Washington State Senate

Health Care Reform Web Dialogue

http://www.webdialogues.net/cs/wasen-healthcare-home/view/di/151?x-t=home.view

January 22 - 23, 2008

Overview

The Washington Senate Health & Long-Term Care Committee hosted a Health Care Reform web dialogue on January 22-23 2008. The comprehensive on-line conversation addressed ways to improve and reduce costs of Washington's health care system. Participants suggested ways to improve the delivery of health care with particular focus on issues of availability, affordability, and quality and choice of health care.

Senator Karen Keiser welcomed participants and encouraged them to participate in the legislative process through health care reform dialogue.

A total of 266 participants representing government, health professions, interested individuals, the media, non-governmental organizations, professional associations, and researchers registered for the discussion. Almost 330 messages were posted in response to the queries about health care reform.

Panelists

Bob Crittenden, MD, University of Washington
Karen Keiser, Senator, Chair, Senate Health & Long-Term Care Committee, Washington State Senate
Mike Kreidler, Commissioner, Office of the Insurance Commissioner
Linda Parlette, State Legislator, Washington State Senate
Cheryl Pflug, Senator, Ranking member, Senate Health & Long-Term Care Committee, Washington State Senate

Accessibility and Availability of Health Care

> *What can we do to attract more health care providers to Washington and make sure residents throughout the state have convenient access? Do we have a moral responsibility to provide a basic level of coverage to all citizens?*

Moral responsibility

> *Do we have a moral responsibility to ensure that everyone gets the health care they need?*

Arguments that recognize our moral responsibility to provide health care for everyone noted that health care is a right to life, not a privilege. Moral teaching focuses on empathic concern for fellow humans, regardless of skin color, ethnicity, or immigration status. Furthermore, as a practical consideration, by taking a holistic and preventative approach to health care, some health care problems can be solved (e.g., treating an illegal tubercular parent to protect children who are citizens). The moral responsibility conversation addressed the notion that, while individuals do have moral responsibility, governments do not--and to support free state-provided health care is to use government to force providing health care for everyone at the expense of the taxpayer. However, according to the World Health Organization's ranking of health care systems, socialized systems received top rankings, while the US ranks poorly and spends nearly three times more money than other nations. It was suggested that an honest

discussion of the costs and benefits of universal health care would reveal the dividends that could be realized. Arguments against providing universal health care cited the tax burden to pay for individuals who don't contribute, break our laws, or make poor choices (e.g., illegal immigrants, welfare recipients, meth addicts). In this view, responsibility would center on helping all underprivileged American citizens.

Participants expressed opinions about who needs universal health care. Some said that a large majority of people in need are employed middle class citizens, while others cited those most at risk are low- and moderate-income people. They make too much money for Medicaid or the Basic Health Plan but not enough to buy health insurance. One person described how the current system perpetuates poverty. Some participants noted the obligation to care for the working uninsured. Others remarked that the costs of caring for the uninsured (uncompensated care costs) are reflected in higher insurance premiums for all, as well as in the income, security, and quality of life in communities. One participant voiced concern that if Americans had free health care, they would abuse the system and ultimately destroy the economy. This reflects the view that people do not value what they have not worked for. However, another participant suggested the system, in all likelihood, would eventually be used appropriately. It was mentioned that while individuals have a moral responsibility to take care of their health (e.g., prevention, exercise, good food) and all should pay into the system, it is those who receive this money that are responsible for spending it wisely. Moreover, if we trust corporations with responsibility for health care, we are not looking at what is best for all people.

Related topics included: the means/resources and commitment to provide health care; making health care affordable through using (sliding scale) co-pays; comparative costs of administration (Medicare vs. private insurance companies); consumer health education; state administered health care for all residents; a "bare bones" basic insurance platform plus riders for additional benefits; dental hygiene for children; pharmaceutical company costs; the cost of limited access to health care; the need for tort reform; allowing the law of supply and demand to work; and using a legislature-appropriated subsidy in the current marketplace rather than setting up another government program with layers of administration.

Medicaid

How can we increase the rates we pay for Medicaid so that providers will accept Medicaid patients?

Medicaid reimbursement rates should be structured to prioritize prevention, provide health care for every person, eliminate inequities in health status, and protect people and communities from emerging health threats. Rather than increasing the money paid for Medicaid, a program of promoting health safety and education would likely reduce the number of people who use Medicaid. Furthermore, it was suggested that any person applying for State benefits (Medicaid and/or Welfare) should be required to participate in some form of birth control that social workers can track; however, such efforts are not constitutional. Other suggestions included combining the federal system with all insurance and eliminating the middlemen and monitoring cases to eliminate abuse of the system. One personal story reflected the urgent need for adequate Medicaid funding.

More providers

How can we attract more health care providers to Washington?

Participants offered many suggestions to attract more health care providers to Washington. Increase reimbursement rates so they are more in line with current community costs. Offer flexible loan repayment in exchange for a contract for services. Base primary care physician payment on management of patient interactions with other providers, time spent counseling patients, and positive outcomes as well as on services provided. Address the widening gap of income between specialists and primary care physicians. Increase Medicare/Medicaid payments. Combine the present insurance systems with Medicare/Medicaid systems so money absorbed by the insurance industry during people's prime is available at the end of their lives. Reduce the costs and administrative burdens of practicing medicine in Washington. Increase medical school enrollments and steer entrance criteria to applicants who are interested in rural and underserved areas. Expand the roles of nurse practitioners, physician's assistants, dental care professionals, and medical assistants. Concern was expressed about the Registered Nurse shortage, the need to retain hospital RNs, and focus on training more RNs.

Planning for changes to the health care delivery must be based on a new reality--that is, one in which there will be a shortage of physicians. Multiple research studies indicate alarming physician shortages are likely to occur. This is

expected to be more severe in rural areas than urban areas. A question was raised about whether adding more physicians will address the over-treatment issues or will increase the quality of care.

Portability

How can we make health care coverage portable when people change employers?

One participant suggested the cure for the portability issue (as well as the access and cost issues) is to provide universal health coverage (not insurance). This could be achieved through a single payer non-profit healthcare system (e.g., per US House Resolution 676 and modified for Washington) that would establish private delivery of services with a single payment of services through the federal government. By uncoupling insurance from our current employment based system, the question of portability becomes moot. Participants cited various benefits of portability: freedom to change jobs without fear of losing coverage as well as support for entrepreneurship, part-time work, and early retirement. Concern was voiced about establishing a universal health care system when current government programs (Medicare, Medicaid) only pay fifty cents on the dollar for services and rely on the private sector to pay the rest.

Other topics of note were presented. One participant mentioned the importance of designing health coverage that encourages people to avoid self-destructive habits, since over 60 percent of claims can be traced to lifestyle decisions. Participants discussed the pros and cons of individual and group insurance plans; employer demands for employee medical treatment; and the need to provide domestic partner rights. While various options for insurance are currently available when leaving a job (e.g., COBRA, individual plans, Basic Health Plan), the issue of plan discrepancy between group and individual plans is a tough problem. Another participant indicated the portability issue could be solved if individuals/families had access to a competitive insurance market for either individual policies or association health plans.

Accessible

How can we make health care more accessible?

A definition of "accessibility" was posited as "availability," as in, access to affordable health care that is available through an employer. Some participants noted that while insurance is accessible, necessary coverage might not be available, for example, coverage for special needs, colonoscopies, or alternative practitioners. One participant suggested restructuring the system so that the mechanism for reimbursement (e.g., Medicaid, Medicare) does not drive what and how care is provided. Currently, access to care is inequitable for people on public insurance. One suggestion included placing Medicaid-eligible people in a group plan structure paid for by State allocated funds (from Medicare federally-mandated matching funds). Participants debated whether insurance or individuals should pay for prevention and wellness exams (basic maintenance) that offer long-term cost savings and improved health.

Access to health resources in rural areas should include enhancing technologies for information sharing so rural health care providers can access the same resources as providers in urban areas. One participant asked if telemedicine/telehealth could be utilized as a delivery tool to rural communities. Access to universal health coverage should include strategies for holding down costs (e.g., administrative costs, end of life coverage) that do not short circuit innovation in health care. Several participants noted the importance of access to dental care. Another contributor would like to see outpatient physical therapy, occupation therapy, and speech language pathology services provided by the Basic Health Plan.

One participant suggested two tiers of accessibility, one for catastrophic insurance, and another for preventive or low level medical care. A proposal is before the legislature (SB 6603 and HB 2640) that would guarantee all Washingtonians access to catastrophic and preventive care. A question was asked about whether the Washington Health Partnership (SB 6221) would improve accessibility. In response, one participant mentioned it would cut down administration costs, but it would not go far enough.

Affordability of Health Care

Health care is costing all of us more each year. Why is health care becoming so unaffordable and what can we do about it? What are the root causes for the high costs of health care?

Cost drivers

Why are health care costs rising faster than inflation?

Participants identified many factors that drive up health care costs: prescription drugs; drug advertising on television; increased use of expensive healthcare services; insurance companies; inefficiencies in the health care system (e.g., the system is not market driven); malpractice premiums and lawsuits; mandated benefits; health insurance that encourages physicians to create prices to maximize their insurance reimbursements; an aging population with more chronic diseases, obesity, and diabetes; end-of-life care; patient use of emergency rooms rather than clinics for not emergent care; and lack of patient education. Furthermore, medical insurance should be about asset protection rather than first dollar benefits--it should be used for catastrophic illnesses. It's inefficient to use insurance to cover routine low-cost primary and preventive care with its associated high administrative costs.

Participants debated costs and benefits of universal health care. One noted that whatever system is chosen, several factors need to be considered: personal responsibility, the global context, rewards for preventive care, tort reform, universal payment, and linking service/quality to provider remuneration. One participant mentioned the need for transparency so people know and understand the cost of care and can shop around. Related topics included: health savings accounts, catastrophic policies, connecting consumers to the cost of their care, and the Japanese health care system.

Administration

Approximately 30 percent of each health care dollar goes to administrative costs. How can we reduce that percentage?

The reasons for high administrative costs are well documented in peer-reviewed scientific journals and numerous credible studies. One 2005 report identified $29.255 billion in savings that would have been realized through a California Single Payer insurance system (SB 840) in 2006 by reducing insurer, hospital, and physician administration; implementing bulk purchasing of prescription drugs and medical equipment; increasing primary care; and reducing provider fraud. One participant noted unnecessary health care dollars dedicated to huge executive salaries, profits to investors not involved in health care, payments for carrier fraud, and a large percentage of premiums spent on avoiding insuring people likely to need care and denying payment for care after it is given.

A study of administrative expenses in the Washington health care system is available through the Insurance Commissioner's office. The next step is to generate savings by streamlining administrative expenses.

Forms and records

Is it possible to standardize forms and use electronic medical records?

Participants noted the inevitability of converting to electronic medical records. They will increase the ability of physicians and hospitals to give good care, as well as save huge amounts of money (e.g., by avoiding ordering duplicate tests). Concerns were voiced about potential HIPPA problems and misuse of personal health information by employers and health and life insurance companies.

Affordability

How can we make health care more affordable?

Participants offered several, sometimes conflicting, suggestions to make health care more affordable. Eliminate the insurance/investor middlemen and the poor quality drug research. Fund the system through employee deductions and join it with Social Security, Medicaid, and Medicare. Save the money collected by the insurance industry in the prime of people's lives for the care needed at the end of their lives. Figure out a way to offer individuals a "group" policy that is maintained by the insurance company and the state as a joint venture. Eliminate mandatory benefits. Reduce doctors' costs of being in business (e.g., malpractice reform). Make people more accountable for their actions and lifestyle. Cultivate more competition in health insurance. Address medical research corruption. Open Washington Basic Health to all residents and make private insurers offer a basic set of services on a par with Washington Basic Health. Require private insurers to give policies to any person regardless of health history without excessive penalties. Eliminate coverage for treatments that are not core to the system (e.g., contraceptives, mental health coverage), or, conversely, provide contraceptives and mental health coverage to reduce the future burden of unwanted children with mental disorders. Provide preventive dental health services. Consider a basic plan with incentives for using a primary care provider and dis-incentives for using the emergency room. Pay providers

according to the effectiveness of the treatments, without causing them to avoid the patients who are most medically challenged.

One suggestion to make health care more affordable included, in part, putting all residents in the same risk pool and having a quality-of-care competition among health care professionals. An independent non-profit financing fund/trust will collect (sliding scale) premiums from people and businesses. Have fee-for-service reimbursement for outpatient services and affordable percent-of-fee co-payments to control utilization. If consumers find the need and quality worthwhile, they will pay. A question was asked about whether the Washington Health Partnership (SB 6221) would improve affordability. The response was favorable. One individual offered considerable documentation for applying "lean process improvement methodology" to the health care field.

Quality and Choice of Health Care Coverage

Are we getting the right kind of care? Can we increase competition without jeopardizing the quality of service?

Prevention

How can we improve preventative treatment?

Suggestions for improving preventative treatments started with prioritizing prevention: providing preventive health care services and funding the existing universal prevention services system--public health. Fully fund the recommendations from the Joint Select Committee on Public Health Financing (4410 report). Add preventative oral health services to medical care (e.g., oral cancer exams, periodontal cleaning, fluoride treatments). Require honesty in the medical system and related research. Recognize that prevention means something different to medical doctors (e.g., vaccinations, pap smears) and alternative care providers (e.g., evaluating a person before symptoms appear, identifying signs that point to a coming disease, and providing treatments). Given this, allow patients twelve visits per year to the practitioner of their choice. Provide both patient education (re personal behavioral choices) and physician education. Create a mindset that individuals are responsible for their health and can affect it (e.g., make whole, natural foods less expensive and tax fast-foods). Utilize the schools to intervene and help obese children. Offer incentives to physicians to keep their patients well and value non-technological and non-drug means to keep people healthy.

Chronic care

How can we improve chronic care management?

Participants offered ideas for improving chronic care management. Provide better rehab facilities for people with chronic conditions who are moved out of hospitals. Base care on needs rather than "days." Provide skilled home health care to provide people with a better quality of life. To determine care needs, one must ask questions regarding history and symptoms (e.g., porphyrias). Offer psychological services related to coping with chronic pain and/or other psychological issues that are often related to this.

Right treatment

It has been reported that 50 percent of treatment is unnecessary. How can we make sure that people get the right treatment?

To receive the right treatment, first people need access to affordable care from a medical professional. Second, they need physicians who have time to listen to them describe their symptoms. Furthermore, hospital and physician groups with higher numbers of generalists have higher quality outcomes--having more generalists means less unnecessary care and better coordination of care. Discourage physicians from being influenced by pharmaceutical representatives. It was mentioned that many unnecessary treatments come in the form of CYA medicine (e.g., an MRI for insurance purposes). This could be mitigated by eliminating the hoops doctors must clear and through tort reform.

Bad doctors

How can we weed out the small percentage of bad doctors?

To weed out the small percentage of bad doctors, participants contributed several ideas. Share reports of incompetence among state medical associations. Attempt to rectify the situation through retraining. Have complaints against doctors reviewed by peers. Give this review board the power to revoke a doctor's license to practice.

In-home care

How can we improve in-home care?

To improve in-home care, make this care and coverage a goal of the Medicaid/Medicare program. Also, allow family members to temporarily check patients into qualified nursing homes or receive an agency's help and receive reimbursement according to the patient's income level. Tie payment to the cost-of-living index so reimbursement allows companies providing caregivers to remain competitive. This is particularly critical for Private Duty Nurses and Agency nurses who provide medically intensive home health care.

Nursing homes & assisted living

How can we improve nursing home and assisted living care?

Suggestions to improve nursing home and assisted living care included rotating student nurses through the facility to supplement the care. Additionally, students could perform community service as part of their training and receive academic credits in the humanities. Provide proper oral hygiene and education to residents. Increase wages for nursing home employees.

Hospitals & clinics

How can we improve Washington's hospitals and clinics?

To improve care in hospitals and clinics, recruit and train a workforce that accurately reflects the populations that seek care. This means health care professionals who can culturally, linguistically, and economically relate to the patient population.

Benefit administration

How can we improve the administration of health care benefits?

A question related to skyrocketing healthcare costs was raised about holding companies and corporations, which receive big tax incentives for medical research or job creation, accountable for those consumer-based monies earned. A question was asked about whether the Washington Health Partnership (SB 6221) would reduce administrative costs. The response noted concern about the Networks, which would and could look like the Managed Care Networks of the 1990s that went broke. Furthermore, the premiums appeared to be higher than what people currently pay.

Other countries/states

How does Washington's health care system compare to other countries or states?

One participant cited a situation in Wisconsin where more information about a pharmaceutical was provided than in Washington. It was also noted that the state-run health care system in Canada is seen by some as a system of rationing and by others as preferable to the US system. In Australia, a dual system provides Medicaid for all and private insurance for additional service. A participant explained how autistic children are not receiving the top treatments for recovering from autism that are being used in 17 other states. A suggestion was made to slow down, give things times to heal, and try less expensive modalities, rather than rush to surgery and expensive drugs. One participant reported on the variability of health systems among countries: some (e.g., Great Britain) have socialized medicine where the government employs the medical providers; others (e.g., Germany) have a private delivery system funded by the government. A few (e.g., Switzerland and Netherlands) have a role for private insurance. All of these countries have universal or near-universal coverage and spend significantly less per capita than the U.S. Another participant mentioned countries (Latvia, Lithuania, Russia) that are trying to create a private system because the national system is broken.

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While these summaries contain highlights from participants' contributions, far more comprehensive information is available in the individual messages.

Thanks to all the enthusiastic participants and panelists!

Sally Hedman
Summarizer