

Prologue

NEED FOR HEALTH SYSTEM REFORM

Problems and Issues

Appropriate and effective health services -- including disease and injury prevention, personal health services, population-based services, and other public health services -- are available to most Washington residents. For those with adequate financial resources, Washington's health system offers some of the most technologically advanced medical care found in the United States or the world. Yet, the state's health system (and the nation's system as a whole) is becoming increasingly dysfunctional, as costs rise unabated at the same time that a growing number of residents go without adequate insurance or access to needed services. Moreover, the system continues to overemphasize treating illness and injuries at the expense of trying to address the underlying causes of health problems.

Washington residents join a growing chorus of concern that fundamental health system reform is needed -- fundamental changes to correct the serious problems of eroding access and escalating costs that cause many citizens to go without essential health services. Those calling for systemic reform recognize that cost and access problems fall more heavily on particular segments of the population. Employees of small firms, the self-employed, children, rural residents, the poor and working poor, the unemployed, and those who are sick or are more likely to need health services either cannot afford or cannot obtain coverage for needed services.

Unless health service cost increases slow down, more and more people will join the ranks of the uninsured -- risking financial ruin and the inability to obtain needed services. Major stakeholders in Washington's health system also recognize these serious problems and have proposed a variety of reforms for consideration by the Washington Health Care Commission. The Commission believes that growing inequities in access, fueled by unsustainable cost increases, must be corrected to ensure an effective, equitable, and affordable health system.

The problems of increasing costs and inadequate access are not new. Congress recognized that the high costs of medical care were a major obstacle to access when it enacted Medicare and Medicaid in 1965. In the ensuing 27 years, these programs have enabled millions of older adults and poor families to obtain medical services. Employers and employees have seen health insurance as a critical safeguard against financial ruin, as well as a key to productivity and competitiveness. Today, most people who are insured receive their health coverage through an employer-sponsored plan. Over 85 percent of all U.S. residents are covered to some extent through public or private health insurance programs.

Unfortunately, this broad network of public and private insurance has been eroding. In 1991, an estimated 550,000 to 680,000 Washington residents were uninsured. This represents from 11 to

almost 14 percent of Washington State's population of 5,000,000 people.¹ Since the early 1980s, the number of uninsured has increased at a rate far exceeding the rate of population growth.

Meanwhile, despite many efforts by government, business, insurers, and providers, health system spending is increasing much faster than growth in personal income or government and business revenues. In other words, spending has increased faster than our ability to pay, as individuals, employers, or governments. The \$13.4 billion state residents spent in 1990 (an estimated \$2,737 per resident/year) is nearly three times as much as the total spent in 1980, reflecting an average annual increase of 11.6 percent per year.² During the same period, national health system expenditures consumed an increasing portion (from 8.5 percent to 11.5 percent) of the Gross National Product (a measure of the nation's total productive output). Escalating health system costs are now seen as a threat to business profitability, competitiveness, employment, and the integrity of local, state, and federal government budgets.

As the problems of access and cost have become more severe, policy makers have begun to understand and confront the complicated, root causes of ill health. Factors pushing costs ever higher do not necessarily lend themselves to technological or medical solutions. Deaths from injury, alcohol and drug abuse, crack and fetal alcohol syndrome babies, domestic violence, Acquired Immune Deficiency Syndrome (AIDS), stress-induced illness, and tobacco-related chronic disease are some of the health problems that originate in the basic fabric of our society. These problems call for social, economic, and public health strategies.

¹ The Washington population estimates are based on Washington State Office of Financial Management, 1991 Population Trends for Washington State, 1991. The estimate of 14 percent uninsured is based on 1990 United States Current Population Survey estimates. The estimate of 11 percent uninsured is based on Washington State Office of Financial Management, The Number and Characteristics of the Uninsured: Washington State -- 1991, November, 1991.

² This estimate includes most expenditures for personal health services and some public health or population-based services. Washington State Office of Financial Management, Washington Private and Public Expenditures for Health Services and Supplies, 1980 - 1990, and Projected, November, 1991.

Today, less than three percent of total state health expenditures are allocated to public health.³ Nationwide, federal support for public health activities has been reduced.⁴

Environment for Reform

In 1965, Medicare and Medicaid took a significant step towards assuring financial access to health services for elderly, disabled, and low-income citizens. The 1970s saw the development of regulatory structures and processes designed to further these access achievements and hold down system costs. The 1980s brought market-related strategies to contain costs. The recent explosion in the number of managed care plans and enrollment in those plans -- as well as the diverse private and public experiments in payment and purchasing methods -- have dramatically increased our understanding of the factors influencing health services access, use, and costs. In spite of these efforts, access continues to decline and costs continue to rise at unacceptable rates.

Washington state has taken some innovative steps to address these issues locally. The Basic Health Plan (1987) and Medicaid eligibility and benefits expansions, especially for maternity care and children's care included in the First Steps (1989) and Second Steps Programs (1990), address access and cost issues for low income residents. The rural health initiatives (1989 and 1990), Omnibus AIDS Act (1988), Mental Health Reform Act (1989), and Long Term Care Commission recommendations (1991) are each designed to improve access. Finally, Washington undertook the nation's first comprehensive study of all state health care purchasing activities, a project carried out by the Health Care Authority. Yet costs soar and access worsens.

Recognizing the disturbing trends in access and costs, more and more people are voicing their dissatisfaction with the U.S. health system. In statewide community health forums and newspaper polls conducted by the State Board of Health for the Washington State Health Report 1990, about 52 percent of the participants said "access to care" should be a high priority goal for Washington State. A 1990 poll of residents across the state, sponsored by Washington Fair Share (now Washington Citizen Action), indicated that 88 percent of the respondents believed health care coverage is a right and 68 percent were willing to pay more taxes to achieve universal coverage. A well-publicized 1988 Harris/Harvard poll of adults in the United States, Canada, and Great Britain found Americans to be the most dissatisfied with their health system; in fact, 61 percent of American respondents preferred a Canadian-type system.

³ Washington State Senate Health and Long Term Care Committee, Estimating the Cost of Certain Health Services, draft memorandum to Bobbie Evans, Washington Health Care Commission, August 8, 1991. Washington State Core Public Health Function Task Force, Core Government Public Health Functions: Report to the Health Services Committee, Washington Health Care Commission, second draft, June 8, 1992.

⁴ Institute of Medicine, The Future of Public Health, National Academy Press: Washington D.C., 1988, page 131.

In response to this growing and active concern, the State Legislature created the Washington Health Care Commission in March, 1990 to make recommendations for reforming the state's health system. The State Legislature charged the Commission with developing recommendations to achieve the following five goals by November, 1992:

- Identify how the state could use its own health care purchases, and improve its coordination with private health care purchasers, to decrease the rate of health care cost inflation;
- Identify, with the help of the private sector, methods to reduce and control health costs;
- Identify appropriate and effective health services, develop incentives to adopt the use of those services, and develop incentives to effect preventive and public health interventions;
- Recommend changes relating to medical malpractice and liability insurance to decrease health costs, increase health access, increase the efficiency and safety of health provider practices, and provide needed coverage for injured consumers; and
- Recommend plans for ensuring access to health care for all people. These plans should include a definition of the responsibilities and funding participation of individuals, the public, and employers.

Many business and labor leaders, nationally renowned researchers, and mainstream medical journals are now calling for fundamental reform of the health system. Major stakeholders in the state health system are also recommending reforms, as evidenced by the number and variety of proposals received by the Commission. The Commission's draft recommendations reflect the complex and interrelated nature of the problems of access and cost control. The Commission believes that the serious problems of the existing health system warrant comprehensive and fundamental reforms, with due consideration for the strengths of the existing system.

Chapter 1

UNIVERSAL ACCESS

Introduction

The Washington State Legislature asked the Commission to "recommend plans for ensuring access to health care for all people." The Commission's recommendations for health system reform are based on achieving universal access while controlling health system costs. In the 1991 Interim Report, the Commission defined "universal access" as:

"The right and ability of all Washington residents to receive a comprehensive, uniform, and affordable set of confidential, appropriate, and effective health services (the `uniform set of health services'). These services must be received in a timely manner and with reasonable effort. They must not be denied because of the inability to pay or pre-existing health conditions. They must be received with appropriate consideration for geographic, demographic, and cultural differences among the state's residents."⁵

In the 1991 Interim Report, the Commission also proposed criteria to evaluate the capacity of health system reform proposals to provide universal access.

The Commission's 1992 draft recommendations identify *who* must be guaranteed access to the uniform set of health services through a broad definition of Washington state residency is presented below. The Commission has also recommended which services people shall have access to, how these services would be paid for, and how barriers to receiving these services would be overcome.

To identify *which* health services people would be ensured access to, the 1992 draft recommendations describe an initial uniform set of health services, including an initial uniform benefits package (the insured portion of the uniform set) and the non-insured portion of the uniform set (core public health functions and health system support). The initial uniform set and package are explained further in Chapter 2. To determine how the health services in the uniform set and package would be paid for, the 1992 draft recommendations address the availability of adequate financial resources to pay for both.

Making health insurance available to everyone is not sufficient to overcome other barriers preventing people from obtaining needed health services. Barriers to access, such as language, cultural/ethnic differences, and lack of transportation, are called "non-insurance" access barriers. The Commission recommends a coordinated effort for developing appropriate flexible strategies to overcome these barriers. The coordinated effort would include roles and responsibilities for state

⁵ The full discussion of "universal access" can be found in Washington Health Care Commission, Interim Report to Governor Booth Gardner and the Washington State Legislature, December 1, 1991, pages 49-53.

and local public health agencies, communities, and a new state board/commission. This recommendation is presented below. Finally, this chapter concludes with a recommendation for phasing in coverage for those individuals without health care coverage ("the uninsured").

Recommendation 1.1 -- Definition of State Residency

For purposes of the Washington Health Care Commission's recommendations for health system reform, the following persons shall be deemed "Washington residents:"

- **Individuals living in the state who intend to reside in the state permanently or indefinitely. To determine the authenticity of a person's intent to reside in Washington, the governing authority would consider all relevant factors. Individuals who come to the state of Washington for the primary purpose of obtaining health services without the intent of remaining on a permanent or indefinite basis would not be considered residents.**

- **People, including accompanying family members, who (1) are in the state for the purpose of engaging in employment for more than one month, (2) do not enter the state for the primary purpose of obtaining health services, and (3) lack necessary and sufficient health care coverage.**

A resident shall be entitled to coverage during his/her first year of residency in the state for any medical condition which existed prior to becoming a resident of the state only to the extent that the cost of such coverage exceeds the available resources of such resident.

Nonresidents shall not be refused emergency health services, but shall not otherwise be covered by the state.

DISCUSSION

In defining state residency, the Commission's first goal is to assure universal access for legitimate residents. The Commission also seeks to provide access to non-residents who work in the state and who make significant contributions to the state's economy. Specifically, the Commission seeks to cover migrant and seasonal farm workers, upon whom much of our agricultural economy depends, during the time they are working in the state.

The residency definition also seeks to protect the state from people coming to Washington primarily to seek the benefits of our health system. Because the U.S. Constitution prohibits an absolute ban on health coverage for new residents, the definition addresses this concern in two ways:

- (1) People who come to the state solely for health services and without an authentic intent of remaining permanently would be denied coverage; and

(2) There would be no coverage of pre-existing conditions during a new resident's first year of residency, except in the case of indigence.

Two issues were not resolved with this definition. First, the Commission was not able to resolve portability of benefits for retirees who leave Washington after working in the state. Second, the Commission did not resolve the issue of employees working in Washington but who, unlike migrant farm workers, never maintain a home in Washington.

Recommendation 1.2 -- Non-insurance Access Barriers

Given the broad array of barriers to access and the need to allow for flexible responses to them, the Commission recommends that the state use a coordinated effort for developing appropriate flexible strategies to overcome these non-insurance access barriers. The coordinated effort would include the appropriate roles of and relationships among the public health agencies described in Chapters 2 and 6 and the new state board/commission recommended in Chapter 4. This coordinated effort would empower communities to respond to specific access barriers as they arise.

DISCUSSION

Providing universal health insurance, which the Commission recommends, solves some but not all access problems. State residents may face many types of non-insurance barriers to obtaining appropriate and effective services, including barriers relating to geography and language, supply and distribution of resources, socio-economic and cultural factors, lack of education and information, and health system rigidity.

The Commission recognizes that ensuring access to needed health services requires a number of coordinated strategies. After much analysis and testimony about programs designed to overcome some of these barriers, the Commission has concluded that the nature of an access barrier is often unique to a particular community or health care environment, requiring programs or strategies customized for that situation. In addition, specific access barriers may be best addressed by different "systems," such as public health, insurance, social service, or education. Finally, similar access barriers may best be minimized by using different methods in different locales. Thus, while some issues can be addressed by statewide policy bodies such as the new state board/commission, others must be left to local initiatives.

Based on these conclusions and on the recommended uniform set of health services presented in Chapter 2, the Commission has outlined the following coordinated structure for overcoming access barriers:

Public Health System

Local public health agencies should have the primary responsibility for identifying access barriers in their regions. This should be accomplished through continuous community surveillance and cooperative efforts with all segments of the communities, including service providers, certified health plans, other public agencies, schools, communities of color, civic organizations, businesses, elected officials, and residents. In fulfilling its policy development and assurance functions, the local public health agency should identify the organizations best able to address identified access barriers through existing, enhanced, or new services. This role should include appropriate recommendations (directly or through the state Department of Health or Board of Health) for action by the state board/commission, certified health plans, or health service providers. At a minimum, these recommendations should include any proposed changes to the uniform set of health services and the uniform benefits package.

While local public health agencies should coordinate responses to access issues, other local organizations should also be identifying barriers or needs, and taking appropriate action. Local public health agencies should participate in and cooperate with these efforts, and incorporate, as appropriate, the recommendations of these other organizations. These other local organizations should also make recommendations to the State Department of Health, Board of Health, state board/commission, certified health plans, and health service providers, as appropriate.

The State Department of Health and Board of Health should have primary responsibility for identifying statewide access barriers. This should be accomplished through continuous community surveillance and cooperative efforts with local public health agencies, service providers/associations, certified health plans, other state and local public agencies, schools, communities of color, civic organizations, businesses/associations, elected officials, and residents.

The Department of Health has statutory specific responsibility to address health worker supply and distribution issues through developing a health professions resource plan and administering the health professions loan repayment program. The Department should develop strategies to improve the distribution and availability of primary care providers.

Through the assessment, policy development, and assurance functions described in Chapter 2, the Department of Health and Board of Health should recommend strategies to address non-insurance access barriers. As appropriate, these recommendations should be included in the Board's biennial State Health Report.

The Department and Board should review and recommend to the state board/commission changes to the uniform set of health services and the uniform benefits package. The Department and/or Board should have primary responsibility, in cooperation with local public health agencies, to ensure the accessibility of services included in the uniform set but not in the uniform benefits package, within their respective statutory authorities.

Finally, the Department and Board should recommend strategies to be implemented through other entities. Some examples of such entities and strategies are listed below:

- State colleges and universities would create a recruitment and training program for refugees/immigrants as caregivers or translators, including specific requirements for cross-cultural sensitivity within professional education curricula.
- Office of the Superintendent for Public Instruction would develop requirements for K-12 health education curricula.
- Counties would develop and implement public transportation plans.
- Department of Social and Health Services would increase state subsidies for medical related transportation and enhance funding for health services language bank capacity.
- The state legislature would enact tax credits and/or employer requirements to allow worker leave time to obtain needed health services.

State Board/Commission

The new state board/commission described in Chapter 4 would be responsible for defining and revising a uniform set of health services and uniform benefits package, determining the maximum premium for the package, certifying health plans, and setting uniform administrative rules. When an access barrier has been identified -- through the board's/commission's own work, through information from certified health plans or providers, or upon recommendations from local or state public health agencies -- the board/commission should consider strategies to address the barrier through one or more of the following processes:

Uniform set of health services and uniform benefits package

The state board/commission should consider the feasibility, desirability, and affordability of including a specific access and/or public health service (for example, medical-related transportation, translation services, or child care) in the uniform set and/or package.

Premiums and alternative financing mechanisms

The state board/commission should consider factoring in the costs for providing certain access services (for example, transportation, translation, and child care) into its determination of the maximum premium, perhaps targeting specific regions or specific health plans that have enrolled people who need these services to overcome identified access barriers.

For access services that are part of the uniform set but not part of the package, the state board/commission should determine an alternative financing mechanism to ensure that related access barriers are addressed throughout the state. Such mechanisms could include direct prospective payment, fee-for-service reimbursement, capitation grants, or other appropriate methods.

•Health plan certification

The state board/commission should consider requiring, as a condition of certification, that health plans attain certain access-related performance standards. For access services that are part of the uniform set but not part of the package, the state board/commission should also determine mechanisms to ensure that related access barriers are addressed throughout the state. For example, the new board/commission could expect local public health agencies to work with and provide assistance to certified health plans to ensure people have access to health services.

•Uniform administrative rules

The state board/commission should consider promulgating rules that enhance "user-friendliness," such as requiring uniform, simple eligibility or enrollment forms.

In performing the foregoing functions, the state board/commission should consider the recommendations of the Board of Health's biennial Washington State Health Report, 1992.

Recommendation 1.3 -- Phasing In the Uninsured

The Commission recommends that for the first five years of health system reform, there should be a process to phase in health care coverage of the uninsured in order to achieve universal access. The process should phase in people with the greatest need first. Those uninsured individuals who could afford to pay for coverage themselves would do so.

DISCUSSION

To achieve universal access to health services, the Commission recommends that all Washington residents have access to a uniform benefits package. The Commission has defined universal coverage as 98 percent of the state's population having coverage for the package. Currently there are 550,000 to 680,000 people who lack health care coverage. The Commission recommends that, once health reform begins to be implemented, it will take five years to achieve universal access.

The Commission recommends 10 percent of the uninsured should be enrolled in the first year, 30 percent in the second year, 50 percent in the third year, 75 percent in the fourth year, and then in the fifth year, the goal of 98 percent coverage would be met. Phasing in the uninsured at this pace would allow for health system cost controls to be put in place, necessary delivery system changes to occur, and necessary additional revenues, if any, to be raised. The costs of phasing in the uninsured are discussed in Chapter 5. Financing issues are discussed in Chapters 3, 5, and 9.

Chapter 2

UNIFORM SET OF HEALTH SERVICES

Introduction

The Commission believes health system reform for Washington state goes beyond ensuring access to and controlling the costs of medical care. The Commission envisions a system which integrates policy making for improving the health status of the entire population (public health) with policy making aimed at improving individual health status (personal health). This can be accomplished by strengthening the core functions of the public health system and then linking them with changes in the personal health services delivery system. This integration would result in an overall health system that protects and improves the health status of all Washington residents. To the degree that such reform is successful in creating universal access to health services, the public health system will necessarily undergo significant changes.

The Commission recommends ensuring universal access to a *"uniform set of health services,"* including a uniform benefits package of personal health services to be provided by certified health plans, *and* other health services to be provided primarily through the public health system. The following draft recommendations identify the components of the uniform set of health services, including the components of short-term and long-term uniform benefits package(s). The Commission requests public comment on our approach to the uniform set and package. Recommendations for financing the set and package are presented in Chapter 5.

Recommendation 2.1 -- Uniform Set of Health Services

The "uniform set of health services" consists of all services to which Washington state residents are ensured access. It includes an insured uniform benefits package comprised of personal health services provided by certified health plans and a variety of non-insured services provided by the public health system. The uniform set consists of three major components: core public health functions, health system support, and personal health services.⁶

⁶ Some of this text comes from Washington State Core Public Health Function Task Force, Core Government Public Health Functions: Report to the Health Services Committee, Washington Health Care Commission, second draft, June 8, 1992.

DISCUSSION

The uniform set of health services is based on "Categories of Appropriate and Effective Health Services," identified in the Commission's 1991 Interim Report. These services include adequate food/housing for vulnerable populations, access services, population-based services, personal health services, and health-system support. The Commission has divided them between a package of services financed through health insurance (the "uniform benefits package"), and the "non-insured" portion of the uniform set financed primarily through the public health system.

Core public health functions, health system support, and personal health services are interrelated and are essential components of the health system; however, they are financed and used very differently. Since the majority of health system financing goes to pay for personal health services, most reform proposals tend to focus on those services. People are also more aware of personal health services because they are provided directly to individuals. Public health services are often provided to the entire population of a state, county, or community. To achieve the Commission's goals for health system reform, public health functions and health system support must also be considered.

Core public health functions include assessment, policy development, and assurance.⁷ Public health must have the capacity to assess trends in morbidity, mortality, and other health needs to inform development of local and state policies which assure that the general population has access to appropriate and effective services. These functions are described further in Recommendation 2.2, below. Currently, these core functions comprise only about two to three percent of the total health system costs in Washington. Of this relatively small amount, most is dedicated to assuring direct provision of illness services to those without other resources. The functions of the public health system need to be restored to help guide and assure our investment in the health system.

Assessment and policy development are primarily functions of government. Assurance, however, includes arrangements for the delivery of population-based health services and personal health services. It also includes quality assurance activities related to all health services.

The assurance of population-based health services should continue to be organized and financed primarily through the public health system, comprised of the Washington State Board of Health, the State Department of Health, and for some areas of responsibility, other public agencies.⁸ The

⁷ The 1988 Institute of Medicine study, The Future of Public Health, clearly articulated that these are the three fundamental responsibilities of public health.

⁸ For example, the Department of Ecology is responsible for some areas of environmental protection which protect health, and the Department of Labor and Industries is responsible for enforcing worksite safety and health requirements. The State Board of Health has a policy coordinating role across all agencies through its recommendations in the State Health Report.

assurance of personal health services should be carried out and financed primarily by the new state board/commission and certified health plans (discussed in detail in Chapters 3 and 4). The public health system will require leadership and coordination directed at assuring necessary service provision by others. It will also need to develop regulatory measures to protect health, measures to assure the quality of services, and maintenance of administrative capacity to provide or purchase other needed services.

"Health system support" includes health personnel education, clinical and health-related research, health system development, and system regulation. It is unclear how funding for these critical components of the health system will need to change as health reform occurs. In any event, the state's universities will continue to play a major role in providing some of these components. Health services personnel are discussed in Chapter 6. Clinical and health-related research is discussed in Chapter 3. The Commission has addressed health system development and regulation throughout its work on the delivery system, health care liability reform, and the finance and payment system.

Personal health services included in the uniform benefits package will be insured by certified health plans. Personal health services are provided directly to an individual or family by a provider. Certified health plans and the state/board commission, as well as the public health system, will need to perform assessment, policy development, and assurance functions affecting personal health services. The uniform benefits package is discussed below in Recommendation 2.3.

Recommendation 2.2 -- Non-Insured Portion of the Uniform Set

The non-insured portion of the uniform set of health services will be provided primarily by the public health system. The non-insured portion of the uniform set is comprised of public health functions and health system support. The focus of state and local public health departments will necessarily change as a result of significantly reducing the provision of personal health services by local health departments as access to the private sector increases. This will also occur as a result of significant increases in state and local capacities to perform assessment and policy development functions and assure the availability of population-based preventive efforts. Annual funding for the public health system should increase from \$233 million to \$520 million.

DISCUSSION

The core public health functions of assessment, policy development, and assurance all have governmental and non-governmental aspects, but the broadest responsibilities for these functions in the reformed health system would be governmental. The existing public health system will play a major role in carrying out these functions, as well as the new state board/commission. The three core public health functions are explained below. Chapter 6 expands upon roles within the public health system.

Assessment

Assessment means to identify trends in illness and death, environmental and human factors which may cause these events, available health resources, unmet health needs, and citizens' perceptions about their health. It includes comparisons among population groups to discover whether improvements in health status are uniformly shared and whether there are inequities in access. Community-wide assessment is primarily a governmental public health function using public and private data sources. It includes the regular collection, study, and sharing of information about health status, health conditions, and health services in the community. Many other public and private organizations, however, perform assessment activities in various parts of their communities.

The information may take the form of personal and environmental health data, community concerns and resources, results from scientific studies, data on the range and quality of services, and clearly presented analysis and interpretation of these data so they will be meaningful to decision-makers. These decision-makers range from individuals shopping for services, to local boards of health, to health care providers and the state board/commission.

Policy Development

Information identified by assessment is then used to develop local and state policies. As the Institute of Medicine noted, good policy cannot be made in the absence of good information⁹. Policy is developed using information from assessment, analysis, and consideration of political, organizational, and community values. Policies are incorporated into community priorities and plans, public agency budgets, local ordinances, and state statutes. This information may be used by private health care systems in developing their service plans as well.

Policy development for health status improvement and for population-based health services is a public function performed by the public health system. Policy development for personal health services will be performed by the new state board/commission, by certified health plans in their role as care managers, and by providers, with the public health system providing feedback through assessment and assurance activities.

Assurance

⁹ Institute of Medicine, The Future of Public Health, 1988.

The third public health function, assurance, consists of a variety of activities which translate policies into services, and which maintain the quality and accessibility of all health services provided in both the public and private sectors. Public health capacities, population-based health services, and personal health services all must be assured. Each calls for different approaches.

In the case of public health capacities, assuring means taking action. The public health system must maintain the ability to respond to health emergencies and apply regulatory measures which protect health (such as water quality and food safety regulations), and which assure service quality (such as professional licensure). Public health agencies also must provide leadership and coordination and must have administrative mechanisms for providing or purchasing other services when necessary. These capacities should be publicly funded.

Assurance of other population-based health services, such as community health promotion and education, services to improve access to care, and adequate food/urgent housing for vulnerable populations, can be accomplished in several ways. Public health agencies can provide the services, purchase them using public funds, or encourage other entities to provide them using their own resources. Attachment 1 at the end of this chapter provides examples of population-based health services which the public health system would assure.

The primary way personal health services will be assured is by universal access to a uniform benefits package. It is expected that access to services will be insured by the certified health plans that contract with private and community/public health providers. Nevertheless, additional assurance activities will be needed, including oversight of certified health plans by the state board/commission and monitoring of service, quality, and access by public health agencies.

Financing the Non-insured Portion of the Uniform Set

For some areas of the state, public health agencies do not have sufficient resources to carry out the basic activities necessary to protect their communities' health, such as monitoring health hazards and illness trends, and assuring that needed services are in place. An adequate public health system must have an expanded capability to allocate resources to preventive services rather than treating illness, mobilize efforts to resolve access barriers, and ensure that environmental hazards are addressed.

Efforts to reform the overall health system provide a significant opportunity to refocus the efforts of public health system. The core public health functions described above need to occur for every area of the state. To accomplish such change, revenues spent on public health need to increase from about \$233 million to \$521 million after many years of being squeezed down. This investment in our health system's infrastructure will enable the health reform goals to be assessed and assured.

Enhanced public health financing should be implemented over a five year period as discussed in Chapter 5. Many resources needed to fund assessment and policy development are already in

place. The Washington State Core Public Health Function Task Force estimates that currently available funds support one-third of the needed assessment function and one-half the needed policy development function.¹⁰ Increased resources to support governmental assessment and policy development functions at the state and local levels should be among first priorities of a reformed health system.

Assessment and policy development require a sufficient population base to support the various areas of expertise required, including epidemiology, data management and analysis, and policy analysis and development. The population base must be large enough to be able to develop a meaningful information base, but small enough to develop a working familiarity with the community. A minimum level of funding is needed so that even the most sparsely populated areas have sufficient resources to perform these functions. Some form of regionalization may benefit less densely populated areas. A funding ceiling for assessment and policy development should be set to take into account economies which can be gained in the more populous areas.

Financing for the assurance function is more complex. Public agencies are currently providing personal health services that would be included in the uniform benefits package. These agencies may have to continue to provide these services until provider shortages in some regions are corrected. Moreover, federal waivers may be required before categorical grants can be shifted to support services in a private system comprised of certified health plans. Between five and ten years may be required before these two conditions can be satisfied.

Financial requirements to carry out the public health assurance function have been estimated; however, they are not based on pricing a specific, invariable "service package." The estimates assume that local public health agencies will develop priorities for population-based health services, based on community health assessment and policy development. These local priorities will guide the use of a local public health budget which must support core assurance capacities *and* supply the funds for providing or purchasing selected additional services. Once fully implemented, about 30 percent of the assurance activity would be conducted by private sector organizations, 60 percent by local health departments, and 10 percent by the State Department of Health.

The Washington State Core Public Health Task Force also estimated that 45 percent of needed funding is currently expended by state and local public health agencies from a variety of sources, including federal, state, and local tax dollars and private fees. Additional state funding for the non-insured portion of the uniform set of health services could come from several sources discussed in Chapter 5. Additional resources will be necessary, mostly on a one-time-only basis, to support these changes, including such initiatives as the development of new policies, the development of a linked health data system, additional facilities, a telecommunications network, employee retraining and recruitment (see Chapter 6).

¹⁰ *Op. cit.* Core Government Public Health Functions.

Recommendation 2.3 -- Comprehensive Uniform Benefits Package

All Washington residents should be covered for a comprehensive, uniform, and affordable benefits package. To afford this package, the Commission recommends a short-term uniform benefits package to be used for the first five years of health reform implementation, followed by implementation of a comprehensive long-term package.

DISCUSSION

The Commission recommends all state residents be ensured access to a comprehensive, uniform, and affordable benefits package. The package, composed of personal health services, would be insured by certified health plans (described in Chapter 3). The Commission believes the package must be comprehensive in order to provide incentives for people to prevent avoidable illness and to obtain early intervention, rather than to delay care until they are very sick and need expensive care. Having everyone covered by a comprehensive package is also necessary to get health system costs under control.

The Commission has wrestled with how to make a uniform benefits package both affordable *and* comprehensive. Balancing these two competing priorities has been a difficult and challenging task. The Commission has gone through an extensive process working with consulting actuaries, Milliman & Robertson and A. Foster Higgins, to translate "categories of appropriate and effective services" into a uniform benefits package for which cost estimates would be developed. The Commission sought public review on the design and costs of several sample packages and then proposed draft initial packages. Now the Commission is proposing the design and cost of an initial uniform benefits package using the following approach.

Short-term/Long-term Approach

During the first five years of reform implementation (considered the short-term), the new state board/commission will be working hard to achieve cost control through reforms to the finance and payment system. The state will also be phasing in health coverage for all state residents, promoting delivery system changes to increase capacity, and obtaining essential waivers from the federal government, including ERISA, Medicare, and Medicaid waivers. For this initial implementation period, the Commission recommends a "short-term" uniform benefits package. As the system's cost control measures take effect and federal Medicare and Medicaid waivers are obtained, long-term care services will be added to make the uniform benefits package truly comprehensive.

Packages I and II

Two packages, which are actuarial equivalents (they have the same premiums), are being considered for the short-term approach. The two packages have the same set of services, however,

they vary by the amount and type of cost-sharing required.¹¹ The estimated premium cost of each of these packages is \$130 per person per month. This estimate is based on the cost of covering the average state resident, excluding anyone with Medicare or Medicaid eligibility. In addition, people would pay whatever point-of-service cost-sharing they accrue up to an annual out-of-pocket expense limit. Package I would have an estimated \$22 of net cost-sharing compared to \$34 of net cost-sharing for Package II. The net cost-sharing for Package I is considerably less than Package II because Package I is more managed than Package II. Packages I and II are summarized in Attachment 2 at the end of this chapter.

Package I, called "Moderate Point-of-Service Cost-Sharing," requires moderate copayments whenever an individual obtains services. It is most similar to the traditional HMO with the amount of copayment varying by type of service. When the specified annual out-of-pocket expense limit is met, no point-of-service cost-sharing would be required for the remainder of the year.

Package II, called "Comprehensive Major Medical," requires a deductible to be met before the individual would be reimbursed for services used. After the deductible is met, the individual would pay a percentage of billed charges at point-of-service. It is similar to traditional indemnity plans; however, it provides an incentive for an individual to use providers that contract with the certified health plan.

For the long-term, Packages I and II would be changed by (1) removing visit limits on outpatient mental health services, and (2) including long-term care services. The reasons why outpatient mental health services and long-term care services are being treated like this are explained below. The estimated average per person monthly premium for the average state resident, including anyone eligible for Medicare and Medicaid, is \$183 for the long-term package.

Long-term Care

The short-term package includes a broad range of health services, such as preventive and primary care, hospital services, prescription drugs, dental services, home health care, and mental health and chemical dependency services. Because of the need for Medicare and Medicaid waivers, the short-term package excludes long-term care. When the state receives the federal waivers and is able to use Medicare and Medicaid dollars, long-term care services would be incorporated into the uniform set of services. This means that long-term care services will either be covered in the uniform benefits package or financed and provided through the non-insured portion of the uniform set.

Mental Health Services

¹¹ "Individual point-of-service cost-sharing" includes **copayment** (an individual pays a flat dollar amount when a health services 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).

The short-term package limits outpatient mental health visits. While the short-term package is in effect, the state should determine how certified health plans could manage the use of mental health services so that artificial limits would not be necessary.

Medicare Beneficiaries

Without a federal Medicare waiver, the state cannot cover Medicare beneficiaries for the uniform benefits package through certified health plans. The Commission recommends that the state apply for this waiver at the earliest possible time. The Commission is considering whether and how to cover Medicare beneficiaries for benefits included in the short-term package that are not covered by the Medicare program. The Commission is considering the following two options:

Option 1 -- Until the state receives its Medicare waiver, Medicare beneficiaries would not receive coverage for services in the uniform benefits package not covered by Medicare.

Option 2 -- While awaiting a Medicare waiver, the state would begin phasing in uniform benefits package coverage for Medicare beneficiaries, based on income level and extent of coverage. Low-income Medicare beneficiaries not otherwise covered by supplemental insurance would be phased in first.

Ability to Pay

The Commission proposes that cost-sharing of premiums and at point-of-service should be based on one's ability to pay. The Commission also wants public comment on whether the cost-sharing provisions listed in the draft packages are reasonable.

Recommendation 2.4 -- Preventive Personal Health Services

Preventive personal health services should be provided primarily through the uniform benefits package. Principles and criteria should be used to determine when these services should be provided through the public health system.

DISCUSSION

The Commission recognizes an overlap between personal health services and core public health functions, especially in the area of prevention. These services are now financed and provided through both the insurance/medical care system and the public health system, as well as other public systems such as schools. Who finances and provides these services may depend on the resources and organizations of a particular community.

To help determine whether a preventive personal health service should be financed and/or coordinated through the public health system rather than a certified health plan providing the uniform benefits package, the Commission recommends using the following principles and criteria:

Principles

- If a preventive personal health service can be insured, it should be provided through the uniform benefits package. For example, immunizations or family planning services should be part of the uniform benefits package.
- If a preventive personal health service can be made part of a total managed care responsibility, it should be. For example, certified health plans should be responsible for making sure that immunizations and family planning services are received by individuals.
- Preventive personal health services should be delivered and financed in a way that minimizes cost, promotes continuity of care, provides the best incentives, and provides the best access. For example, a certified health plan may choose to contract with and pay a local health department to deliver immunizations or Planned Parenthood to delivery family planning services.
- The option should be left open to provide preventive health services through multiple approaches when appropriate. For example, certified health plans in King County may provide immunizations directly to its enrollees, while certified health plans in Lewis County may contract with their local health department to deliver immunizations. Different counties may also vary how they provide family planning services.
- There are essential linkages between local and state public health and certified health plans to assure access to and delivery of preventive personal health services.

Criteria

A preventive personal health service should be provided through the public health system when:

- The potential harm to the broader population requires the collective action of the public health system to protect the total population on an ongoing basis (for example, sexually transmitted diseases and immunization protection).

- The intervention needs to be organized on a population basis to ensure comprehensiveness in order to prevent further harm to the total population (for example, food or water-borne illnesses that require both treatment and investigation, as well as communicable disease outbreaks).
- A consistent state- or community-wide message is necessary to promote health and prevent disease or injury (for example, smoking cessation, mammography, and dietary changes). Disruption caused by changes in employment, insurance plan, or place of residence must be minimized to make the intervention more cost effective.
- There is a need for a large segment of the population to have access to the specific preventive service (for example, childhood immunizations and cancer screening). The subgroup could be defined by region, age, sex, or ethnicity. In such cases, public sector action will assure standardization, accuracy, quality, and/or continuity for follow-up.
- Total health services costs will be less than if the intervention is insured and included in the uniform benefits package.

Attachment 1

EXAMPLES OF THE ASSURANCE FUNCTION

Assurance of Public Health Capacity: Maintaining the capacity of official public health agencies to manage day-to-day operations and provide the core public health functions. Part of that capacity is providing protective services, such as the ability to respond to critical situations and emergencies; certain health promotion services; and certain access services.

Assurance of Population-based Health Services: The following examples include community health protection, community health promotion and education, services to improve access to care, and adequate food/urgent housing for vulnerable populations.

•**Community health protection:** Environmental measures that protect large population groups in communities or worksites. Those which are inherently regulatory are government public health functions that cannot be delegated. Non-regulatory health protection measures may be assured in various ways. Community health protection includes environmental health protection, as well as occupational safety and health. The following are examples of community health protection services:

- Maintenance of emergency response capacity for disease outbreaks/communicable disease control; toxic spills; product recalls; maintenance and planning of emergency medical response systems.
- Maintenance of administrative capacity through: providing the services; purchasing or subsidizing the services; or otherwise encouraging others to provide the services. Necessary administrative capacities include personnel, contracting, budgeting, accounting, and legal counsel and representation.
- Population-based health protection services which require exercise of government regulatory powers: drug safety; water quality; air quality; food sanitation; waste management (sewage, solid, toxic); radiation protection; agricultural commodities safety; occupational health and safety standards enforcement.
- Environmental health protection examples: radon screening and modification of housing structures to reduce exposure; lead screening and abatement; industrial investments (whether required by regulation or not) to reduce toxic emissions or clean up hazardous wastes; rabies immunization for target animal populations to reduce risk of human infection; chlorination of water supplies.
- Occupational safety and health examples: establishing and using worksite safety and health programs; substitution of methods or equipment which reduce injury potential or workers' exposure to toxic substances.

•**Community health promotion and education:** A wide variety of services and organizing efforts aimed at enabling people to increase control over (and thus improve) their health. These can be community mobilization efforts using the influence of many institutions such as schools, churches, workplaces, and community organizations. They also include more narrowly focused school-based or worksite-based health education and health promotion. The following are examples of community health promotion and education:

--Community campaigns to reduce specific health problems, as defined by a community. Health problem areas in which this has been effective include: heart disease and associated risk factors; tobacco use (including reducing access by minors); unintentional injuries; interpersonal violence; teen pregnancies, in communities which have defined this as a health problem; HIV/STD transmission (e.g., through use of safer sex practices); use of illegal drugs; community decisions to fluoridate water supplies.

--School-based health education including such topics as: nutrition; personal health practices/hygiene; prevention of AIDS and other STDs; injury prevention; substance use and abuse; sexuality education; parenting education; skills for making and asserting behavior choices; skills for peer support and combating depression; skills for cost-effective use of personal health services.

--Worksite health promotion: programs which have been evaluated as effective in reducing health risks and/or absenteeism have focused on combinations of: smoking cessation; cardiovascular fitness and recreation; lipid control; diet improvement; stress management; high blood pressure control.

•**Services Which Improve Access to Care:** provided on a population basis, or on an individual basis by certified health plans. Services or service enhancements needed to ensure that individuals, families and communities receive other appropriate health services. These address potential barriers to accessing health services.

--Information and referral; outreach (for example, using culturally "indigenous" health workers); communication, including translation and/or bilingual staff; transportation to services and/or mobile services; case management, including linkages, education for "working the health care system"; facilitating new resources development (providers, facilities).

--Public health nursing services to families of children with special health needs or home visits to families where child abuse prevention and intervention is required.

•**Adequate Food and Urgent Housing for Vulnerable Populations.** Provision or subsidy of food for nutritionally "at risk" populations, as well as the provision of shelter to individuals or families who are at serious health risk due to inadequate housing.

- Women, Infants and Children (WIC) program; school lunch and breakfast programs; home-delivered meals for adults whose functional disabilities and isolation place them at nutritional risk; targeted promotion of breastfeeding; soup kitchens and other community food programs for homeless or low income people.
- Domestic violence shelters; shelter for homeless persons who are "at-risk" for illness or suffering from exposure to the elements; affordable alcohol-/drug-free housing for poor and indigent chemically dependent persons (when essential following treatment).

Assurance of Personal Health Services: The primary way personal health services will be assured is by universal access to a uniform benefits package. It is expected that access to services will be provided by the certified health plans that provide the uniform benefits package. Nevertheless, there will be the need for additional assurance activities.

- Assurance of capacity activities.** Action by the new commission urging certified health plans to expand or develop resources in underserved areas; activities to help recruit or retain health care practitioners.
- Assurance of quality activities.** Health professions licensing and discipline; facility licensing
- Assurance of health services delivery.** The new commission certifying and monitoring the performance of certified health plans, which have a responsibility to actually deliver the services in the uniform benefits package; advocating for service delivery from certified health plans, local provider groups, and/or the state board/commission; local health departments actually delivering personal health services during periods of transition or when other delivery systems do not exist.¹²

¹² In addition to this assurance function, some local public health agencies may choose to become personal health service providers under the same ground rules that apply to any other provider in a certified health plan.

Draft Recommendations

September 2, 1992

ubp chart

Draft Recommendations

September 2, 1992

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Draft Recommendations

September 2, 1992

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Draft Recommendations

September 2, 1992

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Chapter 3

FINANCE AND PAYMENT SYSTEM

Introduction

This chapter describes the Commission's draft 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.

The Commission's recommended finance and payment system models (presented in Figures 1 and 2 below) include the following major features and strategies for health system reform:

- Universal coverage for the uniform benefits package;
- Individual choice among competing health plans;
- Price competition among competing health plans within a maximum premium;
- Uniform rules set by a permanent and independent state board or 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.

A major unresolved issue is whether the reformed system should continue to have employers act as sponsors of health benefits for their employees. The Commission is offering an "employer-based, multiple sponsor" option and a "residence-based, single sponsor" option for public comment.

The Commission believes government, employers, and individuals should equitably share the burden of financing the health system in order to minimize disruptive cost shifting and ensure the long-term financial viability of the system. The draft recommendations would 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. The employer contribution would be limited to the price of the lowest priced plan(s) to promote cost-conscious choices by employees. The Commission has not yet recommended whether employers should help finance coverage for dependents. Employers' financial responsibility should be limited to a percentage of payroll.

Individual and employer financial responsibilities should be limited to minimize adverse effects. Government should provide financial support when employer and individual financial means are insufficient, and should be the primary financier of coverage for the low-income unemployed.

This chapter 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 (including the uniform benefits package), setting maximum premiums, setting rules for fair competition among certified health plans, determining individual and sponsor financial participation, addressing access barriers, and monitoring system performance.

Recommendation 3.1 -- Sponsoring the Uniform Benefits Package

The Commission recommends a finance and payment system model that includes universal coverage for a uniform benefits package; competing health plans; price competition among plans within maximum premiums; uniform rules set by a new state board/commission; financing shared fairly by individuals, employers, and governments; and innovative relationships among certified health plans and service providers. The Commission is considering two options within this recommended model: an employer-based, multiple sponsor option, and a residence-based, single sponsor option.

DISCUSSION

"Sponsorship" is an unresolved element of the Commission's recommended finance and payment system. 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 issue is whether employers should continue to manage health benefits for their employees -- a **multiple sponsor system** (Figure 1) -- or whether a single entity should sponsor benefits for all state residents -- a **single sponsor system** (Figure 2). The Commission strongly believes that a mandated structure -- either through required participation of all employers or through shared financing of a single sponsor -- is necessary to assure universal coverage and equitable, stable financing.

Option 1: Multiple Sponsor System (Figure 1)

Under Option 1, employers could still sponsor benefits for their employees or be required to finance their employees' health coverage through a public sponsor. Consistent with universal access, uniform administrative rules, and the uniform benefits package, public and private sponsors would select cost-effective and high quality plans from which their beneficiaries would chose. The major features of Option 1 include:

- Employers or other purchasers could chose to sponsor the uniform benefits package for their beneficiaries. They would offer choices from among the certified health plans available in their area(s). Alternatively, employers could choose to pay a public sponsor to provide the uniform benefits package to their employees. In either case, employers would be allowed to provide or offer supplemental benefits.
- The state would create a sponsoring entity¹³ through which all publicly sponsored individuals (beneficiaries of public programs, including those now uninsured) must be covered. Individuals, employers, or other groups would be allowed to purchase benefits through this entity. 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 to ensure access, quality, and control costs.
- The state board/commission would seek an ERISA waiver so that other sponsors (self funded employee benefit plans) 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 board/commission would be required to implement plans for a single state sponsor for all state residents.
- The state board would be required to evaluate the system's performance and make any proposals for further reforms by a date certain.

Option 2: Single Sponsor System (Figure 2)

Under Option 2, 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 2 include:

- The state would create a sponsoring entity as in Option 1.
- The state would require all state residents be covered by the sponsoring entity by a date certain.
- The state board/commission would be required to develop and implement a phase out plan for employers that sponsor benefits.
- The state board/commission would be required to perform an evaluation and make any proposals for further reforms by a date certain, as in Option 1.

¹³ "Sponsoring entity" could mean a consolidation of existing public programs into a single state agency or close coordination among separate agencies. See Chapter 9 for specific policies to guide the creation of this public sponsor.

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 residence-based, single sponsor system will be less complex and costly to administer, as well as more likely to ensure uninterrupted coverage for all state residents. The Commission seeks public comment on these two sponsorship options within the context of the other features of the recommended finance and payment system model.

Recommendation 3.2 -- 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. The individual's share of the premium should be defined in relation to the price of the lowest priced plan or plans available to stimulate their cost-conscious choices of health plans.

DISCUSSION

Employees, including seasonal and part-time workers, should be responsible for paying a portion of the premium defined in relation to the lowest priced certified health plan(s) available. As discussed under Recommendation 3.5, this method of premium sharing is meant to encourage cost-conscious choices by individuals and price competition among certified health plans. Under an employer-based, multiple sponsor system (see Recommendation 3.1) unemployed, non-poor individuals (defined by a sliding scale) should pay all of the premium, unless otherwise sponsored.

The Commission believes that individual point-of-service cost sharing -- copayments, coinsurance, and deductibles¹⁴ -- is an important way to sensitize people to the costs of services. The two alternative benefits package designs (see Chapter 2) each 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:

¹⁴ "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).

- 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 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.

Recommendation 3.3 -- Individual Mandate

Within the context of the Commission's draft recommendations on universal coverage and cost control, all individuals should be required to enroll themselves and their dependents in certified health plans.

DISCUSSION

In order to assure that individuals are able to comply with this mandate, the state board/commission should facilitate enrollment through education and outreach. The board/commission should also establish criteria for and monitor enrollment processes of employers, certified plans, and state agencies 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 board/commission should therefore also establish an uncompensated care pool, grants, or other mechanisms to pay providers who provide health services to uninsured individuals.

Recommendation 3.4 -- Employer Financial Responsibilities

Employers should be responsible for paying a portion of the premium defined in relation to the lowest priced certified health plan(s) available for all employees, including part-time and seasonal workers. The employer's financial responsibility should be limited to some percentage of payroll in order to lessen harmful economic effects. The Commission is considering three options for the employer's responsibility for financing coverage for dependents.

DISCUSSION

The Commission's health system financing and payment model -- in either single or multiple sponsor scenarios -- mandates that all businesses help to finance uniform benefits coverage for at least their employees. Because the Commission is concerned about the cost to employers, it has

not yet decided to what extent they should finance coverage for dependents. The Commission is considering three policy options:

Option 1:Employers should not be responsible for financing coverage of dependents.

Option 2:Employers should be responsible for the same level of financing coverage of dependents as they are for employees.

Option 3:Employers should be responsible for financing coverage of dependents, but at a lower contribution level than for employees.

Recommendation 3.5 -- Responsibilities and Authorities

To be successful, the Commission's recommended 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. The Commission recommends creating a new state board or commission with the responsibility and authority to define and revise the uniform set of health services (including the uniform benefits package), set maximum premiums, set rules for fair competition among health plans, determine individual and sponsor financial participation, ensure the certification of health plans, address access barriers, 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 guide implementation of these strategies, a new state board/commission should have the following "responsibilities and authorities" (see Chapter 4 for a discussion of the structure and composition of the recommended board/commission):

- Define and update the uniform set of health services (including the uniform benefits package)**

The new state board/commission should create a process -- including experts, industry stakeholders, and the public -- to define and update the uniform set and package. The process should be used to decide whether new technologies should be incorporated in and financed through the package. The process should also consider incorporating practice parameters, as appropriate (see "Recommendation 3.6 -- Practice Parameters," below).

- Determine maximum premiums and set price competition rules for the uniform benefits package**

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 has concluded that an important way to change the incentives is to cap the premiums charged by certified health plans for the uniform benefits package. The new state board/commission should have this authority as a way to control how fast premiums increase each year.

Some Commissioners believe that price competition among health plans is more likely to create incentives for efficiency and innovation. They suggest that the state board/commission set rules limiting the sponsor's share of the premium to the cost of the lowest priced plan or plans. Individuals could choose higher priced plans, but they would have to pay the extra costs (there would be limits on premium costs for those with lower incomes). This approach would encourage plans to lower their prices and consumers to be more cost conscious when selecting a plan.

The Commission recommends the state board/commission employ maximum premiums *and* rules to promote price competition in order to control costs.

•Determine individual and sponsor financial participation

The state board/commission should set rules to limit sponsor premium contributions in relation to the price of the lowest priced plan(s). The rules should require that individuals be responsible for premium costs above this sponsor contribution. The board/commission should also incorporate appropriate levels of point-of-service costs in the uniform benefits package. The board/commission should set sliding scales to ensure that individual cost-sharing is not a barrier to obtaining appropriate and effective health services.

•Determine provider payment *methods* and, in certain limited circumstances, determine provider payment *levels*

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

•Determine billing and claims policy and procedures, as well as utilization management policy

The state board/commission should set uniform policies and procedures for billing and claims, as well as uniform policies to guide utilization management strategies in order to streamline health system administration.

•Equitably distribute the financial effects of medical risks

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.

In order to promote equitable distribution of the financial effects of medical risks, the board/commission should require the use of age and sex adjusted community-rated premiums, prohibit pre-existing condition exclusions, require open enrollment periods, regulate plan marketing practices, monitor quality of and access to health plan services, and consider the special needs of small communities and small or new health plans. In order to provide a mechanism for plans to distribute the financial risks of adverse selection, the state should sponsor a voluntary stop loss insurance or reinsurance pool program funded by the plans themselves (see "Recommendation 3.7 -- Medical Risk Distribution," below). Another method of distributing medical risk would be the single sponsor option described under Recommendation 3.1. Under this option, the single sponsor could control all funds for the uniform benefits package and could pay premiums to health plans in a way that would fairly distribute the financial effects of medical risks.

•Control use of medical technologies¹⁵

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. The Commission recommends four additional strategies to ensure the use of medical technology supports an efficient, innovative health system that improves the health of Washington residents.

The state board/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 (see "Recommendation 3.8 -- Medical Technology," below).

•Ensure that health plans are certified

The state board/commission should oversee a certification process(es) that ensures health plans comply with the uniform rules that promote fair competition, cost control, uniform benefits, quality, and access. The process(es) should address consumer protection and quality, health plan financial viability, and fair competition. The state board/commission (or other appropriate agency) should have civil enforcement tools that allow for graduated remedies and sanctions. The board/commission should ensure these functions are carried out with a minimum of duplication and overlap among responsible agencies (see "Recommendation 3.9 -- Health Plan Certification," below).

•Restrict provider conflicts of interest

The state board/commission should, as appropriate, prohibit or restrict provider investments that constitute a conflict of interest.

•Monitor health system performance

¹⁵ "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 state board/commission should continuously monitor health system costs, quality, and access. The board/commission should also ensure that an independent evaluation(s) of health system reform is performed.

•Develop and implement strategies to overcome non-insurance access barriers

The state board/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 board/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 1 for the Commission's draft recommendations on non-insurance access barriers).

Recommendation 3.6 -- Practice Parameters

The Commission recommends that the new state board/commission work with health professionals, professional training programs, health plans, consumer groups, and others to facilitate the development, dissemination, and use of practice parameters. The board/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 board/commission's process for evaluating and updating the uniform benefits package should consider incorporating practice parameters, as appropriate. The board/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."¹⁶ Most discussions of clinical guidelines recognize that they must incorporate the best scientific evidence and expert opinion.

¹⁶ Institute of Medicine, Division of Health Care Services, "Guidelines for Clinical Practice: From Development to Use," National Academy Press, 1992 (manuscript copy).

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.

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.¹⁷ 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

¹⁷ 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.

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."¹⁸ 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.

Recommendation 3.7 -- Medical Risk Distribution

The Commission recommends that the reformed health system include the following rules and mechanisms for equitably distributing the financial effects of medical risks among certified health plans (some of these strategies are also recommended separately):

- **In order to ensure residents can enroll in the certified health plan of their choice, regardless of health status, the state board/commission should:**
 - Define a uniform benefits package;**
 - Require certified health plans to comply with community rating rules, allowing for adjustments to reflect differences in age, sex, and other easily measurable demographic variables, (adjustments for differences in health status should be used if appropriate, practical, and cost effective); and**
 - Implement a mandatory system for collecting data from certified health plans 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 board/commission should determine whether separate policies concerning medical risk distribution are needed for small communities, small plans, or new plans.**
- **The state should sponsor a voluntary "stop-loss" insurance or reinsurance pool program to be funded by the plans themselves.**

¹⁸ op. cit., Institute of Medicine.

- 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.**

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 certified 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. To focus competition on these important goals, plans must be assured they will compete on a level playing field. To accomplish this objective, the above rules and mechanisms for equitably distributing the financial effects of medical risks among health plans should be adopted.

Recommendation 3.8 -- Medical Technology

"Medical technology" means the drugs, devices, and medical or surgical procedures used in the delivery of health services, and the organizational 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 both diagnostic and therapeutic purposes.

In order to ensure the use of medical technology supports an efficient, innovative health system that improves the health of Washington residents, the new state board/commission should:

- Advise the State Legislature regarding the number and type of health care professionals needed for an efficient, effective health system.**
- Encourage selective contracting by certified health plans or groups of plans for services likely to experience improved quality outcomes or lower costs if performed in high volume (including, if necessary, strategies to overcome antitrust barriers).**
- Regulate payment levels under certain limited circumstances:**
 - Where a monopoly exists, no market price competition for a specific technology exists, and access is negatively affected; and**

- When necessary to assure access to the uniform benefits package (for example, payment to providers in rural communities who are not operating under a certified health plan).**
- Require providers to report significant capital expenditures and to collect data necessary to monitor system capacity.**
- Have the *reserve power* to regulate capital expenditures to ensure efficient health system capacity through the following process:**
 - The state board/commission would monitor and document growth in total health system and capital expenditures.**
 - If growth exceeds acceptable limits or targets, the board/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.**
 - The board/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.**

DISCUSSION

The Commission recognizes that medical technology often drives up health care expenditures. The incentives within the current health system favor the development, adoption, and use of technologies regardless of cost or health benefit. The Commission has previously made the following policy recommendations that will likely dampen the cost-increasing effects of medical technology:

- Health plan price competition and maximum premiums will limit total funds available for technology;
- The uniform benefits package provides a vehicle for defining which technologies will be paid for through insurance, based on criteria of appropriateness and effectiveness;
- Utilization management policies may provide incentives for or encourage appropriate use of technology; and
- Encouraging prospective payment methods that shift financial risk to providers creates incentives for efficient use of technology.

Given the powerful incentives encouraging the development and use of medical technologies, the Commission believes the additional strategies recommended above are very important.

Recommendation 3.9 -- Health Plan Certification

The Commission recommends that the state board/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 draft 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 board/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 board/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 board/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 board/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 board/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, existing laws and regulations administered by the Insurance Commissioner and the Department of Health), unless the state board/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 board/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 survey

•Plan Development

Through the certification process(es), the state board/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 3.10 -- Clinical and Health-Related Research

The Commission believes that recommendations regarding clinical and health-related research should promote (or at least compliment and not detract from) health system and public policy goals. Therefore, the Commission recommends the following:

- Levels of support for clinical and health-related research should be explicit and within the overall spending limits established for the health system. The state's spending limits should not prohibit institutions from going outside the state for additional funding.
- 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.
- Criteria to prioritize 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.
- Clinical and health-related research should focus on developing ways to achieve cost-effective care and better outcomes, rather than more and more expensive care.
- The new state board/commission should help determine how clinical and health-related research would be financed in Washington.
- The new state board/commission should encourage and participate in a process for making decisions about coverage for disputed treatments.

•In support of the issues discussed above, 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 critical ability to 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. The Commission recognizes this important need and has included clinical and health-related research in the uniform set of health services, within the category of "health system support." 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. The guidelines recommended above should be used for that process.

Draft Recommendations

September 2, 1992

chart

Draft Recommendations

September 2, 1992

chart

Chapter 4

GOVERNANCE

Introduction

After agreeing on the responsibilities and authorities necessary to control costs and help ensure universal access (see Chapter 3), the Commission reaffirms the need for a central authority to carry them out statewide. The Commission continues to believe that the multifaceted nature of our health system provides strong incentives for each stakeholder to further its own interests, minimizing its own financial burdens in part by avoiding risks and shifting costs to others. The Commission has concluded that these shortcomings require some central authority to guide the health system in the public interest. This central, public authority should be in the form of a state board or commission. Chapter 4 includes draft recommendations for the state board/commission's structure and membership, stakeholder participation, and Service Effectiveness Advisory Committee.

In developing recommendations regarding the membership and structure of the new board/commission and stakeholder participation, the Commission carefully considered numerous issues. These issues included: (1) the optimal number of members on the board/commission; (2) whether the board/commission members should be full or part-time; (3) whether members of the board/commission should be allowed to have any financial interest in the health system; (4) how public involvement in the board/commission could be ensured; and (5) how the board/commission should be staffed.

Each issue was evaluated in relation to the following goals: (1) effective and efficient functioning of the board/commission; (2) the ability to carry out the recommended responsibilities and authorities in an unbiased and balanced manner; and (3) the ability to attract the most qualified individuals to serve on the board/commission. The Commission recognizes the controversy that has surrounded these issues in the past, and is especially interested in receiving public comment on its recommendations in this area.

Recommendation 4.1 -- Structure and Membership

A new state board/commission should be established by the State Legislature to carry out the responsibilities and authorities included in these draft recommendations. The independent board/commission should have five full-time members who have no current financial interest in any health service activity regulated by the board/commission.

DISCUSSION

In making this recommendation, the Commission evaluated existing and proposed board/commission models in Washington and elsewhere, including the Washington State Employees Benefits Board, the Minnesota Health Care Commission, the Vermont Health Care Authority Board, the National Board on Health Care Quality, Japanese advisory councils, and the German Concerted Action Committee. This evaluation led the Commission to consider several alternative structures for the state board/commission.

One alternative strongly considered was a seven member board/commission, with a full-time chair and six part-time members. Five of the members, including the chair, could have no financial interest in any health services activity regulated by the new board/commission. The remaining two members would be health services providers or insurers. Another alternative proposed that the board/commission be composed of equal numbers of health care purchasers, health care providers, and consumers. Other commissioners proposed that, rather than creating a new board/commission, existing state agencies be modified as necessary to carry out the responsibilities and authorities included in these draft recommendations.

The Commission considered valid arguments in favor of and against each of these alternatives. For example, some commissioners oppose a full-time board/commission because of their concern that it would "micro-manage" the health system. Other commissioners believe that it would be very difficult to recruit the most qualified individuals to serve on a part-time board/commission, especially if those individuals were prohibited from having any financial interest in the health system during their term. Some Commissioners contend that stakeholders (individuals with a financial interest in the health services system) must be represented on the board/commission. Others feel that individuals or entities regulated by the board/commission should not be represented on it.

The Commission concluded that five, full-time board/commission members should be appointed to staggered terms by the Governor, subject to confirmation by the State Senate. To attract the most qualified individuals to serve as members, the Commission recommends they be compensated at a level comparable to the private sector. This recommendation is modeled, in part, upon the structure of the Federal Reserve Board.

The Commission recommends that the state board/commission guide health system reform by exercising the responsibilities and authorities summarized below and explained in detail in Chapter 3. While the responsibility to guide and govern clearly rests with the new board/commission, it should enlist and coordinate existing state agencies and private resources to achieve efficient administration and minimize overlapping authority and duplication of effort.

The state board/commission should have the following major responsibilities and authorities recommended in Chapter 3:

- Define and update the uniform set of health services (including the uniform benefits package);

- Determine the maximum premium for the uniform benefits package;
- Determine how much individuals and sponsors should pay for the package;
- Determine provider payment *methods*, and in certain limited circumstances, payment *levels*;
- Determine billing and claims policy and procedures, and utilization management policy;
- Equitably distribute the financial effects of medical risks for certified health plans;
- Control the use of medical technologies, including capital investment if necessary;
- Restrict provider conflicts of interest;
- Assure that health plans are certified;
- Monitor health system performance; and
- Develop and implement strategies to overcome access barriers.

Recommendation 4.2 -- Stakeholder Participation

The new state board/commission must appoint a standing technical advisory committee with balanced representation of the various stakeholders. The board/commission should also have the authority to appoint ad hoc technical advisory task forces to provide advice on specific issues.

DISCUSSION

The Commission recognizes the importance of providing a formal mechanism for stakeholder participation in the new board/commission's activities. For this reason, the Commission recommends the new board/commission be required to appoint a standing technical advisory committee, with balanced representation from various stakeholders. This advisory committee is essential for two reasons. First, the committee will be a valuable source of technical expertise for the new board/commission. Second, to the extent these stakeholders have participated effectively in the process of reforming the health system, they may be more likely to work toward improving it.

Recommendation 4.3 -- Service Effectiveness Advisory Committee

A "Service Effectiveness Advisory Committee" should be formed to provide technical guidance to the state board/commission. The advisory committee would be composed of 10 to 15 technical experts (such as general practitioners, specialty physicians, health service

researchers, health ethicists, epidemiologists, and other public health experts) who reflect the state's ethnic and cultural diversity. The advisory committee would perform several functions, such as assessing the effectiveness of the uniform set and package based on the health status of the population.

DISCUSSION

The Commission recommends that all Washington residents be guaranteed access to a uniform set of health services, including a uniform benefits package. The Commission has developed an *initial* uniform set and package to serve as the foundation for the uniform set and package to be implemented in a reformed health system. Formulation, implementation, and periodic changes to the actual uniform set and package will need to occur once health reform legislation is enacted. These responsibilities will be carried out by the state board/commission recommended above.

The new board/commission will have to balance the same competing priorities the Commission has wrestled with in developing the initial uniform set and package:

- (1) How to make the set and package *affordable* for individuals and society; and
- (2) How to make the set and package *comprehensive*, providing universal access to disease and injury prevention, health promotion, and diagnosis and treatment of diseases, injuries, and disabling conditions that impair a person's capacity to work and/or carry out the general functions of daily life.

To fulfill these responsibilities, the state board/commission will need technical and scientific information, analysis, and expertise to assess which services are appropriate and effective, including new and emerging services or technologies; add or delete services from the uniform set and/or package; and perform other service analyses as appropriate.

Specifically, the Service Effectiveness Advisory Committee should perform the following functions:

- Assess the effectiveness of the uniform set and package, based on the health status of the overall population or special populations;
- Suggest revisions to the set and package -- specific services to add to the set or package (including new and emerging technologies) or specific services to drop from the set or package;
- Suggest service limitations, if any, based on considerations of effectiveness, including relative cost-effectiveness;
- Assess whether services are effective, and in what situations appropriate, regardless of whether they are covered for all state residents;

- Disseminate information on appropriate and effective health services;
- Assist the state board/commission in performing special studies pertaining to health services (for example, how to incorporate comprehensive long term care into the set or package); and
- Where possible, suggest guidelines or parameters for appropriate and effective use of services.

The Service Effectiveness Advisory Committee should be chaired by a member of the new board/commission and staffed by the board/commission. The advisory committee membership should have the following attributes:

- Understanding of public goals regarding the use of information on service effectiveness and appropriateness;
- Sensitivity to public values and diverse cultures;
- Ability to evaluate research on health service effectiveness;
- Ability to remain impartial in disputes among professions;
- Ability to maintain credibility with the purchasers, providers, insurers, consumers, and government officials;
- Ability and willingness to balance research findings with professional judgment in areas where formal research findings alone are not adequate;
- Ability to consider objectively the full range of health services and to use outside expertise regarding them; and
- Special abilities in applying the disciplines of logic and ethics to the analyses.

The Service Effectiveness Advisory Committee should be able to assess personal and population-based health services, based on national and state research literature, data, and evaluations of service efficacy. Insurance and population-based data bases should be used as recommended in Chapter 6.

The technical experts on the Service Effectiveness Advisory Committee would often need to weigh conflicting information in performing their analyses and developing their proposals to the new board/commission. The advisory committee should be objective and impartial, providing independent, scientifically-based guidance to the new board/commission. The advisory committee should encourage health plans, medical associations, and other organizations to use the findings on service effectiveness and participate in the committee's process.

Chapter 5

COSTS OF HEALTH SYSTEM REFORM

Introduction

Forecasting the total costs of health system reform requires the Commission to make several difficult policy judgments:

- How much and how fast can the rate of growth in health system costs be reduced as a result of the Commission's draft recommendations?
- How quickly can affordable universal coverage be achieved?
- What will be the net cost of providing coverage to people who are now uninsured, taking into account the costs of a comprehensive uniform benefits package, current "uncompensated" care expenditures, the number of people with inadequate coverage, the effects of system efficiencies, and additional demand stimulated by universal coverage?

This chapter presents forecasts of health system costs, based on the Commission's draft recommendations for health system reform. The draft recommendations set, as a goal, a reduction of per capita spending increases from the current ten percent per year to five percent per year by the end of the century. The Commission also recommends a five year phase-in of universal coverage and enhanced public health funding, estimates a range of costs to cover people who are now uninsured of \$115 to \$154 per person per month,¹⁹ and identifies several potential sources of additional revenues, if needed.

Recommendation 5.1 -- Per Capita Spending Growth

Health system reform should reduce per capita spending growth from the current ten percent per year to five percent per year by the seventh year of reform implementation (the year 2000, if reform begins in 1994).

¹⁹ These estimates of the cost of covering people who are now uninsured take into account the proposed uniform benefits package premium and enhanced coverage for the under-insured, increased system efficiencies over time, and the price effects of decreased cost-shifting over time.

DISCUSSION

The Commission recommends reforms of the health system that are designed to promote price competition among health plans, cost-conscious choices by consumers, administrative efficiency, and more appropriate and effective provision of health services. This reformed system would be governed by a new state board/commission that would ensure costs would be controlled, in part by establishing maximum premiums for a uniform benefits package. The Commission projects the cumulative effect of these and other recommendations for health system reform will reduce the rate of spending growth from the current ten percent per person per year to five percent per person per year by the seventh year of reform implementation. (See Table 1, Line G.)

This goal reflects the Commission's recommended policy that health system spending should grow no faster than the per capita gross state product,²⁰ so that health services would no longer take a growing share of the wealth of the state. To attain a five percent annual per capita growth rate requires eliminating most of the increases in health spending potentially under the control of the health system, but not those caused by general inflation (the Consumer Price Index) and by the aging of the population.²¹ The Commission believes that its draft recommendations will not only reduce the health care inflation rate, but will also help to eliminate unnecessary services now being provided, paid for, and used.

Recommendation 5.2 -- Phased Universal Coverage

Providing coverage for the uniform benefits package for people who are now uninsured should be phased in over a five-year period. This means that by the fifth year of health system reform, 98 percent of all state residents should be covered (there will always be a relatively small number of people who are not enrolled in a certified health plan).

DISCUSSION

The Commission recommends that coverage of the uninsured for the uniform benefits package should be phased in over five years. (See Table 1, Lines E and F.) Ten percent of the uninsured (about 60,000 people) should be covered in the first year of implementation, reaching coverage of 98 percent of the state's residents by the fifth year.

Recommendation 5.3 -- Cost of Insuring the Uninsured

²⁰ The "gross state product" measures all goods and services produced in the state, and its growth each year includes inflation.

²¹ According to U.S. Health Care Financing Administration data, about half of the annual health care spending increases are due to factors that would be directly affected by the Commission's recommendations, medical prices, new technologies, and service use rates. The other half is due to general inflation and population changes.

The net cost of providing uniform benefits coverage to people who are now uninsured should be in the range of \$115 to \$154 per person per month.

DISCUSSION

The Commission recommends a conservative estimate of the net cost of covering people who are now uninsured will be \$115 to \$154 per person per month in 1992 dollars. This range reflects a number of factors: the cost of uniform benefits coverage of about \$140 per person per month;²² enhanced coverage for the under-insured; increased system efficiencies over time; and the price effects of decreased cost shifting over time.

Recommendation 5.4 -- Public Health Funding Enhancement

Funding for public health programs should be increased from the estimated current level of \$3.89 per resident per month to \$8.68 per resident per month by the fifth year of reform implementation.

DISCUSSION

For some areas of the state, public health agencies do not have sufficient resources to carry out the basic activities necessary to protect their communities' health, such as monitoring health hazards and illness trends, and assuring that needed services are in place. To ensure these core functions are performed throughout the state, the Commission recommends that public health funding be increased from the estimated current level of \$3.89 per resident per month to \$8.68 per resident per month (in 1992 dollars). The Commission recommends a five-year phase-in of this enhancement.

(See Table 1, Line H.) The estimates are based on an annual inflation factor of 3.6 percent from 1992 through 2000 and a steady rate of enhanced financing of 17.5 percent per year from 1994 through 1998. (See Chapter 2 for a discussion of the recommended public health enhancement.)

Recommendation 5.5 -- Additional Revenue Sources

If additional revenues are needed to implement health system reform, the State Legislature should consider Basic Health Plan and Medicaid expansions, as well as cigarette/alcohol taxes, payroll taxes, and/or taxes on services and providers.

²² The estimated \$140 per person per month includes approximate cost-sharing paid by an average state resident, excluding anyone with Medicare or Medicaid eligibility.

DISCUSSION

If additional revenues are needed to fund a reformed health system (as is indicated by the forecasts presented in Table 1), the state should consider the following strategies:

- Allow employers, employees, and other non-subsidized individuals to purchase coverage through the Basic Health Plan (the premiums paid by these newly insured people would constitute "new" revenue for attaining universal coverage);
- Maximize federal matching funds for Medicaid coverage, especially for expanded eligibility of the medically needy; and
- Increase taxes on cigarettes and alcohol ("sin" taxes), tax services, tax health service providers, and/or institute a payroll tax.

If the State Legislature decides to consider additional tax revenues to fund health system reform, the Commission believes certain principles will be helpful in assessing the merits of various tax options. Before listing the principles, it is well to keep in mind two basic concepts which explain how various taxes are intended to apply. One is the *ability-to-pay concept* by which the impact of a tax is related to a taxpayer's income. The other is the *benefit concept* which considers whether the taxpayer uses the services funded by the tax.

The following are the major tax principles to be considered in evaluating whether and which taxes should be enacted:

- **Progressivity.** One of the key components of the concept of tax equity, or fairness, is a progressive relationship between taxpayers' income (a proxy for ability-to-pay) and their tax liability.
- **Stability.** Revenue collections should not fluctuate dramatically, and receipts should be relatively easy to forecast.
- **Neutrality/Economic Growth.** The tax system should not influence business decisions or favor certain activities at the expense of others. For individuals, the concept of neutrality implies that taxes should not be used to influence personal behavior.
- **Productivity.** This principle refers simply to the potential of a tax to raise revenue, that is, are the revenue collections sufficient to justify imposition of the tax? Further, do the collections keep pace with the economy and the demands for funding of state programs?
- **Cost of Administration.** For the State Legislature and the administering agency, the cost to administer a tax is an important consideration.

- Taxpayers' Cost of Compliance.** For individual and business taxpayers, the cost of complying with tax reporting requirements should be considered.
- Flexibility.** Optimally, the tax system will permit the State Legislature to respond to changing economic conditions and the need for different expenditure levels.
- Broad-based System.** Theoretically, the tax system should cover as many sources as possible and the rates should be commensurately low. This helps assure that all individuals, all business activities, and all sectors of the economy will have some tax liability, so they will contribute toward financing the governmental services the state provides.
- Minimal Tax Exemptions.** Consistent with a broad-based tax system, preferential tax treatment should be minimized.

The revenue options presented below are examples of tax packages that could generate \$150 million or \$450 million per year. They should be considered as *illustrations* of tax strategies to generate additional revenues, if needed. Generally, these various tax options present a number of political and practical issues:

- Existing taxes in Washington state tend to be regressive rather than progressive. On the other hand, it is much easier to build on existing taxes than to create new ones.
- "Sin" taxes not only generate revenue, but decrease the use of harmful substances. Washington's alcohol and cigarette taxes are already relatively high, however, and increases could induce tax avoidance and evasion behaviors.
- Taxes on providers could be used to promote managed care, but they may simply increase costs to purchasers.
- A payroll tax may be progressive and productive, as well as fairly easy to administer (other payroll taxes already exist), but it could be challenged legally as an income tax that requires a constitutional amendment.
- A sales tax on all or selected services would increase the progressivity of the overall tax system, but this tax would face significant opposition from the State Legislature and the general public.

If additional revenues are needed to fund health system reform, the following options could each raise \$150 million annually (the figures are in millions of dollars for fiscal year 1993):

Option 1: "Sin" Taxes Only

Cigarette tax (increase of 21 cents to 55 cents/pack)	\$ 83.6
Liquor taxes (surtax of 62%)	<u>68.6</u>
TOTAL ANNUAL YIELD	\$152.2

Option 2: "Sin" Taxes/Provider Tax

Cigarette tax (increase of 7 cents to 41 cents/pack)	\$ 28.5
Liquor taxes (surtax of 20.7%)	22.9
New tax on hospitals (1.2% of gross receipts)	28.9
New tax on providers (1.2% of gross receipts)	<u>73.3</u>
TOTAL ANNUAL YIELD	\$153.6

Option 3: "Sin Taxes"/Payroll Tax

Cigarette tax (increase of 7 cents to 41 cents/pack)	\$ 28.5
Liquor taxes (surtax of 20.7%)	22.9
Payroll tax (.242%)	<u>99.8</u>
TOTAL ANNUAL YIELD	\$151.2

If even more revenues are needed to fund health system reform, the following options could each raise about \$450 million annually (the figures are in millions of dollars for fiscal year 1993):

Option 4: "Sin" Taxes/Provider Tax/Payroll Tax

Cigarette tax (increase of 14 cents to 48 cents/pack)	\$ 56.3
Liquor taxes (surtax of 41.4%)	45.8
New tax on hospitals (2.6% of gross receipts)	62.5
New tax on providers (2.6% of gross receipts)	158.9
Payroll tax (.543%)	<u>224.9</u>
TOTAL ANNUAL YIELD	\$447.4

Option 5: "Sin" Taxes/Sales Tax on All Services

Cigarette tax (increase of 14 cents to 48 cents/pack)	\$ 56.3
Liquor taxes (surtax of 41.4%)	45.8
Sales tax on all services (2.95%)	<u>350.0</u>
TOTAL ANNUAL YIELD	\$452.1

Option 6: Sales Tax on *All* Services

Sales tax on all services (3.8%)	<u>\$450.0</u>
TOTAL ANNUAL YIELD	\$450.0

Option 7: Sales Tax on *Selected* Services²³

Sales tax on personal services (6%)	\$347.9
Sales tax on business services (6%)	<u>102.1</u>
TOTAL ANNUAL YIELD	\$450.0

Forecasts of Spending Under Reform

Since 1980, the average amount spent on health services for each Washington resident has been growing ten percent per year. Continuation of this rate of inflation would cause total spending on personal health services in Washington to increase from about \$13 billion this year to about \$31 billion in the year 2000. (See Table 1, Line C.) With per capita income expected to grow only about five percent each year, Washington residents will be forced to spend an ever increasing proportion of their incomes on health services.

Table 1 and Figures 1 and 2 display the forecasts of spending under health system reform, both total and net (that is, the difference between a reformed system and the current system). Figure 2 shows how the net result of reform could require additional funds in the early years, but result in savings in the long run. These forecasts represent the combined effects of the first four policy recommendations noted above: reduced spending growth due to cost control, phased coverage expansion, net costs of expanded coverage, and enhanced public health funding. The forecasts produce the following results:

- If expanded coverage costs \$154 per uninsured person per month in 1992 dollars, the maximum annual net cost of reform will be about \$326 million in the second year of reform. The cumulative, seven-year result of reform would be a \$6 billion saving. "Budget neutrality" (the point at which system reform costs the same as if we did nothing) would be attained in the fourth year.
- If expanded coverage costs \$115 per person per month in 1992 dollars, the maximum annual net cost of reform will be about \$216 million in the second year of reform. The cumulative, seven-year result of reform would be a \$7.9 billion saving. Budget neutrality would be attained in the third year.

²³ The sales tax on selected services would apply to business and personal services (such as consulting, legal, accounting, and janitorial services, as well as cable television and admissions to motion pictures and sports events), but would exclude advertising, financial, and medical services.

After implementation, if the reformed health system does not seem to be meeting the five percent cost growth target, revised and additional policies could be adopted, including a longer phasing of coverage for the uninsured, phasing of the uniform benefits package, and additional incentives to encourage providers and consumers to be even more cost conscious.

Draft Recommendations

September 2, 1992

chart

Chapter 6

DELIVERY SYSTEM

Introduction

To achieve a reformed health system, we will need to build on the strengths of the current delivery system, change some aspects of it, and improve coordination among its component parts. This chapter presents nine recommendations in three major components of the delivery system: delivery system changes, health services personnel, and health information systems.

DELIVERY SYSTEM CHANGES

Recommendation 6.1 -- Definition of "Managed Health Care System"

"Managed health care system" means a system using a defined network of providers who agree to abide by the system's practices, reimbursement levels, and other requirements intended to maximize access to needed health services while providing services cost-effectively.²⁴

DISCUSSION

The definition of "managed health care system" is central to the Commission's overall recommendations. The Commission's recommendations include certification of health plans that would assume responsibility for managing care and assuming financial risk for providing the uniform benefits package. (See Recommendation 3.9 on "Health Plan Certification.") The definition of "managed health care system" is needed to identify the essential characteristics of health plans which could seek to become "certified health plans" under the Commission's recommended finance and payment system. To proceed without any definition risks misinterpretations. For example, some people think only of staff-model health maintenance organizations (HMOs) when they hear "managed health care system," which is a more restricted meaning than the Commission intends. Managed care systems typically place a strong emphasis

²⁴ Health Care Authority, Study of State Purchased Health Care, December, 1990, page 3. The study was mandated by the state legislature as part of the Health Care Reform Act of 1988 (enabling legislation for the Washington Health Care Authority). The study emphasizes the importance of purchasing care within a "system," as contrasted with the purchase of individual units of service, and notes that "managed care systems generally share the financial risk of treating their enrolled population with the purchaser of care".

on primary care, but their detailed arrangements in this regard are diverse. Certified health plans should have the flexibility to use different approaches.

Recommendation 6.2 -- Integration of Services

Delivery systems which integrate primary and preventive care, specialty medical care, long-term care, mental health services, and dental services should be encouraged. However, appropriate specialized service delivery components may exist for an indefinite period, perhaps permanently. Strong mechanisms for referral, coordination, and in some cases contracting, are essential.

DISCUSSION

The Commission recognizes that multiple delivery components exist providing a continuum of health and social services in areas such as mental health, developmental disability services, and long-term care. Some services provided by these components are part of the uniform benefits package while others are considered to be non-insured health services within the scope of the uniform set of health services. Still others lie outside the uniform set of health services entirely. For example, many forms of housing assistance, and many of the employment-related habilitation services provided to adult developmentally disabled individuals are considered social services rather than health services, even though they improve an individual's well-being.

Certified health plans should consider including appropriate and effective health services that may currently be outside their traditional area of responsibility (for example, home health care or case management). Integrating services will require substantial effort and likely raise sensitive, controversial issues such as who is best equipped to deliver health services to people with developmental disabilities -- the State Department of Social and Health Services (DSHS), certified health plans, or both in coordination? Multiple delivery systems may exist for an indefinite period and will need strong mechanisms for referral and coordination to assure that people receive appropriate and effective services from any combination of the systems with a minimum of difficulty. These issues are also discussed in Chapter 9

Case management services will be a critical way to coordinate the identification and delivery of appropriate health services. Case management can occur in many forms, including current distinct case management systems for people who are chronically mentally ill, have developmental disabilities, or need long-term care. The mental health system, the developmental disabilities system, and the long-term care system all organize services primarily under social service models rather than medical models, and all three systems have developed specialized case management capacities. Certified health plans should have the option (at least temporarily) to contract for case management and other services in the package from existing organizations in these systems (whether private or governmental), and health plans should be required to coordinate with them.

Recommendation 6.3 -- Integrating Effective Service Providers

Community and migrant health centers and other established providers of primary and preventive health services for low income and minority populations should be strongly supported through a transition period and carefully integrated with the service networks of certified health plans. Other community-based organizations with a history of effective service delivery, innovation, advocacy, or community mobilization should also be encouraged to play a role in the reformed system.

DISCUSSION

Community and migrant health centers/clinics are key resources for the delivery of primary personal health services to underserved populations. The clinic system should be maintained, strengthened, and carefully integrated with certified health plans so that traditionally underserved populations which have used the clinics can retain their primary point of access into the system if they choose to. The clinic system would also offer important and essential qualities to certified health plans, including cultural competency community outreach, prevention and early intervention, and success in overcoming non-insurance access barriers. Their relationship with or as certified health plans could take several forms.

The state should also use the community clinic system as an important resource for achieving universal access. The clinic system already has established necessary networks to recruit health professionals and to start new programs in underserved areas of Washington. Existing and new clinics could be expanded as effective providers of early intervention and primary care for the broader population, especially in areas where people face access difficulties.

Certified health plans should also be strongly encouraged to contract with other existing providers that have established relationships with their communities. For example, Planned Parenthood has been an important provider of family planning services and should have a place in a reformed health system. This is also true of physicians and other practitioners in traditionally underserved areas, as well as home health care organizations.

Efforts to integrate existing organizations into the reformed health system will need to go beyond the provision of personal health services. Successfully mobilizing voluntary community efforts is a critical component of health promotion and many other population-based services. Community-based organizations with a proven ability to mobilize members of their community around health issues, perform service outreach functions, act as advocates, and help develop community policies should be included in approaches to delivering personal and population-based services to assure their communities' health needs are met.

Recommendation 6.4 -- Role of State and Local Public Health Agencies

State and local public health agencies, acting in partnership, must carry out the core public health functions described in the "uniform set of health services."

- **With some exceptions, public health policy should be developed and owned by citizens in the local community. Local health departments/districts and their boards should collect and interpret local information including the perceptions of local citizens; develop local priorities and plans in partnership with the entire community; and organize the response to priority health needs, including emergency response and assuring the local provision of population-based services.**
- **The State Department of Health should take the lead in statewide health surveillance, data compilation, and comparative analysis; provide technical assistance to local departments; develop or draft statewide objectives, policies, and media messages; respond to statewide health emergencies; enforce statewide laws and quality standards; and participate in health policy development with other appropriate state agencies.**
- **The State Board of Health's role should focus on preparation of the State Health Report (which sets priority health goals for the state and identifies strategies to meet them), as well as identification of statewide access barriers, recommendations for adequate funding of population-based health services, and participation in developing state health policy.**

DISCUSSION:²⁵

The public health system is made up of the State Board of Health, the State Department of Health, and local public health departments and districts. The public health system needs to perform certain governmental public health functions which are essential to an efficient and responsive health system. For example, the public health system must have the capability to respond to health emergencies, the enforcement of regulatory measures to protect personal and environmental health, the ability to assess impact on health status and the measures to ensure the quality of personal and population-based health services. The following identifies specific roles for the state and for local health departments given the three public health functions (assessment, policy development, and assurance) identified in Chapter 2:

²⁵ This section on the roles and responsibilities of the public health system was modified from Core Government Public Health Functions: Report to the Health Services Committee, Washington State Health Care Commission, prepared by the Core Government Public Health Functions Task Force, Second Draft, June 8, 1992.

•**Assessment:** Assessment activities include the assembling of information, analysis, and results of useful findings and reports regarding health status. State and local health departments should collaborate to define essential data elements and collection points for the data, in coordination with health providers, insurers, and others.

In most instances, the State Department of Health should be responsible for establishing and maintaining surveillance systems, collecting and assembling health status and utilization information, and performing analysis. Expertise is needed for comparative analysis and forecasting local, regional, and state trends. The Department also needs the capacity to provide technical assistance to local health departments for local forecasting and interpretation of data. Finally, the Department should provide general leadership on public information related to health issues and generate media messages and state health reports.

The assessment function is also performed by the State Board of Health. This occurs throughout the data collection phase of the State Health Report as the Board reviews and analyzes sentinel health indicators of health status improvement and equity among populations. The Board also identifies statewide access barriers to overcome in order to achieve improved health status.

Local health departments should be responsible for serving as "data collectors" for state or regional assembly of data, and should collect specific health perceptions of local citizens as an important part of local assessment activities. With the assistance of the state, local health departments should provide local interpretations and forecasts of health status and other related information and serve as the repository of such information for the county or counties served. Health departments should provide leadership at the local level in providing information, including highly visible, comprehensible health status reports to the community.

•**Policy Development:** In initiating or developing policy, governmental health agencies should use scientific knowledge, assessment information, and consideration of political, organizational, and community values. With regard to personal health services, public policy development is generally focused on issues of access, new or untreated conditions, and special populations, rather than the specifics of service organization or delivery.

The state should play several roles in policy development. The state should be responsible for assembling a regular state health report, identifying priorities and goals on a statewide basis, and reflecting a series of local community planning efforts. In partnership with local public health agencies, the state should initiate and/or develop draft policies on health issues which require statewide efforts (for example, policies for smoking cessation or air and water quality improvements). These roles should be the primary mission of the Board of Health and the Department of Health. They should participate in health policy development and collaborate with other state agencies where overlapping functions exist. The Board should continue to recommend priority health goals for the state. The Board should also help the

new board/commission integrate the goals into the uniform set of health services by regularly reviewing services and strategies which contribute to achieving the goals.

Except for emergencies and threats to health, breach of local community process, or scientifically defensible interventions, much of public health policy should emerge from the local community. Regional or state policy development efforts ought to occur only with the agreement of the local community that such centralized development is more efficient and effective, and then only with active participation of the local communities. This approach is based on the assumption that the strongest public health policy is developed and owned by citizens in the local community. Local health departments should provide a leadership role in developing local priorities and plans in partnership with the entire community. Local health departments may initiate, develop and draft local ordinances or rules for health-related issues requiring a specific local response.

•**Assurance:** Knowing what services are needed does not guarantee they are provided, therefore official public health agencies need the capacity to assure policies are translated into services, critical needs are responded to, and local priorities are implemented.

The Department of Health needs adequate legal authority, resources, and trained leadership to provide a range of health services, including maintenance of emergency response capacity at the state level, enforcement of standards and laws, and maintenance of quality assurance in the service delivery system. Under the reformed system, the Department and the Board of Health also need to hold local health departments and local boards of health accountable for the performance of essential core public health functions. The state also needs to assist in organizing local and/or regional health departments.

The responsibility for assuring adequate financing mechanisms for public health should be shared by the Board of Health. The Board should participate in determining the per capita amount allocated for population-based health services through review of population health status indicators. The Board should also participate in determining the sources of those funds. In addition, the Board should recommend adequate funding for those services which contribute to each of the priority health goals, as well as goals which contribute to targeted populations within communities.

Local health departments need the capacity to advocate, coordinate, and organize responses to priority health needs in the communities they serve. Local health departments also need the capacity to respond to major regional or local emergencies, enforce regulations, and provide essential outreach functions, including transportation and communication assistance to assure that difficult-to-serve populations have access to the delivery system. When no other resources are available to provide direct services to members of the community, local health departments need the capacity to purchase or directly provide those services identified as priorities. Finally, local health departments and/or other community organizations need the capacity to provide population-based health promotion, health

protection, and preventive services to the community. Such efforts are crucial if costs of the overall system are to be controlled.

Recommendation 6.5 -- Transition

The transition to integrated managed health care systems, provider networks, and redefined public health roles will require cooperation, technical assistance, imaginative administrative approaches such as subcontracting and possibly regionalization, and special efforts to make sure that certified health plans coordinate with other systems and serve all people equitably.

DISCUSSION

The vision of integrated managed care bridging the often separate worlds of medical care, mental health services, developmental disabilities services, dental services, and long-term care is very important, but it is not well developed and is controversial. It is essential for clients and service providers in each of these systems to consider how their services should be integrated or coordinated with the certified health plans. This will require people to reconsider their visions of the specialized service systems they spent years developing and supporting because these visions were often developed with the assumption that the "personal health system" was incapable of operating in a coordinated way. If the Commission's recommendations are successfully implemented such an assumption will need to be reexamined. The vision of core public health functions also requires re-integrating service systems in new ways. Several activities need to occur to facilitate the transition:

- Provide Technical Assistance:** Long-term technical assistance and system support will be necessary to enable existing certified health plans and service providers to reorganize their relationships into more comprehensive care management and financial risk-sharing systems. New financial and contractual links must be developed. Service providers and consumers must be educated to understand the recommended reforms to participate in successfully carrying out the changes.

Technical assistance will be needed to develop the capacity of local health departments to carry out the core public health functions discussed above. Together, the Department of Health and the Board of Health could develop a process for local boards of health to obtain this needed technical assistance.

Assistance also will be necessary to develop new managed care and primary care capacity in parts of the state which lack them. The Commission's recommendations for health plan certification includes encouraging expansion of existing managed health care systems and the creation of new ones. Recommendation 6.6 on health personnel deals with ways to assure an adequate supply, distribution, and training of primary care providers.

- Meet Special Assurance Needs:** Providers and insurers need to have help clarifying their roles in the reformed system. The expectations of certified health plans must be clearly articulated and monitored. The performance expectations for service providers and systems not financed through certified health plans also must be clear and will need to occur as part of the broad assurance responsibilities of the public health system and other governmental agencies. Special attention will be needed to assure referral and coordination of services, equitable access for all population groups (including quality assurance) and formal monitoring of service use and health status for minority populations in relation to the population as a whole.

- Support Regional Organization:** Certain communities may favor regional organizations to pool resources rather than small local organizations. The issue of regionalization of health networks, health departments and boards, and other health-related organizations must be examined and supported wherever and however appropriate.

HEALTH SERVICES PERSONNEL

Recommendation 6.6 -- Health Personnel Resource Plan

A reformed health system is likely to require more and different health practitioners than we have now. The Commission supports the Health Personnel Resource Plan, required every two years by 1991 legislation, as a way to decide how to achieve adequate and appropriate supply, distribution, education, and training of health services personnel and caregivers in Washington. The state legislature should add the new state board/commission recommended in Chapter 4 to the five other statutory participants responsible for creating the Plan.

DISCUSSION

As the Commission developed recommendations for achieving adequate and appropriate supply, distribution, education, and training of health services personnel and caregivers, it relied on the work of the Washington State Health Personnel Resource Plan. The Plan is a joint effort by five Washington State agencies: the Department of Health, the Higher Education Coordinating Board, the Department of Social and Human Services, the Board of Community and Technical Colleges, and the Superintendent of Public Instruction. These five agencies recently completed their July 8, 1992 draft report, "Philosophies, Policies, and Strategies.

The Commission supports the Health Personnel Resource Plan as the state's vehicle for coordinating the assessment of health personnel needs in Washington and recommends the Plan also be used to help guide state efforts to ensure an adequate and appropriate supply and distribution of health personnel. The agencies identified in the Plan should immediately implement the Plan's strategies.

The scope of the 1992 Health Personnel Resource Plan, focusing on primary care providers, is consistent with the goals and objectives of the Commission's recommendations for health system reform. In future years, however, additional work must be supported and performed to address the health personnel resource needs identified in the Plan's mandating legislation. This work should also consider assessing support and training of non-regulated caregivers.

Once the new state board/commission discussed in Chapter 4 is established, the state legislature should mandate in statute that the Health Personnel Resource Plan Statutory Committee include representation from the new board/commission. The form of representation should be left flexible, rather than specifically requiring a commission member to participate. This would be consistent with the range of representatives from the other agencies.

The new board/commission should consider the appropriate strategies identified in the Health Personnel Resource Plan. For example, what types and mix of health professionals do certified health plans need to deliver the uniform benefits package? The new board's/commission's health plan certification process should include actions for certified health plans to take to ensure they have an adequate supply and distribution of providers. Guided by the new board/commission, financing for professional training should influence the training of appropriate types of providers, such as primary care practitioners.

It will be important to link identification of health personnel resource needs with the activities and experience of certified health plans. These plans should regularly participate in the development and implementation of the Health Personnel Resource Plan.

HEALTH INFORMATION SYSTEMS

Recommendation 6.7 -- Principles for Health Data Management

Every aspect of the Commission's work has emphasized the need for data to develop, implement, and monitor health reform, and to enable all participants in the health system to make effective choices. A cooperative approach to sharing data for public and private decision making is necessary. The Commission recommends the following twelve principles for health data management:

- (1)The purpose of collecting data is to improve decision making. Adequate resources must be devoted to analyzing the data available, as well as collecting it.**
- (2)Data must be clearly interpreted and communicated if it is to empower better decision making by the general public. This should be a responsibility of certified health plans, service providers, and public agencies.**
- (3)Duplicative data collection should be avoided. In preference to new data collection, existing data should be used for all relevant purposes if done cost-effectively. Data should be accessible to all legitimate users. Data systems should be linked when**

feasible in preference to duplicative data collection. The new board/commission should use existing data to meet as many of its needs as possible, and when it needs additional data, it should coordinate with other users in the interest of efficiency.

(4)Confidentiality must be maintained about personally identifiable information. Access to such information should be permitted only for the following specified purposes:

- Use by the individual affected;**
- Use by service providers in the course of providing health services (subject to standards of client consent);**
- Use in payment, utilization review, and eligibility or plan membership processes which conform to standards set by the new board/commission;**
- Legally required reporting of births, deaths, communicable diseases, and other information;**
- To carry out or cooperate with epidemiologic investigation of disease outbreaks by state or local public health authorities;**
- For confidential research, when properly authorized by an institutional review board; and**
- In order to establish linkage among data sources necessary to avoid duplicative data collection burden.**

(5)The identities of service providers generally should not be masked in data, since performance measurement is a necessary and legitimate use of data. There will be specific exceptions, for example, the names of practitioners who participate in legally confidential peer review activities.

(6)Data should be managed with integrity regardless of who has "ownership."

(7)Technical methods used to collect, store and retrieve data should be efficient.

(8)Both the direct cost of data collection/data systems, and the burdens associated with providing data, should be considered in relation to benefits.

(9)The Department of Health should retain its role as the state agency with lead responsibility for obtaining, organizing and disseminating health data. This is a major part of the assessment function included in the "uniform set of health services". Some aspects of the Department of Health's role also are described in the portion of Recommendation

6.4 which addresses state and local roles in carrying out the "assessment" function of public health.

(10) Many other existing state agencies have important and specialized roles related to health data. These should continue and be coordinated.

(11) All state agencies with health data should act as "data custodians" rather than "data owners." They should manage their data with attention to all legitimate uses, not solely for the original purposes (often administrative) of the data collection.

(12) All public and private entities which collect or maintain health data should strive to develop a common vision of how they will use technological developments such as automation and electronic data exchange to obtain and share data cost-effectively and with a minimum of duplicative primary data collection.

DISCUSSION

The foregoing twelve principles for data management should serve as the foundation for developing more specific approaches to health data collection, analysis, and information dissemination. These principles are supported by the purposes for data collection, the kinds of data required, and the extent of current public-sector health data collection discussed below.

There are many important purposes for health data collection and use. For example, the broadest purpose is to provide information for decisions by individuals, employers, providers, insurers, communities, and government. Data collection and use is also necessary to plan for and implement reform, as well as to monitor and develop a longitudinal data base to measure the actual impacts of reform on costs, access, service use, equity, service quality, and the health of the population.

Many kinds of data are necessary to carry out the purposes of data collection and use. These include information on personal health services encounters and resulting charges/payments, as well as health status indicators for various populations, from all state residents to demographically distinct groups within a community or within the enrollment of a particular certified health plan. These are just a few of the examples of kinds of data needed. In most of the kinds of data, demographic information (including race and ethnicity) should be available to allow examination of equity issues. Identifying data about individuals and service providers should be collected to facilitate linkage of data from more than one source.

An enormous amount of data is already collected by the public and private sectors, for both public and private uses. Major problems include duplication of data collection, difficulty in usefully aggregating data, and the inaccessibility of privately held data. Duplication in data collection has been cited as a contributing factor in the upward spiral of health system costs. In addition, data from different sources are often not comparable, and often cannot be linked.

Existing public sector data resources are an obvious starting point for evaluating the ability to address the data needs identified above. The Department of Health has a statutory mission to serve as a clearinghouse for health data, and has worked actively since its creation in 1989 to perform this role. Other local, state, and federal agencies have rich data resources, generally related to their specific service missions. A number of agencies in Washington are nationally noted for their achievements in areas related to health data. There are also important private efforts underway in Washington, such as the Foundation for Health Care Quality, working towards similar goals.

Recommendation 6.8 -- Public-Private Partnership

In the area of personal health services, the Commission's work indicates that public sector and private sector decision making require much more comprehensive data than are now available in any one place. The way these data needs are met should take into account the rapid shift toward automated bill-payment and medical records which already is occurring. The Commission supports the vision of a public-private partnership to develop uniform technical standards for such data transmissions, uniform core data requirements to meet both private and public needs, and a "data repository" which would make needed data available to all legitimate users under cost-effective, confidential conditions.

DISCUSSION

Fulfilling the purposes and needs for health data collection and use will require much more comprehensive data on personal health services than is now available. The vision of a public-private partnership is a long-term approach for making personal health services data available. It would capitalize on the automation of personal health services data through a public-private partnership established by statute. This vision builds on the twelve data principles in Recommendation 6.7 and takes into account the proposed Community Health Management Initiative (CHMI) presented to the Commission by representatives of the Health Care Purchasers Association.

This recommendation is called a vision rather than a plan because the Commission has not had the opportunity to consider the many technical and financial issues necessary to form a firm assessment of how Washington should proceed. The Commission's vision includes the following elements:

- Health services "transactions" data concerning patients, providers, services rendered, payers, coverage plans, and claims/payments details will be stored and transmitted electronically. The data collection model must include "service encounters" occurring in managed care organizations, as well as fee-for-service encounters for which a bill needs to be processed.
- There should be uniform technical standards for equipment, transmission of transaction information, and uniform core data requirements, to assure an efficient exchange of data by all parties. Many standards already have been developed or are being developed at the national level, for example by the American National Standards Institute (ANSI).

- Within these technical standards, there should be competing providers of equipment, software, and services such as bill processing.
- Either a single "data repository," or a set of separate data systems which are efficiently linked to simulate a single repository, should be created in Washington. Whatever the technical approach, the "repository" would receive core data elements from transaction and encounter data and aggregate the information in a usable data base. If a single repository is created, data probably would enter it in the form of electronic copies of transmissions occurring to meet administrative needs, supplemented by "data deposits" by health plans that do not use billings (for example, staff-model HMOs).
- The data in the repository should be accessible to all legitimate users. Personal (client) confidentiality must be assured. The identities of providers (for example, physicians and hospitals) should not be masked.
- The content of data and arrangements for access must assure that basic needs for data to achieve public policy goals can be met, such as monitoring the impact of health reform and the health status of the population.
- The capital investments necessary to establish this vision may be financed by a combination of private investment and statutory assessments against providers. An example of private investment would be a private concern which provided "health plan card readers" and computer terminals in practitioners' offices in exchange for transaction fees. An example of a mandatory assessment would be if all providers paid a small percentage of revenues to support the data repository. There is an analogy with the Comprehensive Hospital Abstract Reporting System (CHARS), which is operated under contract to the Department of Health and supported by a statutory assessment of 4/100 of one percent of each hospital's gross operating costs.
- Because of the need for guaranteed data uniformity, the likely efficiency of a single data repository, and the tax-like aspects of provider assessments, a governmental role is essential. It would be consistent with the general principles in Recommendation 6.7 for the governmental link to be established through the Department of Health, possibly with an advisory data board or council, rather than creating a new entity for this purpose.

Recommendation 6.9 -- Other Data Needs

Other methods (beyond a personal health care "data repository") should be pursued to compile and effectively use public health, malpractice, and survey data, and to monitor whether reforms meet the state's goals. The Department of Health, Office of Financial Management, and other public and private entities will need to pursue these data needs:

•Data System for Core Public Health Functions

Discussion: The Commission's recommendation for the uniform set of health services includes the need for an integrated data system to support the assessment process and to link results at the local and state level. This "system" does not mean a single, gigantic computer system, but it does require a complete inventory of relevant data sources and the capacity to integrate information from them. This "system" should draw information from personal health services sources, but will require coordinated use of many other data sources as well.

The Department of Health should continue to work with local health departments, community health service providers, and other stakeholders to develop this capability.

•Modeling the Impacts of Health Reform

Discussion: The process of legislative policy making for health reform, and the detailed implementation planning for adopted reforms, will lead to continuing demands for modeling and estimating the impacts of reform, including total cost, cost to different economic sectors, and identification of the magnitude of remaining access problems and "coverage gaps." The Office of Financial Management should continue its work in this area. A Robert Wood Johnson Foundation grant to Washington will provide financial support for this activity for a period of up to two years starting September 1, 1992.

•Health Care Liability Data System

Discussion: The Commission's recommendations for health care liability reform (see Chapter 7) identify special data needs, many of which are distinct from those discussed above. A focal point for liability data from judicial and liability insurance sources needs to be identified.

•Need for Additional Survey Data

Discussion: Additional survey data will be necessary for several purposes, including to monitor population health status and health risks, to monitor access to services on a population basis, and to estimate impacts of reform on employers. Surveys should be managed in a coordinated fashion, bearing in mind that a single sample survey of households or of businesses can cover many different topics, whether related to health reform or not. Opportunities to "piggy-back" questions on existing surveys should be pursued to minimize cost.

Chapter 7

HEALTH CARE LIABILITY SYSTEM

Introduction

The goal of the Commission is a health care liability system that (1) minimizes the number of consumers injured by substandard health care practices; (2) fairly and promptly resolves malpractice liability disputes, and (3) ensures patients injured as a result of malpractice receive appropriate care and compensation. If this goal can be achieved, significant contributions can be made to controlling health system costs. These contributions include reducing inappropriate "defensive medicine" and lowering health care liability insurance premiums by reducing the transactional costs²⁶ associated with malpractice disputes and reducing the incidence of adverse health outcomes, thereby reducing the number and severity of medical malpractice claims.

In developing its draft recommendations, the Commission focused on two types of strategies -- prevention strategies and process strategies. **Prevention** strategies are intended to improve the quality of health care practices, prevent injuries caused by negligence and support reasonable public expectations of health care practices. They include strategies that improve our ability to discipline substandard health care practitioners; increase the use of quality assurance systems, such as continuous quality improvement, in medical facilities; teach health care practitioners how to avoid bad health outcomes; and educate the public.

Process strategies are intended to (1) improve access to appropriate compensation for persons injured by medical malpractice and (2) improve the efficiency of the systems that identify, adjudicate, and finance risks or outcomes of injuries caused by medical malpractice. They include strategies that provide an opportunity for informal review of claims by experts before a lawsuit is filed, require mediation of malpractice disputes, and more fairly determine and allocate responsibility for paying damages when malpractice has been proven.

²⁶ "Transactional costs" include attorneys' fees and other costs of litigation, as well as any other costs (except damages) associated with a malpractice dispute.

RECOMMENDED PREVENTION STRATEGIES

Recommendation 7.1 -- Expenditures in Excess of Appropriations

Expenditure of funds from the health professions and medical disciplinary accounts in excess of appropriated levels should be authorized when necessary to meet unanticipated demand for investigation of, and disciplinary action against, unsafe or impaired health care practitioners.

DISCUSSION

The Commission recommends that the current legislative practice of appropriating funds biennially from the health professions and medical disciplinary accounts for health professions licensing and disciplinary activities be continued with one modification. The Revised Code of Washington (RCW) 43.70.320 should be amended to authorize the Office of Financial Management to approve the expenditure of funds from the health professions and medical disciplinary accounts in excess of appropriated levels. This could be done upon a showing by the State Department of Health, on behalf of individual health care practitioner licensing and disciplinary boards, that such expenditures are necessary to meet unanticipated public demand for investigation of, and disciplinary action against, unsafe or impaired health care practitioners.

Recommendation 7.2 -- Civil Penalties

The Secretary of Health should be given explicit authority to assess civil penalties against people acting as health care practitioners without a license.

DISCUSSION

The Uniform Disciplinary Act (Chapter 18.130 RCW) authorizes the Secretary of Health to investigate complaints concerning unlicensed health care practitioners. If an investigation results in a finding that someone is acting as a health care practitioner without a license, there are three enforcement remedies available, which are not mutually exclusive. The Secretary of Health can issue a cease and desist order, which must be enforced in Superior Court, or seek a court injunction ordering the individual to stop practicing until a license is secured. In addition, unlicensed practice can be prosecuted criminally as a gross misdemeanor. Each of these enforcement remedies involves the Superior Courts. These activities are funded through the health professions accounts, and currently cost about \$250,000 per biennium.

The Uniform Disciplinary Act does not provide adequate administrative remedies against unlicensed health care practitioners. For this reason, the Commission recommends that Chapter 18.130 RCW be amended to give the Secretary of Health explicit authority to assess civil penalties

against persons acting as health care practitioners without a license. The proceeds of such penalties should accrue to the health professions account, to provide financial support for investigation of, and remedies against, unlicensed health care practitioners.

Recommendation 7.3 -- Quality Assurance Plans

The Department of Health should develop a regulatory system that supports the development and maintenance of quality assurance plans throughout the medical community.

DISCUSSION

The Department of Health has primary regulatory responsibility for quality assurance in health care facilities and services. State licensure requires formal quality assurance plans in the following facilities: acute care hospitals, child birth centers, home care agencies, home health agencies, and hospice agencies. Licensure requirements currently do not mandate formal quality assurance plans in other medical facilities. In addition, ambulatory surgical centers and medical clinics are not licensed in the state of Washington.

The Commission endorses the planned Department of Health process to evaluate whether additional medical facilities, such as ambulatory surgical centers and medical clinics, should be subject to licensing by the state. The Commission also recommends that the Department of Health encourage the development and maintenance of quality assurance plans in medical facilities deemed appropriate by the department, through regulation, technical assistance, or otherwise. Any quality assurance regulations developed by the department should incorporate, where appropriate, quality assurance plan requirements imposed by organizations such as the Joint Commission on Accreditation of Health Care Organizations.

Recommendation 7.4 -- Continuing Education Programs

The Commission encourages the Department of Health and health care practitioner organizations to include discussion of effective communication techniques, cost control, liability insurance, and the health care liability system in continuing education programs for health care practitioners.

DISCUSSION

The Commission recognizes the value of educating health care practitioners in areas such as effective communication techniques, cost control, liability insurance, and the health care liability system. Attempting to mandate health care practitioner education through the continuing education system has not been shown to be an effective strategy. Therefore, the Commission encourages the Department of Health and health care practitioner organizations to include these topics in their continuing education programs.

Recommendation 7.5 -- Malpractice Insurance Coverage

As a condition of licensure and relicensure in Washington state, every medical doctor and doctor of osteopathy should be required to provide evidence of a minimum level of malpractice insurance coverage.

DISCUSSION

One of the purposes of the health care liability system is to provide appropriate compensation to individuals who have been injured by negligent health care practices. Requiring a minimum level of malpractice coverage for physicians furthers this purpose.

Recommendation 7.6 -- Risk Management Training

Liability insurers and self-insured health care providers should be required to condition a physician's coverage, staffing privileges, or employment upon that physician's participation in risk management training.

DISCUSSION

Physicians who have received risk management training have fewer malpractice claims filed against them, and those claims that are filed are easier to defend. The Commission recommends that liability insurers who insure medical doctors and doctors of osteopathy in Washington State be required to condition coverage upon their participation in risk management training. Linking risk management training to malpractice insurance coverage is appropriate because of the direct benefit that malpractice insurers realize from their insured's participation in meaningful and effective risk management training.

Some physicians obtain their malpractice coverage through self-insured entities rather than a third party liability insurer (for example, physicians employed by Group Health Cooperative of Puget Sound). The standards for health plan certification should require each certified health plan to make assurances that a self-insuring entity has conditioned each physician's coverage by that entity upon the physician's participation in risk management training.

Recommendation 7.7 -- Practice Parameters

The development and use of practice parameters should be actively encouraged by the new state board or commission. At this time, however, compliance with practice parameters should not be an absolute affirmative defense in malpractice litigation.

DISCUSSION

Currently, practice parameters are used by claimants and defendants in malpractice litigation as evidence of the applicable standard of care. When practice parameters are introduced into evidence, there are several issues for the judge or jury: (1) Is the practice parameter sufficiently authoritative to be admitted into evidence? (2) Is the practice parameter applicable to the specific facts at issue in the case? and (3) If the practice parameter is applicable, did the physician comply with it? If there is more than one practice parameter related to a specific practice area, each of the parties would likely provide expert testimony that their practice parameter is the one that should apply to the conduct or omission at issue in the case. The Commission assumes that as the number and credibility of practice parameters grows, their prominence as a measure of the applicable standard of care will grow as well. The Commission recommends that the development and use of practice parameters be actively encouraged by the new state board/commission.

At this point, however, the Commission does not recommend that compliance with practice parameters be an absolute affirmative defense in malpractice litigation. The state of Maine has begun a demonstration project in this area which continues into 1995. A similar demonstration project is in Florida's 1992 health care reform legislation. The Commission recommends that the new board/commission closely review the results of these demonstration projects as they become available and decide at some later point whether a comparable approach would be appropriate for Washington state. If, however, the new board/commission links certified health plan or health care practitioner payment to compliance with specific practice parameters, then it may want to make compliance with those practice parameters an affirmative defense in malpractice litigation. To do otherwise would put certified health plans and health care practitioners in the very difficult position of having one standard of care for payment and another for malpractice litigation.

Recommendation 7.8 -- Quality Improvement Activities

Washington law should be amended to allow legitimate quality improvement activities to be undertaken in health services settings without the threat of these activities being used against them in malpractice litigation. The amendments also should ensure, however, that protection of quality improvement activities does not extend to activities that are not created specifically for those purposes.

DISCUSSION

Federal and state statutes address two types of protection of peer review activities -- antitrust immunity and protection of peer review proceedings from discovery in civil actions. The federal Health Care Quality Improvement Act of 1986 insulates medical peer review activities from liability in damages under any federal law, including antitrust laws. Similar protections are provided under state law (RCW 70.41.200 and RCW 4.24.240).

Under current Washington law, the protection of quality assurance proceedings and documents from discovery in malpractice actions is limited to activities undertaken by hospital quality assurance committees meeting specific requirements, or regularly constituted review committees of professional societies. Continuous quality improvement, and other quality assurance activities, can involve individuals and committees that may not meet the current statutory definitions of quality assurance or peer review committees, and may be conducted in settings other than hospitals. Yet, quality assurance activities, including continuous quality improvement, should be encouraged throughout the health system.

The Commission recommends ensuring that protection from discovery does not extend to documents that are not created specifically for the purposes of quality assurance or continuous quality improvement activities. To do otherwise could create significant barriers to individual malpractice claimants who have the burden of proving that a health care practitioner's negligence caused their injuries. In addition, the Commission supports the inclusion of quality assurance or continuous quality improvement requirements in health plan certification standards.

Recommendation 7.9 -- Health Care Liability Data System

The State Legislature and the new state board or commission should facilitate a private-public cooperative effort to develop a uniform, universal, comprehensive, and publicly accessible health care liability data system.

DISCUSSION

This data "system" need not be a single computerized data bank, but must at least be a closely coordinated system of data sets. The data system should support private and public decision making concerning preventable injuries, risk management, the development of practice parameters, disciplinary actions, professional education and training, public education, access to compensation, civil justice system transaction costs, and insurance practices. The data system should support the responsibilities of the new state board or commission.

The data system should be based on common definitions, as well as uniform and universal collection and reporting rules. It should also coordinate existing data sources. The data should be readily accessible to the public and to private and public sector interests and decision makers. The data system should provide reasonable protection for proprietary interests and help minimize

unreasonable discrimination against providers. The data system should include insurance data, professional practices data, and civil justice data.

Recommendation 7.10 -- Public Education

The State Legislature and the new state board or commission should facilitate programs that educate the public about how best to use health services, and promote realistic and reasonable consumer expectations of the health system.

DISCUSSION

For these purposes, the Legislature and the new state board/commission should work with state agencies, voluntary organizations, public and private schools, health service providers, certified health plans, trade unions, and business and civic organizations. Educational programs should target at least the following groups: K-12 students, college and university students, certified health plan enrollees, and the general public. The content of these programs should address (as age-appropriate) death and dying, healthy personal behaviors, disease prevention, understanding of risk, the limits of medical interventions, consumer rights and responsibilities, the appropriate use of health services and practitioners, controlling health services costs, and the health care liability system.

Recommendation 7.11 -- Health Plan Certification

Provider credentialing, the use of contracted providers, peer review, and quality assurance activities should be included in the health plan certification requirements.

DISCUSSION

Certification standards related to health care provider credentialing, peer review, and the use of managed care can improve the quality of care provided to certified health plan enrollees, thereby preventing adverse outcomes resulting from substandard practice.

RECOMMENDED PROCESS STRATEGIES

Recommendation 7.12 -- Informal Pre-filing Review

An informal, voluntary system should be developed for facilitating pre-filing review of medical malpractice claims by one or more medical or health services experts chosen from a pool maintained by each of the health care practitioner associations.

DISCUSSION

By agreement of the injured claimant and the allegedly negligent health care provider, such an informal review would be initiated at the point at which a medical malpractice claim is submitted to a malpractice insurer or a self-insured health care provider. By agreement of the parties, an expert would be chosen from a pool of medical/health services experts who have agreed to review claims on a voluntary basis. A pool of available experts would be established for each category of health care practitioner by the corresponding practitioner association, such as the Washington State Medical Association or the Washington State Nurses Association. The mutually agreed upon expert would conduct an impartial review of the claim and provide his or her opinion to the parties. The parties could agree, at the outset, to be bound by the opinion of this expert.

The organizations that would use or contribute to the operation of this recommendation were asked by the Malpractice Committee to participate in a collaborative effort to develop the informal review system described above. Initial responses from these organizations indicate a willingness by most, if not all, of the organizations to participate in a planning effort.

Recommendation 7.13 -- Mandatory Mediation

Washington law should require that a reasonable attempt be made to mediate prior to trial every malpractice dispute brought against health care practitioners.

DISCUSSION

Mediation of malpractice claims provides a less expensive, less time consuming, and less stressful alternative to trial. In addition, mediation has the potential to remedy one of the major weaknesses in the current health care liability system -- the inability of individuals with relatively small malpractice claims to be compensated appropriately for their damages.

The Commission's recommended mandatory mediation statute would require that the parties file a notice with the court, within a fixed number of days of filing a lawsuit, identifying their agreed upon mediator or stating that mediation has been waived by a mediator after careful consideration of the appropriateness of the case for mediation. If mediation is waived, the parties should be required to participate in at least one settlement conference prior to trial.

Oral and written mediation proceedings would be protected from disclosure at any subsequent trial. Some minimum amount of agreed upon discovery should take place during mediation to increase its chances of successfully resolving the dispute. The mandatory mediation system could require that an initial meeting with the mediator be held within a fixed number of days of filing a medical malpractice lawsuit. If the parties have previously had the claim reviewed by a medical or health services expert through the informal claims review process described above, the information derived from the review could be used in the mediation process. There would be no impairment of the right to a jury trial following an unsuccessful attempt at mediation.

Recommendation 7.14 -- Collateral Source Offset

To avoid double recovery from negligent health services providers and third party insurers by claimants in malpractice actions, all public and private insurers should be given subrogation rights against damages awarded to a successful claimant.

DISCUSSION

Under this draft recommendation, a public or private insurer who has paid expenses of an insured claimant that were caused by a health services provider's negligence would recover the amount that it paid from the damages awarded to the claimant. Based upon case law in Washington state, however, the subrogation rights of a public or private insurer would not be unqualified. Only after an insured claimant has been fully compensated for his or her losses would an insurer be reimbursed for payments made for the same losses caused by a negligent health care practitioner. Due to ERISA, these common law subrogation provisions may not be applicable to self-insured employee health benefit plans. Under this recommendation, double recovery by injured claimants would be eliminated, while still making the defendant responsible for the costs of the injury caused by his or her negligence.

Recommendation 7.15 -- Joint and Several Liability

RCW 4.22.070 should be amended to: (1) provide that, even where the plaintiff is not at fault, the defendants before the court be severally, but not jointly, liable for the plaintiff's non-economic damages; and (2) eliminate the "empty chair" status of defendants who have previously settled with the plaintiff (that is, at trial, fault would not be apportioned to a defendant that has previously settled with the plaintiff).

DISCUSSION

The traditional rule of joint and several liability provides that if a plaintiff proves his or her case against two or more defendants, then each defendant is legally responsible for the entire harm done to the plaintiff. With only a few exceptions not directly related to medical malpractice actions, the 1986 Tort Reform Act modified the traditional rule of joint and several liability.

Under RCW 4.22.070, whether a plaintiff is at fault or not, he or she may not be fully compensated for his or her damages. In all personal injury cases where more than one person or entity is at fault, there is a determination of the fault attributable to every person or entity that caused the plaintiff's damages. At trial, damages are assessed against only those defendants that are before the court. This means that the share of damages caused by fault attributable to: (1) entities that the plaintiff has settled with, (2) entities immune from liability to the plaintiff, or (3) entities that have another defense against the plaintiff, are not the responsibility of the defendants before the court.

The Commission recommends that the current rule be modified in two respects. First, even where the plaintiff is not at fault, the defendants before the court should be liable only for their proportionate share of the plaintiff's non-economic damages. This change will have the effect of limiting payments for non-economic damages when a liable defendant in a multi-defendant case does not have sufficient malpractice insurance to cover his or her share of the plaintiff's damages. It will, however, bring a greater degree of predictability to the liability of health care providers who have higher levels of malpractice insurance coverage. Several commissioners expressed concern about this recommendation, stating that a malpractice claimant should be fully compensated for both economic and non-economic damages.

At trial, fault should not be apportioned to a defendant that has previously settled with the plaintiff. This change will remove a disincentive to settle cases that is in current law. To ensure that plaintiffs do not recover an amount greater than the total damages determined at trial, the amount of the settlement should be deducted from the damages determined at trial. The remaining amount of unpaid damages should then be apportioned among the defendants, according to their proportion of fault.

Recommendation 7.16 -- Accelerated Compensation Events System

The Accelerated Compensation Events (ACE) system should be adopted for quality assurance purposes on a demonstration basis in Washington state.

DISCUSSION

The Commission reviewed several "selective no-fault" strategies that have been proposed or are currently in use in other states. The Commission concluded that the ACE system should be adopted for quality assurance purposes on a demonstration basis in Washington state.

ACEs are medically caused injuries that are usually, though not invariably, avoidable through good health care. To date, ACEs have been developed for obstetrics/gynecology, general surgery, and orthopedic surgery. ACEs can be used in several contexts -- as an alternative to the civil justice system, as a dispute resolution tool within the existing health care liability system, as a technique to help liability insurers resolve current cases or design risk management programs for their insureds, or as a quality assurance mechanism. Because ACEs are avoidable adverse outcomes, their use in a quality assurance context should encourage prevention of medically-caused injuries.

After careful consideration, the Commission concluded that it is premature to apply ACEs as an alternative to the current civil litigation system. The ACEs concept has sufficient merit, however, to justify an initial test in a quality assurance context. Implementation of this recommendation would require a commitment by a public or private health services purchaser, or a large managed care plan, to incorporate the use of one or more categories of ACE's into its quality assurance system. Facilities and practitioners would be educated as to the "avoidability" of the adverse outcomes identified as ACEs. In addition, systems would be developed to incorporate those practices that can avoid ACE adverse outcomes into the operation of the health plan. To the extent that ACE adverse outcomes did occur, they could be reviewed through a formal peer review process or some other post hoc review. The goal of the review would be to determine how practice patterns could be modified to avoid future adverse outcomes.

As a part of this test, a foundation-funded longitudinal study could be carried out to evaluate the impact of the use of ACEs on outcomes and costs, how the ACE adverse outcomes that did occur were compensated in the current system, and how the ACE adverse outcomes that occurred could have been compensated in an alternative administrative no-fault system.

Recommendation 7.17 -- Expert Witnesses

A Rule of Evidence addressing the qualifications of expert witnesses in medical malpractice proceedings should be adopted in Washington State.

DISCUSSION

To assist the courts in evaluating whether an expert witness in a medical malpractice case is qualified to testify, a new Rule of Evidence should be adopted in Washington state. The rule should provide as follows:

"In determining whether a proposed medical expert is qualified to present expert testimony in a medical malpractice proceeding, the court shall consider the following factors:

- (1) Whether the proposed medical expert is board certified in the medical specialty at issue in the proceeding, or has completed the training required for board certification in the medical specialty at issue in the proceeding;
- (2) Whether the proposed medical expert is engaged in the active practice of medicine at the time the alleged negligence occurred; and
- (3) Any other factors deemed necessary or appropriate by the court."

This proposed Rule of Evidence has been submitted to the Washington State Bar Court Rules and Procedures Committee, which will begin its review of the proposal in late 1992.

PREVENTION STRATEGIES *NOT* RECOMMENDED

Consolidation of Licensing/Disciplinary Functions

The Commission questions whether consolidating health care practitioner boards for licensing or disciplinary purposes would result in increased efficiency or significant cost savings. Regardless of whether there are several boards or one, the system needs managers to supervise the work, investigators to find the facts, health professionals to make judgments about competence and conduct, and attorneys to provide legal advice and prosecute cases. Courts expect disciplinary orders to be based upon expert information of health professionals in the same field as the practitioner being sanctioned. If a board does not have that health professional expertise, the courts will expect the record to contain the opinion of outside experts, who would have to be paid by the disciplinary board.

Combining the licensing and disciplinary functions for medical doctors, chiropractors, dentists and nurses also was rejected by the Commission. Currently, one individual serves as the executive director for each profession's licensing and regulatory board, providing an essential link between the activities of the two boards. Each of the boards is sufficiently busy that combining functions would not result in significant savings or administrative efficiencies.

Licensing Only in Areas of Competency

The Commission explored various methods of evaluating health care practitioner competency. It concluded that such evaluation is adequately addressed in the existing health services system through board certification programs, liability insurance underwriting requirements, and procedures for granting clinical privileges in health care facilities. Therefore, the Commission is not recommending that health care practitioners be licensed only in demonstrated areas of competency.

General Fund Financing

The Commission does not recommend that investigations and enforcement actions against unlicensed health care practitioners be funded from the state general fund. It is reasonable to require that funds dedicated to licensing activities be used for the purpose of taking action against unlicensed health care practitioners. In addition, given the projected deficit in the state general fund budget, it would be unreasonable to place further demands on it.

Experience Rating

The Commission explored the extent to which physicians' liability insurance premiums are experience rated, and found that the physician-owned and commercial liability insurers in Washington state currently consider the physician's experience in determining his or her liability insurance premium rate. Since this strategy is already used in Washington state, it is not necessary to adopt it formally.

PROCESS STRATEGIES *NOT* RECOMMENDED

Mandatory Screening Panels

The Commission considered a strategy providing for mandatory review of medical malpractice claims by a screening panel as a precondition to litigation of those claims. The strategy was modeled after the screening panel system operating in Nevada. In that state, the majority of cases are settled at the panel or settlement conference stage. The screening panel requirement has been a disincentive to filing smaller claims, however, because of the added cost of preparing for review by the panel.

The Nevada panels are composed of three physicians and three lawyers. They base their review on written documents only. The panel decides liability, not damages. If the panel finds no liability, and the claimant files and loses his or her lawsuit, then the claimant pays the defendant's costs and attorney fees. If the panel finds liability, and the parties cannot agree on damages, then a lawsuit can be filed. A judge then holds a mandatory settlement conference and makes a recommendation regarding damages. If the claimant goes to trial and is awarded more than the judge's recommendation, the defendant pays the claimant's costs and attorney fees. If the claimant is

awarded less than the judge's recommendation at trial, then the claimant pays the defendant's costs and attorney fees.

The Commission raised several important distinctions that called into question the appropriateness of adopting a mandatory screening panel approach in Washington state:

- (1) Screening panel review should not be necessary in a health care liability system with mandatory mediation of medical malpractice claims;
- (2) Nevada's mandatory screening panels are inconsistent with the Commission's goal of promoting resolution of malpractice disputes quickly and in a non-adversarial manner; and
- (3) Apportionment of fault may not be easily integrated into a screening panel system in Washington, which is a comparative negligence state.

Medical Injury Review and Adjudication System

The Medical Injury Review and Adjudication System (MIRAS) was presented to the Commission by Dr. Loren Winterscheid, a technical advisor to the Malpractice Committee. It would replace the present tort system with a fault-based administrative adjudication system.

MIRAS has four stages. At Stage I, a claim reviewer reviews each claim by patients alleging injury as a result of negligent care. If the parties agree with the findings of the reviewer, the matter is resolved. If either party rejects the findings, the dispute is referred to the next stage.

At Stage II, an administrative law judge mediates the claim. If settlement is achieved through mediation, the matter is closed. If settlement is not achieved, the judge enters an order of settlement. If the parties accept the judgment, the matter is closed. If either party rejects the judgment, the claim is referred to Stage III.

At Stage III, the claim is adjudicated before a hearing tribunal. A pre-hearing settlement conference and hearing are scheduled. If the hearing tribunal's judgment does not improve the results for the party appealing the administrative law judge's decision by \$10,000 or 20 percent, whichever is greater, that party must pay the full cost of the tribunal and up to \$25,000 of the opposing party's costs and attorney fees.

At Stage IV, either party may then appeal the judgment of the tribunal to a jury trial. Evidence at trial is limited to the transcript and documents from the proceedings below. The findings of the jury are final.

During the Commission's deliberations, significant concerns were expressed regarding the costs of MIRAS and its administrative complexity. The Commission chose not to recommend adoption of this strategy, choosing instead to pursue changes to the current health care liability system. If these

changes prove ineffective in achieving the purposes of the health care liability system, then the MIRAS proposal could be reconsidered by the new board or commission and state policy makers.

Selective "No-Fault" System

The Commission chose not to recommend the selective no-fault approach adopted by Virginia and Florida in their birth-related neurological injury programs. First, the definition of birth-related neurological injury in the two statutes is very narrow, and affects only a very small number of injured infants each year. In those cases that might qualify under the program, proving that a neurological injury was indeed caused by the act or omission of a physician during childbirth significantly limits the programs' stated no-fault character. Secondly, there are insufficient protections for potential claimants under the programs. Finally, it is questionable whether the funding mechanisms used in the two programs are sufficient to compensate adequately those individuals who file claims.

Limits on Damages/Valuation of Damages

In Sofie v. Fibreboard Corp., 112 Wn.2d 636 (1989), the Washington State Supreme Court held that the provision of the 1986 tort reform act capping non-economic damages in personal injury cases violated the Washington State Constitution's jury trial right and was no longer operative. After fully reviewing the Sofie decision, the Commission discussed whether other proposals to limit non-economic damages could possibly be found to be constitutional in Washington state.

Proposals considered but not recommended include: (1) giving jury instructions with information concerning the distribution of prior awards that includes an upper and lower boundary amount; (2) developing a binding matrix of values, based upon past awards for non-economic damages, that would award fixed damage amounts according to the severity of injury and the age of the injured claimant; (3) giving juries non-binding scenarios describing an injury and providing associated dollar values of non-economic loss, based on past awards; and (4) giving juries binding ranges of non-economic damages that vary with injury severity and claimant age.

The Commission recognizes the lack of predictability in awards of non-economic damages, and the inequities that may result from the lack of information or assistance given to juries determining non-economic damages. The Commission concluded, however, that the Sofie decision makes clear that any proposal that interferes with, or attempts to influence, the jury's fact finding function will likely be found to violate the Washington State Constitution. To the extent that the medical malpractice cause of action is eliminated and replaced by an administrative no-fault system, such as ACEs, the Commission would support a more standardized and predictable system for valuation of non-economic damages.

Certificate of Merit

Certificate of merit proposals provide that a certificate must be filed by a malpractice claimant's attorney stating that at least one qualified expert has reviewed the case, and based on the review conducted by the expert, there is reasonable and meritorious cause to file the case. In the major studies of tort reform efforts to date, none has found certificate of merit requirements to have an effect on the number of claims filed or the amount of damages awarded.

Under Washington Civil Rule 11 (CR 11), an attorney must certify on every pleading that, to the best of his or her knowledge, and after reasonable inquiry, the pleading is well grounded in fact and is warranted by law. If a violation of CR 11 is found, the court is required to impose sanctions upon the attorney who violated the rule, or the party he or she represents.

The Commission concluded that the "reasonable inquiry" requirement of CR 11, and the requirement that sanctions be imposed if the rule is violated, embody essentially the same protections as a certificate of merit requirement. The Commission understands that on June 18, 1992, the Board of Governors of the Washington State Bar Association recommended to the Washington State Supreme Court that CR 11 be amended to remove the sanctions provision. The Commission recommends that the sanctions provision be retained in the rule. If the Supreme Court removes the provision, then the certificate of merit strategy should be reconsidered by the state legislature.

Attorneys' Fees Limitations

The Commission reviewed and discussed proposals to limit malpractice claimants' attorneys fees. Several states have limited claimants' attorneys fees by establishing contingency fee percentage ceilings based on the total amount of the award.

The health care liability system should ensure that individuals who have been injured by negligent health care practices are compensated appropriately. Contingency fee arrangements provide access to the courts for middle and lower income people who are injured by negligent health care practices, because they free these individuals from the burden of having to pay attorney fees on an hourly basis prior to receiving an award of damages from the court. The Washington State Supreme Court's Novack Commission found that percentage-ceiling controls on contingent fees are arbitrary, unrelated to the varying factors of individual cases, devoid of statistical support as to reasonableness or effectiveness, and bound to cause injustice to the client or lawyer, or both, in many situations.

RCW 7.70.070 specifically requires that the court determine the reasonableness of each party's attorneys fees in medical malpractice actions. In practice, however, that determination is rarely made.

Some Commissioners remain concerned about large contingency fees paid in some cases. Their concern relates to the question of whether a claimant is adequately compensated when one-quarter to one-third of a large award may be paid to their attorney, and to the impact of large contingency fees on transactional costs. These Commissioners are also concerned about increasing defensive

medicine and encouraging a "sweepstakes mentality". Despite these concerns, given the information and findings discussed above, the Commission decided not to recommend that claimant's attorneys fees be limited.

Conclusion

In preventing adverse health outcomes that lead to malpractice claims, one of the most significant Commission recommendations is that the uniform benefits package be delivered through managed care systems. In David Axene's presentation to the Commission, he noted that Milliman & Robertson found that the rate of malpractice claims in managed care systems is one-third that of unmanaged systems.²⁷ Managed care systems can contract with or employ selected physicians and define guidelines for their clinical practice. Compliance with these guidelines can lead to higher quality care and therefore, a lower incidence of malpractice claims. Moreover, the greater attention to practice parameters and standards of care that occurs in a managed care setting can reduce the use of unnecessary defensive medicine.

If the Commission recommends linking compliance with practice parameters to payment, then the incidence of unnecessary use could be reduced. If the Commission does not initially link practice parameters with payment, but instead recommends that certified health plans aggressively promote the use of practice parameters by their salaried or contracting practitioners and hospitals, unnecessary defensive practices could be reduced. Finally, if the Commission endorses the concept of continuous quality improvement within certified health plans, there is potential to reduce the rate of unnecessary tests and procedures.

Axene also noted that 90 percent of the physicians that Milliman & Robertson considers high quality are also cost-efficient physicians. A high quality physician can distinguish between clinical tests and procedures that are justified and those that are not. For these physicians, rational and careful clinical care is the appropriate substitute for unnecessary defensive tests and procedures. Moreover, those physicians who use rational and careful clinical care are less likely to delay diagnoses, cause medical complications in their patients, or inappropriately treat their patients. By avoiding the costs associated with inappropriate practice patterns, these physicians are both cost-effective and less likely to have a malpractice claim filed against them. Thus, there does appear to be a style of medical practice that is cost-effective *and* avoids malpractice claims -- that is, it is possible to practice medicine in a high quality manner that does not use unnecessary defensive tests and procedures, yet does not render the individual physician more vulnerable to malpractice claims.

²⁷ "Uniform Benefits Package(s)," presentation to the Washington Health Care Commission by David Axene, Consulting Actuary, Milliman & Robertson, March 27, 1992.

Chapter 8

INCENTIVES

Introduction

In creating the Washington Health Care Commission, the State Legislature charged the Commission to:

"Identify appropriate and effective health services, develop incentives to adopt the use of those services, and develop incentives to effect preventive and public health interventions."

Virtually every aspect of the Commission's work could be discussed under the heading "incentives."

In particular, the Commission's recommendations establish a general approach to health system reform that emphasizes incentives for providing appropriate and effective health services. To make the health system more cost-effective, the recommendations for comprehensive system reform focus on financers and payers as well as providers and consumers. The Commission's framework for reform would have a global impact on organizational and personal behavior, rather than a "micro" approach that would regulate every part of the system.

The Commission's recommendations in many other areas also are focused on establishing incentives within which individuals and communities can make decisions which improve health and the cost-effectiveness of health services.

The Commission has incorporated many incentives for use of the most effective services and improved health into its recommendations. Since the goals of these incentives include cost-effective operation of the health system and reduction of ill health which could require future services, it is tempting to ask for an estimate of the future cost impacts of implementing the incentives. However, the Commission cannot measure or predict the actual impact of these incentives separate from other elements of system reform. There is insufficient evidence to make a determination of the potential savings or cost-effectiveness of individual incentives. The Commission's approach in Chapter 5 has been to make a global judgment about the changes in the future costs of health services which might be expected if all of its recommendations are implemented. The Commission urges on-going evaluation of the impact of incentives to assess their cost-effectiveness when implemented.

This chapter is different from the others in the Commission's draft report because most of its content duplicates statements made in other chapters. The development of the incentive structures in the Commission's recommendations occurred over the last two years in the Commission's four committees. Without this chapter, it would be difficult to obtain an overview of all the ways the Commission's recommendations use incentives. Because the Legislature's charge to address incentives is so specific, the Commission has devoted a chapter to a thorough discussion of this subject. This chapter is divided into two major sections:

•**Incentives for the provision and use of services.** Incentives for **providing** appropriate and effective health services operate through their impact on service providers. Incentives for encouraging the **use** of appropriate and effective health services operate through their impact on consumers and on communities (in the case of population-based health services). These two types of incentives deal with **services**. They are presented together because they tend to become intertwined.

•**Incentives for encouraging healthy behaviors.** By all individuals (as distinct from the acceptance and use of services).

Throughout this chapter, recommendations which are not presented elsewhere in this report are highlighted for public comment.

INCENTIVES FOR THE PROVISION AND USE OF SERVICES

The following is a synopsis of the major ways that incentives for the provision and use of appropriate and effective health services are built into the Commission's recommendations.

Fundamental Reform

The Commission believes that fundamental reform of the health system's finance and payment system is necessary to control costs and achieve universal access. Incentives for providing appropriate and effective health services are embedded in these major recommendations.

- All Washington residents should be guaranteed access to a uniform set of health services (including a uniform benefits package), based on their ability to pay. By making sure all residents can obtain health insurance, many more people will have a positive incentive to get preventive or early care, rather than expensive emergency care that could have been avoided. By helping to reduce the financial burden for low income individuals, many more people who cannot afford health services will be able to obtain them.
- Certified health plans would be required to offer the entire uniform benefits package. The plans would assume the financial risk for enrollees, creating a strong incentive for plans to manage care effectively. Certified health plans will have incentives to develop and use practice parameters and to build their own internal incentives for practitioners to comply with them.
- Certified health plans would be restricted from selecting only healthy individuals and excluding others. Plans will need to provide the most appropriate and cost-effective health services for less healthy individuals, rather than look for ways to avoid serving them. This includes providing preventive and primary care to all plan enrollees.

Uniform Set of Health Services

Development of the uniform set of health services (including the uniform benefits package) incorporates the following provision and use incentives:

- Including in the uniform set and package only services which can be used effectively.
- Setting criteria for the uniform set and package which state that preventive services and services which improve the health of the population as a whole must be given the highest priority.
- Including preventive and primary care in the uniform benefits package, with low point-of-service cost-sharing.
- Emphasizing the function of a particular service (rather than the type of provider) as long as it encourages cost-effective care. Moving away from fee-for-service to other methods of payment also encourages this result.
- Including effective population-based services in addition to personal health services encourages the use of preventive health services on a personal and population basis.
- Supporting the mobilization of community health promotion and disease/injury prevention efforts in the Commission's framework of health reform. This encourages the provision and use of services that help keep people from getting sick.

Service Effectiveness Advisory Committee

The formation of a Service Effectiveness Advisory Committee reporting to the new board/commission represents an important way to assure that the scientific knowledge on service efficacy is used (see Recommendation 4.3). This information would be used by the board/commission to revise the uniform set and package. It would also be disseminated more generally for many potential uses, including voluntary incorporation of best practices, development of practice parameters, and utilization management activities of payers or care managers.

Overcoming Non-Insurance Access Barriers

The following approaches to reducing or eliminating non-insurance barriers to access that interfere with appropriate use of services are either incorporated in the Commission's recommendations or are suggested as subjects for public comment on whether they should be added to the Commission's recommendations:

- Current recommendations to overcome non-insurance access barriers focus on a coordinated effort to develop policy strategies, recognizing the appropriate roles and responsibilities of various systems, including the new state board/commission and state/local public health agencies. (See Recommendation 4.1.)
- Specific services to improve access, such as specialized transportation and language/culture accommodation, should be included in the uniform set and package and/or provided through other parts of the health system. *Public comment is invited on whether to include these access services through the uniform benefits package or through the public health system.*
- Special efforts should be pursued to make preventive services convenient and to hold certified health plans accountable for delivering them. *Public comment is invited on whether these objectives should be included as specific plan certification and monitoring requirements.*
- Ease of access has a large impact on whether preventive services are used. Services such as mammograms, blood pressure testing, and prenatal care should be available at times and locations convenient to the people who need them.
- Successful delivery of preventive services to enrollees should be a core requirement in certifying and monitoring health plans and integrated service networks.
- The Commission supports the coordinated effort of the Health Professions Resource Plan to encourage adequate supply, distribution and training of health personnel. (See Recommendation 6.6.)

Individual Point-of-Service Cost-Sharing

In the "Criteria for the Uniform Set and Package" included in the 1991 Interim Report, the Commission stated, "...the uniform set and package should require individuals to help finance their health services in order to promote prudent utilization and purchasing decisions, without imposing barriers to universal access to those services. The Commission considers individual "point-of-service" cost-sharing to be an incentive for promoting cost-effective use of services and reducing the inappropriate use of services, as well as a means for contributing to financing the uniform benefits package.²⁸ For example, the Commission recommends low point-of-service

²⁸ The Commission has considered the RAND Health Insurance Experiment (1983) that the

cost-sharing to encourage the use of preventive services, while recommending high point-of-service cost-sharing for emergency room care to discourage unnecessary use.

The Commission expects individuals who have adequate financial resources will pay part of the package premium, as well as copayments, deductibles, and/or coinsurance at point-of-service. The amount of cost-sharing would vary by income level. The Commission has not defined a specific sliding scale. The amount of cost-sharing should not create a barrier to obtaining needed care. As an illustrative example, someone with an income below 100 percent of the federal poverty level (FPL) may pay nothing towards the premium and would not be required to pay a cost-share at point-of service, someone with an income 100 to 250 percent of the FPL may share in the cost of the premium and pay a certain amount at point-of-service based on a sliding scale, and someone with an income over 250 percent of the FPL may pay a full percentage of the premium, and higher point-of-service cost-share.

The following incentives are either incorporated in the Commission's recommendations or are suggested as subjects for public comment on whether they should be added to the Commission's recommendations:

- Consider assigning zero cost-sharing to clinical preventive services. *Public comments on this suggestion are solicited; it is not included in the uniform benefits package recommended in Chapter 2.*
- Reduce cost-sharing obligations for certified health plan enrollees who have gone to all recommended preventive service visits and adhered to personal follow-up actions. *Public comments on this suggestion are solicited; it is not included in the uniform benefits package recommended in Chapter 2.*
- Maintain *total* individual cost-sharing obligations (point-of-service plus premium contribution) within limits related to one's ability to pay.
- Make sure the cost-sharing process is not so complicated that it unduly adds confusion and creates barriers to obtaining health services, while adding administrative costs to the system.
- Sensitize people to use health services effectively through awareness of the costs and options.

In addition, the Commission seeks public comments about whether health insurance premiums should be higher for people with unhealthy behaviors such as smoking or not using seatbelts and bicycle helmets. On the one hand, this approach might provide a financial incentive to change these unhealthy behaviors. On the other hand, evidence that such incentives actually work is weak, especially for addictive behaviors, and such premium differentials would run counter to the concept

more people had to pay for health services, the less they use; however, this reduction was as strong for appropriate use as it was for inappropriate use of services.

of community rating. Comments will be most useful if they state what specific, easily verifiable risk behaviors (if any) should be made the basis for premium differentials.

Choosing Cost-Effective Service Systems and Providers

Individuals and communities should choose cost-effective and appropriate ways to obtain health services because good consumer/community decision-making creates market incentives for cost-effective performance. These choices include cost-effective systems of services; for example, when a person selects one of several available certified health plans. They include choice among types of providers and individual practitioners who can provide the same service. For example:

- A pregnant woman should be encouraged to seek prenatal care from an appropriate and cost-effective provider, whether physician or nurse midwife.
- Within a specific certified health plan, an individual could choose to receive primary care from a nurse practitioner or physician assistant, rather than a medical doctor. A full range of specialists should be available when needed, subject to the plan's specific rules for referral and the state board/commission's approval of these rules in the plan certification process.

Choices of appropriate systems and providers apply to population-based services as well:

- Adjusting to the characteristics of a community is very important to get people to use needed health services. To accomplish this, one's culture, language, and background need to be taken into account. In some circumstances, the use of health aides who understand the community can be effective.
- The public health functions (assessment, policy development, and assurance) included in the uniform set of health services provide an ongoing structure for communities to develop appropriate services for their needs, encourage their use, and assure they are delivered.

Continuity of Care

Continuity of care should be encouraged and supported. This can be accomplished by minimizing an individual's need to change health plans, regardless of job changes or changes in financial status.

Continuous coverage increases the likelihood that anyone who needs health services will get them. This, in turn, can help prevent serious illnesses and injuries. Continuity of primary care also promotes long-term courses of treatment in place of limited, episodic interventions. Continuity of care would be enhanced by the following incentives, which are either incorporated in the Commission's recommendations or are suggested as subjects for public comment on whether they should be added to the Commission's recommendations:

- Using community rating (or modified community rating) and other insurance access reforms which eliminate the certified health plans' ability to "dump" bad risks (people likely to be sick).

- Making coverage "portable" -- that is, the ability to remain in the same plan as job and income status changes. Methods to assure portability would need to be different depending on what form of plan sponsorship is recommended by the Commission in its final report. (See the two options discussed in Recommendation 3.10. One of the benefits of the "residence-based, single sponsor" option is easier portability.
- Encouraging individuals to maintain enrollment in a certified health plan.
- Certified health plans maintaining enrollees by providing high quality and easily accessible services.
- Plans experiencing enhanced economic viability by providing preventive services and health education. A plan should be able to reap the benefits of providing health education and preventive services by retaining enrollees over a long period of time.
- Plans recognizing that their economic viability is enhanced by retaining enrollees over time who consistently receive appropriate and effective services.

Controlling Technology Proliferation

The Commission's recommendations to control technology proliferation include incentives. First, setting a maximum premium for the uniform benefits package limits the money available for technology. Second, the uniform benefits package should exclude unnecessary technology. Third, selective contracting by certified health plans would be encouraged for services likely to improve quality or lower costs if performed in high volume. Fourth, provider payment *levels* would be regulated under unique circumstances where no market competition exists, access is negatively affected, or when a monopoly exists. (See Chapter 3.)

Health Care Liability Reform

The Commission's recommended reforms to the health care liability system include incentives for providing appropriate and effective health services. In Chapter 7, the following strategies were identified as promoting the provision of appropriate and effective health services by providers or promoting the use of appropriate and effective services by consumers:

- Requiring quality assurance programs in medical facilities, as determined by the State Department of Health;
- Encouraging education of health care practitioners in effective communication techniques, cost control, health care liability insurance, and the health care liability system;
- Requiring medical doctors and doctors of osteopathy to be trained in effective risk management techniques;
- Encouraging the development and use of practice parameters;
- Amending existing peer review statutes in Washington State to protect a broader scope of quality assurance and continuous quality improvement documents from disclosure in malpractice litigation;
- Facilitating programs that educate the public about how best to use health services and promote realistic and reasonable consumer expectations of the health system;
- Including provider credentialing, the use of contracted providers, peer review, and quality assurance activities in health plan certification requirements; and
- Achieving the overall goal of the Commission's recommended process strategies -- to resolve malpractice disputes in a manner that is less costly, less time consuming, and less emotionally burdensome for consumers and providers. The intended effect of the recommended process strategies is to minimize the inappropriate incentives in the current health care liability system for providers to order unnecessary tests and procedures.

INCENTIVES FOR ENCOURAGING HEALTHY BEHAVIORS

The following summarizes the incentives to encourage healthy behaviors included in the Commission's recommendations. Some of these recommendations, as noted, do not appear elsewhere in this report. As noted in the introduction to this Chapter 8, it is impossible to measure or predict the financial impact these incentives will have. Changes in behavior will need to be monitored over time to measure the success of these incentives.

State Health Report

The Commission supports the priority health goals and strategies outlined in the draft 1992 Washington State Health Report. To the extent possible, the Commission recommendations on health incentives have been coordinated with those in the draft report. The draft report includes seven priority health goals for Washington State during 1993-95:

- Reduce preventable infant morbidity and infant mortality;
- Reduce the incidence and preventable consequences of infectious diseases, including measles, HIV/AIDS, and other sexually transmitted diseases;
- Control and reduce exposure to hazards in the environment in which we live, work, and play;
- Reduce tobacco use;
- Reduce the misuse of alcohol and other drugs;
- Reduce the incidence and preventable consequences of unintentional and intentional injuries; and
- Assure access to population-based and personal health services, including preventive services, illness care, and health education, as necessary to maintain, improve or restore health.

The State Health Report includes action strategies to meet the seven goals and identifies the groups in Washington that should play a role in each strategy. The Commission supports the efforts of the State Board of Health to determine and meet these goals. The recommended state board/commission should work in coordination with the Board of Health to achieve the priority health goals, and may wish to participate in suggesting priorities. *Public comment is invited on how the new state board/commission should be linked with the State Board of Health for this purpose.*

Community Health Promotion

Cutting across the specifics of the State Health Report's recommendations, and many of the Commission's draft recommendations as well, is the concept of community health promotion. Viewed as a kind of service, this is part of the uniform set of health services and is within the scope of the public health assurance function described in Chapter 2. Mechanisms to support community health promotion and disease prevention activities should be developed and implemented. These include activities to increase personal self-esteem, as well as education about unhealthy behaviors. The Commission may be unique in incorporating the link between personal health and public health interventions in its approach to health system reform. The Commission acknowledges that in an individual's community, cultural pressures, peer opinion, and institutions are very influential in determining individual behavior that affects health.

Behavioral Changes to Improve Health

The Commission's Health Services Committee heard from a number of experts in effecting improvements in health which depend on a changes in personal behaviors. The following three draft recommendations, all related to motivation and incentives, stand out as particularly important. They are recommended as considerations in deciding *how* to carry out health promotion and disease/accident prevention efforts:

- "Community psychology"** Develop behavioral incentives which tap the power of "community psychology." Contemporary health promotion theory strongly emphasizes the role of the community in maintaining norms, applying peer pressure, and mobilizing the will and the means to change behaviors. Two examples of using community psychology to change behavior are the "Healthy Babies/Healthy Mothers" campaign in Washington and the "Safe Streets" campaign in Pierce County.

Specific strategies which build on effective community processes include:

- Involving communities as partners in assessing which health problems are most important and what can be done about them
- Involving multiple, locally credible community organizations in concerted campaigns to change behavior (for example, efforts to increase immunization rates or to reduce drug use or community violence)
- Make health promotion "messages" sensitive to nuances in language and culture.

- Public education strategies.** While information is most effective in combination with other incentives, a wide variety of information strategies are necessary. They should be developed in coordination with local boards of health and local health departments. Community curricula and priorities should be coordinated. Examples include:

- A comprehensive program should provide appropriate health education for each and every grade in the K-12 school system. Education topics should include: nutrition, personal health practices and hygiene, prevention of AIDS and other sexually transmitted diseases, injury prevention, substance use and abuse, sexuality education, parenting education, making and asserting behavior choices, skills for generating peer support and combating depression, and cost-effective use of personal health services. The model education curricula should be culturally appropriate. School staff and administrators should also be informed about the benefits derived from implementing a comprehensive health education program and should participate in it. Student outcome measures should be used such as knowledge, skills, attitudes, and practices related to healthy behaviors and lifestyle.

- Adult education on similar topics is needed. Approaches range from mass media presentations to specialized classes at the worksite or in health care institutions.
- General education to sensitize people to the costs of health services to individuals/ society and the costs of preventable diseases is necessary to create incentives for specific interventions at the community and individual level.
- Education to facilitate personal decision-making about healthy behaviors, as well as choices about health services when ill. For example, people need to know the implications of a living will and how to prepare one.
- Rewards** Provide rewards, tangible as well as psychological, for healthy behaviors. Good health itself is not always enough to stimulate changes in unhealthy behaviors.
- For example, the Healthy Mothers/Healthy Babies Campaign, after careful market research and field testing, has developed a "baby book" which is available free to pregnant women who make an initial prenatal care contact. The women who receive this prize care about their babies' health, but the book still appears to increase the likelihood they will go in for early prenatal care.
- Rewards, often simple, should also be used to reinforce healthy behaviors in children. For example, some schools give certificates and awards to entire classes which resist tobacco and drugs for the school year. The President's Awards for Physical Fitness are a well established incentive for fitness (as distinct from competitive success in athletics).

Taxation

Consider taxation options which increase the cost of harmful commodities. The classic examples are cigarette and alcohol taxes ("sin taxes"). Raising the price of cigarettes can reduce consumption by teenagers and other "initial users," a particularly critical point of influence. According to the American Cancer Society, the United States ranks last among industrialized nations in taxing tobacco products. In the United States, the tax rate as a percentage of retail price is 27 percent, compared to 50-77 percent in other industrialized countries.

The behavioral changes resulting from the tax need to be considered separately from the revenue it will raise because the changes in behavior will lead to lower revenues from the tax. The revenue options presented in Chapter 5 for implementing the initial investment costs of health system reform include potential increases in alcohol and tobacco taxes. However, the improvements in health would be the same even if the tax revenues were used for other purposes.

Regulatory Approaches

Carefully consider and adopt appropriate regulatory approaches to reducing harmful behaviors. For example, legal sanctions are effective in increasing seat belt use, and seat belt use is effective in reducing vehicular injuries and death. The Board of Health may be an effective source for evaluating regulatory incentives for risk reduction because the Board combines public health values, access to information supported by the Department of Health, and experience serving as a public forum for debate on such issues. Other state agencies have the appropriate expertise to deal with specific regulatory approaches to health. For example, worker safety is one of the principal responsibilities of the Department of Labor and Industries, which uses regulatory powers to accomplish this goal.

Community Economic Incentives

Develop economic incentives for communities to implement community campaigns addressing serious health problems. Community-level economic incentives are different from economic incentives directed at individuals. Examples to consider include:

- The state formula for sharing K-12 education costs should include comprehensive health education based on meeting state guidelines;
- Communities which fluoridate drinking water supplies in order to achieve fluoride levels adequate for caries prevention could receive some financial reward. If dental treatment is covered in a uniform benefits plan, it might be feasible to finance this incentive from funds which otherwise would pay for additional fillings. A variation on this approach would provide more generous dental benefits for residents of communities with adequate fluoride levels in the water.
- More complex and ambitious approaches are possible, which would reward neighborhoods or communities with property tax reductions if they can "beat the odds" by surpassing projected, demographically adjusted health status objectives.

Public comment is invited on these potential community economic incentives since they are not included in other chapters of the Commission's report.

Multiple Methods

Combine multiple incentives to affect behaviors in order to reduce or prevent health problems.

Reducing tobacco use. Nearly one in five deaths in Washington is directly attributable to smoking. The estimated annual economic impact of smoking in Washington ranges between \$760 million to \$924 million. Examples of action strategies to reduce tobacco use include:

- Education and media campaigns on the personal and public health risks of tobacco use for high risk populations, such as adolescents and pregnant/parenting women;

- Model health education curricula for local school districts that include education designed to prevent tobacco use;
- Continuing education of health care practitioners about tobacco cessation programs, the availability, cost, and appropriate use of nicotine substitutes; and the risks of tobacco use;
- Require and fund comprehensive tobacco use prevention education in schools, especially targeting the primary grades;
- Increase worksite and school efforts to promote a smoke-free environment, supported by a clearly understood rationale;
- Reduce, regulate, or ban the advertising of tobacco products, concentrating on advertising for sporting events and billboards, and advertising aimed at youth, minorities, and women;
- Substantially increase taxes on tobacco products with some of the revenue increases designated for tobacco prevention, counter-advertising, and cessation programs, especially targeted at minors;
- Direct a percentage of current revenues generated by tobacco sales to tobacco prevention, counter-advertising, and cessation programs; and
- Allow and encourage differential health care premiums for smokers.

Reducing injuries. Injuries are the leading cause of death, disability, and hospitalization for individuals up to age 44. Lost productivity for unintentional injury cost about \$573 million annually in Washington State. Examples of action strategies to reduce the incidence and preventable consequences of intentional and unintentional injuries include:

- Use of media and public education to teach children in grades pre-K through 12 techniques for building self-esteem, managing anger, and resolving conflict.
- Enhance vehicle and operator safety by increasing enforcement of existing seat belt and car seat requirements, traffic laws, and motorcycle helmet laws;
- Increase workplace safety by tighter interpretation, application, and increased funding of enforcement of existing laws and regulations; and
- Provide informational brochures in appropriate languages addressing domestic violence as a health concern. Make them available in community clinics, health professional offices, schools, and local health departments.

The same wide range of methods, with different details, can contribute to the effectiveness of meeting other health-related goals. For example, the Northwest AIDS Foundation uses many

approaches to reducing HIV virus transmission in its work among gay and bisexual men and others they may expose through sexual contact. Examples include reducing the incidence and preventable consequences of infectious diseases; reducing the misuse of alcohol and other drugs; and reducing preventable infant mortality and morbidity.

Chapter 9

IMPLEMENTATION OF REFORMS

Introduction

The Commission recognizes that reforming the state's health system will take time -- time to enroll from 550,000 to 680,000 state residents who are now uninsured, time to create effective incentives to control health system costs, and time to obtain necessary federal waivers. A carefully staged strategy must include negotiating agreements with the federal government, streamlining state administrative functions, and expanding the health system's capacity for managing services. In addition, state government, service providers, insurers, and consumers must begin working together *now* to develop the technical, monitoring, and data systems needed to support health reform.

This chapter outlines the Commission's draft recommendations for phasing in reform and staging the integration of public programs under a single state sponsor. The chapter also catalogues issues that can only be resolved through cooperative efforts between the state and federal governments.

PHASING IN REFORM

Regardless of the ultimate shape taken by health system reform, practical and policy considerations suggest some phased approach. The following draft recommendations reflect what the Commission believes to be rational timing and sequencing for health system reforms.

Recommendation 9.1 -- Reauthorize the Basic Health Plan

The Legislature should reauthorize the Basic Health Plan for 1993 and continuing through the period required for health system reform adoption and implementation.

DISCUSSION

The Basic Health Plan (BHP) could be an important element of a reformed health system. Right now it is a valuable tool for learning how to develop and implement managed care programs for the previously uninsured. Furthermore, the BHP covers a segment of people who would otherwise be uninsured during the time reforms are being implemented and provides a ready mechanism for insuring others (for example, employees of small businesses and non-low income uninsured individuals). Reauthorization of the BHP is an important step toward full scale health system reform.

Recommendation 9.2 -- Implement Certain Reforms *Immediately*

The Commission recommends the following elements of health system reform be adopted in 1993, even if the total reform package is not adopted:

- Create a state board/commission** (see Recommendation 4.1)
- Create a state sponsoring entity, with priorities for phasing** (see Recommendations 3.1 and 9.7);
- Phase in universal coverage over five years** (see Recommendations 1.3, 5.2, and 5.5);
- Phase in enhanced public health funding over five years** (see Recommendations 2.2 and 5.4);
and
- Seek necessary federal waivers and changes in law** (see Recommendations 3.1 and 9.8).

Recommendation 9.3 -- Adopt a Phased Implementation Schedule

The Commission recommends that the "Time Schedule for Phasing in Elements of Reform" (Figure 1) be adopted. The elements displayed in Figure 1 should be initiated in 1993 and completed as soon as possible (and in any event no later than the schedule shown in Figure 1).

Recommendation 9.4 -- Consider Health Insurance Reforms

The Commission recommends that in 1993, the State Legislature consider strategies for reforming the health insurance market to make health insurance more affordable, especially for small businesses.

Recommendation 9.5 -- Long-Term Care Integration Study

The Commission recommends that, in preparation for implementing the long-term uniform benefits package, there be a study of long-term care benefits and how they will be integrated into the uniform benefits package or the non-insured portion of the uniform set. (See Recommendation 2.3)

Recommendation 9.6 -- Mandate Coverage by the Fifth Year

The Commission recommends that all state residents be required to obtain uniform benefits coverage for themselves and their dependents by the fifth year of reform implementation.

DISCUSSION

Commissioners agree that implementing health system reforms requires careful preparation and time to accomplish. As the foregoing recommendations indicate, the Commissioners also believe it would be imprudent to delay implementing some reforms until all elements of a reformed system are adopted. The arguments for a phased approach and some pitfalls are summarized below:

- Preparation time** -- A reformed health system will require a number of technical systems to operate effectively, including uniform data, electronic billing, and quality assurance. Developing, testing, and implementing these systems will take one or more years. Providers, insurers, purchasers, consumers, and government officials should all be involved in the design of these systems and this participation will take time.
- Covering the-uninsured** -- Absorbing 550,000 to 680,000 people in the first year of system reform would be very difficult, if not impossible. It would be the equivalent of creating a new Group Health Cooperative all at once or adding 25 times the number of people enrolled in the Basic Health Plan in one-third the time. It will take time to expand administrative and managed care capacity to provide coverage for all of these individuals.
- Ironing out details and disagreements** -- Even after the Commission has agreed on the design of a reformed health system, people will have concerns about the specifics of how the system will work; and some people will continue to disagree with the Commission's recommendations. A one or two year period of detailed design work on the various system elements will provide an opportunity to address various specific concerns, enhance a sense of ownership on the part of different interests, and demonstrate that the system can operate effectively and collaboratively.
- Keeping the momentum** -- A commitment to certain elements of the phase-in could ensure that critical work is started and (in some cases) completed, even if the State Legislature does not enact comprehensive system reform in 1993. For example, the Legislature or Governor could proceed to sponsor or facilitate the development of one or more of the necessary technical systems. The technical systems themselves, and the cooperative development process, could strengthen the foundation for system reform.
- Waiting for Senator Leahy** -- U.S. Senator Leahy of Vermont has proposed legislation encouraging states to adopt comprehensive health system reform and providing/facilitating waivers of federal laws, including ERISA, Medicare, and Medicaid. A phased approach to implementation may allow time for Leahy's bill or an alternative to be enacted, thus facilitating Washington state's reform process.
- Proving system capabilities** -- One potential advantage of a phased approach is to give public and private entities the opportunity to demonstrate they can successfully develop and carry out elements of system reform. Success could increase confidence that additional strategies -- and comprehensive reform as a whole -- can work.

There are important arguments against, concerns about, or weaknesses of a phased approach:

- Phasing without a tangible and binding commitment to comprehensive health system reform may politically undermine the drive toward universal coverage and fundamental reform;
- Effective cost control may be achievable only with total reform and universal coverage; if phasing is protracted, the effects of cost controls may be diluted, resulting in erosion of continued support for system reform; and
- Many incremental improvements have been implemented in the past, and they have not significantly controlled total health system costs or achieved universal coverage.

INTEGRATING PUBLIC PROGRAMS

The Commission has recommended the state create a single sponsor for all residents who are not covered through an employer-sponsored plan to create a more "seamless" and less complex health system (see recommendation 3.1). The Commission also believes there are critical advantages to more closely integrating the many existing public programs, regardless of employers' sponsorship role. Integration, or even close coordination of some or all public programs, would maximize cost control potential and promote the most efficient methods of financing and coordinating services. Integration would also further minimize seams in coverage and reduce system complexity for beneficiaries and providers, which are the basic goals of creating a single state sponsor.

Creating a single state sponsor and integrating programs will be a complex undertaking, even if we ignore the details of combining programs or agencies, and even if the goal is scaled down to coordination rather than integration. Major policy, cultural, legal, and regulatory hurdles remain, and the process must assure adequate financing for integrated programs. The Commission recommends the following general policies to support the overall purposes of the single state sponsor and a tiered implementation strategy for integrating public programs.

Recommendation 9.7 -- Public Program Integration Policies

The Commission recommends integrating public programs and creating a single state sponsor, guided by general policies that create seamless coverage, simplify eligibility, provide a choice of certified plans, ensure adequate financing, and protect the state sponsor from the effects of covering a sicker population.

DISCUSSION

The Commission expects the single state sponsor to be guided by policies that support the overall objectives of creating a seamless, simplified, efficient, and adequately financed state-sponsored plan. The following five policy guidelines elaborate the Commission's expectations:

- The state sponsor must ensure immediate coverage when an eligible resident no longer is insured through an employer plan.
- The state sponsor must provide for uniform eligibility requirements, forms, and processes. If multiple public programs exist, changes in eligibility among these programs should be "transparent" to the affected individuals; that is, no new applications or information should be required.
- All residents covered by the state sponsor must have a choice of certified health plans available in their locales.
- If a beneficiary group (for example, Medicare enrollees) is to be covered by the state sponsor, the funds from that program must be transferred or otherwise made available.
- The single state-sponsored plan must be protected from adverse selection, which may occur if employers continue as sponsors. Employers may tend to pick the less expensive option of sponsoring ("playing") or paying taxes ("paying"). This could result in higher risk groups of employees going into the state plan. Therefore, premiums will need to be adjusted to account for the differences in risk.

Recommendation 9.8 -- Public Program Integration Implementation

The Commission recommends a two-tiered process for integrating public programs which allows public and private employee groups the option of joining the single state sponsor plan, seeks waivers and clears legal and regulatory hurdles, and ranks integration of public programs. Recommended program priorities are identified below in the section entitled, "Priorities for Integration." Recommended responsibilities for making legal and regulatory changes are set out below in the section titled, "Legal and Regulatory Changes."

DISCUSSION

Program integration or coordination will use the resources of state/federal agencies and community organizations. Therefore, the Commission believes choices about priorities and staging will have to be made. The Commission recommends the following process which incorporates a priority-based, phased approach to integrating programs:

Priorities for Integration

•First Tier Priorities: Beginning as soon as possible, the state sponsor should develop plans that include strategies to obtain federal waivers and change laws or regulations needed for integration. The Commission recommends that all employers, public and private (including government and K-12 school employees), should have the option of joining the public program as soon as possible. The state sponsor should move quickly with plans to accommodate employer groups. Finally, the state sponsor should determine how and when to include or coordinate the following programs:

--Medicaid medical and acute care;

--Department of Social and Health Services (DSHS) aging and adult services;

--The community services portion of DSHS developmental disabilities;

--The community services portion of DSHS mental health programs;

--Other state medical assistance programs, including the medically needy, General Assistance-Unemployable, and medically indigent;

--The Basic Health Plan; and

--Medicare.

•Second Tier Priorities: Because of their substantially different financing and delivery systems, the new state board/commission should undertake studies to determine whether, how, and when the following programs should be integrated:

- Medical services of the worker's compensation program;
- Health services in jails and correctional facilities;
- Community and migrant health centers and other categorical grant programs;
- Indian Health Service;
- Institutional services of the developmental disabilities and mental health programs; and
- State and federal veterans' health services.

Legal and Regulatory Changes

The new state board/commission should have the responsibility to identify and analyze changes to state and federal laws and regulations needed to implement health system reform in Washington state, including the creation of a state sponsoring entity or mechanism. State agencies should be required to assist in this effort, and the board/commission should be required to establish a private sector advisory committee to ensure other stakeholders participate in this process. Specific topics include:

- Identify and propose changes in state law and regulation to coordinate/integrate Medicaid and other medical assistance programs, the Basic Health Plan, and state/local public and K-12 employees health insurance (should they elect to join the public plan);
- Identify and negotiate with Congress for necessary statutory changes to or exemptions from ERISA;
- Identify and negotiate with Congress and/or the federal Department of Health and Human Services for necessary statutory or administrative waivers to Medicaid, Medicare, and/or other federal programs (for example, community/migrant health centers, and AIDS services);
- Negotiate with appropriate federal agencies, including the Department of Defense, to integrate CHAMPUS, veterans, and federal employees health programs; and
- Identify and propose state legislation necessary to overcome anti-trust barriers to integration.

FEDERAL ISSUES AND ACTIONS

The Commission's discussions and draft recommendations have identified a number of areas of Washington state health system reform in which the federal government could or should be a partner. These areas are catalogued below:

Federal Waivers

The state may need to request that Congress change or grant waivers from some or all of the following (established administrative mechanisms through which the state would request waivers may not exist for all needed changes):

- ERISA**, in order to be able to apply uniform rules to all purchasers. Such a request may be necessary (though different in nature and scope) for either multiple or single sponsorship alternatives.
- Medicare**, in order to "capture" current Medicare expenditures, administratively integrate Medicare into the reformed system, integrate Medicare provider payment methods, mold Medicare benefits into the uniform benefits package, require Medicare beneficiaries to enroll in certified health plans, and perhaps other purposes.
- Medicaid**, in order to "capture" current Medicaid expenditures, administratively integrate Medicaid into the reformed system, integrate Medicaid provider payment methods, mold Medicaid benefits into the uniform benefits package, require Medicaid beneficiaries to enroll in certified health plans, and perhaps other purposes.
- Older Americans Act**, in order to capture and integrate funds for certain personal support services, especially those that would be covered under a long term care benefit.
- Public Health Service Act**, in order to capture and integrate, as appropriate, current public health expenditures into the reformed system.
- Other federal programs**, in order to capture and integrate, as appropriate, the funding for programs such as community and migrant health centers, maternal and child health, and AIDS.

Federal Tax Policy

State health reform would be enhanced by aligning federal tax incentives concerning employee health benefits with Commission recommendations that give incentives to employers and employees to choose lower cost plans. The state would need to petition Congress to enact such

changes. Examples of tax policies that may need to be aligned with Commission recommendations include the following:

- Income tax incentives for corporations to provide richer health benefits over other types of taxable compensation may need to vary for supplemental versus uniform benefits package coverage.
- Unequal tax treatment of corporations, partnerships, and single proprietorships, which produces conflicting incentives to provide and not provide health coverage, may need to be made uniform.
- Individual income tax policy which provides weak incentives to obtain health coverage may need improvement.

Other Federal Issues and Actions

The state will need to negotiate agreements with various federal agencies in order to develop/coordinate the data system(s) necessary to support state health system reform:

- Practice Parameters and Research** -- The state should request that federal agencies developing practice parameters and those funding research consider cost-effectiveness as a high priority in these efforts.
- Plan Certification** -- The state may need to negotiate with existing federal agencies to minimize duplicative and contradictory regulatory actions as part of the health plan certification process(es).
- Prescription Drugs** -- The state may need to request that Congress enact legislation to control drug costs.
- Health Manpower** -- The state may need to request that Congress or other existing federal agencies provide financial incentives to improve the supply and distribution of primary care providers.

Draft Recommendations

September 2, 1991

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