WashACE

COMPETITIVENESS BRIEF

Washington Alliance for a Competitive Economy

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THE BOTTOM LINE

The growth in health care costs presents a major competitiveness challenge for businesses and strains the budgets of the federal and state governments.

With leadership from the business community, the focus in health care reform has shifted to improving the quality of care and involving consumers more directly in decision-making through consumer-driven health care.

As state government works to restrain the growth in its own health care spending, it should support and emulate the private sector's efforts.

The Prescription for Health Care:

Quality and Consumer Choice

Driven by rapid advances in technology, health care spending now exceeds 15 percent of the nation's gross domestic product (GDP). By 2014, projections show such spending will reach 18 percent of GDP. Much of health care is funded through employment based health insurance or government programs such as Medicare and Medicaid. The growth in health care costs presents a major competitiveness challenge for businesses and strains the budgets of the federal and state governments.

The growth in health care costs is a particularly acute problem for Washington State government. Health care spending consumes nearly 18 percent of the general fund and is growing nearly twice as fast as general fund revenues. This situation is unsustainable.

Through the 1990s, reform efforts in both the private and public sectors focused on holding down costs through mechanisms such as managed care. Consumers value their health highly and resisted these cost-control efforts. More recently, with leadership from the business community, the focus in health care reform has shifted to improving the quality of care and involving consumers more directly in decision-making through what is called consumer driven health care.

To restrain the growth in its health care spending, the state should follow the lead of the private sector. It should make employees pay a larger share of cost of their health insurance. Similarly, the state should restructure medical assistance using cost-sharing mechanisms to harness market forces and personal responsibility to improve health care delivery while tailoring benefit packages more carefully to the needs of various populations.

GROWTH IN HEALTH CARE SPENDING

In 1960 spending on health care equipment and services represented 4.7 percent of GDP. By 2003 it had grown to 14.7 percent, according to estimates prepared by the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS). CMS forecasts that by 2014 health care spending will be 18.0 percent of GDP. (See Chart 1.)

Shifts in the sources of funding accompanied the growth in spending from 1960 to 2003. (See Chart 2.) Most notable were the drop in consumers' out-of pocket-share from 52 percent of spending to 14 percent,

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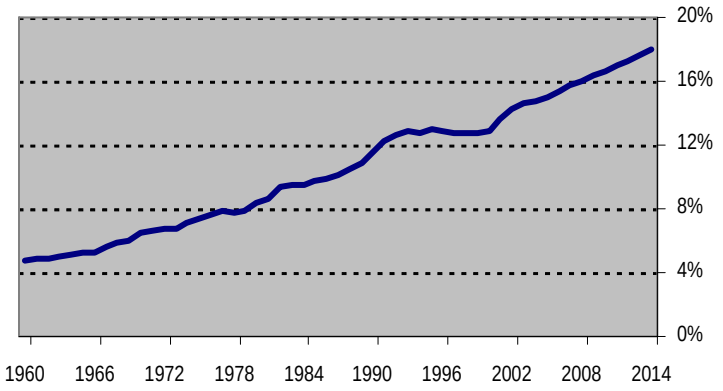
the increase in the federal government's share from 9 percent to 31 percent, and the increase in private insurance's share from 23 percent to 37 percent. Note in particular the jump in the federal share between 1965 and 1967, when Medicare phased in, with the offsetting decreases in the out-of-pocket and private insurance shares.

Chart 1: Health Equipment and Services Spending as Percent of GDP



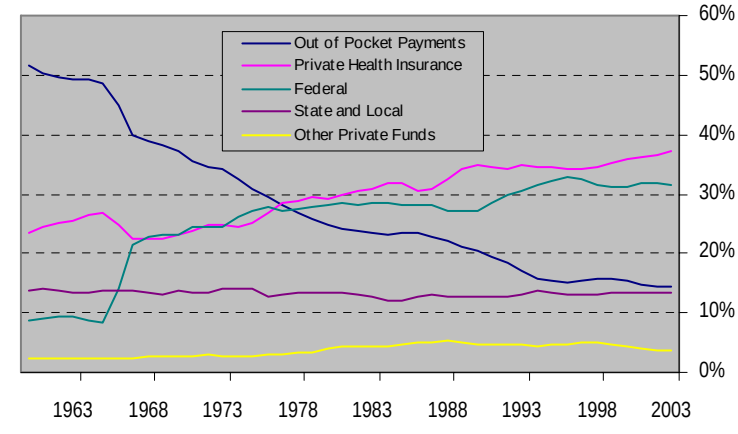
Source: National Health

Most private insurance today is provided by employers. From the points of view of both employers and government, the rise in health care expenditures has been magnified by the rise in the shares that they bear. Consumers, on the other hand, have been shielded, to some extent, by the decreasing share of out-of-pocket expenses. Not surprisingly, controlling medical spending growth has been a higher priority for business and government than for consumers.

The old view: insurance promotes over-utilization of health care

During the 1970s and 1980s, the prevailing explanation of the growth in health care spending emphasized the role of insurance. The typical fee-for-service health insurance policy paid for any treatment the doctor prescribed (subject to deductibles and co-payments) so long as it was on the policy's list of covered procedures. These policies provided patients and physicians little incentive to consider whether the benefits of any particular procedure exceeded its costs; a particular problem was the over-utilization of expensive new technologies (e.g. computerized axial tomography scans).

Chart 2: Health Equipment and Services Spending as Percent of Total



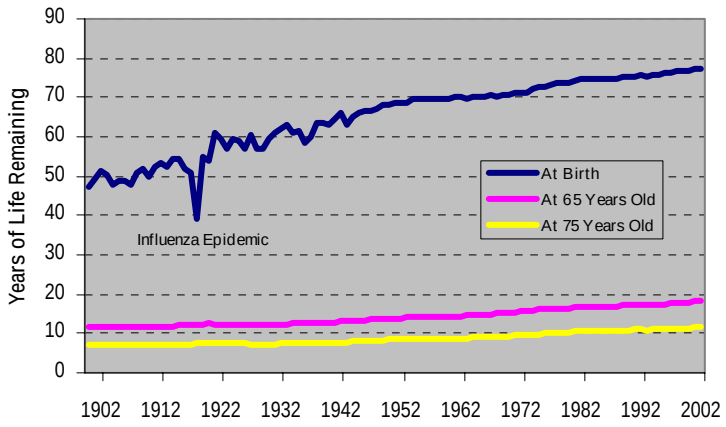
Source: National Health

Based on this analysis, governments and businesses undertook a number of initiatives to restrain the consumption of health care services. For example: In the 1970s, state governments began requiring hospitals to obtain certificates of need before adding capacity or expensive equipment. In the 1980s, Medicare adopted the diagnostic related group (DRG) system of reimbursement for hospitals, under which hospitals are compensated based on the disease a patient has rather than the particular treatment they receive. Many private insurers piggybacked on the federal DRG system. In the 1990s, employers shifted employees away from traditional fee-for-service insurance plans and into health maintenance organizations (HMOs). In theory, the HMOs were to manage care, applying cost effectiveness criteria to eliminate over-utilization.

The shift to HMOs was particularly effective in restraining growth in costs, as health care's share of GDP did not grow from 1993 to 2000. However, the reason for this seems to be less that HMOs squeezed out unnecessary care and more that they pushed down prices received by doctors, hospitals and other providers (Halvorson and Isham). The squeezing seems to have reached its natural limit in 2000. From 2000 to 2003, health care spending grew from 12.8 percent of GDP to 14.7 percent, as increases in market power allowed providers to push back more effectively.

Consumers, at least those who have insurance, tend to be skeptical of attempts to control their access to health care. The Clinton health care plan intended to squeeze out unnecessary care, through a complex system of "managed competition." The plan failed because the public at large feared that what would be cut was care they needed. In addition, there has been considerable public pressure to loosen the controls of managed care. Since 2000 the HMO has been replaced by the preferred provider organization (PPO) as the most popular form of health plan (Draper et al 2002, White 2004).

Chart 3: Life Expectancy in the United States



Source: National Center for Health Statistics

In recent years, the emphasis of many health policy experts has subtly shifted away from controlling costs towards improving the quality of care, in the belief that higher quality care, particularly with respect to chronic health conditions, will both improve health outcomes and lower overall spending.

Consumers value health spending

A number of analysts now argue that a fundamental cause of rising health care spending is the high value consumers place on improving their health status. As personal incomes increase and advances in science and technology provide attractive new treatment opportunities, it is natural for health care spending to rise.

Joseph Newhouse, professor of health policy and management at Harvard University, argues that health care spending is driven not by overconsumption, but rather by "the march of science and the increased capabilities of medicine." Technological progress has provided a wealth of new machines, medicines and procedures. In some cases (e.g. polio vaccine) new technology has lowered costs, but generally the effect is to increase spending. Insurance makes it possible for consumers to pay for access to expensive new technology and thus provides a key incentive for its creation. But, Newhouse says, "there is reason to think that consumers want to pay" for access to these new technologies (Newhouse 1992).

Certainly as the share of GDP devoted to health care has increased dramatically, the nation's health, at least as measured by life expectancies, has also increased. Average life expectancy at birth grew from 47.3 years in 1900 to 77.3 years in 2002. Over the same period life expectancies at age 65 similarly grew from 11.9 years to 18.2 years. (See Chart 3.)

David Cutler, professor of economics at Harvard University, calculates that Americans are willing to pay an average of $100,000 for an additional year of life lived in good health (Cutler 2004). He notes that improvements in medical care for two conditions, low birth weight babies and cardio vascular patients, have added about three and one-half years to life expectancy at birth since 1950 (about 40 percent of the total increase). The value of these three and one-half years of life added are about equal to the increase in lifetime health care expenditures since 1950. Including improvements related to other conditions the benefits of the increased health care spending exceed the cost (Cutler, p. 63).

William Nordhaus, professor of economics at Yale University, estimates that the economic value of increasing life expectancy over the twentieth century is about equal to the value of the increase in consumption of non-health goods and services and poses this question:

> Consider the improvements to both health and non-health technologies over the last half century (say from 1948 to 1998). Health technologies include a variety of changes such as the Salk polio vaccine, new pharmaceuticals, joint replacement, improved sanitation, improved automobile safety, smoke-free workplaces, etc. Over this period, life expectancy at birth increased from a little above 68 years to a little less than 76 years. Non-health technologies were also wide-ranging and include the jet plane, television, superhighways, VCRs, and computers. . . .
>
> Now consider the following choice. You must forgo either the health improvements over the last half-century or the non-health improvements. That is, you must choose either (a) 1948 health conditions and 1998 non-health living standards or (b) 1998 health conditions and 1948 non-health living standards. Which would you choose? (Nordhaus 2002)

People find this question hard to answer, but Nordhaus reports more choose current health conditions than choose current non-health living standards.

Charles Jones, Professor of Economics at the University of California at Berkeley, notes, “As we get richer and richer, one of the most valuable and productive opportunities for our spending is to purchase better health and longer lives” (Jones 2005). In a paper written with Stanford University economist Robert Hall, Jones estimates that consumer preferences will continue to drive health care spending to grow at a fast rate, perhaps exceeding one-third of GDP by 2050 (Hall and Jones 2004).

Quality

While in aggregate the increased spending has increased well-being, there remains wide recognition that the current pattern of health care spending is wasteful and that it should be possible to rearrange spending in ways that would both improve health and lower costs.

Mark Chassim, professor of health policy at Mount Sinai Medical Center, contrasts successes of businesses, using the Six Sigma strategy, at improving quality, with the record in health care. Businesses using Six Sigma set a goal of reducing the rate of occurrence of errors to less than 3.4 per million opportunities. Chassim notes that the health care system routinely accepts much higher rates of error.

> If the performance of certain high-reliability industries, whose standards of excellence we take for granted, suddenly deteriorated to the level of most health care services, some astounding results would occur. At a defect rate of 20 percent, which occurs in the use of antibiotics for colds, the credit card industry would make daily mistakes on nine million transactions; banks would deposit 36 million checks in the wrong accounts every day; and deaths from airplane crashes would increase one thousandfold. (Chassim 1998)

A pair of influential reports by the Institute of Medicine (IOM), an arm of the National Academy of Sciences, put a spotlight on the issue of quality. The first of these reports, *To Err Is Human: Building a Safer Health System*, examined preventable medical errors made in hospitals, which were estimated to cause between 44,000 and 98,000 hospital deaths per year. The second report *Crossing the Quality Chasm: A New Health System for the 21st Century*, looked more broadly at the quality problem. This report reviewed more than 70 studies that documented quality shortcomings and framed the problem thusly:

> There is little doubt that the aging population and increased patient demand for new services, technologies, and drugs are contributing to the steady increase in health care expenditures, but so, too, is waste. Many types of medical errors result in the subsequent need for additional health care services to treat patients who have been harmed. A highly fragmented delivery system that largely lacks even rudimentary clinical information capabilities results in poorly designed care processes characterized by unnecessary duplication of services and long waiting times and delays. And there is substantial evidence documenting overuse of many services—services for which the potential risk of harm outweighs the potential benefits. (IOM 2001, p. 3)

Low quality care costs not only lives but also money. The treatment of heart attack victims and diabetics are widely cited examples. Most people who have had a heart attack should be on beta blockers, which reduce the rate of recurrence by about one-quarter. However only about one-quarter of heart attack survivors are on these medications (Cutler, p. 69). Nearly one-quarter of Medicare spending is on diabetics. Early treatment of diabetes can reduce by 40 percent the worst (and most expensive) complications of the disease (Halvorson and Isham, pp. xxvi and 19).

A recent study by researchers at the RAND Corporation looked at the quality of care in 12 U.S metropolitan areas, including Seattle. The researchers conducted telephone interviews and examined medical records for 6,712 people. The quality measure was based on 429 quality indicators for 30 separate medical conditions. Overall, the study found that patients received only 55 percent of recommended care. Seattle ranked highest among the 12 metropolitan areas in the study with patients receiving 59 percent of recommended care.

High quality care is not necessarily expensive care. John Wennberg, of Dartmouth University, and colleagues have documented that practice patterns vary widely across the country. In one study of Medicare patients, researchers grouped 306 U.S. hospital referral regions into quintiles, based on a measure of the average level of spending. Examining detailed patient records, they compare the quality of care and the health outcomes across these spending quintiles. Patients in the highest spending quintile receive on average about 60 percent more care than those in the lowest spending quintile. Neither quality of care nor access to care was better in the high spending regions than in low spending regions. Mortality rates were slightly higher in regions with greater spending (Fisher et al 2003a, 2003b).

Wennberg concludes that practice variations reflect three different types of errors: under-use, misuse, and overuse. Restructuring financial incentives for health care providers might reduce all three.

- Under-use of most kinds of effective care, such as the use of beta-blockers for people who have had heart attacks and screening of diabetics for early signs of retinal disease. The causes of under use include discontinuity of care (worse when more physicians are involved in the care) and lack of infrastructure to assure outreach and the timely use of these services. Pay-for-performance should lead to reduction in underuse.
- Misuse of preference-sensitive care, where treatment options involve significant tradeoffs that should be based on the patient's own values. The causes include failure to accurately

communicate the risks and benefits of the alternative treatments and the failure to base choice of treatment on the patient's opinion rather than that of others. Adjustment of economic incentives to reward adopters of shared decision making could lead to a reduction in unwarranted variation. Medical savings accounts may make patients more involved in active participation in decision making.

- Overuse of supply-sensitive care, particularly in the management of chronic illness. The causes include overdependence on acute hospital care and lack of infrastructure to support continuous management of chronically ill patients in other care settings. Hospital-specific measures profiling performance in managing chronic illness can help identify efficient providers. Pay-for-performance and related strategies to reward efficient providers and pay for infrastructure for managing chronic illness could promote reform. (Wennberg 2005)

HEALTH CARE REFORM TODAY

Reforms are proceeding today along two broad fronts. The first involves restructuring the purchase of insurance and care to make the consumer more involved in decision-making. The second aims to improve the quality of care. In this area, common strategies include publishing quality ratings of providers and practice guidelines based on research into the most effective treatments for various conditions (i.e., evidence-based medicine).

Consumer-Driven Health Care

Consumer-driven health care is an emerging broad approach to providing health benefits to employees. The goal of this approach is to involve the health care consumer more directly in decision-making at various levels.

One consumer-driven strategy pairs high deductible health insurance policies with personal accounts, such as Medical Savings Accounts, Health Reimbursement Arrangements, Flexible Spending Accounts or Health Savings Accounts, from which consumers can pay the cost of care below the deductible level. Health Savings Accounts, which passed Congress in December, 2003 (part of the legislation that established the Medicare drug benefit), are growing in popularity. Early worries that the accounts would be attractive only to the young, the wealthy, the healthy and the already insured have not materialized as problems (WashACE 2004).

High deductibles provide incentives for consumers to economize on the use of health care services below the deductible threshold. Furthermore premiums for high deductible policies are relatively low, making these policies affordable for individuals and small businesses who might not otherwise be able to purchase insurance (eHealthinsurance 2005a).

A second consumer-driven strategy focuses on the choice or design of health plans. Under such schemes employers give employees a choice from a number of plans with varying networks of providers and benefits packages. The employers' contribution towards the cost of the plan is fixed with the balance of the cost borne by the employee.

A third strategy is to provide consumers with more information on the relative benefits of the various care options that they may choose among. 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 and a 16 percent increase in preventative

care. Members enrolled in the pharmacy plan increased their use of generic medicines by nearly 13 percent (Aetna 2004).

In the early 1990s, Group Health in Seattle and Kaiser Permanente in Denver implemented a system of shared decision making that involved patients more fully in the choice between watchful waiting and surgery for enlarged prostate glands. As part of the process, patients were provided with decision aid that helped explain the relative merits of the two options. Rates of surgery fell by 40 percent, as patients chose the less aggressive treatment more frequently than they otherwise would have (Wennberg, p 12).

The National Committee for Quality Assurance

The National Committee for Quality Assurance (NCQA) is a private organization which has been accrediting managed care organizations since 1991. Thirty states use NCQA accreditation as a regulatory requirement for health plans. Many large employers also require NCQA accreditation for a plan to be offered to their employees.

NCQA has developed the Health Plan Employer Data and Information Set (HEDIS), which is used by most health plans to benchmark performance. HEDIS includes more than 60 specific performance measures. NCQA uses HEDIS data to prepare an annual State of Health Care Quality report, which gives an overall assessment of the nation's health care system. Employers and health plans compare detailed HEDIS performance measures for individual health plans through a web-accessible database called Quality Compass. The federal Centers for Medicare and Medicaid Services collect HEDIS data for Medicare managed-care plans and publishes results to the web.

The Leapfrog Group

As purchasing agent for their employees, businesses have a great stake in the health care market and collectively have undertaken efforts to improve the quality of care in a variety of ways.

On the national level, The Leapfrog Group formed in 1998 when a group of large employers came together to discuss ways that they might use their market power as purchasers of medical care to lower costs and increase quality. The group currently has more than 170 members including The Boeing Company, Microsoft, Nordstrom, Washington Mutual, and the Washington State Health Care Authority.

The group took its initial focus from the Institute of Medicine's 1999 report on preventable medical errors. Leapfrog conducts a hospital quality and safety survey to determine whether hospitals meet specific quality and safety practices (hospitals in the Seattle area were in the first group invited to participate in the survey). The results of the survey are published on the group's website. Research commissioned by Leapfrog indicated that adoption of these practices by all non-rural hospitals could save 65,341 lives with a net positive impact of $31.5–$41.5 billion per year.

Leapfrog also works with its members to develop systems of incentives and rewards that will encourage hospitals to adopt the quality and safety practices.

Local Consortiums

Businesses have also been instrumental in the formation of local consortiums of health care purchasers. The San Francisco-based Pacific Business Group on Health (PBGH) is the epitome of these local consortiums. PBGH is a business coalition of 50 health care purchasers formed in 1989. The

group's mission is to improve the quality and availability of health care while at the same time moderating costs. PBGH is a Leapfrog member.

PBGH helps its members make value based purchasing decisions to promote efficient delivery of services. It operates the Negotiating Alliance through which 17 members negotiate rates, benefits, and performance measures with health plans.

PBGH initially convened and now manages the California Cooperative Healthcare Reporting Initiative (CCHRI), a collaborative of health care purchasers, plans and providers. Using the HEDIS framework, CCHRI collects data on quality from ten health plans, which together represent 95 percent of the commercial health insurance market in the state of California. These data are summarized in an annual report that allows consumers to compare the quality provided by managed care plans. PBGH maintains a web site called Healthscope, an online guide to health plans, medical groups and hospitals.

PBGH also operates PacAdvantage, a small business purchasing group through which employers with 2 to 50 employees may obtain health insurance.

Puget Sound Health Alliance

The Puget Sound Health Alliance was formed in early 2005 under the auspices of King County Executive Ron Sims, who chairs its board of directors. Margaret Stanley recently became the Alliance's Executive Director. The members of the Alliance include public and private sector employers, health providers, health provider associations, and health plans. Business members include Starbucks, Recreational Equipment, Inc. Washington Mutual, Port Blakely Companies, Puget Sound Energy, Fisher Communication, and the Boeing Company.

The stated goals of the Alliance are to: "improve the quality of care; slow the rate of increase in health care expenditures in the Puget Sound region; improve the health outcomes for people; improve consumers' and health care professionals' ability to become partners in managing health; and ensure collaborative decision-making based on evidence." The Alliance currently envisions providing five services: a repository of clinical guidelines for providers, a repository of evidence-based health management tools for consumers, a warehouse of data on cost and quality, regional reports on cost and quality, and an information structure to support quality improvement.

The Democratic Leadership Conference's State and Local Playbook identifies "cutting medical costs by collaborating to improve health care quality" as one of 15 key "plays" and identifies the Puget Sound Health Alliance as a model initiative. (DLC 2005)

THE MARKET FOR HEALTH INSURANCE

Most people pay for health care services through health insurance plans, and for them the cost of insurance is the cost of health care. State regulations can profoundly affect the price and availability of health insurance, independent of the underlying costs of services.

Washington's health insurance market is regulated by the state through a series of mandates, which specify conditions and treatments policies must cover. A number of these mandates are legacies of the state's failed attempt to restructure the health care market through the Health Services Act of

Table 1: Health Insurance Monthly Premiums: Top 50 Cities

City	Single Male Premium	Rank	Single Female Premium	Rank	Family Premium	Rank
Albuquerque, NM	$79.04	23	$94.83	25	$422.26	9
Atlanta, GA	$77.00	26	$95.70	24	$281.40	23
Austin, TX	$112.00	12	$139.00	9	$246.65	30
Baltimore, MD	$68.55	32	$84.79	32	$248.00	29
Boston, MA	$267.57	2	$267.50	2	$767.30	1
Charlotte, NC	$107.25	14	$121.20	15	$541.85	3
Chicago, IL	$81.68	20	$107.30	18	$359.01	12
Cleveland, OH	$59.86	39	$72.98	38	$208.32	38
Colorado Springs, CO	$70.36	29	$86.59	29	$255.61	28
Columbus, OH	$52.38	50	$63.86	42	$182.28	48
Dallas, TX	$132.00	6	$163.00	5	$339.82	15
Denver, CO	$78.35	24	$96.43	23	$280.75	24
Detroit, MI	$65.00	34	$79.37	34	$226.55	34
El Paso, TX	$107.00	15	$133.00	12	$340.00	14
Fort Worth, TX	$116.00	10	$144.00	6	$328.86	16
Fresno, CA	$56.00	44	$56.00	48	$190.00	41
Honolulu, HI	$98.25	18	$98.25	21	$291.75	20
Houston, TX	$129.00	8	$165.00	4	$429.00	8
Indianapolis, IN	$81.56	21	$99.44	20	$283.84	22
Jacksonville, FI	$79.86	22	$98.01	22	$305.44	18
Kansas City, MO	$60.88	37	$75.09	35	$171.86	50
Las Vegas, NV	$100.00	17	$128.00	14	$359.00	13
Long Beach, CA	$54.00	47	$54.00	50	$180.00	49
Los Angeles, CA	$63.00	35	$63.00	43	$212.00	36
Memphis, TN	$78.01	25	$86.66	28	$263.00	27
Mesa, AZ	$53.13	49	$64.77	40	$184.88	46
Miami, FL	$132.46	5	$172.80	3	$524.18	5
Milwaukee, WI	$69.19	31	$84.87	31	$241.92	32
Minneapolis, MN	$121.00	9	$121.00	16	$529.00	4
Nashville-Davidson, TN	$70.34	30	$85.75	30	$244.78	31
New Orleans, LA	$106.59	16	$143.90	7	$400.55	11
New York, NY	$334.09	1	$334.00	1	$712.77	2
Oakland, CA	$58.00	40	$58.00	44	$190.00	41
Oklahoma City, OK	$82.35	19	$102.40	19	$297.84	19
Omaha, NE	$54.62	46	$66.59	39	$190.09	40
Philadelphia, PA	$74.08	28	$90.31	27	$265.80	26
Phoenix, AZ	$60.61	38	$73.89	37	$210.92	37
Portland, OR	$116.00	10	$116.00	17	$441.00	6
Sacramento, CA	$56.00	44	$56.00	48	$190.00	41
San Antonio, TX	$111.83	13	$139.00	9	$315.16	17
San Diego, CA	$57.00	43	$57.00	47	$199.00	39
San Francisco, CA	$58.00	40	$58.00	44	$190.00	41
San Jose, CA	$58.00	40	$58.00	44	$190.00	41
San Juan, PR	$133.10	4	$133.10	11	$284.05	21
Seattle, WA	$143.00	3	$143.00	8	$410.00	10
St. Louis, MO	$65.85	33	$80.28	33	$229.15	33
Tucson, AZ	$53.15	48	$64.77	40	$184.88	46
Tulsa, OK	$75.15	27	$93.46	26	$272.52	25
Virginia Beach, VA	$61.36	36	$74.80	36	$218.74	35
Washington, DC	$132.00	6	$132.00	13	$436.00	7

Source: eHealthinsurance

Table 2: Individual Health Insurance Monthly Premiums

State	Premium	Rank
Alabama	$173	6
Alaska	$157	11
Arizona	$153	14
Arkansas	$209	3
California	$140	21
Colorado	$120	40
Connecticut	$174	5
Delaware	$131	30
Dist. Columbia	$193	4
Florida	$148	16
Georgia	$159	10
Idaho	$162	9
Illinois	$140	21
Indiana	$125	37
Iowa	$103	45
Kansas	$128	33
Kentucky	$125	37
Louisiana	$135	25
Maryland	$166	8
Michigan	$112	43
Minnesota	$143	19
Mississippi	$131	30
Missouri	$139	22
Montana	$145	18
Nebraska	$129	32
Nevada	$155	12
New Jersey	$340	1
New Mexico	$121	39
New York	$295	2
North Carolina	$130	31
Ohio	$132	28
Oklahoma	$134	26
Oregon	$145	18
Pennsylvania	$138	24
Rhode Island	$116	41
South Carolina	$138	24
South Dakota	$124	38
Subtotal	$150	15
Tennessee	$127	34
Texas	$133	27
Utah	$114	42
Virginia	$154	13
Washington	$169	7
Wisconsin	$126	35
Wyoming	$107	44

Note: No data for Massachusetts, West Vrginia, Maine, New Hampshire, Hawaii, North Dakota or Vermont

Source: eHealthinsurance

1993 (E2SSB 5304). The 1993 reforms followed the managed competition model being developed on the national level by the Clinton administration's health care taskforce, and fell apart when the Clinton plan collapsed.

Heavy-handed regulation persisted, however, and the market for individual insurance nearly failed in the late 1990s. Though the burden of regulation has loosened somewhat, the cost of insurance in the state appears to be higher than elsewhere in the country.

It is difficult to compare the costs of insurance between states because of the wide variation in policy terms. However, data developed by eHealthinsurance, the nation's largest online health insurance brokerage indicate that insurance costs are higher in Washington than in many other states. A study released December 2004 compared the cost of a standard policy for a family of four in the 50 largest U.S. Cities. Seattle was the 10th most expensive. A study released in June 2005 compared the cost of a standard policy for individuals. Seattle was the 3rd most expensive for a 30-year old single man and the 7th most expensive for a 30-year old single woman. (See Table 1.) A third study released in October 2004 compared the average costs of policies actually purchased by individuals through the web site by state. Forty-three states were included in this comparison. The average price paid by Washington customers ranked 7th highest. (See Table 2.)

A reason that insurance costs relatively more in Washington may be the fact that the state imposes a relatively large number of mandates on insurers. The Council of Affordable Health Insurance (CAHI) estimates "mandated benefits currently increase the cost of basic health coverage from a little less than 20 percent to more than 50 percent, depending on the state." A 2002 Pricewaterhouse-Coopers study estimated that 15 percent, about $10 billion, of the increase in health insurance costs between 2001 and 2002 could be attributed to government mandates and regulation. That increased cost contributed to the inability of employers and individuals to purchase health care policies, swelling the ranks of the uninsured nationally by 1.4 million. A Galen Institute report study placed Washington with sixteen states considered the "most aggressive" in passing mandates, noting that in these states uninsured populations grew eight times faster than in the other 34 states.

A January 2005 report by CAHI ranked Washington seventh highest in the nation, with 48 separate mandates. (Bunce and Weiske 2005) In March the

legislature added a 49th, mental health parity. The bill SHB 1154 requires that insurance policies provide the same amounts and terms of coverage for mental-health services that are provided for other medical services. The requirement phases in over five years and applies only to groups of more than 50.

Some argue that mandates ultimately do not greatly raise the cost paid for insurance: Most consumers want the mandated coverages and will buy them if they are optional.

STATE SPENDING ON HEALTH CARE

In April Governor Christine Gregoire named Steven R. Hill administrator of the Washington State Health Care Authority and announced that Hill would lead a major effort to contain state spending on health. Gregoire stated clearly that she did not favor reducing the number of people served by state health-care programs, rather she hoped to restrain costs by limiting "wasteful, unnecessary and ineffective treatment." (Gregoire 2005b)

Most of the state's health expenditures are concentrated in three broad areas: employee compensation, medical assistance and the basic health plan. The Office of Financial Management (OFM) projects spending on these programs for the 2005-07 biennium will total $9.66 billion. Of this, 39 percent will come from the state general fund, and 11 percent will come from the health services account. (The health services account receives revenue from the cigarette and tobacco products taxes, insurance premiums tax, liquor, beer and cider taxes, and the B&O tax on public and not-for-profit hospitals. It also receives money from the tobacco settlement.) The remaining 50 percent of funding will come from a combination of other sources, primarily federal but also including state and local.

The $4.96 billion flowing to health expenditures from the general fund represents 17.6 percent of "near general fund" spending for 2005-07.

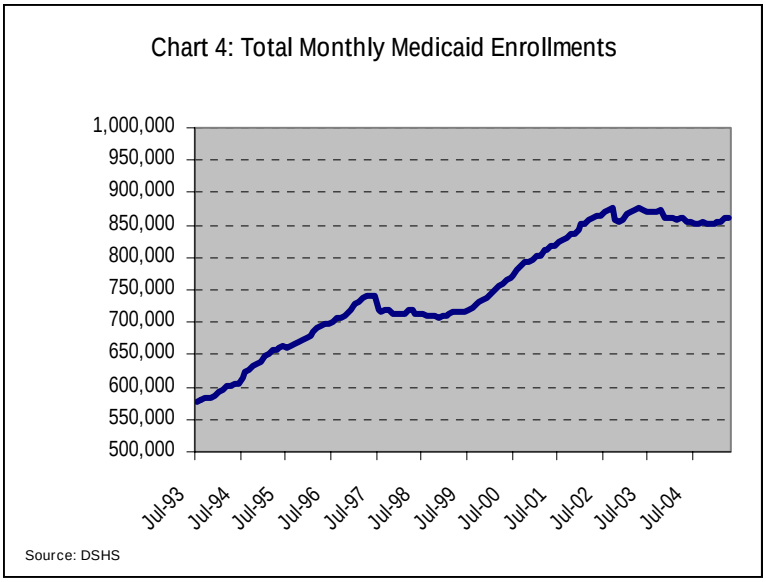
Health care costs are growing more rapidly than the revenues that are used to pay for them. Health care spending from the general fund and health services account combined is expected to grow by 16.6 percent from the 2003-05 biennium to the 2005-07 biennium. Growth rates like that crowd out other spending. OFM places the long run growth rate for general fund revenues at 10 percent per biennium assuming current rates of inflation and population growth. The rate of growth in health services account revenue is lower, 3 percent per biennium.

Employee Benefits

The state funds health benefits for its own employees and provides money to school districts to fund the health benefits of K-12 employees.

State employees receive health care benefits through the Public Employee Benefits Board (PEBB), which is responsible for designing benefits packages and setting employee contribution rates. Under the collective bargaining agreements approved by the legislature, the state is to contribute $663 per represented employee per month to PEBB in FY 2006 (a 13.4 percent increase over FY 2005) and $744 per represented employee per month in FY 2007 (a 12.2 percent increase over FY 2006). Negotiators calculated these contribution rates assuming medical cost inflation would be 11 percent per year and that employees would share 12 percent of premium costs. However, under the contract the state contribution is fixed. If health care costs grow less than the assumed 11 percent, the share of premiums paid by employees might fall.

The Legislature extended the same health benefits to state employees who are not union represented. In FY 2007 the state would provide $663 per non-represented employee per month to PEBB. In FY 2007 the state would contribute $618 per month, which PEBB would supplement with $126 per employee per month drawn from its surplus funds.

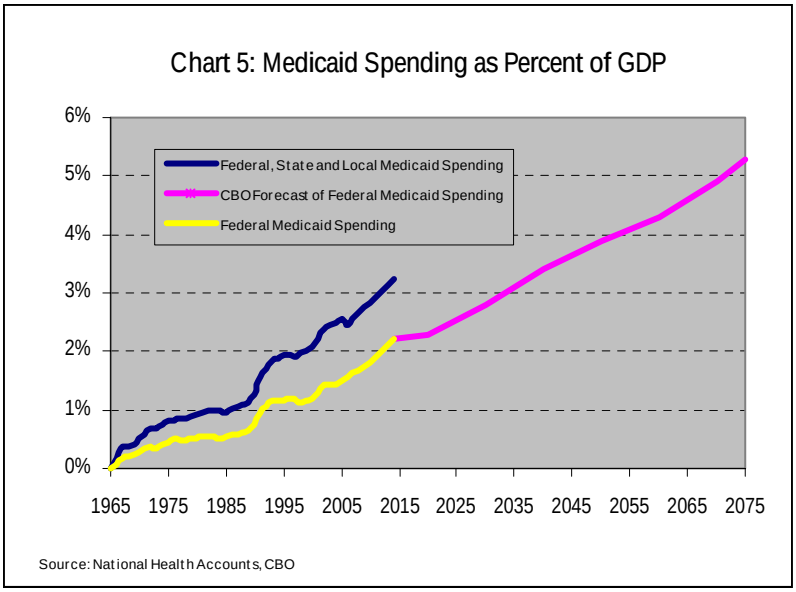


The state provides health benefit funding to school districts for K-12 employees at the average funding rate for state employees. Thus the 2005-07 budget provides to school districts $663 per employee per month in FY 2006 and $689 per employee per month in FY 2007. (The latter number is the weighted average of the funding for represented and non-represented state employees.)

PEBB currently offers state and higher education employees a choice among eight different health care plans, although not every plan is available in every county of the state. Six of the eight are managed care plans and two are PPOs. In June, 2005, 104,447 employees subscribed to a plan. (Including dependents, 220,098 individuals were covered.) Fifty-two percent of employees were in a managed care plan while 48 percent were in a PPO. The most popular managed care plan, with 34,384 subscribers, was Group Health Cooperative. The most popular PPO, with 48,835 subscribers, was the Uniform Medical Plan (UMP). UMP is a self-funded plan designed by PEBB and administered by the state Health Care Authority.

State employee health care benefits are generous; the 12 percent share of premiums paid by employees is low. A survey by the Kaiser Family Foundation and the Health Research and Educational Trust (KFF–HRET) found in 2004 the typical employee covered by employer-sponsored health insurance paid 15 percent of the cost of single coverage and 27 percent of the cost of coverage for a family of four. A Towers Perrin survey of 200 large employers found that for 2005 the average employee's share was 21 percent.

The Towers Perrin survey pegged the average monthly employer contribution per employee at $512.50 for 2005.



Medicaid/Medical Assistance/BHP

Through medical assistance and the basic health plan, the state provides health care for 955,000 low-income residents. This is 15 percent of the state's population and includes one of every three children and four of every ten pregnant women.

The Department of Social and Health Services's Medical Assistance Administration provides means-tested health care to about 855,000 Washingtonians (average monthly enrollment). For most of these enrollees, state funds are matched by federal money under the Medicaid program and for this reason medical assistance is popularly referred to as Medicaid. (Note, however, that Medi-

caid also provides federal money for other state programs, such as long-term care and developmental disabilities.) The 2005 edition of the Fiscal Survey of the States compiled by the National Association of State Budget Officers observes, “Medicaid now is the largest and fastest growing category of state spending [having surpassed elementary and secondary education in 2004] and continues to drag heavily on state budgets.”

In addition to those enrolled in medical assistance, the state provides coverage to 100,000 low income state residents through the basic health plan (BHP), administered by the health care authority. BHP premiums are subsidized, the degree of subsidy varying with income.

Nationally, medical assistance is one area where managed care remains strong (Draper et al 2004). In Washington, most medical assistance and basic health plan recipients are served through managed care plans.

Medicaid is an entitlement program. That means there are no upper limits on the commitment of federal/state resources. Once granted eligibility, beneficiaries are entitled to receive the program’s benefits. Usage and cost of services then drive the total required expenditures. States are not required to participate in Medicaid, but because it enables states to leverage federal funds to assist with the medical needs of the poor, all states have opted in. States that participate in Medicaid must cover several categories of eligible people. In addition, states have the option of extending coverage to a number of optional categories

The federal program also mandates provision of certain services, such as inpatient and outpatient hospital care, physician, laboratory and x-ray services, family planning, nurse practitioner and surgical services of a dentist. Many other services, such as prescription drugs, rehabilitation and optometric services may be provided at the state’s option. Within those broad national guidelines, each state establishes its own eligibility criteria, scope of services and rates of payment.

Conceived as a relatively Spartan program, Medicaid coverage was initially limited to doctor and hospital services for families on welfare, as well as the blind and aged who were well below the Federal Poverty Level. Eligibility for Medicaid coverage was dependent upon receipt of federally assisted income payments such as welfare or Supplemental Security Income (SSI).

That is no longer the case, and the program is no longer Spartan. In the late 1980s and throughout the 1990s, the federal government increased options and permitted expansions of coverage for Medicaid to various poverty-related groups. Particularly notable were expanded coverage for children and pregnant women. Increasing public coverage has “crowded out” private insurance. David Cutler and Jonathan Gruber estimate that half of the people added to the Medicaid rolls in the early 1990s expansion would otherwise have been covered by private insurance. (Cutler and Gruber 1996)

Washington State’s Medical Assistance Administration (MAA) has noted, “Washington eagerly grasped each opportunity and soon became a bellwether state experiencing tremendous growth in coverage, clients, and expenditures.” Over one-quarter of current enrollees in Washington need not be covered under federal rules.

As Chart 4 shows, between July 1993 and April 2005 the number of Washingtonians covered by Medical Assistance grew from 576,000 to 862,000, an increase of 50 percent. Over the same period state population grew by 18 percent.

Without changes in law, Medicaid spending will continue to grow much faster that the state's economy. Chart 5 shows estimates and forecasts of federal Medicaid spending as a share of GDP. (The forecast through 2014 was prepared by the Center for Medicare and Medicaid Services, while the forecast beyond 2014 comes from the Congressional Budget Office.) Federal spending on Medicaid is forecast to grow from 1.5 percent of GDP in 2005 to 2.2 percent of GDP in 2014 (a 50 percent increase in spending relative to GDP). Absent changes in federal or state law, Washington State spending on Medicaid as a share of gross state product should grow by 50 percent by 2014.

By 2075, CBO forecasts federal spending on Medicaid will be 5.3 percent of GDP.

Growth rates in Medicaid spending such as this are certainly not sustainable on the state level. Under the existing federal rules, the major way open for states to control spending is to throw people off of the program. In its call for Medicaid reform, the National Governors Association (NGA) NGA calls for the federal government to give to states much more flexibility:

> A new vision for cost-sharing should make Medicaid look more like [the State Children's Health Insurance Program (S-CHIP)], where states have broad discretion to establish any form of premium, deductible, or co-pay for all populations, for all services, and could make them enforceable. . . .
>
> Medicaid reform should include the ability to offer a different level of benefits, using S-CHIP as a model, to certain Medicaid beneficiaries, such as those for whom Medicaid serves as a traditional health insurance program. This discussion extends beyond the traditional distinction between "mandatory" and "optional" populations, which are arbitrary distinctions when it comes to the need for health care services. This would include an improved ability to set benefit limits and cost sharing amounts, do employer buy-in programs, eliminate retroactive eligibility periods, and establish different benefit packages for different populations or in different parts of the state. Medicaid can be improved by focusing more on improving health outcomes rather than adhering to a sometimes-arbitrary list of benefits mandates (that are often the result of effective lobbying by provider interest groups). (NGA 2005)

Beginning in 2001, the Department of Health and Social Services (DSHS) did pursue a waiver of federal regulations in order to gain more flexibility in the state Medicaid program. As originally conceived, this waiver would have allowed the state to impose co-payments for various services, to require premiums of clients with incomes above 100 percent of the federal poverty level, and to vary the package of benefits offered across optional populations. Eventually, the scope of the waiver request narrowed considerably, to the implementation of premiums for children in optional Medicaid programs. The federal government did grant this waiver. However, the state has yet to impose these premiums. In June 2004, Gov. Gary Locke postponed implementation until July 2005. Subsequently, Gov. Gregoire deferred the premiums indefinitely. (DSHS, Gregoire 2005a)

DISCUSSION AND RECOMMENDATIONS

Medical technology continues to move forward rapidly and pressure to increase health care spending will continue for the foreseeable future. This is not necessarily a bad thing, as consumers place a high value on their health. The evidence shows, however, that the quality of health care is often lower

than it could be and that higher quality would both lower spending and improve health.

A significant fraction of the nation's health care is purchased through employment-based health insurance. This puts private employers at the center of the struggle to bring efficiency to the health care market. Their recent efforts have focused on two broad strategies: consumer driven health care and purchaser consortiums for quality improvement. Both show promise.

The state is an important player in the health care market both as a regulator of the market for health insurance and as a purchaser of health care services.

The eHealthinsurance studies show that health insurance costs are relatively high in Washington. The large number of mandates that the state imposes on insurers surely contributes to this high cost. The state should permit insurers to issue a basic insurance plan that provides standard coverage, unburdened by costly and unconventional mandates.

As a major purchaser of health care, the state appropriately participates in consortia such as The Leapfrog Group and the Puget Sound Health Care Alliance. Such consortia work best when they are lead by the business sector, where the norms of quality and efficiency are strongly rooted. Government should thus participate with a light hand.

By allowing employees to select from a range of plans, the state is part way down the path to consumer-driven health care. It should move further. A larger fraction of the cost of insurance should be paid directly by employees, and high deductible policies paired with health savings accounts should be among the options offered.

Advancing technology continually richens the benefits packages under the state's medical assistance program, driving spending higher. As currently structured, the program is not sustainable.

The state should endeavor to use market forces and personal responsibility to improve health care delivery in the medical assistance system, while allowing limited state resources to do the greatest amount of good. It should support the NGA efforts to reform federal Medicaid laws so as to allow states greater flexibility in cost sharing and benefit design. Until these efforts are successful, the state should use waivers of federal regulations to experiment with cost sharing and flexible benefit designs.

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