

Chapter 5

FINANCE AND PAYMENT SYSTEM

Introduction

This chapter describes recommendations on how health services would be financed and paid for under a reformed health system. They involve major changes in how consumers, providers, insurers, purchasers, and government behave. Taken together, these recommended strategies would create strong incentives to control costs, enhance efficiency, promote prudent use of services by consumers, and share the financing of the health system fairly.

These recommendations focus on insurance as a key financial access mechanism and emphasize four important policies:

- Choice:** The health service delivery system should offer individuals a reasonable choice of types of providers and systems from which to obtain health services and offer practitioners a reasonable choice of work environments. This policy assumes managed care strategies and systems will be an increasingly important characteristic of the service delivery system.
- Portability:** The finance and payment system should enhance the portability of health coverage and "smooth the seams" that may occur as the result of changes in employment, financial status, or place of residence. The need for individuals to change health plans and providers should be minimized, consistent with prudent cost control measures.
- Health Status:** Behaviors or decisions that discriminate based on health status should be minimized. The system should minimize incentives for employers to employ only healthy workers, for providers to serve only healthy individuals, and for health plans to enroll only healthy people. In other words, health plans, providers, and insurance sponsors should not be able to control their own costs by shifting costs to others.
- Supplemental Benefits:** Coverage for "supplemental benefits" that are not part of the uniform benefits package may be purchased. Unless otherwise stated in this chapter, finance and payment mechanisms and relationships regarding these supplemental benefits are left up to the individuals or organizations involved in financing, paying for, providing, and using such benefits. Supplemental benefits would not be allowed to pay for point-of-service cost sharing provisions of the uniform benefits package.

The Commission's recommended finance and payment system model (presented in Figure 1) includes the following important features and strategies for health system reform:

- Universal coverage through a single sponsor for the uniform benefits package;
- Individual choice among competing health plans;
- Limits on sponsor premium contributions;
- Price competition among competing health plans within a maximum premium;

- Uniform rules set by a permanent and independent state commission to guide fair, managed competition among certified health plans;
- Shared financing by individuals, employers, and government to promote cost consciousness, and affordability; and
- A regulatory structure that promotes innovative relationships among certified health plans and service providers.

The issue of who "sponsors" health insurance benefits for residents of Washington state was a central one. After considerable discussion and public input, a majority of the Commission voted to recommend a single sponsor for all state residents; a large minority, however, favor a system of multiple sponsors that could be either large employers or large groupings of smaller employers and/or individuals, sometimes called "purchasing cooperatives" (see Figure 2).

The Commission believes government, employers, and individuals should equitably share the burden of financing the health system in order to minimize disruptive cost shifting, ensure the long-term financial viability of the system, and promote cost-conscious behaviors. The recommendations require individuals to pay certain point-of-service costs (such as copayments and deductibles, as included in the alternative benefits packages discussed in Chapter 2), as well as a share of the premium. These costs would be adjusted depending on the individual's ability to pay.

Employers would pay a share of the premiums for all their employees and dependents. The employer contribution would be limited to between 50% and 95% of the price of the lowest priced plan to promote cost-conscious choices by employees. Each year, the new state commission should set limits on employers' financial responsibility according to a percentage of payroll and limits on individuals' or households' financial responsibility according to a percentage of income; these limits should be set at levels that minimize adverse economic effects on each sector. Government should provide financial support when employer and individual financial means are insufficient, and should be the primary financer of coverage for people who are low-income and unemployed.

This chapter also describes the "responsibilities and authorities" that should guide health system reform and, specifically, the finance and payment system. These include defining and revising the uniform set of health services and uniform benefits package, setting maximum premiums, determining and setting limits for household and employer financial responsibility, creating rules for fair competition among certified health plans, addressing access barriers (in cooperation with state and local public health agencies), and monitoring and evaluating system performance.

FACTORS DRIVING UP HEALTH COSTS

Chapter 1 points out that spending for health services in Washington State has been increasing at two to three times the general inflation rate. Neither the regulatory programs of the 1970s nor the market strategies of the 1980s appear to have slowed this rate of spending growth.

What drives up the cost of health services so fast? The federal Health Care Financing Administration (HCFA) defines four general categories of "cost drivers:" *population changes*

(such as the increasing proportion of older adults), *general inflation* (price increases in the economy as a whole), *medical inflation* (price increases for health services and products over and above general inflation), and *other factors* (such as new technologies, increased demand for health services, increased use of testing or procedures for each patient, and increased administrative complexity). The graph on the next page shows how important these categories of cost drivers have been in contributing to increased spending on health services.

One overriding explanation for the continuing growth in spending -- which takes into account the four HCFA categories -- is that the health system "market" does not work like other competitive markets to hold down costs. Experts point to "market imperfections" and other major causes of increasing health system expenditures:

- Traditional methods of paying health providers place few limits on and, in fact, give economic incentives to use more services, to do all that is possible for each patient, and to expand capacity for health services, regardless of their cost or benefit.
- Providers of health services are often the actual decision makers about the amount, frequency, and types of services used. Consumers and purchasers often lack sufficient information to choose prudently among providers or service options.
- Consumers demand more and technically complex health services, in significant part due to insurance coverage that shields individual consumers from having to pay directly the costs of their services.
- New and expensive medical technologies and treatments are rapidly developed and used, often without sufficient evaluation of their relative costs and benefits. Providers *and* consumers demand to use these new technologies.
- The costs of administering public and private health programs and provider services have been increasing rapidly.
- The supply of physicians continues to grow, increasing from 1.6 per 1,000 people in 1970 to 2.4 per 1,000 in 1990. Research indicates that the growing supply of physicians increases (rather than decreases) costs because physicians have significant influence on the price levels and use of services they provide. Also, as the supply of physicians increases, it tends to occur within specialties rather than in primary care.
- The aging population means an increasing need to treat chronic illnesses.
- Health policy and management responsibilities are diffuse and fragmented, making coordination of care, access to appropriate levels and types of services, and cost control difficult.

Chart - interim report p. 65/HCC has original

- Information regarding the costs and benefits of many medical treatments, other health services, and professional practice patterns is often inadequate or unavailable.
- The health care liability system contributes to rising costs: high liability insurance premiums push prices for services higher; clinicians order unneeded tests or treatments to protect against possible liability claims or lawsuits (known as "defensive medicine"); and the insurance and civil justice processes are inefficient in determining liability and providing compensation for patients injured as a result of negligence.
- Competitive insurance practices have led to higher costs for some purchasers than for others, based on the medical risk of the insured group and the market power of the purchaser, causing widening disparities in costs of coverage.

ATTEMPTS AT COST CONTROL

There are many examples, both past and present, of cost control strategies that have been used to target each of these supply and demand cost drivers. Some of these strategies have been "successful" to the extent that a specific symptom may have been alleviated for a specific problem. For example, Diagnostic Related Groups (DRGs), the prospective payment method created by Medicare in 1983, was developed to control hospital expenditures, the largest category of health care spending. The DRG system pays hospitals a fixed fee for a given patient, regardless of how long that patient is in the hospital or how many services are used. By putting hospitals at financial risk, DRGs created incentives for greater efficiency. As a result, the DRG system helped to decrease Medicare hospital lengths-of-stay and moderate *inpatient* hospital spending increases. The program's hospital-based outpatient and ambulatory care expenditures have accelerated, however, and Medicare's *overall* expenditures have continued to increase.¹

A second example of targeted cost control strategies is the Certificate-of-Need (CON) program. This program attempted to control the proliferation of, among other things, high cost diagnostic technologies such as Magnetic Resonance Imagers (MRIs) and Computer-Aided Tomography (CAT) scanners. In Washington State, as in nearly all states, CON regulations concerning the purchase of new high cost equipment applied only to hospitals. While the program may have moderated the proliferation of certain technologies by hospitals, these diagnostic machines were instead purchased by physicians and other non-hospital entities. As with the DRG example, the CON program appears to have shifted rather than controlled *total* costs.²

¹ See Davis, Carolyne K. et al, "The Impact of DRGs on the Cost and Quality of Health Care in the United States," Health Policy, 9:117-121, 1989; and Rosko, Michael D., "A Comparison of Hospital Performance Under the Partial-Payer Medicare PPS and State-All-Payer Rate-Setting Systems," Inquiry, 26:48-61, Spring, 1989.

² State of Washington Legislative Budget Committee, Sunset Review of the Washington State Hospital Commission and Hospital Cost Containment, 1988, pages 58-61.

A final example comes from the private sector. In the past decade, as awareness of "the health cost problem" has grown within the business community, employers have undertaken various strategies to control their health costs. Efforts were targeted, in part, at increasing the employee's share of costs and their cost-sensitivity as they make decisions about when and how to use health care and, in part, to induce more efficient service delivery by providers and health plans (through greater use of managed care strategies). According to a U.S. General Accounting Office report, the percentage of firms that paid full premiums for their employees fell from 74 percent in 1980 to 55 percent in 1988 for individual coverage plans, while for family coverage plans the percentage fell from 54 to 37 percent. During 1982-88, average monthly employee contributions nearly doubled (from \$9 to \$18 for individuals and from \$27 to \$52 for families), far exceeding the 23 percent economy-wide inflation rate during that time. Between 1980 and 1988, the proportion of employer-sponsored plans with a deductible of \$150 or more rose from less than 10 to about 40 percent.³

Employers also increased their use of managed care systems. By 1988, more than 70 percent of employees covered through their work place were enrolled in such systems.⁴ Firms also implemented care management techniques of their own, including mandatory second opinions for surgeries and pre-hospital admission review. Over 60 percent of employer plans in the United States included preadmission review requirements in 1988. Yet, in spite of the rapid expansion of managed care and the trend towards greater employee cost sharing, increases in employer spending on health services have continued to outpace inflation by two to three times each year.⁵

The Commissioners studied and discussed at length the reasons why these targeted cost control strategies have not been successful in controlling the health system's financial appetite. The Commission concluded that the many cost drivers and the complex relationships among them require a *comprehensive* approach with complementary strategies to ensure universal financial access, control total health system expenditures, and promote incentives for efficiency and effectiveness. Therefore, rather than focus on controlling only certain specific cost drivers, the Commission decided to evaluate and reform the overall "finance and payment system" -- the incentives and rules that govern the relationships among financers, payers, providers, and consumers of health services. In addition to consumers, these elements of the finance and payment system are defined as:

- Financers** -- the sources of funds used to purchase health services, including individuals/households, public and private employers, and federal/state/local taxes.
- Sponsors** -- Entities that offer choices of certified health plans to subgroups of the state population and pay premiums directly to health plans on behalf of subgroup members who

³ U.S. General Accounting Office, Health Insurance: Cost Increases Lead to Coverage Limitations and Cost Shifting, May, 1990, pages 18-19.

⁴ Id., page 24.

⁵ Foster Higgins, Health Care Benefits Survey, 1989, pages 11-14.

enroll in those plans. Such entities may be private (for example, businesses, trade unions, professional associations, and consortiums) or public (for example, Medicare, Medicaid, Veterans Administration, and public employers).

•**Payers** -- entities that pay service providers directly, including individuals, self-funded employers, private insurance plans, certain managed care plans, and public insurance programs. In some cases, a payer may also be a financier; for example, an individual or self-funded business that pays service providers directly.

•**Providers** -- individuals and organizations that provide health services to individuals or communities. Providers include facilities (such as hospitals, clinics, and nursing homes), health care practitioners (such as physicians, dentists, and nurses), private organizations (such as pharmacies, home care agencies, and community health centers), and public agencies (such as local health departments).

The Commission chose to define the terms financiers, payers, and providers for its deliberations in order to be clear about which entities have which roles in the finance and payment system⁶. In order to guide the development of comprehensive reforms to the system, the Commission also adopted the cost control criteria presented on the next page.

Cost Control Criteria

The following criteria were used by the Commission to evaluate the strengths and weaknesses of alternative financing and payment systems in controlling health service costs, and are the basis for the recommendations in this chapter:

CRITERIA TO CONTROL COSTS

Does the proposed financing and payment system:

- (1)Comprehensively address all elements of the health system so as to control total system expenditures?
- (2)Minimize unnecessary administrative costs by encouraging simplicity and cost-effective administrative activities at all levels of the system?
- (3)Promote the efficient delivery of appropriate and effective health services (including the appropriate and effective service, timing, location and setting, type of provider, and payment level), with safeguards to prevent inadequate, unnecessary, or harmful care?

⁶ The Commission's definitions do not necessarily match the meaning these words have for others involved in the health system. For instance, the terms "purchaser" and "payer" often refer to what the Commission calls "financers."

(4) Encourage the use of appropriate, effective, and timely health services by consumers and discourage inappropriate use of those services?

COST-RELATED CRITERIA

Does the proposed financing and payment system:

- (1) Promote health, healthy behaviors, and disease/injury prevention through financing decisions?
- (2) Ensure adequate financing of operating expenses, capital, and professional education/training so as to support an efficient system of appropriate and effective health services?
- (3) Encourage the equitable distribution of financial burdens, so they do not fall disproportionately on particular individuals, employers, employees, providers, private insurers, communities, or governments?
- (4) Promote organizational structures that encourage efficient management and delivery of appropriate and effective health services at the local level?
- (5) Encourage the creation and appropriate dissemination of effective and efficient innovations and developments?

Recommendations

Recommendation 5.1 -- Finance and Payment System Model

The Commission recommends a finance and payment system model that ensures universal coverage for a uniform benefits package through a single state sponsor; competing health plans; price competition among plans within maximum premiums; uniform rules for fair competition set by a new state commission; financing shared fairly by individuals, employers, and governments; and innovative relationships among certified health plans and service providers. This reformed system is presented in Figure 1.

DISCUSSION

The Commission's recommendations to reform the finance and payment system in Washington State come together in a system "model" -- a description of the desired relationships among financiers, sponsors, payers, providers, and consumers of health services. The "Finance and Payment System Model," depicted in Figure 1, shows these relationships, including the proposed new state commission (see Chapter 6) and its responsibilities and authorities. The critical elements of this model are presented in Recommendations 5.2 - 5.7.

Recommendation 5.2 -- Competing Certified Health Plans

The uniformed benefits package should be managed primarily by managed health care systems (see definition in Chapter 8) or "certified health plans." These plans should have direct financial and contractual relationships with individual service providers. Competing health plans could be sponsored by existing private insurers, health maintenance organizations, health service contractors, employers, other managed care plans, and state or local governments.

Guaranteeing universal access to a uniform benefits package means that some entity or entities must manage the package and ensure that the covered services are, in fact, available and provided when needed. The two general options for packaging benefits and delivering services are: (1) the state or an agent/contractor of the state, or (2) two or more intermediaries or "health plans."

The first option defines a "single-payer" system similar to British Columbia's, in which the state has direct contractual relationships with individual practitioners, facilities, and other service providers. This option would mean the elimination of what we call "managed care systems" (though the state could be considered *the* managed care system).

The Commission chose the second option because it believes that, within the context of a reformed finance and payment system, managed care plans have the potential to control costs by changing the incentives and behaviors of consumers and providers. Incentives for efficient management and service delivery and innovation encouraged by competing plans are valued by the Commission as well. These health plans should be certified (see Recommendation 5.7.8) to assure they offer the uniform benefits package, are financially sound, and comply with other rules that promote fair competition, access to needed services, and consumer protection.

Recommendation 5.3 -- Sponsoring the Uniform Benefits Package

The Commission recommends that the state develop a single sponsor to provide coverage for all state residents, replacing the current system in which most employers and government agencies sponsor benefits for their own beneficiary groups.

DISCUSSION

Today, most people have health insurance coverage through their employers. As sponsors, employers (often with their employees) decide who can be covered, the scope of benefits, and which health plans to offer. For other people, public programs -- such as Medicare (for older adults) and Medicaid (for those with low incomes) -- act as sponsors, determining eligibility, benefits, and plan choices.

The Commission discussed extensively the issue of whether a single entity should sponsor benefits for all state residents -- **a single sponsor system** (Figure 1) -- or whether employers should continue to manage health benefits for their employees -- **a multiple sponsor system**

(Figure 2)⁷. For either system, the Commission strongly believed that a mandated structure -- either through required participation of all employers or through shared financing of a single sponsor -- would be necessary to assure universal coverage and equitable, stable financing. Within the context of its comprehensive recommendations and proposed model for health system reform, the Commission considered two sponsorship options.

Option 1: Single Sponsor System (Figure 1)

Under Option 1, all state residents would receive their benefits through a single public sponsor. Employers would still help finance the system and would still be allowed to provide or offer supplemental benefits. The major features of Option 1 include:

- The state would create a sponsoring entity⁸ through which all state residents (including those now uninsured) must be covered. The new sponsoring entity would be required to employ mechanisms that promote individual choice of health plans based on cost and quality, and to comply with other rules set by the new state commission to ensure access, quality, and control costs. Employers would still be able to sponsor supplemental benefits. (Current legal opinions suggest that the state may not require a waiver from or change to ERISA in order to implement a single sponsor system.)
- The state would require all state residents be covered by the sponsoring entity by the fifth year of implementation.
- The state commission would be required to develop and implement a phase out plan for employers that sponsor benefits.
- The state commission would be required to perform an evaluation and make any proposals for further reforms by a date certain.
- If the Legislature declines to enact a single sponsor system, the state would implement a multiple sponsor, "play or pay" system with aggressive and immediate efforts to obtain necessary changes in, or waivers from, ERISA.

Option 2: Limited Multiple Sponsor System (Figure 2)

⁷ This report uses the terms "single sponsor" and "multiple sponsor" rather than "residence-based" and "employer-based," respectively. These terms avoid the confusion and debate over whether employers could sponsor benefits in a residence-based system and whether employers are the only alternative sponsor to a single state sponsor.

⁸ "Sponsoring entity" could mean a consolidation of existing public programs into a single state agency or close coordination among separate agencies. See Chapter 11 for specific policies to guide the creation of this public sponsor. The proposed new state commission may or may not be the public sponsor.

Under Option 2, large employers and groupings of smaller employers and/or individuals (sometimes called "purchasing cooperatives") could purchase benefits directly from certified health plans. Large employers would also have the option of financing their employees' health coverage through a public sponsor. Smaller employers that did not join a larger purchasing group would be required to help finance coverage for their employees through a public sponsor. Consistent with universal access, uniform administrative rules, and the uniform benefits package, both public and private sponsors would select cost-effective and high quality plans from which their beneficiaries would choose. The major features of Option 2 include:

- The state would create a sponsoring entity as in Option 1. This entity would cover all unemployed individuals, employees of large businesses that chose not to sponsor benefits themselves, and all smaller business employees and self-employed people not otherwise participating in a larger purchasing cooperative.
- Employers or purchasing cooperatives sponsoring benefits on behalf of smaller employers and individuals could choose to sponsor the uniform benefits package for their beneficiaries, if they met certain minimum criteria (e.g., having at least 25,000 covered lives). These private sponsors would offer choices from among the certified health plans available in their area(s). All employers would be allowed to provide or offer supplemental benefits.
- The state commission would seek an ERISA waiver so that other sponsors (self funded employers and purchasing cooperatives) could be required to comply with rules to ensure access and quality, and control costs.
- If an ERISA waiver is not obtained by a specific date, the state commission would be required to implement plans for a single state sponsor for all state residents, as in Option 1.
- The state commission would be required to evaluate the system's performance and make any proposals for further reforms by a date certain.

There are important strengths and weaknesses of continuing to have multiple sponsors for the uniform benefits package. Some Commissioners think an employer-based, multiple sponsor system will make health system reform go more smoothly, since it builds on the current system. They also argue that, if employers continue to be managers of health benefits, they will be more motivated to improve the system. Other Commissioners say a single sponsor system will be less complex and costly to administer, as well as more likely to ensure uninterrupted coverage for all state residents.

After carefully and extensively considering these strengths and weaknesses, a majority of the Commission support a single sponsor system. However, a large minority of Commission members continue to favor a multiple sponsor as proposed in Option 2.

Recommendation 5.4 -- Individual Financial Responsibilities

Individuals must share in paying premiums, co-payments, deductibles, and/or co-insurance

for the uniform benefits package, but not to the extent that such cost sharing poses a barrier to obtaining appropriate and effective health services. Premium for the uniform benefits package would be priced according to modified community rates. The individual's share of the premium should be defined in relation to, and should be at least 5% of, the price of the lowest priced plan available, in order to stimulate cost-conscious choices of health plan. All individual cost-sharing requirements (both point-of-service and premium) should be subject to sliding scales based on income. The new state commission should define the individual's financial responsibilities, based on a determination of what is affordable and will not be a barrier to access.

DISCUSSION

Subject to an income based sliding scale, all state residents, including all workers, dependents of workers, and people who are unemployed or retired, should be responsible for paying a portion of the premium defined in relation to the lowest priced certified health plan available. This method of premium sharing is meant to encourage cost-conscious choices by individuals and price competition among certified health plans. Under the fallback employer-based, multiple sponsor option (see Recommendation 5.2) unemployed, non-poor individuals (defined by a sliding scale) should pay all of the premium, unless otherwise sponsored.

Example: The new state commission decides an individual should pay 10% of the lowest priced plan available in her/his area. If the individual chooses a more expensive plan, s/he would also pay the difference between that plan and the lowest-priced plan(s). So, if Plan A costs \$100/month and Plan B costs \$125/month, the person who chooses Plan B would pay \$20 (20% of the lowest-priced plan) plus \$25 (the difference between Plan A and Plan B), totalling \$45/month.

In addition, the Commission believes that individual point-of-service cost sharing -- copayments, coinsurance, and deductibles⁹ -- is an important way to sensitize people to the costs of services. The two initial benefits package designs (see Chapter 3) define the individual's financial responsibility for these costs. Package 1 requires moderate copayments (except for preventive and prenatal care) with a moderate annual expense limit. Package 2 includes coinsurance (rather than copayments) and a deductible to be paid before coverage starts.

An individual's responsibility for financing health services should be based on ability to pay, consistent with the following criteria:

- Cost sharing (both premium and point-of-service) should sensitize people to the cost of health services and inhibit the demand for services. Coordination of benefits and other coverage policies should not permit avoidance of applicable point-of-service cost sharing

⁹ "Individual point-of-service cost-sharing" includes **copayment** (an individual pays a flat dollar amount when a health service is received), **coinsurance** (an individual pays a percentage of the billed charge at point-of-service), and **deductible** (the amount an individual must satisfy before anything is paid by the insurer).

requirements.

- Cost sharing should not create a barrier to access to appropriate and effective services or result in an individual's or family's income falling below subsistence level. Sliding scales -- in which individuals or families with higher incomes would pay greater shares of the costs -- should be used for premiums and point-of-service charges. The sliding scales should have a reasonable number of steps to ensure equity and should provide a "zero point" below which individuals would not pay.

In determining individuals' or households' premium share each year, the new state commission should set a range of or limit to *total* financial responsibility, taking into account premium and point-of-service cost-sharing. This range or limit should promote price sensitivity and provide for a fair share of the financial burden by and among households, but ensure the this burden does not act as a barrier to needed care.

Example: The new commission determines that households should spend no more than 15% of their income on health services, including premiums, POS costs, and taxes.¹⁰ Households with lower incomes may spend a lower percentage.

Recommendation 5.5 -- Employer Financial Responsibilities

Employers should be responsible for financing a portion of the premium defined in relation to the lowest priced certified health plan available for all employees and dependents. Premium for the uniform benefits package would be priced according to modified community rates. In the single sponsor system, this responsibility would be carried out by paying a payroll tax sufficient finance between 50% and 95% of the premium costs for all workers and dependents. In the multiple sponsor option, employers and purchasing cooperatives that sponsor the uniform benefits package would be required to pay 50-95% of premium costs for their employees and dependents (not otherwise covered by another sponsor). Under either system, an employer's financial responsibility should be limited to some percentage of payroll in order to lessen harmful economic effects.

DISCUSSION

The proposed health system financing and payment model -- in either single or multiple sponsor scenarios -- mandates that all businesses help finance uniform benefits coverage for employees and dependents (not otherwise covered by another sponsor). The Commission proposes the employer premium share range of 50-95% of the price of the lowest priced plan to allow for a phase-in of financial responsibility, especially for employers who do not now provide health

¹⁰ National and state data (from the Office of Financial Management, Families USA, and the U.S. Bureau of Labor Statistics) consistently estimate that household *now* spend an average of about 5% of income on premiums and point-of-service costs, and another 5% on taxes that finance health services.

insurance. Under the proposed single sponsor system, the new state commission should define an appropriate payroll tax level or levels, based on a determination of what is affordable for different business sectors (e.g., different sizes, industries, or regions of the state) and what would not detract from economic viability and development.

Recommendation 5.6 -- Individual Mandate

Within the context of the Commission's recommendations for universal coverage and cost control, all individuals should be required to enroll themselves and their dependents in certified health plans. This mandate should not take effect until health system reform has achieved coverage of 98% of all state residents.

DISCUSSION

In order to assure that individuals are able to comply with this mandate, the new state commission should facilitate enrollment through education and outreach. The commission should also establish criteria for and monitor enrollment processes of employers (in the case of the fallback multiple sponsor option), certified plans, and state agencies/the single sponsor to attain maximum coverage of state residents. Even with system reforms, some proportion of the state's population will still be left without coverage. The commission should therefore also establish an uncompensated care pool, grants, or other mechanisms to pay providers who provide health services to uninsured individuals.

Recommendation 5.7 -- Responsibilities and Authorities

The Legislature should create a new state commission with the responsibility and authority to define and revise the uniform set of health services and the uniform benefits package (including levels of point-of-service cost sharing), set maximum premiums, determine individual and sponsor financial participation (including premium contributions), control medical technology, determine provider payment methods, distribute the financial burden of medical risks equitably, set uniform rules for billing and claims, uniform policies for utilization management, ensure the certification of health plans, address access barriers, restrict provider conflicts of interest, and monitor system performance.

DISCUSSION

The Commission has developed integrated strategies that have the potential to control health system spending and promote access to needed health services. To be successful, the Commission's strategies to reform the finance and payment system must be carried out within a system of uniform rules and equitable relationships among consumers, providers, insurers, purchasers, and government. To guide implementation of these strategies, a new state commission should have the "responsibilities and authorities" defined in Recommendations 5.7 - 5.7.13 (see Chapter 6 for a discussion of the structure and composition of the commission).

Recommendation 5.7.1 --Uniform Set of Health Services and Uniform Benefits Package

The new state commission should define and periodically update the uniform set of health services and the uniform benefits package, incorporating both public views and priorities, and scientific knowledge.

DISCUSSION

The state commission should create a process -- including experts, industry stakeholders, and the public -- to define and update the uniform set and package (see Chapter 4). The process should be used to decide whether new technologies should be incorporated in and financed through the package, to incorporate outcomes research findings and practice parameters into the benefits package, as appropriate, and to exclude services that are inappropriate and/or ineffective. (see Recommendation 5.7.10 -- Practice Parameters).

Recommendation 5.7.2 -- Maximum Premiums

The new state commission should determine maximum premiums that certified health plans will be allowed to charge for the uniform benefits package.

DISCUSSION

To avoid the failures of past targeted cost control strategies, total system expenditures for the uniform benefits package must be controlled. Controlling the costs incurred by only certain providers, payers, or financers is not sufficient. Real cost control will require changing the financial incentives in the health system. After analyzing various existing and proposed health system reform strategies, the Commission recommends that the finance and payment system must include a mechanism to define and control the *maximum* resident/month premium that health plans will be allowed to charge for the package as an important way to change the system's incentives. Different maximum premiums could be defined for different situations (such as urban or rural, or groups with higher than average medical risks). The maximum premium, leading to a target or budget expenditure level and developed through an analytic process, should be adequate to fund the package through an efficient, effective, and quality service delivery system, and should be used to help meet cost control targets.

The Commission also believes that price competition among health plans will be an important strategy to create incentives for efficiency and innovation. Recommendation 5.7.3 would require that the state commission set rules limiting the sponsor's share of the premium to the cost of the lowest priced plan. Individuals could choose higher priced plans, but they

would have to pay the extra costs. This approach would encourage plans to lower their prices and consumers to be more cost conscious when selecting a plan.

Thus, the Commission recommends the use of both maximum premiums *and* rules to promote price competition in order to control costs. Maximum premiums should be set high enough to allow for and promote price competition among health plans.

Recommendation 5.7.3 --Individual and Sponsor Financial Participation

The state commission should determine individual and sponsor financial participation to promote price sensitivity, equitable shares of system financing, and access to needed services, and to minimize adverse economic effects.

DISCUSSION

The state commission should set rules to limit sponsor premium contributions to no more than 95% of the price of the lowest priced plan available. The rules should require that individuals be responsible for premium costs above this sponsor contribution (Premiums would be priced according to modified community rating). The commission should also incorporate appropriate levels of point-of-service costs in the uniform benefits package. The commission should set sliding scales to ensure that individual cost-sharing (both point-of-service and premium) is not a barrier to obtaining appropriate and effective health services (see Recommendations 5.4 and 5.5).

In defining individual and sponsor financial responsibilities, the new state commission should determine:

- A reasonable total expenditure requirement, range, or limit as a percentage of household income that promotes price sensitivity, provides for an equitable share of system financing, and does not act as an access barrier to needed services;
- A reasonable total expenditure requirement, range, or limit as a percentage of employers' payroll (may vary by sector, such as by size of business, industry, or geographic location) that promotes cost consciousness, provides for an equitable share of system financing, and minimizes negative effects on economic viability and development; and
- The amount of government revenues needed to finance coverage for all public beneficiaries, subsidize lower income households, and maintain the integrity of employer financial responsibility limits.

Recommendation 5.7.4 -- Medical Risk Distribution

The new state commission should develop mechanisms to equitably distribute the financial

effects of medical risks among certified health plans. These mechanisms should include community rating rules, allowing for adjustments for age, sex, and other easily measurable demographic variables (adjustments for health status should be used if appropriate, practical, and cost effective), open enrollment, and a mandatory system of collecting data from plans. The state should also sponsor a voluntary "stop-loss" insurance or reinsurance pool program to be funded by the plans themselves.

DISCUSSION

In today's health system, insurers who enroll people with higher medical needs (and therefore whose costs are higher) are at a competitive disadvantage. This provides a disincentive for health plans to cover the individuals who need protection the most. In a reformed system, health plans should compete on the basis of the quality of their services, the efficiency and productivity of their operations, and their price, rather than their ability to avoid people with greater needs. In order to focus competition on these important goals, plans must be assured they will compete on a level playing field.

The definition of a uniform benefits package for which all state residents will be covered forms the essential basis for allowing all state residents to enroll in the health plan of their choice, regardless of health status. Risk distribution rules will further mitigate barrier to choice and the financial effects on health plans of adverse selection. A mandatory system for collecting data from certified health plans is needed in order to track adverse and favorable selection, and foster research to develop tools to predict future utilization and costs.

Controls on risk distribution may be difficult to apply to small communities, small plans, or new plans, especially if policies encourage every community -- regardless of size -- to have a choice of plans. The state commission should determine whether separate policies concerning medical risk distribution are needed for small communities, small plans, or new plans.

Ideally, the detailed design of these mechanisms should be prepared prior to implementing health system reform. If that is not practical, simple mechanisms should be used initially and more sophisticated mechanisms should be developed as soon after initial implementation as possible.

Recommendation 5.7.5 -- Provider Payment Methods

The new state commission should determine methods by which certified health plans would pay service providers to promote efficient service delivery.

The commission should determine *methods* by which certified health plans would pay service providers to promote efficient service delivery. The commission should also regulate payment *levels*, but only under circumstances in which monopolies exist or managed care plans have not been organized.

Recommendation 5.7.6 -- Medical Technology

In order to ensure efficient and effective use of medical technologies¹¹, the state commission should: (1) advise the State Legislature regarding the number and type of health professionals needed; (2) encourage selective contracting by certified health plans or groups of plans for high technology services; (3) regulate provider prices if monopolies exist or managed care systems cannot be organized; and (4) monitor capital expenditures for plant and equipment with the reserve power to regulate capital spending, if necessary.

DISCUSSION

The incentives within the current health care system favor the development and use of medical technologies regardless of cost or health benefit. The Commission's draft recommendations for uniform benefits, fair competition, and maximum premiums will provide incentives to curb the unnecessary use of technology. These additional strategies are needed ensure the use of medical technology supports an efficient, innovative health system that improves the health of Washington residents.

Health services research has shown that selective contracting for certain services may improve quality outcomes or lower costs if performed in high volumes. The new commission may need to develop strategies to overcome antitrust barriers. Provider payment level regulation may be necessary in some areas, for example, in rural areas in which providers are not operating within managed care systems.

The reserve power to regulate capital expenditures should be exercised through the following process:

- The state commission would monitor and document growth in total health system and capital expenditures.
- If growth exceeds acceptable limits or targets, the commission may develop and submit to the State Legislature a plan for controlling capital expenditures. The plan should include appropriate analysis of the effects of capital expenditures on expenditure growth rates and the anticipated effects of the plan on health system efficiency and effectiveness.

¹¹ "Medical technology" means the drugs, devices, and medical or surgical procedures used in the delivery of health services, and the organization or supportive systems within which such services are provided. It also means sophisticated and complicated machinery developed as a result of research in basic biological and physical sciences, clinical medicine, electronics and computer sciences, as well as the growing body of specialized professionals, medical equipment, procedures, and chemical formulations used for diagnostic and therapeutic purposes.

- The commission would submit the capital expenditures control plan to the Legislature by December 1st of that year. The plan would be implemented unless the Legislature rejects it within 60 days of the start of the legislative session following the December 1 deadline.

Recommendation 5.7.7 -- Billing, Claims, and Utilization Management

The new state commission should determine billing and claims policy and procedures, and utilization management policies to promote greater administrative efficiency and simplicity for consumers, providers, health plans, and sponsors.

Uniform administrative rules will help reduce system administrative expenditures. The commission's rules should promote the development and use of utilization management techniques when they cost effectively reduce unnecessary and inappropriate services. Utilization management policies should promote uniformity and simplicity to extent they do not interfere with the development and application of cost-effective utilization management techniques.

Recommendation 5.7.8 -- Health Plan Certification

The new state commission ensure that health plans are certified by overseeing a process or processes that include mandatory certification, policies, administration, certification topics, enforcement, and plan development.

DISCUSSION

The Commission's recommendations envision a system of competing certified health plans. These plans would accept financial risk for covering enrollees for a uniform benefits package. They would compete on the bases of efficiency, innovation, and value, and according to rules set by a new state commission. Fair competition and consumer protection would be assured through a certification process or closely coordinated processes. The certification process(es) should include:

- Mandatory Certification

All health plans must be certified in order to operate in the state of Washington. If plans regulated by ERISA remain, the state commission should encourage them to comply with and seek certification voluntarily.

- Policies

The certification process(es) should promote the following policies:

- Encourage the growth of efficient health plans that provide quality services for all state residents;
- Promote cost control through fair competition;
- Assure, to the extent community size and cost management make it practical, that consumers have a reasonable choice of health plans;
- Protect consumers from insolvent health plans and assure continuous coverage in the case of a plan failure; and
- Support implementation of a reformed health system.

•Administration

The state commission should set overall policies and oversee/coordinate the process(es) of health plan certification. Specific elements of certification may be the responsibility of other agencies. For example, the Insurance Commissioner may continue to be responsible for assuring financial solvency and/or other consumer protection functions. The state commission should set policies and, if necessary, propose legislation, to assure that certification is carried out in the most effective, efficient, and timely manner, without overlapping or duplicating regulatory activities. The state commission should assure health plan certification through regulatory and contractual methods, as appropriate for each element.

•Certification Topics

The certification process should comprise standards of plan performance in the areas listed below. These standards should be assured through existing laws and regulations (for example, those now administered by the Insurance Commissioner and the Department of Health), unless the state commission determines that health system reform requires changes to these laws and regulations.

--Consumer protection and quality

- Consumer grievance procedures
- Anti-discrimination rules
- Conversion provisions
- Advertising and marketing
- Governance
- Eligibility
- Service accessibility and availability
- Quality assurance
- Out-of-state services
- Enrollment procedures

--Financial viability

- Solvency rules and deposits
- Disclosure of financial records
- Accounting requirements

--Cost control and competition

- Uniform benefits package (with cost-sharing provisions)
 - Premium maximums and shares
 - Billing and claims
 - Utilization management policies (including practice parameters)
 - Provider payment methods
 - Provider conflicts of interest
 - Coordination of benefits
 - Risk management
 - Data reporting
 - Continuous quality improvement
 - Provider credentialing
 - Continuing education
- Enforcement

The state commission should have enforcement and implementation tools that allow for graduated remedies and sanctions, including:

- Contract termination
 - Financial and/or enrollment penalties
 - Receivership or other crisis intervention
 - Recertification requirements
 - Post-certification monitoring and supervision, including inspections and surveys
- Plan Development

Through the certification process(es), the state commission should actively:

- Encourage existing health plans to participate in the reformed system and to improve their managed care capabilities;
- Collaborate with plans to achieve the goals of cost control, increased coverage, and enhanced access to appropriate and effective health services;
- Manage the financial risks confronting health plans;
- Encourage the development of a variety of types of managed care plans with appropriate certification rules; and
- Provide technical assistance for the development of new plans.

Any subsidies and support for new plans should be budgeted separately and explicitly, and the start-up period for new plans should be limited. Normal plan premium payments and policies should not contain hidden subsidies.

Recommendation 5.7.9 -- Provider Conflicts of Interest

The state commission should, as appropriate, prohibit or restrict provider investments that

constitute a conflict of interest.

Recommendation 5.7.10 -- Practice Parameters

The new state commission should work with health professionals, professional training programs, health plans, consumer groups, and others to facilitate the development, dissemination, and use of practice parameters. The commission should require that certified health plans have formal processes through which practice parameters are reviewed and used, as appropriate, for quality improvement, payment, and liability purposes. The commission's process for evaluating and updating the uniform benefits package should consider incorporating practice parameters, as appropriate. The commission should encourage the use of cost-effectiveness as one criterion in the development and implementation of practice parameters by the federal government, professional organizations, and health plans.

DISCUSSION

The medical literature uses the terms "practice parameters" and "practice guidelines" synonymously. According to the Institute of Medicine (IOM), "clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances." The IOM definition distinguishes guidelines as prospective aids from medical review criteria, which are retrospective tools that "can be used to assess the appropriateness of specific health care decisions, services, and outcomes."¹² Most discussions of clinical guidelines recognize that they must incorporate the best scientific evidence and expert opinion.

Practice parameters or guidelines are not new. For many years, health professional schools have been providing practitioners-in-training with rules to guide clinical decisions in medicine, nursing, dentistry, and other professions. In addition, specialty societies have sponsored formal and informal evaluations of their practices in order to improve their members' clinical judgments and treatments. What *is* new, however, is the more recent focus on research/evidence based guidelines and the processes necessary to promote their use.

Practice parameters have been linked to almost every aspect of health care reform, from costs, quality, and access, to medical liability, benefits, and rationing. This wide array of expectations has led analysts to characterize practice parameters as everything from "cookbook medicine" to the "silver bullet" for cost control and quality. While it may be unrealistic to view practice parameters as a silver bullet for health reform, practitioners, purchasers, and policy makers seem to agree that the development of research/outcomes-based, systematic clinical guidelines is important and worth investing in to help improve the health system.

¹² Institute of Medicine, Division of Health Care Services, "Guidelines for Clinical Practice: From Development to Use," National Academy Press, 1992 (manuscript copy).

Once developed, practice parameters may be important tools in health system reform, to the extent their use results in more effective and efficient clinical decisions. The question is how best to obtain these results. That is, what methods of "implementing" practice parameters are possible and reasonable (given the state of scientific knowledge and professional consensus) and will most likely change clinical behaviors. Should they be used as **suggestive methods**, such as use in curricula, continuing education, patient/consumer education, peer review, or quality assurance processes; or as **prescriptive methods**, such as use as affirmative or absolute defenses against claims of negligence, or as a criteria to determine payment.

Clinical decisions are affected by a number of factors: treatment effectiveness, physician and patient characteristics, peer opinion, tradition, organization of practice, financial incentives, and patient expectations.¹³ Even if treatment effectiveness is known perfectly, the other factors may still create the uncertainties that result in "inappropriate" care or differences in clinical practice. On the other hand, better understanding of the relationship between treatment and outcomes can be used to change patient expectations, peer opinion, and tradition.

Health services research literature suggests that practice guidelines help to improve practice under certain circumstances. First, the guidelines should be discussed, promulgated, or adopted by a group or organization with which the practitioner feels closely affiliated (for example, hospital staff, insurance plan, and local medical or specialty society). Second, the guidelines must be combined with other strategies to change clinical decisions (for example, prospective payment methods, peer pressure, and concerns about medical liability). And third, locally developed guidelines may be more effective than national ones.

Outcomes research is in its infancy, as is our understanding about successful methods for integrating scientific evidence and clinical experience. In addition, considerable differences exist concerning the criteria to be used in developing practice parameters. For example, members of the IOM Committee on Clinical Practice Guidelines "could not agree that guidelines developers were ... the right source of judgments about cost-effectiveness" and concluded that "every set of guidelines need not be based on formal judgments of cost-effectiveness."¹⁴ Finally, as noted above, our understanding of how to use practice parameters to effect practice is not yet adequate to provide sufficient opportunities to change clinician and patient behaviors.

¹³ See Leape, Lucian L, "Practice Guidelines and Standards: An Overview," Quality Review Bulletin, 16(2):42-9, February 1990; Eisenberg, John M, Doctors' Decisions and the Cost of Medical Care, Ann Arbor, Health Administration Press, 1986; Greer, A.L., "The State of the Art Versus the State of the Science," International Journal of Technology Assessment in Health Care, 4:5-25, 1988.

¹⁴ op. cit., Institute of Medicine.

Recommendation 5.7.11 -- Clinical and Health-Related Research

The new state commission should help determine how clinical and health-related research should be financed in Washington to promote (or at least compliment and not detract from) health system and public policy goals, including quality, efficiency, and cost effectiveness. The commission should also encourage and participate in a process for making decisions about coverage for disputed treatments. Levels of support for research should be explicit and within the overall spending limits established for the health system.

Consistent with health system reform, research and training institutions should: develop practice parameters; teach new health practitioners and re-educate established health practitioners in efficient use of health system resources; train health practitioners to develop a ability to critically evaluate the benefits of services they provide; and use health-related research to investigate cost-effective ways to use alternative types of health personnel.

DISCUSSION

Clinical and health-related research must continue in a reformed health system and is included in the proposed in the uniform set of health services (see Chapter 4). Along with every other component of the uniform set, clinical and health-related research should be governed by the goals of a reformed health system. Whether funded by taxation through institutions like the National Institutes of Health at the United States Public Health Service, private endowment funds, payment directly from individuals, payment directly or indirectly by certified health plans and other health insurers, or through the state's uniform set of health services, funding must occur through some mechanism(s). Implementation and continued health system reform planning should include determination of how best to finance clinical and health-related research.

If clinical and health-related research are partly financed through payment for health services in the uniform benefits package, then the financial risk this method poses to certified health plans should be minimized in order to preserve universal access to a comprehensive, and affordable uniform benefits package. In addition, the state's spending limits should not prohibit institutions from going outside the state for additional funding.

Criteria to rank funding for clinical and health-related research and training should be developed. The criteria listed below are suggested as a starting point. Clinical and health-related research should:

- Improve the health status of the population;
- Align with public health goals;

- Promote cost-reducing and/or cost-effective technologies;
- Support an efficient health system; and
- Facilitate initial and continuing education for practitioners that teaches efficient use of health resources.

Recommendation 5.7.12 -- Monitoring Health System Performance

The state commission should continuously monitor health system costs, quality, and access.

The commission should also ensure that an independent evaluation(s) of health system reform is performed. (see Chapter 11 for recommendations concerning health information and evaluation)

Recommendation 5.7.13 -- Non-Insurance Access Barriers

The state commission should consider strategies to overcome non-insurance access barriers, including, for example, transportation, language, and cultural barriers.

The strategies could involve development of the uniform set and package, determination of the maximum premium or alternative financing mechanisms, health plan certification, and setting of uniform administrative rules. The commission should set policies (and rules, if appropriate) to address insurance access barriers, including mandated adjusted community rating, a ban on exclusions for pre-existing conditions, required open enrollment, and marketing controls. (See Chapter 3 for detailed recommendations on non-insurance access barriers).

chart -- Finance and Payment Figure 1

chart -- Finance and Payment Figure 2