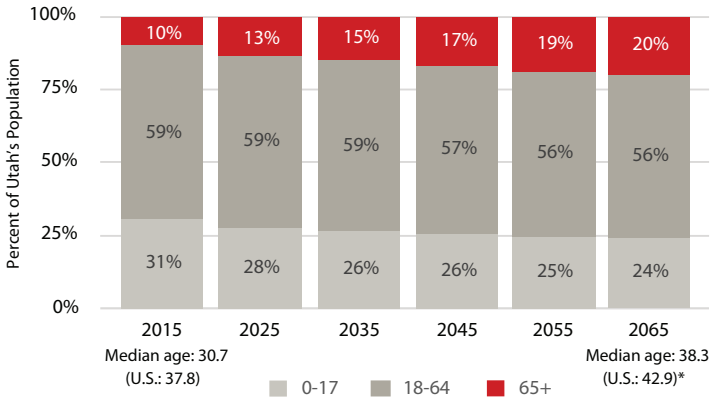
A Growing Percentage of High-Deductible Health Plans

The purchase of health savings account (HSA)-qualified high-deductible health plans has also significantly increased since the mid-2000s. These plans have lower monthly premiums, but the higher deductibles require individuals and families to pay more in out-of-pocket costs before their insurance plan begins to cover expenses. Today, HSA-qualified high-deductible family health plans have a minimum deductible of $2,700 with a maximum of $13,300 in out-of-pocket expenses.[4] This means that consumers enrolled in these plans are responsible for paying $2,700 of their covered health care expenses (or more if the deductible is higher) before the insurance company begins to pay a portion of the costs.

While high-deductible health plans may save individuals and families money in the short run through lower monthly premiums, they have been found to deter some individuals from seeking appropriate medical care because of the higher, upfront out-of-pocket costs.[5] Data from the National Health Interview Survey show that about one in ten adults report delaying or going without medical care due to costs. This portion increases to one in four among uninsured adults.[6] Data also show that four out of 10 adults would either have to borrow money, sell personal items, or simply not be able to pay the cost if faced with a $400 unexpected expense.

Unexpected medical procedures or emergencies often cost thousands of dollars, leaving people with high-deductible health plans vulnerable to the expense.[7] A survey conducted in 2016 found that only 40 percent of individuals with high-deductible health plans saved for future health services.[8]

Figure 3
Selected Age Groups as a Percent of Utah's Total Population, 2015–2065



*2060 projection. Source: U.S. Census Bureau 2017 National Population Projection Tables. Source: Kem C. Gardner Policy Institute 2015-2065 State and County Projections. U.S. median age from U.S. Census Bureau, Population Division Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2017.

High-deductible health plans currently comprise about 30 percent of Utah's commercial health insurance market, compared to only three percent in 2007. They make up 36 percent of Utah's large group market (defined as employers with 51 or more employees), 31 percent of the state's small group market, and 21 percent of health plans purchased in the individual market.[9]

New federal rules provide greater access to short-term and other health plans exempt from Affordable Care Act provisions. While these rules create more variety in the market, limited coverage options could potentially leave persons with high costs when faced with a medical emergency.

Utah's Demographics Are Changing

An Aging Population

While population growth, growth in the use and intensity of health care services, and the rising price of medical goods and services were the primary drivers of national health care spending from 1991–2014,[10] Utah's aging population could have more of an impact in the future. The percent of the population age 65 and older in Utah is expected to double over the next 50 years,[11] which could place upward pressure on individual, system, and state-level health care spending and resources (Figure 3).

People age 65 and older visit a physician more than twice the rate of people age 18–44 (7.5 visits per year v. three visits).[12] This age group also tends to have a higher prevalence of chronic conditions, which is a key driver of health care spending. For example, Utah data show that only 4.6 percent of adults under age 65 have diabetes, compared to 20.9 percent of adults age 65 and older.[13] Many chronic conditions, such as diabetes, develop over time and may go undiagnosed until later in a person's life when their effects become more acute.

A 2017 RAND study found that individuals with one-to-two chronic conditions spend more than twice the amount of money on health care services than those with no chronic conditions, while those with five or more chronic conditions spend 14 times more.[14] Individuals with one-to-two chronic condition account for 23 percent of total health care spending, and those with five or more chronic conditions account for 41 percent.[15]

Table 1
Prevalence of Utah Adults Age 65+ with Chronic Conditions, 2015 vs. 2065

Chronic Conditions	Prevalence of chronic conditions for age 65+	Estimated number of adults age 65+with chronic conditions	
	2015	2015	2065
Alzheimer's*	9.5%	29,000	112,174
Arthritis	50.3%	153,552	593,951
Asthma	9.3%	28,390	109,816
Cancer (skin)	22.6%	68,992	266,865
Cancer (all others)	16.5%	50,370	194,835
Chronic Obstructive Pulmonary Disease	8.7%	26,559	102,731
Diabetes	20.9%	63,802	246,791
Depressive Disorder	18.4%	56,170	217,271
Heart Conditions	19.5%	59,528	230,260
High Blood Pressure	56.4%	172,174	665,981
Poor Oral Health**	26.4%	80,592	311,736
Total Population Age 65+		**305,273**	**1,180,818**

Note: The chronic conditions with the fastest growing prevalence in adults age 65 and older are diabetes and depression. Estimates are not mutually exclusive and include adults who have ever been diagnosed with the condition. "Heart Conditions" includes adults who have ever suffered a stroke, from angina/coronary heart disease, and/or a heart attack. "Poor Oral Health" is adults aged 65+ who have lost six or more teeth due to tooth decay or gum disease.
Source: Kem C. Gardner Policy Institute analysis of Utah Behavioral Risk Factor Surveillance System data, Office of Public Health Assessment, Utah Department of Health and Kem C. Gardner Policy Institute 2015-2065 State and County Projections.
*Source: Kem C. Gardner Policy Institute analysis of data from the Alzheimer's Association Report, 2015 Alzheimer's Disease Facts and Figures.
**Source: 2016 prevalence data. Behavioral Risk Factor Surveillance System.

Table 1 shows the expected increase in the number of adults age 65 and older with chronic conditions in 2065. The estimated increase is solely a function of population growth and assumes that the percent of the population with each chronic condition remains constant over the next 50 years. The analysis does not account for possible increases or decreases in the prevalence of chronic conditions over time that could result from changes in the health or demographics of the state's population, improvements in medical therapy, or the implementation of state or system-level policies and programs that promote healthy behaviors. These statistics illustrate the potential impact population growth will have on Utah's health care system as well as highlight the need to further understand the upward pressure an aging population will place on individual, system, and state-level health care spending in Utah.

Table 2
Utah Counties impacted by an Aging Population, 2015–2065

Counties with the Greatest Increase in the Portion of their Population Age 65+		Counties with the Fastest Growing Population Age 65+	
County	Percentage Point Increase	County	Average Annual Rate Increase
San Juan	17.3	Wasatch	3.9%
Grand	16.4	Tooele	3.6%
Summit	16.4	Utah	3.5%
Tooele	15.9	Juab	3.3%

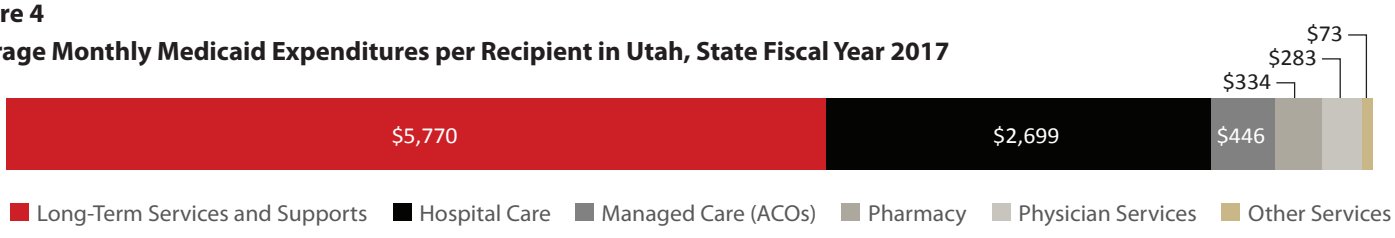
Source: Kem C. Gardner Policy Institute 2015-2065 State and County Projections.

An aging population that is prone to a higher prevalence of chronic conditions will not only place greater stress on Medicare and the federal budget, but the state's budget as well. Based on current population projections, more than one million people in Utah will be enrolled in Medicare in 2065 compared to roughly 384,000 in 2018.[16]

In terms of state spending, Utah currently has the lowest per capita Medicaid spending in the country, which is in part explained by Utah's low Medicaid enrollment rate as well as its low proportion of enrollees over age 65 or who have a disability.[17] However, this level of spending could change as the state's population ages. Medicaid, which is a federal program jointly administered and funded by each state, is a major payer of long-term services and supports for the senior population (e.g., nursing home care, home and community-based services, etc.). Long-term services and supports is also the most expensive type of care for the state to provide (Figure 4).[18] Compounding this issue is the fact that there will be a smaller percentage of people in the workforce to support the aging population as the demand for federal and state-funded health care services increases (Figure 3).

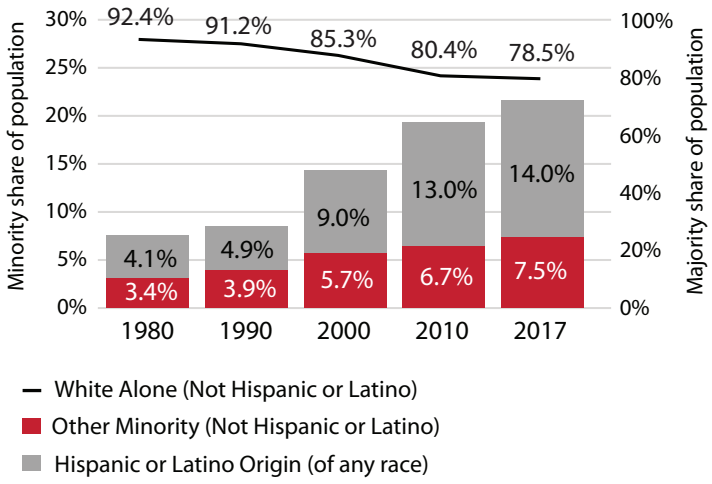
Utah's aging population could have a disproportionate effect on health in the state's rural areas as many of these counties are already struggling with a growing shortage of physicians. Research from the Utah Medical Education Council projects that

Figure 4
Average Monthly Medicaid Expenditures per Recipient in Utah, State Fiscal Year 2017



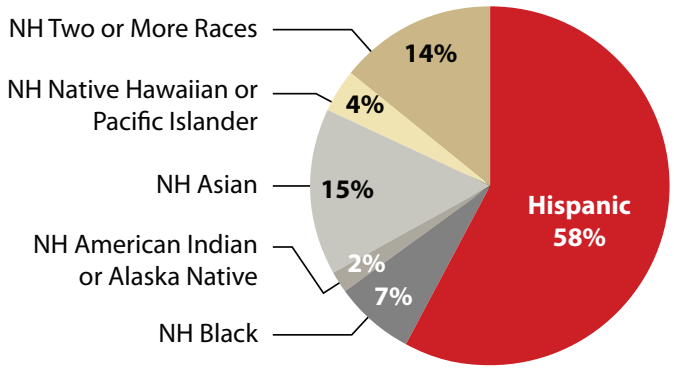
Note: Costs are inflation-adjusted using the medical care CPI (Consumer Price Index) from the U.S. Bureau of Labor Statistics. Costs represent Medicaid fee-for-service expenditures. All ACO costs are reflected in the managed care category.
Source: Division of Medicaid and Health Finance, Utah Department of Health.

Figure 5
Growth in Utah's Minority Population, 1980–2017



Sources: U.S. Census Bureau Population Division 2017 Vintage Estimates; 2010 Decennial Census; 2000 Decennial Census; 1990 Decennial Census; 1980 Decennial Census.

Figure 6
Shares of Minority Growth by Race and Hispanic Origin in Utah, 2016-2017



Note: NH = Non-Hispanic.
Source: Kem C. Gardner Policy Institute analysis of U.S. Census Bureau, Population Division, June 2018.

Utah's health care systems will need to replace almost 19 rural area physicians per year over the next decade to account for physician retirement.[19]

Utah's rural areas also have high proportions of U.S. veterans. For example, the counties with the highest percentage of U.S. veterans include Kane County (11.4 percent), Piute County (11.3 percent), Garfield County (10 percent), and Tooele and Washington counties (9.7 percent).[20]

Persons who served in the Gulf and Vietnam Wars now make up the majority of veterans in all of Utah's counties[21]—and today these veterans are roughly between the ages of 45 and 70. Individuals currently serving in the Iraq and Afghanistan wars will be reaching retirement age in the next 50 years. Many of these veterans return from combat experiencing posttraumatic stress disorder, traumatic brain injuries, and pain.[22]

As Utah's veterans age over the next several decades, it is important to ensure that their physical and mental health care needs can be adequately addressed in both urban and rural areas.

Growing Diversity

Utah's population is becoming more diverse and the state's changing demographic profile may place new demands on Utah's health care system as different population groups have different health care needs, different approaches to food and exercise based on their culture or religious affiliations, different approaches to mental and behavioral health, and different access to the health care system.[23, 24, 25]

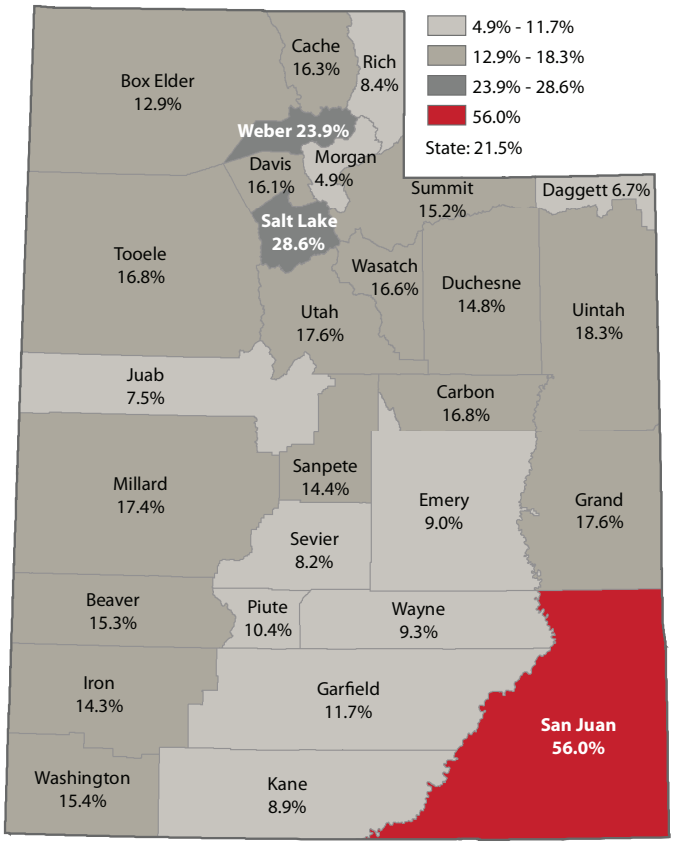
In 2017, Utah's net migration (people moving into the state minus people moving out of the state) was 11.2 percent higher than in 2016 (26,989 v. 24,261) and comprised 46 percent of Utah's population growth. Natural increase (annual births minus annual deaths) contributed the other 54 percent.[26]

Between 2016 and 2017, just over 40 percent of the state's population growth came from minority groups (defined as any race category that is not non-Hispanic white) and people identifying as Hispanic or Latino.[27] Over half of this growth (58 percent) was from the Hispanic or Latino population (Figure 6). At a county level, the percentage of populations comprised of minority groups range from 4.9 percent in Morgan County to 56 percent in San Juan County.[28] At a state level, most of Utah's minority populations reside along the Wasatch Front (Figure 7).

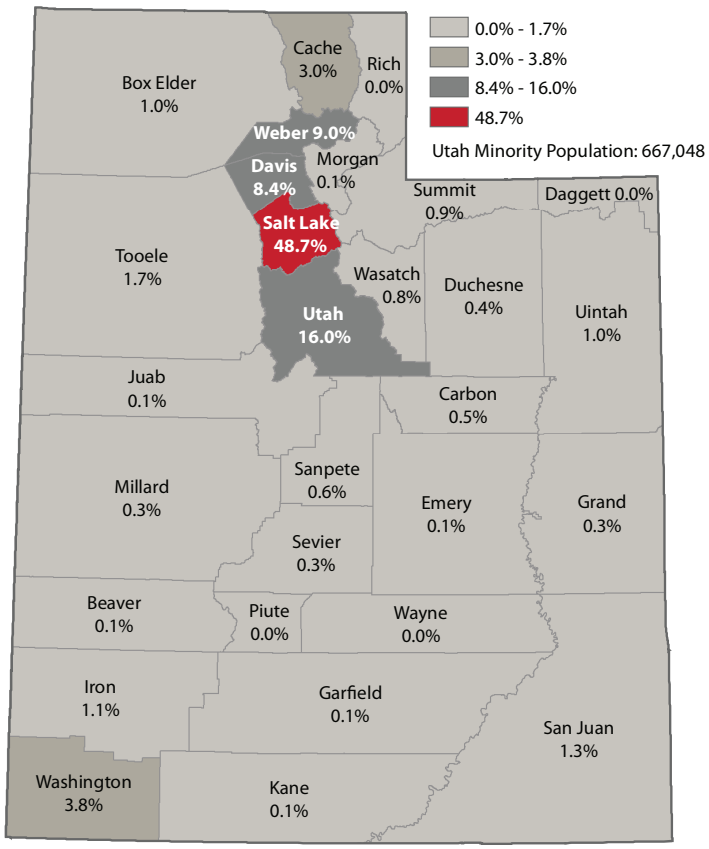
While different population groups have different health care needs, the severity of these needs vary based on individuals' genetics, behaviors, and socioeconomic status. National data show that low-income adults are almost five times as likely to report having only fair or poor health, and more than three times as likely to have activity limitations due to severe chronic conditions, compared to adults with family incomes above 400 percent of the federal poverty level (roughly $100,000 for a family of four).[29, 30]

The state of Utah has a relatively low poverty rate compared to other states,[31] but minority populations in Utah have significantly higher poverty rates than non-minorities (Figure 9). Income levels also differ considerably by county and data show a clear urban-rural divide on key economic indicators and health care outcomes. Figure 10 shows the percent of households and families in each county with incomes less than $25,000. It also shows which counties have rebounded from the recession and which counties have a higher percent of low-income households and families in 2016 compared to 2010 (the height of the recession).

Figure 7
Minority Share of Population by County, 2017

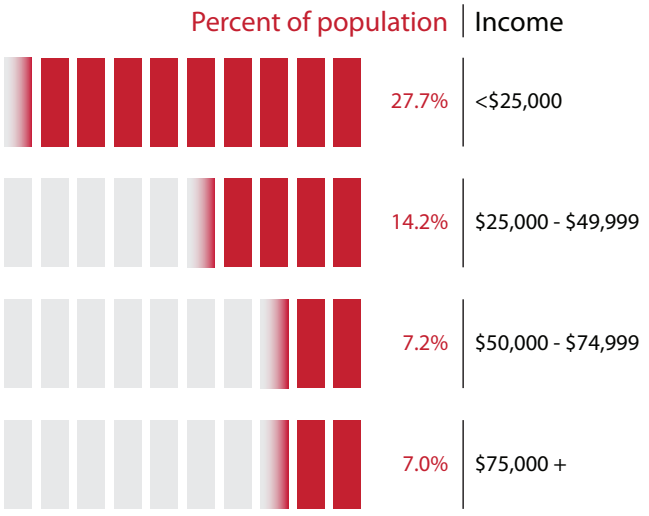


Share of Utah's Total Minority Population by County, 2017



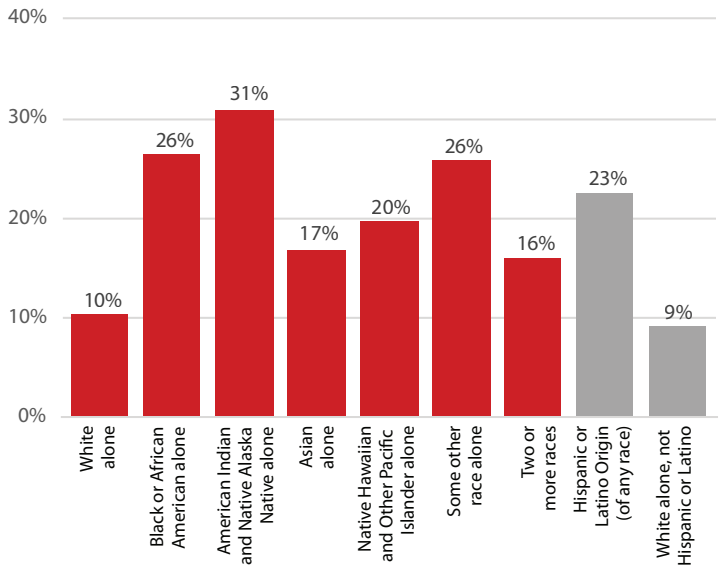
Source: U.S. Census Bureau Population Division 2017 Vintage Estimates.

Figure 8
Fair or Poor General Health in Utah Adults by Income, 2016



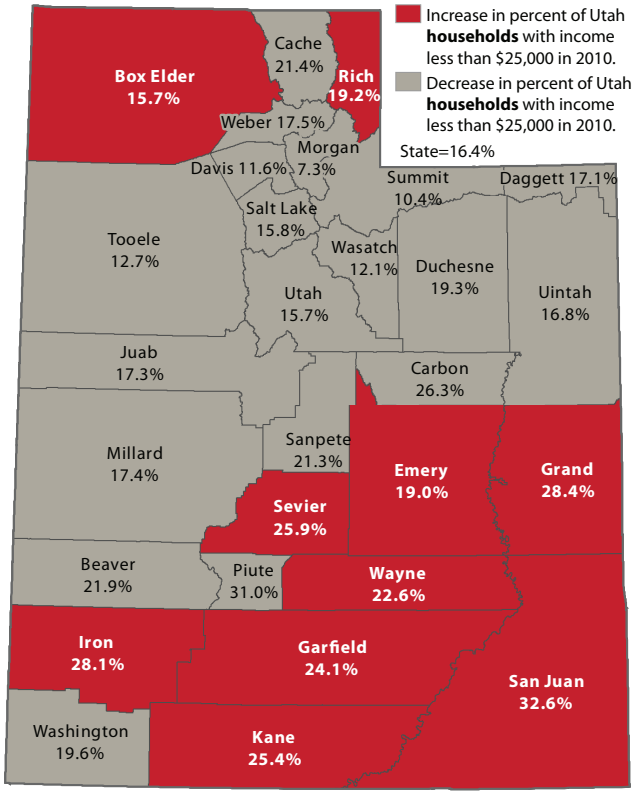
Note: Each rectangle represents three percent. Red indicates the percent of the adult population (age 18+) with fair of poor general health. Data is age-adjusted.
Source: Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health.

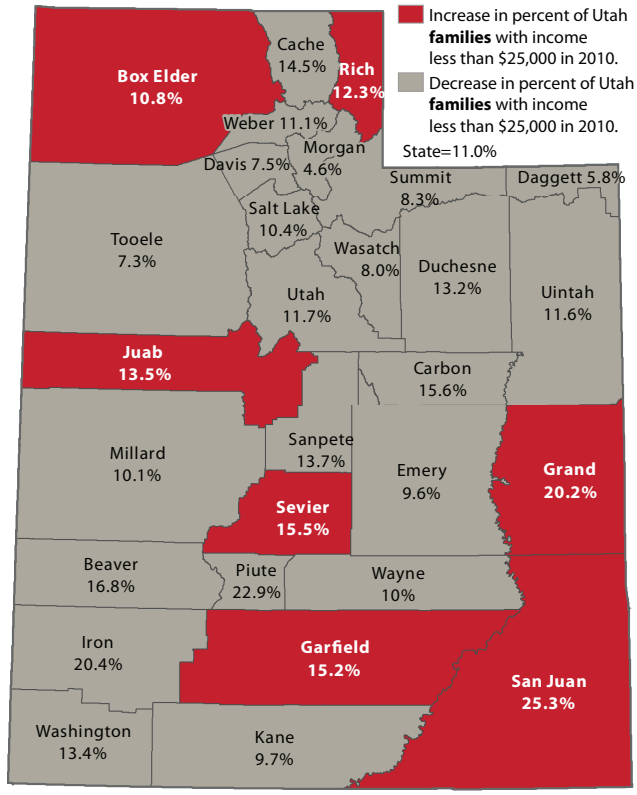
Figure 9
Percent of Utah's Population in Poverty by Race and Ethnicity, 2016



Note: Poverty is defined as having poverty status anytime in the previous 12 months. Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who is in poverty.
Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates.

Figure 10
Percent of Utah Households and Families with Yearly Income Less Than $25,000, 2016





Note: Red indicates counties that experienced an increase in the percent of population with income less than $25,000 since 2010 (2016 inflation-adjusted dollars compared to 2010-inflation adjusted dollars). Grey indicates a decrease in percent of population with income less than $25,000 since 2010.
Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates.

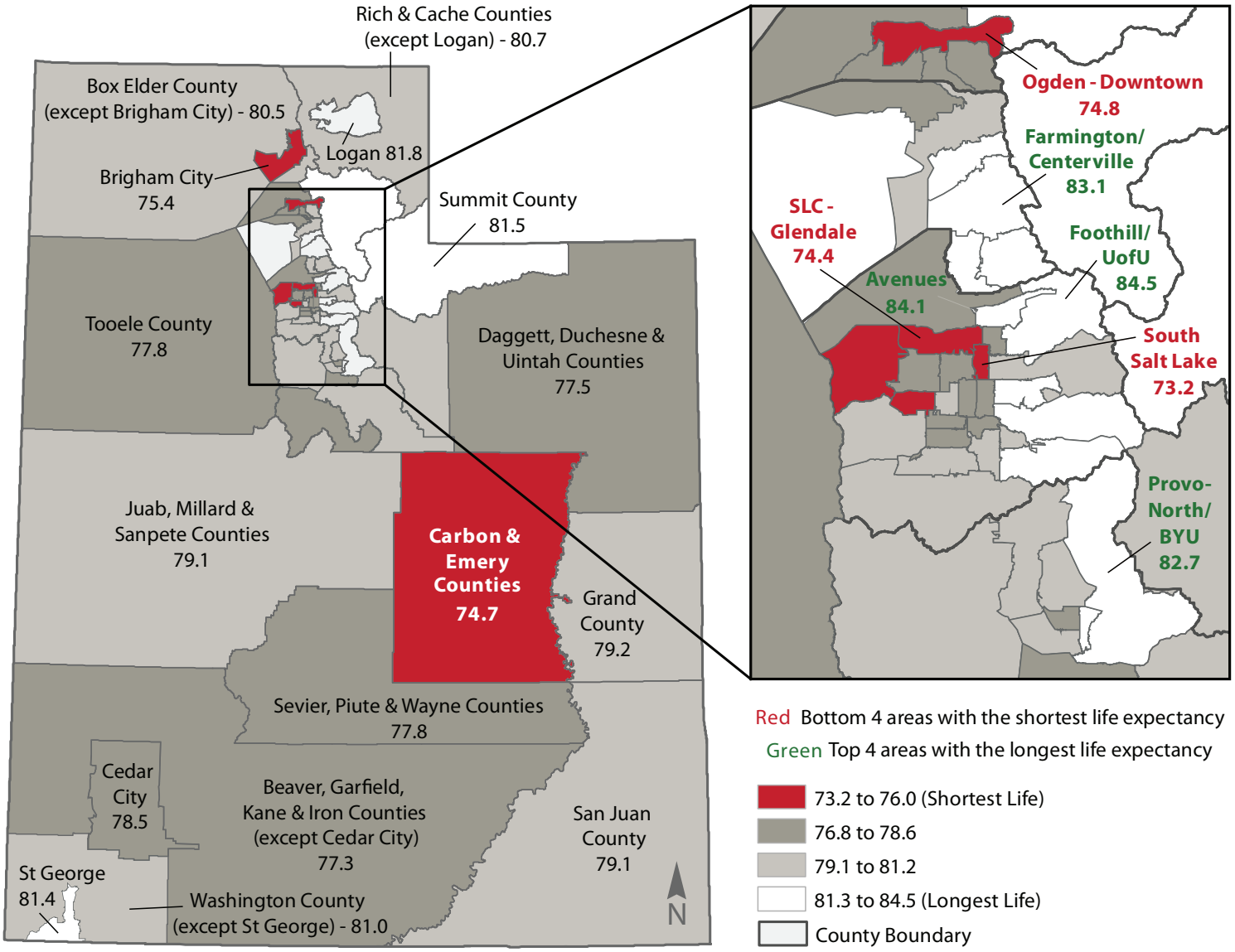
Table 3
Birth Outcomes by County

County	Infant Mortality Rate per 1,000 Births, 2016	Percent of live low-weight births, 2016
State of Utah	5.1	7
Beaver	8.9*	8
Box Elder	5.2	7
Cache	4.6	6
Carbon	2.9*	10
Daggett	NA	NA
Davis	4.7	7
Duchesne	5.1	7
Emery	6.6*	8
Garfield	NA	8
Grand	4.5*	8
Iron	7.1	8
Juab	5.4*	6
Kane	10.4*	8
Millard	5.1*	7
Morgan	4.5*	7
Piute	NA	11*
Rich	NA	NA
Salt Lake	5.0	7
San Juan	5.9*	7
Sanpete	5.8	7
Sevier	5.1*	9
Summit	4.6	9
Tooele	4.2	8
Uintah	4.4	8
Utah	5.0	6
Wasatch	4.1	7
Washington	4.9	6
Wayne	NA	10*
Weber	6.4	8

*Has a relative standard error greater than 30% or is an unreliable estimate.
Note: Infant mortality is the number of infants who died before they were one-year old (from 0 through 364 days of age). Seven-year average (2010-2016).
Source: Office of Vital Records and Statistics, Utah Department of Health.
Note: Low-weight births are defined as when the infant weighs less than 2,500 grams (approximately 5 lbs., 8 oz.). Seven-year average (2010–2016).
Source: County Health Rankings & Roadmaps, The Robert Wood Johnson Foundation.

Birth outcomes and life expectancy can be used to gauge the overall health of a community. Table 3 shows the fetal mortality rate and percentage of low-weight births by county. In terms of life expectancy, Figure 11 visually presents the differences in health and wellbeing among Utah's neighborhoods and shows that there is a more than a 10-year difference in life expectancy between neighborhoods with the highest life expectancy (the Avenues and Foothill) and the shortest life expectancy (Glendale and South Salt Lake). This is despite there only being about a five mile difference between these areas.

Figure 11
Life Expectancy at Birth by Utah Small Area, 2016

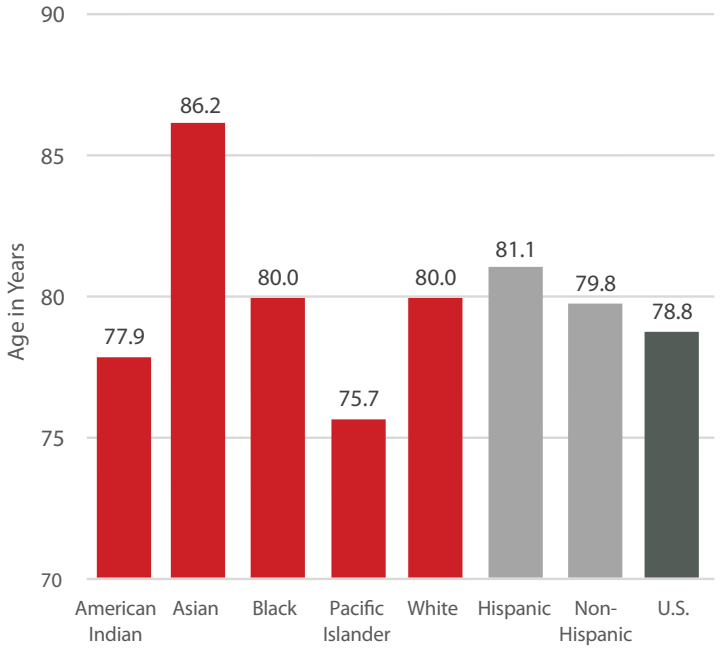


Note: Life expectancy can be used to gauge the overall health of a community. Five-year average (2012-2016).
Source: Center for Health Data and Informatics, Utah Department of Health.

Utah's minority populations have shorter life expectancies with the exception of Asians and Hispanics (Figure 12). As a whole, Asians tend to be one of the healthiest population groups, which contributes to the gap in life expectancy. One study found that Asians tend to be older than whites for almost all causes of death. That said, statistics from the Utah Department of Health show that the Asian population has higher rates of tuberculosis (Figure 13) and gestational diabetes.[32]

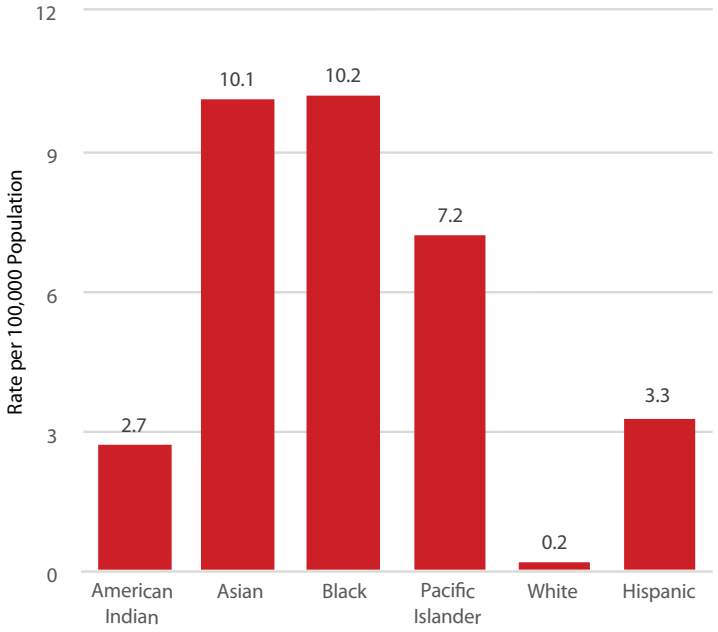
A study from the Centers for Disease Control and Prevention (CDC) found that Hispanics have a higher life expectancy than non-Hispanics due several factors, including lower self-reported smoking rates and lower death rates for a majority of the leading causes of death such as cancer, heart disease, and unintentional injuries.[33] However, substantial differences exist among Hispanics by origin, nativity, and sex—and as a population, Hispanics have higher death rates from diabetes, chronic liver disease/cirrhosis, and homicide. Hispanics also have a higher prevalence of obesity.

Figure 12
Life Expectancy by Race and Ethnicity in Utah, 2016



Note: Life expectancy at birth by race and ethnicity was calculated using death counts over a span of five years (2012-2016).
Source: Center for Health Data and Informatics, Utah Department of Health.

Figure 13
Tuberculosis Rates per 100,000 in Utah by Race and Ethnicity, 2017



Note: Rate is cases per 100,000 population. Five-year average (2013-2017). Data does not indicate it is age-adjusted.
Source: Utah Behavioral Risk Factor Surveillance System.

While adolescent obesity rates vary by race and ethnicity (Figure 14), data shows that total adolescent obesity in Utah increased from 5.4 percent in 1999 to 9.6 percent in 2017. Boys are more than twice as likely as girls to be obese (13.9 percent vs. 5.3 percent).[34]

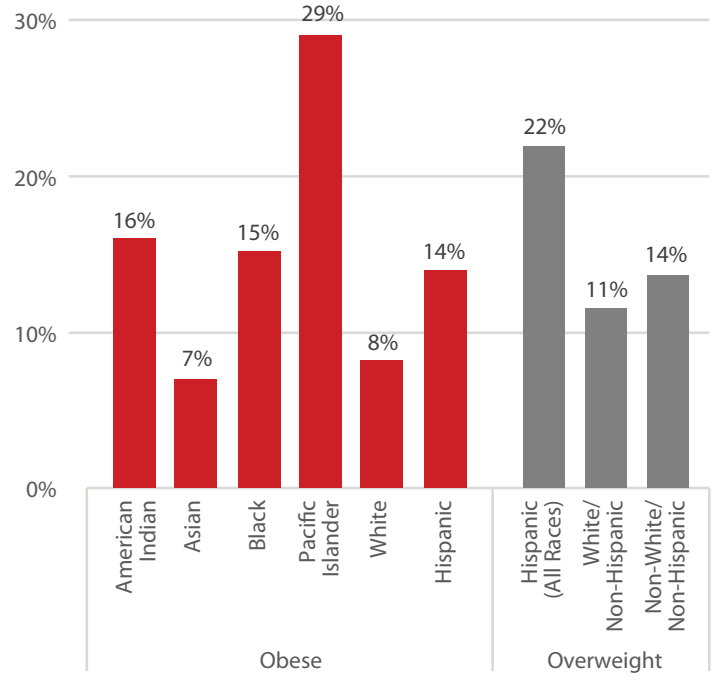
In terms of mental health, American Indians and Whites/Non-Hispanics have the highest rates of depression and suicide among Utah's population groups (Figure 15).

The data presented in this section represent only a small snapshot of Utah's health and demographic picture. In order for Utah's health care system to continue to adapt to the state's changing demographics, it will be important to understand the evolving health care needs and challenges facing different individuals, population groups, neighborhoods, and counties—all in the context of an aging population.

Unmet health care needs not only impact a person's health and wellbeing, but their ability to be a productive and producing member of the economy as well. The CDC estimates that productivity losses due to employee absenteeism cost U.S. employers $225.8 billion per year.[35] An aging workforce, chronic conditions, and mental health care issues such as stress, anxiety, and depression additionally impact employers' revenue.[36]

If Utah's changing physical and mental health care needs are not adequately planned for, then Utah's reputation as one of the healthiest states may slip.

Figure 14
Adolescent Obesity and Overweight Prevalence by Race and Ethnicity in Utah, 2017



Note: Obesity data come from grades 8, 10, and 12. Overweight data come from grades 9, 10, and 12 (at or above the 85th percentile but below the 95th percentile for body mass index, by age and sex). Given these data are based on self-reported height and weight, it is likely they under represent the prevalence of overweight or obesity among high school students.
Source: 2017 Prevention Needs Assessment. Utah Youth Behavioral Risk Factor Surveillance System.

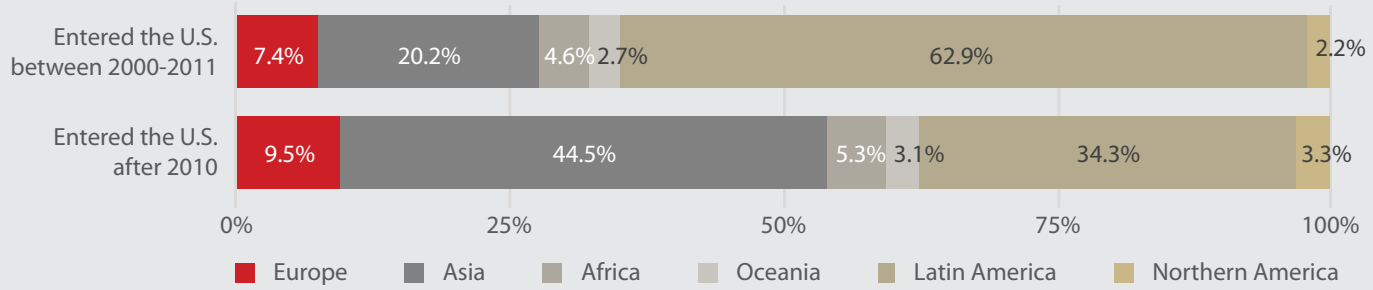
Details on Utah's Foreign-Born Population

Data from 2016 show that 33,036 foreign-born individuals have moved to Utah since 2010. About 20 percent of this population is enrolled in college or graduate school. Historically, 81,728 foreign-born individuals moved to Utah from 2000 to 2009.[37]

The composition of this population has also changed over time. The proportion of people migrating from Asia has grown as a share of Utah's total foreign-born population, while the proportion migrating from Latin America has decreased (Figure A). These numbers are consistent with national data, which show 43.4 percent of the foreign-born population entering since 2010 were from Asia and 36.4 percent were from Latin America.[38] Utah has a higher percent of immigrants from Oceania and Northern America than the U.S. average and a lower percent of immigrants from Africa.

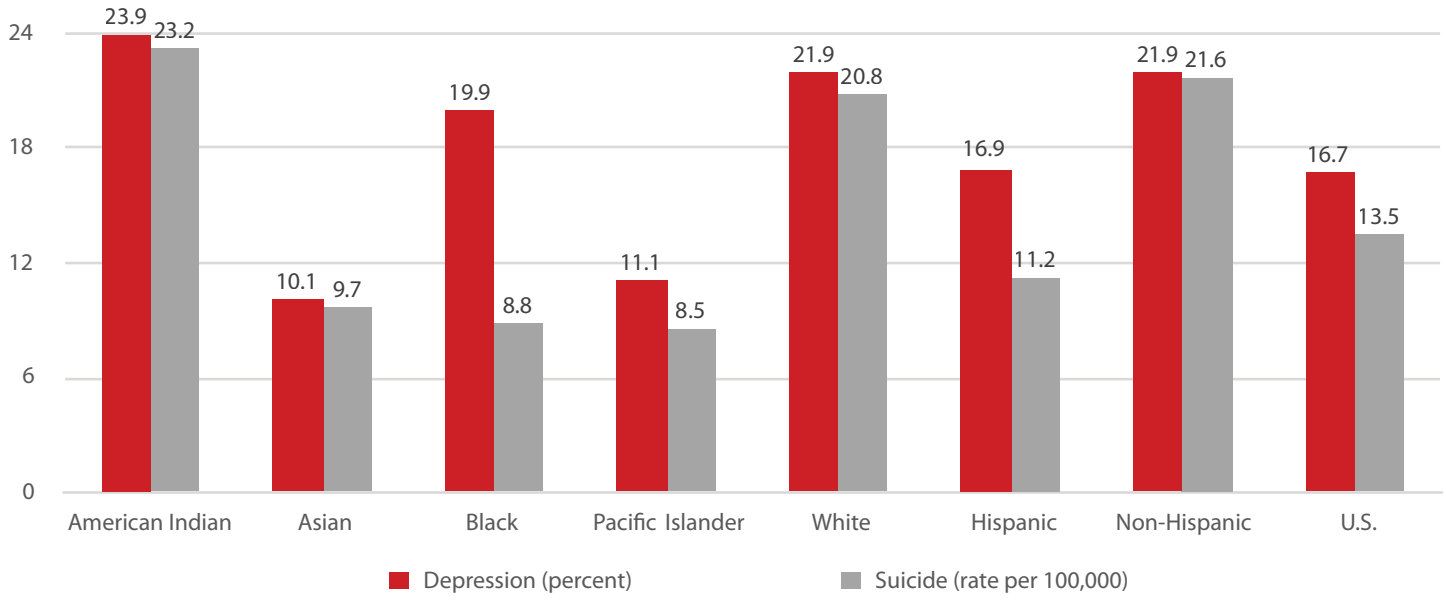
The Census Bureau's definition of foreign-born population includes "naturalized U.S. citizens, lawful permanent residents (immigrants), temporary migrants (such as foreign students), humanitarian migrants (such as refugees and asylees), and unauthorized migrants."[39]

Figure A
Utah Foreign Born Population, Recent Arrivals by Region of Birth, Entering After 2000 vs. 2010



Note: Data for the population entering after 2000 come from the 2007–2011 American Community Survey. Data for the population entering in 2010 or later come from the 2012–2016 American Community Survey.
Sources: U.S. Census Bureau (2000) and American Community Survey 5-Year Estimates; Kem C. Gardner Policy Institute Calculations.

Figure 15
Utah Mental Health Indicators by Race and Ethnicity, 2016



Note: Depression is percentage of adults age 18 and older who have ever been told by a doctor, nurse, or other health professional that they have a depressive disorder, including depression, major depression, dysthymia, or minor depression. Reflects lifetime diagnosis and not current major depression. The suicide rate is the number of resident deaths resulting from the intentional use of force against oneself per 100,000 population. Two-year average (2014-2016). U.S. is 2016 data. All data is age-adjusted. *Has a relative standard error greater than 30%.
Source: Utah Behavioral Risk Factor Surveillance System.

Utah's Position as the Healthiest State Has Slipped

Several indicators measure how Utah's health compares to other states. According to America's Health Rankings, Utah ranked as the fifth healthiest state in 2018.[40] This is an improvement from eighth in 2016, but lower than the 1990s when Utah consistently ranked first. Measures that Utah ranks poorly on compared to other states include:

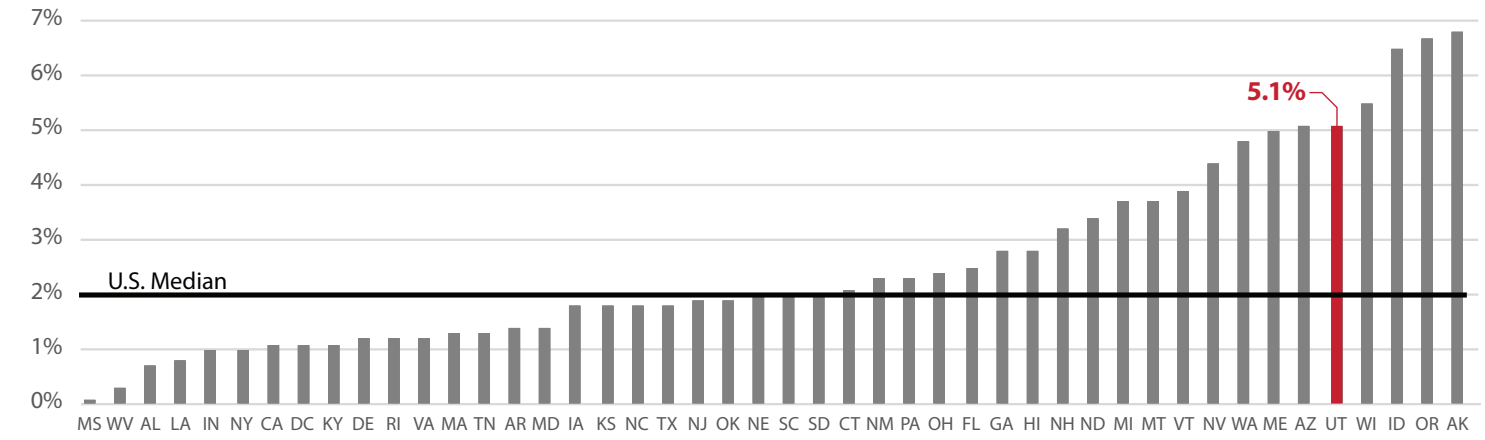
- Low number of primary care physicians per 100,000 population
- High incidence of new cases of pertussis or whooping cough and low child immunization rates
- High rate of deaths due to drug injury of any intent (unintentional, suicide, homicide, or undetermined)

In the Commonwealth's 2018 Scorecard on State Health System Performance, Utah ranked fifth.[41] The state's overall rank did not change from the previous report; however, Utah ranked worse in the areas of "access and affordability" and "prevention and treatment." Utah ranked better in the area of disparity, which evaluates the margin of difference in select measures by income level.

Specific measures Utah ranks poorly on include:

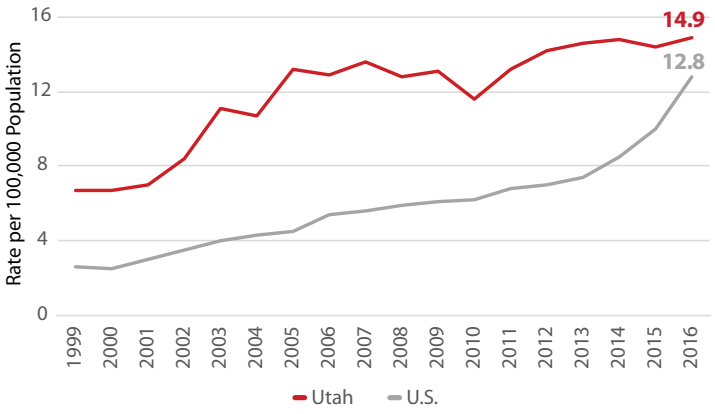
- High out-of-pocket medical spending
- Adults without a usual source of care
- Adults with mental illness who report an unmet need

Figure 16
Percent of Kindergarteners with an Exemption from One or More Vaccines, 2016-17 School Year



Note: Non-medical exemptions in Utah rose from 3.6% in 2009-2010 to 4.9% in 2016-2017. Medical exemptions have remained stable at 0.2%. Sample designs vary by state. Medical and non-medical exemptions may not be mutually exclusive and some children may have both exemptions. Utah allows for both religious and personal belief exemptions.
Source: National Center for Immunization and Respiratory Diseases.

Figure 17
Unintentional and Undetermined Opioid Deaths per 100,000 Population, Utah and U.S., 1999–2016



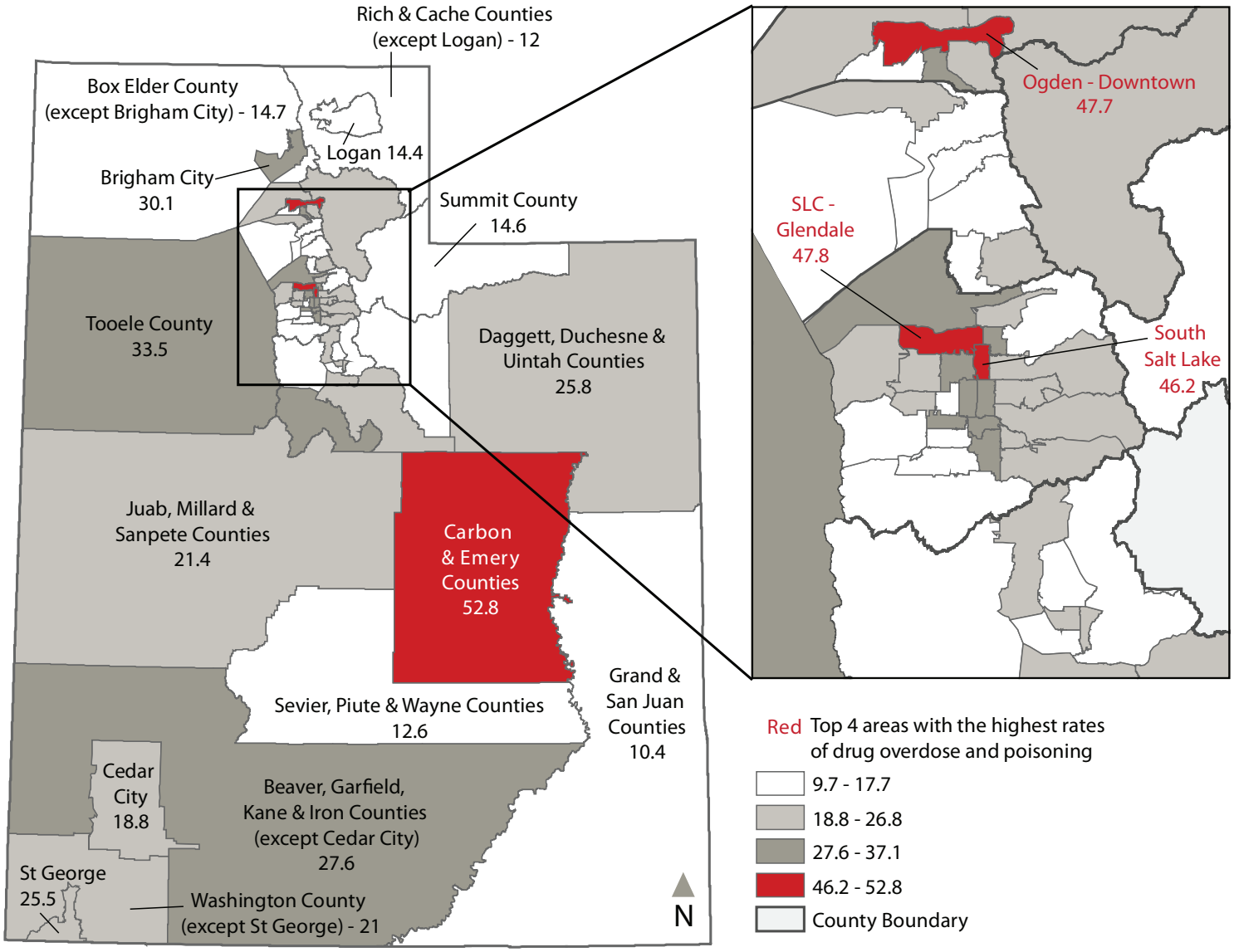
Source: CDC National Center for Health Statistics. Data is age-adjusted.

Evolving Behavioral Health Care Needs

Some of these indicators reflect Utah's changing health care needs, specifically an increasing prevalence of mental health needs and substance use disorders. Utah experiences depression and suicide at higher rates than the national average (Figure 15) and has long experienced high rates of drug deaths (Figure 17 and Figure 18). Coupling this with a shortage of mental health providers (particularly in rural areas),[42] exacerbates the inability of individuals to get necessary care.

There is also a growing need to address the behavioral health of Utah's children. The impacts of unmet behavioral health needs are not only immediate (in 2015, suicide was the leading cause of death for Utahns ages 10 to 17),[43] but long-lasting as well. Research from the Utah Department of Health shows that Adverse Childhood Experiences (ACEs), which include exposure

Figure 18
All Drug Overdose Deaths per 100,000 Population by Utah Small Area, 2015



Note: Includes drug overdose and drug poisoning deaths. The rate for the state of Utah is 22.1. The rate for the U.S. is 14.9. Data is age-adjusted. Three-year average (2013–2015).
Source: Violence and Injury Prevention Program, Bureau of Health Promotion, Division of Disease Control and Prevention, Utah Department of Health.

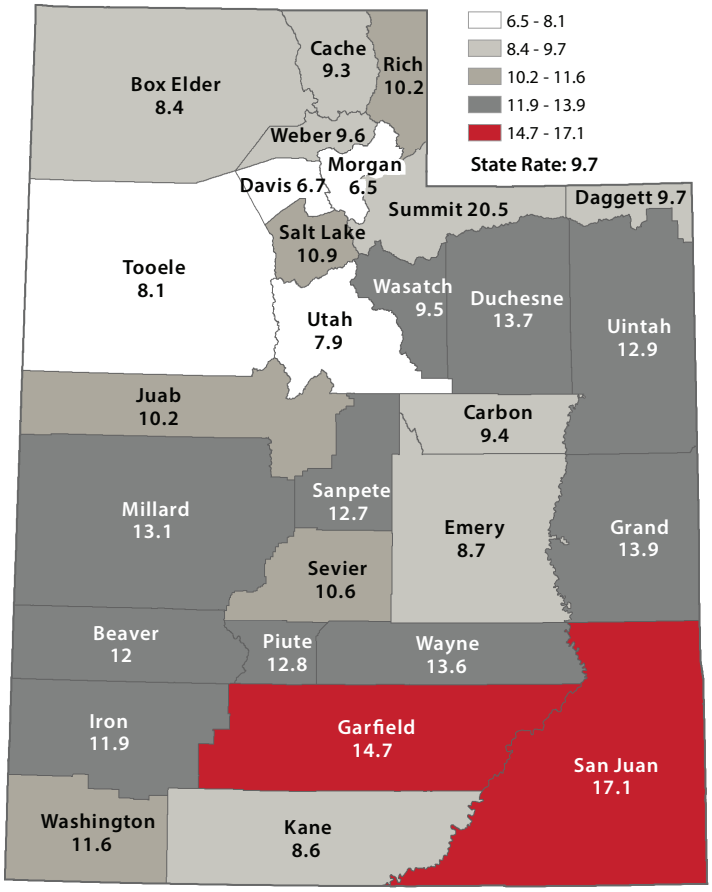
to physical, sexual, or verbal abuse as well as exposure to mental illness, substance abuse, divorce, incarceration, or witnessing abuse, were statistically associated with developing obesity, fair or poor health, smoking, binge drinking, and depression as adults.[44]

As Utah's behavioral health needs continue to grow, more restorative initiatives, like Operation Rio Grande, may be necessary to deal with the negative consequences of unmet behavioral health issues until larger-scale preventive measures can be implemented.

Diverging Access to Health Care

Utah's uninsured rate is relatively low compared to other states that have not expanded Medicaid.[45] However, this low uninsured rate is not consistent throughout the state or for all population groups. Utah's uninsured rates for persons under age 65 range from a low of 6.5 percent in Morgan County to a high of 17 percent in San Juan County (Figure 19).[46] Utah's Hispanic population also has the highest uninsured rate among racial/ethnic groups, with over 22 percent of the population being uninsured. This is compared to seven percent of Caucasians and 11 percent of African Americans who are uninsured.[47]

Figure 19
Utah's Uninsured Rates by County, 2016



Note: Uninsured rate is for those age 65 and younger.
Source: Kem C. Gardner Policy Institute analysis of Census Bureau Small Area Health Insurance Estimates 2016.

When specifically looking at persons with low income (below 138 percent of the federal poverty level, FPL), Summit County and Wasatch County have the highest uninsured rates (30.5 percent and 27.8 percent respectively).[48] Salt Lake County and Utah County have the largest total number of uninsured individuals with income below 138 percent FPL.

The variation in the uninsured rate by county may be partially explained by the availability of jobs that provide health insurance. The majority of Utahns receive health care coverage through their employers (60–65 percent) and Utah has the highest rate of employer-sponsored insurance (ESI) in the country.[49] That said, the availability of ESI may be greater in some counties than others as larger employers are more likely to provide employees with health insurance than small employers. A 2017 study by the U.S. Bureau of Labor Statistics found that slightly more than half of all establishments with fewer than 50 workers offered health insurance to at least one employee. Comparatively, 97 percent of establishments with more than 500 workers offered health insurance to at least one employee.[50]

Table 4 shows the number of private sector establishments by size in each county. Small businesses make up the majority of establishments in each county, but the data also show that some counties simply lack access to large employers that are more likely to provide health insurance (while some exceptions apply, employers with 50 or more employees may receive a penalty for not offering health insurance to their employees). The data also show the percent of private sector employees vs. government employees in each county.

Research also shows that the percent of private sector workers with access to ESI is heavily related to workers' wages. Nationally, only 22 percent of workers with an average wage in the lowest 10 percent of wages had access to ESI, compared to 93 percent of workers with an average wage in the highest 10 percent.[51] The average annual wage of private sector employees by county is also presented in Table 4.

Moving Forward

Utah is a healthy state when compared to other states in the country; however, rising health care expenditures, a growing senior population, and a changing demographic profile will impact Utah's future health care needs. To stay ahead of the curve, Utah decision makers should continue to seek innovative health care policies and proactively develop new approaches to providing health care, improving the health of Utah residents, and lowering health care cost trends.

Table 4
Utah Employment Statistics, 2016

County	Private Sector						Percent of Total Employees		Average Annual Private Sector Weekly Wage
	Number of Establishments by Firm Size					Total Establishments	Private Sector	Government	
	1 to 9 employees	10 to 49 employees	50 to 99 employees	100 to 499 employees	500+ employees				
State of Utah	57,248	16,287	2,192	1,555	222	77,504	83.9%	16.1%	$871
Beaver	124	41	2	3	0	170	72.2%	27.8%	$628
Box Elder	859	205	26	21	4	1,115	86.4%	13.6%	$711
Cache	2,574	633	66	65	6	3,344	81.4%	18.6%	$655
Carbon	358	111	17	7	0	493	76.3%	23.7%	$785
Daggett *	18	3	1	0	0	22	50.0%	NA	$446
Davis	5,263	1,475	204	109	9	7,060	77.6%	22.4%	$771
Duchesne	499	117	9	4	1	630	71.7%	28.3%	$933
Emery	123	55	1	5	0	184	72.3%	27.7%	$927
Garfield	144	22	2	3	0	171	78.3%	21.7%	$512
Grand	323	125	8	3	0	459	82.6%	17.4%	$564
Iron	1,054	262	14	19	0	1,349	77.1%	22.9%	$576
Juab	150	44	6	4	0	204	78.1%	21.9%	$712
Kane	201	40	6	2	1	250	79.0%	21.0%	$567
Millard	193	51	11	2	0	257	77.5%	22.5%	$794
Morgan	234	39	3	2	0	278	77.0%	23.0%	$742
Piute *	27	1	0	0	0	28	46.7%	NA	$433
Rich	84	8	0	1	0	93	73.6%	26.4%	$459
Salt Lake	22,480	7,115	1,114	780	109	31,598	85.5%	14.5%	$987
San Juan	191	55	7	3	0	256	60.7%	39.3%	$671
Sanpete	323	94	5	8	1	431	65.7%	34.3%	$571
Sevier	364	136	8	12	0	520	80.9%	19.1%	$646
Summit	1,854	432	44	26	7	2,363	89.5%	10.5%	$801
Tooele	614	190	12	17	2	835	75.3%	24.7%	$719
Uintah	810	214	12	10	0	1,046	75.6%	24.4%	$835
Utah	9,754	2,490	319	256	33	12,852	87.1%	12.9%	$840
Wasatch	759	138	12	10	0	919	81.9%	18.1%	$704
Washington	3,705	925	105	57	3	4,795	86.8%	13.2%	$649
Wayne	67	18	1	0	0	86	73.7%	26.3%	$497
Weber	3,774	1,163	159	101	15	5,212	81.5%	18.5%	$749

*State and local government employment numbers were not available.
Note: County totals do not sum to state total given sampling error and non-sampling error estimates. Private sector establishment statistics exclude data from self-employed individuals (i.e., non-employers), employees of private households, railroad employees, agricultural production employees, and most government employees.
Source: Kem C. Gardner Policy Institute analysis of U.S. Census Bureau 2016 County Business Patterns and Bureau of Labor Statistics Quarterly Census of Employment and Wages, 2016 Annual Averages.

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