EXECUTIVE SUMMARY

The following is a summary of the most important recommendations in the Washington Health Care Commission's December 1, 1991 Interim Report to the Governor and the Washington State Legislature.

Need for Health System Reform

For Washington residents with adequate resources, the state's health system offers some of the most technologically advanced medical care in the United States. Yet, the health system is increasingly dysfunctional, with costs rising unabated while a growing number of residents go without adequate health insurance or access to needed health services. While spending for health services in Washington has been increasing at two to three times the general inflation rate, an estimated 550,000 to 680,000 Washington residents do not have health insurance.

Washington citizens -- joined not only by business, labor, and health system leaders, but also by the Governor and the State Legislature -- continue to voice their growing concern that fundamental changes are needed to correct the serious problems of eroding access and escalating costs. These problems affect all state residents, but they fall more heavily on some segments of the population: employers and employees of small firms, the self-employed, children, rural residents, the poor and working poor, the unemployed, the disabled, and those who are sick or are more likely to need health services.

Recognizing these cost and access problems, the State Legislature in March, 1990 created the Washington Health Care Commission to make recommendations for reforming the health system in Washington State. The recommendations must include identifying methods to control health system costs and to decrease the rate of cost inflation through improved state health care purchasing. The Commission must also recommend plans for ensuring access to health services for all people in the state and develop incentives to use appropriate and effective health services. In addition, the Commission must recommend reforms to the health care liability system.

This Interim Report presents initial recommendations based on the Commission's belief that the state's health system requires comprehensive and fundamental reform, with due consideration for the strengths of the existing system.

What the Health System Should Do

The goals of Washington's health system should be to help people stay healthy, regain functioning lost through illness or injury, and reduce pain and discomfort. Health disparities among population groups should be reduced as well. To achieve these goals, the Commission developed principles and values that reflect its vision for improving the state's health system.

The fundamental purpose of the health system should be to maintain or improve the health of all state residents at a reasonable cost. The Commission believes health system reform must balance the needs of individuals with those of society, while considering the special needs of underserved residents. The "stakeholders" -- business, labor, providers, insurers, government, and consumers -- must all participate in reform, help control costs, and share responsibility for financing an improved system. All individuals and communities should have the right to make reasonable choices about their health and the information needed to make those choices.

The costs of health services borne by individuals should not be a barrier to universal access, but should discourage inappropriate use of those services. Individuals and communities should assume greater responsibility for maintaining and improving their own health by minimizing unhealthy behaviors, taking appropriate preventive measures, and making cost-effective decisions about the use of health services. The Commission also believes a substantial majority of the state's population should receive health services through integrated delivery systems that manage care and assume financial risk for providing health benefits.

Ensuring Universal Access

The State Legislature asked the Commission to "recommend plans for ensuring access to health care for all people." The Commission realizes that ensuring *universal access* involves many factors, including the numbers and types of practitioners and facilities, transportation, health insurance or other funds to pay for care, and cultural or ethnic differences. The Commission's access recommendations are based on the following definition of "universal access:"

Universal access means 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 due to 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.

The Commission believes the following key elements will be critical to ensuring universal access in a manner that satisfies public values:

•Total spending on health services must be controlled to ensure they are affordable;

•Consistent with responsible cost control, individuals should have a reasonable choice of cost-effective service delivery systems and providers;

•To the extent feasible, all Washington residents should be ensured continuity of care with their health provider(s), regardless of changes in life circumstances, employment, or source of insurance coverage.

•Resources -- including outreach programs, health personnel, an effective referral network, and transportation -- should be adequate and appropriately distributed throughout the state to ensure timely access; and

•The health system should encourage and empower people to take personal and financial responsibility for their health and health services.

The Commission has focused its 1991 recommendations to ensure universal access on removing *financial* barriers to access. As the Commission continues its work in 1992, it plans to address how to overcome *nonfinancial* barriers to access.

Universal Access to What?

The Commission recognizes that the services we traditionally think of as "health care" -- such as those provided by physicians, hospitals, nursing homes, and dentists -- are not the only services that can maintain or improve health. Health education, community drug prevention, workplace health promotion, communicable disease control, and environmental and occupational health protections are among the many services that help people stay healthy. All these services are part of the health system.

The Commission strongly believes *all* state residents must be guaranteed access to a uniform set of health services. The Commission is considering certain health services in the following five categories as *candidates* for the uniform set:

•**Population-based services** include community health protection, community health promotion and education, and communicable disease prevention and control;

•**Personal health services** include diagnosis/assessment and selection of treatment/care, clinical preventive services, emergency health services, reproductive and maternity services, clinical management and treatment, and therapeutic drugs, biologicals, supplies, and equipment;

•**Access services** include those services needed to ensure that individuals and families receive other appropriate and effective health services;

•**Adequate food/housing for vulnerable populations** consists of food for nutritionally "at risk populations," as well as shelter for individuals and families who are at serious health risk due

to inadequate housing; and

•**Health system support** includes health personnel education and regulation, public health support, system development/regulation, and health research.

Most health services are now financed through private or public insurance. The Commission expects insurance will remain an important mechanism for financing most health services, though not the only one. The *insured* portion of the uniform set of health services -- which will probably include most personal health services and some public health services -- is called the *"uniform benefits package."* This package includes services to which all state residents will be assured financial access through public or private health insurance.

The Commission recommends the package be "more comprehensive than lean," in order to bring total health system expenditures under control and to provide the range of services required to meet most of the health service needs of state residents. Since designing and providing an *affordable* package is critical, the Commission also recommends requiring individual cost sharing (based on ability to pay) and limitations on services included in the package.

During 1992, the Commission plans to complete development of the *initial* uniform set of health services and uniform benefits package. The Commission's 1992 Work Program will also address how to finance services in the uniform set that are not included in the uniform benefits package.

The Commission's recommended criteria for developing the uniform set and package include:

•All Washington residents should have access to a uniform set of health services encompassing their basic needs for disease and injury prevention, personal health services, population-based services, and other public health services;

•While the uniform set and package should be comprehensive, they must also be affordable to society.

•To help finance a comprehensive *and* affordable package, individuals should share the cost of health services based on their ability to pay;

•Highest priority should be given to appropriate and effective health services that improve the health of the overall population; and

•The uniform set and package should include acceptable techniques and incentives to encourage the appropriate use of health services.

Finance and Payment System Reform

The Commission is convinced that fundamental changes in the way health services are financed and

paid for are critical to controlling costs *and* guaranteeing universal access. The Commission's recommendations for finance and payment system reform focus on health insurance as the primary financial access mechanism and emphasize the following four key policies:

•Individuals should have a reasonable choice of service delivery systems and types of providers from which to obtain health services;

•The finance and payment system should enhance the portability of health insurance coverage and "smooth the seams" that may occur as the result of changes in employment, financial status, or place of residence;

•Health status should not affect one's ability to have health insurance coverage; and

•"Supplemental benefits" beyond the uniform benefits package may be purchased.

To promote efficient service delivery and the use of appropriate and effective health services, the finance and payment system should also encourage the elimination of charge-based fees and move toward prospective payment methods that shift a greater portion of financial risk to providers.

The Commission developed a number of cost control criteria to evaluate the strengths and weaknesses of alternative financing and payment systems. Pursuant to these criteria, system reform should address all elements of the health system in order to control total system expenditures, minimize unnecessary administrative costs, promote efficient service delivery, and encourage the use of appropriate and effective health services. In addition, the finance and payment system should help promote health; ensure adequate financing of health services and professional education; distribute the costs of services fairly; and encourage effective and efficient innovation.

The Commission has formulated a finance and payment system model describing its vision of the relationships among financers, sponsors, payers, providers, and consumers of health services. Under the Commission's recommended model diagrammed on page 10, the responsibility for financing the health system would be equitably shared by government, employers, and individuals. The question to be addressed by the Commission in 1992 is not whether each sector should pay, but *how* and *how much*.

Multiple, certified health plans -- managed by private insurers, health care service contractors, health maintenance organizations, employers, or state/local governments -- would offer the uniform benefits package. The plans would compete on the basis of administrative efficiency, quality, and consumer satisfaction, not on their ability to enroll healthy members.

To control total health system expenditures and provide an affordable uniform benefits package, the Commission believes that some important elements of the finance and payment system must be *uniform.* To assure uniformity, the Commission recommends creating an independent state board or commission to guide the reformed health system by exercising the following key responsibilities

and authorities:

•Design the uniform benefits package;

•Determine the maximum premium that payers/insurers may charge for the package, leading to a target or total budget expenditure level;

•Establish how much individuals should pay for uniform benefits, including premium shares, copayments, deductibles, and coinsurance;

•Determine methods of payment to service providers;

•Control the proliferation of high-cost technology;

•Develop mechanisms to distribute equitably the financial impacts of variable medical risks;

•Determine billing and claims procedures for all payers and providers and establish utilization management policy;

•Prohibit or restrict provider investments that present conflicts of interest; and

•Ensure the participating health plans are certified.

The five to nine full-time, paid members of the new state board/commission -- appointed by the Governor and confirmed by the State Senate -- should represent the public interest and have no financial interest in any health service activity during their terms. The board/commission should include members with experience in various elements of the health system. The board/commission should be required to establish structures and processes that ensure effective participation of stakeholders (including business, labor, government, providers, insurers, and consumers) in its decision-making process.

Uniform Benefits Package Sponsorship

While the Commissioners all agree that government, employers, and individuals must share in financing the uniform benefits package, the Commissioners examined but did not resolve the issue of whether employers should have the option to sponsor the uniform benefits package in the reformed system. The Commissioners identified arguments for and against allowing employers to sponsor uniform benefits through multiple, certified health plans.

From one point of view, it is a question of the relative costs and benefits of having employers involved in selecting or restricting the choices of health plans available to their employees and dependents. From another perspective, it is a question of whether employers can exert pressure on the health system to control costs, over and above the other system reforms recommended by the Commission to control costs. Political, tax reform, and labor/management issues also are central to the question of employer sponsorship.

Commissioners are concerned that a "seamless" system and portability of coverage could not be achieved with an employer-based system. They agreed that *if* employers do sponsor benefits, then a unified state program should cover all state residents who do not have employer-sponsored coverage, including people who are now uninsured, Medicaid recipients, enrollees in the Basic Health Plan, and Medicare enrollees.

Health Care Liability System

The State Legislature asked the Commission to recommend medical malpractice and liability insurance reforms to decrease costs, increase access to health services, increase the efficiency and safety of health provider practices, and provide needed coverage for injured consumers. The Commission analyzed how the "health care liability system" -- health care practices, liability insurance, and the civil justice system -- can prevent malpractice from occurring and ensure injured patients receive appropriate care and compensation in an efficient and timely manner.

As a result of this analysis, the Commission agreed on three main purposes for the health care liability system:

- Efficiently provide appropriate compensation to individuals who have been injured by negligent health care practices;

- Promote the provision of and access to appropriate and effective health services; and

- Minimize the incidence of adverse health outcomes resulting from negligent health care practices.

The Commission also identified the special roles in the system for health care practices, liability insurance, and the civil justice system. In addition, the Commission developed criteria for evaluating potential strategies for reforming the health care liability system. Finally, the

Commission identified a number of *prevention* and *process* strategies to be refined and evaluated during 1992.

The Commission decided to focus on developing and evaluating prevention strategies, because the best way to address the adverse impacts of the health care liability system on access and costs is to reduce the need for that system. Changes to the legal and insurance systems alone cannot resolve the problems related to medical injury. The Commission initially recommends: exploring potential reforms of health care practitioner regulation; requiring risk management education for practitioners; developing guidelines or parameters for professional practice; establishing a uniform format for collecting data on provider practices; and implementing purchasing strategies to improve quality.

To streamline the compensation process, during 1992 the Commission will evaluate alternative methods of resolving disputes and settling claims, simpler and less costly legal procedures, methods of discouraging insupportable claims, and liability insurance reform (including a "selective no-fault system").

Additional Recommendations

The Commission has developed five additional recommendations to promote universal access and cost control. First, the Commission recommends extending the Basic Health Plan for at least an additional two years. Second, the Commission recommends considering immediate health insurance reforms to improve access pending fundamental health system reform. Third, the Commission recommends that attention be paid to the need for adequate numbers, types, and distribution of service providers, as well as increased reliance on delivery systems that manage care and assume financial risk for providing health benefits. Fourth, the Commission recommends that mechanisms be developed to adequately fund training and education of health personnel. Finally, the Commission recommends improving public and private data collection efforts to support health system reform.

Public Participation

The Commission considers an effective public participation program to be a critical factor in successfully meeting the challenge of health system reform. Since its first public meeting in June, 1990, the Commission has pursued a wide variety of approaches for enabling and encouraging the public to participate in the work of the Commission. This has been achieved through Commission and committee meetings, a strategic planning conference, the extensive use of technical advisors, panel discussions and presentations, speaking appearances, and many mailings to a growing list of interested organizations and individuals.

To develop and evaluate its recommendations, the Commission has worked with a wide range of health experts and representatives of various sectors of the health care industry. The Commission also heard from many people in communities throughout the state at the front lines of the health

system where services are delivered and received. The Commission provided numerous and varied opportunities for the general public to participate in the preparation of its recommendations, including public hearings, community health days, the distribution of flyers and other informational materials, and proactive solicitation of written comments.

The Commission will continue these and other public participation efforts in 1992 as it finishes addressing the State Legislature's five goals for health system reform. The Commissioners are grateful for the time, support, and information received from numerous groups and individuals throughout the state as the Commission grappled with complex, controversial, and important health issues.

1992 Commission Work Program

In 1992, the Commission will address a number of important health system reform issues, including the following priority tasks:

•Continued design and cost analysis of an initial uniform set and package;

•Evaluation of additional finance and payment system reforms, including the role of employers, responsibilities for system financing, additional responsibilities and authorities of the new state board/commission, and a method for financing those uniform health services not included in the uniform benefits package;

•Development of strategies for overcoming *nonfinancial* barriers to accessing health services;

•Identification of incentives to encourage the use of appropriate and effective health services and to encourage healthy behaviors; and

•Further development and evaluation of the prevention and process strategies identified by the Commission in 1991 to reform the health care liability system.

The Commission has identified a number of *candidate* tasks to be included in its 1992 Work Program. By January, 1992, the Commission will select the most important of these tasks to be completed for the Commission's Final Report to the Governor and State Legislature, due November 1, 1992.

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CHAPTER 1

NEED FOR HEALTH SYSTEM REFORM

Introduction

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 are voicing growing concern that fundamental health system reform is needed. They are joining national business and labor leaders, nationally renowned researchers, and respected medical journals in calling for 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. Representatives of Washington's physicians, hospitals, insurers, and businesses -- major stakeholders in the 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 26 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. Wage and price controls imposed during World War II encouraged employers to offer health plans as a way of enhancing employee compensation. 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 are uninsured. This represents from 11 to almost 14 percent of Washington State's population of 5,000,000 people.[1] Previous estimates by the Washington Health Care Project Commission (1986) and the Washington State Medical Association's Access Task Force (1989) estimated the rate of uninsured at about 17 percent. The lower rates used in this Interim Report reflect a change in the method of estimating, not a decrease in the number of uninsured state residents. 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] This includes expenditures for health services by private businesses, households, governments (state, local, and federal), and non-patient revenues such as interest and philanthropic donations. 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. Many of the 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 individual and group programs to promote healthy behaviors, provide support for dysfunctional families, and nurture vibrant communities -- in short, social, economic, and public health strategies. Today, however, less than three percent of total state health

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[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.

expenditures are allocated to public health.[3] Nationwide, federal support for public health activities has been reduced.[4]

Current Health System

Washington's current health "system" has been aptly described as a patchwork of private and public programs, with goals and objectives as varied as the groups and organizations represented in the system. The Commission recognizes the strengths in such a diverse system -- for example, its ability to adapt, innovate, and provide a range of choices for consumers. Yet, the existing system has significant weaknesses that leave many state residents without access and allow costs to rise uncontrolled. The Commission's recommendations for addressing the problems of cost and access are based on an understanding and evaluation of the state's existing health system described below.

GOVERNANCE

Governance of Washington's health system is multi-faceted, involving important public and private entities. Governance includes responsibility for activities such as policy development, regulation, administration, financing, and purchasing.

Private Sector

Governance of private sector health programs is the responsibility of many types of entities:

•In 1990, 29 health care service contractors, 17 health maintenance organizations, a host of preferred provider organizations, and over 200 commercial health insurers operated in Washington State.[5]

•Most large and medium sized businesses, as well as many small firms, sponsor health insurance benefits for their employees; many also cover dependents. Employees and trade unions are involved, formally or informally, in determining the extent and nature of these benefits.

•Many of the larger businesses not only finance health coverage, but they also "self-insure" by

[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 Commissioner, August 8, 1991.

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

[5] Washington State Office of the Insurance Commissioner, October, 1991.

assuming the financial risk of paying providers without intervening insurance carriers.

Each of these entities is involved to some extent in determining eligibility, benefit packages, purchasing strategies, cost controls, and overall policies for its own group(s) of employees, members, subscribers, or enrollees.

Public Sector

Federal Government

The federal government oversees, regulates, and funds a variety of health activities in Washington State, including Medicare services for disabled or older adults, community and migrant health centers, Veterans Administration and military health care facilities, professional education programs, and numerous public health and safety programs. The federal government also partially funds and sets standards for operating the state-run Medicaid program, the Women, Infants, and Children (WIC) supplemental food program, and family planning programs. Many health research and demonstration projects are also federally financed.

State Government

Washington State government exerts considerable control over various aspects of the health system: licensing and regulating health professionals and facilities; regulating certain insurance, hospital, nursing home, and high technology activities; purchasing health care for low income people, injured workers, and public employees; and providing care for veterans, mentally or physically disabled persons, and prison inmates. The state also governs programs aimed at protecting the health and safety of the population as a whole, such as communicable disease control, food and drinking water quality, waste disposal and pollution emission controls, home and work place health and safety, and disaster planning.

The Governor is a key player through political influence and appointment of administrative officers of most health-related state agencies. The Washington State Legislature influences health matters through legislative action and oversight by policy and budget committees.

Key state agencies involved in governing the health system through policy making, financing, regulation, and providing health services include the following:

- The Department of Social and Health Services administers a variety of health and welfare programs, including Medicaid and related medical programs for people with low incomes; long term care for the low-income elderly and others with chronic disabilities; services for individuals who are acutely or chronically mentally ill or seriously disturbed; developmental disabilities programs; child welfare services; alcohol and substance abuse treatment; and refugee assistance.

- The Department of Health administers a variety of public health programs, partially funds personal

health services (especially maternal and child health services) delivered by local health departments and community clinics, and carries out data collection, health professions and facilities regulation, policy and planning, data-based evaluation of service effectiveness, and cost monitoring.

•The Health Care Authority is responsible for administering health and related insurance benefit programs for about 253,000 state and political subdivision employees, retirees, and their dependents.

•The Department of Labor and Industries administers laws pertaining to employers, employees, and places/conditions of work, including no-fault workers' compensation insurance, which covers health services for treatment of work-related illness and injury, as well as disabilities. The Department also administers the Crime Victims Compensation Program.

•The Basic Health Plan administers a pilot program of contracted managed care for about 24,000 low income individuals who are otherwise uninsured.

•The Department of Veterans Affairs provides health services for the state's veterans, including restorative health services, in two state-operated nursing homes.

•The Insurance Commissioner regulates the insurance industry, focusing on financial solvency and consumer protection, as well as the operations of health care service contractors and health maintenance organizations. The Commissioner also oversees a high risk health insurance pool for individuals who are otherwise "medically uninsurable."

•The departments of Agriculture, Ecology, and Transportation, the Board of Health, and the Superintendent of Public Instruction each have or share responsibility for various aspects of public health and safety such as environmental protection, food and water quality, population-based preventive health services, and health education.

Local Governments

Local governments are also involved in health policy making and financing, purchasing, regulating, and providing health services. City and county governments, through their health departments, provide a variety of personal health, environmental health, and other population-based health services. They also develop and oversee mental health, chemical dependency, developmental disabilities, emergency medical services, and AIDS-related programs. Public hospital districts, another form of elected local authority, oversee and operate a number of hospitals and other services, mostly in rural areas throughout the state.

FINANCING

As discussed above, overall health system expenditures in Washington State totalled $13.4 billion in 1990. Financing of these expenditures was shared by the many public and private entities noted above. Federal, state, and local public programs accounted for 34.2 percent of this total (federal programs, including Medicare, made up 14.6 percent, while Medicaid and other state and local programs represented 19.6 percent). Private employers contributed 29.8 percent of total expenditures, while an additional 31.2 percent comprised direct financing or cost-sharing by households. The chart on the next page shows these sources of financing for state health expenditures in 1990.

The share of health system expenditures varies considerably by type of service. For example, Medicaid funds about 46 percent of all nursing home spending, while consumer out-of-pocket payments represent 50 percent, and private insurance and Medicare each account for two percent of such spending. For hospital services, private insurance and consumer out-of-pocket payments represent 50 percent of all spending, with 37 percent covered by Medicare and 13 percent by Medicaid.

State government agencies (predecessors to the State Department of Health) reported spending about $92 million on public health programs in Fiscal Year (FY) 1989.[6] Local health departments spent an additional $86 million from other sources. Funds for state government public health programs are roughly 53 percent federal and 47 percent state and local. Local health departments rely substantially on local funding, with an average of 42 percent of their funds raised locally. Dependence on local funding and a wide variation in funds available from other sources means significant variation by county in per capita spending and services available. Per capita public health expenditures in 1990 ranged from a low of $8.11 in Mason County to a high of $35.20 in King County.[7]

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[6] Washington State Department of Health data for Fiscal Year 1989, as reported to the Public Health Foundation for its national public health data base.

[7] Washington State Department of Health, Local Per Capita Public Health Support by Health Department, 1990, August, 1991.

Chart

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BENEFITS

Each of the public and private personal health care programs noted above has its own unique structure of benefits or services. Moreover, private insurers and managed care plans often provide somewhat different benefits to different enrollee groups, depending on labor contracts and sponsor preferences. Eligibility for benefits and cost-sharing are determined by each plan. For example, about 49 percent of covered employees pay a portion of premiums, 47 percent are not required to contribute to premiums, and four percent pay their entire group premium rate.[8]

In 1989, about 54 percent of the state's 4.6 million residents were eligible for benefits under group (primarily employer-sponsored) insurance plans, 12 percent had individually-purchased insurance, 13 percent were Medicare enrollees, eight percent were covered by Medicaid-related programs, six percent had military-related coverage, and 11 to almost 14 percent were uninsured.[9]

Many public health programs benefit large groups of Washington residents, while other programs benefit specific groups at high risk or protect individuals against specific diseases. Programs protecting large groups or populations include air quality control, drinking water supply, food quality control, sanitation, and workplace and home environmental safety. Programs to prevent and treat communicable diseases through immunization, aggressive outreach to exposed individuals, and public education are often categorized as personal health services by public health agencies. Screening programs allowing for early treatment of chronic illness such as cancer, diabetes, genetic disorders, and vision and hearing impairments are also operated by public health programs. Preserving health through family planning, nutrition for mothers and babies, preventive dental care, and education are other examples of public health program benefits.

SERVICE DELIVERY

Health services in Washington are delivered primarily by private individuals and organizations, with some services provided directly by state and local governments. The chart on the next page shows the portion of total health system expenditures spent for various types of health services in 1988, including personal health services tracked by the

[8] Applied Demographics, Health Care Access in Washington State, prepared for the Health Access Task Force of the Washington State Medical Association August, 1989.

[9] The data on insurance by type of sponsor is from the Health Access Task Force, Washington State Medical Association, Health Care Access in Washington State, August, 1989. The sources of the percentages of the uninsured are cited in footnote 1 on page 12. The total does not add to 100 percent because of the use of different sources.

Chart

State Department of Health, as well as clinical disease prevention and health promotion. The chart excludes many population-based health promotion and prevention services. In describing the current delivery system, traditional categories or types of services are used, primarily because information is collected according to these historical categories. For the purpose of developing a uniform set of services, in Chapter 2 the Commission defines categories of services that differ from the historical categories used in the following description.

Primary, Acute, and Other Professional Services

According to 1988 data, inpatient hospital services are provided in 12,700 beds by 103 non-federal hospitals, the vast majority of which are operated by non-profit corporations or public hospital districts. The state's 2.8 bed per 1,000 population ratio is about 25 percent lower than the U.S. average. In 1987, hospitals in Washington State employed nearly 44,000 full-time equivalent workers (3.5 per bed), including 14,000 licensed nurses.

Washington State licenses, registers, or certifies about 130,000 individuals in over 40 health provider categories, including 9,900 licensed physicians, 1,200 chiropractors, 40,900 registered nurses, and 3,100 dentists.[10] Nationally, there are more specialists than primary care physicians, with 60 percent specialists and 40 percent primary care physicians. In recent years, shortages of some types of health personnel -- primary care physicians, nurses, and nursing assistants -- have occurred. These shortages have been experienced nationally, statewide, and in particular locations such as rural areas and inner cities. The state's approximately 50 community and migrant health clinics, operated by non-profit entities and some local health departments, are important primary care providers to people with low incomes.

The majority of health service practitioners are self-employed or employed by private organizations. They are paid through a variety of means including salary, capitation (a fixed amount per enrollee in a health plan), and fee-for-service. Many licensed nurses, nursing assistants, and other health personnel are represented by labor organizations, most prominently the Washington State Nurses Association, the Service Employees International Union, the United Food and Commercial Workers, and District 1199NW National Union of Hospital and Health Care Employees.

Long Term Care

A variety of in-home, community-based, and residential long term care services are provided in Washington State to people with chronic physical or mental disabilities. Clients enter long term care programs through many different entry points, although state policy has been encouraging a more coordinated system, both among programs and among primary, acute, and other professional service providers.

[10] Washington State Senate Health and Long Term Care Committee, Health Professional Shortages in Washington State, 1990. The number of licensed, registered, and certified providers includes those who may not be actively practicing.

Nursing home care is provided by 307 private (mostly for-profit) facilities, containing 31,000 beds (a ratio of about 50 beds per 1,000 people aged 65 years and over).[11] Room, board, and some personal support and health services are also available in other residential settings, such as over 800 private adult family homes, 120 private boarding homes, and individual apartments. Home nursing, homemaker, respite, and other personal support services are offered by a number of private for-profit, private non-profit, and community agencies, as well as some local health departments.

The Department of Social and Health Services, primarily through its local Community Service Offices, determines eligibility for certain services for state-funded individuals. The state contracts with regional, publicly sponsored area agencies on aging for many activities on behalf of elderly long term care clients, including program planning and coordination, eligibility for specified programs, case management, and information/referral. The state also contracts with regional support networks at the county level for the delivery of services to emotionally disturbed people.

Public Health Services

Responsibility for setting policy, administering, and delivering most public health services in Washington is split among federal, state, and local governments. The State Board of Health and Department of Health carry out the bulk of public health functions at the state level. Local health departments and boards of health set local policy and implement programs in 32 single or multi-county areas.

The goal of public health services is to protect and improve the health of Washington residents. In pursuit of this goal, a wide array of programs and services have been established to protect environmental and occupational health, prevent communicable and chronic diseases, and provide personal health services. Many of these functions are carried out by the Department of Health and local health departments. The departments of Social and Health Services, Ecology, Agriculture, Transportation, and Labor and Industries, as well as the Office of the Superintendent of Public Instruction, also have public health and safety responsibilities that require coordination with state and local health departments.

In addition, many employers have implemented work place health promotion and injury prevention programs for their employees. Some of these programs use in-house staff, while others are provided on contract with specialized businesses, health service providers (such as hospitals or home health agencies that have developed such programs), and public health departments.

Problems and Issues

[11] The state's policy goal is to reduce this ratio to 45 nursing home beds per 1,000 people aged 65 and over, while increasing the availability of other long term care resources.

The following sections discuss the major problems and issues facing the health system in Washington State.

BARRIERS TO ACCESS

The State Legislature asked the Commission to develop plans to ensure that all Washington residents have access to appropriate and effective health services. Ensuring access means that the services are available in adequate quantities *and* that individuals can obtain the services when needed. The state's health system provides reasonable access to many services for many people. Unfortunately, however, a growing number of individuals face substantial access barriers:

- As discussed above, between 550,000 and 680,000 Washington residents are without health insurance at any point in time, which leaves many people without financial access to needed services. This represents 11 to 14 percent of the state's total population.

- Even with health insurance, some communities and individuals are unable to obtain needed health services because there is a lack of appropriate providers able or willing to provide those services. For example, many rural (and some urban) areas are without obstetrical care providers, while other areas have seen their hospitals close. Some Medicaid clients have been unable to obtain needed services, because some physicians are unwilling to provide them for the low fees paid by that state program. Access to primary care practitioners is a particular problem for some geographic areas of Washington and some groups of residents. Some of the areas suffering these shortages have been designated "Federal Primary Care Shortage Areas" by the U. S. Department of Health and Human Services in consultation with state health officials.

- Inadequate transportation and/or geographic isolation can impede access to health services.

- Demographic and cultural differences -- such as age, gender, race, ethnicity, language, and national heritage -- may make it difficult to provide and receive services.

- Access may be impeded because of insufficient information about program eligibility, providers, and services.

- A pre-existing health problem may make obtaining health coverage difficult or impossible.

- Access to public health services may be diminished when federal, state, and local budgets are cut.

Insurance is a key factor in gaining access to Washington's health system, since obtaining health services often depends on one's ability to pay. As noted above, having health insurance does not guarantee access, but lacking insurance prevents timely access to services for many and may even

result in different outcomes of care.[12] Because of the importance of insurance in providing financial access to services, the Commission focused its 1991 efforts on developing recommendations for a health system designed to assure that all Washington residents are covered for a uniform package of benefits. The Commission's work in 1992 will include ways to overcome *non-financial* access barriers.

The uninsured population in Washington State has the following characteristics:[13]

•About 24 percent (132,000 to 163,000) of the uninsured are children;

•About 55 percent (302,000 to 374,000) of the uninsured have incomes less than 200 percent of the federal poverty level;

•About 46 percent (251,000 to 313,000) of the uninsured are employed; and

•An estimated two-thirds to four-fifths of all uninsured people are either employed or dependents of employees.

This last characteristic is especially important, because the majority of Washington residents currently depend on employment for their health insurance. Either as employees or as dependents, 54 percent of the state's population is insured through the work place. Yet a growing number of employees and their dependents are not insured.

[12] *See* Hadley, Jack, et. al, "Comparison of Uninsured and Privately Insured Hospital Patients," Journal of the American Medical Association, 265(3), January 16, 1991, page 374, which found in-hospital death rates for uninsured patients 1.2 to 3.2 times higher than for insured patients; and Braveman, Paula, et. al, "Adverse Outcomes and Lack of Health Insurance Among Newborns in an Eight-County Area of California, 1982 to 1986," New England Journal of Medicine, 321(8), August 24, 1989, page 508.

[13] The distribution of the uninsured is based on national rates from the 1990 United States Current Population Survey.

Many uninsured employees work for low wages and/or small firms. For many small, marginal, and start-up businesses, as well as the self-employed, health insurance is too costly to begin or continue. Health coverage for small employers may cost 10 to 40 percent more than for large employers. Whether an employer offers health coverage is related to the size of the business and the type of industry:[14]

- In manufacturing industries, 83 percent of the employees have employer-sponsored group health insurance. The rate falls to 68 percent in wholesale trade, 48 percent in construction, 36 percent in retail trade, and 18 percent in agriculture, forestry, and fisheries.

- About 56 percent of all businesses offer health insurance to employees, ranging from nearly 100 percent of firms with 500 or more employees, to 92 percent of firms with 25 to 99 employees, to 46 percent of firms with one to nine employees.

- About 59 percent of all businesses offering health insurance to employees also cover dependents. Of those businesses with one to 24 employees, 48 percent offer dependent coverage, while 64 percent of firms with 500 or more employees cover dependents.

Health insurance coverage based on employment status has resulted in special financial access problems: coverage may be lost when a person is unemployed or changing jobs, or when an employer changes insurance plans. In each instance, an individual may lose all coverage or coverage for pre-existing conditions, have to endure a waiting period before new coverage takes effect, or be forced to switch insurance plans and/or providers. Potential loss of coverage for an employee or dependents may impede his/her job change options.

Problems with the health care liability system[15] have also affected access. High liability insurance premiums have caused some practitioners to limit or cease providing some types of services. Practitioners also report that fear of malpractice suits is a reason for not accepting patients with high risk conditions. Some areas of the state -- most notably rural communities, but also some urban and suburban areas -- have experienced significant access problems, because practitioners or provider organizations have limited or ceased to provide

[14] Health Access Task Force, Washington State Medical Association, Health Care Access in Washington State, August, 1989.

[15] The "health care liability system" includes the civil justice system, health care liability insurance, and health care practices. See Chapter 5 for a detailed description and discussion of the system.

services.[16]

Access to public health programs that affect the health of large segments of the population has worsened as emphasis and resources have flowed toward illness/treatment and away from wellness/prevention. The health problems that could be reduced by these public health interventions are enormous. As a significant risk factor in the four leading causes of death -- heart disease, cancer, stroke, and chronic obstructive pulmonary disease -- tobacco use is fully or partially responsible for one-fifth of all deaths in Washington . Public health strategies (such as prevention and education) that encourage smokers to quit and keep a certain number of people from taking up the habit are less available than their positive effect on health warrants. Injuries -- the leading cause of death, disability, and hospitalization of people under the age of 44 -- are another instance where education and prevention could have a positive impact on the lives and health of Washington residents, yet these programs have not been aggressively supported or adequately funded.[17]

Just as access to health insurance varies for Washington residents, so does access to public health services. Geographic variability occurs in the monitoring and enforcement of drinking water quality, diagnosis and treatment of sexually transmitted diseases, and the availability of professionals, such as epidemiologists, to investigate and direct efforts during outbreaks of communicable disease. This is due in part to the over four-to-one disparity in per capita funding from county to county. Limited access to public health and preventive services affects health in the following measurable ways, for example:

•Only 75 percent of pregnant women in 1986 received prenatal care in the first trimester. In 1988, only 57 percent of African-American women, 56 percent of Hispanic women, and 53 percent of Native American women received prenatal care in the first trimester.

•Postneonatal mortality rates have remained unchanged for the last ten years and are well above the national average. In 1988, for example, the rate for African-Americans was 9.2 per thousand and 9.7 per thousand for Native Americans, in contrast to 4.3 per thousand for the total population.

•Since 1987, the number of cases of infectious syphilis has continued to rise.
•The number of cases of measles began to rise in 1988, after reaching an all time low in 1987.[18]

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[16] *See* Rosenblatt, R., et al., "Are Rural Family Physicians Less Likely to Stop Practicing Obstetrics Than Their Urban Counterparts: The Impact of Malpractice Claims," Rural Health Working Paper, April, 1990; and WAMI Rural Health Research Center, University of Washington Department of Family Medicine, "Tort Reform and the Obstetric Access Crisis: The Case of the WAMI States," Rural Health Working Paper, June, 1991.

[17] Washington State Board of Health, Washington State Health Report 1990, June, 1990.

[18] Interview with Dan Rubin, Chief, Office of Health Policy Support, Washington State Department of Health, October, 1991.

INCREASING COSTS

The increasing costs of health services are straining the resources of individuals, businesses, and governments. For more than 20 years, health spending, especially on personal health services, has been growing at rates far exceeding the growth rate of the economy as a whole and the general inflation rate. Policy makers, both public and private, have made a number of unsuccessful attempts to control these costs.

In the 1960s and 1970s, for example, federal and state governments instituted regional health planning and certificate-of-need regulations to control spending on new hospitals and nursing homes, as well as expensive new technologies. A number of states, including Washington, created state agencies to regulate hospital budgets and rates. These regulatory strategies failed to hold down total health system expenditures.

During the 1980s, cost control strategies focused on non-regulatory mechanisms, including selective contracting, utilization review, prospective payment systems (such as Medicare's hospital payment system using diagnostic related groups), and managed care. The number of managed care plans in Washington and their enrollments increased dramatically in that decade. Between 1986 and 1990, for example, enrollment in the top ten health maintenance organizations increased 64 percent, while subscribers of the top ten preferred provider organizations jumped nearly 600 percent. Yet, like the "era of regulation," these market-oriented strategies have not slowed the increase in total health system spending.

Nationally, 1990 spending on personal health services (an estimated $660 billion) consumed over 12 percent of the gross national product.[19] Some estimates suggest this figure will rise to 16.4 percent by the year 2000.[20] Adjusting for inflation, per capita expenditures rose 4.9 percent per year from 1970 to 1989, growing from $950 to $2,354 per person in constant 1989 dollars. U.S. per capita spending on personal health services is an estimated one-third higher than Canada, double that of Japan and West Germany, and nearly triple Great Britain's.

As indicated by the examples listed below, growth in Washington's personal health services expenditures mirror the national experience:

•Total Washington health service expenditures went from $4.5 billion in 1980 to $13.4 billion in 1990, an average annual growth rate of 11.6 percent.

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[19] "MBSTAT: Health and the GNP," Medical Benefits, Volume 8, Number 14, July 30, 1991, page 5.

[20] Rich, Spencer, "U.S. Health Costs Expected to Grow Drastically," The Seattle Times, August 24, 1991.

•Per capita expenditures rose at an annual rate of 9.7 percent, increasing from $1,081 per person in 1980 to $2,737 per person in 1990.

•Per capita health service expenditures increased more than twice as much as per capita personal income increased from 1980 to 1990.

•State government will direct health expenditures of over $2.8 billion in FY 1991, half of which are financed from the State General Fund. These expenditures have increased by nearly 14 percent annually since FY 1987.[21]

•The health portion of State General Fund spending jumped from 14.6 percent in the 1981-83 biennium to 21.4 percent in the 1991-93 biennium.[22]

•From 1982 through 1988, hospital revenues in the state grew by an average of almost 15 percent per year.

•Total earned premiums for the state's health care service contractors and health maintenance organizations grew from about $1 billion in 1982 to just over $2 billion in 1988, a 14.3 percent annual increase.

These indicators of health service expenditures stand in stark contrast to an approximate annual Consumer Price Index (CPI) increase of only three percent for 1982-88. If the current rates of increase continue, Washington residents will be saddled with per capita health service costs of more than $4,600 (in 1990 dollars) by the year 2000, a 68 percent increase over 1990 costs.[23]

In addition to creating barriers to access, the health care liability system exacerbates increases in health expenditures through the costs of unnecessary health services and increases in liability insurance costs. Some research indicates that practitioners have changed their practice patterns for fear of malpractice litigation. These changes in practice behavior include performance of additional tests which are not considered medically necessary for optimal patient outcomes. Also, additional time spent documenting care and discussing treatment with patients tends to increase administrative and other costs. While unnecessary diagnostic testing does nothing to improve patient care, more thorough documentation of treatment may have improved the quality of medical

[21] Washington State Health Care Authority, Study of State Purchased Health Care, December, 1990.

[22] Washington State House Appropriations Committee, The Growth of Health Costs in the General Fund State Budget, November, 1991.

[23] Washington State Office of Financial Management, Washington Private and Public Expenditures for Health Services and Supplies, 1980-1990, and Projected, November, 1991.

practice.[24] Reliable estimates of the costs of these practices, commonly called "defensive medicine," have not been established.

Competition among insurers has affected total health system expenditures and the distribution of financial burdens in the system. Insurers compete for employer group contracts based in part on price. This provides an incentive to avoid insuring sick people or people at a higher risk of needing health services. The result is that the cost of coverage for some people is low, especially large groups of relatively healthy people, while other individuals and groups that are on the average less healthy or have less market power are charged higher premiums. An added cost implication of the current insurance market is that policies for individuals and small groups are much more expensive to administer. Thus, these small purchasers pay an administrative "surtax" of 10 to 40 percent. Carried to extremes, the practice of excluding the sick and charging premiums based on a group's or individual's likely use of health services works against one of the fundamental original purposes of health insurance -- to spread broadly the financial impacts of illness and injury.

Environment for Reform

With the creation of Medicare and Medicaid in 1965, the United States took a significant step towards assuring financial access to health services for its elderly, disabled, and low-income citizens. The 1970s saw the development of regulatory structures and processes (such as certificate of need, organized health planning, and hospital rate regulation) designed to further these earlier access achievements and moderate rapidly inflating health system costs. The 1980s featured discussion and implementation of 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.

In the absence of comprehensive solutions, Washington State has taken some important and 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), were initiated to 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

[24] Pritchard, J. Robert S. et al, Liability and Compensation in Health Care: A Report to the Conference of Deputy Ministers of Health of the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care, 1990. This report is commonly called "The Pritchard Report." A discussion of the findings of the Pritchard Report may be found in Health Policy Analysis Program, University of Washington, Medical Liability and Compensation: A Discussion of Themes in British Columbia and Washington State," June, 1991, pages 20-21.

(1991) are each designed to improve access in specific sectors of the health system. Finally, Washington undertook the nation's first comprehensive study of all state health care purchasing activities, a project carried out by the State Health Care Authority in 1991.

The State Legislature has also made a number of changes in regulatory programs, in part with an eye towards controlling costs. State Hospital Commission statutes were revised in 1984 to promote price competition by authorizing negotiated rates between hospitals and payers. The Hospital Commission itself was ultimately eliminated in 1989, as was the certificate-of-need review of many hospital activities.

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. Respondents to a 1991 Wall Street Journal/NBC News poll said health care is one of the country's most urgent domestic concerns; 69 percent supported universal access to health care even if that required a tax increase. A 1991 survey of 87 large U.S. corporations conducted by the Washington Business Group on Health found that 89 percent of the respondents said that limited market reforms could not fix the health system.

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 decease 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 initial recommendations in this Interim Report 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.

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CHAPTER 2

BASIS FOR SYSTEM REFORM

Introduction

Early in 1991, the Washington Health Care Commission decided to identify and clearly express the conceptual basis for its recommendations for health system reform. This chapter presents the results of that effort and lays the foundation for the Commission's recommendations for fundamental reform. As the Commission developed its recommendations, it identified 14 "principles and values" that reflect its vision for improving the health system in Washington State. They provide an overview of the Commission's major policy directions and are presented first in this chapter.

The Commission also identified "personal and societal expectations" which are presented next. They help lay the foundation for evaluating the Commission's reform strategies by stating the fundamental purposes and desired outcomes related to people's health and the performance of the health system.

In House Concurrent Resolution 4443, the Washington State Legislature charged the Commission to "identify appropriate and effective health services" and "develop *incentives* to adopt the use of those services." The Commission began its legislative charge by identifying the important characteristics of "appropriate and effective health *services*" and an "appropriate and effective health *system*." The results of this effort are presented in this chapter. Some incentives are contained in the Commission's recommendations for developing a uniform benefits package (Chapter 3) and for reforming the finance and payment system (Chapter 4). Others will be addressed in developing and implementing the Commission's 1992 Work Program discussed in Chapter 8.

The final section of this chapter presents the Commission's recommendations for categorizing health services. The recommendations build directly on the characterization of "appropriate and effective health services" and reflect a commitment to address health *services* rather than health service *providers*.

Principles and Values

The following principles and values reflect the Commission's vision for improving the health system in Washington State:

(1)The fundamental purpose of the health system should be to maintain or improve the health of all Washington residents at a reasonable cost.

(2)The health system must balance the competing priorities of extending the lives of individuals and improving the collective health of our society.

(3)There should be fundamental reform of the health system with due consideration for the strengths of the existing system.

(4)Reforms of the health system should consider the special needs of underserved populations.

(5)All Washington residents shall be guaranteed access to a comprehensive, uniform, and affordable set of confidential, appropriate, and effective health services (the "uniform set of health services"), regardless of their ability to pay or pre-existing health conditions.

(6)All residents should be assured that their health problems will not result in their financial impoverishment.

(7)Individuals and communities should assume greater responsibility for maintaining and improving their own health by minimizing unhealthy behaviors, taking appropriate preventive measures, and making informed, cost-effective decisions about the use of health services.

(8)Financing the uniform set of health services and controlling health system costs are the shared responsibility of all members of society.

(9)The costs of health services borne by individuals should not be a barrier to universal access to appropriate, effective, and affordable health services, but they should discourage inappropriate use of those services.

(10)Health service costs should be controlled in significant part by techniques and incentives to reduce the provision and use of inappropriate and ineffective health services.

(11)Public policy should strive to shift a substantial majority of the state's population into integrated delivery systems which manage care and assume financial risk for providing a uniform benefits package to their beneficiaries.[25]

[25] The "uniform benefits package" is a subset of the "uniform set of health services" referred to in Principles and Values (5) and (8). As discussed in Chapter 3, the Commission recommends that universal access to the uniform benefits package be financed through some form of "insurance

(12)Negligent health care practices should be minimized, and residents who are injured as a result of such practices should be compensated appropriately.

(13)All individuals and communities should have the right to make reasonable choices about their health (including the use of health service providers) and the information needed to make those choices.

(14)There should be broad public participation in developing and implementing fundamental health system reform, including business, labor, health service providers, insurers, government, consumers, and other members of the public.

Personal and Societal Expectations

The personal and societal expectations listed below express the fundamental purposes and the desired outcomes of the health system:

PEOPLE'S HEALTH

The personal and societal expectations related to people's health include:

•Promotion of the health of each person and of all people;

•Preservation, support, and/or restoration of physical, mental, and social functioning;

•Prevention of disability, pain, disease, injury, and premature death;

•Control and reduction of risks to health and life; and

•A dignified death without avoidable pain or discomfort.

An additional societal expectation related to people's health is the lessening of disparities in health between various population groups.

HEALTH SYSTEM PERFORMANCE

The societal expectations related to health system performance include the following:

•**Acceptability** -- a reasonable level of satisfaction expressed by users, service providers, and

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mechanism." See the "Glossary of Special Terms" in Appendix A.

other affected persons regarding operation of the health system.

•**Accessibility** -- the degree to which "universal access" to health services is achieved.

•**Accountability** -- the degree to which the health system is held responsible for meeting the personal and societal expectations of the system.

•**Adaptability** -- openness to innovation and the capacity to adjust, correct, and improve operations based on information and changing circumstances, both within and outside the health system.

•**Affordability** -- the degree to which those who must pay for health services are able to pay the costs and, collectively, find the costs reasonable.

•**Appropriateness** -- use of health services only in situations when they are likely to be effective and only for individuals, populations, and conditions for which they are likely to be effective. Health services are appropriate only when the affected individuals (in the case of personal services) or communities (in the case of population-based services) are aware of any known risks and have chosen to proceed with using the health services.

•**Effectiveness** -- the degree to which health services and systems attain expected improvements in health outcomes and produce more good than harm.

•**Efficiency** -- effectiveness in relation to the costs and resources used.

Characteristics of Appropriate and Effective Health Services/System

HEALTH SERVICES

The following describes the characteristics of "appropriate and effective" health services:

•Health services are **"appropriate"** when:

·They are used only in situations where they are likely to be effective and only for individuals, populations, and conditions for which they are likely to be effective; and

·They are used only when the affected individuals (in the case of personal services) or communities (in the case of population-based services) are aware of any known risks and have chosen to proceed with using the health services.

•Health services are **"effective"** when they attain expected improvements in health outcomes and produce more good than harm. A health service may be effective for some individuals and

ineffective for others.

HEALTH SYSTEM

Appropriate and effective health services alone do not guarantee achievement of expected outcomes; the health system must also have certain characteristics. Specifically, an "appropriate and effective" health system should:

•Include incentives for the appropriate and effective provision and use of health services;

•Deliver appropriate and effective health services;

•Define and meet objectives for the health of communities and the general population;

•Provide for the initial and continuing education, training, and development of competent health professionals and other caregivers;

•Include reliable data and processes for ongoing, cost-effective refinement and application of knowledge about which services are appropriate and effective;

•Be accessible, efficient, affordable, accountable, and adaptable;

•Include services which prevent or lessen disease, injury, and disability;

•Be acceptable to people, allow opportunities for personal and community choices, and encourage individuals and communities to take responsibility for their health; and

•Provide the information, mechanisms, and other resources needed to evaluate the effectiveness of the health system.

Categories of Health Services

As a basis for its recommendations, the Commission developed a conceptual framework for understanding health services. The Commission's recommended framework distinguishes *health services* from the *health system* and the broader *determinants of health*. It also establishes *categories* of health services that encourage careful, logical consideration of which services should be made universally accessible or otherwise encouraged through incentives.

The major determinants of good or bad health can be broken into four groups:

•The natural environment (for example, naturally occurring radiation);

•Human biology (for example, a genetic predisposition to diabetes);

•Human behavior, both individual and societal/cultural (for example, the individual act of smoking cigarettes and peer acceptance or rejection of smoking); and

•The "health system" -- the arrangements for services, protections, and purposeful incentives/interventions which have a substantial impact on health.[26]

The health system is broader than most people's idea of "health services." For example, all of the economic and government activities associated with meeting basic human needs such as food, shelter, and personal safety contribute to health. This broad view of the health system is important because, at any point in time, the environmental, behavioral, and biological determinants of health may present opportunities for further protections and interventions (changes in the health system) which could improve health. The Commission's concept of health services strikes a balance between including almost everything (because everything affects health to some degree) and including only "medical care" (too narrow to achieve the personal and societal expectations of the health system, as understood by the Commission).

The Commission's "categories of appropriate and effective health services" are listed on the next page. Consistent with its charge from the State Legislature, as well as the Commission's goal of relating its work to personal and societal expectations of the health system, the Commission first tried to identify entire categories of health services which are inherently appropriate and effective. After much effort, however, the Commission concluded that specific health services must be examined to determine whether and under what circumstances they are truly appropriate and effective. Unfortunately, the research to support these decisions often is nonexistent, and the use of many services may be appropriate and effective in some situations but not in others. Therefore, the Commission chose the categories of health services based on evidence that each category contains examples of specific health services that are effective, when used appropriately. The five major categories listed on the next page are discussed on pages 40 to 42, with brief definitions and comments. The examples given are illustrative only; they are not a list of all health services included in a particular category.

[26] A more formal definition is "any set of arrangements in a society . . . which assigns social roles and resources to achieve the goals of protecting or restoring health." Weinerman, E.R., "Research on Comparative Health Service Systems," Medical Care, 9:272, 1971.

CATEGORIES OF APPROPRIATE AND EFFECTIVE HEALTH SERVICES[27]

Adequate Food/Housing for Vulnerable Populations

Access Services

Population-based Health Services[28]

•Community health protection
- Community health promotion and education
- Communicable disease prevention and control

Personal Health Services[29]

- Diagnosis/assessment and selection of treatment/care
- Clinical preventive services
- Emergency health services
- Reproductive and maternity services
- Clinical management and treatment
- Therapeutic drugs, biologicals, supplies, and equipment

Health System Support

- Health personnel education and regulation
- Public health support
- System development and regulation
- Health research

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[27] An earlier version of these categories of health services is discussed extensively and illustrated with examples in Washington Health Care Commission, Categories and Examples of Appropriate and Effective Health Services, July 2, 1991.

[28] See page 43 for a discussion of public health services, which include these population-based health services plus some other services.

[29] Includes long term care as follows: "Functional needs assessment and care management" are part of diagnosis/assessment and selection of treatment/care; "functional support and supervision of health and safety" are part of clinical management and treatment, as is "long term rehabilitation and habilitation."

ADEQUATE FOOD/HOUSING FOR VULNERABLE POPULATIONS

This category includes the 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. While everyone needs adequate food and shelter to survive, the focus of this category is on targeted services which address the highest risks of malnutrition, exposure, and residential injury. Examples of specific services include the Women, Infants, and Children (WIC) food program, domestic violence shelters, and short-term shelter for other homeless persons who are ill or suffering from exposure to the elements.

ACCESS SERVICES

This category includes services or service enhancements needed to ensure that individuals and families receive other appropriate and effective health services. They address potential barriers to accessing health services. Examples of access services include transportation or child care necessary to receive health services; translation or use of bilingual staff; active outreach efforts to assure that a pregnant woman actually receives prenatal care; or spending extra time with a patient to understand cultural beliefs which will affect the patient's ability and willingness to follow health promotion recommendations.

POPULATION-BASED HEALTH SERVICES

This category includes health promotion and disease/injury prevention efforts directed at entire populations or communities rather than to a succession of individuals. Population-based services should be contrasted with the personal health services discussed below. The following are three major sub-categories of population-based services:

- **Community Health Protection** consists of environmental or regulatory measures that protect large population groups in communities or worksites. They address issues such as occupational safety and health, other unintentional injuries, food and drug safety, and the general public's exposure to environmental hazards, including harmful chemicals, biological agents, and radiation.

- **Community Health Promotion and Education** includes a wide variety of services and organizing efforts aimed at enabling people to increase control over (and thus improve) their health. Examples include 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.

- **Communicable Disease Prevention and Control** consists of measures to prevent and reduce the spread of communicable diseases. Examples include epidemiological investigations of

disease outbreaks and aggressive outreach efforts to contact and influence the behavior of infected or exposed individuals. There is some overlap between this category and personal health services (for example, in the case of immunizations).

PERSONAL HEALTH SERVICES

This category includes health services provided to individuals or families ("patients" or "clients") by a wide range of health professionals or other caregivers, which may be preventive, diagnostic, curative, restorative or palliative. The bulk of what is conventionally thought of as "health care" is personal health services. Long term care services in this category include support to maintain personal function and other daily activities, as well as supervision when necessary to maintain personal safety. The following describes the six major sub-categories of personal health services:

•**Diagnosis/Assessment and Selection of Treatment/Care** consists of services needed to establish the cause of symptoms based on a patient's history, direct observation, and the use of necessary tests and procedures. Selection of treatment or care connects the diagnosis/assessment with other personal health services.

•**Clinical Preventive Services** are delivered to everyone or to all members of a population which is "at risk" for a health problem which can be prevented or can be successfully treated if detected early. These services are generally provided on a one-to-one basis, but sometimes can be carried out in a mass setting such as a vaccination clinic. They include screening tests, immunizations, counseling and education, and preventive dentistry.

•**Emergency Health Services** are provided to victims of injuries and acute, overwhelming illnesses on an immediate basis to preserve life, minimize disability, or prevent severe complications. They include basic and advanced life support at the scene of an accident, transportation to a hospital in an acute medical emergency, stabilization of a patient's condition, and any definitive, immediate treatment.

•**Reproductive and Maternity Services** consist of several distinct components, including prenatal care, maternity care, care for healthy newborns, contraceptive services, and termination of pregnancy.

•**Clinical Management and Treatment** contains the largest component of personal health services. Treatment includes measures to improve or maintain functional level, reduce pain, and increase comfort, as well as interventions that have the potential to cure or repair underlying conditions. This sub-category also includes the management and treatment of mental conditions and chemical dependency. Treatments can be provided by a wide variety of practitioners and can occur in many settings and facilities.

•**Therapeutic Drugs, Biologicals, Supplies, and Equipment** consist of prescription or non-prescription medications, biological material, restorative devices, and supplies and equipment which are necessary to carry out effective treatments.

HEALTH SYSTEM SUPPORT

This category includes supportive or "indirect" services and activities necessary for the direct health services in the foregoing categories to be effective. These activities are carried out in both the public and private sectors and include public policy development on health topics; education and training of practitioners; administrative activities such as service eligibility determination, utilization management, and payment; regulation of health service providers and insurers; public health infrastructure such as epidemiological data bases and public health laboratories; and health research. The following describes the four major sub-categories of personal health services:

- **Health Personnel Education and Regulation** addresses two objectives: preparation of health professionals and other personnel to perform their roles in providing health services; and oversight of their work to assure quality standards are met.

- **Public Health Support** includes support for population-based services and public policy decision-making regarding the health of the public, the targeting of public health interventions, and the allocation of resources to meet policy objectives. It includes such specific activities as public health laboratories, epidemiology, and vital statistics systems.

- **System Development and Regulation** activities support the organization and administration of coordinated service delivery, reimbursement, and service quality assurance through public and private providers, payers, and insurers at all levels.

- **Health Research** includes research, development, and evaluation activities related to all aspects of the health system.

The Commission's choice of categories of appropriate and effective health services is a deliberate effort to encourage careful consideration of what services accomplish and their relative importance. The categories are functional and differ from the ways we are accustomed to thinking about health services, which have tended to emphasize:

- Service providers, including kinds of practitioners, health facilities, or agencies (for example, physicians, nursing homes, chiropractors, hospitals, and public health agencies);

•Specific categories of clients or diagnoses, such as children's health services, developmental disabilities, geriatric care, cancer services, and treatment of mental conditions; and

•Broad goals which do not specify services, such as injury prevention or nutrition.

The Commission's categories reflect an emerging new paradigm which is intended to broaden thinking in regard to health services, while taking into account the importance and validity of traditional definitions. The figure on page 45 is a graphic representation of this new paradigm and also demonstrates the conceptual overlap among the five major categories of health services.

A particularly important clarification concerns *public health services*. This term is not included as a health service category, but the Commission emphatically believes there are many appropriate and effective public health services. Consistent with the Commission's commitment to define services functionally rather than in relation to providers, public health services are best defined in relation to the mission and functions of public health.[30] Much of the core of public health services consists of population-based services as defined above, along with certain health system support services. Public health services also include many access and personal health services when used in close association with population-based services and approaches. The figure on page 45 shows how public health services relate to the Commission's five major health service categories.

Listed below are several additional examples of how the Commission's categories deal with health services differently than conventional approaches:

•**Long term care:** Long term care services are integrated with other personal health services;

•**Mental health and chemical dependency services:** Diagnosis and treatment of mental disorders and chemical dependencies are also integrated with other personal health services; and

•**Injury prevention:** A community-wide injury reduction campaign and a school's driver safety education program are examples of community health promotion and education services. Regulatory programs to reduce worksite injuries (occupational
safety and health) or injuries in public swimming pools (environmental health) are community health protection services. A physician counseling new parents to use infant car seats is a clinical preventive service (personal health services).

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[30] An influential report by the Institute of Medicine defines the *mission* of public health as "the fulfillment of society's interest in assuring the conditions in which people can be healthy," and identifies the core, non-delegatable *functions* of public health as assessment of health needs, policy development, and assurance that services necessary to achieve agreed upon goals are provided. This report also documents that there is not a uniform set of public health services which is available in all localities. Committee for the Study of the Future of Public Health, Division of Health Care Services, Institute of Medicine, The Future of Public Health, 1988.

Chapter 3 uses the foregoing categories of health services, the "Principles and Values," the "Personal and Societal Expectations," and the "Characteristics of Appropriate and Effective Health Services/System" presented in Chapter 2 as the foundation for defining "universal access" and identifying *candidates* for which appropriate and effective health services people will be guaranteed access to under a reformed health system.

CHAPTER 3

UNIVERSAL ACCESS TO HEALTH SERVICES

Introduction

The "principles and values" recommended by the Washington Health Care Commission state that, "all Washington residents shall be guaranteed access to a comprehensive, uniform, and affordable set of confidential, appropriate, and effective health services (the `uniform set of health services'), regardless of their ability to pay or pre-existing health conditions." As discussed in Chapter 1, there are serious financial and nonfinancial barriers to access that must be overcome to achieve the goal of universal access.

The high cost of health services and health insurance are major financial barriers to ensuring universal access. There are many individuals and families who have no health insurance or have such limited insurance that many needed services remain unaffordable or demand a heavy financial sacrifice. Certain people face financial barriers more than others due to their employment status, the size of the employer they work for, their current or previous health status, and/or their economic status. Financing also is a barrier to public health services to a varying extent in different local areas.

Given limited resources, a key to overcoming these financial barriers is to ensure that available funding is used effectively and efficiently, while also ensuring that total spending is controlled. At the same time, the Commission believes that the health system should encourage and empower people to take personal and financial responsibility for their own health and health services.

Adequate and well-allocated funding may also be an issue in breaking down *non-financial* barriers to access. Shortages of some types of providers, especially primary care providers, exist in many areas of the state and for certain segments of the population. Language and cultural differences may hamper basic clinical interactions, as well as the communication and use of relevant health information. Additional or reallocated funds may be necessary to overcome these non-financial barriers.

Differences in "average" health status between Caucasians and some people of color suggest not only barriers to accessing services, but also underlying societal problems -- joblessness, poverty, inadequate housing, and racism. These problems reveal themselves, in part, through ill health and high mortality rates. For example, African-American infants in Washington and the nation as a whole are at a much greater risk of dying than are Caucasian infants. Native Americans face an even higher risk.[31] African-American males face a much higher risk of dying of violent causes than Caucasian males.[32]

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[31] Washington Child Health Research and Policy Group, State of Washington's Children, June, 1991.

[32] National Health Policy Forum, Young Black Males in Jeopardy: Risk Factors and

Access may also be impeded by a lack of transportation or child care necessary to actually receive health services, the absence of service delivery approaches that bring services to consumers, or limited service hours and locations. Other barriers include lack of information on how to care for one's own health, how to recognize when services are required, where services are available, how to get them, and how to use them appropriately.

Disparities in the availability of public health protections and services (such as safe drinking water, disease outbreak investigations, and the diagnosis and treatment of sexually transmitted diseases) among various localities create barriers that are related in large part to differences in funding. Differences also exist in the level of organization and activism in various communities, affecting their ability to mobilize health promotion and education efforts directed at health problems such as tobacco use, abuse of alcohol and illegal drugs, community violence, and poor diet.

The Washington State Legislature asked the Commission to "recommend plans for ensuring access to health care for all people." To develop recommendations for ensuring universal access, the Commission addressed two key questions: What does "universal access" mean? What are the health services to which universal access will be guaranteed?

The Commission has addressed the first question by defining "universal access" and by developing eight criteria to evaluate alternative proposals for ensuring access for all state residents. These recommendations are presented in the next section, "Universal Access Definition and Criteria."

To address the second question (universal access to what?), the Commission recognizes that the services we traditionally think of as "health care" -- such as those provided by physicians, hospitals, nursing homes, and dentists -- are critical, but are not the only services that maintain, improve, or restore health. Education, community drug prevention, workplace health promotion, and environmental and occupational health are also key elements of the health system, as discussed in Chapter 2.

The Commission has identified a list of appropriate and effective health services as *candidates* for a uniform set of health services to which access for all Washington residents will be guaranteed. From that uniform set of health services, a subset called the "uniform benefits package" will be developed initially by the Commission. The package will consist of those health services to which universal access will be financed through some form of insurance mechanism.

This chapter includes the Commission's recommended criteria for developing and evaluating the uniform set of health services and the uniform benefits package, as well as the *candidate* services for the uniform set and package. In addition, the Commission has identified a number of potential limitations and cost-sharing options to help define the insured uniform benefits package. This chapter concludes with a summary of the Commission's plans for completing development of the

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Intervention Strategies, George Washington University, Issue Brief Number 494, June 1, 1988.

uniform set and package.

Recognizing that guaranteeing access to health insurance coverage is not enough by itself, the Commission plans to address two other important issues during 1992: how best to finance universal access to appropriate and effective health services *not* financed by insurance; and how to overcome *non-financial* barriers to access.

Universal Access Definition and Criteria

GENERAL DEFINITION

"Universal access" means 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.

DEFINITIONS OF SPECIFIC TERMS

"Right and ability" means that receipt of the health services is a tangible reality, not just a theoretical right. Achieving access will require adequate availability and distribution of health service resources.

"Washington residents" means all people regularly living in the State of Washington. In 1992, the Commission intends to develop a more precise definition of "resident."

"A comprehensive, uniform, and affordable set" of services consists of some subset of "appropriate and effective health services," as defined by the Commission in Chapter 2. Since affordability of the uniform set of health services is a critical consideration, the Commission has also recommended a list of cost-sharing options and potential limitations on insured services that will be in the uniform benefits package (a subset of the uniform set of health services).

"Appropriate and effective health services" have been defined by the Commission in Chapter 2. Some of these services are population-based interventions available on a community basis, rather than personal services directed at individuals. While the Commission has considered the effectiveness of health services, it is understood that the receipt of services will not guarantee equal health status.

To receive health services **"in a timely manner and with reasonable effort"** means to actually get the health services when they are desired and needed, without undue delay or personal effort. It does not imply that health services will be instantly available or that no effort will be required to

obtain them. "Reasonable effort" implies some degree of personal responsibility to seek and accept health services and advice, but within a framework of sensitivity to the impact of social conditions and societal pressures upon personal actions.

Not to deny health services because of the **"inability to pay"** means that the services will be received without regard to individual or family income levels, assets and investments, or the extent of coverage by existing private or public insurance. It also means that people should not be impoverished by paying their fair share of the costs of the services. This does not mean that health services will be "free;" the costs will need to be paid. Our collective ability to pay will be considered.

Not to deny services based on **"pre-existing health conditions"** means that access will not be limited solely because of the presence or absence of specific health problems. Different health services may be appropriate and effective, however, for people with different health problems.

"With appropriate consideration for geographic differences" means that *timely* access to services is ensured; however, standards of timeliness may differ by location.

"Demographic and cultural differences" include age, gender, race, ethnicity, language, and national heritage. Such differences among people should not affect *access* to health services, but they may affect the appropriateness and effectiveness of *specific services* due to legitimate differences in health problems, prognosis, or linguistic/cultural adaptations intended to improve access.

ACCESS CRITERIA

The following criteria have been developed to evaluate the strengths and weaknesses of existing or proposed health systems with respect to their capacity to provide universal access to the uniform set of health services. The criteria are derived from specific terms included in the Commission's recommended definition of "universal access."

Criterion 1. All Washington residents are ensured universal access to a comprehensive, uniform, and affordable set of health services which are deemed to be appropriate and effective.

Key Elements:

•In addition to personal health services, the uniform set of health services includes population-based services available on a community basis.

•The affordability of the uniform set of health services is monitored and evaluated on an on-going basis, and mechanisms are in place for maintaining affordability by containing total expenditures.

•Consumers, employers, employees, providers, private insurers, communities, and governments are active participants in assessing the adequacy of access to and the affordability of the uniform set of health services.

•Consistent with responsible cost control, individuals have a choice of efficient and economic service delivery systems and providers within those systems.

•To the extent feasible, all Washington residents are ensured continuity of care with their health provider(s), regardless of changes in life circumstances, employment, or source of insurance coverage.

•The uniform benefits package, a subset of the uniform set of health services, should be more comprehensive than lean, leaving a relatively small portion of total health expenditures outside the package.

Criterion 2. Universal access to the uniform set of health services is achieved in a timely manner without undue delay or effort.

Key Elements:

•The availability and distribution of health service resources is adequate to meet appropriate demand.

•The health system includes the necessary access services, such as an effective referral network, appropriate outreach programs, and transportation.

Criterion 3. Universal access to the uniform set of health services is ensured regardless of an individual's ability to pay.

Key Elements:

•The lack of private insurance or personal financial resources does not restrict access to the uniform set of health services.

•The cost of the uniform set of health services would not result in personal financial impoverishment.

Criterion 4. Universal access to the uniform set of health services is achieved with appropriate consideration for geographic location.

Key Elements:

•Timely access to the uniform set of health services is ensured for all Washington residents.

•Standards of timeliness may differ by location.

Criterion 5. Universal access to the uniform set of health services is ensured regardless of an individual's pre-existing health conditions.

Key Elements:

•Access to the uniform set of health services is not limited because of the presence or absence of specific health problems.

•Different health services may be appropriate and effective for people with different health problems.

Criterion 6. Universal access to the uniform set of health services is achieved with appropriate consideration for demographic and cultural factors.

Key Elements:

•Demographic and cultural factors include age, gender, race, ethnicity, language, and national heritage.

•Demographic and cultural differences among people should affect access to the uniform set of health services only when they are legitimately related to differences in health problems or prognosis.

•Appropriate consideration for demographic and cultural factors may include cultural or linguistic adaptation of services.

Criterion 7: The system for providing universal access to the uniform set of health services should encourage and empower individuals to take personal and financial responsibility for their health status.

Key Elements:

•Individual responsibility to seek out and accept appropriate and effective health services must be encouraged.

•As long as payment does not present a barrier to receiving the uniform set of health services, individuals will pay for some portion of the cost of services received.

•Individuals must have reasonable access to sufficient information and resources in order to take personal and financial responsibility for their health status.

Criterion 8: All Washington residents are ensured confidentiality when seeking and receiving the uniform set of health services.

Key Elements:

•Confidentiality is ensured regardless of an individual's financial status or the source for financing an individual's health services.

•Confidentiality is ensured with appropriate consideration for demographic and cultural differences.

•Confidentiality is ensured with appropriate consideration for an individual's health status, including the presence or absence of specific health problems.

Uniform Set of Health Services and Uniform Benefits Package

DEFINING THE UNIFORM SET AND PACKAGE

The Commission's definition of universal access will not be complete until the uniform set of health services it refers to has been defined in detail. The Commission will define the initial uniform set during 1992. This Interim Report presents a progress report on this project.

Chapter 2 identifies the characteristics of "appropriate and effective health services," which are the foundation for developing the uniform set of health services. The definition of "universal access" specifies that services in the uniform set must be "appropriate and effective."

The uniform set of health services will be broader than the uniform benefits package. This point is important, because the means of guaranteeing financial access to some of the services in the uniform set may not be the same as those used to finance access to the uniform benefits package. Coverage for the services included in the uniform benefits package would be provided through an

insurance mechanism,[33] while other services in the uniform set may lend themselves to different financing (such as certain population-based services financed directly from public funds). The Commission's finance and payment system recommendations (discussed in Chapter 4) deal with financing the uniform benefits package. Financing universal access must also include a specific means to provide adequate funding for the population-based health protection, health promotion, and disease/injury prevention services included in the uniform set. During 1992, the Commission plans to develop recommendations on how to finance these services.

The Commission agrees that insurance is an appropriate mechanism for financing the uniform benefits package and some other services in the uniform set. Traditionally, health insurance has protected against unexpected loss as well as predictable or expected loss. Other types of general insurance have been used as protection against extraordinary financial loss.

Today, health insurance covers services -- such as hospital care, surgery, and treatment for high cost illnesses -- that meet the criteria of unpredictability, infrequency, and unaffordability. In some cases, health insurance also covers routine services such as preventive screening, immunizations, and prenatal care which are not unpredictable, infrequent, and high-cost events but are services that large portions or all of the population are expected and encouraged to use. As the Commission continues to develop an initial uniform set and package, it will have to decide which of the appropriate and effective health services listed in the "Candidate Services" on pages 58 to 60 are best financed through insurance, and which should be financed in some other way.

CRITERIA FOR THE UNIFORM SET AND PACKAGE

The Commission recommends the following eight criteria for use in developing and evaluating the **uniform set of health services** ("the set") and the **uniform benefits package** ("the package"):[34]

(1)There should be one comprehensive, uniform, and affordable set of confidential, appropriate and effective health services accessible to *all* Washington residents, encompassing their basic needs for disease and injury prevention, personal health services, population-based services, and other public health services.

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[33] Insurance is a mechanism to share or spread the costs of these events among a large group of individuals so that no one person will be financially ruined should such an event occur. Insurance mechanisms can be either privately or publicly administered. See the "Glossary of Special Terms" in Appendix A.

[34] As indicated in the "Glossary of Special Terms" in Appendix A, the "uniform set of health services" consists of the "appropriate and effective" health services to which "universal access" will be guaranteed. The "uniform benefits package," a subset of the uniform set of health services, consists of the appropriate and effective health services to which universal access will be financed through some form of "insurance mechanism."

(2)The uniform set and package should assure the receipt of only those health services that are appropriate and effective.

(3)While the uniform set and package should encompass a significant share of total health service expenditures, they must also be affordable to society.

(4)To help finance a *comprehensive* package, it should include cost sharing provisions based on an individual's ability to pay.

(5)The uniform set and package should give the highest priority to appropriate and effective health services which improve the health of the overall population, 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. Development of the uniform package should give priority to defining and covering primary care as the foundation of personal health services.

(6)Development of the uniform set and package should begin by considering the health services common to most current health benefit plans and public health programs. This process should not exclude services based solely on arbitrary distinctions among types of body systems, or exclude those services essential to achieving the health outcomes expected from a covered service.

(7)The uniform set and package should be defined in terms of health services, not providers. Potential limitations on providers should be addressed as a matter of cost-effective service provision once the services are determined.

(8)The uniform set and package should include acceptable techniques and incentives to encourage appropriate use of the health services. In particular, 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's work in developing a uniform set of health services and a uniform benefits package will also be based on the following five assumptions which are more related to implementation than to the content of the set or package:

•The uniform benefits package (and perhaps other health services) must be subject to a number of limitations and cost-sharing provisions in order to be affordable. The Commission's recommended list of potential limitations and cost-sharing options appears on the next page.

•While Washington residents 65 years of age and older will be primarily covered by Medicare, they should be guaranteed access to that portion of the uniform benefits package not covered by Medicare. For example, if prescription drugs are included in Washington's package, then a state resident covered by Medicare would share costs for the covered drugs to no greater extent than a resident with the same income who does not qualify for Medicare.

•For universal access to a uniform set of health services to be achieved, significant changes will be needed in the current health services delivery system, such as greater integration of services, primary care providers, and public health clinics. (See the discussion of health services delivery systems in Chapter 6.)

•Cost control will more likely be achieved if a substantial majority of the health services "economy" is included in a total negotiated cost/premium for the uniform package.

•The best way to assure maintenance of a reasonable service "floor" for the poor is to provide the same set and package for all Washington residents.

The Commission recognizes the difficult and important challenge it faces in developing a uniform set and package that are both affordable *and* comprehensive in nature. The next section discusses how the Commission is approaching this challenge.

CANDIDATE SERVICES, LIMITATIONS, AND COST-SHARING

Using the foregoing criteria and assumptions, the Commission has prepared a list of *candidates* for the uniform set of health services and the uniform benefits package. The candidate services -- together with the criteria for developing and evaluating the uniform set and package -- represent a solid foundation for meeting the Commission's commitment to recommend an *initial* uniform set and package which would be revised over time by the new board or commission recommended in Chapter 4.

An earlier version of a preliminary list of candidate health services was included in the Commission's September 11, 1991 Draft Interim Recommendations with a specific request for public comments on the list. As discussed in Chapter 7, extensive public comments were received about the services. Few comments indicated any services which should *not* be included in the uniform set and package, while many people expressed concern that the uniform set and package must be *affordable* (as recommended above in the Commission's "Universal Access Definition and Criteria" and "Criteria for the Uniform Set and Package").

Limitations on the health services and cost-sharing provisions will be necessary for the uniform benefits package to be affordable. During 1992, the Commission will evaluate the following cost

sharing options and potential limitations:

Cost Sharing Options

•Premium sharing by individuals and families;

•Deductibles and co-insurance; and

• Point-of-service cost sharing up to a total out-of-pocket cap on expenses.

Potential Limitations

•Limits on the number of visits or other utilization limits for certain services;

•The requirement to go through a "care manager" or "gatekeeper" in order to receive coverage for certain health services;

•Limitations on who gets which services (consistent with legitimate distinctions concerning appropriate and effective service use);

•Limits on choice of providers;

•Limits on methods of reimbursement to providers;

•Making some services available based on a means-tested sliding scale; and

•Making some specific services available on a population-basis, in schools or places of business, rather than in an individual practitioner's office.

The cost sharing options and potential limitations listed above deal primarily with the design of the uniform benefits package and the operation of the insurance mechanism through which the health services will be financed. Other constraints may need to be developed to control the costs of services included in the uniform set of health services that will be financed in other ways.

Individual participation in financing health services is critical for the uniform set and package to be affordable, as stated in the Commission's recommended "Principles and Values," "Universal Access Definition and Criteria," and "Criteria for the Uniform Set and Package." The Commission is convinced that sharing in the cost of services provides an incentive for individuals to use services more efficiently and appropriately, while ensuring that the financial responsibility to provide universal access is shared equitably.

The overall configuration of the health system will have a major impact on the cost and affordability of the uniform set and package. Effective cost control will permit a broader scope of services to be included in the uniform set and package. The Commission has developed

recommendations for fundamental reform of the finance and payment system that are critical to controlling costs and ensuring universal access to an *affordable* uniform set and package. These recommended reforms are discussed in Chapter 4.

The candidate services for the uniform set of health services and the uniform benefits package are listed below.

CANDIDATE SERVICES[35]

Adequate Food/Housing for Vulnerable Populations

Access Services

- Case management
- Child care necessary to receive services
- Information and referral
- Outreach for infectious disease control
- Public health nursing
- Translation and communication
- Transportation to receive services

Population-Based Health Services

- Community Health Protection

    - Environmental health
    - Occupational health and safety

- Community Health Promotion and Education
- Communicable Disease Prevention and Control

Personal Health Services

- Diagnosis/Assessment and Selection of Treatment/Care

    - Chemical dependency assessment
    - Diagnostic services by medical specialists
    - Diagnostic testing

[35] The Commission has not yet completed identification of the candidate health services within the following three categories: Adequate Food/Housing for Vulnerable Populations, Population-Based Health Services, and Health System Support.

- ·Long term care need determination (using functional assessment approaches) and care management
- ·Primary care ("office and clinic visits")

•Clinical Preventive Services

- ·Immunizations
- ·Pediatric and adult dental cleaning
- ·Periodic adult check-ups
- ·Vision and hearing screening
- ·Well-child care

•Emergency Health Services

- ·Ambulance
- ·Detoxification
- ·Emergency room
- ·Severe mental health crisis
- ·Urgent care

•Reproductive and Maternity Services

- ·Contraceptives
- ·Newborn care
- ·Obstetrics
- ·Prenatal care
- ·Termination of pregnancy

•Clinical Management and Treatment

- ·Acute inpatient care
- ·Chemical dependency treatment (inpatient/outpatient)
- ·Clinical ambulatory services
- ·Functional assistance and safety supervision (long term care "maintenance" services
- ·Home health care[36]
- ·Hospice
- ·Long-term rehabilitation and habilitation
- ·Medical services
- ·Mental health treatment

[36] Should be separately considered both as a substitute for hospitalization and as a long term care service.

·Pediatric dental treatment
·Primary care
·Radiation/chemotherapy
·Rehabilitation (including physical, occupational and speech therapy)
·Skilled nursing/nursing home care[36]
·Surgical services
·Transplants

•Therapeutic Drugs, Biologicals, Supplies, and Equipment

·Durable medical equipment
·Hearing aids and eyeglasses
·Prescription drugs

Health System Support

• Public Health Support

Development of the Uniform Set and Package

The Commission chose not to finish developing the uniform set and package in 1991 for the following reasons:

•The complexity, detail, and time required to identify the categories of appropriate and effective health services was greater than expected.

•The Commission was unable to develop useful estimates of the costs of making the candidate health services universally accessible. The obstacles to analyzing and determining the cost included:

·The breadth of the health services considered;

·Uncertainty about the impacts of the Commission's recommended finance and payment system reforms as well as the effects of other cost controls and service limitations; and

·Limitations on available cost data, especially to the data needed estimate the costs under different service delivery, finance, and payment systems other than those that now exist.

•Vigorous and extensive (but inconclusive) public comment was received, which underscored the importance of conducting a careful cost analysis of the candidate services, potential limitations, and cost sharing options.

The Commission is continuing its work to define an affordable *and* comprehensive uniform benefits package. Since the initial package will most likely go through various revisions before implementation, existing data will be used first. The Commission plans to work with actuaries and other experts, as well as interested organizations and individuals, to perform this analysis. In addition, the Commission will examine similar efforts in other states, such as Oregon, Hawaii, and Minnesota, as well as analyses performed on Washington State's Uniform Medical Plan and Basic Health Plan.

Several sample benefits packages will be formulated to inform the Commissioners about the cost and financing implications of a benefits package. These sample packages will be based on answers to the following questions:

- **Delivery System Definition**: What kind of system will deliver and finance the uniform benefits package? The Commission will estimate costs in the current system, as well as in one or more systems which are more efficient, effective, and managed.

- **Scope of Services**: Which appropriate and effective health services should be included in the sample packages? The scope of services will be based on the Commission's list of candidate services for the uniform set and package presented above, as refined using the "Criteria for the Uniform Set and Package," also presented above in this chapter.

- **Benefit Determination**: How much of a service will be reimbursed and what is the proper amount, type, and distribution of cost sharing, such as premium sharing, deductibles, or copayments?

Following resolution of the foregoing questions, costs of the system or the benefits offered will be estimated, based on actuarial assumptions about demographics and other factors.
Estimates of the amount and sources of funding under the current health system will be developed. The Commission will then project what the costs might be assuming implementation of its recommended reforms to the system. The difference, if any, between the amount of expected funds and estimated costs will be calculated for each sample package. To the extent that estimated costs exceed current financing resources, the sample packages may be adjusted, additional cost control reforms recommended, and/or additional financing sources identified.

Cost estimates for public health services will be made as well. For example, the Commission will examine efficiencies that could be achieved by providing certain clinical preventive services in the public sector rather than in a private physician's office. As stated above, the Commission's approach to financing universal access includes identifying a specific means to provide adequate funding for a uniform set of population-based health protection, health promotion, and disease/injury prevention services. Developing a recommended means to finance these services will also be addressed in the Commission's 1992 Work Program.

CHAPTER 4

FINANCE AND PAYMENT SYSTEM

Introduction

This chapter describes the Washington Health Care Commission's recommended finance and payment system reforms to ensure universal financial access to a uniform benefits package and to control overall expenditures for those benefits. As discussed in Chapter 3, these recommendations focus on insurance as a key financial access mechanism and emphasize four important policies:

- **Choice:** The health service delivery system should offer individuals a reasonable choice of types of providers and systems from which to obtain health services and offer practitioners a reasonable choice of work environments. This policy assumes managed care strategies and systems will be an increasingly important characteristic of the service delivery system.

- **Portability:** The finance and payment system should enhance the portability of health coverage and "smooth the seams" that may occur as the result of changes in employment, financial status, or place of residence. The need for individuals to change health plans and providers should be minimized, consistent with prudent cost control measures.

- **Health Status:** Behaviors or decisions that discriminate based on health status should be minimized. The system should minimize incentives for employers to employ only healthy workers, for providers to serve only healthy individuals, and for health plans to enroll only healthy people. In other words, health plans, service providers, and insurance sponsors (such as state programs and employer-sponsored plans) should not be able to control their own costs by shifting costs to others.

- **Supplemental Benefits:** Coverage for "supplemental benefits" that are not part of the uniform benefits package may be purchased. Unless otherwise stated in this chapter, finance and payment mechanisms and relationships regarding these supplemental benefits are left up to the individuals or organizations involved in financing, paying for, providing, and using such benefits.

FACTORS DRIVING UP HEALTH COSTS

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

What drives up the cost of health services so fast? The federal Health Care Financing Administration (HCFA) defines four general categories of "cost drivers:" *population changes* (such as the increasing proportion of older adults), *general inflation* (price increases in the economy as a whole), *medical inflation* (price increases for health services and products over and above general inflation), and *other factors* (such as new technologies, increased demand for health services,

increased use of testing or procedures for each patient, and increased administrative complexity). The graph on the next page shows how important these categories of cost drivers have been in contributing to increased spending on health services.

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

•Traditional methods of paying health providers place few limits on and, in fact, give economic incentives to use more services, to do all that is possible for each patient, and to expand capacity for health services, regardless of their cost or benefit.

•Providers of health services are often the actual decision makers about the amount, frequency, and types of services used. Consumers and purchasers often lack sufficient information to choose prudently among providers or service options.

•Consumers demand more and technically complex health services, in significant part due to insurance coverage that shields individual consumers from having to pay directly the costs of their services.

•New and expensive medical technologies and treatments are rapidly developed and used, often without sufficient evaluation of their relative costs and benefits. Providers *and* consumers demand to use these new technologies.

•The costs of administering public and private health programs and provider services have been increasing rapidly.

•The supply of physicians continues to grow, increasing from 1.6 per 1,000 people in 1970 to 2.4 per 1,000 in 1990. Research indicates that the growing supply of physicians increases (rather than decreases) costs because physicians have significant influence on the price levels and use of services they provide. Also, as the supply of physicians increases, it tends to occur within specialties rather than in primary care.

•The aging population means an increasing need to treat chronic illnesses.

•Health policy and management responsibilities are diffuse and fragmented, making coordination of care, access to appropriate levels and types of services, and cost control difficult.

Chart

•Information regarding the costs and benefits of many medical treatments, other health services, and professional practice patterns is often inadequate or unavailable.

•The health care liability system contributes to rising costs: high liability insurance premiums push prices for services higher; clinicians order unneeded tests or treatments to protect against possible liability claims or lawsuits (known as "defensive medicine"); and the insurance and civil justice processes are inefficient in determining liability and providing compensation for patients injured as a result of negligence.

•Competitive insurance practices have led to higher costs for some purchasers than for others, based on the medical risk of the insured group and the market power of the purchaser, causing widening disparities in costs of coverage.

ATTEMPTS AT COST CONTROL

There are many examples, both past and present, of cost control strategies that have been used to target each of these supply and demand cost drivers. Some of these strategies have been "successful" to the extent that a specific symptom may have been alleviated for a specific problem. For example, Diagnostic Related Groups (DRGs), the prospective payment method created by Medicare in 1983, was developed to control hospital expenditures, the largest category of health care spending. The DRG system pays hospitals a fixed fee for a given patient, regardless of how long that patient is in the hospital or how many services are used. By putting hospitals at financial risk, DRGs created incentives for greater efficiency. As a result, the DRG system helped to decrease Medicare hospital lengths-of-stay and moderate *inpatient* hospital spending increases. The program's hospital-based outpatient and ambulatory care expenditures have accelerated, however, and Medicare's *overall* expenditures have continued to increase.[37]

A second example of targeted cost control strategies is the Certificate-of-Need (CON) program. This program attempted to control the proliferation of, among other things, high cost diagnostic technologies such as Magnetic Resonance Imagers (MRI's) and Computer-Aided Tomography (CAT) scanners. In Washington State, as in nearly all states, CON regulations concerning the purchase of new high cost equipment applied only to hospitals. While the program may have moderated the proliferation of certain technologies by hospitals, these diagnostic machines were instead purchased by physicians and other non-hospital entities. As with the DRG example, the CON program appears to have shifted rather than controlled *total* costs.[38]

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

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

A final example comes from the private sector. In the past decade, as awareness of "the health cost problem" has grown within the business community, employers have undertaken various strategies to control their health costs. These efforts were targeted, in part, at increasing the employee's share of costs and their cost-sensitivity as they make decisions about when and how to use health care and, in part, to induce more efficient service delivery by providers and health plans (through greater use of managed care strategies). According to a U.S. General Accounting Office report, the percentage of firms that paid full premiums for their employees fell from 74 percent in 1980 to 55 percent in 1988 for individual coverage plans, while for family coverage plans the percentage fell from 54 to 37 percent. During 1982-88, average monthly employee contributions nearly doubled (from $9 to $18 for individuals and from $27 to $52 for families), far exceeding the 23 percent economy-wide inflation rate during that time. Between 1980 and 1988, the proportion of employer-sponsored plans with a deductible of $150 or more rose from less than 10 to about 40 percent.[39]

Employers also increased their use of managed care systems. By 1988, more than 70 percent of employees covered through their work place were enrolled in such systems.[40] Firms also implemented care management techniques of their own, including mandatory second opinions for surgeries and pre-hospital admission review. Over 60 percent of employer plans in the United States included preadmission review requirements in 1988. Yet, in spite of the rapid expansion of managed care and the trend towards greater employee cost sharing, increases in employer spending on health services have continued to outpace inflation by two to three times each year.[41]

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

- **Financers** -- the sources of funds used to purchase health services, including individuals/households, public and private employers, and federal/state/local taxes.

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

[40] Id., page 24.

[41] Foster Higgins, Health Care Benefits Survey, 1989, pages 11-14.

•**Sponsors** -- Entities that offer choices of certified health plans to subgroups of the state population and pay premiums directly to health plans on behalf of subgroup members who enroll in those plans. Such entities may be private (for example, businesses, trade unions, professional associations, and consortiums) or public (for example, Medicare, Medicaid, Veterans Administration, and public employers).

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

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

The Commission chose to define the terms financers, payers, and providers for its deliberations in order to be clear about which entities have which roles in the finance and payment system[42]. In order to guide the development of comprehensive reforms to the system, the Commission also adopted the cost control criteria presented on the next page.

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

Cost Control Criteria

The following nine criteria have been used by the Commission to evaluate the strengths and weaknesses of alternative financing and payment systems in controlling health service costs:

CRITERIA TO CONTROL COSTS

Does the proposed financing and payment system:

(1)Comprehensively address all elements of the health system so as to control total system expenditures?

(2)Minimize unnecessary administrative costs by encouraging simplicity and cost-effective administrative activities at all levels of the system?

(3)Promote the efficient delivery of appropriate and effective health services (including the appropriate and effective service, timing, location and setting, type of provider, and payment level), with safeguards to prevent inadequate, unnecessary, or harmful care?

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

COST-RELATED CRITERIA

Does the proposed financing and payment system:

(1)Promote health, healthy behaviors, and disease/injury prevention through financing decisions?

(2)Ensure adequate financing of operating expenses, capital, and professional education/training so as to support an efficient system of appropriate and effective health services?

(3)Encourage the equitable distribution of financial burdens, so they do not fall disproportionately on particular individuals, employers, employees, providers, private insurers, communities, or governments?

(4)Promote organizational structures that encourage efficient management and delivery of appropriate and effective health services at the local level?

(5)Encourage the creation and appropriate dissemination of effective and efficient innovations and developments?

Responsibilities and Authorities

The Commission studied existing and proposed health systems from a number of countries and states, including British Columbia, Germany, Japan, Hawaii, Massachusetts, Minnesota, New York, and Oregon. Combined with the lessons learned from past cost control efforts in Washington, this review helped the Commissioners develop a range of strategies that potentially could control system expenditures and ensure universal financial access, consistent with the cost control and access criteria recommended by the Commission.

The Commission's comprehensive approach to reforming the finance and payment system begins with certain key characteristics drawn from the Commission's recommendations and policy statements presented in Chapters 1 through 4 of this Interim Report:

•**Stakeholders** -- All stakeholders (consumers, employers and employees, providers, insurers, and governments) should participate in developing and implementing system reform.

•**Choice** -- Consistent with responsible cost control, individuals should have a reasonable choice of efficient and effective service delivery systems and providers within those systems. Service providers should have a reasonable choice of practice environments.

•**Financing Responsibility** -- Financing the health system should be shared equitably by individuals/households, employers, and governments. Shared (or pluralistic) financing ensures each sector has a direct stake in the system, providing checks and balances against the economic dominance of any one interest or perspective.

•**Cost Control** -- Cost control mechanisms must be comprehensive so as to control total health system expenditures.

•**Incentives** -- Health costs should be controlled in significant part by incentives (for payers, providers, and consumers) to reduce the provision and use of inappropriate and ineffective health services. Incentives should promote integrated organizational structures that efficiently manage and deliver appropriate and effective health services at the local level. The system should encourage the creation and appropriate dissemination of effective and efficient innovations and developments.

Based on these key characteristics, the Commission defined the following nine "responsibilities and authorities" that would create strong incentives to control total health system spending, enhance the efficiency by which health services are delivered, promote prudent use of services by consumers, and equitably distribute the financing of the health system.

UNIFORM BENEFITS PACKAGE

To ensure universal financial access, the uniform benefits package must first be designed. All state

residents should have insurance coverage for a uniform benefits package, determined within criteria and other parameters set by the State Legislature. The package should be more comprehensive[43] than lean, leaving a relatively small portion of total health service expenditures outside the package. Mechanisms should be in place to ensure that the package remains comprehensive over time, consistent with controlling total expenditures for the package.

TOTAL EXPENDITURES

To avoid the failures of past targeted cost control strategies, total system expenditures for the uniform benefits package must be controlled. Controlling the costs incurred by only certain providers, payers, or financers is not sufficient. Therefore, the finance and payment system must include a mechanism to define and control the *maximum* resident/month premium that payers/insurers will be allowed to charge -- or that managed care plans will be paid -- for the package. Different maximum premiums could be defined for different situations (such as urban or rural, or groups with higher than average medical risks). The maximum premium, leading to a target or budget expenditure level and developed through an analytic process, should be adequate to fund the package through an efficient and effective service delivery system.

INDIVIDUAL FINANCIAL PARTICIPATION

Individuals must help finance their uniform benefits package in order to promote prudent service use and purchasing decisions, equity, and affordability of the package, but not to the extent that financial participation becomes a barrier to obtaining appropriate and effective health services. To this end, the finance and payment system should include mechanisms to:

- Determine levels and limits of individual financial responsibility for premium sharing and point-of-service cost sharing (copayments, deductibles, coinsurance, and maximum out-of-pocket spending) based on an individual's ability to pay (determined by income and/or asset-based sliding scales);

- Apply point-of-service cost sharing primarily as an incentive for the appropriate use of services and secondarily as a means of financing the uniform benefits package;

- Determine whether absolute levels, maximums, or ranges of individual financial participation are appropriate for premiums and point-of-service cost sharing; and

[43] "Comprehensive" in this context refers only to the *scope* of health services covered, not to the level or distribution of financial coverage for or other limitations on services (for example, number of visits and levels of coinsurance, deductibles, and copayments), which may vary by service and type of beneficiary.

•Ban or limit the extent to which supplemental benefits are allowed to cover cost sharing provisions intended to act as incentives for the appropriate use of uniform benefits.

PROVIDER PAYMENT METHODS

To promote efficient service delivery and the use of appropriate and effective health services, the finance and payment system should encourage the elimination of charge-based fees and move toward prospective payment methods that shift a greater portion of financial risk to providers. The system should include a mechanism to determine provider payment methods, including the power to limit the number of allowable methods and to ban certain methods, for both uniform and supplemental benefits.

BILLING, CLAIMS, AND UTILIZATION MANAGEMENT

The finance and payment system should contain a mechanism to determine uniform billing and claims policy and procedures, and utilization management policy for uniform and supplemental benefits. Utilization management techniques should be used when they cost-effectively reduce unnecessary and inappropriate health services. Utilization management policy should promote uniformity and simplicity to the extent it does not interfere with the development and application of cost-effective utilization management techniques.

MEDICAL RISK DISTRIBUTION

The finance and payment system should include a mechanism to distribute the financial effects of medical risks equitably among all insurers/payers and providers. This mechanism is necessary to reduce the incentives to reduce costs by avoiding medical risks. How to accomplish this objective must be evaluated further.

HIGH COST TECHNOLOGY

The finance and payment system should include a mechanism to control the proliferation of high cost technologies. This is necessary because high cost technologies -- especially diagnostic tests -- are a significant driver of spending increases for health services: medical tests represent about seven percent of total expenditures; 20 to 60 percent of tests may not contribute to diagnosis or treatment; and technology may account for 25 to 75 percent of hospital cost increases.[44]

PROVIDER CONFLICTS OF INTEREST

[44] Friedman, David, Travelers Health Network, testimony to the Washington Health Care Commission's Cost Control Committee, March 7, 1991.

The finance and payment system should include a mechanism to prohibit or restrict provider investments that constitute a conflict of interest (for example, an X-ray or laboratory partially owned by a physician who refers patients to that laboratory).

HEALTH PLAN CERTIFICATION

The finance and payment system should include a mechanism to ensure that health plans are "certified;" that is, an official determination that a health plan is capable of providing uniform benefits coverage consistent with the policies and regulations promulgated pursuant to these responsibilities and authorities. This must be implemented so as to avoid duplication with the responsibilities of the Office of the State Insurance Commissioner and other existing state agencies.

Central State Authority

After determining the responsibilities and authorities necessary to ensure financial access and control costs, the Commission agreed that an entity is needed to carry out the responsibilities and authorities. The multifaceted nature of our current 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 believes these shortcomings require some central authority to guide the health system in the public interest.

The Commissioners considered existing entities in both the private and public sectors, including those at the federal, state, and local levels. Emphasis was placed on ensuring independence from existing state bureaucracies, an arms-length relationship with the State Legislature, and accountability. The Commission concluded that a permanent and independent state board or commission would be best able to coordinate and guide the numerous public and private entities involved in financing, purchasing, and delivering health services to Washington residents.

Therefore, the Commission recommends that the State Legislature establish a permanent and independent state board or commission to carry out the "responsibilities and authorities" described in the previous section. The new state board/commission should have the characteristics discussed below.

The board/commission should consist of five to nine full-time, paid members, appointed by the Governor and confirmed by the State Senate for defined terms. The members of the board/commission should represent the public interest and have no financial interest in any health service activity during their terms. The board/commission should include members with experience in various elements of the health system. It should have independent rule-making authority which, pursuant to state law, requires formal public involvement in its decision-making process.

The new state board/commission should be required to establish structures and processes that

ensure the formal participation of stakeholders (including business, labor, government, providers, insurers, and consumers) in its decision-making process. The Commission's discussions emphasized the need for ensuring a balance among the stakeholder interests to reflect the public interest. The Commission also believes that it is essential to have expertise regarding the various elements of the health system as part of its policy and decision-making process. These attributes are necessary to implement successfully the reformed health system envisioned by the Commission.

For the specific purpose of refining and updating the uniform benefits package, the board/commission should implement a stakeholder process that incorporates at least the following functions:

•Collate national research on health service effectiveness and appropriateness;

•Provide access to and collate data on health service appropriateness and effectiveness in Washington State;

•Set priorities for assessing the appropriateness and effectiveness of health services;

•Identify data needed for necessary evaluation;

• Assess how well specific health services meet technical criteria;

•Disseminate information about the degree to which health services are appropriate and effective;

•Assess public values necessary to determine to which health services all residents should have access;

•Recommend revisions to the uniform benefits package, applying Washington-specific values as well as technical criteria; and

•Assess how well the uniform benefits package achieves expected health system outcomes.

Finance and Payment System Model

The Commission's recommendations to reform the finance and payment system in Washington State come together in a system "model" -- a description of the desired relationships among financers, sponsors, payers, providers, and consumers of health services. The "Finance and Payment System Model" diagrammed on page 79 shows these relationships, including the new state board/commission and its responsibilities and authorities. Descriptions of specific parts of the Commission's recommended model are presented below.

COMPETING HEALTH PLANS

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

The first option defines a "single-payer" system similar to British Columbia's in which the state has direct contractual relationships with individual practitioners, facilities, and other service providers. This option would mean the elimination of what we call "managed care systems" (though the state could be considered *the* managed care system). The Commission believes managed care systems have the potential to control costs by changing the incentives and behaviors of consumers as well as providers. Incentives for efficient management/
service delivery and innovation encouraged by competing plans are valued by the Commission as well.

Therefore, the Commission recommends multiple, competing health plans that would manage the uniform benefits package. These plans would have direct financial (and perhaps contractual) relationships with service providers. Competing health plans could be sponsored by existing private insurers, health maintenance organizations, health service contractors, employers, other managed care plans, and state or local governments.

These plans would be certified as discussed above, to assure they offer the uniform benefits package, are financially sound, and meet other relevant standards. How best to maintain a seamless system, but still have multiple plans, needs to be addressed further by the Commission.

SHARED FINANCING RESPONSIBILITIES

The Commission recommends that governments, employers, and individuals equitably share the burden of financing the health system. The question still to be addressed by the Commission is not whether each sector will pay, but *how to pay and how much to pay*. The Commissioners agree that the following policies should govern how the financing burdens are shared:

•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 accessing appropriate and effective health services.

•*If* employers are allowed to provide health coverage directly by sponsoring certified plans,[45] then:

·Employers should be the primary financers of health coverage for their employees and their dependents; and

·Government should be the primary financer of health coverage for the unemployed. Government should also help finance coverage for low income, part-time, and seasonal employees and employees of some businesses (such as small or start-up firms).

The Commission has not yet addressed the foregoing policies regarding the financial burdens of employers and government if employers are *not* allowed to sponsor certified plans.

STATE BOARD OR COMMISSION

As discussed above, the Commission recommends that a permanent and independent state board or commission be the central authority created to carry out the responsibilities and authorities necessary to control costs and ensure universal financial access. In defining the responsibilities and authorities, the Commission recommends that the system of financing, managing, and delivering services/benefits exhibit certain uniform characteristics. In order to control total spending on health services and produce these uniform characteristics, the Commission recommends that the new state board/commission ensure that health plans are "certified" to cover a uniform benefits package consistent with the board's/commission's policies and procedures.

UNIFORM BENEFITS PACKAGE SPONSORSHIP

Employer Sponsorship

[45] The issue of whether or not employers should continue to provide health coverage is discussed below on pages 77 to 78.

The remaining variable in the Commission's recommended finance and payment system model is whether employers will *sponsor* uniform benefits packages through certified plans. (As stated above, the Commission recommends that employers must, in any case, help finance these benefits.) From one point of view, this is a question of the relative benefits and costs of having employers involved in making or restricting the choices of health plans available to their employees and dependents, in addition to the new state board/commission doing so through a certification process. From another perspective, it is a question of whether employers can exert pressure on the health system to control costs, over and above the other system features recommended by the Commission to control costs (such as maximum premiums, uniform billings and claims, and provider payment methods). Political and labor/management issues are also central to the question of employer sponsorship of the uniform benefits package.

The arguments *for* continuing to allow employers to provide uniform benefits coverage directly by sponsoring certified plans include:

- The rest of the country operates that way and federal reform is unlikely to change that practice in the future.

- Prohibiting employers from paying directly for health coverage would mean more money would have to flow through taxes. This would require major changes in the state tax structure and may not be politically feasible.

- If an employer wants to offer supplemental benefits, it may be more efficient to purchase uniform and supplemental benefits in one package.

- Many employers already have the administrative mechanisms in place to offer the uniform benefits package, minimizing the amount of system "retooling" necessary.

- Policies of the new state board/commission could provide incentives for employers to seek value and efficiency in the health system. Employers could in turn create similar incentives for employees, and the combination could create continuous pressure on competing health plans to be more efficient.

- Employers would have the choice of either covering their employees and dependents for the uniform benefits package or paying equivalent funds into a government-sponsored program.

•Health benefits are an important part of employer-employee relationships. Such relationships could be traumatized if employers are not allowed to sponsor certified plans.

The arguments *against* allowing employers to provide uniform benefits coverage directly by sponsoring certified plans include:

•Businesses would continue to be an added layer of administration in the health system.

•To date, the experience of employers exerting pressure for greater system value and efficiency is equivocal.

•There would be a risk of employers hiring only healthy people, creating a bias against less healthy individuals.

•The system would maintain inconsistencies for individuals changing jobs, retiring, or moving.

•If employers sponsor uniform benefits, then the system will continue to have a "seam" defined by one's employment status, forcing changes in an individual's health plan or service provider when his/her employment status changes.

•Even if a maximum premium is set by the new state board/commission, small employers may be at a disadvantage in negotiating coverage rates from plans compared to large employers.

•Employers could exert pressure on the state board/commission to reduce the uniform benefits package.

•Employers could exert pressure on providers to discount rates for them, leading to cost-shifting to other payers.

The Commission decided to continue evaluating the pros and cons of employer sponsorship of the certified plans before making a final recommendation in 1992. The question mark in the diagram on the next page represents this unresolved issue.

State Program

While not yet resolving the issue of employer sponsorship, the Commission did agree on who should sponsor the uniform benefits package for residents not covered through employers if they do sponsor these benefits. The Commission recommends that one state-sponsored program cover all state residents who do not have employer-sponsored coverage, including people who are now uninsured, Medicaid recipients, enrollees in the Basic Health Plan, and Medicare enrollees.
Chart

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CHAPTER 5

HEALTH CARE LIABILITY SYSTEM

Introduction

The Washington State Legislature asked the Washington Health Care Commission to recommend medical malpractice and liability insurance changes to "decrease health costs, increase health access, increase the efficiency and safety of health provider practices, and provide needed coverage for injured consumers. The Commission recognizes the importance and difficulty of accomplishing this task. Health care liability issues have been, and continue to be, very divisive. The Commission has therefore addressed these issues in a deliberate and reasoned manner, considering the views of all concerned parties. This continuing effort will constitute a significant part of the Commission's 1992 Work Program.

Concerns about the current health care liability system are often expressed in terms of its impacts on access to health services. Malpractice concerns have been documented to influence specialty choices, most notably to enter or leave obstetrics. Other evidence indicates these concerns may also affect the willingness of physicians to perform certain procedures.[46] For some state residents and communities, these decisions have reduced access to needed care.

Others have expressed concerns about the impact of the health care liability system on the costs of health services. These impacts include the costs of "defensive medicine" discussed below, malpractice premiums, and the transactional costs of malpractice claims and litigation reflected in those premiums. Malpractice insurance constitutes less than two percent of total health system expenditures, while the exact magnitude of the costs of defensive medicine are unknown.[47]

In evaluating potential reforms of the health care liability system, the Commission recognizes the need to use all available data and studies related to the impact of the system on the delivery, cost, and quality of health services in Washington State. Unfortunately, Washington State lags, as do other states, in developing public data that illustrate the functioning of the tort system as a source of remedies or that make clear the effect of the tort system on the cost, quality, and availability of medical care.[48] Fortunately, recently published studies of the current health care liability system

[46] Wadlington, W., "Legal Responses to Patient Injury: A Future Agenda for Research and Reform," Law and Contemporary Problems, Volume 54, Number 2, Spring, 1991, pages 199 and 205.

[47] Danzon, P., "Malpractice Liability: Is the Grass on the Other Side Greener?," Tort Law and the Public Interest, 1991, pages 176, 180, and 193.

[48] Hicks, G., and Katz, A., Medical Liability and Compensation: A Discussion of Themes in British Columbia and Washington State, 1991, page 1.

provide new and valuable data on this important issue.[49]

Findings from two studies confirm that the incidence of medical injury caused by malpractice is much larger than the number of liability claims pursued through the legal system. A 1974 study conducted in California hospitals found that medical injuries resulting from negligence were ten times more numerous than the equivalent malpractice claims filed for this period.[50] A 1984 Harvard University study of New York hospital records found that the number of adverse events caused by negligence was eight times as large as the equivalent number of malpractice claims.[51] This information can be of great importance in assessing the economic feasibility of any selective no-fault scheme of compensating individuals for medical injuries.[52]

In 1984, the American Medical Association asked physicians to report changes in their practice patterns in response to the threat of liability for malpractice. Forty-one percent reported ordering extra tests, 36 percent spent more time with patients, 57 percent kept more detailed records, and 45 percent referred more cases.[53] A survey of physicians, conducted by the Pritchard Commission in Canada, found similar changes in patterns of practice among Canadian physicians. Like physicians in the United States, the Canadian physicians reported an increase in laboratory tests ordered; an increase in the documentation of procedures, diagnosis, and treatment in patient records; and an increase in the time spent with patients discussing the benefits and risks of treatment.[54]

As noted above, several surveys have found that physicians have changed some aspects of their practices to decrease their risk of malpractice claims (commonly called "defensive medicine"). Despite the widespread recognition that defensive medicine is practiced, there is little agreement about its impact on health care costs or even its definition. There is no broad agreement on what constitutes "undesirable" defensive medicine. The Canadian and U.S. physician surveys discussed above include some practice changes that might be considered effective quality assurance measures, such as spending more time with patients or keeping more detailed medical records. No studies to

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[49] Law and Contemporary Problems, Volume 54, Numbers 1 and 2, Winter and Spring, 1991.

[50] Mills, Boyden, and Rubsamen, editors, Report on the Medical Insurance Feasibility Study, Sutter, 1977, cited in Wadlington, W., supra note 46, at pages 203 and 204.

[51] Harvard Medical Practice Study, Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York, Harvard University Press, 1985, cited in Wadlington, W., supra note 46, at page 204.

[52] Wadlington, W., supra note 46, at pages 203-204.

[53] Dewees, D., Trebilcock, M., and Coyte, P., "The Medical Malpractice Crisis: A Comparative Empirical Perspective," Law and Contemporary Problems, Volume 54, Number 1, Winter, 1991, pages 217 and 230.

[54] Hicks, G., supra note 48, at page 20.

date have attempted to segregate procedures induced by the threat of liability that have little or no therapeutic value from those that may reduce the risk of injury from negligence.[55] Finally, consideration of defensive medicine should include the societal costs of health providers turning some patients away or curtailing or abandoning practice.[56]

A significant finding of recent malpractice studies funded by the Robert Wood Johnson Foundation is that the civil justice and health care liability insurance systems, as they are now structured, provide neither an efficient nor an equitable means of compensating injured consumers, nor adequate deterrence against medical negligence.[57] There is some difference of opinion on this issue. One commentator notes that the tort system probably has served a greater role in upholding standards of quality than has generally been recognized. When other control procedures are lacking or inadequate, the tort system provides a mechanism through which reasonable standards can be determined and enforced.[58]

The challenge then, is to identify other and more effective mechanisms for medical quality control, such as efficient and responsive disciplinary procedures, more effective institutional and peer review practices, practice parameters that define standards of care, and risk management activities. For example, physician-owned malpractice insurers in Washington State have recognized the benefits of offering risk management training to their insured physicians.

Recent trends in the premium rates for health care liability insurance, and in claims frequency and severity, also are relevant to thoughtful consideration of malpractice issues. The last general malpractice premium rate increase by the Washington State Physicians Insurance Exchange and Association (WSPIEA) was on January 1, 1988, an increase of seven percent. In 1989, there were no changes in general rates. Rates for a small group of specialties decreased 25 percent in that year. Rate changes in 1990 resulted in an overall rate decrease of 4.3 percent. In 1991, there was no change in rates. In 1992, WSPIEA anticipates an overall rate decrease of 8.6 percent.[59]

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[55] Dewees, D., supra note 53, at page 230.

[56] Wadlington, W., supra note 46, at page 207.

[57] Robert Wood Johnson Foundation, A Bridge: A Selected Summary of Recently Published Research by Grantees, Spring, 1991, page 1.

[58] Wadlington, W., supra note 46, at page 208. A recent study of obstetrical malpractice cases in Washington found that non-meritorious claims -- instances in which a poor outcome does not appear to have been caused by medical negligence -- are rarely successful, and that the major cause of significant awards is medical negligence. Rosenblatt, R., and Hurst, A., "An Analysis of Closed Obstetrical Malpractice Claims," Obstetrics and Gynecology, Volume 174, Number 5, November, 1989, pages 710 and 713.

[59] Telephone conversation with Pamela Tinsley, Underwriting Supervisor, WSPIEA, Seattle, Washington, November 4, 1991.

WSPIEA insures from 62 to 65 percent of the physicians in Washington State who purchase their own malpractice insurance coverage.[60]

The Doctor's Company, which insures about ten percent of Washington physicians, has decreased premium rates for physicians an average of 30 to 40 percent over the last four years. These recent years have been the longest period of continued decreasing premiums since professional liability for physicians and surgeons became an issue in the early 1970's. One local expert predicts this period of decreasing premiums will end, but future rate increases will approximate the general rate of inflation.[61]

Claims frequency, or the rate at which malpractice claims are filed, has declined as much as 40 percent over the past four years for the Doctor's Company. Claims frequency is the most significant factor in rate determinations. In Washington State, claims frequency was 21 per 100 doctors in 1986. By 1990, that frequency rate had declined to slightly less than 10 per 100 doctors.[62] Claims severity, which is the amount paid per claim, has continued to increase for the Doctor's Company, but at a slower rate than in earlier years, with increases of about 10 to 15 percent over the past four years. National trends are comparable to Washington's experience in premium rates, claims frequency, and claims severity.[63]

Several studies have attempted to determine the effect of the 1970's and 1980's tort reform efforts on the frequency and severity of malpractice claims. Some tort reforms -- including caps on non-economic damages, shorter statutes of limitation, arbitration, and mandatory collateral source offsets -- have helped slow the growth of liability costs. Other tort changes have seemingly been ineffective.[64]

In developing its health care liability recommendations, the Commission has divided its analysis into those strategies that relate to prevention and those that relate to process. *Prevention* strategies include improving the quality of health care practices, preventing injuries caused by negligence, and supporting reasonable public expectations of health care practices. *Process* strategies include improving access to appropriate compensation for persons injured by medical malpractice and improving the efficiency of the systems that identify, adjudicate, and finance risks or outcomes of

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[60] Telephone conversation with Tom Fine, WSPIEA, Seattle, Washington, November 15, 1991.

[61] Telephone conversation with Phillip Dyer, President, Washington and Oregon Agencies of the Doctor's Company, Seattle, Washington, November 4, 1991.

[62] Id.

[63] Ferraiolo, D., "Medical Malpractice Insurance: A Disquieting Calm," Best's Review, 1991, page 10.

[64] Wadlington, W., supra note 46, at page 204.

injuries caused by medical malpractice.
The Commission has decided to focus most of its efforts on prevention strategies, because the best way to address the adverse impacts of the health care liability system on access and costs is to reduce the need for that system. Changes to the legal and insurance systems alone cannot resolve the problems related to medical injuries caused by negligence.

Studies focusing on non-legal reforms have found that the use of practice parameters can reduce claims by reducing injury.[65] Other commentators question the perceived benefits of practice parameters.[66] The Commission regards practice parameters as an important strategy that will receive attention in its 1992 Work Program. The potential application of practice parameters will be addressed in the context of determining appropriate and effective health services and controlling costs. Findings from the medical malpractice studies funded by the Robert Wood Johnson Foundation indicate considerable potential of other non-legal reforms to prevent injuries, such as developing new, more formal professional standards and identifying and correcting incident-prone situations and settings through risk management.[67]

Other Commission recommendations in this Interim Report have some potential to impact health care liability. Some have argued, for example, that if every Washington resident were assured access to a uniform benefits package, there would be less need to bring malpractice claims because future medical expenses related to a medical injury would be covered. Increasing medical malpractice claims frequency in Canada casts some doubt on the validity of this contention.[68] Others might argue that the identification of appropriate and effective health services for inclusion in the uniform benefits package can positively influence standards of care used by health practitioners, thereby preventing injuries.

In its effort to respond to the concerns discussed above, the Commission began by identifying the purposes and roles of the health care liability system, and developed criteria for evaluating health care liability strategies. The purposes, roles, and criteria are presented below on pages 87 and 88. The Commission has considered over 40 potential strategies to address the impacts of the health care liability system on access to health services and their costs. Of these, 11 prevention strategies and seven process strategies will receive further consideration and evaluation during 1992. These 18 strategies are discussed below on pages 89 to 93.

The five initial recommendations included on pages 89 and 90 in this report were identified as showing significant potential to prevent medical injuries that may result in the filing of malpractice

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[65] Wadlington, W., supra note 46, at page 205.

[66] Kosterlitz, J., "Cookbook Medicine," National Journal, March 9, 1991, page 574.

[67] Robert Wood Johnson Foundation, supra note 57, at page 1.

[68] Hicks, G., supra note 48, at page 22.

claims. The Commission's major recommendations related to the health care liability system will be included in its Final Report, to be submitted to the Governor and the State Legislature by November 1, 1992.

Purposes and Roles

The following summarizes the purposes and roles of the health care liability system:

PURPOSES

The "health care liability system" includes the civil justice system (as it pertains to malpractice disputes), health care liability insurance, and health care practices. The overall purposes of the health care liability system are to:

- Efficiently provide appropriate compensation to individuals who have been injured by negligent health care practices;

- Promote the provision of and access to appropriate and effective health services; and

- Minimize the incidence of adverse health outcomes resulting from negligent health care practices.

ROLES

To achieve these purposes, each of the following three components of the health care liability system has its special role (to be carried out in an efficient, effective, and equitable manner):

- **Health care practices**, including professional licensing and disciplinary processes, should set and enforce standards of health care, determine the limits of acceptable health care practice, and promote the provision of and access to appropriate and effective health services.

- **Health care liability insurance** should identify and fund the risks of health care liability and associated legal costs, help determine the existence and extent of such liability, and finance appropriate compensation to individuals who have been injured by negligent health care practices.

- The **civil justice system** should resolve malpractice disputes, determine the existence and extent of liability, and ensure appropriate compensation to individuals who have been injured by negligent health care practices.

Criteria for Evaluating Strategies

Strategies to improve the health care liability system should promote the following results:

(1)Ensure that individuals injured by negligent health care practices receive appropriate compensation in a timely manner;

(2)Minimize the direct transaction (legal, administrative, and financial) costs of the civil justice and liability insurance systems;

(3)Minimize the barriers for individuals injured by negligence to obtain access to a dispute resolution system;

(4)Minimize the frequency of filings of non-meritorious health care negligence claims or lawsuits;

(5)Promote malpractice premium prices that accurately reflect health care liability costs;

(6)Support the provision of quality health care by efficiently and effectively enforcing licensure and disciplinary rules and standards of health care conduct and practice;

(7)Minimize barriers to affordable health care liability insurance in order to support access to appropriate and effective health services;

(8)Deter negligent health care practices;

(9)Minimize the incidence of health care practices that do not benefit patients ("defensive medicine");

(10)Minimize unreasonable and unnecessary fears on the part of health care practitioners concerning the civil justice and liability insurance systems;

(11)Promote realistic and reasonable consumer expectations of the health system; and

(12)Help control the rate of growth in total health system expenditures.

Health Care Liability Strategies

INTRODUCTION

After identifying and prioritizing numerous problems in the health care liability system, the Commission considered over 40 potential strategies to address these problems. The strategies were organized into two general groups:

•**Prevention strategies** that attempt to improve the quality of health care practices, prevent injuries caused by negligence, and support reasonable public expectations of health care practices; and

•**Process strategies** that attempt to improve access to appropriate compensation for persons injured by medical malpractice and improve the efficiency of the systems that identify, adjudicate, and finance risks or outcomes of injuries caused by medical malpractice.

Of the strategies considered, the Commission selected 11 prevention strategies and seven process strategies that show potential to address priority problems in the health care liability system. The Commission has developed initial recommendations related to five of the prevention strategies. During 1992, the Commission will continue to research and evaluate all 18 strategies summarized below and develop recommendations for implementing each strategy as appropriate.

RECOMMENDATIONS

The Commission adopted the following initial recommendations to begin implementing five of the 11 prevention strategies summarized below.

•**Regulation of Practitioners**: Careful screening of applicants for health care practitioner licenses can protect consumers of health services and improve the quality of those services. Timely identification and discipline of substandard health care practitioners is an important tool in preventing consumer injuries. With these goals in mind, the Commission recommends exploring the potential of the following practitioner regulation strategies:

·For categories of health care practitioners that are currently licensed and disciplined by separate boards, consolidation of licensing and disciplinary functions into a single board;

·Consolidating licensing and/or disciplinary functions across categories of health care practitioners; and

·Modifying and strengthening health care practitioner licensing and disciplinary procedures.

•**Risk Management**: Current Washington State law requires that hospitals maintain a risk management program. The benefits of effective risk management include prevention of injuries caused by negligence and mitigation of injuries that may occur. The Commission recommends that all licensed health care practitioners be required to receive education on effective risk management techniques as a condition of licensure or relicensure.

•**Practice Parameters**: Studies have found that the use of practice parameters can reduce malpractice claims by reducing injury. Practice parameters also show some potential for the development of clearer standards of care in malpractice claims. The Commission supports the development and evaluation of practice parameters in specific practice areas, as a means of reducing the incidence of negligence and bringing more certainty to the determination of standards of care.

•**Uniform Data Format**: The lack of uniform data on provider practices complicates the task of disciplining health care practitioners and defining standards of care. The Commission supports establishing a uniform data format and standards to characterize, profile, and track provider practices.

•**Purchasing:** Prudent health care purchasing practices can help prevent injuries caused by negligence through the inclusion of prevention strategies in purchasing contracts. The Commission recommends the promotion and implementation of purchasing strategies that require or encourage health care provider credentialing, peer review, and the use of managed care.

PREVENTION STRATEGIES

During 1992, the Commission will research and evaluate the potential of the following 11 prevention strategies to address major problems of the health care liability system:

•**Regulation of Practitioners**: Strategies related to increasing the authority, resources, and effectiveness of health care practitioner regulation might include: consolidating activities of some regulatory boards; licensing specific scopes of practice only within demonstrated areas of competency; authorizing regulatory boards to spend the full amount of practitioner licensing fees without appropriation by the legislature; providing general fund support for enforcement actions against unlicensed practitioners; authorizing disciplinary boards to use civil penalties against unlicensed practitioners; and addressing problems presented by the "conspiracy of silence" (that is, many local health care practitioners are reluctant to judge publicly the practices of their peers).

•**Risk Management**: Washington law requires that all hospitals maintain a coordinated risk management program to help identify and prevent medical malpractice. No analogous

requirement exists for other health care practitioners.

•**Licensure and Relicensure**: Health care practitioner regulatory boards could require education or skills in the following areas as a condition of licensure or relicensure: effective communication techniques, cost control, health care liability insurance, and the health care liability system.

•**Continuing Medical Education**: The Washington State Board of Medical Examiners has statutory authority to establish mandatory continuing medical education requirements as a condition of physician license renewal. The board could be directed to establish requirements in specific subject areas, such as risk management, cost control, and the health care liability system.

•**Practice Parameters**: Practice parameters are standardized specifications for health care practice, whether for use of a specific procedure or treatment of a particular clinical problem. Practice parameters have been or are being developed by numerous medical specialty societies, the Agency for Health Care Policy and Research, the United States Preventive Services Task Force, the RAND Corporation, health maintenance organizations, private health insurers, and private utilization review companies. In 1990, the State of Maine enacted legislation establishing the Medical Liability Demonstration Project, which mandates the development of practice parameters in specified practice areas, and authorizes their use as an affirmative defense in medical malpractice lawsuits against physicians who have agreed to comply with the practice parameters.

•**Peer Review**: Washington law currently provides immunity to health care providers participating in peer review activities and provides an exclusive legal remedy for actions by peer review entities that are not related to the competence or professional conduct of a health care provider. Refinements in peer review will be investigated by the Commission in relation to improved monitoring of quality of care, federal antitrust questions, and compensation of individuals injured as a result of negligent health care practices.

•**Liability Coverage**: Washington State does not mandate liability coverage as a condition of licensing health care practitioners. While most hospital medical staff bylaws require that physicians with admitting privileges carry malpractice insurance, about 200 physicians in Washington have active practices without hospital admitting privileges. Maintenance of a minimum level of liability insurance coverage could be a condition of licensure and relicensure.

•**Experience Rating**: Refinements in current experience rating practices for health care practitioner liability insurance will be explored by the Commission, with the goal of increasing the financial incentives for improving quality of care and risk management.

•**Uniform Data Format**: This strategy involves the development of a uniform format and standards for health insurance claims, service use, billing, and other data.

•**Purchasing**: Health care purchasers could use purchasing strategies that encourage improved quality of care by including standards in purchasing agreements related to health care provider credentialing, peer review, and the use of managed care.

•**Public Information**: The Commission will explore methods to provide greater and more detailed information to the public regarding health care practices and outcomes. This exploration will include consideration of how health care consumers can be educated to prevent bad health outcomes, and how the health services system can encourage such conduct by consumers.

PROCESS STRATEGIES

During 1992, the Commission will research and evaluate the potential of the following seven process strategies to address major problems of the health care liability system.

•**Selective No-fault**: A selective no-fault system designates "compensable events," removes them from the traditional tort system, and provides compensation to individuals suffering the designated injuries regardless of fault. For example, Virginia and Florida have implemented selective no-fault systems to compensate children that have suffered severe birth-related neurological injuries. Awards are limited to the costs of medically necessary and reasonable care not covered by collateral sources.

•**Alternative Dispute Resolution**: Several non-judicial procedures for resolving disputes (such as arbitration and mediation) are currently in use in Washington, but are not broadly applied to malpractice claims. In arbitration, an arbitrator makes a decision that is binding on the parties to the dispute, unless the decision is appealed to a court of law. County Superior Courts can mandate arbitration in disputes requesting up to $35,000 in damages. In mediation proceedings, the mediator's role is not to make a decision, but to facilitate an agreement between the parties to the dispute.

•**Pretrial Screening Panels**: In several states, pretrial screening panels, generally composed of medical and legal experts, review medical malpractice cases prior to trial. The panels render an opinion regarding liability, and some address the issue of damages as well. Review by a pretrial screening panel may be voluntary or mandatory, depending upon the state statute establishing the panel.

•**Expert Witnesses**: Testimony of expert witnesses at trial could be limited to Washington State licensees or to a fixed maximum number of experts.

•**Collateral Source Offset**: Once liability has been determined, but prior to fixing the amount of an award, the court would be required to reduce the judgment in the amount of damages paid by a collateral source. Such sources include private health insurance or disability insurance that do not require subrogation (repayment of the insurer if the injured person receives

payment from a negligent third party). In addition, the court can be required to limit the reduction by the amount the injured party has paid the collateral source for coverage, such as insurance premiums or payroll deductions.

•**Joint and Several Liability**: Washington law provides that when an injured plaintiff is free of negligence, the defendants in a lawsuit are jointly and severally (or each fully) liable for the sum of their shares of negligence, but not for the proportion of negligence attributable to another entity that is not a defendant in the suit. Some have proposed that in this situation, the defendants should not be jointly and severally liable for the non-economic damages incurred by an injured plaintiff, while retaining such liability with respect to economic damages.

•**Attorneys Fees**: Currently in Washington, a judicial determination regarding the reasonableness of attorneys fees is mandatory in all medical malpractice cases. More restrictive controls of attorney fees would regulate the percentage of a medical malpractice award allocated to attorneys fees, based upon the amount of the total award or the stage of the lawsuit at which the award is made.

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CHAPTER 6

ADDITIONAL RECOMMENDATIONS

Introduction

To assure its recommended health system reforms control costs and ensure universal access, the Washington Health Care Commission has developed five additional policy recommendations. The first recommendation -- extending the Basic Health Plan for *at least* an additional two years -- focuses on continuing a program that could play an important role in a reformed health system. The second recommendation recognizes that health insurance reform may be beneficial, pending full implementation of the Commission's recommendations for health system reform. The third recommendation addresses the responsiveness of the health services delivery system to the new demands placed on it by a reformed health system. Providing support for training and education of health personnel in the reformed health system is the thrust of the fourth recommendation. Finally, the Commission recommends improving health services data collection to support health system reform.

During 1992, the Commission will continue to develop and evaluate additional strategies to help ensure effective implementation of the recommended health system reforms. The Commission's 1992 Work Program is discussed in Chapter 8 of this Interim Report.

Basic Health Plan

The Basic Health Plan, a pilot project which provides health insurance coverage to about 24,000 Washington residents, is scheduled to "sunset" on June 30, 1992. The Plan provides subsidized health care coverage for a portion of those individuals without access to health insurance and is an important example of innovation in service delivery and financing.

The Commission supports extension of the Basic Health Plan for *at least* an additional two years (until June 30, 1994). Because the Commission has not completed its recommendations for health system reform, it has not yet taken a position on the appropriate future role of the Plan. Extending the Plan, at least until after the Commission completes its work and health system reform is underway, preserves the option of giving the Plan an important role in a reformed system, as well as continuing health coverage for many state residents.

Health Insurance Reform

Numerous health insurance industry practices inhibit access to health coverage and/or increase costs for many Washington residents. In many cases, health insurance coverage is unaffordable and people are often excluded from coverage due to high risk and pre-existing conditions. Major barriers to receiving necessary health services include lack of coverage between jobs; denial of coverage for pre-existing conditions; and the high costs of coverage for individuals, small businesses, and self-employed individuals.

To many individuals in the state, a single-payer system appears to be the best solution to these problems because it would guarantee continued coverage regardless of employment status. A single-payer system is not necessarily the only way to correct these inequities. The problems of waiting periods or exclusions for pre-existing conditions -- as well as exclusions or expensive premiums for small groups (businesses) or individuals -- could also be corrected through reform of the health insurance market.

For example, small groups and individuals could be allowed to join a large pool where rates would be lower because risk would be distributed broadly. Exclusions and waiting periods for pre-existing conditions could be prohibited. These methods and others could be explored in a multiple-payer system that is employer-based or residency-based.

Therefore, the Commission recommends that, pending full implementation of its recommendations, there should be immediate consideration by the Governor and the State Legislature of reforms to make health insurance more affordable and accessible for small groups and individuals. State government should consider policies to guide the private sector toward more responsible competition in health insurance benefits, including community rating, bans on excluding those with pre-existing conditions, guaranteed issue and renewability, portability, waiting periods, open enrollment, full disclosure of rating practices, and acceptance or rejection of entire groups rather than individuals. To achieve affordable and seamless coverage, competitive insurance practices that limit coverage or exclude people based on medical risk should be eliminated.

Health Services Delivery System

The Commission's recommendations about universal access and cost control do not assure a health services delivery system able to meet the new demands of a reformed health system. The question that needs to be asked and answered is: "How must the health services delivery system be changed in order to control costs and deliver appropriate and effective health services to all who need them?"

As discussed in Chapter 1, there is a shortage of primary care practitioners in certain areas and for certain populations in the state. An inadequate supply of practitioners may result from inadequate reimbursement or from insufficient incentives for health practitioners to train in primary care and to locate in underserved areas. In some areas and for many individuals, the primary sources of health

services are local public health departments and community and migrant health clinics. These organizations need to be integrated into a reformed delivery system.

The Commission believes that universal access can only be achieved if appropriate planning, coordination, training, and outreach occur as health system reforms are implemented. Continued innovation, as well as a variety of licensed practitioners to provide appropriate and effective health services, must be encouraged. The Commission also supports the development of integrated systems that provide the different levels of care necessary for maintaining health and treating illness and injury.

The Commission strongly supports the development of managed care systems, because they have the potential to provide incentives for efficient use of resources, with less need for regulatory intervention into provider practices or delivery system management. The Commission therefore recommends that public policy strive to shift a substantial majority of the state's population into integrated delivery systems which manage care and assume financial risk for providing the uniform benefits package to their beneficiaries. At the same time, the Commission believes it is important to encourage innovation and encourage a wide variety of lawful practitioners to provide appropriate and effective health services.

Education and Training

The Commission recognizes that a cost-effective health system depends on an appropriate mix of competent, well-educated, and trained health personnel distributed to meet community needs throughout the state. To accomplish this, the health system must continue to educate, train, and develop new health professionals and other health personnel, generate new knowledge and research, and renew the competence of existing health practitioners.

Money for professional education, training, and clinical research performed by health service providers currently flows partly from research grants and other direct subsidies, and partly from health insurance coverage, both public and private. The Commission believes that reform of the state's finance and payment system should include mechanisms to adequately fund these activities.

The Commission also believes that health system reform must include adequate funding for education and training of non-professional health personnel. To make the health system more efficient and more responsive to the health needs of state residents, the training of non-professional health personnel must be encouraged. These personnel, working with health professionals, can help meet the primary care and chronic care service supply shortages that exist in parts of Washington.

In addition to adequate funding, a planning process is necessary for establishing community and state priorities for educating and training health personnel. The Commission recognizes that the initial State Health Personnel Resource Plan, mandated by the 1991 Washington State Legislature, focuses on this kind of centralized planning and requires a report to the Governor by June, 1992.

The Commission supports this effort and believes that institutions providing education and training must help meet the existing supply problems.

Health Services Data

If the Commission's recommendations are to be implemented successfully, policy makers -- both public and private -- will need very good data about health services and their effects. Much of these data are either not yet available or not available in a form that can be used to evaluate and design health system reform strategies.

As a result, the Commission recommends a public-private cooperative effort to develop uniform health services data gathering and reporting processes. These processes should be designed to support both public and private information needs for health policy and budget development issues, provider contracting, outcomes research, determination of services for inclusion in the uniform benefits package, investigation of service use patterns, development of practice parameters, and quality improvement.

The Commission also supports current efforts in the state that are trying to meet the need for relevant and usable data. These efforts are taking place on both a public and private level. The Commission is pleased to see this support for *informed* health system reform.

CHAPTER 7

PUBLIC PARTICIPATION PROGRAM

Introduction

The Washington Health Care Commission was charged by the Governor and the Washington State Legislature with the major challenge of developing recommendations to control health system costs, provide access to health services for all, develop incentives to use appropriate and effective health services, reform the health care liability system, and improve state health care purchasing. To assist the Commissioners in meeting this challenge, their work has received substantial review by a wide variety of individuals and organizations who have a stake in the health system.

The Commission has worked extensively with a wide range of health care experts and representatives of various sectors of the health care industry. In shaping its recommendations, the Commission also heard from people in communities throughout the state who are at the "front lines" of the health system where services are delivered and received.

The Commission has provided numerous opportunities for the public to participate in the Commission's efforts to improve the health system in Washington State. In developing its recommendations, the Commission reached out across the state and communicated with numerous representatives of business, labor, health and human services providers, insurers, government officials, and consumers of health services. The Commission's public participation program was designed both to educate the public about the major policy issues being addressed by the Commission and to receive a wide range of expertise, advice, and other information on those issues.

The Commission considers its public participation program to be a critical factor in successfully meeting the challenge of health system reform. Public interest in health issues is high, but the technical and financial parameters for making responsible decisions about the health system are complex and difficult. The biggest public participation challenge is the very complex and interrelated nature of the health system itself. In developing the public participation program, the Commission allowed for different kinds of participation regarding different elements of the health system -- its management, economics, social policy, quality, and a host of other concerns.

Another major challenge is the large geographic area and the diversity of communities within the State of Washington. Health issues vary among communities, and so do the most effective methods for disseminating and receiving information. In addition, many of the counties and cities within the state are currently undertaking planning activities in related issue areas, each with their own public participation process.

During 1991, the Commission embarked on a multi-faceted strategy for informing and involving the diverse groups and individuals who have an interest in understanding and influencing the Commission's policy recommendations. The major objectives of the Commission's public participation program are to:

•Assure that the Commission's policy recommendations for improving Washington State's health system are responsive to the needs of the state's residents and communities;

•Build public understanding and support for health system reform and the Commission's policy recommendations; and

•Provide decision makers with a better understanding of the range of public opinions about health system problems and solutions.

Public Participation Activities

Since its first public meeting in June, 1990, the Commission has pursued numerous approaches for enabling and encouraging the public to participate in the work of the Commission. To ensure *informed* public participation, the Commission conducted the following public participation activities:

•**Work Program:** Encouraged broad public participation from representatives of business and labor, government, health service providers, insurers, and consumers in the development of the Commission's initial work program objectives through the following activities:

·A questionnaire was sent to over 400 organizations and individuals asking them to recommend the key issues to be addressed by the Commission; and

·A Strategic Planning Conference attended by 140 stakeholders was held in September, 1990 to help focus and prioritize the issues.

•**Committee Meetings:** Involved interested members of the public in numerous working sessions conducted by the Commission's four committees (Access, Cost Control, Health Services, and Malpractice) in various locations in Washington State. The committees met monthly (and in many cases, twice a month) to prepare recommendations for consideration by the full Commission. All committee meetings were open to the public, attendance averaged 25 to 30 citizens per meeting, and comments from them were encouraged.

•**Technical Advisors:** Involved 23 technical advisors -- representing a wide variety of backgrounds, expertise, and perspectives -- as non-voting members of the Commission's four committees. The technical advisors showed a high degree of dedication and enthusiasm in assisting the Commissioners in formulating their recommendations.

•**Presentations:** Organized numerous panel discussions and other presentations to the Commission and its four committees. Each of the four committees, as well as the full Commission, heard presentations from many individuals and organizations representing a wide variety of perspectives and expertise regarding the policy issues facing the Commission. One of many

examples is the series of presentations heard by the Health Services Committee in preparation for recommending categories of appropriate and effective health services. The four committees asked for information and advice not only from health experts but from consumers affected by current health system policies and programs.

•**Speaking Appearances:** Solicited and facilitated opportunities for Commissioners and staff to make speaking appearances before interested organizations. Since June, 1990, Commissioners and staff have made hundreds of speeches to a wide variety of organizations on health system reform and the Commission's work. These appearances usually gave Commissioners an opportunity to solicit public comment, as well as to discuss the Commission's recommendations.

•**Publications:** Worked with a variety of organizations interested in health system reform to communicate with their members through newsletters and other publications. The Commission has communicated frequently with major stakeholders to help keep their constituencies informed of the Commission's progress.

•**Mailing List:** Developed the Commission's mailing list (which currently numbers over 2,100 media representatives, organizations, government officials, and interested persons) to disseminate information about and receive written public comment on the Commission's meetings, policy recommendations, and other activities. The Commission's work program, meeting notices and agendas, draft recommendations, and other major documents have been made available to hundreds of interested individuals and organizations through the use of this mailing list.

•**Media Relations:** Worked with representatives of the media throughout the state to inform them about the Commission's goals, objectives, and policy recommendations, and to communicate with the general public through articles, editorials, interviews, and talk shows. The Commission has routinely mailed meeting notices, agendas, and other materials to over 300 media representatives. Numerous interviews have been given, specific documents provided, meetings held with editorial boards, and appearances made on television and radio talk shows. These efforts have contributed to a growing amount of media coverage of health system reform and the work of the Commission.

•**Public Hearings:** Held a number of public hearings on the Commission's policy recommendations and other elements of the 1991 Work Program. From mid- September through early October, 1991, the Commission conducted major public hearings and community workshops in eight cities throughout the state. This portion of the Commission's public participation program is discussed in detail in the next section.

Community Involvement

PUBLIC INFORMATION

From early September through early October, 1991, the Commission conducted a statewide program of public information and community involvement. The program was designed to receive extensive and diverse public comment on the draft recommendations developed by the Commission during 1991 and approved at a workshop on August 22-23, 1991. The challenge was to provide information for individuals and organizations with different levels of knowledge and interest about the health system. The major elements of the public information program included:

•A Public Participation Committee consisting of Community Health Care Day coordinators and representatives of interested organizations (Group Health Cooperative, Washington Citizen Action, the Washington State Hospital Association, the Washington State Nurses Association, the Washington State Department of Health, the Washington State Board of Health, and the Washington State Medical Association). The Public Participation Committee assisted in planning and implementing the Commission's statewide public information and community involvement program.

•A consulting contract with Rita Brogan, President of Pacific Rim Resources, who helped formulate the Commission's public participation program and designed Washington Health Care's Quiet Crisis, a four-page summary flyer which explained the Commission's draft recommendations to the public;

•A network of business, labor, health care, insurer, government, and consumer organizations that assisted the Commission in distributing the summary flyer to their members. Through these organizations, the Legislative Hotline and Community Health Care Days discussed below, and other activities, the Commission distributed about 35,000 flyers statewide. The following 25 organizations participated in the Commission's efforts to disseminate the draft recommendations to interested citizens:

- American Association of Retired Persons
- Association of Washington Business
- First Choice Health Plan
- Group Health Cooperative
- Health Care for All
- Health Care Purchasers Association
- Hotel/Motel Association
- Joint Council of Teamsters
- Partners in Change (Blue Cross and Blue Shield Plans of Washington)
- Seattle/King County Division on Aging
- Washington Association of Community Health Centers
- Washington Association of Health Underwriters
- Washington Citizen Action
- Washington Community Mental Health Council

- Washington Roundtable

- Washington Senior Citizens Lobby
- Washington State Biotechnology Association
- Washington State Board of Health
- Washington State Dental Association
- Washington State Department of Health

- Washington State Hospital Association
- Washington State Labor Council
- Washington State Medical Association
- Washington State Nurses Association
- Washington State Trial Lawyers Association

•A media relations program, including television and radio appearances, editorial board briefings, media packets, news releases, and public service announcements. These efforts were quite successful, resulting in substantive and positive television, radio, and newspaper coverage in each of the eight cities regarding the Commission's draft recommendations and the public's opportunities to comment on them.

•The Legislative Hotline staff, who helped the Commission staff respond to numerous requests for the summary flyer, the draft recommendations, and other information. Use of the Hotline helped distribute 35,000 flyers and about 1,300 copies of the draft recommendations.

•Use of the statewide system of local libraries to make available to interested citizens copies of the summary flyer and the draft recommendations.

COMMUNITY HEALTH CARE DAYS

From mid-September through early October, 1991, "Community Health Care Days" were organized and conducted to increase grassroots awareness of the issues confronting Washington State's health system and to obtain public comments on the Commission's draft recommendations. In addition to holding major public hearings in Aberdeen, Seattle, and Tacoma, the Commission held five Community Health Care Days in the following cities: Burlington, Pasco, Spokane, Vancouver, and Yakima.

The Community Health Care Days were organized and coordinated by Commission staff with the help of the Public Participation Committee members. Their efforts included contacts with local media representatives and community leaders, organization of the community workshops, facilities arrangements for the public hearings, and general assistance toward ensuring that the maximum number of interested persons and organizations were aware of the opportunities for public comment on the Commission's draft recommendations. Described below is a sample Community Health Care Day:

Sample Community Health Care Day

12:00 noon - 1:30 p.m. Luncheon presentation to a local service club regarding the Commission's draft recommendations

1:45 p.m. - 2:45 p.m. Informal briefing of local media representatives

3:00 p.m. - 5:00 p.m. Workshop with local community leaders

5:15 p.m. - 6:45 p.m. Informal dinner with local health system leaders

7:00 p.m. - 10:00 p.m. Public hearing on the Commission's draft recommendations

The workshops with local community leaders were an integral part of the Community Health Care Days. Workshop invitations were issued to a broad spectrum of individuals and organizations in each community. The workshops enabled Commissioners to dialogue for two hours with 25 to 40 representatives of labor, business, the health professions, education, senior citizens, consumer advocacy groups, and other health system stakeholders. From three to five Commissioners attended each of the workshops which began with a summary overview of the draft recommendations. Small group discussions followed which provided an opportunity for dialogue among the Commissioners and workshop participants.

From six to twelve Commissioners attended each Community Health Care Day and public hearing. In addition to the public testimony, a questionnaire was prepared and distributed in an effort to solicit reactions to the Commission's draft recommendations from everyone who attended the public hearings.

During the Community Health Care Days, Commissioners and staff enjoyed numerous opportunities to learn how current state health policies and programs affect individuals and organizations at the local level. They were also able to speak and listen to a variety of individuals concerned about health and health policy in order to receive their reactions to the Commission's draft recommendations.

Highlights of the Public Comments

PUBLIC HEARINGS

The Community Health Care Days successfully promoted public knowledge of and reactions to the Commission's draft recommendations. An important element of this success was the diversity of individuals and organizations who participated in the public hearings and other Community Health Care Day activities. They represented a wide variety of perspectives, backgrounds, and approaches to health system reform. As shown in the table below, the public hearings were attended by almost 1,200 people, the Commission heard testimony from almost 380 people, about 150 people

completed written questionnaires, and 165 community leaders participated in the workshops.

PUBLIC HEARING ATTENDANCE AND PARTICIPATION
(September 19, 1991 to October 7, 1991)

	Attended	Testified	Completed Questionnaire	Attended Workshop
Aberdeen60	22	2		
Burlington	130	56	11	35
Pasco	70	27	4	25
Seattle	300	65	34	
Spokane	100	47	4	35
Tacoma	300	85	80	
Vancouver	90	34	6	30
Yakima	130	36	7	40
TOTALS1,180	372	148	165	

Consistent themes were heard in all eight cities: "The health system needs fundamental reform." "Everyone needs access to health services at an affordable price." "Access to health services should be a right of every citizen." "More emphasis is needed on prevention and health promotion." Each community also contributed its own particular perspective. In Yakima and Pasco, for example, Commissioners heard of the need for primary care physicians. In Vancouver, people spoke of the complexity of their situation as a border community: "How will the new health system deal with the issue of Oregonians who work in Washington and vice versa?" The hearings in major cities (Seattle, Spokane, and Tacoma) emphasized a variety of urban concerns, and the Commissioners heard testimony from numerous advocates of a single payer/Canadian approach to health system reform.

Perhaps the most poignant and powerful testimony came from individuals whose lives had been shattered by ill health and the accompanying financial problems. Many spoke of their financial impoverishment caused by lack of access to health insurance due to a pre-existing condition. Such testimony spoke to the Commissioners with much more impact than statistics, system diagrams, and technical jargon.

Shown below is a tabulation of the major issues addressed in the oral testimony and written questionnaires. The figures do not reflect the significant number of written comments received by mail.

Number of Comments	Summary of Public Comments
	Universal Access
152	Discussed the difficulties experienced in accessing needed health services because of high costs, including personal stories of financial hardship and worsening health due to lack of access to health services
10	Supported expanding the Basic Health Plan
	Uniform Set and Package
93	Supported including alternative health services (such as chiropractic, massage therapy, and naturopathic medicine) in the uniform benefits package
74	Supported the concept of a *comprehensive* set of uniform health services and a uniform benefits package
24	Favored a "core" or "basic" uniform set and package
36	Supported increased individual responsibility for financing health services
34	Supported the inclusion of long term care, home care, and access services in the uniform set and package
8	Opposed the inclusion of long term care in the uniform set and package
6	Supported the inclusion of mental health services in the uniform set and package
49	Supported increased emphasis on preventive measures and incentives for healthy behaviors
25	Supported an increase in public health services
	Finance and Payment System
67	Urged that administration of the health system be simplified and/or that administrative costs be reduced
13	Supported the concept of a new state board/commission
28	Opposed or expressed concerns about the concept of a board/commission

27Supported a multiple payer system

10Supported a "residence-based" system

72Supported a single payer system

39Expressed concerns about the inability of small businesses to absorb additional costs for health services

Health Services Delivery System

12Supported an increased emphasis on managed care

34Discussed the need for an increase in primary care physicians

11Supported funding for education and training of health professionals

Other Comments

22Supported reform of the health care liability system

6Supported proposals from the Alliance for Health Care Reform

WRITTEN COMMENTS

The Commission received over 1,200 pages of written testimony and other comments from 137 organizations and 189 individuals. The following sections highlight these comments.

Uniform Set and Package

The Commission's recommendations for a uniform set of health services and a uniform benefits package drew extensive comments indicating some controversy and confusion about the fundamental characteristics of both:

- Despite the Commission's efforts to distinguish between a uniform set of health services and a uniform benefits package, for some the distinction was confusing;

- Public comment was polarized between a "comprehensive" package and a "basic" or "core" package, with substantial support for a comprehensive package;

- Some people who favored comprehensive services and benefits were concerned about maintaining individual choices for the quantity and diversity of services and benefits they wanted; and

- There was some confusion about the meaning of "public health," "population-based," "insurable," "health promotion," and other terms. Many comments also defined services primarily by identifying providers, a practice the Commission is trying to avoid.

There was strong public support for the Commission's recommendation that the uniform benefits package should be "more comprehensive than lean." In many cases, there was a blanket endorsement of the list of candidate services, sometimes combined with advocacy for including specific services. Those opposing a comprehensive set and package asserted that it would be unaffordable and politically unrealistic. Rather than guaranteeing a uniform package, a variable benefits package based on income was suggested, with broader benefits for low-income people unable to afford the "option" of supplemental coverage.

Comments on which specific health services should be included in the uniform set and package were voluminous but inconclusive. Many comments supported maintaining or adding specific services; few recommended deleting services. The "Criteria for the Uniform Set and Package" were well received.

The health services receiving the most public support included: primary care, "public health services" (including clinical services and population-based services), clinical preventive services, long term care, access services (such as transportation and use of a consumer's language), health promotion and education (including comprehensive school-based health education, nutrition education, and injury prevention), dental/oral care (including dental hygiene and other preventive services, dental treatment, and dentures), mental health and psychiatric services, prescription drugs, massage therapy, chemical dependency services, and diagnostic specialties (for example, psychiatric and family violence assessment).

Regarding clinical preventive services, there was a specific recommendation to include all of the U. S. Preventive Services Task Force recommendations. Specific comments regarding long term care included the importance of functional assessment, home care (including respite for family caregivers), hospice, and on-going functional assistance, as well as care "in lieu of hospitalization."

Other health services were also supported. They were often presented in relation to a particular group of practitioners. Podiatrists, denturists, nutritionists, naturopaths, chiropractors, dental hygienists, massage therapists, optometrists, ophthalmologists, and ocularists all made presentations to the Commission.

Many organizations and individuals urged the Commission to develop specific proposals for what should be included in the uniform set and package, rather than pass this task on to a future entity. Generally, they were skeptical that "affordability" could be discussed until specific services and costs are considered together. Some advocates of specific services also encouraged the Commission to identify the uniform set and package.

Public Health Services

The lack of a Commission recommendation for financing population-based services and other public health services was criticized. Several comments noted that the general discussion of a uniform set of health services implies there should such a recommendation. Some comments also indicated that the Commission's recommendations are hampered by the ambiguous use of the term "public health."

Numerous comments supported the importance of public health and preventive services. These topics were addressed from a variety of perspectives, including state and local public health officials, hospitals, health professionals, and consumer organizations. Many individual comments also discussed the importance of individual actions to remain healthy.

Several comments indicated that the following terms and concepts need to be clarified:

•Public health *agencies* are a kind of service provider. Like other providers, they will face changing roles and expectations as a result of fundamental health system reform.

•The *services* those agencies provide are not uniform. Most of the services are preventive, but they are a mixture of personal health services (such as vaccinations or prenatal care), population-based services (such as drinking water protection, restaurant inspection, or stop-smoking campaigns), and system support (such as epidemiological investigations)

•Local health departments (and migrant/community clinics) have unique roles in providing health services to certain populations, such as minority communities.

•Public health agencies are not the only providers of population-based or preventive services. Most health professionals practice some clinical prevention. Public schools play an important role in health education and promotion. The Washington State Department of Labor and Industries carries out preventive industrial safety and health functions.

•There is not a clear set of public health services to which Washington residents have access regardless of location.

Even though some comments suggested that the Commission should define specific population-based health objectives, the missions of the State Board of Health and State Department of Health already include this responsibility.

Responsibilities and Authorities

Numerous public comments indicate widespread concern about controlling health system costs. Nearly all agreed with the need for cost control, but some voiced concerns that innovation would be suppressed under the Commission's recommended responsibilities and authorities. The responsibility for determining billing and claims policy and procedures was most frequently cited

and supported. Other responsibilities and authorities frequently cited as appropriate and effective in controlling costs were:

•Determination of provider payment methods with incentives for efficient resource use; and

•Determination of individual financial participation (based on the ability to pay) to promote prudent service use and purchasing decisions.

A few commented on the following responsibilities and authorities, with about equal numbers commenting for and against:

•Determination of total expenditure limits through caps or budgets;

•Utilization management review techniques;

•Control of technology and capital expenditures; and

•Determination of provider payment levels (more opposed than favored).

Alternatives and additions to the Commission's recommended responsibilities and authorities, such as competitive market incentives and "managed competition," were also discussed.

Managed care systems (such as capitated payment systems and gatekeeper systems) were cited as effective in controlling cost and service use. (The gatekeeper strategy was a concern to some types of providers.) Incentives for healthy behaviors and the use of preventive services, as well as practice parameters, were also viewed by some as effective means of controlling costs.

State Board/Commission

About half of those commenting on the new state board/commission favored it as recommended, and half expressed concern or opposition to the creation and/or authority of the board/commission, as well as the extent of government involvement generally in the health system. Suggested alternatives to the new board/commission included:

•A "public/private consortium," as proposed (but not defined) by the Alliance for Health Care Reform; and

•Distribution of the board's/commission's responsibilities and authorities to existing government agencies.

Of those who supported a new state board/commission, several favored regional administration of the board/commission to promote flexible responses to local situations. While some thought the advisory role of key stakeholders is appropriate, others stated that key stakeholders should be represented among the board/commission members.

Some believe that further definition of the new state board/commission depends on which finance and payment system model is recommended by the Commission. Therefore, they argued, further definition of the board/commission should follow a Commission recommendation for a specific finance and payment system.

Responsibilities for System Financing

Numerous comments indicated dissatisfaction with the current distribution of responsibilities for financing the health system. The share of small businesses was most often cited as being unfairly high. The shift of financial burdens or "cost shift" from the public to the private sector ranked second as a concern. Cost shifts from employers to employees, the relatively high burden on low income workers, and individuals experiencing high out-of-pocket expenses were each thought inequitable by a few. Concerns were also expressed about the unestimated costs of the uniform benefits package, as well as how and to whom the costs would be distributed under a reformed health system.

The comments split about evenly between "employer-based" financing and "residence-based" financing. Some specified who should sponsor particular groups under the employer-based option:

•Government should finance the low-income employed and unemployed;

•Employers should finance at least half the cost for employees and dependents; and

•Individuals should finance some portion of their coverage on an income-based, sliding scale, but not at a level that impoverishes an individual or discourages the use of needed health services.

Several public comments also supported the Commission recommendation to subsidize some small/marginal businesses and low-income individuals if employment-based financing is recommended.

Finance and Payment System Model

This issue received much more comment than any other finance and payment system recommendation. The numerous comments on the three models (multiple payer, single payer, and voucher) included in the Commission's draft recommendations usually reflected support for or opposition to specific models:

•The residence-based, single-payer model was favored over the employer-based, multiple-payer model by more than three to one; and

•The tax-financed voucher model was new or vague to many, with most unwilling to comment without further information.

A number of comments expressed concern about the economic impacts of employer mandated coverage; several suggested tax incentives rather than mandates. A few favored existing proposals or systems, including the Alliance for Health Care Reform proposals, the Canadian system, the Braddock II proposal, and the New York proposal.

A number of individuals and organizations favored systems other than the Commission's three models included in the draft recommendations. These can be generally characterized as expansion of existing programs such as Medicaid and the Basic Health Plan. "Managed competition" was also favored by some.

Basic Health Plan

Several individuals and organizations commented on various aspects of the Washington Basic Health Plan. A few suggested that the Commission use the Plan's benefit package as the basis for the uniform benefits package, adding certain prescription drugs, mental health, and chemical dependency benefits. Others urged the Commission to recommend expanding the Plan to allow individuals to enroll at full cost regardless of their income level. Some also suggested that small businesses be allowed to enroll their employees in the Plan. Finally, the Commission was encouraged to recommend that the Plan be expanded throughout the state.

Health Insurance Reform

A large number and wide variety of people complained about insurance industry practices that inhibit access to coverage and/or increase costs for many state residents. Instances of unaffordable health insurance coverage and exclusion due to high risk and pre-existing conditions were mentioned frequently. Major barriers to receiving necessary health services include the lack of coverage between jobs, denial of coverage for pre-existing conditions, the expense of coverage for individuals not covered in large groups, and the expense of coverage for small businesses and self-employed individuals.

Individuals who shared their own personal experiences complained they had health insurance provided by their employer, but were dropped from the group or could not obtain coverage when changing jobs because of a pre-existing diagnosis or condition. Small business owners commented on the high, often unaffordable cost of coverage for their employees or dependents who had diagnosed health problems.

To obtain and maintain affordable coverage, many claimed that a single-payer system would guarantee continued coverage regardless of employment status. Some noted that a single-payer system is not necessarily the only way to correct these inequities. The serious problems of waiting periods or exclusions for pre-existing conditions and exclusion or expensive premiums for small groups (such as businesses) or individuals could be corrected through insurance industry reform. For example, small groups and individuals could be allowed to join a large pool where rates would be lower because risk would be distributed broadly. Exclusions and waiting periods for pre-existing conditions could be prohibited. These methods and others could be explored in a multiple-payer system that is employer-based or residence-based.

Health Services Delivery System

Comments on the health services delivery system were received from a wide variety of representatives of providers, insurers, and public health departments, as well as the general public. Concerns were expressed that the delivery system would not be able to meet the needs and demands of a health system guaranteeing universal access to a uniform set of health services. Several important points were raised by the public comments:

- ***Primary Care Practitioners:*** Many people commented on the current shortage of primary care practitioners (especially at the public hearings and workshops in Yakima and Pasco). Increasing access to health services and emphasizing primary care could exacerbate this shortage. Some people commented that the inadequate supply of primary care practitioners results from inadequate reimbursement, as well as insufficient incentives for health practitioners to train in primary care and to locate in underserved areas.

- ***Managed Care*:** Many individuals and organizations expressed support for managed care systems as models for providing comprehensive personal health services. These systems contain incentives for consumers and providers to use resources efficiently without the need for regulatory intervention into provider practices or delivery system management.

- ***Freedom of Choice***: Concerns were expressed that a gatekeeper model might improperly restrict access to other providers or to necessary consultations and treatment.

- ***Public Health Departments/Clinics***: A number of people stressed the importance of community and migrant health clinics and public health departments. In many communities, they are the only sources of health services. People expressed the need for these organizations to have adequate resources, offer flexible hours, and be integrated into a reformed delivery system.

- ***Underserved Groups***: Representatives of specific underserved groups -- including the poor, disabled, minorities, migrant workers, homeless, and victims of violence -- expressed their particular concerns about the delivery of health services.

The Commission's explanation of universal access in the draft recommendations did not assure that universal access would be achieved in a reformed health system. The Commission was often asked during the public participation process to emphasize how the system must change in order to deliver health services to all who need them.

There was also confusion about a few technical issues: differentiating between "retirees" and "residents;" the potential constraint of "who gets a service" versus "who gets which service;" and differentiating coverage for people working in the state yet living outside the state, compared to people who live in the state yet work outside.

Professional Education and Training

A number of individuals and organizations commented that incentives promoting an appropriate number, mix, and distribution of health professionals should be considered as the Commission recommends reforms to the finance and payment system. Concerns were expressed that the supply of primary care physicians, as well as incentives for new health professionals to work in rural communities, might be jeopardized in a reformed system.

Comments were also received stressing the need to develop new generations of health professionals through education and training in order to maintain the health system. Additional comments stressed the importance of funding for clinical research.

Health Care Liability System

Several individuals and organizations urged the Commission to endorse the use of practice parameters as an affirmative defense in malpractice actions against health care practitioners who have complied with such parameters.

A number of individuals and organizations found the language of the draft recommendation to explore combining licensing and disciplinary functions unclear. They requested clarification regarding: the actual changes that would be made in health care practitioner licensing and disciplinary procedures; and why such changes would have the potential to reduce substandard health care practices.

The Commission's draft recommendations indicate that it will research and evaluate the potential of *selective* no-fault systems to address major problems of the health care liability system. Several individuals recommended that the Commission also evaluate a pure no-fault system, under which *all* malpractice claims would be handled outside of the traditional civil justice system.

One organization requested that the Commission consider what patients can do to prevent bad

outcomes and how the health services system can encourage such conduct by patients. One attorney commented that the Commission's recommendation to consider a certificate of merit strategy is unnecessary, given Civil Rule 11 and current practice in malpractice litigation.

Summary and Conclusions

The Commission's public participation program was designed to meet the challenge of providing a variety of opportunities for members of the public to comment on a comprehensive and complex package of recommended health system reforms in a short period of time, and with a limited budget. Central to the public participation program was the Commission's multi-faceted public information and community involvement efforts. The program relied heavily on grass roots, community-based activities and a network of volunteer support from organizations and individuals who have an interest in health system reform.

The Commission's recommendations are ambitious and require diverse communities of interest to set aside short term differences to build a reformed health system that will be effective and equitable well into the twenty-first century. The public participation program was structured on the premise that any package of health system reforms must be sensitive to a wide variety of concerns and interests to be successful. Within limited budget and time constraints, the program provided for a variety of opportunities for involvement by all who have a stake in the state's health system.

The Commission's public participation program helped inform the public about the Commission's goals and objectives, while providing the Commissioners with a better understanding of public attitudes towards health system reform and the Commission's specific recommendations for improving the state's health system. The Commission's recommendations presented in this Interim Report were heavily influenced by the successful results of the public participation program.

CHAPTER 8

1992 COMMISSION WORK PROGRAM

Introduction

Despite the Washington Health Care Commission's significant progress in 1991, there are many unanswered questions that need to be addressed in order to complete and implement the Commission's recommendations for fundamental health system reform. Although the recommendations presented in this Interim Report lay the foundation for responsible reform, they do not provide all the guidance necessary to successfully implement a reformed health system.

When the Washington State Legislature created the Commission in March, 1990, it recognized that achieving the Commission's mandate would take two and one half years of research, analysis, public review, and decision-making. The Commission has focused its first 18 months on laying a responsible foundation for fundamental reform of the health system.

Next year promises to be even more challenging for the Commission than 1991. Based on the Commission's recommendations and the public comment presented in this Interim Report, the Commission has begun preparing its work program for 1992. This chapter briefly discusses the Commission's highest priority tasks. Also presented are a number of candidate tasks, many (but not all) of which will be addressed by the Commission during 1992. By the end of January, 1992, the Commission will determine which of the candidate tasks will be included in the 1992 Work Program.

Priority Tasks for 1992

The following sections describe the priority tasks the Commission currently plans to address as part of its 1992 Work Program.

UNIVERSAL ACCESS

The Commission will evaluate and recommend strategies to address *non-financial* barriers to access, such as culture, language, geography, lack of useful information and the supply/availability of health services. The Commission will continue to identify and develop cost-effective incentives and techniques to encourage the use and delivery of appropriate and effective health services, including preventive and public health interventions. Both financial and non-financial incentives to encourage healthy behaviors will also be addressed. Appropriate responsibilities for delivering health services (including community-based outreach programs), encouraging healthy behaviors, and promoting individual responsibility and accountability in the use of health services will also be studied by the Commission.

UNIFORM SET AND PACKAGE

As discussed in Chapter 3, the Commission will perform the following tasks regarding the uniform set of health services and the uniform benefits package: define a process for the Commission to determine an *initial* uniform set and design an *initial* package; design an initial uniform set of health services to which there will be universal access; design and determine the approximate costs of several uniform benefits packages; determine the costs and financing for that portion of the uniform set of health services *not* included in the initial package; and define an on-going process and structure(s) for refining and updating the uniform set and package.

FINANCE AND PAYMENT SYSTEM

Role of Employers

The Commission will continue to evaluate and recommend the appropriate role(s) of employers in a reformed finance and payment system. If employers are allowed to continue sponsoring health insurance coverage, how will the finance and payment system be restructured to minimize the problems associated with employer sponsorship? Will the system be more efficient with or without employer sponsorship? The Commission will also recommend how various types of employers should contribute to financing the uniform benefits package.

Responsibilities for System Financing

The Commission must further define the financial responsibilities for employers, government, and individuals, distributing the burden as equitably as possible. To do so, the Commission will evaluate and recommend whether additional revenues are needed to finance the initial uniform benefits package and if so, how much and from which source(s). Estimates of the cost of the initial package and possible funding sources will be undertaken immediately to inform the public and the Commission's policy decisions concerning equitable and adequate financing.

Additional Responsibilities and Authorities

The Commission will evaluate and recommend whether the new state board/commission should have additional authorities and responsibilities, such as determining provider payment *levels*, regulating capital expenditures for plant and equipment, and controlling cost-shifting and discounting. The Commission will also analyze and recommend how the financial impacts of medical risks can be distributed equitably and efficiently.

HEALTH CARE LIABILITY SYSTEM

As discussed above in Chapter 5, the Commission plans to refine and evaluate 11 *prevention*

strategies and seven *process* strategies for minimizing the problems of the health care liability system. Based on this evaluation and public review, the Commission will recommend a number of specific strategies for improving the system.

Candidate Tasks for 1992

The following is a list of *candidate* tasks for the 1992 Commission Work Program. The Commission will not be able to accomplish all of these tasks by November 1, 1992, when the Commission submits its Final Report to the Governor and State Legislature. Given limited time and resources, the Commissioners and staff will work together by January, 1992 to select which of the candidate tasks should be included in the 1992 Work Program.

UNIVERSAL ACCESS

•Define state residency for the purposes of guaranteeing universal access, including provisions for migrant workers, retirees, Washington residents working outside the state, and Washington employers with employees living outside the state.

FINANCE AND PAYMENT SYSTEM

•Evaluate the impacts of the Commission's recommended finance and payment system reforms on business, employment, utilization, and scope of coverage.

•Analyze the effects and implications of the Employee's Retirement Income Security Act (ERISA) self-funding provisions on health costs, including the role of self-insured employers exempted from providing mandated benefits and from participating in the State's high risk pool.[69]

•Evaluate taxation, Medicare, Medicaid, and other implementation issues involved in reforming the finance and payment system.

•Develop recommendations and phased implementation plans that are linked to financing. Such plans should define individual, government, and employer responsibilities and consider: incentives that encourage broad public participation to address the problem of the uninsured; methods to assure that financing is adequate for those providers that serve a disproportionate share of traditionally underserved populations; methods to assure that providers serve a balanced proportion of all patients, regardless of payment source; methods to assure that providers are reimbursed equitably and appropriately; and financing mechanisms and delivery

[69] Included as an objective in the "Goals and Objectives of the Washington Health Care Commission," adopted by the Commission on November 16, 1990.

systems for rural health care.[70]

•Determine what role the new state board/commission would have in controlling the introduction and dissemination of medical technology, including the development and use of practice parameters.[71]

•Determine whether to use absolute levels, maximums, or ranges of premium shares and point-of-service cost sharing.[71]

•Develop official process(es) and structure(s) for stakeholder participation in the new board's/commission's decision-making process.[71]

•Determine whether or not, and if so how, to deal with regional differences when implementing the board's/commission's responsibilities and authorities.[71]

•Determine how to assure adequate financing of public health and other population-based services.

•Develop a certification process to verify that health plans can deliver the services/benefits they are promising. The process should include financial and organization verification, as well as quality assurance.

HEALTH CARE PURCHASING

•Identify opportunities for public/private cooperation and coordination, including:

·Cooperative and coordinated purchasing strategies;

·Incentives that encourage innovative public/private partnerships to achieve efficiencies and quality; and

·Recommendations to minimize cost-shifting.[72]

•Address the cost-control implications of the state purchasing study for the health system in Washington State.[72]

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[70] Included as an objective in the "Goals and Objectives," supra at note 69.

[71] Approved unanimously by the Washington Health Care Commission on August 23, 1991 and included in the Commission's Draft Interim Recommendations, published on September 11, 1991.

[72] Included as an objective in the "Goals and Objectives," supra at note 69, and reaffirmed in the Commission's Initial Report to the Washington State Legislature, published in January, 1991.

•Develop potential strategies for using state health care purchases to decrease the rate of health care cost inflation in the private sector.[72]

HEALTH SERVICES DELIVERY SYSTEM

•Identify adequate and appropriate supply, distribution, education, and training of health services personnel.

•Identify the roles of and coordination with existing state agencies, community and migrant health centers/clinics, local health departments, and managed care systems.

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GLOSSARY OF SPECIAL TERMS

Acceptability: A reasonable level of satisfaction expressed by users, service providers, and other affected persons regarding operation of the health system.

Accessibility: The degree to which "universal access" to health services is achieved.

Accountability: The degree to which the health system is held responsible for meeting the personal and societal expectations of the system.

Adaptability: Openness to innovation and the capacity to adjust, correct, and improve operations based on information and changing circumstances, both within and outside the health system.

Affordability: The degree to which those who must pay for health services are able to pay the costs and, collectively, find the costs reasonable.

Appropriate and effective health services: All health services which satisfy the Commission's definitions of "appropriateness" and "effectiveness" listed below. The range of such services includes adequate food/housing for vulnerable populations, access services, population-based health services, personal health services, and health system support. Some of these services are population-based interventions available on a community basis, rather than personal health services directed at individuals.

Appropriateness: Use of health services only in situations when they are likely be effective and only for individuals, populations, and conditions for which they are likely to be effective. Health services are appropriate only when the affected individuals (in the case of personal services) or communities (in the case of population-based services) are aware of any known risks and have chosen to proceed with using the health services.

Central state authority: The permanent and independent state board or commission assigned specific responsibilities and authorities to implement the Commission's recommended finance and payment system.

Comprehensive services: Refers only to the *scope* of health services covered, not to the level or distribution of financial coverage for or other limitations on services which may vary by service and type of beneficiary.

Cost sharing: An individual paying part of the costs of his or her health services. This financial participation could be through paying part of an individual premium, deductibles, coinsurance, and/or copayments.

Demographic and cultural differences: Include age, gender, race, ethnicity, language, and national heritage. Such differences among people should not affect access to health services, but they may affect the appropriateness and effectiveness of specific services due to legitimate differences in health problems, prognosis, or linguistic/cultural adaptations intended to improve access.

Effectiveness: The degree to which health services and systems attain expected improvements in health outcomes and produce more good than harm. A health service may be effective for some individuals and ineffective for others.

Efficiency: Effectiveness in relation to the costs and resources used.

Financers: The sources of funds used to purchase health services, including individuals/households, public and private employers, and federal/state/local taxes.

Health care service contractor: In Washington State, a legal entity which may be sponsored by certain health professionals or has contracts with health professionals to provide prepaid health services. Health care service contractors include medical bureaus and other corporations that contract to provide medical, dental, and vision services.

In a timely manner and To actually get the health services when they are desired

with reasonable effort: and needed, without undue delay or personal effort. It does not imply that health services will be instantly available or that no effort will be required to obtain them. "Reasonable effort" implies some degree of personal responsibility to seek and accept health services and advice, but within a framework of sensitivity to the impact of social conditions and societal pressures upon personal actions.

Insurance mechanism: A method for financing health services whereby an entity guarantees, through contract or law, payment for a defined package of health benefits used by an insured, enrolled, or eligible person. The monies used to pay for these benefits may be derived from prospectively fixed premiums, tax appropriations, or some combination. The insurance mechanism may be sponsored and/or operated by a private entity, a government, another public entity, or some combination.

Payers: Entities that pay service providers directly, including individuals, self-funded employers, private insurance plans, certain managed care plans, and public insurance programs.

Personal health services: Services provided to individuals or families by a wide range of health professionals that may be preventive, diagnostic, curative, restorative, or palliative. The actual services may be delivered in any number of public or private settings: at home, in a clinic or office, a hospital, or other type of health care facility.

Pooling: A concept of health insurance where all persons within a defined group are consolidated for the purpose of measuring the costs of their health benefits. The "group" might be large or small in numbers of individuals, and some "high-risk pools" might be created only for those individuals with costs well above average.

Population-based health services: Health services directed to the entire population or communities, rather than to a succession of individuals. This category includes prevention and control of communicable diseases (such as sexually transmitted and vaccine-preventable diseases), community health protection (such as food and drug safety, radiation protection, occupational health and safety measures, and safe drinking water), and a wide range of health promotion and education activities in communities, schools, and workplaces.

Preventive services: These include personal health services and population-based services directed at preventing illness, injury, disability, or their consequences.

Primary care: Basic personal health care which emphasizes the point when the patient first seeks assistance from the health system, the provision of preventive services, and the care of the simpler or more common illnesses. A primary care provider usually assumes ongoing responsibility for the patient in both health maintenance and treatment of illness.

Providers: Individuals and organizations that provide health services to individuals or communities. Providers include facilities, health care practitioners, private organizations, and public agencies.

Right and ability: Assuring that receipt of the health services is a tangible reality, not just a theoretical right.

Sponsors: Entities that offer choices of certified health plans to subgroups of the state population and pay premiums directly to health plans on behalf of subgroup members who enroll in those plans. Such entities may be private (for example, businesses, trade unions, professional associations, and consortiums) or public (for example, Medicare, Medicaid, Veterans Administration, and public employers).

Uniform benefits package: The subset of the "uniform set of health services" that is guaranteed to all state residents through an insurance mechanism.

Uniform set of health services: The set of "appropriate and effective health services" to which access will be guaranteed to all state residents.

Universal access: 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.

Washington residents: All people regularly living in the State of Washington.

With appropriate consideration for geographic differences: Timely access to services is ensured; however, standards of timeliness may differ by location.

Without regard to ability to pay: Services will be received without regard to individual or family income levels, assets and investments, or the extent of coverage by existing private or public insurance. It also means that people should not be impoverished by paying their fair share of the costs of the services. This does not mean that health services will be "free;" the costs will need to be paid. Our collective ability to pay will be considered.

Without regard to pre-exisisting conditions: Access will not be limited solely because of the presence or absence of specific health problems. Different health services may be appropriate and effective, however, for people with different health problems.

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COMMISSION ORGANIZATION

The Washington State Legislature adopted House Concurrent Resolution (HCR) 4443 on March 21, 1990, establishing the 17-member Commission on Health Care Cost Control and Access (the "Washington Health Care Commission"). HCR 4443 authorized the President of the Senate and the Speaker of the House to appoint three senators and three representatives, respectively. The Governor was authorized to appoint 11 citizens representing the business community (2), employee organizations (2), state government (1), health service providers (2), health care service contractors (1), senior citizens (1), and the public at large (2). A copy of HCR 4443, a roster of the 17 Commissioners and four Commission staff, and their summary biographies are included in Appendix B.

The State Legislature created the Commission to make recommendations for achieving the following five goals:

- 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.

HCR 4443 directs the Commission to prepare and submit three reports to the Governor and the State Legislature. The Initial Report, submitted January, 1991, primarily addressed the state health care purchasing goal. This 1991 Interim Report features the Commission's initial recommendations for addressing the goals to guarantee universal access, control costs, and reform the health care liability system. The Commission's Final Report, due November 1, 1992, will provide additional recommendations for addressing all five of the goals.

In November, 1990, the Commission established five working committees, each assigned one of the five goals: Access, Cost Control, Health Services, Malpractice, and Purchasing. The Purchasing Committee, which developed the recommendations for the Initial Report, was merged into the Cost Control Committee once the Initial Report was completed in January, 1991. Each of the four remaining committees has been addressing the objectives for its assigned goal included in the "Goals and Objectives of the Washington Health Care Commission," adopted on November 16, 1990 and revised in the "1991 Threshold Policy Recommendations" approved by the Commission

on July 19, 1991. All Commissioners serve on one or more of the four committees. A list of their committee assignments is included in this Appendix B.

Twenty-three technical advisors with a wide range of expertise and perspectives have participated as non-voting members of the Commission's committees. Each technical advisor is assigned to one of the four committees. They have worked closely with Commissioners to address the goal and objectives assigned to their particular committee. A list of the 23 technical advisors and their positions, as well as a list of their committee assignments, are included in this Appendix B.

To provide organizational, research, analytical, and administrative support, the Commission's full-time staff is comprised of an Executive Director, a Research Director, an Administrative Assistant, and a Clerk Typist. These four staff work with a variety of people in the public and private sectors to help meet the Commission's needs for technical advice, research and analysis, public comment, and other relevant information. Summary biographies of the Commission staff are included in this Appendix B.

Several organizations provide valuable staff support to the Commission. The Health Policy Analysis Program at the University of Washington provides policy analysis and research support to the full Commission and its committees. Staff from the Washington State Department of Health and the State House of Representatives Democratic Research Services provide policy analysis and research support to the Commission's Health Services Committee and Malpractice Committee, respectively. Staff from the Senate Health and Long Term Care Committee and the Washington State Health Care Authority performed special projects for the Commission's Health Services Committee. Corcoran Consulting Group facilitated the Commission's two decision-making workshops. Pacific Rim Resources assisted in the formulation and implementation of the Commission's public participation program. SLR Health Care Consultants helped the Commission plan, organize, and implement its September, 1990 Strategic Planning Conference.

To ensure broad public participation, the Commission held numerous public hearings, Commission meetings, and committee working sessions. Over 1,600 interested persons and organizations and more than 300 media representatives are on the Commission's growing mailing list. As discussed in Chapter 7 of this Interim Report, the Commission held public hearings around the state to encourage broad public participation in the preparation of the Commission's recommendations. The Commission will continue to pursue many different ways to encourage a wide variety of people representing business, labor, government, health service providers, insurers, consumers, and others to help the Commission pursue its five goals.

House Resolution

House Resolution

House Resolution

House Resolution

Commissioner and Staff Roster

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COMMISSIONER AND STAFF BIOGRAPHIES

Commissioners

Bobbie (Evans) Berkowitz, Health Services Committee Chair. Dr. Berkowitz has served as Chief of Nursing Services for the Seattle-King County Department of Public Health since 1986. She also holds adjunct faculty appointments with the University of Washington and the Seattle University School of Nursing. From 1980 to 1986, she was Director of Nursing for the Whatcom County Health Department in Bellingham, Washington. Her nursing career has included a variety of staff and supervisory positions, primarily in public health. Dr. Berkowitz serves as a member of the Washington State Board of Health. She is also active in the Washington State Nurses Association and the Washington State Public Health Association. Dr. Berkowitz received a Bachelor of Science degree in nursing and a Masters of Nursing degree from the University of Washington. She also received a PhD in nursing science from Case Western Reserve University in Cleveland, Ohio.

Ros M. Bond, Malpractice Committee Chair. Mr. Bond is President of Network Management, Inc., a managed health care organization he co-founded in 1981. In addition, he is vice-president of Network Health Plan, a health care service contractor and one of only three Medicare risk contractors in Washington State. Prior to founding Network Management, Inc., Mr. Bond served as president of Safeco Life Insurance Company. For seventeen years, he worked in various other management positions at Safeco. He has served as a board member of the Northwest Kidney Foundation, CAPRI, the American Outdoor Safety League, and the Smoking Policy Institute. Mr. Bond served as an officer in the U.S. Navy for three years and graduated from Bowdoin College with a Bachelor of Arts degree in economics.

Representative Dennis Braddock, Commissioner. Representative Braddock has served in the Washington State House of Representatives since 1982, representing the 42nd Legislative District (Bellingham). He has served as chair of the Health Care Committee since its creation in 1987. He sponsored the Washington Universal Health Access and Cost Containment Bill and has supported Medicaid expansion for pregnant women and children, model AIDS legislation, and rural health legislation. He served as a member of the Bellingham City Council for nine years. He also served in the Peace Corps and was a captain in the U.S. Army, serving as a helicopter pilot. Representative Braddock received a Bachelor of Arts degree from Washington State University.

Tom Hilyard, Access Committee Chair. Mr. Hilyard has served as Executive Director of the Human Services Department in Pierce County since 1987. From 1985 to 1987, he served as the director of three agencies under the Human Services Department. From 1981 to 1985, he served as manager of the Pierce County Community Action Agency, focusing on anti-poverty programs. Among his other positions, he was a Program Development Specialist for the Department of Human Development in Tacoma. He is currently chair of the Washington Basic Health Plan Advisory Council. He has also served as chair of the Health Policy Committee of Governor Gardner's 1984 transition team and as chair of the Pierce County Facilities Review Committee. Mr. Hilyard received a Bachelor of Arts degree in sociology and anthropology from Western Washington University.

Kent Hull, Commissioner. Mr. Hull is President and owner of Hullpak Manufacturing of Spokane, a manufacturer of packaging machinery for worldwide food, beverage, and consumer products. He served on the Technical Advisory Committee for the Health Care Authority's state health care purchasing study. He has also been a member of the Governor's Small Business Improvement Council. Mr. Hull served as chair of the Council's Economic Development Task Force and served on the Council's Human Services Task Force. He received a Bachelor of Science degree in mining engineering from the University of Idaho.

Senator Mike Kreidler, Commissioner. Senator Kreidler has served in the Washington State Senate since 1985, representing the 22nd Legislative District (Thurston County). He is the ranking democratic member on the Senate Health and Long Term Care Committee. He is also a member of the Law and Justice and Ways and Means committees. He served in the State House of Representatives from 1977 to 1984 and on the North Thurston School Board from 1973 to 1977. He is currently employed as a Doctor of Optometry with Group Health Cooperative of Puget Sound. He is a director of First Community Bank in Thurston County. He is also a Lieutenant Colonel in the U.S. Army Reserve. Senator Kreidler received a Masters of Public Health degree from the University of California, Los Angeles and a Bachelor of Science degree from the College of Optometry at Pacific University in Oregon.

Merriam E. Lathrop, Commissioner. Ms. Lathrop is a consumer advocate active in the Governor's Council on Aging, the Senior Citizen's Lobby, and the Pierce County Department of Aging and Long Term Care. She served on the Health Services and Access Technical Advisory Committee of the Long Term Care Commission. She has also served as President of the Senior Citizen's Lobby and on the National Advisory Committee of the American Association of Retired Person's Health Care Campaign. She retired from the Washington State Nurses Association in 1975 where she was Director of Nursing Education and Practice. During her professional career, Ms. Lathrop practiced all phases of institutional nursing, including four years in the Army Nurse Corps during World War II. She received a Masters of Nursing degree from the University of Washington, a Bachelor of Science degree in education from Ohio State University, and a diploma in nursing from St. Joseph Hospital School of Nursing in Lancaster, Pennsylvania.

Gary Moore, Commissioner. Mr. Moore has served as Executive Director of the Washington

Federation of State Employees (WFSE) since 1985. He has served on the WFSE staff since 1975. He is International Vice President of the American Federation of State, County, and Municipal Employees. He is also a member of the Washington State Investment Board and the Washington State Employees Benefit Board. Mr. Moore received a Bachelor of Arts degree from the University of Washington and a Master of Arts degree in public administration and labor relations from the University of Wisconsin.

Representative John Moyer, Commissioner. Representative Moyer has served in the Washington State House of Representatives since 1985, representing the 6th Legislative District in Spokane. He serves on the Health Care Committee, the State Government Committee, and the Trade and Economics Committee. From 1955 to 1985, he was a practicing obstetrician/gynecologist in Spokane. Representative Moyer is a clinical professor of obstetrics and gynecology at the University of Washington Medical School. He also works as an obstetrical consultant in Othello, Washington. He is a fellow of the American College of Obstetrics and Gynecology and is a past president of the Washington State Medical Association. Representative Moyer received a medical degree from the University of Illinois and completed a residency at Cook County Hospital in Chicago, Illinois.

Paul A. Redmond, Commission Chair. Mr. Redmond has served as Chairman and Chief Executive Officer of the Washington Water Power Company since 1985. He was elected president and chief operating officer in 1982. He held numerous management positions with the company prior to being elected vice president in 1978, senior vice president of operations in 1979, and executive vice president and a member of the board of directors in 1980. Mr. Redmond is one of four founding chairmen of Momentum, an organization working to stimulate economic development and the creation of jobs in the Spokane area. He is chairman of the Spokane Area Chamber of Commerce and a past president of United Way of Spokane. Mr. Redmond is a retired Lieutenant Colonel in the Washington National Guard. He graduated from Gonzaga University with Bachelor of Science degrees in biology and electrical engineering.

Patricia Schrom, Commissioner. Ms. Schrom is President of Schrom & Associates, a woman-owned business providing professional management consultation with an emphasis on information networking. She brings over 30 years of professional expertise in business administration, community development, and legislative affairs to her volunteer work on behalf of illness/injury prevention and health promotion. She is chair of the board of directors of the Columbia Basin Health Association and is also active in national and statewide organizations dealing with primary care and rural health care issues. While all of her volunteer work on health has been non-partisan, she is serving her sixth year as chair of the Grant County Democratic Party. She also was an intern in the Washington State House of Representatives. Ms. Schrom's formal education included studies at Northwestern University and Eastern Washington University.

Jeffrey D. Selberg, Cost Control Committee Chair. Mr. Selberg has served as President and Chief Executive Officer of Southwest Washington Medical Center in Vancouver, Washington since 1987. He also spent seven years with Good Samaritan Hospital and Medical Center in Portland, Oregon and five years with Samaritan Health Services in Phoenix, Arizona. Mr. Selberg is a board

member and secretary/treasurer of the Washington State Hospital Association. He is also active with the Greater Vancouver Chamber of Commerce, the Columbia River Economic Development Council and the Washington State University Advisory Board. He is a past board member of the Oregon Association of Hospitals, the Oregon Heart Institute, and the Washington Trauma Advisory Committee. Mr. Selberg earned a Bachelor of Science degree from Oregon State University and a Masters of Health Administration degree from Washington University in St. Louis, Missouri.

Representative Arthur D. Sprenkle, Commissioner. Representative Sprenkle is serving his fourth term in the Washington State House of Representatives, representing Legislative District 39B in Snohomish County. He is a practicing physician with a multispecialty medical group at The Everett Clinic where he specializes in allergic respiratory diseases. As a state representative, he was the prime sponsor of the Health Care Reform Act of 1988. He helped create and is a member of the Washington State Efficiency and Accountability Commission which develops recommendations to decrease costs and increase the efficiency and effectiveness of state government programs. Representative Sprenkle earned a Bachelor of Arts degree from Columbia College and a medical degree from Columbia Medical School in New York.

Margaret Stanley, Commission Vice-Chair. Ms. Stanley is the Administrator of the Washington State Health Care Authority and chair of the State Employees Benefits Board. She is also a member of the National Council on Graduate Medical Education. She previously served as executive vice-president and chief health care management officer of Blue Cross of Washington and Alaska. She was the founder of their health maintenance organization affiliate, HealthPlus, serving as its chief executive officer from 1981 to 1988. From 1977 through 1980, Ms. Stanley served as outpatient administrator and clinic manager at Group Health Cooperative of Puget Sound. She earned a Masters of Health Administration degree from the University of Washington and a Bachelor of Arts degree in political science from Bucknell University.

Senator Leo K. Thorsness, Commissioner. Senator Thorsness has served in the Washington State Senate since 1988, representing the 11th Legislative District in King County. He is chair of the Energy and Utilities Committee and vice chair of the Law and Justice Committee. He is a member of the Governor's Council on Substance Abuse, the Municipal Research Council, the Task Force on City/County Financing, the Task Force on Homelessness, and the Task Force on Sentencing of Adult Criminal Offenders. He is also the national president of Veterans Against Drugs and a board member of Washington Drug Free Business. Senator Thorsness served in the U.S. Air Force during the Viet Nam War and was awarded the Congressional Medal of Honor. He received a Bachelor of Arts degree from the University of Omaha and a Masters of Science degree from the University of Southern California.

Senator Jim West, Commissioner. Senator West has served in the Washington State Senate since 1987, representing the 6th Legislative District in Spokane. He has served as chair of the Senate Health and Long Term Care Committee since 1988. As chair, he helped reform the state mental health system, draft and approve measures to prevent head injuries, create a statewide trauma care system, and improve the stability of rural hospitals. Prior to his election as a State Senator, he served two terms in the State House of Representatives. He has also served as a member of the Spokane City Council and as a deputy sheriff for Spokane County. Senator West received a Bachelor of Arts degree in criminal justice from Gonzaga University in Spokane.

Cindy Zehnder, Commission Secretary. Ms. Zehnder is Coordinator for the Western Conference of Teamsters, which includes the local Teamster unions and councils in the 13 western states. She is also Coordinator for the Joint Council of Teamsters No. 28, which includes 20 local unions and 60,000 members in Washington State. She is an International Teller for the International Brotherhood of Teamsters and General Secretary-Treasurer of the International Teamsters Women's Caucus. Before joining the Joint Council, she worked as an organizer and business representative for Local 117. She also served as the Director of Social Services for Teamsters Local 174, where she ran an employee assistance program. She began her career with the Teamsters as a truck driver. Ms. Zehnder is co-chair of the Joint Labor/Management Task Force on Long Term Disability, a member of the Washington State Industrial Insurance Advisory Committee, and vice president of the Washington State Humanities Commission. She is also a Certified Employee Assistance Professional. Ms. Zehnder earned a Masters degree in educational psychology and a Bachelor of Arts degree in anthropology from the University of Washington.

Commission Staff

Randy Revelle, Executive Director. Mr. Revelle has served as Executive Director of the Washington Health Care Commission since July, 1990. From 1986 to 1989, he served "of counsel" to Stoel, Rives, Boley, Jones & Grey, a major Northwest law firm. He served as King County Executive from November, 1981 through 1985 and as a Seattle City Councilman from 1974 through 1981. As King County Executive, he had policy making and overall management responsibilities for the Seattle-King County Department of Public Health, Harborview Medical Center, emergency medical services, and King County's mental health, alcohol and drug abuse, and developmental disabilities programs. He also served as chairman of the Seattle Commission on Children and Youth and as a board member of the American Cancer Society and the Community Psychiatric Clinic. Mr. Revelle received a Juris Doctor degree from Harvard Law School, a certificate in politics and economics from the Centre Europeen Universitaire at the University of Nancy, France, and a Bachelor of Arts degree from the Woodrow Wilson School of Public and International Affairs at Princeton University.

Doreen D. Garcia, Research Director. Ms. Garcia has served as Research Director of the Washington Health Care Commission since January, 1991. She joined the Commission staff after working as a health policy analyst for the Prospective Payment Assessment Commission (ProPAC) in Washington, D.C. from 1987 through 1990. At ProPAC, she focused on health care financing issues, particularly pertaining to the federal Medicare program. From 1986 through 1987, she was a project analyst for Hospital Health Plan Corporation, a company that helped community hospitals form their own health maintenance organizations. Ms. Garcia received a Masters of Public Policy degree from the John F. Kennedy School of Government at Harvard University, with an emphasis on health policy and long term care. She received a Bachelor of Arts degree in communication studies from the University of California, Los Angeles.

Claudia Chittim, Administrative Assistant. Prior to joining the Washington Health Care Commission staff in March, 1991, Ms. Chittim served for two years as Lead Secretary at the Washington State Office of the Superintendent of Public Instruction. From 1983 to 1988, she was co-owner of Rally Week Northwest, a tourism promotion agency which organized a world championship motorsport event. She was responsible for budget management, merchandise sales, public relations, and liaison with international competitors, journalists, and motorsports authorities. She organized educational group trips to international motorsports events in Europe and Scandinavia. She also developed the organizational structure for Rally Week Northwest and its 1,500 volunteers. She founded and served as President of Rally Organizers Society, an affiliate of the Sports Car Club of America. Ms. Chittim attends Evergreen State College and anticipates receiving a Bachelor of Arts degree in 1992.

WASHINGTON HEALTH CARE COMMISSION

Technical Advisors

The following 23 technical advisors, representing a wide range of expertise and perspectives, participated as non-voting members of the Commission's committees. Each technical advisor was assigned to one of the four working committees. They worked closely with the Commissioners to address the goal and objectives assigned to their particular committee.

ACCESS COMMITTEE

Harold R. Clure, M.D.
Chairman, Executive Committee
Washington State Medical Association

Cynthia C. Curreri
President
Municipal League of King County

Aubrey Davis
President Emeritus
Group Health Cooperative

Mary Selecky
AdministratorHealth Services Consultant
Northeast Tri-County Health District

Jack Thompson
Director
Seattle Health Services Division
Seattle King County Department
of Public Health

COST CONTROL COMMITTEE

Donald A. Brennan
President and CEO
Sisters of Providence Corporation

Frank V. Chopp
Executive Director
Fremont Public Association

Robert Cowan
Former Vice President, Finance
Goodwill Games Organizing Committee

Christine Hill

M. Lynn Ryder
Senior Vice President
Washington Mutual Savings Bank

Donald Sacco
President
Pierce County Medical

HEALTH SERVICES COMMITTEE

Peter K. Domoto, D.D.S.
Associate Professor and Chairman
Department of Pediatric Dentistry
School of Dentistry
University of Washington

Kristine Gebbie
Secretary
Washington State Department of Health

James L. LoGerfo, M.D.
Medical Director
Harborview Medical Center

Florence Reeves
Executive Director
Community Health Care Delivery System

George A. Tanbara, M.D.
Physician
Pediatrics Northwest

MALPRACTICE COMMITTEE

Cecile Bostrom
Public Member
Washington State Board of
Medical Examiners

Keith M. Callow
Former Chief Justice
Washington State Supreme Court

Philip E. Dyer
President
The Doctor's Agency of Washington

David D. Hoff
Attorney
Riddell, Williams, Bullitt &
Walkinshaw

Judy K. Massong
Attorney
Schroeter, Goldmark & Bender

Thomas M. White
President and CEO
Empire Health Services

Loren C. Winterscheid,M.D.
Associate Dean for Administration
School of Medicine
University of Washington

WASHINGTON HEALTH CARE COMMISSION

Committee Roster

ACCESS COMMITTEE

Commissioners (7)

Tom Hilyard, Chair
Kent Hull, Vice Chair
Dennis Braddock
Bobbie (Evans) Berkowitz
Mike Kreidler
Arthur D. Sprenkle
Jim West

Technical Advisors (5)

Harold R. Clure, M.D.
Cynthia C. Curreri
Aubrey Davis
Mary Selecky
Jack Thompson

COST CONTROL COMMITTEE

Commissioners (7)

Jeffrey D. Selberg, Chair
Cindy Zehnder, Vice Chair
Ros M. Bond
Dennis Braddock
Gary Moore
Arthur D. Sprenkle
Margaret Stanley

Technical Advisors (6)

Donald A. Brennan
Frank V. Chopp
Robert Cowan
Christine Hill
M. Lynn Ryder
Donald Sacco

HEALTH SERVICES COMMITTEE

Commissioners (5)

Bobbie (Evans) Berkowitz, Chair
Patricia Schrom, Vice Chair
Merriam E. Lathrop
John Moyer
Leo K. Thorsness

Technical Advisors (5)

Peter K. Domoto, D.D.S.
Kristine Gebbie
James L. LoGerfo, M.D.
Florence Reeves
George A. Tanbara, M.D.

MALPRACTICE COMMITTEE

Commissioners (3)

Ros M. Bond, Chair
Arthur D. Sprenkle, Vice Chair
Margaret Stanley

Technical Advisors (7)

Cecile Bostrom
Keith M. Callow
Philip E. Dyer
David D. Hoff
Judy K. Massong
Thomas M. White
Loren C. Winterscheid, M.D.