

WashACE REPORT

Washington Alliance for a Competitive Economy

Shaping Up Health Care

Washington's Employer-Provided Health Care: Historically High Quality at Relatively Low Costs

After several years of relative stability, employer costs for health benefits are on the rise again, nationally and in Washington State. Average health benefit costs per employee grew more than 10 percent between 2002 and 2003 for the nation's largest employers (with more than 500 workers). At 14 percent, the change for Washington's major employers was even greater, well ahead of national growth and ahead of growth for large employers in the West of about 12 percent (Mercer 2003; see Figure 1).

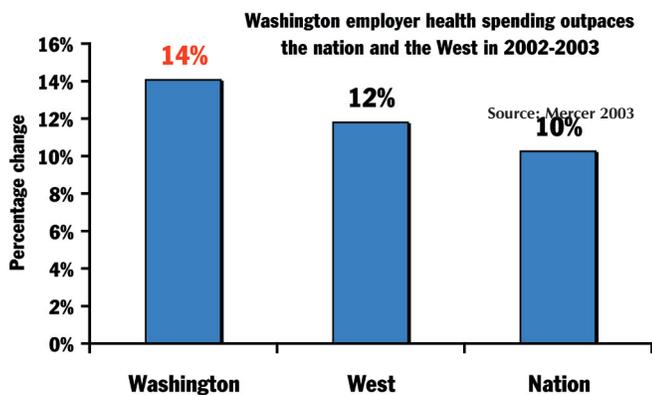


Figure 1

The available information is both detailed and incomplete. While the quality and quantity of information is part of the problem, we know that centralized planning is not the answer. The system, which is heavily burdened with government regulation and mandates, is not working for anyone—not for consumers, providers, insurers or purchasers.

Harvard professors Michael Porter and Elizabeth Olmsted Teisberg studied the U.S. health care system and concluded:

We believe that competition is the root of the problem with U.S. health care performance. But this does not mean we advocate a state-controlled system or a single-payer system; those approaches would only make matters worse. On the contrary, competition is also the solution, but the nature of competition in health care must change. Our research shows that competition in the health care system occurs at the wrong level, over the wrong things, in the wrong geographic markets, and at the wrong time. Competition has actually been all but eliminated just where and when it is most important.

This report pieces together the various data and perspectives on health care costs and conditions in order to understand their effects on employers and on the business climate in which they must compete. We find changing national policies and trends in health care that provide some optimism for the future. But Washington State has significant work to do if it hopes to benefit from these national trends and reforms and to be competitively positioned for continued economic recovery.

Paying for Health Care

The way we pay for health care causes much of the confusion. Third-party payers—employer-based insurance through private insurance companies (70 percent of insured) and government health programs (26 percent) like Medicare, Medicaid, the military, and in Washington, the Basic Health Plan—pay most of our health care bills (Census 2003a). Employers negotiate with insurance companies for the plans designed to cover their employees. Government plans pay for the health coverage of low-income and elderly populations. Individual consumers seldom buy their own health insurance directly—only 11 percent in 2002 (Census 2003a). For this reason, most people have little appreciation for how much health care they are consuming and little ability to equate various health care services with their value, either in terms of the prices charged or the quality of outcome. And while there is a relationship between the cost of health insurance and the underlying costs of health care, they are not the same.

Further complicating health care cost comparisons is the web of subsidies on which the system depends. Premiums paid by healthier patients subsidize patients requiring more costly care. Taxpayers and insured people subsidize low-income, uninsured people through their higher taxes and insurance premiums. Profitable procedures and services subsidize the unprofitable. Prices for various health care products and services, as a result, have historically had little opportunity to influence individual demand behavior.

These conditions have been changing slowly over the last 20 years. Insurance policies increasingly require co-pays for doctor and emergency room visits and prescription drugs. And, these requirements have been partially responsible for a redistribution of health care spending.

With the rapid run-up in insurance premiums in Washington in the last 24 months, health care costs are imposing an increasingly heavy drag on Washington business competitiveness. And with

important changes at the federal level in consumer-driven health care initiatives, new opportunities exist for realigning key relationships. This report reviews the state of health care in Washington in order to determine the specific steps that can be taken here to lower underlying health care costs.

Washington Health Care Spending is Historically Lower Than National Average

Washington and other western states have typically spent less per unit for health care than the national averages:

- On a per-capita basis: \$3,391 per capita in Washington compared with \$3,312 in the West and \$3,760 nationally in 1998 (CMS 2002a).
- On a per-employee basis: \$5,583 for large employers in Washington compared with \$5,948 for large employers in the West and \$5,758 for large employers nationally in 2002 (Mercer 2003).
- On a cost-per-hour-worked basis: \$1.39 per hour worked for private industry in the West compared with \$1.41 per hour worked for private industry nationally. (BLS 2004; see Figure 2)

Health Care Spending Comparisons			
	Per Capita 1998¹	Per Employee 2002²	Per Hour Worked 2003³
Washington	\$3,391	\$5,583	N/A
Western States	\$3,312	\$5,948	\$1.39
United States	\$3,760	\$5,758	\$1.41
Sources:	¹ CMS 2002a	² Mercer 2003	³ BLS 2004

Figure 2

In part this is due to a lower percentage of elderly people, who require more expensive types of care, like hospitals and nursing homes. In Washington, for example, 10 percent of the population was over the age of 65 years in 2002, while the average nationally was 12 percent (Census 2003a).

Also key is Washington's share of insured and uninsured people. Insured people typically choose to visit their doctor (a less expensive alternative) rather than hospital emergency rooms, for which insurance companies require higher co-pays.

Washington has typically ranked high for insurance coverage. In the 1990s with comparatively low unemployment, 88 to 90 percent of people in Washington had health insurance coverage.

On the flip side this means that Washington has typically had a lower percentage of uninsured people than the national average—12 percent in Washington compared with 15 percent nationally in 1995. By 2002 Washington ranked 2nd among western states only after Utah for the lowest percentage of uninsured people (see Figure 3).

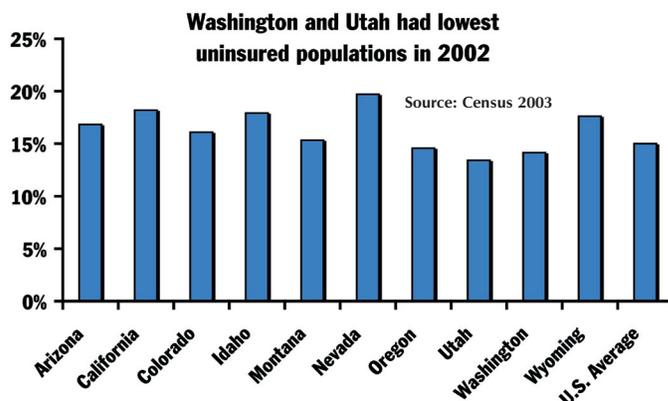


Figure 3

Within these numbers it is also important to note that Washington's population over 65 years of age is nearly 100 percent covered by some form of insurance and that Washington's share of uninsured children under 18 years (at 9 percent) ranks the lowest of the 10 western states and well below the U.S. average of nearly 12 percent.

Washington's Health Care Costs are Growing Faster Than the Nation's

The state is in the midst of a disturbing trend, however. During the recession, Washington's share of uninsured people grew to 14 percent in 2002—closer to the national average of 15 percent. Health care costs per employee have also increased in Washington so that by 2003 we looked more like the nation as a whole. Washington's large employers paid an average of \$6,368 per employee for health benefits, greater than the \$6,348 per employee paid by large employers nationally. Just a year earlier, the national average exceeded Washington by \$175 per worker (Mercer 2003).

Data from the Bureau of Labor Statistics (BLS) also documents this trend. Health costs per hour worked for private employers in the West grew 46 percent between 1997 and 2003, compared with growth nationally of 42 percent (BLS 2004). BLS does not offer these data for separate states, but based on the available evidence, it is likely that Washington's private employers have experienced faster growth in recent years than the nation (Mercer 2003).

A 2002 article in Health Care Financing Review summarizes recent employer health care cost history. After the health care inflation of the late 1980s and early 1990s, "[m]any employers began offering cost-controlling managed care plans... Eager to acquire new business, managed care insurers kept premium growth low for most employers, resulting in strong enrollment growth in these plans... Beginning in 1998 and continuing through 2000... the improved economy increased businesses' willingness to absorb premium growth, and the increasingly tight labor market encouraged employers to offer less restrictive (and more expensive) health plans desired by workers." (Cowan et al. 2002)

State and Local Government Employers Lead Growth in Health Care Spending

If these private sector trends depict a problem, the pattern in the public sector reveals a system out of control. Government employers nationally pay twice what private employers pay per hour for health care and their health care costs grew more than 50 percent between 1997 and 2003 (BLS 2004). Given Washington's public labor laws on binding arbitration, contract negotiation, and collective bargaining, state and local government health care costs here are likely growing as fast as or faster than the national average. Although the focus in this paper is on private employers, it is important to understand the upward pressure on industry compensation packages imposed by exceedingly generous public employee provisions.

Washington's labor market during the late 1990's was as tight as any in the country and large employers in Washington went beyond the coverage norms to offer extraordinarily generous benefits. For example (Mercer 2003):

- 71 percent of Washington's major employers require workers to contribute to their health insurance premiums, compared with 88 percent in the West and 83 percent nationally.
- Those employers who require a contribution require a substantially lower contribution amount in Washington —\$40 on average monthly compared with \$73 per month in the West and \$78 per month nationally on average.
- 38 percent of Washington's major employers offer same-sex domestic partner coverage, compared with 21 percent for large employers nationally.
- 64 percent of Washington's large employers offer "alternative medicine coverage," like acupuncture, biofeedback, chiropractic, homeopathy, and massage therapy, compared with 50 percent in the West and only 27 percent nationally.
- 77 percent of Washington's large employers offer vision coverage, compared with 54 percent nationally.

But extraordinarily generous benefits eventually take their toll in higher costs and increasing insurance premiums. Conditions that have allowed Washington employers to have a competitive advantage and provided employees a good value in health coverage are changing. Washington's large employers expect insurance premiums to increase by more than 14 percent again in 2004 and 50 percent of them plan to ask employees to share more of the costs, both through higher premium contributions and through higher physician, hospital, and drug co-pays (Mercer 2003).

Speaking to the National Governor's Association conference in Seattle earlier this year, Orin Smith, president and CEO of Starbucks, captured the growing problem for area employers, "double-digit

increases in health insurance premiums could jeopardize one of [our] best tools for recruiting and retention." (Song 2004).

Following are several important issues that many analysts believe are driving health costs. In each of these, state public policy has a role to play. These are:

- Government health insurance mandates.
- Litigation costs.
- Hospital costs.
- Prescription drugs and drug importation.

Government Mandates Contribute to Increased Costs and Restricted Access to Insurance

Washington State ranks 7th highest in the country in its number of state insurance mandates. With 48 mandates, Washington ties California in its national ranking. Together with Nevada, which has 47 mandates, these three states are the only western states in the national top ten. The Council of Affordable Health Insurance (CAHI) defines a health insurance mandate as "a requirement that an insurance company or health plan cover . . . health care providers, benefits and patient populations." (Bunce and Wieske 2004)

A number of the mandates in place today are legacies of the state's failed attempt to restructure the healthcare market through the Health Services Act of 1993 (E2SSB 5304). The 1993 reforms followed the managed competition model being developed on the national level by the Clinton administration's health care task force.

Cornerstones for the plan were two mandates. The first required all individuals to obtain health insurance coverage, the second required all employers to cover a portion of employees' health insurance costs. These mandates were scheduled to phase in beginning in 1995 and to be fully effective in 1999. The employer mandate, however, required a waiver of the federal Employee Retirement Income Security Act (ERISA), which precludes states from regulating the health benefits of self-insured employers (primarily large and medium-sized businesses). The Health Services Act instructed the governor to negotiate with the federal government for a waiver of ERISA.

To serve those less able to afford the cost of health insurance, the Act expanded the Basic Health Plan and extended the state Medicaid program to cover all children in families with incomes below 200 percent of the federal poverty level.

The Act also instructed the state insurance commissioner to formulate and adopt interim insurance reforms. She did so in early 1994. Among the provisions imposed were:

- **Guaranteed Issue**—Companies offering coverage cannot reject any individual who wishes to buy from them.
- **Preexisting Conditions**—Plans may exclude coverage of pre-existing conditions for the first 90 days only.
- **Portability**—When an individual switched plans, insurers were required to credit any portion of the 90-day waiting period that had been satisfied with the previous insurer.

By early 1995, it was clear that Act needed extensive revision. ERISA-employers were not bound by the employer mandate as the state had not received an ERISA waiver. The Clinton health care reform debacle helped sour the public towards reform. The 1995 legislature passed ESHB 1046, which substantially repealed the Health Services Act.

The new Act did incorporate the provisions regarding guaranteed issue, preexisting conditions and portability adopted administratively by the commissioner. In addition the new law imposed a modified form of community rating for plans in the individual and small group markets, allowing rates within each insurance plan to vary only by age, family size, region and whether individuals participated in employer wellness programs.

ESHB 1046 also introduced the “every category of provider” mandate, which requires every health plan to cover clinically indicated services from every category of provider licensed in the state. (This does not, however, mean that the plan must cover services from every individual provider within each of these categories.)

In 2000 the legislature enacted E2SSB 6067. This bill revised the guaranteed issue provision somewhat. Each year, carriers in aggregate may deny coverage to 8 percent of applicants. Those denied are then eligible for subsidized coverage through the Washington State Health Insurance Pool. In the individual and small group market the 90-day waiting period for coverage of preexisting conditions was extended to nine months.

In 2004, ESHB 2460 provided increased flexibility in the small group market. Under existing law, for groups of between one and 25 employees each insurer could offer one specific plan that was exempt from many of the state’s mandates with respect to conditions and providers. The new law allows that plan to be offered to groups of up to 50 employees and redefines “small group” to exclude groups of one. Health plans may now offer small groups a limited health plan covering a limited schedule of services.

As important as the number of mandates, though, is the nature of the particular mandates a state requires. A state’s choices of mandates can be more or less expensive. California and Nevada are both more mainstream than Washington in their choices of mandates (see Figure 1). Washington, for example, is the only state in the country that requires coverage of neurodevelopment therapy (primarily for abused children). In addition Washington is:

- One of two states requiring port-wine stain elimination.
 - One of two states requiring coverage of denturists.
 - One of three states requiring prescription drug coverage.
 - One of three states requiring coverage of chiropractors.
 - One of four states requiring coverage of massage therapists.
 - One of four states requiring coverage of naturopaths.
- (Bunce and Wieske 2004; see Figure 4)

Mandated Benefit Comparison 2004: Washington, Western States & U.S. Average												
National Ranking (Includes D.C.)	7th	37th	7th	27th	51th	16th	9th	34th	26th	34th	U.S.	Total
Western State Ranking	1st	9th	1st	6th	10th	4th	3rd	7th	5th	7th	UT	WY
	WA	AZ	CA	CO	ID	MT	NV	OR	UT	WY		
BENEFITS												
Alcoholism	Y		Y	Y		Y	Y	Y	Y		45	
Alzheimers											2	
Ambulatory Surgery		Y									12	
Ambulance							Y				8	
Ambulatory Cancer Treatment											1	
Autism											5	
Birthing Centers/Midwives	Y			Y							6	
Blood Lead			Y								6	
Blood Products											1	
Bone Marrow Transplants											10	
Bone Mass Measurements			Y								12	
Breast Reconstruction	Y	Y	Y		Y	Y	Y	Y	Y	Y	48	
Cancer Pain Medications											1	
Cervical Cancer Screening			Y				Y	Y		Y	26	
Chemotherapy											3	
Chlamydia											3	
Cleft Palate	Y			Y	Y						12	
Clinical Trials		Y	Y				Y				19	
Colorectal Cancer Screening							Y			Y	21	
Contraceptives	Y	Y	Y	Y	Y		Y				29	
Congenital Bleeding Disorders											2	
Dental Anesthesia	Y		Y	Y							27	
Diabetes Self-Management	Y	Y	Y	Y				Y		Y	22	
Diabetic Supplies	Y	Y	Y	Y		Y	Y	Y	Y	Y	47	
Drug Abuse Treatment	Y	Y	Y		Y	Y	Y	Y	Y	Y	35	
Emergency Services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	46	
Hair Prothesis											7	
Hearing Aid											9	
Home Health Care	Y	Y	Y	Y		Y	Y				19	
Hospice Care	Y						Y				11	
In Vitro Fertilization			Y			Y					15	
Kidney Disease											1	
Long Term Care									Y		3	
Lyme Disease											3	
Mammogram	Y	Y	Y	Y	Y	Y	Y	Y		Y	50	
Mastectomy			Y								24	
Mastectomy Stay			Y								24	
Maternity	Y		Y	Y		Y		Y		Y	21	
Maternity Stay	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	50	
Mental Health General	Y		Y	Y	Y	Y	Y	Y	Y	Y	40	
Mental Health Parity	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	42	
Min Hysterectomy Stay											1	
Min Testicular Cancer Stays											1	
Morbid Obesity Treatment											4	
Neurodevelopment Therapy	Y										1	
Newborn Hearing Screening						Y					13	
Newborn Sickle-cell Testing											2	
Off-label Drug Use	Y	Y	Y				Y	Y			37	
Orthotics/Prothetics			Y	Y							10	
Ostomy Related Supplies											1	
Other Infertility Services			Y			Y					8	
PKU/Formula	Y	Y	Y	Y			Y	Y	Y	Y	33	
Port-wine Stain Elimination	Y										2	
Prescription Drugs	Y										3	
Prostate Screen			Y	Y			Y	Y		Y	34	
Rehabilitation Services											7	
Second Surgical Opinion	Y		Y								11	
TMJ Disorders	Y						Y				19	
Well-Child Care			Y	Y		Y				Y	31	
Wilms Tumor											1	
PROVIDERS												
Acupuncturists	Y		Y			Y	Y	Y			11	
Chiropractor	Y										3	
Chiropractors	Y	Y	Y	Y		Y	Y		Y	Y	47	
Dentists	Y	Y	Y	Y		Y	Y	Y	Y	Y	36	
Denturists											2	
Dieticians										Y	4	
First Nurse Assistant											4	
Lay Midwives	Y										3	
Licensed Health Professional	Y						Y		Y	Y	11	
Marriage Therapists							Y				11	
Massage Therapists	Y										4	
Naturopaths	Y					Y			Y		4	
Nurse Anesthetists	Y	Y		Y		Y	Y			Y	20	
Nurse Midwives	Y	Y	Y	Y		Y	Y		Y		32	
Nurse Practitioners	Y	Y	Y	Y		Y	Y		Y	Y	30	
Nurses	Y			Y					Y	Y	13	
Occupational Therapists		Y	Y						Y	Y	3	
Opticians											3	
Optometrists		Y	Y	Y			Y	Y	Y	Y	44	
Oral Surgeons							Y				7	
Osteopaths	Y			Y					Y	Y	24	
Pain Management Specialist											2	
Pastoral Counselors											2	
Pharmacists											4	
Physical Therapists	Y					Y	Y		Y	Y	17	
Physician Assistants	Y					Y	Y		Y	Y	17	
Podiatrists	Y	Y	Y				Y		Y	Y	35	
Professional Counselors			Y			Y			Y		16	
Psychiatric Nurse			Y			Y	Y		Y		17	
Psychologists	Y	Y	Y	Y		Y	Y	Y	Y	Y	44	
Public or Other Facilities	Y	Y	Y		Y	Y	Y	Y	Y	Y	25	
Social Workers		Y	Y	Y		Y	Y	Y	Y	Y	28	
Speech or Hearing Therapists	Y		Y			Y	Y		Y	Y	18	
COVERED PERSONS												
Adopted Children	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	42	
Continuation/Dependents	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	44	
Continuation/Employees	Y		Y	Y	Y	Y	Y	Y	Y	Y	44	
Conversion to Non-Group	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	42	
Dependent Students											10	
Handicapped Dependents	Y	Y	Y	Y	Y	Y	Y		Y	Y	39	
Newborns	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	51	
Non-Custodial Children									Y	Y	10	
Total	48	28	48	35	13	39	47	31	36	31	1,818	

Source: Bunce & Wieske 2004

Figure 4

These mandates drive up the cost of health care insurance—CAHI estimates by as much as 45 percent in some markets—and increase the percentage of people who go without insurance coverage due to cost. According to America’s Health Insurance Plans (AHIP), an additional 1.4 million people nationally “have been

priced out of the system” due to runaway litigation, government mandates and regulation, diminished market competition and fraudulent billing practices” (AHIP 2002).

The 2002 PricewaterhouseCoopers study on which their report was based estimated that 15 percent—about \$10 billion—of the increase nationally between 2001 and 2002 could be attributed to government mandates and regulations (PwC 2002).

In addition to increasing the costs of health insurance coverage, mandates contribute to increasing the percentage of uninsured. As discussed earlier, they can add to higher health care costs by prompting people to opt for more expensive service options. The Galen Institute called Washington and 15 other states the “most aggressive” in passing health care mandates. These states saw “their uninsured populations grow an average of EIGHT (emphasis in the original) times faster” than the other 34 states, driving up prices, restricting innovation, drying up competition, and forcing businesses to cater to regulators and not consumers (Turner 1999).

Litigation Contributes to Cost Growth and Restricted Access to Physicians

Topping \$233 billion in 2002, the U.S. tort system costs about \$809 per person. This compares with a cost of about \$93 per person in 1975, amounting to about 94 percent growth adjusted for inflation. Growing more than 2.5 times faster than total tort costs between 1975 and 2002, medical malpractice costs grew 246 percent, from about 6 percent of total tort costs in 1975 to nearly 11 percent in 2002 (Tillinghast-Towers Perrin 2003). At \$24 billion nationally in 2002, these costs amounted to about 2 percent of health care spending (CBO 2004).

Many analysts believe there is a direct relationship between increasing litigation costs and rising insurance premium rates, both for medical malpractice and for product liability. It is a subject of heated debate among the medical community, insurance companies, and trial attorneys.

Various legal actions and remedies have been proposed. The most common include:

- **Non-Economic Damage Caps:** Limitations on awards for pain and suffering that go beyond medical fees and lost productivity.
- **Statute of Limitations:** Time period after which claims cannot be brought, regardless of legitimacy.
- **Joint and Several Liability Restriction:** Limitation or elimination of the ability to assign any one injurer full responsible for injury that was caused by more than one party.

But litigation costs are not the cause of malpractice premium growth, claims the Association of Trial Lawyers of America (ATLA). The main problem, they say, are the insurance compa-

nies, which, in an attempt to maintain their profitability, are raising malpractice premium rates in response to low stock market investment returns.

Physicians and insurers counter that the uncertainty and greater risk inherent in excessive jury awards necessarily results in higher insurance premiums. They also point to surveys indicating that doctors are leaving their practices or limiting them to lower risk procedures and practicing overly defensive medicine.

Recent reports from the U.S. General Accounting Office (GAO) and the Congressional Budget Office (CBO) do not offer much guidance, concluding that the data are “at best ambiguous.” (GAO 2003, CBO 2004)

“GAO confirmed instances in the five states [reviewed] of reduced access to hospital-based services affecting emergency surgery and newborn deliveries in scattered, often rural, areas where providers identified other long-standing factors that also affect the availability of services... GAO also determined that many of the reported provider actions were not substantiated or did not affect access to health care on a widespread basis... [Further] physicians reportedly practice defensive medicine in certain clinical situations, thereby contributing to health care costs; however, the overall prevalence and costs of such practices have not been reliably measured... [finally] GAO could not determine the extent to which differences in premiums and claims payments across states were caused by tort reform laws or other factors that influence such differences.” (GAO 2003)

But while they call the available evidence ambiguous, neither CBO nor GAO calls the claims untrue. In a recent 2004 examination, CBO says that tort restrictions in the HEALTH Act of 2003 “would lower premiums nationwide by an average of 25 percent to 30 percent from the levels likely to occur under current law.” (CBO 2004)

A recently released Rand study finds that 45 percent of the 257 California jury awards reviewed (of trials between 1995 and 1999) required adjustment by judges in order to conform to that state’s \$250,000 cap (under the law juries cannot be told of the cap). Critics of tort reform say the juries obviously believed that larger payouts were justified (Pace, Golinelli, and Zakaras 2004).

Tort reform advocates, on the other hand, say this means the caps are working. Attorney fees were reduced 60 percent overall (Pace, Golinelli, and Zakaras 2004).

At the state level there is strong evidence that California’s caps on non-economic damages have contributed to slower growing malpractice insurance premiums in that state. Legislation passed in 1975 limited non-economic damages in California to \$250,000 . Data developed by the National Association of Insurance Commissioners show that while California malpractice insurance premiums grew 167 percent between 1976 and 1999, premium growth nationally was 505 percent (HHS 2002). Tort reform critics question the existence of a cause-and-effect relationship.

In late 2001 Washington Casualty Company notified 1,900 Washington State physicians that it would no longer provide malpractice insurance. Not long after another national underwriter announced it would drop coverage of all of its emergency medicine specialists and obstetricians (WSMERF 2002). In June 2004 Elway Research surveyed physicians statewide. Among their findings were:

- 51 percent of physicians were less willing to perform risky procedures.
- 44 percent of physicians said they had stopped providing certain high-risk services.
- Specialties most affected include neurological surgery, ObGyn, orthopedics/orthopedic surgery and family practice.
- 75 percent said their practice of defensive medicine had increased.

(WSMERF 2004)

Businesses in a competitive environment value certainty, attempting to lower or eliminate as many risk factors as possible. To the extent that risks are contained, prices will be lower and more stable.

Conversely, in cases of medical, drug, and product liability, when risks of legal action are unconstrained and jury awards can reach amounts sufficient to bankrupt large corporations, supply markets (like medical practitioners and drug companies) will necessarily try to mitigate the potential for damage. Some of these responses could be positive, like offering more careful treatments and assuring that products are fully tested. However, as CBO says, damage awards that are “arbitrary and unpredictable do not provide incentives for precaution but do raise costs, thereby distorting pricing signals,” and harming the whole system of care (CBO 2004). Areas for legislative consideration include:

- Capping non-economic and punitive damages.
- Establishing a statute of limitations on claims.
- Restricting or eliminating joint and several liability.

Hospital Regulation Reform is Part of the Answer

Hospital spending in Washington was \$6.4 billion in 1998, amounting to 33 percent of total health spending (CMS 2004b). This was a smaller proportion than hospital spending for the nation as a whole; however, Washington has been growing faster than the national average since 1990—49 percent for the U.S. compared with 62 percent in Washington. Adjusted for inflation, growth of hospital spending in Washington was flat from 1990 to 1998, while the nation actually fell by about 7 percent, due to primarily lower utilization. In an area of the health care system that is so large and so important, then, understanding the causes and possible deterrents to cost growth have great potential for large payoffs (See Figure 5).

Hospitals are 33% of state's 1998 health spending.

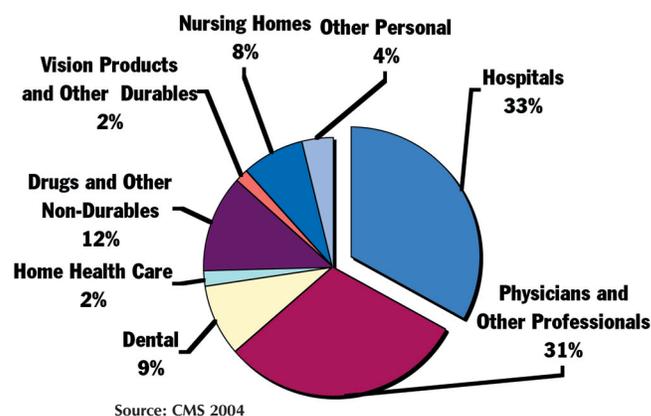


Figure 5

Like several other complex areas of public policy, health care and hospitals, in particular, are fraught with myriad internal cross-subsidies. High-profit services and procedures that bring in excess money subsidize low-margin or money-losing procedures and people with full health insurance coverage subsidize others with inadequate or no health insurance. Rather than separate functions and populations that lose money and design a system of public subsidy specifically tailored to solve their funding needs, we have burdened the entire health care system with a level of complexity, regulation and administrative expense that the Washington Hospital Association calls, “unprecedented.”

Calling for administrative simplification, the association says, “Hospitals must add staff to deal with the ever-increasing level of administrative complexity. Rules surrounding patient eligibility, referrals, and prior authorizations are extensive and confusing... The amount of information that must be collected and processed... results in delays, mistakes, and duplication.” (Byron 2004) The association calls for fair, adequate, and timely payments (from insurers and government programs), improved Certificate of Need standards and processes, a leveling of the playing field with regard to boutique (specialty) hospitals, and funding for an increased pool of trained workers (Revelle 2004).

These solutions make sense within the constraints of the current system, but they represent symptomatic responses to a systemic problem with how hospital care is currently priced and delivered.

At the heart of the problem says John Goodman of the National Center for Policy Analysis, are the uninsured “free-riders,” who are willing to lean on the 86 percent of the population who have health care insurance. “In our society, people who choose not to pay for insurance know that they are likely to get health care anyway (often through hospital emergency rooms)—even if they can’t pay for it. The reason is that there is a tacit, widely shared agreement that no one will be allowed to go without care. As a result, the willfully uninsured impose external costs on others—through the higher taxes or higher prices which subsidize the cost of their care.” (Goodman 2001)

Untangling and understanding the complex web of regulation, pricing schemes, and barriers to hospital competition are beyond the scope of this paper. However, if health care costs are to be brought under control, public policies currently governing hospitals—one-third of our health care spending—must be on the table for reform.

Prescription Drug Spending is Growing Faster, but May Be Part of the Answer

Prescription drugs are suffering to some extent from their own success. New “wonder” drugs, like those to lower cholesterol, control stomach acids, arrest bone density loss, treat AIDS, and strengthen respiratory function, have demonstrated their ability to improve the lives of millions of individuals. In some cases drugs have been able to substitute for more expensive surgeries or hospitalizations.

Due to their efficacy newer, better, and, yes, more expensive drugs have replaced older, cheaper drug remedies. They have also created a higher expectation of well being for sufferers of various chronic afflictions. Together, these result in greater drug use and the increased share of health care spending associated with pharmaceuticals. Nationwide, prescription drug expenditures topped \$90 billion in 1998—nearly 8.9 percent of total personal health care spending, up from about 5.7 percent in 1980. (CMS 2002b) Washington State, which has consistently represented about 1.8 percent of the nation, spent more than \$1.6 billion on prescription drugs in 1998.

Drugs are 12% of state's 1998 health spending.

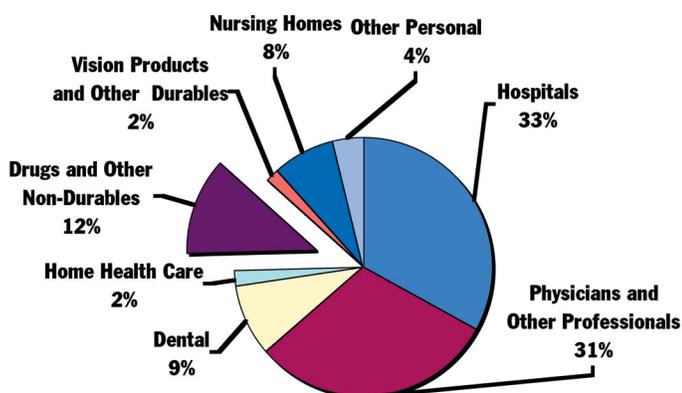


Figure 6

And following national trends, prescription drugs represent an increasing share of total health care spending in Washington. But while long-term growth of drug spending in Washington is similar to that of the nation, spending on prescription drugs in Washington has grown faster in recent years than national growth. For example, from 1995 to 1998 (the latest year available for comparative data), national spending on prescription drugs grew 35 percent, compared with growth in Washington State of 42.5 percent. As shown in Figure 6, spending on drugs and other non-durable products was 12 percent of total health care spending in

1998. Prescription drugs are a subset of this category, accounting for about 8 percent of total spending in Washington (CMS 2002b).

Federal patents prohibiting duplication of successful drug formulas by generic manufacturers allow pharmaceutical companies a chance to recover their front-end investment and to make a profit. Intellectual property protections encourage investment into research and development of new remedies, and they result in the higher prices that exist until patents expire. These conditions cause many people to seek ways to ‘get control’ and slow the growth in drugs prices and utilization.

A couple of approaches have gained popularity, drug formularies and drug importing. They are the wrong responses.

Drugs formularies are basically lists specifying and restricting the drugs covered by various insurance policies. HMOs and other insurers, as well as states in their public health programs, adopt them to limit or direct the use of prescription drugs. In some cases the formulary drug choice for a particular health condition is not a big problem, but formularies that are rigid or slow to incorporate new information can preclude patients from taking the most effective drug for their particular condition.

Studies have shown that newer, more expensive drug treatments can lower overall health care costs. The Agency for Healthcare Research and Quality conducted research on the protease inhibitors used to keep HIV from reproducing in AIDS patients. While using protease inhibitors was a more expensive pharmacy choice, total average medical costs (including inpatient, outpatient, pharmacy, community care, and emergency room costs) were lower by as much as 35 percent. Similarly, AIDS patients taking drugs to prevent opportunistic diseases like pneumocystis carinii pneumonia (PCP) accounted for a lower share of hospital stays associated with this illness, lower total charges, and were less likely to die (Bass-Bartelmes and Bosco 2002).

Washington’s “dispense as written” language allowing physicians to override the state formulary has softened the most problematic aspects of this policy issue for publicly funded programs.

Drug importing takes different forms. Several states and cities have considered purchasing prescription drugs in bulk from Canada and some individuals are purchasing their drugs from cheap on-line sources. These options can be dangerous. According to the Galen and Heartland Institutes, 88 percent of the imported drug shipments examined by the Food and Drug Administration (FDA) in 2003 did not meet FDA standards (Turner and Meier 2004). Instead, they contained unapproved or counterfeit drugs (FDA 2003). As well, Canada is increasingly importing part of its drug supply from other countries—like Bangladesh, China, Saudi Arabia, and Iran—some with dubious histories and reputations for drug safety and legality.

The potential savings from bulk drug importation is smaller than what some have initially estimated. The state of Massachusetts, for example, did not purchase drugs from Canada when it learned that an estimated \$10.4 million savings would shrink to just \$1.4 mil-

lion after co-pay waivers (offered in order to be attractive to insured individuals) and loss of rebates from drug companies. Further, “borderless drug stores, including those in Canada”, according to Turner and Meier, require people to waive liability. States and cities, therefore, assume this liability risk in the event they facilitate import of counterfeit or illegal drugs that result in harmful consequences (Turner and Meier 2004).

Even if drug import schemes were fully successful in actually getting quality drugs into the American marketplace for less than American manufacturers charge, it would stifle the economic conditions that produced these pharmaceutical successes in the first place—namely the large profits possible under ideal conditions. The promise of extraordinary profit attracts investors and their capital to these highly risky investments. Most drug research does not result in a successful product. But even successful formulas require years of testing, clinical trials, and certification processes to generate any profitable return.

Going forward, Mercer analysts “expect to see more restrictions and limitations in some of the more costly drug categories, and plan design incentives to encourage employees to utilize more cost-effective drugs (such as generics) and more cost-effective channels for purchasing drugs (such as mail order).” Large employers in Washington State are relatively aggressive in requiring patient co-pays, compared with other western states and nationally. For example 71 percent of the large employers reporting in Washington use three tiers of co-payment (for generic, brand formulary, and brand non-formulary) compared with only 46 percent of large employers in the West and 57 percent of large employers nationally.

If newer drugs are more cost effective, but are, at the same time, discouraged (by high cost sharing) or disallowed (by formularies), total health care costs are driven up unnecessarily, with potentially disproportionate effects on lower income individuals and families.

Although formularies and importation may be dubious strategies for controlling rising drug costs, laws limiting product liability hold some promise. According to the Canadian consultancy, Ward Health Strategies, differences in product liability laws are “the largest single factor contributing to price differences between Canada and the United States” (Ward 2004). Similar to the effects of runaway tort claims on medical malpractice insurance, product liability laws magnify the downside risks of adverse product side effects for drug manufacturers. As the laws are currently constructed, litigants have little disincentive to bring suit—there is nothing to lose and potentially tremendous gains. The risks and uncertainty attending these possible actions are ultimately factored into drug prices.

What’s Needed? Consumers with Greater Control and More Information

Advocates of consumer-driven health care reforms say that the main problem with health care is its third-party payer system. Whether it is an insurance company, a self-insured employer, gov-

ernment (through Medicare and Medicaid), or Washington’s Basic Health Plan, third-party payers’ interests are not the same as patients’ interests. Bruce Braker, President of the Tooling and Manufacturing Association, captures the sentiment in an article for Association Management, “If somebody else is paying my bill, I don’t really care how big that bill is... if it’s my money, then I care” (Levesque 2004).

Reform proponents call for reestablishing a more direct supply-demand relationship between the primary purchasers and suppliers of health care—the patient and his or her doctor. There is cause for optimism.

HSA and Consumer-Driven Health Care

Health Savings Accounts (HSA) were approved by Congress as part of the Medicare legislation passed in December 2003. Similar to Individual Retirement Accounts (IRA), HSAs are designed to help individuals build their own income tax-sheltered, interest-bearing savings accounts to pay their medical and drug bills. HSAs provide individuals the opportunity to self-insure and keep the dollars they don’t spend.

The HSA legislation requires individuals and families to purchase a high-deductible (\$1,000 for individuals and \$2,000 for families) insurance policy to cover major medical needs, including surgery and hospitalization. The individual may then invest money in an HSA (\$2,600 annually for an individual and \$5,150 for a family) and employers may supplement this amount, ultimately allowing patients to pay cash for smaller, more predictable expenses like annual doctor’s visits, drugs, and lab tests.

HSA money is invested out of pre-tax earnings, thereby lowering the income on which an individual is assessed income tax. As well, HSAs earn interest tax free and, unlike IRAs or other IRS tax-sheltered accounts, money in an HSA can ultimately be spent tax free. And, because individuals or families own their own account:

- The account is portable, moving with the person no matter where he works or for whom.
- The patient chooses her own doctors and level of care.
- Funds remaining at the end of the year roll-over into the following year.
- Any remaining funds at death become part of the individual’s estate.

Initial concerns cited by HSA critics have been laid to rest by the early evidence (Turner 2004). Critics have claimed that HSAs are for the young, the wealthy, the healthy, and the already insured and won’t be used for prevention. Galen Institute reports, however, that:

- More than 70 percent of Assurant Health HSA purchasers are over age 40.
- An Aetna study found that the age and family status of customers enrolled in its consumer-driver plan, which is

sold mostly to large employers, reflected the general population.

- EHealthInsurance data show that nearly half of HSA purchasers make less than \$50,000 a year. Assurant found that 27 percent of its HSA purchasers had a net worth of less than \$25,000 a year.
- Only a small percentage of HSA purchasers (6.1 percent of Assurant's purchasers) were not able to buy other coverage, "meaning 94 percent were" healthy enough, according to Galen.
- EHealthInsurance found that 56 percent of HSA purchasers with incomes under \$15,000 were previously uninsured and that 46 percent with earnings between \$15,001 and \$35,000 were previously uninsured.
- Assurant found that preventive care office visits were up by 31 percent, consistent with earlier Aetna findings.

Small groups are especially interested in this new solution. According to Carl Levesque in Association Management, "The National Small Business Association (NSBA), Washington, D.C., hadn't even officially launched its health savings account offering when the phones started ringing. No press release had gone out, nor had any marketing brochure or e-mail broadcast. The 10 calls a day were coming in 'just from people bumping by our Web site' and seeing the product's availability, says Director of Communications Jeremy Claeys." (Levesque 2004)

Levesque also talked with NFIB's national director of health research and development, Jamie Amaral, who says, "We like the HSA because we have so many employer members with part-time employees, and with HSAs the account belongs to the employee and can be co-funded by, say, two employers." (Levesque 2004)

On the supply side physicians are looking for efficiencies through use of better information systems and new technologies that at the same time provide better service and reduce administrative overhead expenses (Kolata 2004).

And by turning to cash-only practices, SimpleCare physicians have lowered their rates by as much as 30 percent to 50 percent, according to the American Association of Patients and Providers (AAPP). They report that "By eliminating administrative costs associated with activities such as billing, producing insurance claim forms, coding diagnoses and procedures, referrals, authorizations, payment delays, EOB reviews, claim denials, re-submissions, collection risks, and other "managed care" costs, you provide patients a fair price for services without the administrative hassles and bureaucracy," says AAPP on its FAQ web link. (AAPP 2004)

Finally, acknowledging that demand and supply markets work most efficiently when both purchasers (patients) and suppliers (physicians, hospitals, and pharmacies) are fully and quickly informed, there are numerous mechanisms being adopted for useful, timely, and accurate information on prices and best practices to consumers and to physicians.

Consumer Information

If consumers are the key to an improved health care system, informed consumers are key to its success. Increasingly aware of the importance of health to American productivity, nearly 40 percent of employers (nationally and in Washington) participating in the Mercer survey promote consumerism. "Defined as informed and responsible spending by employees on health-related goods and services," Mercer analysts call consumerism "more than a catchphrase" (Mercer 2003). They say that employees' preference to go to the physicians and health providers of their choice may have been part of industry's reason for moving away from managed care health systems, but it is also consistent with helping employees, as health care consumers, to understand the cost-value relationship in their health care decisions.

A Towers-Perrin survey conducted in January 2004 finds that 71 percent of employers surveyed offer their employees information and other tools to help them make better decisions about health care coverage and another 14 percent plan to implement such programs in 2005. 63 percent of employers provide their employees information to help them be better consumers of health care services, with 13 percent planning to implement programs in 2005. Employers participating in the survey articulated three top factors key to the success of their company's health care strategy. They were:

- Employees understand that rising costs could impact our ability to succeed as a business.
- Employees understand the true cost of the health care services they use.
- Employees are effective health care consumers.

(Towers Perrin 2004)

Aetna Research has also weighed in on the value of consumerism. In a study of nearly 14,000 members of Aetna HealthFund, analysts found that more information and more personal involvement by members resulted in relatively flat medical cost growth (1.5 percent) and a 16 percent increase in preventive care. Members enrolled in the pharmacy plan increased their use of generic medications by nearly 13 percent (Aetna 2004).

In addition to employer-sponsored information, consumer health care education organizations and websites are popping up everywhere. Blue Cross Blue Shield of Massachusetts in partnership with Consumer Health Interactive (CHI) provides access to web-based information on health concerns, with access also provided to "Mayo Clinic Health Oasis® and Healthwise Knowledgebase®, a comprehensive health and medical library available on the Internet (CHI 1999). And, one can now Google just about any health condition or question and find a multitude of sites providing information, from highly technical clinical explanations and descriptions to ones with more consumer-oriented language.

Conclusions and Recommendations

Asked if there is a particular villain responsible for the current state of health care, economist Michael E. Porter says no one “entity has made the fatal decisions that have caused the system to be the way it is. Indeed, there was a set of incentives created partly by government regulation and partly by history. They have led each actor in the system to behave in ways that were rational for them but were not aligned with improving health care value... The system is not designed to reward to most efficient providers... people have tried all the simple things, and they haven’t worked. I think most people are now stepping back and saying, “... we’ve got to rethink this whole system.” (Holstein 2004)

In a new book on health care former Colorado governor, Richard Lamm strikes a more alarming note, “American expectations for health care over the last thirty years have been developed during the most massive transfer of wealth into one sector (health care) that history has ever seen. Health care is a fiscal black hole into

which we can pour all of our children’s future.” (Lamm 2004)

Health care reform is necessary. There are basically two directions to go from our current situation: Universal care or consumer-driven care. The evidence is compelling that consumer-driven care holds the most promise for success. Informed patients, in consultation with their doctors, have the best potential for deciding how best to spend their health care dollars, sorting through the options available and selecting those most effective for their personal circumstances. Health care markets will respond, in turn, by offering more of what patients discern to have value and less of what they perceive to be unnecessary.

The main question remaining is what specific policies will achieve this outcome. Enactment of federal legislation allowing health savings accounts has taken us a long way in setting the stage for an appropriate consumer-driven response. And markets have already begun to anticipate and respond to the need for better consumer information systems.

The following recommendations address several important health care reforms that remain for state legislative action:

1. In order to encourage the full range of physicians and health practitioners and to discourage unnecessary price spikes for pharmaceuticals:

- Adopt caps on non-economic damages.
- Eliminate or restrict joint and several liability.
- Establish a fair statute of limitations on liability.

2. In order to enhance access to fullest range of personal health insurance products:

- Eliminate state mandates requiring insurers to cover various health providers, services, and patient populations.
- If full elimination of mandates is not feasible, allow insurance companies to offer a more affordable plan for smaller employers.

3. Encourage development of HSA options within insurer portfolios. Include these options in plans offered by government employers and programs.

4. Review existing hospital rate setting, payment, and regulatory systems, in light of new and changing competitive environment that includes opportunities for cash-paying patients and boutique hospitals.

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