Blue Ribbon Commission
On Health Care
Costs and Access

Proposals
Submitted by Stakeholders

Received as of
September 5, 2006

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Tab 1

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August 31, 2006

MEMORANDUM FOR: Hcca_brc@leg.wa.gov

FROM: K. Clark Stevenson, President
ABLEN Consulting
Chief Principal and Project Manager

SUBJECT: Response to RFP – Blue Ribbon Commission on Health Care Costs & Access – Due September 1, 2006 via e-mail

Question 1: What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Heath Care Costs and access? Briefly summarize your proposal.

After reviewing the Washington State Health Commission's information, it appears the proposals being sought are to increase access to health via increasing access to health insurance and quality of care. There is some data to suggest that improving diversity and cultural competency may increase access and quality. However, what appears to be lacking is a positive correlation between improving access/quality and improving competency.

ABLEN Consulting proposes providing cultural competency training to the executive group in the State to better prepare them to understand and navigate the waters as they develop and implement strategies. They will need to be effective cultural brokers in order to make a difference in a project of this scope. Given your parameters, the logical first step seems to be the design and conduct of a "jump-start" type of training program.

This can be a weekend retreat, or a week-long event that focuses on the issues of culture, diversity, access, care and quality. Once trained, the group will be better positioned to select effective strategies and interventions.

Question 2: How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

ABLEN Q represents the partnership between ABLEN and CapacityWare™ and the QWLC Organization Change System to provide change agent technologies fitted together forming a powerful and expanding set of capacity recovery and development techniques. The advantage to the organization is in the speed and staying power of change designs that are available for application to achieve established goals. The CapacityWare™ Practitioner International Network (CWPIN) provides a 21st century development tool – RGB a cornerstone technology – that links directly to other related concepts adding strength to the fabric of organizational capacity. (Visit www.LTODI.org "click" on CWPIN for more information.)

RGB technology is a new millennium tool used to create an "ideal" worklife capacity in complex organizations. The RGB is easier and more quickly adopted into the language and work patterns of a broader range of workers than any other technology in use today. It takes a highly complex condition and makes it simple to understand and use.

Question 3: Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.

ABLEN Consulting's professional consortium of associates and subcontractors brings over 350 years of professional, technical, or legal experiences in relevant areas. We become a tailored cross-functional team to successfully perform the scope of services required by individual contracts. ABLEN's diverse project teams demonstrate a commitment and leadership philosophy that values the full utilization of all members and respects their contributions. Members of the CWPIN are scheduled to provide the retreat and cultural competency training. Kitty Clark Stevenson, President, ABLEN Consulting is the chief principal responsible for the full project performance, quality and administrative control. (Visit www.ablenconsulting.com for more information.)

For this project, staffing includes adding members of the medical and health care profession. Specifically, Vincent E. Schuyler, Director, Transition Services, Program Director, District of Columbia Partnership to Improve Children's Healthcare Quality (DC-PICHQ); Sara Evans, MD, FAAPMR, Chief of Pediatric Rehabilitation, Children's National Medical Center (CNMC); Patricia O'Berry, RN, BSN, CSN, Clinical Coordinator, Division of Pediatric Rehabilitation, CNMC; and Joyce Brooks, NSW, Chief, Children's Bureau, Maternal and Family Health Administration, District of Columbia Department of Health. Mr. Schuyler coordinates and directs programs that provide access to quality healthcare, government or grant-funded services to low-income families, and self-sufficiency programs or transition services. He is also a principal lead on the project.

> The National Center for Cultural Competency at Georgetown University provides the best information on diversity and healthcare, and their information and resources will be used (http://www11.georgetown.edu/research/gucchd/nccc/index.html).

QWLC uses RGB technology and CapacityWare™ within the City of Hampton, Virginia, the Department of Transportation, Commonwealth of Virginia, and various healthcare organizations. The lessons learned within these public- and private-sector organizations will help guide efforts designed for Washington State. For example, the Cultural Capacity Development System includes the proprietary software. The QWLC niche includes large organizations that constitute a community infrastructure, such as government, public education, health care, and industry.

> Cultural Capacity. An organization's cultural capacity is high when it is able to find and fix problems that adversely impact performance, innovation, effectiveness, efficiency, and profitability.

This system is predicated more on the development of relationships required to get the work of the organization done successfully than on the formal structure of the organization.

Question 4: Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?

Costs will be imposed on government funding, limited to the length of the Cultural Competency and CapacityWare™ training events. Because the focus is on "developing relationships" to get the work done, final costs depend upon how many "retreats" or week-long events contracted.

Generally, however, full day (8 hours, including lunch and breaks) retreats start at $2,200 per day. The size of the group usually is under 40 participants. At a minimum, retreats are more successful if 1-1/2 days are scheduled, or $3,300. Travel, transportation, and per diem costs for a 4-member team, per retreat, are also necessary.

Question 5: How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

The identification of stakeholders is a first priority, tapping into those networks already established. We have extensive experience succeeding within the domain of an organization considering: industry, organization form, geographic location, and organizational neighbors.

Question 6: What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

There are three (3) major obstacles – location, stakeholders network presently non-existent, and proposal focusing on executive leadership "jump-start" training.

State leaders and legislators would object to using a company headquarters outside the State. However, professional affiliations and 21st century technology both aid in minimizing or eliminating the effects of this obstacle. In fact, the Blue Ribbon Commission led the way by obtaining information and research from across the country.

Stakeholders already established and familiar with RFP respondents already involved in the work of the Blue Ribbon Commission or related programs within Washington State would be hesitant to start over with a new group. However, we have extensive experience in working with diverse and divergent groups using proven interactive and adult learning model techniques to impart information and knowledge about our work, methodology, technology, and competence.

Finally, because our focus is on executive leadership cultural competency training and cultural capacity supported by software and technology, it may not be viewed as a priority by the decision makers. However, we know that preparing executives to understand and navigate the waters of change associated with this crucial healthcare initiative creates the foundational platform from which all strategies can be successfully launched. QWLC's Cultural Capacity Development System seeks to combine stabilizing potential of cause and effect with the reality of uncertainty. It advances courses of action that have a more-than-even chance of success in altering the current culture toward greater capacity, while acknowledging the probability of an acceptable trade-off at each alternative.

Thank you for the opportunity to respond. Your work for the citizens of Washington State is important and necessary. Our best wishes for great success.

Additional information, to schedule a CapacityWare™ demonstration, and all inquiries should be directed to: Kitty Clark Stevenson, President, ABLEN Consulting, 703.521.8600, 703.521.8601 (FAX), or e-mail at: K_Clark@ablenconsulting.com.

Tab 2

Washington State
Blue Ribbon Commission

on Health Care Costs and Access

PROPOSAL

Accounting For Health

& The Shared Care Plan

PERSONAL HEALTH RECORD

Engaging individuals & communities –
motivating sustained healthy living.

September 2006

Prevention & Personal Health Records For All Washingtonians by 2012!

"An ounce of prevention is worth a pound of cure."
–Benjamin Franklin

What would Old Ben Franklin say if he knew the health care system of the 21st Century spent over 90% of healthcare dollars on the treatment of illness, rather than on its prevention?

He might identify our current system approach as the primary cause of our poor health and out of control increases in health spending.

A significant transformation, from our current treatment approach to a new proactive prevention approach, must occur in order to avoid this impending social-economic health care catastrophe. Our stewardship as health leaders is to stand accountable for the health of our people. Our challenge is to take the necessary actions that will lead to the achievement of ideal health results. We possess the awesome potential to lead our state to become *The Healthiest State in the Nation* and lead our nation to become *The Healthiest Nation in the World*!

To succeed requires the engagement of individuals and communities in evidence-based prevention and intervention! ***Accounting For Health*** is a model approach for engaging people in prevention and sustaining healthy living! ***The Shared Care Plan*** is a personal health record & self-management care plan that connects patients, providers, & payors!

Accounting For Health

A unique web-based health challenge
that tracks participant's health results,
shares these results publicly,
and without dictating behavior –
motivates sustained healthy living.

Engaging individuals & communities
in evidence-based prevention & intervention.

EXAMPLE OF HOW IT WORKS: In June 2006 the following Accounting For Health Report was sent to all households in Garfield County – just imagine how this might affect your community and our entire state!

Initial Results Enclosed!

BMI - Body Mass Index

Blood Pressure

Cholesterol

Special Thanks to Congresswomen Cathy McMorris and her staff!

Accounting For Health

2006 Initial Health Assessment Results*

IDEAL RANGE (highlighted GOLD):		18.5 - 25		<=120 <=80	<200 >=40 <100			<150	<100
Participant		Body Mass Index		Blood Pressure	Cholesterol			Tri-glycer-ides	Glucose-Blood Sugar
ID	(alphebetical or by ID if anonymous)	BMI	Weight	(Systolic /Diastolic)	Total	HDL - Good	LDL - Bad		
258	APPEL, PATTY H	28.6	177	125 / 77	226	58	121	232	101
245	BAGA, ANDREW N	30.2	210	118 / 78	222	43	115	323	81
23	BARTLOW, JERRY E	30.1	245	130 / 98	174	47	105	108	98
19	BARTLOW, DEBBIE	22.7	134	98 / 62	159	53	84	110	89
29	BECKER, MARGARET A	24.9	134	140 / 67	205	41	131	163	83
40	BOWLES, SUSIE L	31.1	178	110 / 80	192	80	100	61	92
44	BRAGG, TAMMI M	24.9	160	126 / 70	192	36	139	84	89
261	BROWN, STEVEN L	31.6	200	113 / 77	364	47	240	387	92
247	BURI, DAVID W	26.5	229	158 / 90	281	41	158	482	100
300	BURI, BECKY C	20.9	145	119 / 74	159	55	90	67	96
49	BYE, TORANCE D	24.6	178	108 / 80	174	62	101	40	94

⇕ Condensed ⇕

326	Annonymous	29.2	162	127 / 92	241	49	162	153	92
327	Annonymous	33.4	188	155 / 81	216	64	125	140	87
329	Annonymous	19.5	140	117 / 79	149	75	66	45	59
330	Annonymous	20.0	131	102 / 78	171	44	115	60	87
331	Annonymous	30.3	193	120 / 90	218	54	134	145	93

⇕ Condensed ⇕

**These results are not intended to diagnose, treat or prevent health related conditions or illness - please consult a primary care provider for interpretation of or to guide decision making based on the above health assessment results. Garfield County Hosptial District and Accounting For Health are hereby held harmless related to your use of this and other information received from Accounting For Health.*

SUMMARY OF IHA RESULTS:

22% of participant's BMI within ideal
25% of participant's BLOOD PRESSURE within ideal
20% of participant's CHOLESTEROL within ideal
OVERALL: Less than **5%** of participants are "Ideal" in ALL measures.

Next steps include:

- Monthly Reporting of updated weight & blood pressure (each month)
- Comprehensive Physical Exam by a Primary Care Provider (by Dec 31, 2006)
- Final Health Assessment (Jan – Mar 2007)

ACCOUNTING FOR HEALTH MISSION SUMMARY

- **Web-based health challenge** – Simple, public, and results focused; Accounting For Health harnesses the power of information technology. There is no other health challenge like Accounting For Health.
- **Tracking participant's health results** – Participants complete a results focused health assessment, which focuses on four universally relevant measures – **Body Mass Index, Blood Pressure, Cholesterol, & Glucose**. These simple results are applicable to all, cost almost nothing to measure, and constitute the primary poor health conditions in society – namely, obesity, cardiovascular disease & illness, and diabetes. Accounting For Health focuses on key health results.
- **Sharing these results publicly** – Based on the principle that accountability and consequences motivate, Accounting For Health, publicly displays all participants' health results! Participant's authorize this disclosure at the time of enrollment, and choose whether to have their name displayed with their results or to remain anonymous using an assigned ID. These results are shared publicly at www.AccountingForHealth.org!
- **Without dictating behavior** – Another unique characteristic of the challenge is that participants are free to choose their own behavior. Accounting For Health does not dictate how or how much to eat or exercise. Each participant, with the guidance of their primary care provider, is responsible (or able to choose their response) to their health results.
- **Motivating sustained healthy living** – the natural results of this approach is health improvement. Participants are motivated through sound health information, delivered in real-time, meaningful, publicly accountable ways, and evidence-based primary care prevention & intervention resulting in people taking charge of their health and choosing healthy living!

THE CHALLENGE (Participation Steps)

- **Annual Health Assessment** – During this 10 minute assessment the following results are measured:
    - BMI – Body Mass Index (weight & height)
    - BP – Blood Pressure
    - CHOL – Cholesterol (the good, bad, and the total)
    - GLUC – Glucose (blood sugar).

    Participants receive a report card comparing their results to the ideal range.
- **Annual Comprehensive Physical Exam**– This exam, completed by a primary care provider, includes a review of the above assessment report card, complete health history, general multi-system examination, and consultation based on all information gathered.
- **Monthly Measurement** – Each month participants submit their updated weight & blood pressure results. Participants immediately receive a progress report comparing these results to their annual assessment results and the ideal range.

What Is the Shared Care Plan?

The Shared Care Plan is a free, easy-to-use, personal health record that lets you organize and store vital health information. You can share this information with your family, physicians and others you feel should have access to this information.
The Shared Care Plan is also much more — it is a self-management care plan, improving your understanding of your own health. It can help you manage chronic conditions, coordinate the care of others, and improve your health. Whether you are living with a chronic condition or are a healthy athlete, the Shared Care Plan can benefit you.

A Personal Health Record

The Shared Care Plan is a place for you to organize and store all of your health information in one place. Some of the information you can track in the Shared Care Plan includes:

- Medications both past and present
- Allergies, reactions, and drug-interactions
- Diagnoses and immunizations
- Hospitalizations, surgeries, and procedures
- Health indicators such as blood pressure, cholesterol, and blood sugars

Coordinating Your Health Care

Your Care Team is the group of people and organizations that you feel play an important role in your health care, such as medical providers, pharmacies, family members, or social workers. You identify this Care Team in your Shared Care Plan, making it easier to share your preferences and health care information with those involved in your care.

Printing out the Shared Care Plan and bringing it to your appointment can improve your conversations with your doctors. Additionally, if you are a family member coordinating care for a loved one, the Shared Care Plan can offer you help with tracking, understanding and communicating health care issues.

IMPLEMENTATION PLAN

Accounting For Health and The Shared Care Plan will engage individuals and communities through a phased, targeted marketing approach to employers and health plans beginning with rural public hospital districts throughout the state. Plans are being finalized to spread to 10 rural hospital districts starting January 2007! These hospitals will be hosting sites as the challenge spreads to their respective communities!

Once the results of these efforts are apparent, we will encourage other employers, insurers, and communities to join the challenge.

IMPACT ON ACHIEVEMENT OF COMMISSION VISION

Access to evidence-based prevention and intervention will be available to all who choose to participate by connecting patients to primary care providers. For many this will become a life-long 'health home' for coordinating care.

Health outcomes (Quality) will dramatically improve using evidence-based prevention and intervention. Once engaged, participants begin to choose healthy behaviors; they seek out education and training on healthy living, and good choices are rewarded continuously with improved and sustained health results.

A study completed in 2003 by the U.S. Department of Health and Human Services titled, *Prevention Makes Common "Cents"*, found significant returns on investments for health promotion and disease management programs, ranging from $1.49 to $4.91 in benefits for every dollar spent on these programs. More recent studies indicate ten fold returns on investments using health information technologies.

"So many of our health problems can be avoided through diet, exercise and making sure we take care of ourselves. By promoting healthy lifestyles, we can improve the quality of life for all Americans, and reduce health care costs dramatically."

Tommy G. Thompson, Former DHHS Secretary

OTHER SIMILAR PROGRAMS & POLICIES

Other health and wellness programs track similar measures, but no other effectively holds participants accountable to their health results like Accounting For Health. PHRs or Personal Health Records are beginning to become more available to the general public. The primary challenge PHRs face is usability by patients and compatibility with existing provider EMRs or Electronic Medical Records. Using advance security and database technology, The Shared Care Plan, has created a patient-friendly PHR which is capable of interfacing with EMRs to share important medical records information.

Together, the two programs become a tool which effectively engages individuals and communities in evidence-based prevention and intervention achieving optimal health outcomes!

COSTS

Using a phased implementation approach, beginning in 2007, the primary costs will include administrative staff expenses ($90,000/yr) and web-site maintenance costs (approximately $18,000).

Sustained funding for these administrative expenses are expected to come from employers and health plans as a result of the savings they will experience from the program. The 10 rural hospitals, with approximately 1,500 plan members, will contribute through monthly insurance premiums.

Again, "An ounce of prevention is worth…" – hopefully, 100's of millions of dollars in reduced health care costs! In addition to improved physical & mental health, financial health will be achieved by employers, health plans, providers, and Washingtonians across the state!

COLLABORATION

Transformation doesn't happen without teamwork! In 2005 **Washington Health Foundation** through the Healthiest State in the Nation campaign, awarded **Garfield County Hospital District** $50,000 to continue the development of Accounting For Health and spread the challenge countywide. **Foundation Northwest** awarded funding which made it possible to cover all non-covered charges to the 350+ participants for their Comprehensive Physical Exams! The **Department of Health's Washington State Collaborative(s)** program has contributed knowledge, technical skill, and tireless encouragement! (This program is fantastic and absolutely worthwhile!) The **National Rural Health Association &** local **WRHA** has been a tool for sharing our success with other rural communities. **Pomeroy School District** participated in the first Accounting For Health Pedometer Challenge in the **Governor's Health Bowl 2005**! **Western States Insurance** conceived the idea to promote Accounting For Health as a wellness program through the innovative **AWPHD's Insurance Trust**. Our local representatives have supported our success – **WA Rep. David Buri and his wife Becky** are stalwart participants, **WA Senator Mark Schoesler** just joined the challenge, & **Congresswomen Cathy McMorris and her staff** have championed our initiative from day 1!

All commission members and staff are invited to join Accounting For Health and create a Shared Care Plan. **WA Rep. Bill Hinkle** completed his health assessment last week – feel free to ask him any questions you may have regarding his experience!

CONCLUSION

Let us collectively remember - Our stewardship as health leaders is to stand accountable for the health of our people. Our challenge is to take the necessary actions that will lead to the achievement of ideal health results. We possess the awesome potential to lead our state to become *The Healthiest State in the Nation* and lead our nation to become *The Healthiest Nation in the World*!

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Tab 3

Improving Health Care Access to the Uninsured: America's Health Insurance Plans Principles*

- ☑ When looking for solutions to provide access to the 43 million Americans that are uninsured, AHIP believes any viable approach must build on the strengths of the present employer-based health care system. This, however, requires a state regulatory environment that does not impose unduly restrictive laws and regulations that inhibit health insurance plans from developing innovative and cost-effective products.

- ☑ AHIP believes quality is a key component to creating an affordable health care system conducive to increasing access to the uninsured. This can be accomplished by maximizing cost savings that can be achieved through making evidence-based medicine the standard for health care, advancing quality and transparency to improve outcomes, eliminating errors, and helping consumers make informed health care choices.

- ☑ History has demonstrated that there is no one-size-fits-all solution to the problem of the uninsured. AHIP believes what is needed is a multi-faceted, multi-dimensional approach that accounts for the specific needs and unique characteristics of each segment of the uninsured population. AHIP endorses a range of strategies that will extend access to care to all uninsured Americans including:
  - Providing access to health care for lower-income through tax credits to help subsidize provided employer-sponsored coverage and to small employers to offset the cost of providing coverage to such individuals;
  - Encouraging younger Americans to seek and maintain health coverage through flexible health insurance coverage offerings such as tax-advantaged HSAs in conjunction with any type of health plan that the company selects, not only high deductible health plans;
  - Intensifying efforts to cover adults and children eligible for but not enrolled in public programs;
  - Creating "high risk" purchasing pools to cover uninsured individuals with especially high health costs;
  - Providing access through public programs for Americans living below poverty by giving states the option of expanding Medicaid and SCHIP coverage to provide health insurance to all individuals with incomes below 100% of poverty; and
  - Providing access through public financing of private health coverage for Americans living near poverty by: (1) encouraging states to subsidize either employer-sponsored or individual insurance premiums for this population; (2) providing additional support to safety net providers that provide access to basic health care services this population; and (3) giving states significant flexibility with regard to coverage, benefits and program structure.

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* Based on America's Health Insurance Plans Board of Directors 2004 Statement *A Commitment to Improve Health Care Quality, Access, and Affordability*.

Tab 4

Schaff, Randi

From: Elizabeth Lemire [Elizabeth@anchormedicalclinic.com]
Sent: Friday, September 01, 2006 11:48 AM
To: Blue Ribbon Commission on Health Care Costs and Access
Subject: Proposal for the Blue Ribbon Commission on Health Care Costs & Access
Attachments: Blue Ribbon Commission RFP.3.doc

Commission Members:

Anchor Medical Clinic, a private retainer model physician office, is forwarding this proposal for a pilot project. Much of what is included in this project is currently in place already being done. We feel the data and experience from this project will add to the body of knowledge and experience of the work the commission has been tasked to accomplish.

Please send all responses to Elizabeth Lemire at elizabeth@anchormedicalclinic.com. , or contact us at 425 347-1666 M-F between 9 AM and 5 PM.

We look forward to working with you to build a healthier Washington.

Respectfully Yours,

Heidi S. Rendall, MD
Elizabeth Lemire, RN, MBA

Washington State Blue Ribbon Commission On Health Care Costs and Access

REQUEST FOR PROPOSAL
September 1, 2006

Heidi S. Rendall, MD

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Executive Summary

1. This proposal creates an effective and efficient link between the High Deductible-Catastrophic Health Plan (HDCP) with a Health Savings Account (HSA) and a Retainer Fee Primary Care Medical Practice (RF). Placed in a partnership they provide a vehicle for a consumer driven health delivery system by creating and enhancing a consumer and physician relationship where the financial incentive is to provide prevention-focused primary care and efficient and effective diagnosis and treatment of illnesses and conditions. Yet, catastrophic coverage is available, if needed for illness or injuries. This coverage combined, can, depending on the age of the patient, be a fraction of what full first dollar insurance plans cost today. Employers could then contribute a set amount and in the manner they wish while the consumer maintains the decision making and purchasing power. Our target market would be small employers and uninsured individuals in the South Snohomish County area who have not been able to afford traditional health plans.

Because of longer appointments (20-30 minutes on average), the retainer physician is able to take a proactive approach to prevention and education with his/her retainer patients. No longer tied to procedural medicine, retainer practices offer physicals and age appropriate office-based health screenings and as many office visits as needed included with the monthly retainer fee. Simple and routine health status outcome measurements can be administered at set intervals. There is only a flat monthly fee, follow-up and ongoing monitoring is at no charge to the patient and therefore compliance with treatment regimens can be more closely monitored.

Financing is a blended funding of patient, employer, and if needed in the case of low income, government sharing the cost with the primary ownership of the arrangement residing with the patient. Thus the combination is portable, affordable and employers can set the contribution amount without having to house and own the entire contract. Employees have freedom to choose the policy and provider who is familiar with their health status, and insurers share the risk with patients, physicians, employers and government.

In case of loss of job the flexible combination can be used to finance premiums until work is found, causing no loss of coverage. Employers can also opt to have a Health Reimbursment Arrangement (HRA) with employees. Tax advantages would necessarily and justly now need to be extended to individuals.

Currently, the only high deductible catastrophic insurance offered in the state is an individual rather than a group policy. **Anchor Medical Clinic and two other independent Primary Care Retainer Practices in the Edmonds and Mill Creek area in addition to other private health care partners offering discounts to those who have high deductibles and pay out of pocket are already doing most of this proposal at the present time. We are looking for individuals and businesses willing to take part in this pilot project.**

2. Wide spread use of the RF Primary Care Practice in combination with a HDCP and an HSA will most likely assist the health delivery system in achievement of the commissions goals in the following ways.

Once the arrangement is funded and maintained it pays for the first dollar of medical expenses for the patient for the year. Patients will need to be financially responsible for both their account and the purchases made with their account or face the risk of unplanned and unaffordable medical expenses. Spending will most likely be limited to those expenditures which will, in the estimation of the trusted physician in cooperation with the patient, be among the best of the alternatives to meet the patient's particular circumstances among the options available. How do we know these proposals will work? We have studies that show arrangements that enhance the direct doctor patient relationship are working and will continue to work in today's environment.[1]

July 16, 2006 [1]

Study Shows Health Savings Account Plans Stimulate Positive Consumer Health Behavior

A three year study conducted by United Healthcare has found that individuals with a Health Savings Account are more likely to be actively engaged in managing their health and making health care decisions than individuals in more traditional arrangements. While the study sample remains relatively small because of the recent introduction of Health Savings Accounts, it is the largest study to date, covering a three-year period and examining more than 50,000 individuals. The results provide solid and measurable examples of how health care spending and consumer behavior can be positively advanced - without adverse effects on health outcomes - when consumers are given the necessary support.

"These results reinforce the revolutionary impact that the concept of consumerism is having by providing vehicles to effectively transfer knowledge and wealth to consumers so they can make wiser, more financially sound decisions about their health care," said MikeTarino, CEO of Definity Health.

The Health Savings Account study compares cost and utilization trends among approximately 50,000 individuals in high-deductible plans connected to Health Savings Accounts to data from roughly 15,000 individuals enrolled in preferred provider organizations (PPOs). The study period was between 2003 and 2005 and consisted of two sample groups drawn from the same employers. This new data reinforces the results of earlier Definity and United Healthcare studies, which have consistently shown that HSA enrollees have higher usage of preventive care services and lower tendency to pursue discretionary acute care services.

Notable findings from the three-year study include:

-- Preventive Care - In each of the three years, up to 5 percent more of the HSA members sought preventive care services than did PPO enrollees.

-- Acute Care - Individuals enrolled in an HSA showed an annual reduction in the use of acute care services (22 percent fewer hospital admissions and 14 percent fewer emergency room visits) without adverse health effects or outcomes, while the relative utilization of those services actually increased year-over-year among PPO members.

-- Chronically Ill - HSA enrollees with a chronic illness also used acute services less (8 percent fewer hospital admissions and 12 percent fewer emergency room visits) but continued to visit their primary care physician at the same rate as chronically ill members enrolled in traditional plans.

-- Overall Costs - Costs per member decreased 3 percent to 5 percent in the HSA plans over the 2004-2005 period, as compared to their 2003 baseline level, while increasing 8 percent to 10 percent among PPO participants (after adjusting for demographics, health status, plan design impact and geography).

"While not yet conclusive, these findings support what we've seen anecdotally for the past several years: **when consumers are given more information and responsibility for their health care, they will make efforts to assume more control over decision-making about the care they need in order to pursue the optimum courses of treatment**. This in turn can help positively impact their health care outcomes and related costs," Tarino said

The simple model mentioned above is based on sound market economics and sound medical practice. When the pull through marketing strategy is used to sell the latest technology (marketing efforts targeted toward the end user), having a physician the patient trusts, in most cases, persuades the end user against need for many unnecessary and expensive tests or specialists. Within our ability to do so we would consider tracking randomly assigned patients through episodes of care and comparing the cost incurred to established cost figures across disease states at the level of family practice within this geographic area.

A key to **improving health indicators** (see above) is the close personal and working relationship established in a RF Practice which allows the time and contact with the patient over repeated intervals and follow-ups, both of which are at no additional charge to the system or the patient. It makes a considerable difference if the face at the other end of the stethoscope is knowledgeable about you and your medical condition, rather than someone to whom you are meeting perhaps only occasionally or for the only time. The tendency can be to over or under treat because the physician does not have the medical history background or the time to read it, if it were available. The physician in relationship with the patient can exact a certain restraint on patient spending by providing accurate information and reasons for treatments.

Improving access is a function of cost (ie. no mandated benefits), availability and portability. Untying the presently defined work/insurance relationship will provide access to lower cost options, enhance price transparency and will maintain the physician patient relationship through job changes.

Most of the health indicators mentioned in the Vision Statement and Goals can be traced to lifestyle choices. It is at precisely this point where a relationship with one physician who knows the individual and family, can and will, make a difference in health related behavior. The responsibility is ultimately up to the patient to make healthy choices and wise consumer decisions. With the retainer fee practice model, the patient holds not only the incentive to make economically wise and physically healthy choices but the direct

purchasing power through the saving account and high deductible catastrophic policy to make those wise choices with the advice of a physician who knows and understands the issues and resources at hand.

Improving affordability comes as a result of change in financing arrangements that enhance direct payment to any provider. Billing and coding are capital and/or labor intensive services which are incorporated into the provider cost structure. By uncoupling the financing of a comprehensive Health Plan from the employer base and spreading it between the employer and the patient, the physician/patient can collaborate in finding the best and less expensive alternatives available for lab, diagnostic imaging and other services for the patient. Involvement of the patient in the decision and financing of the treatment most always provides for better clinical and financial outcomes because the patient has a financial stake in all decisions regarding their care. Fragmented care through multiple physicians in multiple locations will most likely be proven to more costly than arrangements that enhance the doctor patient relationship. True affordability is reached through widespread geographic system adoption of a model which effects downward pressure on the system.[2,3]

June 08, 2006 [2]

Health Savings Account plans being embraced by smaller employers

With health-care costs a top issue among many small businesses and no simple solution on the horizon, Health Savings Account plans appeal to many employers because they involve workers in the process and encourage them to spend wisely, experts say.

"Employers are willing to do almost anything in an effort to try to control the increases they've been seeing year in and year out," said David Levitz, executive vice president at GCG Financial, a Bannockburn firm offering employee benefits to small and mid-size companies. "We're seeing a huge migration, a huge push toward Health Savings Accounts in an effort to control these costs," he said.

Providing top-flight health insurance for workers always has been a high priority at Loop accounting firm Ostrow Reisin Berk & Abrams Ltd.

With competition fierce to recruit and retain accountants, the firm is not about to change its focus now, even as rapidly rising health-care costs eat into profits, said Phil Dunne, administrator at the 85-employee firm.

"We've never tried to take the inexpensive way out," he said. "Our employees work hard and we need them to be healthy."

But as the firm examines the best options this summer in preparation for a Sept. 1 renewal date, what's different this time is the growing number of "consumer-driven" health plans available that include a deductible of $1,000 or more and are tied with a health savings account or health reimbursement arrangement. The plans can be set up so employees have a financial incentive to spend less on health care, often reaping the savings themselves.

In the Chicago area, 23 percent of employers offer consumer-driven health plans, while 29 percent are considering adding one in 2007, according to a survey of 310 area employers conducted by GCG Financial with Milliman Inc., a Seattle-based consulting firm. Many of the plans are new, with 12 percent of respondents indicating they added a consumer-directed plan for the first time in 2006, Levitz said.

Improving quality is a nebulous term. Who really knows if evidence based standards of care are acceptable in all areas to all patients? What a quality outcome means to one patient may not be quality outcome to another. With patents holding the purse strings they determine how far and how much they want to do. In consumer-driven or patient focused medicine, **who** determines quality is far more important that **what** a quality outcome looks like on paper. It only seems logical that the person who must live with the outcome and who is paying for much of the care should decide for himself with advice and help of the physician what outcome is acceptable. The outcome findings can be documented and scored with various outcome measurement tools such as the SF-13 and 36 or others. Functionality and emotional status at home, work and play are important aspects of quality to most retainer patients.

3. Our research has found that this proposal has not been tried or proposed elsewhere.

4. Overall costs, on average, should be lower than these employers anticipated with traditional plans, as we are speaking about a catastrophic plan which is shared between consumer and employer and in some cases government. The three main components are the Retainer Fee primary care practice, the high deductible health plan and the health savings account. For example, if employers contribute a set amount to the cost of the health plan and/or Health Savings Account, the employee can pick up the Retainer Fee and a portion of either of the other two. We would work with an insurance expert to determine how this could be best accomplished and have already selected that agent. Again, financing arrangements and outcome measurements that enhance the doctor patient relationship and the trust between the two can exert downward pressure on costs through a more cooperative model of health care delivery.

Cost estimates will be based on the demographics of the group and shared by the employer and employee. Cost estimates could be made by studying the demographics and relative health status of the employer group. Some of these costs may very well be offset by higher worker health and productivity as well as savings to the employer in L& I injuries, as there is no charge to job injured enrollees who are seen in the RF practice.

Government costs are not included in this study but could be the focus of another study at some point in time. Retainer Fee practices hold much promise in this area.

5. Collaboration is inherent in this proposal. Insurers/agents, underwriters, HSA banks and their representatives, employers, employees, retainer physician and other providers will need to agree upon health plans to be offered in the pilot, retainer fee physician groups to be included, and physicians to agree upon outcome measurement criteria. All parties would be represented and stakeholders would have ample opportunity to provide input into the process. Anchor Medical Clinic and partners it chooses to work with would facilitate the group and oversee the management of the project.

6. Obstacles include the tax status of individual health plans and how that could be circumvented or neutralized, underwriting issues with those groups who have a measure of chronic illness within them that has been hampering their ability to provide health

benefits, and the inclusion of the retainer fee as a qualified IRS medical expense which applies to the deductible for the purposes of the pilot program.

Foot Notes:

[1] July 16,2006 http://www.health--savings--accounts.com/hsa-weblog-rch/general_hsa_info/index.html

[2] June 8, 2006 http://www.health--savings--accounts.com/hsa-weblog-rch/general_hsa_info/index.html

[3] May 5, 2006 http://www.health--savings--accounts.com/hsa-weblog-rch/general_hsa_info/index.html

Tab 5

Blue Ribbon Commission on Health Care Costs and Access

Focus on Elders and People Who Need Chronic Care:
Strategies for Addressing Health Care Access and Cost

Proposal from the Washington Association of Area Agencies on Aging (W4A)
September 1, 2006

With the growing number of seniors in Washington State and the nation, as well as an increasing number of people with chronic conditions that require management and care, a cost-effective approach to wellness, health care, chronic care, and support of unpaid family caregivers is clearly needed.

Area Agencies on Aging (AAAs) in the State of Washington are part of a nationwide network that focuses on the needs of seniors, family caregivers, and adults with chronic care needs. This system represents a community level infrastructure that is

- Consumer-oriented, grassroots
- Local government, non-profit, or tribe
- Focusing on needs of elders and people with disabilities, targeting vulnerable people with chronic care needs and family caregivers
- In every community of the State and Nation: rural, suburban, and urban
- Collaborative, community-based, and a "can-do" culture.

Seniors represent a disproportionate share of the health care costs in our country. The prevalence of chronic conditions among seniors as compared to other age groups is high. In addition, adults with chronic diseases and conditions utilize health care services at a rate higher than the general population. A focus on these groups is likely to result in more positive health outcomes for individuals, thus allowing them to participate and contribute to their families and communities; in addition, costs to the health care and long term care systems can be mitigated as well.

With this in mind, we would offer four strategies to address the vision and goals of the Blue Ribbon Commission as they relate to seniors, family caregivers, and adults with chronic care needs. Each of these strategies builds on effective community-based solutions, local resource management, and assuring services and capacity in every area of the State.

1. What do you propose be done to realize the vision and goals?
We propose four strategies through the State's Area Agencies on Aging to address health care access and costs for seniors and adults with chronic care needs.

<u>First, expand Senior Information and Assistance programs through increased funding to serve the health access needs of older adults and adults who need chronic care</u>. Currently Information and Assistance programs assist seniors in navigating a variety of community resources for support and services, including home care, housing, medications, mental health, and wellness programs. Expansion would provide capacity

to help adults with chronic care needs (not just seniors) and to expand work with local health care resources. For example, finding medical homes for seniors is often a critical problem. Even though a senior may have access to Medicare coverage, health coverage does not guarantee access to medical care. Many physicians no longer accept Medicare patients. Medicare and Medicaid clients in our state frequently have very limited access to necessary medical interventions. The end result of having coverage and no access is identical to having no coverage and no access. Navigating the healthcare system requires outreach, assistance with information and support as well as mentoring and organizational skills. Assistance with prescription drugs, finding durable medical goods through community programs, and educating consumers about the best way to choose and communicate with health care professionals are all ways that Senior Information and Assistance can enhance access to medical care. In addition, many AAA's employ specialists to serve the needs of minority and limited-English proficient clients. This outreach and assistance can bring services to currently underserved populations.

Second, implement the Intensive Chronic Care Management program model statewide. Intensive Chronic Case Management (ICCM) is a program operated through Area Agencies on Aging that provides comprehensive case management by a registered nurse in a team approach. The focus is on integrating both acute and long-term care services to high cost and high risk Medicaid clients. The program goals include: maintaining health, minimizing acute episodes, limiting disability and reducing costs. Approximately 5% of Medicaid clients account for 50% of Medicaid costs. Many of these individuals are also consumers of long term care services – additionally they are more likely to be diagnosed with depression and chronic pain.

ICCM was successfully piloted in two Area Agencies on Aging (Pierce and SE Washington) from 2004 to 2006. During the first year of the project it demonstrated a return on investment of 3:1. There were also significant reductions in utilization: Emergency Room Visits (reduced 9%), Hospital Days (reduced 15%), Prescription Drugs (reduced 19%) and Dr. Office Visits (reduced 22%).

Third, enhance and increase funding to the Family Caregiver Support and Respite programs to support the growing number of unpaid family caregivers who provide chronic care to a loved one. Unpaid family caregivers are the backbone of the chronic care system in Washington State, providing a substantial proportion of long term care support services to family and neighbors. Without their substantial support and involvement, long-term care costs in the State, through Medicaid and other public sources, would be significantly larger. Health conditions that result in some level of chronic disability affect entire families, whether from the birth a child with a developmental disability, a dad injured on the job, a brother with MS, or a mother who is diagnosed with Alzheimer's disease.

Families are our first responders and our best hope for sustained, quality, and loving care. But full-time caregiving is emotionally stressful and physically demanding, and caregivers suffer high rates of illness, depression and mortality. Families and other

informal caregivers are struggling with the challenges of providing and sustaining help over time. Small amounts of help, information, and service have proven to be successful at sustaining family involvement and assisting informal caregivers to manage chronic conditions without more costly public support especially through the over-burdened Medicaid program. Examples of support coordinated by AAAs include respite, adult day services, caregiver counseling, teaching caregivers about good and safe care techniques (through OT and PT, for example), and group training and support.

Fourth, support community-based wellness activities for older adults, particularly those age 70 and older. Various studies show that older adults are disproportionately affected by chronic conditions. Effective methods for managing chronic conditions as well as activities to promote wellness and delay the onset of chronic conditions are important both to preserve the quality of life of individuals as well as minimize health care expenditures. In addition, wellness activities for family caregivers could extend their ability to continue to provide care to a loved one.

Evidence-based wellness programs can make a positive difference for the health of individuals as well as in health care costs. For example, the Enhance Fitness/Enhance Wellness program, an evidence-based model of improving health, showed a 13% improvement in participant social function, a 52% improvement in depression, and a 35% improvement in physical functioning. In addition, cost analysis showed that participant health care costs were only 79% of the costs of non-participants. Other evidence-based prevention and wellness programs, such as falls prevention programs, could yield positive health results and health care cost savings if they were available in communities throughout the State.

2. How will implementation enhance, hinder, or otherwise impact the achievement of the vision and goals?

The goal of improving access to health care would be positively impacted by expansion of Senior Information and Assistance, implementation of the Intensive Chronic Care Management model, and expansion of support to unpaid family caregivers. Each of these strategies includes assistance to help individuals navigate the increasingly complex and fragmented array of health resources in their own local communities and ongoing problem-solving assistance. Area Agencies on Aging are structured to target service and support to underserved populations, including those with limited ability to speak English.

The goal of improving health would be positively addressed by each of the four strategies. Utilizing the infrastructure of Area Agencies on Aging for these programs assures that each area of the State's population will have access to support. The proposed strategies address "everyday" actions that individuals must engage in to preserve health; these actions are the critical adjunct to the intermittent interactions with the formal health care system. In other words, once access to appropriate health care is achieved, support is needed for implementing recommendations, assuring that treatment interventions are received, and implementing behavior changes required to improve health. Community-based supports envisioned in each of these strategies are

well-positioned to support individuals in either improving their health or preventing premature deterioration.

The goal of improving affordability is addressed by each strategy as well. In particular, supporting unpaid family caregivers delays the placement of individuals with chronic care needs in an institutional setting, often at State expense. The ICCM model of chronic care has already shown savings to Medicaid expenditures, and the strategy addressing wellness activities shows promising evidence of decreased health care costs as well.

3. Is your proposal modeled after an existing policy or program within Washington or elsewhere?

Yes, each of the four strategies has been shown to be effective in Washington State. The strategies build on systems already in place and piloting models for improved care. Each of the strategies identified could be implemented Statewide by community-based organizations with solid community partnerships in place.

4. Will your proposal impose costs? Time-limited or ongoing? Estimate? Savings?

Each proposed strategy will require an investment of State and/or Medicaid funds to implement or expand. The investment in each strategy will be ongoing. Savings are projected based on pilot program evidence related to the Intensive Chronic Care Management Model. Savings are also estimated for supporting unpaid family caregivers, allowing them to continue to provide care for a longer period of time than they would be able to achieve without respite and other supports. Information and Assistance expansion will likely result in savings to the health care system through assisting individuals to link with services and supports before their situation becomes a crisis and requires a higher level of intervention. Finally, a number of evidence-based wellness and prevention activities, including fall prevention programs, show significant health care savings.

5. How does your proposal reflect collaboration among various stakeholders?

Area Agencies on Aging are community organizations that partner with a variety of participants on a variety of projects. Community partners include hospitals, clinics, local governments and elected officials, tribes, public health, private business, private non-profits, and communities of faith. Each of the strategies described represents collaboration in development as well as in implementation. For example, Senior Information and Assistance programs work with local community resources such as volunteer centers, food banks, pharmacies, and housing authorities to coordinate services. Case managers work with adults who have chronic care needs and who receive Medicaid in-home services. These case managers coordinate with hospitals, DSHS, DME providers, health clinics, transportation and interpreter brokers, families, and a wide range of local community resources. Due to time constraints we have not

queried our partners on this specific proposal, but a number of stakeholders working on eldercare and chronic care issues in the State have been involved in developing and advocating for these critical and effective strategies.

6. What are the obstacles to implementing your proposal? Objections?
Funding is likely the major obstacle to implementation. We do not anticipate specific objections to these proposed strategies.

Submitted by:

Washington State Association of Area Agencies on Aging (W4A)

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Tab 6

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Washington State's Chamber of Commerce

August 31, 2006

The Honorable Christine Gregoire
The Honorable Pat Thibaudeau
Blue Ribbon Commission on Health Care Costs & Access

Sent via email to hcca_brc@leg.wa.gov

RE: Blue Ribbon Commission Request for Proposals

Dear Governor Gregoire, Senator Thibaudeau, and Members of the Commission:

Thank you for the opportunity to present proposals to the Blue Ribbon Commission on Health Care Costs and Access. The Association of Washington Business (AWB) is the oldest and largest statewide business organization and serves as Washington's Chamber of Commerce as well as an umbrella organization for more than 125 trade and professional organizations. Our 5,800 members employ over 600,000 Washington residents. While AWB's membership includes some of the nation's largest and most influential companies, more than eighty-five percent of AWB's members employ fewer than 100 people and one-third are small businesses with less than ten employees. Health care costs and the ability to provide quality health care coverage for their employees are significant concerns to all of our members, large and small. Thus, we are very interested in the outcomes of the Blue Ribbon Commission and look forward to continuing to work with you to achieve the imperative goal of increasing access to affordable, quality health care.

Unfortunately, due to time constraints, we were not able to develop a proposal that is as detailed as has been requested by the Commission. However, we certainly agree that Washington's leadership must take steps to improve the health care system in Washington. While there is no "silver bullet" solution, the members of the Association of Washington Business believe that the concepts outlined herein will move the state toward the goals of improving access, health, and affordability as outlined by the Commission, and ensuring that Washington citizens, purchasers and consumers alike, receive the best value for their health care dollars.

AWB urges the state must take a hard look at the reasons health care premiums are so high and continue to rise. The decisions necessary to lower premiums will not be easy ones and will often require long-term goals. However, our small businesses, in particular, need help in affording these premiums in the meantime. Businesses, as well as individuals should be incentivized to provide

coverage and should be encouraged to lead healthier lifestyles. Washington's health care market place needs invigorated, and increased competition will generate lower costs. In no particular order, the following is a list of ideas AWB believes will improve Washington's market:

Reduce Health Insurance Regulation
Washington is one of the most regulated states in the nation. It is also very expensive, with little market competition between carriers. The administrative burden to health carriers must be reduced in order to make Washington a viable option for additional carriers seeking to enter the market. Regulatory restrictions on health care options must also be reduced to give employers greater access to plans that are relevant to the health care needs of their workforce with prices they can afford. By allowing insurance companies to offer policies that cover basic medical necessities, premiums would be less expensive, making coverage more affordable. Offerings for additional coverage should be available but not mandated.

Support State and Federal Tax Policy That Encourages Coverage
Because health care is such a vital necessity in our lives, the state and federal government should incentivize (not mandate) coverage by expanding tax reductions to those who purchase coverage Currently, federal tax advantages are available to businesses that purchase coverage, but for many small businesses, the advantage is not great enough to offset their inability to afford coverage. And for individuals, little to no tax advantages are available.

Encourage the Availability of Low Cost, Flexible Health Plans
State-imposed mandates force insurers to offer "one-size-fits-all" coverage that goes beyond basic medical coverage and makes coverage too expensive for many employers and individuals. Small employers, in particular, crave the ability to design coverage that meets the needs of their workforce at prices they can afford. Mandated benefits should be limited. Employers should be encouraged to explore ways to reduce their costs through wellness programs and prudent purchasing.

Supply Information to Consumers Currently Isolated from Cost
Our employer-based system of coverage is such that consumers are often in the dark about the actual costs of their care and are not encouraged to spend wisely. Transparency must be promoted, and consumers must be educated as to the true costs of coverage as well as the role personal responsibility must play in their health-related decisions. Consumer-driven health plans that promote choice, personal responsibility, and individual ownership should be encouraged. Wellness and preventive care should also be encouraged for both employers and individuals.

Improve Productivity/Efficiencies of the Current Health Care System
The US health care system is the "envy of the world in innovation," but it is also wasteful, inefficient, and unnecessarily expensive. Taxpayers, purchasers, and consumers of health care services must be ensured that they are receiving the highest value for their health care dollars. Those dollars should be focused on the most cost-effective, efficacious care available.

In addition to these points, enclosed you will find a copy of AWB's 2007-2008 Legislative Objective on Health Care. It has been approved by a number of AWB committees but has not been

finally approved by the Board of Directors so remains in DRAFT form. Nonetheless, it should provide you with a number of ideas to consider as you mull over your options. I encourage your review of this document because these are the areas that AWB's members believe are deserving of the most focus. In addition to our Legislative Objective, which guides AWB's priorities in the shorter term, we have developed a number of Public Policy Principles against which all propositions are evaluated. All health care proposals are evaluated by AWB's members according to the following guidelines:

1. The health care system should provide access for all citizens to basic health care through an essentially pluralistic, competitive, private sector delivery and purchasing system.

2. The health care system should allow employers the freedom to establish and maintain affordable, innovative health care coverage plans for their employees without government requirements that increase premium costs beyond any legitimate benefit or justification to the employer or employee.

3. The health care system should promote choice in the variety and availability of health insurance coverage and benefits.

4. The health care system should encourage private-sector, market-based solutions for access to and adequate reimbursement for health care coverage and delivery of care.

5. The health care systems that are provided by state and federal health care programs must be fully and adequately funded through broad-based resources.

The Association of Washington Business strongly believes that any proposal reviewed by the Blue Ribbon Commission should be evaluated against these principles, as well.

Finally, we must remember that, for many, Washington's health care system is working, and AWB urges you to be very careful not to upset the value in the system currently in place in an effort to improve upon it.

As I mentioned, we look forward to continuing to work with the Commission, as well as other stakeholders, to meet the goals of improving the accessibility, quality and affordability of Washington's health care system. Please consider the Association of Washington Business a resource at your disposal as you grapple with the enormous task at hand, and please do not hesitate to contact me for additional information.

Sincerely,

Mellani McAleenan
Governmental Affairs Director, Human Resources

Enc.

DRAFT Legislative Objective

Health Care

Association of Washington Business
2007-2008 Legislative Agenda

Health care costs continue to rise at paces far in excess of inflation, causing many employers to either reduce the benefits they provide to their employees, drop existing coverage, or refrain from purchasing new coverage. The high costs of health care coverage have a direct impact on the number of uninsured in the state, and an expensive health care market makes Washington unattractive to new and existing businesses who want to provide good benefits for their employees. Exorbitant health care costs also erode the ability of the state to provide other vital services without raising taxes.

Private and public entities should continue efforts to address the major problems associated with rising health care costs. Citizens should adopt healthier lifestyles. And, they should be more aware of the costs and efficacy of their treatments. Government policies should be revised to reduce unnecessary regulations, most particularly mandated benefits. Insurers should be permitted to offer affordable basic health care plans, free of many of these mandates, along with those that may contain more options. In addition, the availability of consumer driven health plans, such as Health Savings Accounts, should be expanded, allowing employees greater control of and accountability for their health care decisions.

AWB's Position:

AWB supports health care policy that:

Encourages the availability of low cost, flexible health plans

- Oppose new, and support the reduction of, regulatory and legislative requirements that unnecessarily add costs to the system.
- Promote free market delivery and payment for health care services and oppose government programs that unfairly compete with private sector businesses.
- Support measures that allow employers access to health plans that are relevant to the needs of their workforce within price ranges they can afford.
- Support efforts to create tax incentives to offset the high costs of health care coverage for purchasers.

Supplies information to consumers currently isolated from cost

- Support innovations that promote consumer education and awareness as to the cost of their health care, as well as personal responsibility for healthy consumer lifestyles and employer-based wellness programs.
- Support measures that encourage individuals to seek non-emergency treatment at more cost-efficient primary care centers, urgent care centers, and community health centers rather than emergency departments.

Improves productivity/efficiency of the current health care system

- Support measures that focus health care spending on the most cost-effective, efficacious care available.
- Support efforts to reduce costs associated with health care liability, and discourage unnecessary and expensive defensive medicine.
- Support efforts that encourage the efficient use of medical technology without inappropriately hindering access to quality care.
- Do no harm to market-based health coverage plans that have a history of success in Washington State, including the protection of association plans and individual market successes.
- Oppose efforts to mandate the purchasing of health care by employers or the establishment of a single-payer health care system.

Reduces State Costs and Discourages Government Cost Shifting

- Encourage governments to allocate appropriate funding to reduce uncompensated care, pay adequate reimbursement levels, and alleviate cost shifting to the private sector.
- Encourage exploration of all cost saving opportunities in the general fund budget.

For more information on this issue, please contact Mellani McAleenan at 1-800-521-9325 or E-mail MellaniM@awb.org

Tab 7

PROPOSAL TO THE BLUE RIBBON COMMISSION ON HEALTH CARE COSTS AND ACCESS

Submitted by Roger Collier
August 2006

A brief bio: I was formerly CEO of a national health care consulting firm. My experience includes the design and implementation of innovative programs including Arizona's AHCCCS, California's Healthy Families, Tennessee's Tenncare, Washington's Basic Health, Massachusetts' Fixed Budget Medicaid, the Department of Defense's TRICARE, and the Blue Cross/Blue Shield Association's model Point-of-Service HMO plan, as well as numerous other projects for state and federal agencies, HMOs, and Blue Cross/Blue Shield Plans.

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EXECUTIVE SUMMARY—THE SIX QUESTIONS

This paper has been prepared in response to the Blue Ribbon Commission on Health Care Costs and Access's invitation to individuals and organizations to present proposals to realize the Commission's vision and goals. This Executive Summary answers the six questions posed in the invitation.

1. What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission? Briefly summarize your proposal. – The proposed plan consists of five steps designed to respond to the major causes of today's problems of cost, access, and quality. It does not change the roles of today's principal stakeholders (providers, employers, insurers, government and consumers), but does attempt to make their relationships less dysfunctional. It recognizes that although escalating costs are the main driver of the numbers of uninsured, simply controlling costs will at best only stabilize the uninsured numbers, while merely increasing access will exacerbate the crisis.

- **Step 1. Control new resource expenditures –** With high-cost cases the major cost driver, and with many hospitals and specialist groups having effective monopolies, better controls—whether market-driven or regulatory—over new resource expenditures are essential. A revised CON procedure and a process for ongoing development of guidelines for care are recommended.
- **Step 2. Guarantee affordable coverage for employees and dependents –** Full-time employees of all but very small employers should be guaranteed a reasonable level of coverage. Employers should have the option of buying coverage directly from insurers (or self-insuring) or paying a levy to help cover the cost of coverage selected by employees through a central insurance "marketplace" (see next bullet). Employers choosing the levy option would be protected against rate increases above the CPI inflation rate.
- **Step 3. Establish a central insurance "marketplace" –** A central broker function offering standardized "no frills" coverage from multiple insurers, emphasizing prevention and quality care, would create market competition and a greater awareness of costs by those insured.
- **Step 4. Establish a children's coverage mandate –** Every child should have coverage, and every parent should have responsibility for making it happen. This may mean expanding State programs for children and/or mandating that insurers make available child-only coverage
- **Step 5. Provide adequate funding for an effective prevention program –** With many high-cost diseases and accidents (e.g. alcoholism, obesity-related diseases, lung cancer, automobile accidents) readily avoidable, a cost-effective prevention program is essential.

2. How will implementation of your proposal enhance, hinder, or otherwise impact the achievement of the vision and goals established by the Commission? How do you know? – Requiring coverage for all children and all employees and dependents of businesses with ten or more employees will reduce the number of uninsured by up to 400,000 (half today's total), with a further reduction occurring as individuals purchase the proposed new "no frills" coverage. Improvements in health will result from the reduction in uninsured, whose health status has been shown by various studies to be worse than that of comparable insured individuals. The rate of increase in health spending will be reduced as a result of a more effective CON process, guidelines for care, market competition among insurers within the central broker function, greater awareness of costs among individual consumers, and a more cost-effective prevention program.

3. Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes. -- The overall concept ("everyone gives a little") and some components of the proposal (limited employer mandate, central broker function) are based on Massachusetts' 2006 legislation, as well as on the original intent of Basic Health. The children's coverage mandate is more limited than Massachusetts' law, which requires *all* residents to have coverage. The use of guidelines for care reflects the experience gained with such programs as NICE in Britain.

4. Will your proposal impose costs on individuals, businesses, or government? Will these costs be time-limited or ongoing? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by savings? – The intent of the proposed plan is to be budget-neutral in the short term, and to reduce the rate of cost increase to close to the CPI rate in the longer term. Employers and individuals who currently purchase coverage should see savings from reduced cost-shifting, from more effective controls over introduction of new facilities and new treatments, and from more market competition among insurers. The State should also experience these savings, as well as reductions in Basic Health expenditures as more employers assume some of their employees' coverage costs; however, these savings will likely be offset by costs of added Medicaid/SCHIP enrollment and subsidies of small business coverage. Employers (of ten or more employees) who do not currently provide coverage will be required to provide coverage or pay a monthly levy in the $100-$150 range per employee. Parents of children currently without coverage will be required to provide coverage, but many will be able to do so through their employers or State programs.

5. How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it? -- Details of this proposal have been shared with representatives of King County Medical Society, Group Health Cooperative, CodeBlueNow, Health Care for All, the Puget Sound Health Alliance, and individual business owners and providers. Where possible, their feedback has been incorporated.

6. What are the obstacles to implementing your proposal? Who will object and why? How do you suggest these objections be addressed? -- Almost every part of this proposal can be readily incorporated within today's health care system, with minimal changes to the roles of major stakeholders. In terms of Step 1, modifications to the CON process are currently being considered by a State commission, while the recommended process for guidelines for care has as a prototype the work of the Puget Sound Health Alliance, as well as NICE and other programs. Some providers will resist any limitations on their autonomy, and it may be necessary to establish a "carrot and stick" pricing structure for care meeting or not meeting guidelines. In terms of Step 2, there will be objections from lobbyists for businesses not now providing employee coverage; however, the proposed monthly cost is within the range of acceptability indicated by many small business owners. In terms of Step 3, the proposal is consistent with the original legislative intent of Basic Health, but with a design that avoids problems of selection bias. In terms of Step 4, while some parents will object, mandating that children have health care coverage can be argued as no more extreme than mandating that children be immunized. In terms of Step 5, the only objections are likely to come from businesses whose profits may be reduced if the State's citizens adopt healthier lifestyles.

1. INTRODUCTION

The State of Washington's Blue Ribbon Commission on Health Care Costs and Access was created in response to widespread concerns about the affordability, availability, and quality of health care. The Commission's vision statement says: *"In five years, we envision a system which provides every Washingtonian the ability to obtain needed health care at an affordable price."*

This proposal sets out one possible plan for achieving the Commission's vision and the associated goals. The proposal emphasizes the need to *understand* and respond to the causes of the health care crisis—in particular, the causes of the escalating costs that have resulted in Washington's growing numbers of uninsured—and to be feasible within the Commission's five-year timeframe.

One point is worth noting. This proposal is not intended to advance or protect the interests of any particular stakeholder group. Rather, it is an independent proposal reflecting experience gained in implementing a broad range of public and private health care programs over thirty years.

The Magnitude of the Problem

The State of Washington now has between 600,000 and 800,000 uninsured, employer premiums average $6,000 per employee, and State health care expenditures total $8 billion a year.

If present trends continue, and assuming continued Congressional inaction, by 2010—in just four years—Washington will have another 100,000 or more uninsured, employer premiums will rise to close to $9,000 a year, and State health care expenditures will increase to $11 billion annually.

The Causes of the Problem

The causes of Washington's health care problems can be summarized under six headings:

- **No limit on demand** -- The sick want to be well, and if care is available they demand access to it. With fewer than 20 percent of the population incurring 80 percent of health care costs (and *just 1 percent* incurring 30 percent of the total), this is the single greatest driver of health care costs.
- **Too little personal responsibility** – Most people are cushioned from most of their health costs through private insurance or State or Federal coverage, and are often unaware of the total costs. At the same time, many individuals' lifestyles harm their health, while many healthy younger people see little need for insurance.
- **Ineffective market competition** – The insurance market suffers from few insurer choices, difficulties of switching insurers, complexity of coverage options, legislative mandates, and—for insurers seeking to control costs—provider monopolies in many communities.
- **Inadequate preventive efforts** – The current system emphasizes treatment over prevention, often fails to ensure continuity of care, and lacks adequate funding or incentives for preventive care, especially for high-risk populations.
- **High "overhead" costs** – In addition to direct care expenditures, costs are inflated by insurer and provider administrative efforts, insurer marketing costs and surpluses, and by defensive medicine practiced by providers in response to tort liability concerns.

2. REALIZING THE COMMISSION'S VISION

Framework of the Plan

The Blue Ribbon Commission's legislative mandate, vision statement, and associated goals call for a plan that in five years will provide every Washingtonian the ability to obtain needed health care at an affordable price, with specific improvements in access, health status, and affordability.

This combination of ambitious objectives with a short timeframe dictates a plan that recognizes legislative, social, and technical obstacles, yet moves rapidly to achieve its goals. The following ten assumptions form the framework for the proposed plan:

- **ERISA compliance** – For any plan to be viable, it must comply with Federal ERISA regulations relating to self-insured employers.
- **Emphasis on market competition** – Market competition is the most politically acceptable approach to cost-containment. To be effective it will depend on purchasers being able to compare insurance offerings, and on differences in price and quality being meaningful to the consumer.
- **Incorporation of other cost-containment mechanisms** – Market competition alone may be insufficient to control costs, especially with the near-monopoly power of some providers.
- **Emphasis on quality** – High quality care is generally (but not always) cost-effective care, since it is most likely to result in the patient's recovery. Coverage should encourage use of evidence-based medicine and chronic care management.
- **Affordability for small employers** – Most of today's uninsured are employees (or dependents) of small businesses. Health care must be affordable for such employers either through low-cost coverage or a direct or indirect subsidy.
- **Minimal impact on large employers** – Most large employers continue to provide health insurance to their employees (and often families) at rates significantly below the individual and small group markets. Large businesses are likely to resist any approach that increases their costs by requiring them to directly or indirectly subsidize other businesses or individuals.
- **Recognition of crucial role of providers** – Every health system depends on its providers. Cost-containment is essential, but it cannot be at the expense of provider quality or participation.
- **Putting children first** – Healthy children are more likely to become healthy adults; insured children are more likely to choose later to be insured adults.
- **Funding preventive services** – Prevention (and early diagnosis) can be achieved in several ways: funding for clinics for vulnerable populations, funding for "healthy lifestyle" publicity and activities, and mandating preventive care as a condition of coverage.
- **Step-by-step implementation** – Whatever the plan, its implementation in Washington must be incremental, to avoid major system disruption, to make timely assessment of the changes possible, and—given the experience of other states in restructuring elements of their systems—to allow the possibility of reversing course.

The proposed plan reflects each of the above considerations. It consists of five major elements:

- Step 1 -- Control major resource expenditures
- Step 2 -- Guarantee affordable coverage for employees and dependents
- Step 3 -- Establish a central insurance "marketplace"
- Step 4 -- Establish a children's coverage mandate
- Step 5 -- Provide adequate funding for an effective prevention program

Details of these five elements of the plan are provided in the following subsections.

Step 1—Control New Resource Expenditures

Why is it Necessary? -- 80 percent of health care costs are due to only 20 percent of individuals, and 30 percent of all costs are due to just 1 percent of the non-aged population, with facility and specialist charges making up a disproportionate percentage of these costs. *In fact, Washington has the highest inpatient hospital costs of the fifty states.* If the escalating costs of these high cost cases can be constrained, the total costs of health care will be largely brought under control.

Discussion – Rising facility, technology, and drug expenses are the principal drivers of high cost cases. Potential approaches to controlling facility and technology costs include insurers' rate negotiations, Certificate of Need, rate-setting, use of guidelines for care, and central budgeting (used in other countries, but unlikely to be acceptable in the USA).

Insurers' rate negotiations attempt to control expenditure increases, but are limited by the near-monopoly status of many hospitals and specialists, and consumers' preference for providers with the greatest resources (often regardless of need or expense, since most patients bear little of the cost). Insurers may also attempt to constrain the costs of new treatments and drugs by arguing that they are experimental or not medically necessary, but such arguments can be undermined if patients or their advocates can show enough evidence of their use in other comparable cases.

The Department of Health's Certificate of Need process is the only current mechanism for directly limiting expenditures on new or expanded facilities and technology. However, almost all applications are eventually approved (although there may be some sentinel effect) and a State commission is currently reevaluating the CON process. The earlier alternative of facility rate-setting is now considered ineffective and has been abandoned by every state except Maryland.

Guidelines for care may cover treatments, technology, and drugs. In Britain and other countries, guidelines developed by NICE (National Institute for Health and Clinical Excellence) and similar programs are used to establish standards for care and to determine whether national programs will pay for new drugs and treatments. In Seattle, the Puget Sound Health Alliance is working to encourage providers to follow diagnosis and treatment protocols for various chronic illnesses, to prescribe only cost-effective drugs, and to establish incentives for appropriate care.

Plan Details – A two-part strategy is proposed for controlling major resource expenditures: (1) revise the CON process to tie it to a State health resource plan; and (2) create a mechanism for promulgating guidelines for care, together with incentives for following the guidelines.

To make the CON process more effective, it should be revised so that it is limited to new facilities and large facility expansions, and tied to a State health facility resources plan developed and updated periodically by a commission comprising providers, insurers, payers, and consumers.

The health resources commission should also be responsible for setting guidelines for care, including treatments, technologies, and drugs. The commission would not conduct original research, but would review and promulgate established protocols and—for technologies and drugs—cost-effectiveness standards based on the work of recognized experts.

To provide an incentive for following the guidelines, any insurer doing business with the State would be required to demonstrate that its reimbursement policies rewarded consistency with the guidelines.

Step 2—Guarantee Affordable Coverage for Employees and Dependents

Why is it Necessary? – While escalating costs are the primary cause of the growing population of uninsured, just controlling costs won't reduce the numbers. At best, cost controls *alone* will stabilize the numbers of uninsured near today's unacceptable levels. To come close to meeting the Blue Ribbon Commission's goal of "*all Washingtonians will have access to health coverage*," action must be taken to provide coverage to those currently without it.

Discussion – Currently, Washington has between 600,000 and 800,000 uninsured (depending on the data source). Of these, close to 100,000 are children, while the majority of the remainder are business employees or dependents (mostly, but not all, working for small businesses). Of these employees and dependents, an estimated 300,000 or more work for employers of ten or more employees.

Many of the employers not providing insurance indicate that they would like to offer coverage to better compete for employees, but believe insurance is too costly and premiums are increasing too fast. Originally, Basic Health was intended to provide affordable coverage for such small employers, but the unsubsidized part of the program suffered from adverse selection in attracting high cost cases and was abandoned by insurers.

In other states, Massachusetts' 2006 legislation proposes to provide coverage by imposing a $295 annual levy on employers not providing insurance. California's SB2, enacted in 2003 but rolled back in a narrow referendum vote, would have imposed a levy to cover comprehensive benefits. Although Massachusetts' levy amount seems clearly inadequate, while California's was unspecified and lacked any guarantee against future increases, both approaches appear to avoid the problems of ERISA.

Plan Details – As in Massachusetts and California, a levy on all but very small employers is proposed to cover costs of State-sponsored (or brokered) health insurance. To avoid these other states' problems, the proposal is for a levy sufficient for affordable HSA-eligible high-deductible coverage, with levy rate increases limited by law to the CPI rate. The proposed levy would be based on a percentage of payroll, imposed on employers with ten or more employees, except that all employers already spending at least this amount—either by buying coverage directly from insurers or self-insuring—would be exempted. This approach is expected to be compliant with ERISA.

The levy rate (in the $100-$150 per month range) would be consistent with affordability estimates made by small businesses, and used to purchase coverage for employees and dependents through a State-sponsored plan. In the event that costs increase above the CPI rate, benefits would be reduced.

Employees (and dependents) of employers paying the levy would be guaranteed eligible for the lowest cost State-sponsored offering(s) at no additional premium cost. Part-time employees would have the opportunity to buy-in to the full coverage. Employees wishing to enroll in other than the lowest cost plan would pay the difference between the lowest cost offering and their selected plan.

Basic Health would be rolled into the new plan, but as a "deductible subsidy" zero-premium plan rather than continuing today's premiums and premium subsidies, resulting in substantial savings to the State as employers of Basic Health members contribute at the levy rate. These savings could be used to subsidize the costs of the new program.

Future expansion could occur as individuals and employees of businesses below the ten-employee level buy-in at the levy rate, along with some employers who currently purchase coverage for their employees but choose to migrate to the new program.

Step 3—Establish a central insurance "marketplace"

Why is it Necessary? -- A major weakness of today's health care system is the way in which insurance is purchased, typically by employers rather than the insured, and often selected from among disparate offerings. The result is that many purchasers of insurance find coverage hard to compare, while most consumers have little price sensitivity to either the insurance or subsequent care.

Discussion – The lack of a competitive market, in which insurers offer standard benefit packages that purchasers can choose on the basis of price, is a serious problem for small businesses and individuals. Although major employers—whether they self-insure or purchase coverage—are well equipped to negotiate benefits and prices, others have no such advantages. From the insurers' viewpoint, small groups and individuals present problems of costly administration and high health risk and are charged accordingly.

Various business groups and some states (including Washington) have attempted to solve these problems by creating their own "bulk purchasing" programs, but these have almost all failed because of selection bias and insufficient enrollment. The original unsubsidized component of Basic Health is an example: attracting high-cost users resulted in insurers raising rates, thereby discouraging new enrollment, and insurers ultimately abandoned the program.

Plan Details – It is proposed to create a new State-sponsored broker function offering standardized "no frills" coverage from multiple insurers, emphasizing prevention and quality care. The program would initially be available to the more than 300,000 employees and dependents obtaining coverage as described in Step 2, and to enrollees in the existing Basic Health (which would be rolled in to the new program). Future expansion would allow other smaller business employees and individuals to enroll, thereby achieving the Blue Ribbon Commission's goal of access for all to affordable care.

The standard coverage would be comparable to that currently provided by Basic Health, but—for all except Basic Health enrollees—with a high deductible, designed to be eligible for Federal HSA qualification to maximize tax reduction options. Enrollees would pay no premiums for coverage from the insurer(s) offering the lowest cost to the State. Those selecting any option other than the lowest cost plan(s) would pay the cost differential. Basic Health enrollees would have their deductibles reduced, rather than (as now) having premiums subsidized.

More generous coverage could also be offered as an option, with those choosing it paying the additional cost differential.

Offering a standardized benefit package to the estimated 400,000-plus enrollees (including Basic Health) should result in much lower administrative costs and more competitive premium rates than in today's small group and individual markets. Insurer risk will also be reduced since all those eligible

will be enrolled. (Anyone not selecting a specific insurer will be automatically enrolled in the lowest cost plan.) Cost-shifting from uninsured individuals will also be greatly reduced, since the number of uninsured will be fewer.

Insurers would have to compete on price in order to participate, and continue to offer competitive prices to retain enrollees (who would be free to switch insurers during open enrollment periods). Because only the Legislature would be able to change the levy rate, there would also be considerable public pressure on insurers and providers to hold down costs.

The benefit package—in order to be affordable—would not provide the comprehensive benefits envisioned by the 1993 Washington Health Care Commission. On the other hand, a high deductible version of the present Basic Health benefits would provide both preventive care and protection against the overwhelming medical expenses that led to 40,000 bankruptcies in the Washington last year, as well as reducing the levels of bad debt and charity care that providers currently bear. It's also consistent with the traditional concept of insurance: protection against unexpected high cost events.

Step 4—Establish a children's coverage mandate

Why is it Necessary? -- 100,000 Washington children are estimated to lack health coverage. These children are most likely to be from lower-income and minority groups, and—based on national studies—suffer from more health problems than those insured.

Discussion – Reasons for the number of uninsured children include unavailability of employer-sponsored coverage, inability to pay the high cost of individual insurance, unfamiliarity with available State programs like Medicaid/SCHIP, transient family lifestyle, and lack of parental responsibility.

The implementation of Steps 2 and 3 above should significantly reduce the number of uninsured children, as dependents of business employees gain coverage. Additional State and local government efforts to enroll low-income children in Medicaid/SCHIP may further reduce the number, but will still leave some remainder without insurance. However, the cost of children's coverage is relatively low, and should be affordable to the parents of many or most of the remaining group.

Plan Details – It is proposed to mandate that all children in Washington have some basic level of health care coverage. This is likely to involve requiring that insurers offer low-cost children-only coverage, some expansion (at least in terms of numbers) of Medicaid/SCHIP, and establishing rules for enforcement.

Traditionally, there has been little market for children-only insurance coverage, but the proposed children's mandate should make such coverage more attractive to insurers.

Adding some enrollees to Medicaid/SCHIP should involve little increase in State costs, as cost-shifting is reduced and Federal government payments are increased.

While Washington cannot readily enforce a total health insurance mandate—unlike Massachusetts, which can use its state income tax structure for this purpose—it could set rules for children's coverage. For example, just as school entry is dependent on compliance with immunization rules, it could also be dependent on health care coverage.

Step 5—Provide adequate funding for an effective prevention program

Why is it Necessary? -- Prevention is almost always better than treatment. Whether in the form of immunization and other preventive care, healthier lifestyles, or more timely medical advice, prevention is likely to be a cost-effective investment. For example, according to the National Congress on Pre-Symptom Medicine, regular preventive care (e.g. mammograms, flu shots, prostate exams) could cut projected health care costs by fifty percent over the next ten years.

Discussion – The most recent United Health Foundation ranking of health status by state showed that Washington—although ranked fifteenth—had suffered the second greatest health score decline among the fifty states. Part of Washington's failure to achieve a higher score was due to the very low percentage of health care dollars devoted to public health. On the other hand, Washington has one of the lowest rates of hospital inpatient days, suggesting that some limited prevention efforts have been effective.

Plan Details – A two-part strategy is proposed: (1) the State should require that effective preventive care be included as part of the coverage for all State programs; (2) the State should fund an effective public campaign to encourage healthy lifestyles.

Some preventive care is already included in existing benefits as a result of legislative mandates. All such mandates should be reviewed for cost-effectiveness, perhaps using the Cost Effectiveness Analysis registry developed at the Harvard Center for Risk Analysis; only the care determined to be cost-effective should be included in State-sponsored benefits. To ensure that preventive care is provided, incentives should be incorporated, so that—at a minimum—there is no cost to the beneficiary, and perhaps a premium discount.

Health promotion efforts (for example, to discourage alcoholism, obesity, smoking, and automobile accidents) must also be determined to be cost-effective, but almost certainly need more funding than that presently available. Campaigns such as the Washington Health Foundation's "Making Washington the Healthiest State in the Nation" are doomed to failure without adequate resources.

3. IMPLEMENTATION SCHEDULE

If Washington is to avoid huge increases in State health care costs and private sector insurance premiums over the next five years, along with another jump in the numbers of uninsured, an aggressive implementation schedule will be necessary. The following is an outline schedule:

- February 2007 – Legislation enacted to create Health Resources Commission, establish business levy, establish State-sponsored broker function, mandate children's coverage, etc.
- July 2007 – Health Resources Commission staffed and funded
- January 2008 – State Health Resources Plan published; benefit package for State-sponsored coverage finalized
- March 2008 – Initial guidelines for care published
- July 2008 – State-sponsored broker function operational; businesses with 10 or more employees start to pay levy; employees and dependents enroll in State-sponsored plans

- January 2009 – Basic Health rolled in to State-sponsored broker coverage; children's coverage mandatory
- January 2010 – All employees and dependents of very small businesses and individuals eligible to buy-in to State-sponsored coverage.

Tab 8

2409 Pacific Ave SE, Olympia, WA 98501 *phone 360-493-4550* *fax 360-493-7708*

September 1, 2006

Washington State Blue Ribbon Commission on Healthcare Costs and Access

Dear Governor Gregoire, Senator Thibaudeau and Honored Members:

Communities Connect congratulates the Commission's efforts to creatively address the challenges facing the provision of health care in this state. We particularly appreciate the opportunity to respond to your request for proposal and continue to share our thinking on how the state can organize to provide a system of safety-net care that covers all people more cost effectively and with better outcomes.

Attached please find our community-based healthcare proposal, which calls for "achieving better health for everyone by reducing unnecessary costs and coordinating and leveraging care at the community level." Our blueprint is for a three-phased community development model starting with the implementation of a statewide network of community healthcare collaboratives financed through the Community Healthcare Collaboratives Program. These collaboratives are the engine that then drives the implementation of Phase 2, where communities implement specific activities that reduce waste and improve care and outcomes for low-income people.

Once the prescribed activities are in place and sustainable, collaboratives are then in a position to organize for Phase 3, what we are calling, for the time being, Community Health Management Districts (CHMD). These CHMD's are structured to capture the savings from the implementation of Phase 1 & 2 and to organize and finance healthcare for low-income people at the community or county level.

Phase 3 is still a conceptual model and we shared our most recent thinking with the Commission at our presentation to the members in July by sharing our "*Community-Based Health Care Issue Paper, Draft #3.*" Communities Connect will continue to refine this concept with its members over the next month with the goal of having a final paper available for your review later this fall.

Again, thank you for this unique opportunity to be part of the needed changes that can transform healthcare in Washington State. Please feel free to contact either one of us with any additional questions you might have.

Sincerely,

Sue Sharpe
Chair, Communities Connect
Co-Director, Whatcom Alliance for Healthcare Access

Kristen West
Officer, Communities Connect
Executive, CHOICE Regional Health Network

Sam Selinger
Vice Chair, Communities Connect
Project Access Advisor, Spokane County Medical Society Foundation

A community-based healthcare proposal:

"Achieving better health for everyone by reducing unnecessary costs and coordinating and leveraging care at the community level"

Submitted to the Blue Ribbon Commission on Health Care Costs and Access

Final Draft

September 1, 2006

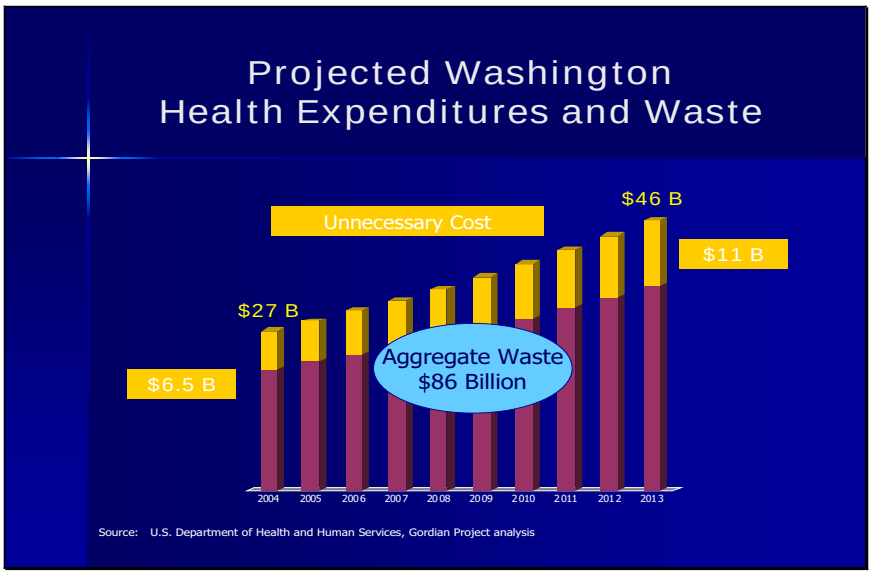
By Communities Connect

Executive Summary

Background/Overview

We have a healthcare access, cost and quality crisis in our state and throughout the nation. Communities Connect (See Attachment A – Communities Connect Map) is a statewide affiliation of community healthcare collaboratives who have organized to improve healthcare access and outcomes at the local level. Our proposal is a blueprint to fund a sustainable healthcare safety-net system that leverages community, state and federal resources, reduces unnecessary expenditures and fragmentation of care and captures the savings to expand coverage and access. Today 1.2 million people in Washington State are considered part of the safety net system; 39% of whom are uninsured.

Between 2004 and 2013, healthcare purchasers in Washington State will spend at least $86 billion in unnecessary costs and each year the amount of unnecessary expenditures increases due to a combination of inefficiencies driven by fragmentation of providers, services and health plans.



Communities Connect proposes a blueprint that promotes three phases of community development that builds on implementation of community based activities (8 Critical Activities) which create the local capacity and the relationships needed to extract unnecessary costs, better coordinate care and then apply those savings to ensure better health for everyone. The Washington State Legislature has already taken steps that support this blueprint by creating the Community Healthcare Collaborative Grant Program (SB6459) and the Prescription Drug Assistance Foundation. This proposal builds upon these earlier and successful Communities Connect legislative priorities.

Communities Connect Proposal

The three-phase community development process needed to implement this blueprint depends upon:

Phase 1: Creation of Community Healthcare Collaboratives (Collaboratives) to build community accountability to define the delivery system integration path and build local capacity. These Collaboratives will also create the community readiness to prioritize, and implement in Phase 2, the portfolio of local capacity building activities critical for reducing fragmentation and capturing savings.

Phase 2: Successful implementation of the 8 Critical Activities. The following activities create the foundation for capturing the savings to improve access and care. This phase positions communities to move to Phase 3.

The 8 Critical Activities are:

1. Outreach and enrollment into existing programs
2. Establishing "health homes" with coordinated services
3. Access to affordable prescription drugs

- Implementation of chronic disease management

4. Providing coverage for low-wage workers
5. Organizing donated clinical care services (Project Access)
6. Promoting prevention and wellness services
7. Maintaining an adequate and stable public and private provider safety-net network

Phase 3: Establishment of Community Health Management Districts (CHMD's) which can organize and finance safety-net care at the community/county level. Communities Connect is finalizing an issue paper that makes the case for why a framework like CHMD's are a potential model for creating a delivery system that redistributes and leverages resources to expand access and improve health outcomes for the healthcare safety-net at the community level. Please see ***"Community-Based Health Care–Issue Paper: Draft #3"*** for Communities Connect thinking to date on this framework. Communities Connect will continue to refine the concepts including the terminology and definitions over the next two months. A final version of the paper will be distributed to the Blue Ribbon Commission when completed.

Blue Ribbon Commission Recommendations

Communities Connect is recommending that the Blue Ribbon Commission endorse this community development blueprint, and in so, take the following actions that support successful implementation of the model:

- Endorse and use purchasing and regulatory powers to stimulate the three phases of community development.
- Solidify the Community Healthcare Collaborative Grant program to support 10-12 regions in the state and provide ongoing funding of the "community engine work" (estimated to about $250,000 a year per collaborative) for the next 5-7 years. Also include 2-year planning and start up grants of $50,000 each for communities initiating Phase 1.
- Provide 20% of the seed capital for building the 8 Critical Activities (in exchange for even bigger state savings and improved outcomes). See page 4 for an analysis done for one Collaborative.
- Authorize in legislation, pilot CHMDs in Washington State.
- Reserve 10% of the Community Healthcare Collaborative Grant Program appropriation in the 2007/2008 biennium to fund a technical assistance program (subcontracted to Communities Connect) for the following:
    - Strengthening or creating Collaboratives;
    - Replicating and customizing the 8 Critical Activities best practice models;
    - Peer to peer technical assistance; and
    - Learning Institutes on: a) social entrepreneurial leadership, b) sustainability and business planning, and c) demonstrating Return on Community Investment (ROCI).

Question #1 – What do you proposed be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission?

The Communities Connect proposal to "Achieve Better Health for Everyone" supports the Blue Ribbon Commission's Vision and Goal Statement by improving access, health outcomes and affordability through reducing unnecessary cost and fragmentation and coordinating services at the community level where the most effective interventions and system changes can be implemented.

This proposal targets the 1.2 million low-income residents in Washington State, which for the purposes of this proposal are defined as people age 65 and younger who are below 250% of federal poverty level. 39% of this population is uninsured and the rest are enrolled in a mix of hard to sustain government programs, such as Medicaid and Basic Health. About 75% of the uninsured group lives in a household where at least one adult works.

This proposal recommends the development of Community Healthcare Collaboratives throughout the state that will have unique differences, but will each be focused on a defined low-income population. These Collaboratives understand and embrace the need to focus on a better future, while simultaneously addressing the realities of a collapsing healthcare safety-net. They will demonstrate a commitment to changing how healthcare is delivered within their region so that it is more cost-effective and will have the capacity to implement the 8 Critical Activities in an integrated way that captures savings to provide access for the low income.

The 8 Critical Activities, once sustainable, create the local foundation for the larger delivery system restructuring to a Community Health Management District which is positioned to:

- Fully fund prevention and primary medical, dental and mental healthcare for the low-income,
- Establish medical or health homes,
- Implement electronic health records,
- Promote evidence-based treatment, and
- Reward consumer stewardship and healthy behaviors, etc.

Phase 1: Establishing a statewide network of Community Healthcare Collaboratives

In 2000 the Institute of Medicine published a report on the healthcare safety net called **"America's Health Care Safety Net: Intact but Endangered."** In this report, they recommended the creation of Collaboratives to stabilize the healthcare safety-net. (See logic model in Attachment B). The federal government, Robert Wood Johnson Foundation and Kellogg responded to the recommendation by making a significant investment in seed capital for the creation of Collaboratives throughout the United States. There has been a second wave of communities (learning from the first wave) who have started Collaboratives by harnessing local dollars. An estimated 600 Collaboratives are in various stages of maturity nationwide.

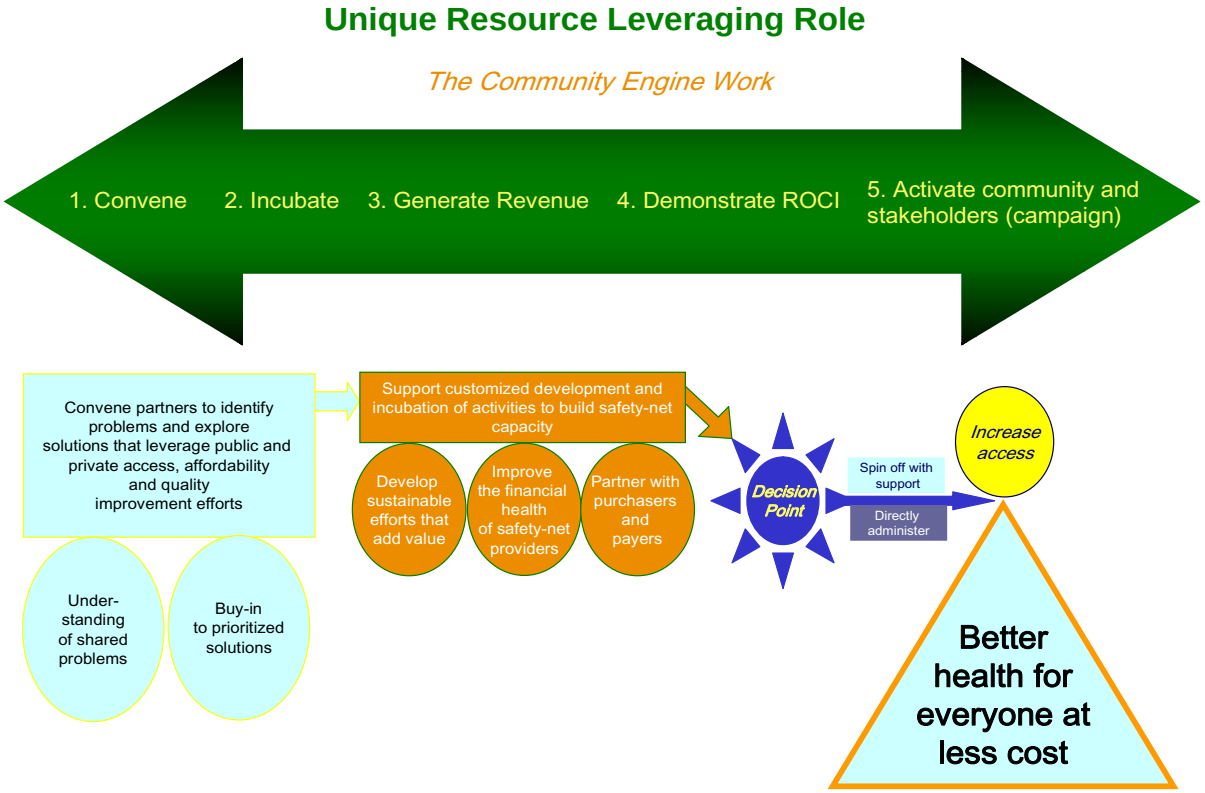
Communities Connect sees the potential power of a statewide network of community healthcare collaborative regions through the newly created Community Healthcare Collaborative Grant Program administered by the Health Care Authority (HCA). These regions would be defined through the Collaborative's creation process.

For purposes of this proposal Communities Connect defines a Collaborative as:

> *"An organization with a formal governance structure that represents a broad base of community partners including healthcare providers (private and public), health care purchasers, social services, consumers, business interests and local and state government agencies. A community healthcare collaborative collectively holds itself accountable at the local level to develop,*

implement and sustain affordable strategies to achieve better health for everyone. Although each community is unique, specific interventions strive for healthcare coverage for all, ensuring access to medical homes (and health homes when needed), reducing inappropriate emergency room utilization, coordinating public and private providers, developing a system for coordinated donated care, reducing barriers to access such as language interpretive and transportation services. They are charged with the coordination and leveraging of local, regional and federal public and private dollars to reduce waste to finance an integrated, comprehensive and cost effective system that improves health status and reduces disparities."

These Collaboratives will convene partners and leverage assets at multiple levels by being the "community engine" that defines the integration of the local delivery system and builds local capacity. Establishment of the "community engine" through the Collaborative's development process creates the platform for attracting and leveraging resources and capturing the savings to support the redesign of the delivery system that improves access and health outcomes.



Collaboratives will also create the community readiness and capacity to prioritize and implement Phase 2, which operationalizes the 8 Critical Activities that reduce fragmentation and extract savings used to improve access and health outcomes. Through Communities Connect about half of the state already has community organizations serving as neutral conveners and doing the preliminary "engine work" that could evolve into the more formal and accountable Collaborative as defined above. The rest of the state would need the blueprint and the incentives for the creation of Collaboratives; which typically takes about two years.

Creation of 10 to 12 regions with sustainable Collaboratives throughout Washington State is strategic in achieving the Blue Ribbon Commission's Vision and Goal Statement because Collaboratives:

- Have a keen understanding of the local healthcare environment and can predict health access, cost and quality trends. They create a dynamic and value-added partnership for healthcare purchasers.

- Are a sophisticated network of relationships that promote new opportunities among existing stakeholders that supports mutually interdependent local and state public policy goals.
- Link state and local government with the providers and purchasers of quality, effective healthcare services.
- Provide for transparent change and the "real-time" identification and monitoring of leverage points among multiple partner organizations.
- Are a trusted convener, facilitator and negotiator of bigger system changes that will reduce costs where the savings are used to increase access.
- Surface existing local resources and attract and leverage new resources.
- Serve to protect the vision of system-wide solutions (vs. solutions that benefit one stakeholder at the expense of another).

Phase 2: Collaboratives build local capacity to implement the 8 Critical Activities

Collaboratives would be responsible for the coordinated development and implementation of the 8 Critical Activities and begin to restructure the delivery system to reduce fragmentation and improve healthcare access and outcomes.

The Collaborative leadership builds the local capacity for the 8 Critical Activities and weaves them into a sustainable safety-net system of care with a measurable impact. Through Communities Connect we have seen our members implement these activities with predictable outcomes when they replicate existing best practice models.

8 Critical Activities	Description of Target Population	Best Practice Examples in Washington State
1. Outreach and enrollment into existing programs/services	Primarily uninsured below 250% of FPL, some recerts for Medicaid and BH	Community Minded Enterprises: Health For All Healthy Mothers/Healthy Babies Kids Get Care CHOICE: Regional Access Program Whatcom Alliance for Healthcare Access Benton Franklin Community Health Alliance
2. Health home with coordinated care (ER diversion)	Primarily Medicaid	St. Peter Hospital: ED Care Coordination Pilot Washington Health Foundation: Healthiest State in the Nation campaign Benton Franklin Community Health Alliance Whatcom Alliance for Healthcare Access
3. Affordable prescription drugs for the uninsured	Uninsured for RX (includes Medicare), primarily with chronic conditions	CHOICE: Pharmacy Assistance Network CC/HCA: Prescription Drug Assistance Foundation Benton Franklin Community Health Alliance
4. Patient-centered chronic disease management teams	Uninsured, Medicaid, BH and Medicare with chronic conditions	Pursuing Perfection Benton Franklin Community Health Alliance
5. Coverage of low wage workers	Uninsured below 250% of FPL	Community Choice
6. Organized donated clinical care	Uninsured below 250% of FPL	Community Health Centers Benton Franklin Community Health Alliance Project Access (Spokane, King, Thurston, Whatcom and Clark counties)
7. Adequate and stable public and private provider safety-net network	Uninsured, Medicaid, BH and Medicare	Community Health Centers Rural Health Clinics
8. Prevention and wellness services	All low-income	Kids Get Care Community Minded Enterprises: Healthy Kids Now!

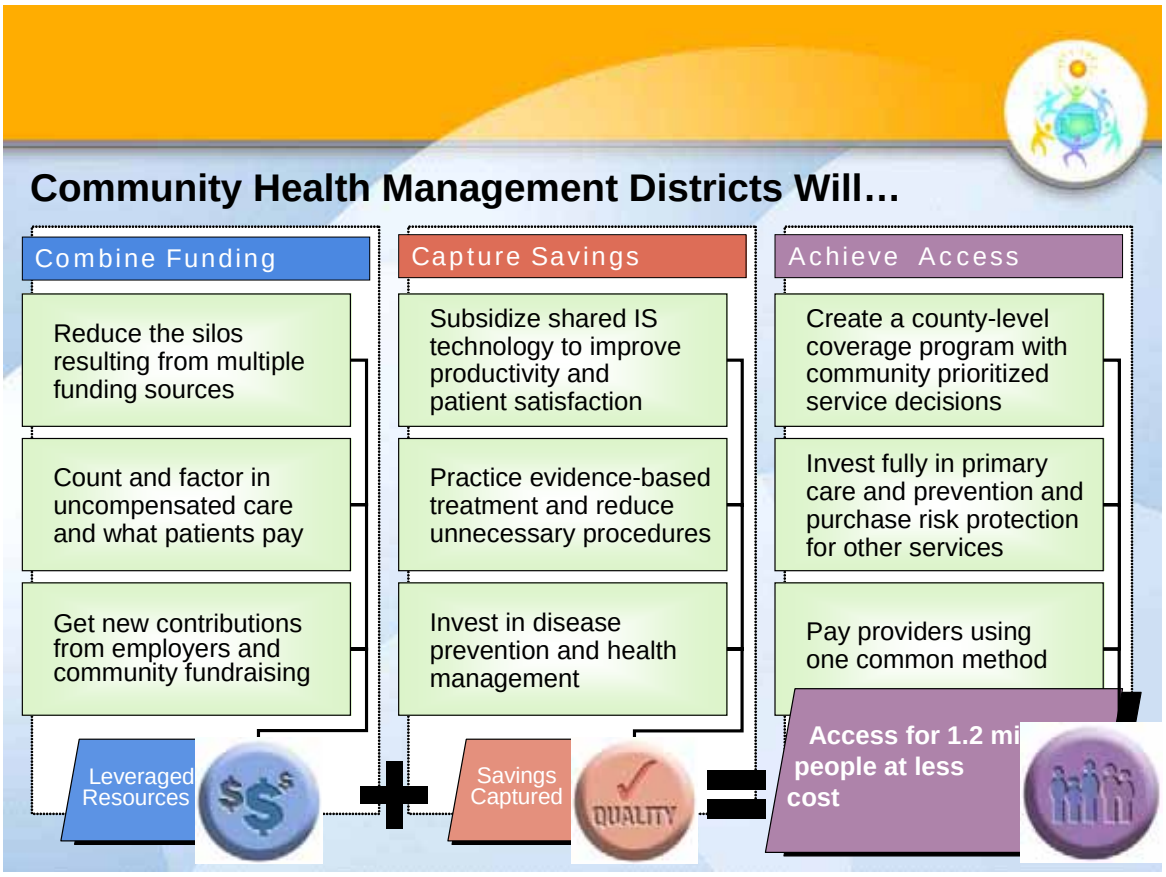
The leadership of each Collaborative works with a diverse array of independent organizations to create an interdependent system of care that reduces the stress on safety-net providers and improves patient navigation. They also serve as the social entrepreneur to attract and leverage the local, state and national private and public resources to build this local capacity. They will sustain investments by communicating outcomes through a community scorecard process. It typically takes 3-5 years to implement all of the 8

Critical Activities (depending on existing local capacity and the ability to attract seed capital). Communities Connect assesses that all of the existing Collaboratives in Washington State have committed to at least one of the Critical Activities, and 1/3 are somewhere in the process of implementing all 8 over time. Examples of successful outcomes[1] through the Federal HCAP and other collaborative grant programs has shown that support of Phase 2 and operation of the 8 Critical Activities creates the following results:

- A $3 million investment in the Community Healthcare Collaborative engine, leverages at least $18 million in assets for the 8 Critical Activities
- Reduction of inappropriate ER use by 33%
- Attracts $6 million a year in free and reduced-price medications for people (primarily with chronic conditions)
- Increases by 25% small employers covering low-wage workers
- Doubles the number of children current on immunizations
- Triples the # of minorities who have received age-appropriate cancer screenings
- Quadruples the # of diabetics in control

Phase 3: Creation of Community Healthcare Management Districts (CHMD's)

Successful implementation of Phase 1 and Phase 2 of the Collaborative's community development model lays the foundation for the ultimate creation of CHMDs, which can organize and finance safety-net care at the county level for people below 250% of FPL. The governance of CHMD's may be an outgrowth of the Collaboratives governance structure or a separate entity.



[1] Contact Communities Joined in Action (CJA) at www.cjaonline.net for evaluation results of national best practices and HCAP grantees.

As mentioned in the Executive Summary, Communities Connect continues to develop this concept but we believe that Community Healthcare Collaboratives can serve as the platform for the creation of CHMD's that can:

1. Fully fund the expanded definition of clinical prevention, pharmaceuticals, and primary medical, dental and mental healthcare for the target population;
2. Better organize the delivery system through major cost-saving interventions that reduce fragmentation, such as subsidized and shared information systems, disease prevention and health management, and evidence-based treatment;
3. Finance an organized delivery system that reduces funding silos, documents and recognizes donated healthcare services and includes employer contributions;
4. Capture the savings from the implementation of the above strategies and use them to cover the uninsured and stabilize safety-net providers using a common payment method;
5. Reward health and consumer stewardship;
6. Support robust community involvement process;
7. Evaluate and communicate outcomes that sustain investment; and
8. Link state programs and funding to effective care delivery at the local level.

It takes a community 2 years under active development to have the political readiness, local capacity, inter-operability among providers and formal accountabilities to successfully administer a Community Health Management District (CHMD).

Recommendations to the Blue Ribbon Commission

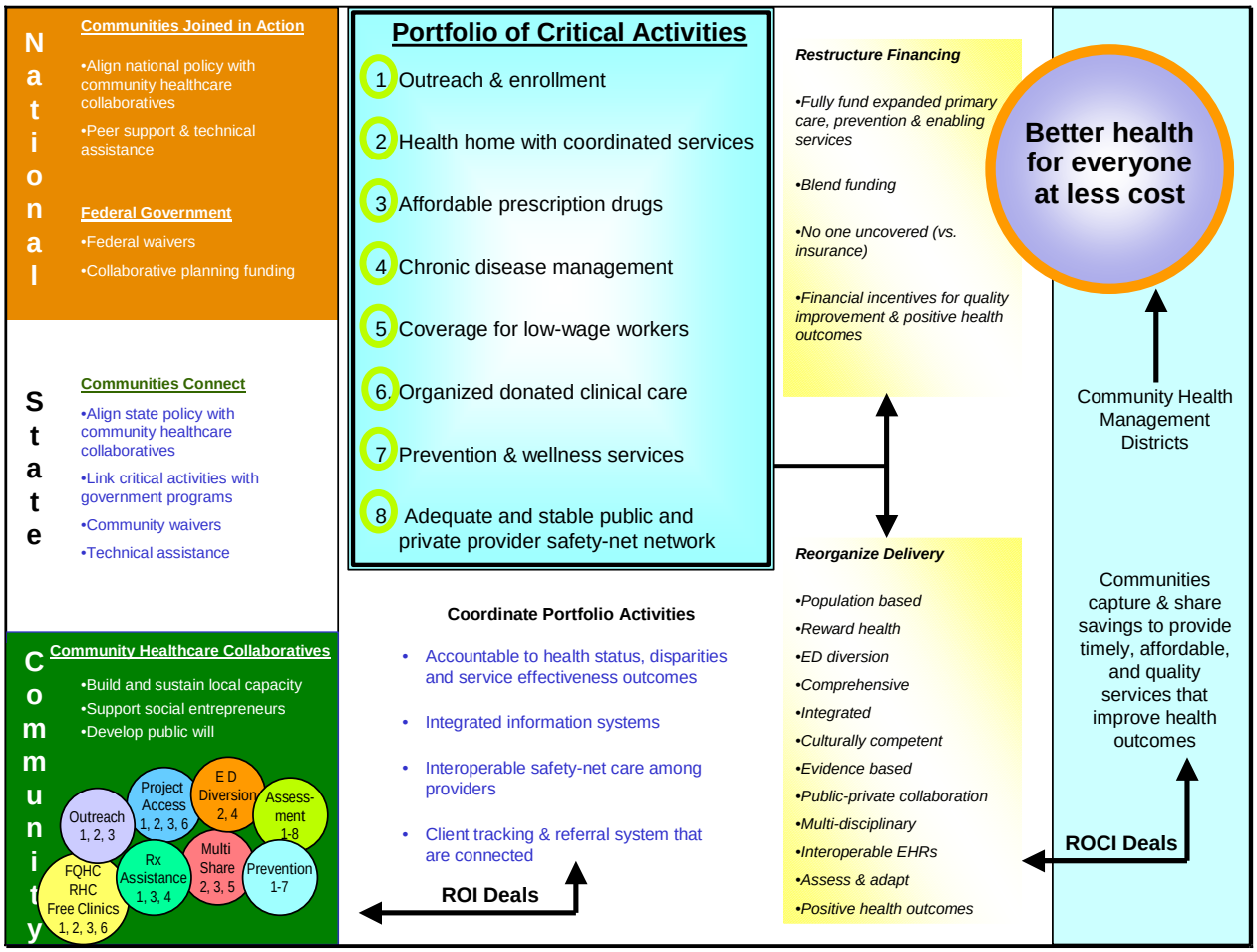
1. Endorse and use purchasing and regulatory powers to stimulate the three phases of community development.
2. Solidify the Community Healthcare Collaborative Grant program to support 10-12 regions in the state and provide ongoing funding of the "engine work" (estimated to about $250,000 a year per collaborative) for the next 5-7 years. Also include 2-year planning and start up grants of $50,000 each for communities initiating Phase 1.
3. Provide 20% of the seed capital for building the 8 Critical Activities (in exchange for even bigger state savings). One five-county region has preliminary estimates that a $20 million investment in seed capital to implement the 8 Critical Activities will generate $88 million in savings within 3 years. Based on these early estimates, a $4 million investment from the state (20% of $20 million) can generate significant savings.
4. Authorize in legislation, pilot CHMDs in Washington State.
5. Reserve 10% of the Community Healthcare Collaborative Grant Program appropriation in the 2007/2008 biennium to fund a technical assistance program (subcontracted to Communities Connect) for the following:
    - Strengthening or creating Collaboratives;
    - Replicating and customizing the 8 Critical Activities best practice models;
    - Peer to peer technical assistance; and
    - Learning Institutes on: a) social entrepreneurial leadership, b) sustainability and business planning, and c) demonstrating Return on Community Investment (ROCI).

Question #2 – How will implementation of proposal impact the achievement of the vision and goals established by the Commission?

The Communities Connect proposal creates a blueprint for the three phases of community development that sequentially build towards the BRC's goals which seek better health for everyone at less cost. It addresses the problem statement at the most effective level for intervention…the local transaction level where healthcare is provided. The following diagram visually shows how this blueprint achieves the BRC vision and goals.

In order to move from many independent and competing local initiatives in response to the access crisis (the bottom left) to "Better Health for Everyone at Less Cost" (the top right) Community Healthcare Collaboratives need to operate strategically at three levels; local, state and national during the 3 phases of community development. At the local level, Collaboratives coordinate the prioritized and integrated implementation of the 8 Critical Activities and are accountable for brokering the institution specific Return on Investment (ROI) deals that leverage the resources to build the critical local capacity. By the middle of Phase 2, Collaboratives will need to be working collectively within a unified statewide vision that supports community-led solutions in order to partner with state government for larger system changes. As a community moves from Phase 2 to Phase 3, they are in a position to begin to facilitate a fundamental restructuring of how healthcare is delivered and the maturity to change how healthcare is financed to support this new and efficient delivery system. Community Health Management Districts create a clear accountability for the performance of this new finance and delivery system, including demonstrating a Return on *Community* Investment (ROCI) for the purchase of healthcare.

Phase 1 **Phase 2** **Phase 3**



Question #3 – Is your proposal modeled after an existing policy or program within Washington or elsewhere?

As mentioned earlier in the proposal the Community Healthcare Collaborative blueprint is modeled after and builds on the successful work of the federal Healthy Communities Access Program (HCAP), Robert Wood Johnson grants and Kellogg initiatives. Communities Joined in Action is a national organization that promotes the implementation of this model throughout the country.

Question #4 – Will your proposal impose costs on individuals, businesses and government? Will the costs be time-limited or on-going? Can you estimate how much these costs will be or suggest how such an estimate could be made? How much if any of these costs will be offset by corresponding savings?

Given the blueprint we are recommending, this is a difficult question to answer. In Phase 1, we are asking for government to use the Community Healthcare Collaborative Grant Program to partially fund the creation or evolution of a statewide network of regional Collaboratives (of which $2 in local resource will match each $1 of state investment). In Phase 2, we're asking for government to provide one-time seed capital for 20% of the development and implementation costs of the 8 Critical Activities, of which the Collaboratives would need to leverage the remaining 80%. In return, this will generate savings for state purchasers and attract new revenue from employers who don't currently cover their low-wage workers (and to a lesser extent, collect revenue from employees and individuals). One geographic region of the state with 425,000 residents (94,000 of whom are in the target population) has preliminary estimates that it would cost $20 million over three years to fully implement the 8 Critical Activities. 20% of that investment would be one-time state government investment of $4 million over three years. As a result of this investment, $88 million in savings would be captured; half of which would go back to the Collaborative to sustain the operation of the 8 Critical Activities and the other half ($44 million) would accrue to healthcare purchasers. Communities Connect is in the process of refining these estimates and cost savings for a statewide network of Collaboratives. We will share our analysis with the Commission when it is complete. In addition, CHOICE Regional Health Network's Sustainable Healthcare Access Council (SHAC) has been working for several years to define coverage and price out the cost and savings that a CHMD might achieve. This analysis for one five-county region of the state is available to the Commission upon request.

Question #5 – How does your proposal reflect collaborations among various stakeholders? Which stakeholders have endorsed it?

The concept was launched at the national level and has been reworked within the state by the Sustainable Healthcare Access Council (SHAC) and Communities Connect members. Communities Connect represents an affiliation of Collaboratives throughout the state who have endorsed this concept. Present members include:

- Benton – Franklin Community Health Alliance (Benton and Franklin Counties)
- CHOICE Regional Health Network (Grays Harbor, Mason, Thurston, Pacific & Lewis Counties)
- Community Choice Healthcare (Okanogan, Chelan and Douglas Counties)
- Community Minded Enterprises (Ferry, Stevens, Pend Oreille, Lincoln, Spokane, Adams, Whitman, Columbia, Garfield and Asotin Counties)
- Human Links Foundation
- Kids Get Care (Snohomish, King and Pierce Counties)
- King County Project Access
- Spokane Project Access
- Thurston/Mason Medical Society
- Whatcom Alliance for Healthcare Access
- Washington Health Foundation

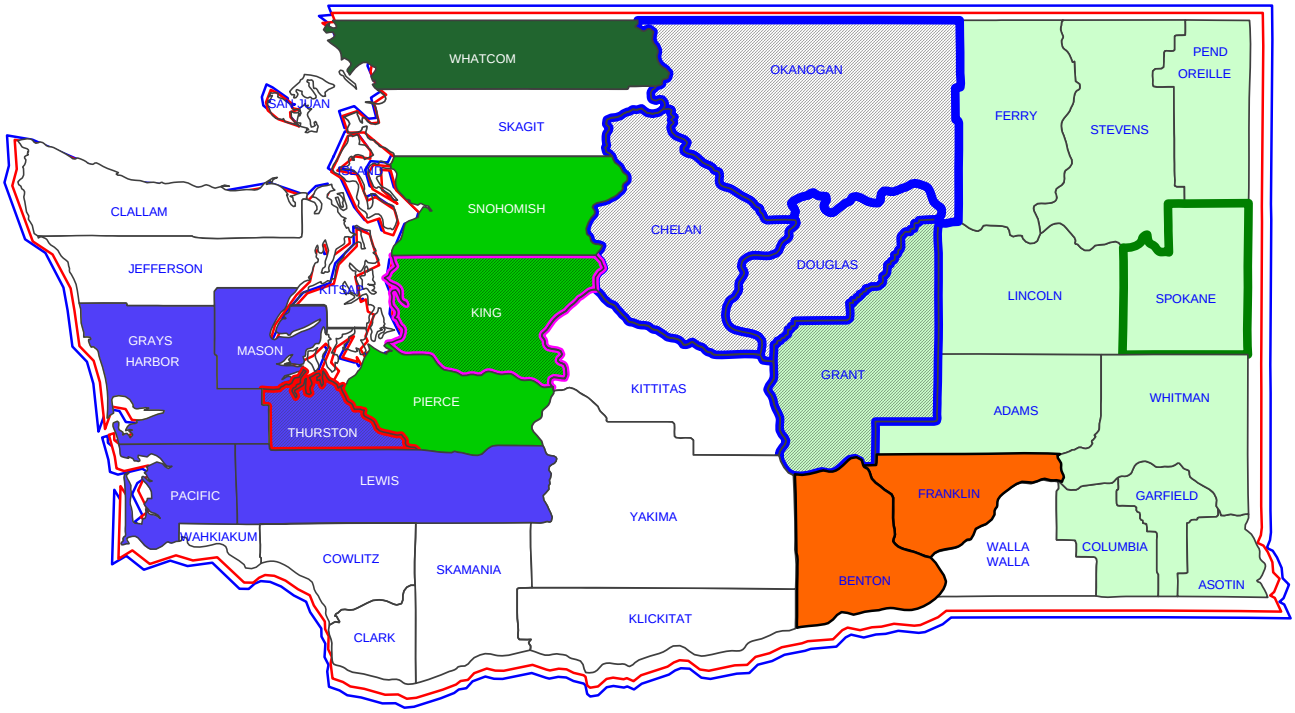
Question #6 – What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

The initial organizing of the stakeholders and partners in the creation of Community Healthcare Collaboratives requires a neutral convener and the establishment of a shared vision so that the partners can take steps to build trust on which they can take collective action to make the changes needed to transform the community healthcare delivery system. Although most partners are disillusioned with the existing healthcare system where resources continue to decline, they have been positioned to compete for those resources with a focus on institutional survival as opposed to being part of larger system change. Changing this dynamic is the ultimate challenge of Collaboratives.

The Community Healthcare Collaborative model is organized at the local level where most partners are prepared to work together to make the needed changes for the win-win goal of improving the system for people in their own community. Stakeholders are willing to make compromises at the local level that they may not be able to make at the state or national level. Secondly, Collaboratives create very real and measurable successes through implementation of the 8 Critical Activities. Those successful outcomes demonstrate that the partners can make meaningful improvements in a system that so many times seems too complex and beyond their grasp. It also motivates them and strengthens their commitment to make greater and more sustainable improvements.

Phase 1 and Phase 2 of the community collaborative development model is easier to implement than Phase 3 which creates Community Health Management District's, because CHMD's impact funding streams and the need to co-mingle resources. Although these issues as they relate to public and private dollars are significant the ability to demonstrate cost savings and the improvements that can be made in health access and outcomes lay a strong foundation for addressing these more complex resource issues.

Appendix A – Communities Connect Map



- Benton-Franklin Community Health Alliance
- Thurston County Medical Society
- CHOICE Regional Health Network
- Community Choice Healthcare
- Community-minded enterprises
- Whatcom Alliance for Healthcare Access
- King County Project
- Kids Get Care
- Spokane County Medical Society Foundation
- Washington Health Foundation
- HumanLinks Foundation

Appendix B – Community Healthcare Collaboratives Logic Model

Resources	*Activities*	*Outputs*	*Outcomes*	*Impact*
Using these resources:	***Community Healthcare Collaboratives will engage in these activities:***	***to produce these results:***	***which, will yield these benefits:***	***with this ultimate effect!***
Private and safety-net providers	Organize, acknowledge and enhance donated medical, RX, dental and mental health services.	Stable safety-net providers. Better access to quality local care.	80% of providers taking fair share of low-income. Access to appropriate services (safety-net capacity) will increase by 25%.	
Hospitals and practitioners	Develop patient care teams/plans to coordinate care for inappropriate Emergency Department users.	Improved communication among providers with high-risk patients.	Reduce inappropriate Emergency Department use by 33%. Reduce unnecessary costs by 10%.	
County Public Health	Sponsor the integrated resource development and implementation of the portfolio of 8 critical activities.	Local management of fully funded primary care and prevention improves health status and increases value.	Health Status improvements for 4% of target population. Replication on a state and national scale.	
Employers, agents and brokers	Set up employer pre-tax accounts for low-wage worker coverage. Apply for premium assistance.	Employers see value for financially contributing to coverage for low-wage workers.	The number of employers contributing to health coverage for low-income employees increases by 25%.	***Better health for everyone at less cost***
Social services, state government and philanthropy	Multiple outreach sites, electronically enroll, refer and case manage (track) using a common system.	Medical home continuity. Those at risk have access to an expanded medical home (e.g., health home.)	All enrolled will have a medical home. At least 2:1 return on community investment (ROCI).	
Client/ Patient/Employees	In control and self-managing wellness and chronic diseases. Actively understand the cost-to- benefit (value) of services (benefit in relation to cost).	Savings redistributed to cover the un- and underinsured.	100% access to covered services. Improvement in client's self-reported health status and lifestyle.	

Community-Based Health Care

Issue Paper: Draft #3

Communities Connect

September 1, 2006

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Community Based Health Care

Description of the Problem

We Spend Too Much on Unnecessary Care

The answer to the health care crisis can't be to just pump more money into the current system. U.S. spending on health care per capita continues to be the highest in the world by huge margins, with little evidence of improved health outcomes. Changing how health care is delivered is one of the most crucial activities of community collaboratives because it has the highest potential to improve quality, reduce costs and increase access. In Washington State, we spend 23.8% more per capita on health care than Utah, the most efficient state (this data has not been adjusted for potential differences in age, sex or reimbursement rates). The only way we will reduce the trend line for health care cost in Washington is if we deliver care differently, more effectively and reduce the number of uninsured. While uninsured people get less care, the care they do receive is typically fragmented and inefficient.

Health Care Needs to be Delivered Differently

The only way we will be able to deliver health care differently is if we have integrated community health systems backed by appropriate technology. These community health care systems are far more likely than purchasing groups or payers to accomplish relationship-based patient care, evidence-based selection of diagnostic and treatment modalities, team care coordination, and ongoing peer-based improvement of both clinical and business processes.

People Can't Afford Their Prescription Drugs

While only one aspect of a much more complex problem, affordable access to medications is a particular visible and urgent issue right now. This paper includes extended discussion of pharmaceutical access due to its high salience.

People Who Work Are Uninsured and Don't Have Access

The way we will dramatically reduce the number of uninsured in the current situation is if we reduce the unnecessary costs and redistribute those savings to cover the uninsured. Since 75% of the uninsured live in a home where at least one adult works, we need to involve employers in coverage solutions that "make cents" to them. Small employers cannot afford the full cost of coverage for low-wage workers, so we will need to better leverage public premium assistance funds with what small employers can contribute and maximize that leverage with pre-tax options to pay for primary care and prevention services. (See the Communities Connect reference paper entitled*: "Leveraging Government Funds with Pre-Tax Accounts and Tax Credits to Increase Small Employer's Financial Contribution for Low-Wage Worker Coverage").*

Consumer Stewardship

The way health care is financed isolates all consumers from the need and ability to be wise and prudent stewards of their body and health services. We believe that most people below 250% of federal poverty are able and willing to be better consumer stewards and we want to create a health care delivery system that makes this stewardship accountability visible, easy and rewarding.

Delivery System

Our outcomes in the United States are poor because the current service delivery system is so anecdotal, complicated, fragmented, and eroded that clients have come to experience the system itself as a barrier to overcome in order to access care rather than a consistent, familiar, and seamless extension of how health care works. Identifying a consistent location of care is increasingly difficult even for patients covered by Medicaid and Basic Health and more difficult still for the uninsured. The challenges of finding a stable medical home make it difficult for patients to cultivate the trusting, ongoing relationship with a health care provider associated with an increased sense of personal responsibility and ultimately improved health outcomes.

Health care delivery is local and the only way these changes will happen is if local communities are in charge and have greater accountability for the value of the health care dollar being spent. Since pricing future health expenditures is based on actuarial models tied to old delivery system models that we know don't work well enough, we will be breaking new ground with trying to predict the financial impacts of delivering community based health care differently and more efficiently. It will be wise to be conservative in predicting the impact of changes, but we should also challenge the actuarial analysis of such change, since this arm of science (while well equipped to predict the impacts of the status quo) is ill prepared to deal with a future model of change.

We Need New Approaches to Access

In the last two years, we've seen a dramatic increase in the number of low-income people whose lives will be compromised due to a lack of health care access. The health safety-net is crumbling before our eyes:

1. Safety net providers (hospitals, private-practice practitioners, Community Health Centers) are stressed to the point of operational instability.

2. More and more employers aren't able to offer affordable coverage to low-wage workers.

3. Low-income people cannot find and keep a medical home.

4. The cost of care is too high. Where savings are achieved, they are not redistributed back into the community to cover the uninsured, so the number of uninsured is on the rise.

5. The quality of care, measured as ability to deliver good healthcare outcomes across the population, is not acceptable and the current over-specialization and inefficiencies are not sustainable (or result in unacceptable public trade-offs).

6. Consumers are isolated from the value equation in personal health decisions and there is no process for a convergence of people's values at the community level for "what health care services are a right and where do we set limits?"

Project Design

We believe we can deliver better health care for more people at less cost by formalizing community collaboratives throughout Washington State who will be "in action" on six interdependent principles: 1) Stabilize the safety net of hospitals and practitioners who provide care to the low-income and uninsured; 2) Create flexible and attractive ways for

employers to financially contribute towards coverage for low-wage workers; 3) Enroll people with limited incomes in a medical home, starting with children; 4) Deliver evidence-based and patient-focused care through health teams; 5) Reduce costs and redirect savings to cover more people; 6) Purchase services of greater value to the community through Community Health Management Districts (CHMDs). The first three principles build local capacity for a coordinated delivery system. While communities start in different places, within three years, a portfolio of critical activities begin to emerge.

Target Population and Number of People to Be Served

Each community-based health care access demonstration will have some differences, but each is built on a defined low-income population, a commitment to change and a set of linked initiatives designed to build on local assets while addressing both the common issues of a collapsing safety net and unique local issues. The following information from the 100% Access Project in Grays Harbor, Lewis, Mason, Pacific and Thurston Counties (CHOICE Regional Health Network) is illustrative.

There are 425,000 people who live in this five county region. 135,000 (32%) of them are under 65 years of age and have low-income (below 250% of federal poverty) About 50,000 of them already have coverage through their employers, federal or state disability status, or other miscellaneous sources. The remaining 85,000 people are the 100% Access Project's target population, of whom 35% are currently uninsured (about 30,000) and 65% are enrolled in a mix of unstable government programs, such as Medicaid and Basic Health. About 75% of the uninsured group lives in a household where at least one adult works. Residents of this region tend to be sicker and poorer than people who live in other parts of Washington. There also has been a 126% increase in Latinos over the last ten years (170% in the 4 rural counties), many of whom know only limited English.

A portfolio of initiatives, all aligned with the 100% Access Project, impact on an estimated 27% of the target population in the first year and 55% by the third year of a Community Health Management Districts (CHMDs) start-up period. By the end of three years, these communities can have the capacity and volume to become Community Health Management Districts capable of providing comprehensive, sustainable, and evidence-based care for all 85,000 low-income residents in the target population through an integrated regional approach.

100% Access Project Portfolio of Initiatives	**Year 1 2005**	**Year 2 2006**	**Year 3 2007**
Regional Access Program	5,000	5,500	6,000
Pharmacy Assistance (Prescription assistance and broader, use of federal "340B" discounts)	900	6,800	10,000
Physician Access (Project Access)	1,000	2,000	3,500
Dental Access	1,000	2,000	3,000
Mental Health Access	600	1,200	1,800
New CHC and RHC	12,000	17,000	24,000
Emergency Department Community Health Advisory Program (Cumulative caseload)	100	250	400
New private practice accepting Medicaid and Basic Health	3,000	6,000	10,500
ConneXions	20,000	25,000	30,000
Employer workshops (# of employees potentially impacted)	600	800	1,000
Consumer Involvement: Councils, forums, surveys	2,500	3,000	3,700
Total Impacted	**46,700**	**69,550**	**93,900**
Unduplicated Total Impacted (minus 50%)	**23,350**	**34,775**	**46,950**
% of target population impacted (unduplicated)	**27%**	**41%**	**55%**

Community Collaboratives are the Builders of Local Capacity

We believe we can deliver better health care for more people at less cost by implementing a portfolio of best practices from around the nation to build community capacity for a sustainable safety-net. These best practices have proven we can save money by delivering higher-quality, less fragmented care. In other words, we must learn how to deliver care very differently from the way it is delivered today, and we must motivate and support providers to make the changes. In order to deliver care better, there needs to be more consistent use of technology and evidence in patient treatment.

We have access to an innovative calculation model developed in Rhode Island that applies national research benchmarks and demonstrates how much Washington State can save by reducing unnecessary costs. Early calculations show that potential savings are more than enough to pay for subsidized coverage for all the state's uninsured. The actual pace of implementation depends on how quickly we can change patient and provider behavior, and additional leveraging of resources will be essential during early implementation (before savings are realized).

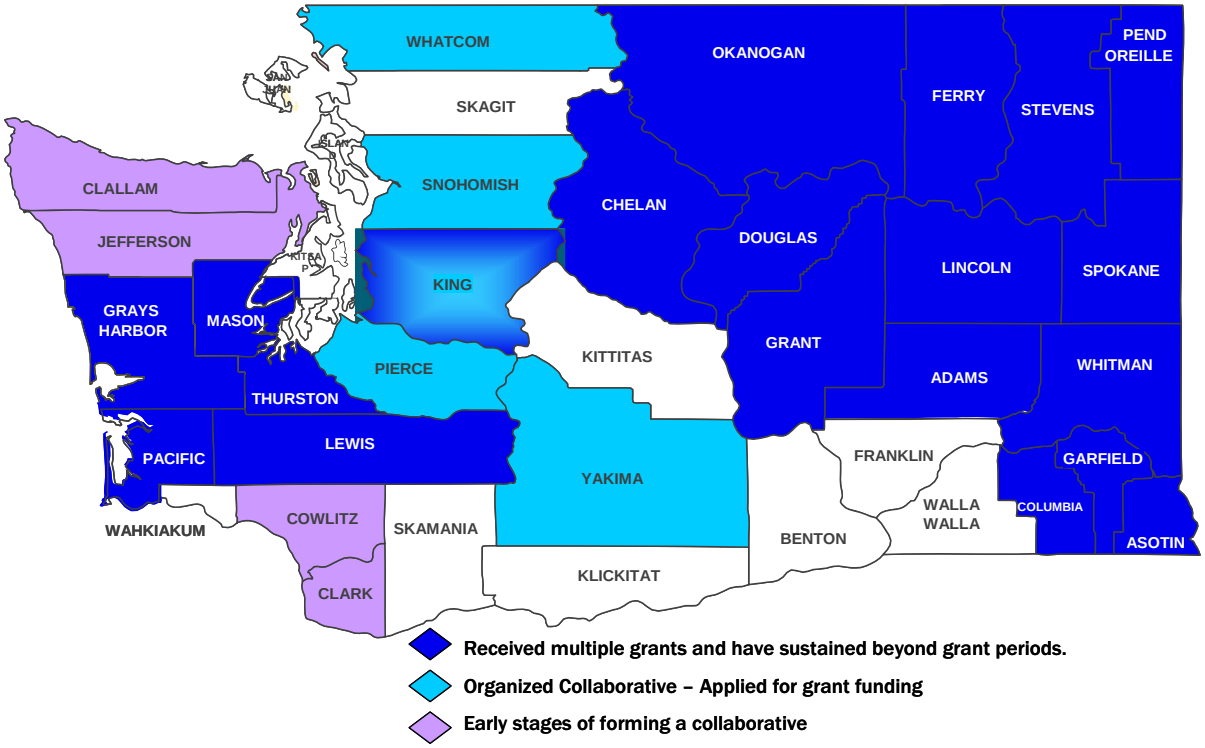
To sustain these changes and reduce health care inflation over time, we need legislation that creates new county-level governance structures that we are calling "Community Health Management Districts". These Community Health Management Districts (CHMDs) will be accountable for building local capacity and improving the performance of the system (including better health status). We believe this will foster a convergence of voters' values around two pivotal questions: "What services does everybody have a right to regardless of their ability to pay?" and "How will we set priorities to pay for these services?" This creates the grass roots support for greater consistency over time in state and federal decisions that relate to health care financing.

Community Collaboratives are the Means by Which to Achieve Better Health Care for More People at Less Cost

Nationally, there are estimated to be over 600 formal community collaboratives. Two hundred of these community collaboratives have participated in an evaluation through the HRSA Healthy Communities Access Program (CAP). This evaluation shows that over twelve months, these 200 collaboratives have provided access to more than 6.4 million low-income people, reduced the cost of care by $1.8 billion and leveraged $6 from the community for every $1 spent by the federal government.

Washington Community Collaboratives by Stages of Development

Many counties in Washington are participating in formal community collaboratives in various stages of evolution. Four community collaboratives, representing 20 counties, participated in the national HRSA CAP evaluation. A federal HRSA Communities Access Program (CAP) grant has funded most community collaboratives in Washington.



The HRSA CAP evaluation also shows that while communities often start at different places, within three years they begin to look alike. The following table outlines the common critical activities community collaboratives evolve to incubate and/or administer. One “x” means little activity in WA, “xx” means some activity and “xxx” means considerable activity.

Critical Activities Nationwide	*WA*
a) Organize volunteer safety-net providers for medical, dental and mental health services with coordinated specialty referrals.	XX
b) Reduce inappropriate Emergency Department use.	XX
c) Administer care coordination and disease case management programs.	XX
d) Leverage public funds with local and private resources, including employer contributions.	X
e) Perform outreach to find the low-income and uninsured and connect them to a medical home, facilitate access to health services.	XXX
f) Partner with state agencies to enroll people in public and private programs for which they are eligible.	XX
g) Create common electronic referrals among local health and human services providers.	X
h) Arrange for affordable prescription drugs on a community-wide basis.	XXX

We have learned that community collaboratives form quickly and have predictable outcomes when they replicate best practices models for critical capacity building activities. Examples of national best practices include:

Principle 1: Stabilize the Safety-Net

Project Access in North Carolina: A physician-led initiative to organize, acknowledge and expand the under compensated care that physicians provide, have been able to reduce the direct cost of care by 33%.

Health Access in Utah: A formal case management and care plan process for Emergency Department clients who inappropriately use the Emergency Department for care. They have reduced frequent users' inappropriate Emergency Department use by approximately 25%.

SKYCAP in Kentucky: An intensive care coordination model where lay-workers are trained to reduce service fragmentation for at-risk individuals.

Principle 2: Create ways for employers to financially contribute

3-Share in Michigan: A program where small employers pay 1/3 of the premiums for comprehensive coverage for their low-wage workers, employees pay for 1/3 and public funds pay for 1/3. They have been able to reduce employee absenteeism and increase productivity.

Principle 3: Enroll everyone in a medical home, starting with children

CHOICE Regional Access Program (RAP) and the Health Improvement Partnership (HIP) in Washington: Intensive outreach, enrollment and case management services for low-income people. They have reduced hospital uncompensated care by $1.7 million a year.

PCAP in Arizona: Automated and delegated enrollment in Medicaid and delegation of this process from state agencies to community-based organizations. They have shown a 5:1 administrative return on investment for Medicaid.

Jesse Tree in Texas: A coordinated and automated system of information and referrals utilizing a regional phone number (2-1-1), along with a universal screening form and application. This simplified application and referral process will increase access to services by making it easier to navigate through the numerous and often confusing sliding fee scale and charitable systems. They have increased immunizations and health prevention screenings by 30%.

Community-Wide Pharmaceutical Access; Coordinated Care Network, Pennsylvania: A network that provides case management and low-cost pharmacy services (qualifying for deep price discounts through the federal "340B" program) to underserved populations in 10 counties across southwestern Pennsylvania (including Pittsburgh). CCN's mission is to reduce "system" costs through its case management and prescription discount programs and in the process generate sufficient earned income to finance health care for its uninsured population.

Kids Get Care in Washington: A program to ensure that children, regardless of insurance status, receive early integrated preventive physical, oral, and developmental health services through attachment to a health care home.

Measurable and Predictable Outcomes

On page 11 is a logic model and listing of activities critical to achieving measurable outcomes. Letters in the "activities" column refer to 8 "critical activities nationwide" (page 9). Outcomes and impacts are illustrative; each CHMD will negotiate guarantees as part of authorization and funding agreements.

Logic Model for Illustrative Activities of a Community Health Management District

Resources →	*Activities* →	*Outputs* →	*Outcomes* →	*Impact*
Using these resources:	***we will engage in these activities:***	***to produce these results:***	***which, will yield these benefits:***	***with this ultimate effect!***
Private and safety-net providers	Organize, acknowledge and enhance donated medical, RX, dental and mental health services. (a,h)	Stable safety-net providers. Better access to quality local care.	80% of providers taking fair share of low-income. Access to appropriate services (safety-net capacity) will increase by 25%.	***Better health for more people at less cost*** Each CHMD's specific guarantees will state levels of impact within a defined period such as 4 or 5 years.
Hospitals	Develop patient care teams/plans to coordinate care for inappropriate Emergency Department users. (b)	Improved communication among providers with high-risk patients.	Reduce inappropriate Emergency Department use by 25%. Reduce unnecessary costs by 10%.	
County Public Health	Sponsor the integrated resource development and implementation of the portfolio of initiatives. (d)	Local management of fully funded primary care and prevention improves health status and increases value.	Health Status improvements for 4% of target population. Replication on a state and national scale.	
Employers, agents and brokers	Set up employer pre-tax accounts for low-wage worker coverage. (d) Apply for premium assistance. (d)	Employers see value for financially contributing to coverage for low-wage workers.	The number of employers contributing to health coverage for low-income employees increases by 15%.	
CHMD, community partners and philanthropy	Multiple outreach sites, electronically enroll, refer and case manage (track) using a common system. (c, e,f,g,h)	Medical home continuity. And those at risk have access to the many existing health management interventions.	All enrolled will have a medical home. At least 2:1 return on community investment (ROCI).	
Client/ Patient/Employees	In control and self-managing wellness and chronic diseases. (c,h) Actively understand the cost- to- benefit (value) of services (benefit in relation to cost).	Savings redistributed to cover the un- and underinsured.	100% access to covered services. Improvement in client's self-reported health status and lifestyle.	

Community Health Management Districts Will Fully Fund Primary Care and Clinical Prevention

Taking the work of the U.S Preventive Services Task Force and the State Board of Health's Critical Health Services a step further, primary care that will be fully funded is defined as follows:

"Primary care is initial health care (where you start) and ongoing care (where you go back for help with health problems), it is provided by trained health professionals. Primary care means having an ongoing relationship of trust that includes health education and the development of self-care plans. The goals of primary care are to prevent illness, maintain health, and stabilize acute episodes of illness or injury. If you have a chronic condition, primary care attempts to maintain normal health, comfort and the ability to carry out usual activities. Primary care includes preventive care, the first level of acute care, and continuing care for chronic conditions. It includes basic dental services and mental health services. It also includes care coordination. This means connecting patients with other needed services, including more specialized medical care, and it means having services to allow patients to be responsible for their own health. Primary care is accessible to all community members regardless of income, and promotes care coordination and practitioner-patient partnership. It is accountable to the community, to patients and to standards of scientific evidence."

As referenced above, "preventive services" includes all services endorsed by the U. S. Preventive Services Task Force using its widely respected approach to rating evidence of effectiveness.

Community Health Management Districts Will be the Pharmaceutical Safety-Net

Because of high current interest, access to prescription drugs offers a good case example of how CHMDs can provide an administrative home for interim as well as comprehensive solutions to problems of access, cost and health care system performance.

Pharmaceutical drugs (medications) are now a component of almost all medical treatment. The increase in the diversity of illness treatable with medication and the increase in cost to develop new treatments have resulted in medications being an increasing percentage of every health bill. However, people in greatest need cannot consistently access affordable medications. Frustration in not being able to obtain affordable medications has echoed through all demographic groups, but those who are low income, uninsured and/or have chronic conditions are most severely impacted by lack of access to affordable medications. One large study of the uninsured (The Access Project, 2003) found that 56% of respondents needed help paying for their prescribed medications. As a result, 13% to 30% of respondents reported obtaining none or only some of their medications. The effects of not being able to obtain medication include increased medical severity, prolongation of illness, unnecessary Emergency Department use, increased total cost of care and poor outcomes, including death.

Current barriers to obtaining affordable medications include:

- Lack of coordination and legal restrictions in the distribution of free sample starter medications from pharmaceutical companies to physicians and clinics, which hampers their use for people without other resources.
- Vendor-sponsored free or reduced-cost Prescription Assistance Programs for those in need are maddeningly complex, have processes and requirements unique to each company and usually require reapplication for each medicine every three months. This complexity places a time and cost burden on physician offices, the patients and those assisting the patient and is a waste of precious resources.
- Low volume purchasing among multiple purchasers contributes to the high rate of pharmaceutical inflation.

- The 340B discount drug pricing program currently provides the least expensive pharmaceuticals, particularly for higher priced non-generics. However, currently only a restricted number of covered entities (e.g., Federally Qualified Health Centers) are able to obtain 340B pricing, and only for their treatment of their patients. Thus, a wide variety of other clinics, charitable physicians and other community programs are unable to obtain similar low pricing for their equally needy patients.
- Low-income patients often float in and out of public program medical coverage and reestablishing benefits is a complex and lengthy process. For instance, patients lose state coverage when imprisoned. Many require multiple pharmaceuticals including expensive mental health pharmaceuticals. Without pharmaceuticals many exhibit costly behavior resulting in increased Emergency Department use, large county expense and recidivism.

Community Health Management Districts will find innovative long-term solutions to funding, acquiring and distributing affordable medications to those most in need.

In addition to the long term potential, some of these solutions can be implemented much sooner as interim measures.

1. Network Adequacy:
    - Each CHMD contracts with a comprehensive range of both individual health providers and health provider networks, including safety-net providers, some of who are eligible to acquire medications through the 340B drug discount pricing program.
    - CHMDs join in a consortium to leverage statewide or large area influence and economies of scale, one of which is to achieve deep discounts on bulk purchasing of pharmaceuticals.
    - A network of pharmacists and Pharmacy Benefits Managers (PBMs) would play a role in the acquisition, distribution and tracking of, and patient education, case management and reimbursement for, pharmaceuticals.
2. Acquisition (the enterprise):
    - Acquisition through federal 340B Program: the ultimate goal is to purchase through the 340B program pharmaceuticals for any low income CHMD enrollee regardless of the site of care. This may require reinterpretation of current law or small incremental additions to current law.
        - Identify all covered entities qualifying for 340B and, through networking and subcontracts, create a system that allows as many CHMD enrollees as possible to purchase medication under their auspices. Two promising examples are involving Disproportionate Share Hospitals (new covered entities) and case management of poly-pharmacy patients (new enrollees).
        - Push for expansion of 340B covered entity definition to include community-based charitable health coalitions and their patients.

For example, Representative Rush's bill HR 4161 could be modified for this purpose.

- o If Texas is successful, work with state policy makers to request a Texas-style waiver that would expand the definition of "patient" eligible for 340B discount.

- Acquisition through group purchasing: work with state policy makers to add CHMD enrollees in the state's new purchasing pool for pharmaceutical discounts for those currently over 50 and low income who are allowed access.
- Acquisition through vendor-sponsored prescription assistance programs: follow the lead of other states that have negotiated successfully with a group of pharmaceutical companies to provide a full spectrum of pharmaceuticals to the state's low income uninsured without having to apply for each medicine individually. Health Indiana has been able to negotiate free medications for such patients under 150% FPL. Negotiate a universal application and standardized process.
- Acquisition through use of vendor-supplied samples: create a system that efficiently acquires and distributes sample medications. Change state law to allow pharmacies associated with charitable activities to repackage and distribute sample medications. Allow samples to be used to start medication delivery in prescription assistance programs while waiting for delivery of program medications from the company.
- Acquisition through Medicare Card: use the new Medicare discount cards with eligible CHMD enrollees.

3. Distribution:

- Key to cost-effective distribution is a centralized pharmacy function. Each CHMD or a consortium of CHMDs can contract with, or create a state-wide, centralized pharmacy company that acquires medications at affordable prices using the strategies above and dispenses medications via a network of pharmacists, mail delivery, or through physician offices. The pharmacy company would handle all the logistics associated with the dispensing of medications.
- Another key to cost-effective acquisition and distribution is development and management of a formulary, developed in consultation with the provider network and pharmacy company.
- The final key to cost-effective distribution is patient education and counseling, and case management of complex, high cost poly-pharmacy patients. Each CHMD will provide or subcontract to provide this vital service.

4. Funding Sources:

- The CHMD will seek to show return on community investment in its pharmaceutical safety-net activities and will use positive Return On

Community Investment (ROCI) to leverage funding sources to redirect savings to cover more people.

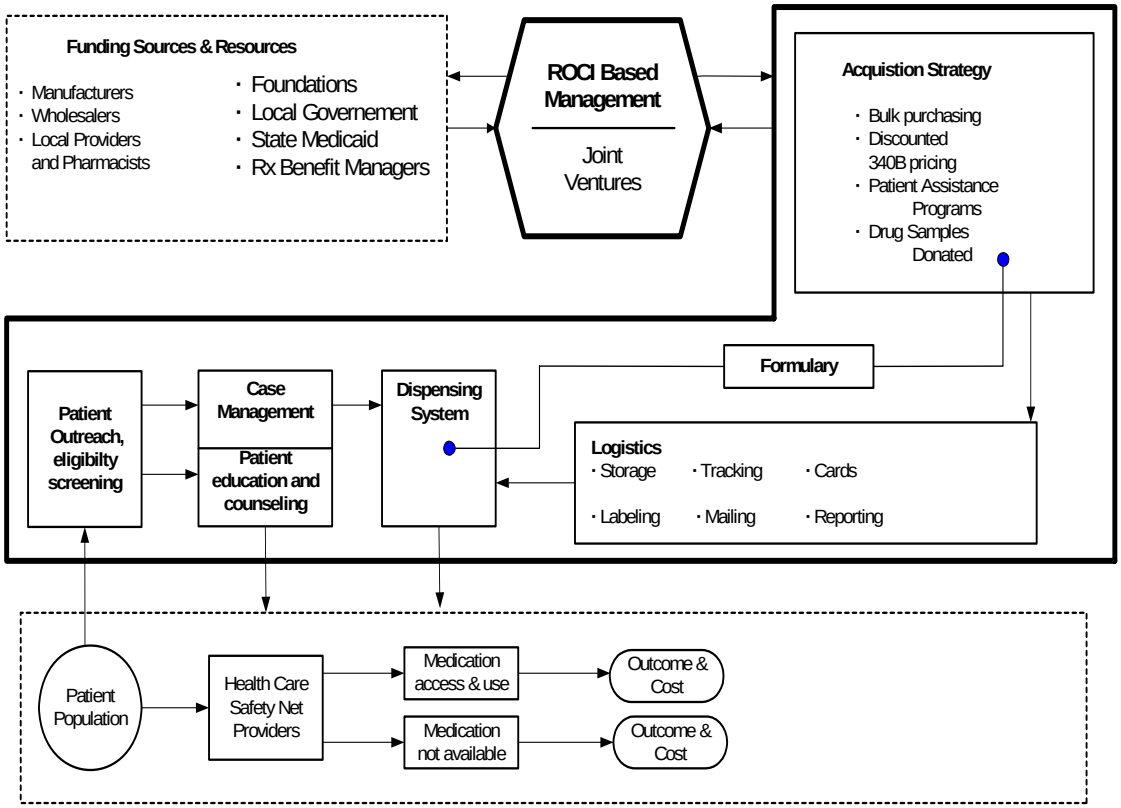
- The CHMD will seek to partner with funding sources in joint venture fashion to create ROCI targets.
- Funding sources include state, county and local governments, pharmaceutical companies and wholesalers, local providers and pharmacists, PBMs and the centralized pharmacy company, and charitable foundations supporting the activities of the CHMD.

5. Organization:

- The graphic below was developed for Communities Joined in Action's RX Learning Institute, held in June 2004, to illustrate a free-standing pharmaceutical access organization, but it is easy to see how these functions could be part of an appropriately organized CHMD.

Context & Elements OF A Community-Wide Pharmaceutical Access Enterprise

(The enterprise is in bold outline)



Community Health Management Districts Will Deliver Medical, Dental and Mental Health Care Differently

Consumers will feel accountable and have the information they need to be good stewards of their bodies and pocket books:

- Consumers will have a stable and predictable method to finance health services that makes consumers aware of the costs of their decisions and the value of their purchases.
- Consumers will have an easy access to a basic level of appropriate and effective health services. This means we will minimize unnecessary costs and medical interventions and create incentives for prevention and primary care that consumers can access in their own neighborhoods.
- Consumers will have an aligned incentives and health management interventions to encourage them to be healthy throughout their life.
- Consumers will have a consistent access to a flexible, multi-disciplinary team approach that meets the needs of consumers because it is respectful, compassionate and evidence-based. By being compassionate we will communicate about and encourage the relief of suffering.
- Consumers will have an annual health assessment process that produces personal wellness reports.

The provider and patient relationship will be more dynamic:

- Patient-centered disease management.
- Health care teams where the use of technology allows continuity of medical records.
- Patient will have stable access to a usual source of culturally competent care where trust can be built over time.
- Patient will receive education from the provider team.

Consumers will use fewer services due to:

- Training in chronic disease self-management, and disease management
- Commitment to care plans.
- Investment in the plan through personal actions and in many cases out-of-pocket dollars.

Practitioners will provide more consistent, higher quality treatment with fewer errors due to:

- Evidence-based treatment norms.
- Peer Quality Improvement (QI) initiatives.

Practitioners will take their fair share of the uninsured:

- 80% of the practicing providers will provide uncompensated care to eligible patients enrolled in Project Access.

- A network of community partners will donate services, products, or funding toward the operation of the project, which ultimately will include medical, dental, mental health, pharmacy and durable medical equipment.
- Network of provider will be developed to serve as the foundation of providers for CHMDs.

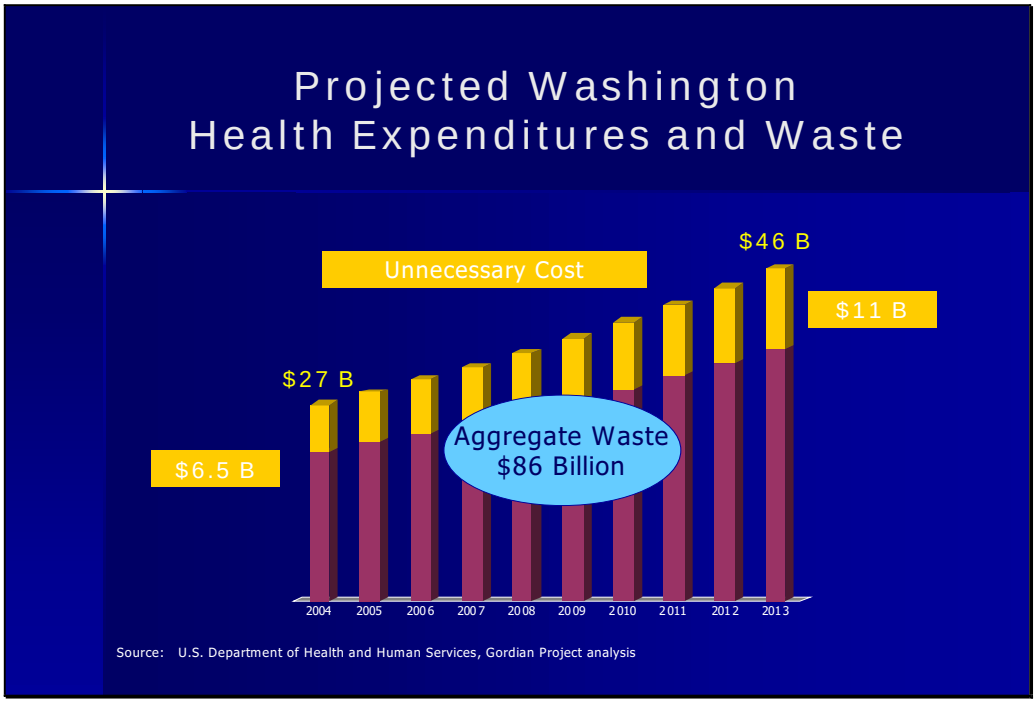
Community Health Management Districts Will Redistribute Savings to Cover the Uninsured

Based on national research, on average 30% of health care expenditures are unnecessary. They are unnecessary costs due to: 1) redundant tests, 2) errors, 3) unnecessary diagnostics, and 4) unnecessary treatments. The level of unnecessary cost in Washington is probably less; the graphic on the next page has a reduced assumption of 24%. Only 8.4% of Washington's population is uninsured (2002 data). Despite concerns that uninsured people will use high quantities of health care if they gain coverage ("pent-up demand"), few of them are in the highest utilizing age group over 65. Additionally, many uninsured people are relatively healthy low-wage workers who are unlikely to become high utilizers. This means that capturing even a third of the potential savings (or 8% of statewide spending for healthcare) would provide the resources to cover the uninsured.

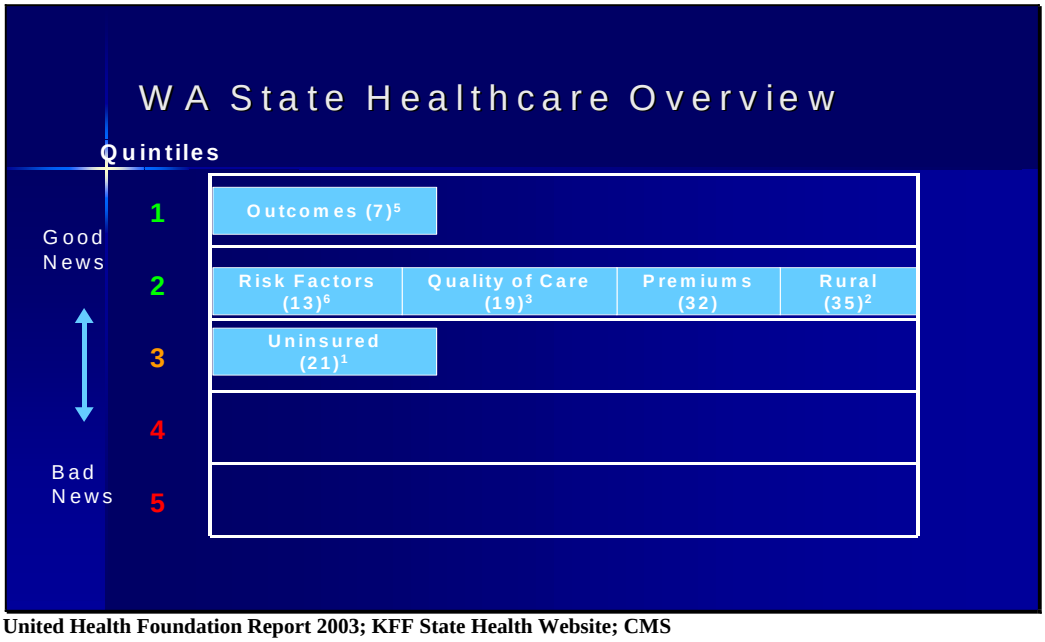
The graphic on "Projected Washington Health Expenditures and Waste" shows the dollar amounts. In 2004, Washington State will spend $27 billion on health care; $6 to $8 billion of that will be unnecessary costs. By 2013, that will escalate to between $11 billion and $14 billion. The ten-year aggregate waste is $86 to $108 billion.

The unnecessary costs were estimated based on benchmarking studies that compare various parameters of the health care market among geographic practices areas. Much of this work goes back to the research of John Wennberg, Elliott Fisher and others, comparing regional variations state-to-state and among groups of markets with similar characteristics. In the state-to-state comparisons used to develop estimates for Washington, Utah is the most cost-effective health care market. The gross comparisons do not correct for demographic and "lifestyle" differences and this in one of the many reasons we do not claim that all theoretical waste can be recaptured.

By taking action now to reduce unnecessary costs, it is possible to generate the savings needed to cover all the uninsured within as little as 5 years, without raising state taxes or reducing provider payments to unsustainable levels, depending on how quickly we can change patient and provider behavior. Without reducing the number of uninsured, we will not be able to dramatically reduce waste, because the care received by uninsured people, while inadequate in quantity, is fragmented and inefficient. As different people cycle through periods of being uninsured this inefficiency greatly impairs the health care system's overall ability to improve health status.



The second graphic shows how Washington ranks in relation to other states on clusters of indicators related to health outcomes, health risk factors, quality of care, premiums, the percent of population in rural areas and the percent uninsured. The numbers in parentheses are actual ranks among 50 states. Most of the data comes from state health rankings that United Health Foundation maintains in partnership with the American Public Health Association. On most factors, Washington is in the top two quintiles (that is, among the 40 states with the best indicators) but we are in the middle quintile when it comes to percent uninsured. This high-level comparison of indicators suggests that clinical outcomes in Washington are good for those who receive care and that on average, our state's residents have fewer risk factors than the median state. Since having a large portion of uninsured in itself contributes to fragmented and inefficient care, Washington may have a particularly good prospect of improving the cost-effectiveness of healthcare in Washington through coverage of the uninsured and supporting heath care providers to do their job effectively.



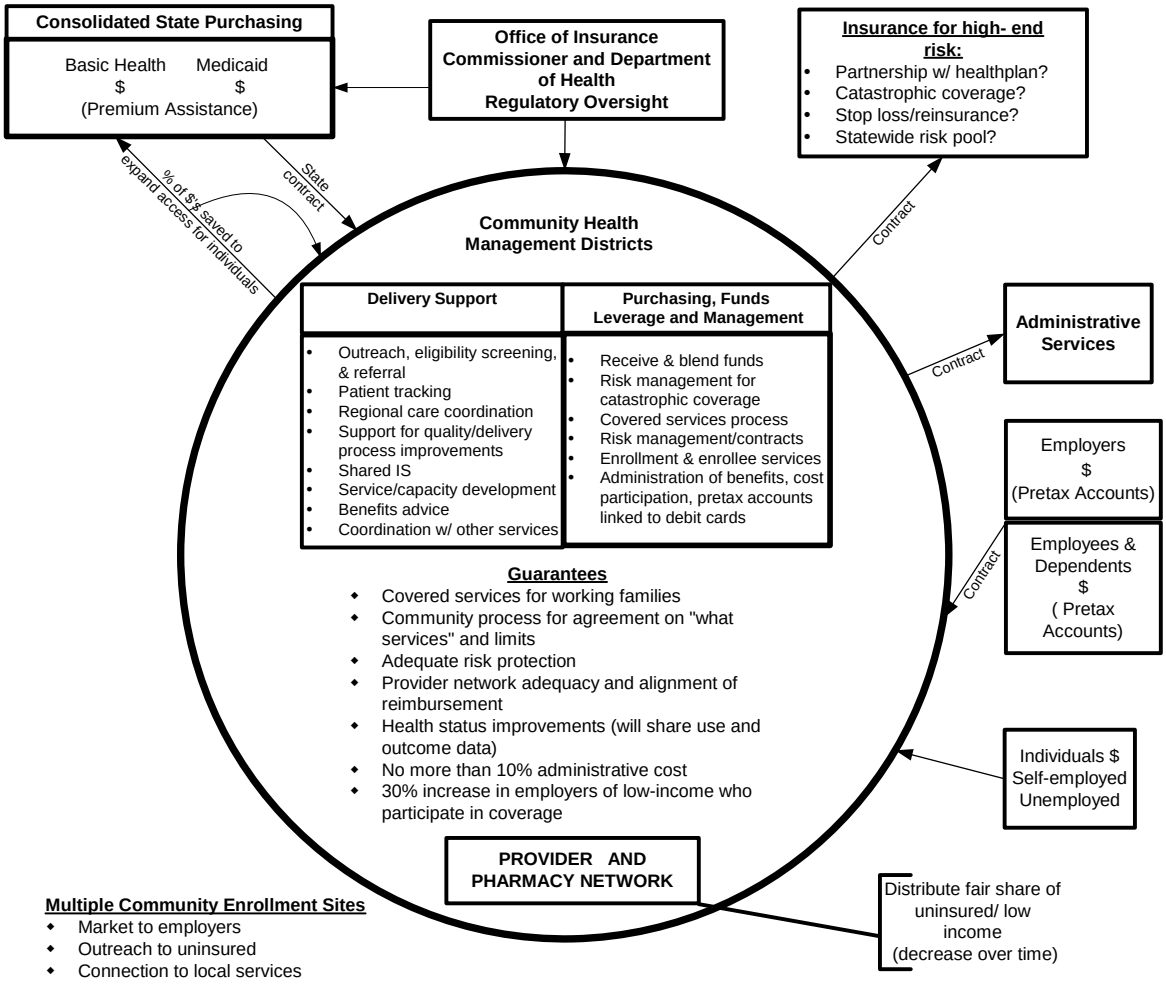
United Health Foundation Report 2003; KFF State Health Website; CMS

Community Health Management Districts Financial Model

The Community Health Management District model, shown in the graphic on page 20, calls for pooling existing funds that pay for low-income care through Medicaid and Basic Health to aid in financing. It is quite possible that not all populations would be pooled at once, to make sure that the model works for the wide variety of situations, including people with severe disabilities. Additional revenue will come from participation by employers and the cost-sharing by low-income enrollees.

To the maximum extent possible, each CHMD pilot site will develop a consistent approach to covering all low-income people. This will mean consistency in services covered, in how cost-sharing works in relation to income and in how providers get paid. The objective is to contract for and pay for the "primary care" tier of services in a way that is as administratively simple and predictable as possible, with the CHMD taking a strong and direct accountability to make this happen. This is feasible because the financial requirements to provide primary care for a population are fairly predictable.

Community Health Management District: Schematic With Illustrative Guarantees



At least for the near term, we foresee the need for CHMDs to have a relationship with another entity that can manage the financial uncertainties of "higher-end" care (beyond the primary care spectrum). Most likely this will involve partnership with an insurance carrier, though a willing governmental entity could also play this role in concept. As the graphic is drawn, money comes into the CHMD for all care and a portion of the money is paid out again for the premium for this high-end care: whether structured as a group catastrophic policy, stop-loss coverage or reinsurance for the CHMD, participation in a statutory statewide risk pool, or some other form of insurance partnership. A large number of operational and practice support functions will need to be carried out, whether by the CHMD itself, an insurance carrier partner or through other contractual relationships.

Community Health Management Districts Will Increase Employer Participation

Employer focus groups repeatedly demonstrate that employers are motivated to provide coverage for themselves and their employees but are unsupportive of mandates and tax increases. CHMDs will tap into this motivation by providing voluntary, affordable and flexible options:

1. Local agents and brokers working with the CHMDs will market the coverage product to employers and employees to increase enrollment;

2. Local agents and brokers will work with employers and employees to maximize their contributions through the use of federal revenue and tax savings (e.g., Health Savings Accounts, Earned Income Tax Credits) and

3. Government subsidized premiums for small employers will increase the affordability of coverage meeting community expectations.

Many employees of small employers are enrolled in subsidized coverage as individuals through Basic Health or Medicaid. Maximizing the substitution of subsidize employer coverage will stretch limited government resources further. An incremental approach (see diagram below) to trade up and leverage employer contributions can be started without any changes to state or federal law.

A Spectrum of Employer Participation Possibilities for 100% Access Model

	A	B	C	D	E	F	G		H
Opportunities		Information, get employers engaged and giving something. Start "trading-up" process somewhere.	After wait for coverage, achieve deep income-related subsidy. Opportunity for employer sponsorship.	Potential to meet most needs for many people. Underinsurance risk is smaller than in A or B and community can try to address.	Benefit design could encourage prevention. Health plan could help us get from E through G and past The Gray Zone.	Provider network means greater value and assurance of finding a "medical home" and other needed services locally.	Premium subsidy is likely to bring in additional employer dollars (compared to F). More uninsured could be covered.		Community "ownership" may maximize leverage of local resources and increase sustainability.
Fear Factor: Ensure we move up spectrum		**Where**	**is minimum start place for Principle 2?**				**How to transition from here to here?**		
Employers	No employer contribution to health care coverage beyond general taxes.	Employers sponsor pre-tax accounts, may also contribute, but no employer contribution to catastrophic insurance.	Inform employees about BH individual (wait list). Consider sponsorship.	Share cost of pre-tax accounts with catastrophic insurance (HS A)	Share cost of HSA with preferred relationship with a health plan	Share cost of HSA + preferred health plan; participate in a local provider network	Same as F with premium subsidy in place from an external source. Lend advocacy support in filling service gaps.	The Gray Zone	Community program for all low-income that employers pay into.
	Red	**Orange**	**Yellow**		**Getting Green**		**Green**		**Green**
Employees	Pay out of pocket, incur debt or go without care. More ED visits because seen as "free". Less primary care and prevention because not seen as "urgent."	Some savings available for medical services to mitigate red zone. May address premium or co-pay costs if employee has Medicaid or BH.	Adults placed on BH waitlist (about 1 yr). Enroll children in Medicaid and adults in Project Access.	Employee contributions determine amount in HSA. HS A can be used for any IRS-defined health care. Financial protection for catastrophic events.	Same as D with more structured incentives to use prevention and primary care.	Same as E with better pricing of and access to services.	More employers participating means greater portability and continuity of coverage.		One integrated program for entire family. Never "uninsured" for services everyone has a right to, regardless of their ability to pay.
Concerns	May include services that are not "evidence-based and effective." May not encourage prevention. Creates false sense of financial coverage.		Long waits for adult coverage. Doesn't leverage resources to the maximum (resulting in less coverage).	Still may not be adequate coverage. May not be designed to encourage prevention.	Needs to be more attractive to employers than yellow zone options. Sliding fee scale deductible? How much control over HS A spending?		Financing sources for premium subsidy needed.		Financing needed to fill gaps in service. Needs to be more attractive to employers than options to left.

(See Communities Connect reference paper entitled: "Leveraging Government Funds with Pre-Tax Accounts and Tax Credits to Increase Small Employer's Financial Contribution for Low-Wage Worker Coverage").

Community Health Management Districts will Retain an Adequate Network of Providers

Washington State communities are struggling with recruitment and retention of physicians in primary care and many specialties, especially when linked to high areas of Medicaid or Medicare population. CHMDs will provide stabilization and increase the success of physician retention and recruitment in several ways:

- Predictable payment;
- Reduced administration at the physician office level;
- Care risk reduction;
- Fair distribution of low income patients;
- Innovative approach to malpractice protection and
- Strong provider-patient partnership and shared commitment to make health care effective for the whole community, making for a positive practice environment.

(See the Communities Connect reference paper entitled: "Recruitment and Retention of Physician")

Community Health Management Districts Will Be a New Local Entity

Authorized by state statute, a Community Health Management District may be a current legal entity, such as a county/municipal health department, a hospital district, a local/regional health care contractor, a tribe or an existing or newly formed non-profit agency that meets criteria set by the Consolidated State Purchasing Agency (integration of state health care purchasers).

The CHMD is a community owned and directed organization that manages more effective health care expenditures. It places emphasis on patient education, wellness and prevention programs to maximize the use of health care dollars. Communities, counties or other geographic regions should have the option to have a county health department, hospital district, tribe, not-for-profit agency or health care contractor serve as the CHMD. The Insurance Commissioner or State Department of Health will be authorized to license, regulate and audit CHMDs.

Multiple Public and Private Options for Governance and Accountability to Best Augment Local Capacity in Place

Public (Local Government)

Pros: Clear line of public accountability to the community, potential taxing authority, may have better chance of long-term sustainability. Statewide legal structure exists.
Cons: Subject to political influences that might not support community needs or consistent public policy. Expands current scope of local government. There will be concerns about "unfunded mandates".

Public/Private

Pros: More responsive to community structures and influences, community based governance, aligned with community resources, more responsive organizationally and strategically, better equipped to coordinate public and private funds.
Cons: May lack long-term sustainability if not connected to a taxing authority. Could potentially be dominated by non-community interests.

Community Health Management District Guarantees

CHMDs will need to provide certain guarantees of improving health system performance through some combination of statutory compliance provisions and performance contracts with state purchasers and other funders or investors. Illustrative examples are included on the CHMD graphic on page 20 and the following serves as a potential list to prioritize:

1. Shared Use and Outcome Data
    - Community/patient utilization of health care dollar
    - Uninsured/socio-economic data
    - Patient census
    - Health provider supply, including appropriate incorporation of both traditional safety –net providers and a broad network.
    - Health access issues
    - Communicable & chronic disease

2. Community Resource (Clearinghouse) for Wellness and Prevention Education
    - Health screenings
    - Community health record
    - Consumer wellness reports

3. Best Practice for Disease Management Models

4. Active Support for Public Health Goals
    - Assuring access (including access to pharmaceuticals)
    - Participating in health campaigns
    - Reporting communicable diseases

5. State and National Health Advocacy Network

6. Reduce Fragmentation (probably regional or multi-county)
    - Transportation
    - Interpreting
    - Care coordination

Community Health Management Districts' Health Interventions

While CHMDs are not themselves health care providers, they can undertake managerial responsibility for interventions that support the health care provider system in patient care. While these interventions themselves will evolve with the state of the art, The Health Plan for Life (***HP4Life***[SM]) model developed by the Seattle-based w ***HP4Life***[SM] workshop coordinated by Dr. Stephen Barchet is a valuable benchmark for what can be done. This model includes a set of health management interventions to support consumer stewardship:

- Consumers attend a 2 hour workshop “You Can Make a Difference” to learn how to actively participate in improving their own health through greater understanding of health care services, cost and utilization.
- Consumers can choose to have a wellness mentor with incentives for wellness achievements.
- Consumers receive medical self-care book by mail.
- Consumers complete annual health questionnaire resulting in a personal wellness report mailed to them with a clinical summary sent to their primary care practitioner.
- Consumers whose wellness report identifies them as “high-risk” receive a telephone call from a wellness coach, which will offer to work with them to develop a patient care plan.
- Consumers, who have certain conditions, are enrolled in disease management programs and complete a shared patient care plan (Pursuing Perfection model).
- Consumers have access to a library of self-directed behavior change and health-related materials and audiotapes that can be sent to them, accessed via the Internet or listened to over the phone.
- Consumers receive a wellness newsletter is sent each month.
- Consumers have access to a 24/7 toll-free health advice line.
- Consumers receive targeted biometric screening (fact-based report on individual’s lab data, immunization history, radiology, etc.) to help them take steps to reduce or eliminate risk.
- Consumers have Linkage to face-to-face health and wellness services.

Possible Tension Points to Resolve with State Agencies

- Community enrollment sites compared to centralized fraud control approach.
- State’s willingness to contract out services they feel they could do with greater consistency statewide and with more fiscal control.
- Reserve? Do we need one? If so, where? State, health management district or carrier?
- Multi-county districts for rural areas (cf. Educational Services Districts).
- Will need to have credible analysis that the additional “layer” will save more money than it costs and reduce administrative complexity rather than add to it. Good outcome data on CHMD’s will be critical.

Phase In an Innovative Statewide Solution

There are four regions in the state with mature and sustainable community collaboratives that could serve as pilot project sites for Community Health Management Districts. These pilots will inform a statewide solution. The communities ready to be pilot sites include:

1. CHOICE Regional Health Network: Thurston and the surrounding rural counties.

2. Health Improvement Partnership and Project Access: Spokane and the surrounding counties.

3. Community Choice: Douglas and the surrounding counties.

4. Whatcom Health Alliance: Whatcom County.

Community Health Works and is Innovative at Multiple Levels

Community

Consumer involvement: There will be a robust annual public process that facilitates a convergence of agreement on what services everyone has a right to and where limits will be set. This will create the grass roots support for greater consistency over time in state and federal decisions that relate to health care financing.
Employer contributions: Employers across the nation and, in Washington State in particular, have resisted coverage mandates and increased taxes. This project creates flexible, local, voluntary and subsidized options for employer coverage which will add new resources not currently on the table. This will better leverage public funds.
Investments in community health status improvements: Communities will measure morbidity and mortality and set targets for improvements. The personal health care system will have an appropriate share of accountability for meeting those targets.

County

Community Health Management Districts: CHMDs will facilitate changes and have the tools in place to deliver care differently. They will blend, leverage and manage health care finances for people below 250% of FPL. CHMDs will guarantee that: 1) There is easy access to covered services, 2) Primary care and prevention is fully funded, 3) There is adequate risk and financial protection, 4) At least 15% of employers contribute to coverage, and 5) There is an adequate network of efficient, high quality providers practicing evidence-based medicine.

Regional

Regional Referral and Care Coordination Service: Given the natural use patterns of consumers and referral patterns of providers, we can operate language access (medical interpreting), transportation, care coordination, specialty referral and client tracking administrative services on a regional basis to support safety-net providers.

State

Reducing unnecessary costs to cover the uninsured: Research shows that 24% of health care expenditures are unnecessary due to: 1) redundant tests, 2) errors, 3) unnecessary diagnostics, and 4) unnecessary treatments. Our four pilot service areas (20 counties) have a total of 23% of the states population. In 2004, they will spend $6.2 billion on health care, $1.4 to 1.8 million of which will be unnecessary. If we are able to capture and redistribute one-third of the unnecessary cost by the end of a several year phase-in period, we will be able to “close the gap” and cover all the uninsured from that point without raising taxes or reducing provider payments to unsustainable levels.

Leveraging public dollars with employer contributions to cover the uninsured: In addition to reducing unnecessary costs, we will be able to add new revenue through employer contributions. A significant number of those enrolled in Medicaid and Basic Health live in

a home where at least one adult works but isn't offered affordable coverage. By increasing employer sponsored coverage by only 15% and subsidizing the premium by one-third, we'll be able to make a significant contribution to covering the uninsured.

National

Community owned Access Case Management Information System (ACMIS): Now that we are learning that community collaboratives across the nation have eight common critical activities, we can combine our user purchasing power for a comprehensive information system to support these activities. Rather than continuously invest government and philanthropic resources in duplicative, customized IS development, we will be a national model for an off-the-shelf system that community after community can implement without risk or waste. The ACMIS will begin with web-based functionality to 1) Client registry and tracking; 2) Enrollment; 3) Resource referral; 4) Case management; 5) Disease management; 6) Prescription assistance; and 7) Donated services management.

Later phases of ACMIS may include additional functions to support CHMD operations, if combining them in the same information system is the most efficient way to achieve desired scope, integration and efficiency. Whether or not the same software package is used, the connectivity and experience with a shared system provided by ACMIS will pave the way for these expansions of function within each community.

- Where is cost and access to health care on your priority list of issues impacting the state?
- Will you support "community driven" solutions to resolving cost and access to care issues?

Tab 9

Introduction

Community Health Network of Washington (CHNW) is the state's largest safety net provider system as well as the parent organization of Community Health Plan, our state's only non-profit safety net managed care plan. The Washington Association of Community & Migrant Health Centers (WACMHC) is a non-profit organization, formed in 1985 to advocate on behalf of Washington's community based health centers. Together, we represent the collective interests of our state's community health centers and their patients and work to ensure that all Washingtonians have access to primary care, regardless of geographic location, nationality, insurance status, or income level.

Proposal Outline

The Blue Ribbon Health Care Commission (BRC) has the unique opportunity to develop a five-year strategy to improve health care access and coverage, and contain costs. Our proposal includes policy ideas that address three key principles that we believe can move us toward the BRC goals of covering all people in Washington in a cost-effective manner.

A. Leverage proven existing programs and models to cover remaining low-income populations
B. Focus on containing cost and improving quality to maximize resources.
C. Shore up the employer-based health care system.

Our proposals are pragmatic and incremental policy recommendations that often rely on existing infrastructure. Taken together, these proposals will help Washington make significant progress in the near term and make efficient use of scarce financial resources. These proposals address the BRC goals of improving health, increasing access and promoting affordability in our health care system.

A. Leverage proven existing programs and models to cover remaining low-income populations

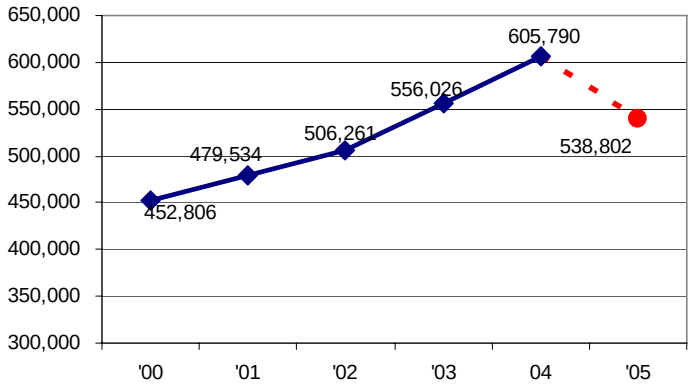
1. Expand Basic Health Plan (BHP)

- Even with year to year changes in benefits, cost sharing, member demographics, and underlying medical trends, the BHP has consistently constrained its costs more effectively than has private insurance on average. While average per member costs for private health insurance were growing at 9% to 15% each year, increases in the annual per member costs for the BHP were consistently lower.[1]

Pragmatic solution: Expand Basic Health Plan by nearly 67,000 slots using the $118 million in net tobacco tax revenues being collected from I-773. Restoration of this sustainable funding source to its intended use could insure nearly 67,000 additional Washingtonians each year.[2]

As demonstrated in the chart to the right, expanding BHP with existing I-773 revenue could reduce the

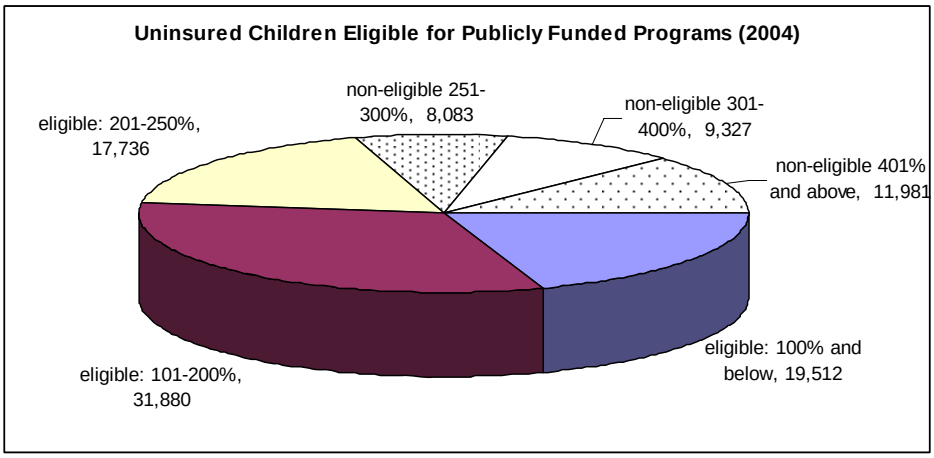
Projected Reduction in WA's Uninsured:
If BHP expanded through I-773 funding (2005)



number of uninsured in Washington by 11%, creating the first decrease in uninsured people this decade.

2. Package Legislation to Cover all Children by 2010

- 70% of Washington's uninsured children are likely eligible today for a publicly funded health insurance program, but the number of children on Medicaid and the State Children's Health Insurance Program (SCHIP) is declining.[3]



- Most of the children that are likely to be eligible for public programs are in working families: 78% of low-income, uninsured children (0-250% FPL) are in families with at least one working member.[4]
- The cost of one hospitalization for a treatable condition like an ear infection costs the same as two year's worth of continuous coverage under Medicaid.[5]

Pragmatic solution: Guarantee that all children are covered under Medicaid and SCHIP, employer plans, or a gap program that blends private and public funding. Children are the least expensive to insure and early investments create savings in other parts of the system, e.g. schools. Legislation should include the following:

a. Definition of and declaration to provide each child a medical care home.

b. Adequate and sustainable funding source.

c. Maximum federal resources: Maximize SCHIP funds including funds for parents of covered kids; tap into Family Opportunity Act for children with special health care needs.

d. Innovative coverage options for children above current public program levels. Expand SCHIP to 300% FPL and draw 65% federal match; consider special population programs (e.g. high risk pool for special needs kids); consider employer coverage blending; leverage existing Small Employer Health Insurance Partnership Program.

e. Ongoing outreach funding, including coordinated development of materials.

f. Adequate provider and plan rates to ensure access for kids. Use coding options and quality measures as a way to target expanded payments.

g. Plan for transitioning to performance-based payment quality measures. Require appropriate and effective services (e.g. well child visits) to be covered in all programs serving kids.

h. Eligibility expansion for non-Medicaid children's programs to mirror Medicaid and SCHIP.

i. Sufficient behavioral and dental health funding as wraparounds to existing coverage and any new children's health program.

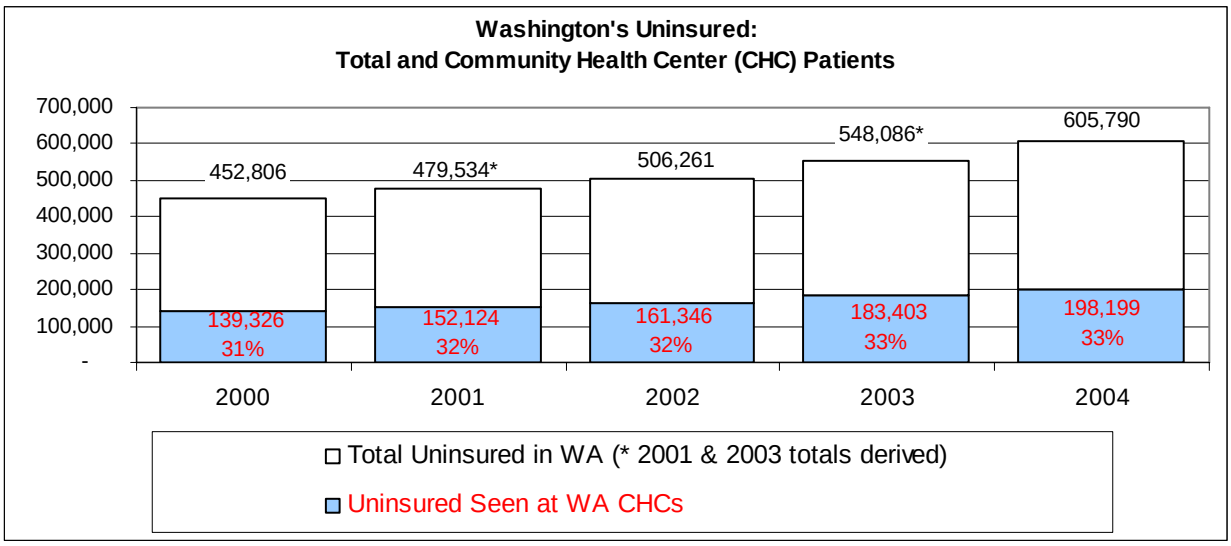
j. Office of Financial Management (OFM) accountability: Yearly estimates of number and percent of uninsured children, health status for Washington children, and emergency room (ER) impacts.

3. Invest in Community Health Centers

- Nationally, low-income, uninsured community health center patients are much more likely to have a usual source of care than the uninsured– 95% vs. 75%.[6]

- Health centers are important providers of prenatal care for low-income women. Communities served by health centers have infant mortality rates between 10-40% lower than communities without a health center. Health centers have lower rates of low birth weight among their patients than nationally (7.0 vs. 7.8) and this gap has widened over the last few years as health center low birth weight rates have dropped while national rates have climbed.[7]

- As shown in the table below, Washington's community health centers increase their capacity to meet the needs of the growing uninsured population in Washington by consistently serving about a third of the state's uninsured residents even as the number of uninsured continues to rise.



Pragmatic solution: Make capital and other investments in community health centers so they can expand primary and preventive care to more vulnerable populations and link patients with coverage. Dollars spent on community health centers provide major returns.

- Over the past 10 years, Washington's CHC system has added over 20 new clinic sites across the state; completed major remodels/expansions to 15 existing sites; added 12 new dental clinics; expanded hours of operation; and added over 400 new primary care providers.

- In just the past four years, Washington's community health centers have expanded access to an additional *206,000* Washington residents.
- Model for quality: All of Governor Gregoire's health care initiatives are areas with which community health centers are very familiar. The community health center model already incorporates evidence-based practices, chronic disease management, health information technology to drive improvements and ensure transparency, and a focus on wellness and prevention.
- Efficient and effective: The community health center model has long proven successful at increasing access, controlling chronic disease, reducing hospital and ER utilization, reducing health disparities and improving overall community health.

B. Focus on containing cost and improving quality

1. Utilize managed care for expensive populations

- A recent study by the Lewin Group found that Medicaid could save *$1.5 billion total over 10 years* - $750 million in Washington State costs and $750 million in federal costs - by converting current fee-for-service temporary assistance for needy families (TANF) and Supplemental Security Income (SSI) populations to managed care.[8]
- Medicaid managed care savings: Enrolling patients in Healthy Options saved Washington State's Medicaid program nearly $150 million from 2001 to 2003.[9] Currently more than half of Washington Medicaid enrollees—primarily low-income kids and their parents—are enrolled in Healthy Options.[10]

Pragmatic solution: Use managed care to contain costs and improve care for the most expensive populations including those with chronic disease, those in the Aged, Blind & Disabled program, and those in the Washington State High Risk Pool. Managed care has created medical homes, higher quality coverage and predictable costs in public insurance programs. Medicaid managed care is a smart investment of state dollars that allows the state to more easily budget expenditures and provide care coordination, utilization management and other value-added services for patients. The responsibility for the patient's care and the cost of that care is placed squarely with the provider and health plan.

- *Example:* Community Health Plan works with community health centers that have a long history of providing high quality care, cost efficiency and a dedication to all people who need care – insured or uninsured. By working in partnership with its provider network, Community Health Plan achieves considerable efficiencies in patient care. For example, the Community Health Plan's generic prescribing rate of 78% is seven points higher than the national benchmark. This partnership also means that Community Health Plan patients have access to case management, translation and transportation services, group visits, chronic disease management and other innovative and proven programs. CHC-based managed care improves health outcomes while reducing costs.

2. Create incentives for best practices and evidence-based care

- CHCs participate in chronic disease collaboratives designed to maximize preventive care and spread best practices for some of the most expensive conditions. Through financial assistance from Community Health Plan,

Washington's CHCs also incorporate Milliman's evidence-based guidelines into daily clinical practice.

Pragmatic solution: Build incentives for best practices and evidence-based care into public programs. Link provider pay increases to commitments to expand access and quality. Use targeted co-payments and incentives to steer patients toward the most appropriate care. Managed care is an existing tool for doing this.

3. Reduce health and health care disparities

- A recent study found that disparities in health status do not exist among health center users even after controlling for socio-demographic factors.[11]
- A landmark report from 2003 found that as health centers serve more low-income people in a state, the state's black/white and Hispanic/white health disparity narrows in such key areas as infant mortality, prenatal care, tuberculosis case rates, and age-adjusted death rates.[12]
- 90% of African American and Hispanic community health center patients with hypertension reported that their blood pressure is under control, more than triple that of a comparable national group.[13]

Pragmatic solution: Implement an action plan to reduce health and health care disparities based on race, ethnicity and income. Community health centers' proven track record on disparity reduction can be an example of how to reduce disparities across the state. Health centers are typically located in underserved areas, are open to all, and provide comprehensive, culturally sensitive care customized to fit the needs of each community. Also, the state could expand the successful Community Health Worker model that CHCs in this state have used to address health disparities in areas such as prenatal care, infant mortality, diabetes and asthma.

4. Integrate primary, behavioral, and dental health care

Behavioral health: Washington State should seize the opportunity to improve its delivery model by supporting further integration of much-needed behavioral health services with medical and dental services.

- Nearly 70% of all health care visits have a primarily psychosocial basis, and 25% of all primary care recipients have a diagnosable mental disorder, most commonly anxiety and depression.[14]
- A combined study by the University of Washington and Harborview Medical Centers showed that a collaborative care treatment model for panic disorder using patient education and psychiatric visits in the primary care setting resulted in significantly more anxiety-free days and no significant differences in total outpatient costs.[15]

Dental health: Washington is spending huge sums of money on *preventable* dental disease.

- More than $50 million is spent each year treating Washington's children for oral disease. In 2003, Medicaid alone paid more than $27.6 million in dental restorative procedures for children.
- Children who develop cavities in their molars by the age of 10 require on average $2,187 in services by the time they turn 79 in order to maintain *each* restoration.[16]

- Many of the FQHCs in our state see over 200 dental clients per provider at a time when most provider groups see 1-10 Medicaid dental clients per provider.[17]
- A further decline in dental school enrollment could lead to a shortage in the supply of dentists, particularly in rural areas. Between 1981 and 2001, total dental school enrollment in the US dropped by nearly a quarter - from nearly 23,000 to approximately 17,000.[18]
- Demographic and employment patterns could decrease patient access to dental care, particularly in rural areas, by the end of the decade. Dentists in Washington are older than the nation-wide average. Statewide half of dentists report plans to retire by 2013; in rural Washington this figure is 57%.[19]

Pragmatic solutions: Invest in integration of behavioral health and dental health with medical care. While private providers have been unable or unwilling to provide these services, CHCs have expanded their capacity and expertise to address the unmet need. Integrating behavioral and dental health care into primary care is a proven cost-effective way to ensure that medical care is not undercut by untreated behavioral or oral health issues. CHCs have led in integrating behavioral and dental health care into primary care but need state support to continue this process. Specific suggestions include:

a. *Behavioral health:* 1. Provide funding for on-going proven models or pilot projects around integrated service systems, e.g. the General Assistance Unemployable managed care pilot. The state will save money over the long term by supporting CHC efforts now to hire or contract with behavioral health specialists to work in clinics. 2. Activate new behavioral health codes to allow mental health professionals to treat and bill directly for non-psychiatric diagnoses, e.g. aid diabetics and heart patients with compliance.

b. *Dental health:* 1. Make capital investments to allow CHCs to expand their dental services. A small investment made in Washington's CHC dental facilities last decade led to major expansions in services. 2. Invest in a dental residency program to develop a culturally competent dental workforce that increases access to dental care and reduces disparities in dental outcomes for underserved populations. Unaddressed dental conditions lead to other major health problems, underperformance in school and at work, and unnecessary added costs. Investing in dental residency programs is a cost-effective way to increase access to dental care.

5. Reduce ER utilization through investments in primary care

- A study by the National Association of Community Health Centers estimated if all non-emergent care in Washington State in 2006 was delivered at a CHC rather than an ER, our state's health care system would have saved an estimated $355 million.[20]

Pragmatic solution: Reduce unnecessary hospital ER utilization by investing in primary care, ER diversion projects, and specialty care programs. The federal Deficit Reduction Act of 2005 includes grant funding opportunities for states to establish alternative non-emergency services providers or networks of such providers. These grants are to support providers or networks serving rural or underserved areas with patients that may lack regular access to primary care. Successful models in other states have used community health workers located in emergency rooms to link

patients to more appropriate, cost-effective care at community health centers and other primary care clinics.

6. Support electronic health record (EHR) conversions

- Nearly 2/3 of Washington's CHCs are well on their way toward implementing EHR systems, with a goal of 100% implementation in the statewide system. The CHCs are ahead of the game: 90% of all medical transactions still occur on the phone, by fax, or on paper.[21]
- While Washington has recognized the importance of helping providers convert to EHRs, there is very little support available for systems that have already started converting.

Pragmatic solution: EHRs allow for increased communication between CHCs and other partners about patient care, effective treatment protocols, and chronic disease management. They also reduce serious medical errors, unnecessary expenses and system abuse by patients. EHRs increase the quality of care and control costs. Better electronic practice management and medical records allow for greater accuracy, less staffing, and more office space.

As leaders, Washington community health centers dedicated their own resources to purchase and implement EHRs before foundations and government agencies offered funding for the start-up phase. State support could ensure that additional community health centers are able to implement EHRs, and mitigate continuing costs, including initial productivity drops during implementation.

C. Shore up the employer-based health care system

- The rate of employer-based health care coverage in Washington continues to slowly decline. In 2000, 63% of residents received their health insurance through an employer; by 2004 this percentage had dropped to 61%.[22] Despite these declines, employer-based insurance is still the bedrock of our state's health care system.
- In Washington, eight out of every nine jobs that do not offer health coverage are in small firms employing 50 or fewer workers.[23]
- In 2005, every private family insurance premium included $1,206 to cover uncompensated care costs for the uninsured.[24]

Pragmatic solutions: Give large employers the option of providing employee health insurance coverage or contributing to the cost of covering employees through state programs. Require insurers to pass on lower premium costs to employers.

Create affordable buy-in options for small employers, with a focus on low-income employees. Legislation passed in 2006 created the Small Employer Health Insurance Partnership Program for small business employees living at up to 200% FPL. This plan could be expanded to 300% FPL to broaden access and participation. If private insurers will not offer coverage under the small business assistance program a Basic Health-like program for this market should be created. BHP has considerably lower trend increases and administrative costs, and is already set up to determine eligibility, handle enrollee premiums, and provide subsidies.

Endnotes:

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[1] Analysis presented in the upcoming September 2006 Working for Health publication, It's Not Too Late: I-773 Revenues Can Increase Access to Care for Washingtonians. Private insurance: The average annual per member cost is defined as the national annual premium cost for individual health insurance coverage, and the 2000 - 2005 data is from Kaiser Family Foundation/Health Research and Education Trust Employer Health Benefits Annual Surveys. (http://www.kff.org/insurance/ehbs-archives.cfm) BHP: Average annual BHP cost is defined as the average state cost per member plus the average individual per member cost for a year's coverage in the BHP and was received from the Washington State Health Care Authority, the agency which administers the BHP, on May 12, 2006.

[2] Analysis presented in the upcoming August 2006 Working for Health publication, It's Not Too Late: I-773 Revenues Can Increase Access to Care for Washingtonians. I-773 revenue figures courtesy of the Department of Revenue and Basic Health cost figures courtesy of the Health Care Authority.

[3] Washington State Planning Grant on Access to Health Insurance, "Report to the Secretary," September 30, 2005.

[4] Washington State Planning Grant on Access to Health Insurance, "Report to the Secretary," September 30, 2005.

[5] Cost is split between federal and state. Comparable hospitalization would cost the same as four year's worth of state spending. Data obtained from the Washington State Hospital Association, Sept. 30, 2004 by the Children's Alliance. 2002 mean cost of one hospitalization for an ear, nose or throat infection = $3920; annual cost for one year of Medicaid coverage= $1,700.

[6] NACHC, "A Nation's Health at Risk II," August 2004.

[7] NACHC, "A Nation's Health at Risk II," August 2004.

[8] The Lewin Group, "Medicaid Capitation Expansion's Potential Cost Savings." Sponsored by: Association of Community Affiliated Plans and Medicaid Health Plans of America, April 2006.

[9] The Lewin Group, "Medicaid Cost Containment: Report No. 1," October 2002, p. 19. Prepared for the Washington State Legislature. Available at: www.lewin.com.

[10] The Lewin Group, "Medicaid Cost Containment: Report No. 1," October 2002, p. 19. Prepared for the Washington State Legislature. Available at: www.lewin.com

[11] NACHC, "A Nation's Health at Risk II," August 2004.

[12] NACHC, "A Nation's Health at Risk II," August 2004.

[13] NACHC, "A Nation's Health at Risk II," August 2004.

[14] U.S. Department of Health and Human Services. (2001). Report of a Surgeon General's working meeting on integration of mental health services and primary health care. Available at: www.surgeongeneral.gov/library/mentalhealthservices.PDF4.

[15] Wayne J. Katon, MD; Peter Roy-Byrne, MD; Joan Russo, PhD; Deborah Cowley, MD, Departments of Psychiatry and Behavioral Sciences, University of Washington Medical School, Cost-effectiveness and Cost Offset of a Collaborative Care Intervention for Primary Care Patients With Panic Disorder. 2002;59:1098-1104.

[16] Based on an analysis of more than 77 million Delta Dental claims submitted to the Dental Data and Analysis Center. Available at: www.dentaldac.com.

[17] Washington State Department of Social and Health Services: Washington State Medicaid Population FY 2004-2005 Dental Services Program. Provider Caseloads by Provider Specialty (as of 5/30/06).

[18] American Dental Association. 2000/01 Survey of Predoctoral Dental Education. Academic Programs, Enrollment, and Graduates, Vol 1.Chicago, 2002.

[19] Washington State Dental Association, Dental Workforce Study 2001.

[20] NACHC, "2006 Access to Community Health Databook: Washington". This report utilizes Kaiser Family Foundation, Medical Expenditure Panel Survey (MEPS) and Uniform Data System (UDS) data to calculate: 1) the cost of non-emergency ER visits in Washington, and then 2) subtract the cost of care at a community health center for the same number of visits. The result is a calculation of $355 million in extra spending for non-emergency care received at an emergency room above the cost of care at a community health center. http://nachc.org/research/wa.asp.

[21] Schmit, J. & Appleby, J. USA Today. July 20, 2004. *Report to promote e-records for health care.* Cited by Tommy Thompson, U.S. Secretary of Health and Human Services.

[22] Analysis of Washington State Population Survey data, 2000-2004.

[23] Milliman, Small Business Focus Group Results, prepared for the State of Washington, December 2005.

[24] Families USA. Paying a Premium. June 2005.

Tab 10

The Value of Community-Based Health

Proposal to: The Blue Ribbon Commission on Health Care Costs & Access

Submitted by: Spokane's *Community-Minded Enterprises* (formerly the Health Improvement Partnership) under the Auspices of the Washington State Department of Health

September 1, 2006

1. *What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access?*

This proposal describes how a community can strengthen preventive health across the entire community. Although the strategies involved will include the traditional healthcare system, this approach will transcend that system by 1) improving upon established healthcare access systems, 2) identifying leverage points through which a community can influence the health behaviors of its citizens, and 3) engaging community systems in a broad, creative campaign for better health through prevention rather than just treatment, thereby broadly improving the health of the community population and reducing the incidence of unnecessary and costly crisis care.

We propose a pilot in Spokane that will *measure and quantify* the financial savings involved as well as the health improvements realized in this *community-based, preventive* approach. This pilot will be replicable in other communities in the future.

At the first meeting of the Blue Ribbon Commission, Commission members discussed balancing responsibilities among the three stakeholders in healthcare: the individual, the employer, and the State. This proposal suggests that there is a fourth stakeholder, one which can ease the burden borne by the other three. The fourth stakeholder is the *community*.

By investing in *community-based, prevention-oriented* solutions, the Washington's healthcare leaders can transcend the dynamics that have undercut so many previous reform efforts. These efforts, though well-intentioned, have had the tendency to pit one healthcare interest group against another. When communities promote better health among their citizens, everyone wins.

Historically, the problem with community-based prevention solutions has been that though they seemed to make sense, they were difficult to measure and quantify. In the face of urgent budgetary pressures, their results have seemed to be vague and long term. This proposal overcomes these problems by engaging professional evaluators to solidify a measurable financial return on investment within a five-year timeframe from the initial State investment. This pilot program will demonstrate how the State can incentivize community-based health prevention solutions in a way that saves significant State dollars over time. The replicability of the pilot will be built into its initial design.

We seek a commitment of a special matching fund of $1 million to be designated by the legislature in 2007 to be made available through the Washington State Department of Health for

a one-to-one match of funds to be raised by a coalition in the Spokane community and implemented via Community-Minded Enterprises, a Spokane-based non-profit which has spearheaded the development of the coalition and the plan and which is in the process of leading the fund development. These funds will be used to execute the plan described in this proposal. We project a minimum 5-to-1 return on this public investment, measurable within five years.

The plan will incorporate the following ten elements:

1. The Community Council. A diverse array of individuals and organizations will co-create the ***Value of Community-Based Health (or Value of Health)*** initiative. As much as possible, these co-creators will approximate and represent the collective "voice of the community." Anticipated institutional partners include local school districts, the regional public health district, community clinics, a local communications firm, a collaboration of faith-based institutions, the Spokane Alliance (a grassroots policy group), the Chamber of Commerce, local government, the media, local foundations, and local universities. At the same time, we will invite the participation of a set of individuals with the personal vision and commitment to participate deeply. These individuals will speak from their own experience and not formally represent any group. They will be parents, teachers, laborers, elders, members and representatives of socio-economic and ethnic minority groups—and, especially, young people. The "chartering" and development this Community Council will be a major focus of the first phase of the project. Once in place, the Council will reach out to others to assemble a map of assets and an array of partnerships which will sustain the ***Value of Health*** campaign.

2. Youth Engagement: The future of our community lies with our youth. It will not be possible to establish a sustainable, healthier community without engaging youth as long-term leaders of the process. We will do that first by linking strongly with the public schools; second, by linking strongly with the various liaison organizations that reach disconnected youth; third, by involving a widening array of individual youth voices (both mainstream and disconnected youth) in the planning as well as the publicizing of the ***Value of Community-Based Health***; and, fourth, by making youth outreach one of the core features of the public awareness campaign.

3. Health at Work: With an eye toward (and a keen interest in) new state policy incentives for worksite wellness, perhaps with Spokane as a pilot site, we will prioritize assistance for employers in offering wellness support services to employees (See "Ongoing Support for Change," below). We anticipate the potential to partner with other existing organizations in this support and to help them expand their services. We will also use the worksite as an access point to the family. The wellness services will be designed to reach not just to the employee, but the family members at home.

4. Inclusiveness: A community-wide initiative such as the one we propose cannot succeed unless it acts as a unifying force, bringing together people from many backgrounds and walks of life. This kind of inclusiveness does not occur without special outreach strategies designed to overcome traditional barriers. Both in the formation of the Community Council and in the unfolding of the various prevention strategies, we will use creative inclusiveness and outreach strategies as critical elements of our design. For example, instead of simply employing a "one-size-fits-all" approach, we will engage the representatives from the various diverse populations

within our community, such as people with various disabilities; elders; both tribal and urban Native Americans; the gay, lesbian, and transgender population; refugees and immigrants from Eastern Europe, the Balkan Peninsula and Africa, and the Latino, African-American, and Southeast Asian communities, to name a few. Strategies and methods will be tailored to each culture's needs based on their recommendations and design. This method has been successfully employed over the past eight years in Community-Minded Enterprises' *Health For All* project, and has had the added effect of already establishing us as an ongoing partner with most of these communities.

5. Asset Mapping: The essence of prevention lies in identifying and building from individual and communal assets. Individuals overcome obesity or a smoking habit or depression not through self blame, but through strengthening belief in their capacity. Communities overcome widespread poverty or widespread substance abuse not through focusing on the details of these problems so much as through mobilizing alternative, positive, unifying strategies that sweep people into new configurations of success. The ***Value of Health*** campaign will identify and promote a positive communal self-image based on research into and innovative definition of our community's assets.

6. Collaborative Prevention Initiatives: We propose to stimulate new collaborative prevention initiatives by supporting approximately ten new high profile ***Value of Health Partnerships*** which will launch various prevention-oriented system change efforts. In the term "system change" we include a spectrum of possibilities: anything from a better way to reach an underserved immigrant neighborhood to an integration of diverse human service information systems to a new school-neighborhood strategy to reach kids who are dropping out.

Within certain criteria, the ten ***Partnerships*** will be chosen for the diversity of their approaches. The Community Council will set these criteria. They will include:

- Does the ***Partnership*** promise to reach significant groups of people and lead to system change that actually impacts people's lives?
- Does it involve an innovative (or *unexpected*) mix of new collaborators?
- Will its strategies reach pockets of underserved people, especially those for whom the messages of the public awareness campaign might not mean a lot without significant support?
- To what degree does the ***Partnership*** focus on children?

In conjunction with various funders, we will provide mini-grants to these collaborations. The public awareness campaign will feature their progress. These selected initiatives will serve as laboratories in which different types of interventions and different prevention topics will be studied to determine their effect on community health.

7. Public Education Campaign: We envision all the ***Value of Community-Based Health*** activities occurring under the banner of a major public awareness and education campaign. This campaign will reach the general public as well as key institutional audiences with messages that move people toward behavior change and system change; it will also share the stories of individuals and institutions as they take adventurous positive steps. Additionally, the public

education campaign will constitute a key vehicle for generating the incentives that fuel the initiative: a key incentive being public recognition itself.

Founded on the view that communities under-invest in preventive health primarily because professionals and citizens alike do not fully appreciate its multiple positive benefits, the campaign will vividly, specifically describe the ***value of health*** to young families, to teachers, to employers, to grandmothers, to the regional economy, to policy makers, to teenagers, etc. In so doing, it will highlight linkages between different people and different institutions—and how we all create an interconnected web in which health and quality of communal life become inextricable. It will also highlight the linkage between social and economic factors and health—reinforcing the key social and economic strategies that the campaign is emphasizing. It will celebrate the courage involved in taking one positive step toward well-being, and it will prize the diversity of such steps: from an employer launching a non-smoking program to a landlord who links tenants with community services to a second-grade child proudly unwrapping a healthy bag lunch in front of her friends. It will refer people to the ***Health for All*** community information line for advice about access to tools and support services, including access to affordable preventive healthcare.

In designing this campaign, we will conduct best-practice research to learn which prevention messages have resulted in a measurable improvement in community health, and we will also look to community members (through surveys, key informant interviews, and focus groups) for input on how to structure the campaign. Building on *Community-Minded Enterprises'* history, we will again seek the involvement of all local media organizations.

8. Ongoing Support for Change: It will be important to link the ***Value of Community-Based Health*** public awareness campaign with a source of follow-up support for both individuals as well as technical assistance for groups and organizations who want to get involved. Over the last five years, Community-Minded Enterprises' *Health for All* information center (HFA) has advised more than 50,000 Eastern Washington residents regarding their healthcare access options and has helped more than 20,000 uninsured people become insured. *Health for All* is well positioned to act as the call-in support hub for ***The Value of Community-Based Health***. Access to preventive healthcare will of course continue to be a key component of its services. But with the inauguration of ***The Value of Community-Based Health***, *Health for All* will expand its services to include various forms of prevention advice and will collect the individual success stories that will fuel the public education effort.

In addition to the organizations involved in the ***Value of Health Partnerships*** described above, (which will receive significant levels of technical assistance), there will be other groups and organizations—such as an elementary school PTA, a fourth-grade classroom, a Head Start staff, a Town Council, a grocery store, an auto repair shop, etc.—which will respond to the public call to action. These groups will also contact the *Health for All* information line and will be referred to the technical assistance wing of ***The Value of Community-Based Health*** for advice about strategies, resources, tracking results, and celebrating successes.

9. State Policy. We will keep in close contact with the unfolding policy dialogue at the State level, including the work of the Governor's Blue Ribbon Commission, for ongoing policy innovations which incentivize community-based prevention.

10. The *Value of Health* Metrics. Anchoring all the above will be the ***Value of Health*** metrics: a comprehensive array of assessment and evaluation components. With the help of professional researchers from local universities, *Community-Minded Enterprises* assessment/evaluation staff will 1) Scour the national data to quantify the multiple long-term community-wide benefits of prevention; 2) Act as consultants to the Community Council and to organizations and groups to help them establish the value of health in their terms (for example, for an employer, defining the potential bottom-line benefit of a wellness program) and to help them monitor the benefits of their prevention initiatives; 3) Establish a key set of community-wide *value of health* indicators to monitor over time and to publicize as an ongoing report card on the progress of the effort; 4) Establish and monitor a core set of ***Value of Health*** indicators which allow us and others to monitor our overall success—that is, the ability of a community to "*strengthen preventive health across the entire community*—" a critical factor for making the effort replicable; 5) Work incrementally toward the development of a *value of health* currency, a flexible, multi-faceted way to translate preventive steps into savings, discounts, and rewards for those who take them; and 6) and most important, **establish a mechanism for delineating and reporting on financial return on investment for the initial state investment in the project.**

2. *How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?*

The Vision: ***The Value of Community-Based Health*** will help build "a system which provides every Washingtonian the ability to obtain needed healthcare at an affordable price" by demonstrating how the precursors to health and healthcare—the preventive behaviors and understandings that promote healthy living—can become part of the fabric of community life. As communities (via neighborhoods, schools, workplaces, public programs, etc.) take more responsibility for promoting healthy behaviors, the overall cost of healthcare will go down for everyone.

By using sophisticated research models to measure the financial return on state investment directly in terms of avoided crisis care, we will take this "community prevention quotient" issue out of the clouds and make it quantifiable and replicable.

The Goals:

1) **Improving Access**
Our public information campaign and our call-in help line will include specific guidance for people in how to enroll on available health coverage and how to understand if they are eligible (Community-Minded Enterprises has eight years experience doing this work).

2) **Improving Health**

Our ***Value of Health*** engagement process reaches deliberately to diverse ethnic and minority groups and to various under-engaged populations (see above). As for making Washington one of the healthiest states in the nation, we believe that this pilot could attract national attention, and a roll-out of incentives for community-based health prevention could be a groundbreaking program nationally that would attract significant resources to Washington.

3) Improving Affordability

The core of the ***Value of Community-Based Health*** idea is to make healthcare more affordable by incentivizing and shifting responsibility for prevention to a local community context, improving overall health status community by community, and thus reducing unnecessary and costly crisis care across the statewide population.

How do we know? There is a vast body of research and best practice which makes these conclusions inescapable. What we need now is a pilot test in a community like Spokane with a rigorous evaluation component that will quantify the financial return on investment.

3. *Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.*

Elements of this program have been modeled after other successful programs that have been conducted by Community-Minded Enterprises. For example, through our work on the Healthy Kids Now! public information campaign, we have been able to help over 125,000 previously uninsured children in Washington State access health insurance. We will build on the strategies learned through this program, which was designated a national best practice for conducting public information campaigns.

In addition, through our *Health for All* program, we have helped more than 50,000 uninsured individuals in eastern Washington access healthcare. More than 20,000 uninsured people became insured through our efforts.

The proposal has taken shape over the past two years through a careful planning process involving extensive research into the successful elements of community-based prevention as well as input from a broad base of community members as well as guidance from the W.K. Kellogg Foundation.

4. *Will your proposal impose costs on individuals, businesses or government? Will these costs by time-limited or ongoing? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?*

The financial cost of the project will be $2 million over the course of five years. We are seeking support from the State in the form of a $1 million pledge to match one-to-one dollars that the Spokane community coalition raises (primarily from private sources) in support of this program. We are in the process of seeking these funds from the Kellogg Foundation and others.

In addition, there will be a much larger outlay of volunteer and in-kind contributions from diverse individuals and organizations in the Spokane community who will see it in their interest to take advantage of the campaign as an opportunity to achieve and/or promote breakthroughs in preventive health.

This proposal is undertaken in the spirit of and with the awareness of the Communities Connect collaboration, to which the authors of the proposal (Community-Minded Enterprises) belong. Communities Connect would be a natural vehicle for its replication in other communities.

Can you estimate how much these costs will be, or suggest how such an estimate could be made?

The $ 1 million in state funds plus the $1 million raised privately ($2 million total) will pay for the coordination costs of this program, including the strong public education, technical assistance, and evaluation components. Project coordinators will leverage a powerful contribution of grassroots volunteer and in-kind involvement from the Spokane community based on the personal and social benefit to be gained from prevention activities.

We project that an investment in the ***Value of Health*** will yield a 5:1 financial return for the State dollars after five years. In other words, we will be able to track $5 million or more in avoided public crisis care costs due to specific interventions—a savings that would not have occurred otherwise. In addition to money saved through a decrease in claims made to state-funded insurance programs through appropriate and timely preventive measures and primary care, the local economy will also benefit. For example, by helping the uninsured access subsidized coverage or care *before they get sick*, the local hospital system is less likely to take a financial hit from an uncompensated emergency room visit for a condition that could have been prevented through a timely visit to a primary care physician. Plus, when more eligible individuals access subsidized insurance, fewer businesses pay the costs associated with employing uninsured people. In addition, healthier people mean fewer work and school days missed due to illness. In other words, there will be innumerable secondary benefits or positive ripple effects, some of which may be difficult to measure. But the 5-to-1 return on investment will be measurable.

5. ***How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?***

The proposal is the result of numerous planning sessions involving Community-Minded Enterprises' staff and board and an array of more than twenty-five community partners interested in community-based access and prevention, including (partial list):

Spokane Neighborhood Action Programs
New Priorities Foundation
Desautel Hege Communications
Spokane Regional Health District
Partners with Families & Children
HollisterStier Laboratories LLC

Providence Healthcare
Community-Minded Enterprises
Washington State University Spokane
Marycliff Institute
The City Of Spokane
Inland Imaging
Volunteers of America

6. ***What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?***

One challenge of course will be to raise the $1 million that will trigger the matching fund we seek from the legislature. But with the legislature's commitment, we believe that this will be doable. We work with a lot of philanthropic organizations nationally, and we understand that many are eager for an opportunity to invest in a pilot project involving state-level incentives for communities to increase community-based prevention. If states can successfully incentivize communities to come together locally, plan creatively and take a more active role in the "upstream" healthcare issues, the issues that help people be healthier and thus lower overall crisis healthcare costs, then a national trend could develop in the direction of building prevention capacity into communities. Foundations seem to be interested in investing in this concept.

Of course, if we fail to raise the matching amount, the state legislature will not have risked anything.

Many national foundations understand communities to be an under-utilized resource in the healthcare reform equation. Though often disorganized, though often lacking an effective convening or coordinating entity, local communities possess unique assets that can contribute to healthcare access and general healthcare reform solutions.

Many people do not understand that it is possible to coordinate collaborative, grassroots campaigns at the community level. State-level planners can sometimes fall into the habit of thinking that improvements have to be choreographed from the state level only. Our track record and the work of countless organizations like ours demonstrates that local community coordination is not only a critical ingredient of healthcare reform, it is also an available ingredient, given the right encouragement from state leaders.

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Tab 11

To: Blue Ribbon Commission Member
From: Steve Critchlow
Re: Resolution of health care availability.

Primary proposal:
+Enact Laws that requires all agencies in the state use a common set of the definitions of terms in regulating, or purchasing Health Care.

Secondary proposal:
+Enact Laws that mandates the collection, and dissemination of Evidenced Based Medical date.

Benefits:
+Responding to the BRC vision and goals, consistent definitions as outlined in this proposal will assure equity for all individuals insured through private or publicly funded plans.

Costs:
+Initial funding may be required to compile the definitions into a single document.
+When definitions are applied uniformly and EBM data used to satisfy experimental & investigational criteria clearly established, the cost of appeals could be reduced or eliminated from insurer's actuarial formulas.
+Reduced cost should be realized as EBM data is disseminated allowing insurers both state and private to eliminate the expense of technical review corporations.

Patient Bill of rights (PBR)
RCW 48.43.500
It is the intent of the legislature that enrollees covered by health plans receive quality health care designed to maintain and improve their health. The purpose of chapter 5, Laws of 2000 is to ensure that health plan enrollees:
(1) Have improved access to information regarding their health plans;
(2) Have sufficient and timely access to appropriate health care services, and choice among health care providers;
(3) Are assured that health care decisions are made by appropriate medical personnel;
(4) Have access to a quick and impartial process for appealing plan decisions;
(5) Are protected from unnecessary invasions of health care privacy; and
(6) Are assured that personal health care information will be used only as necessary to obtain and pay for health care or to improve the quality of care.

Evidences Based Medicine (EBM) will provide both patient and provider clear treatment recommendations and guidelines that can assist in selecting appropriate treatment options, thereby satisfying intent number 1 of the PBR. Additional initiatives to bring (EBM) to fruition have the potential to resolve many current issues surrounding the introduction of new treatments. Clear laws for EBM data will facilitate new health technologies as they develop allowing transition from FDA clinical trials to common patient treatment. EBM data must not preclude the use and reasonable insurance

coverage of new treatments, medications and devices as this these new technologies achieve pre-established data credibility.

As the Blue Ribbon Commission (BRC) and the legislature consider various aspects of health care and improving access to it, at the same time remaining true to Patient Bill of Rights (PBR), many aspects must be considered. It seems that items 2 and 3 of this law have waned in importance with respect to preserving the financial health of insurance companies, both profit and non-profit.

Satisfying intent no. 2 requires the availability of continually innovative treatment methods. Thus; adopting the provisions of existing codes, from MAA, using as example WAC 388-531-0050 and 388-531-0550 into the RCW that includes the privately insured seems prudent. This action would expand the requirements and provide the same definitions for terms used in all of the health care systems in the state. Obviously a review and consolidation of all definitions used for medical care must be performed. A few additional definitions would be required to remove ambiguity in some areas.

Explanation:
Laws (RCW) in force for State purchased or supported health care and code (WAC) that regulates the private health insurance companies are not the same. For example, WAC 388-531-0050 and 388-531-0550 etc. applicable to MAA (DSHS) and have defined most of the terminology for use by those agencies. There are no definitions of terms in WAC or RCW that apply to the private health insurance industry. WAC 284-96-015, 284-50-377, 284-46-507 others related to privately coverage administered under the OIC are for experimental or investigational treatment; however these codes actually allow insurers to define coverage as they chose. Because there is no other control of definitions for health care insurance carriers they make their own definitions. The result of this inequity leads to inconsistent access for many covered by privately for health care coverage in Washington State. Coverage paid from personal budgets.

Recognizing the complexity of the various factors noted above, suggested criteria for law is offered.

Note also: the state of Washington oversees doctors and their credentialing. We need to allow those doctors and surgeons to do their job. Create laws that guide and allow doctors actively involved the clinical trial process to provide new treatments until sufficient EBM data is collected. Encourage them to train others.

Under the authority of the State agencies – Washington State Legislature, Health Care Authority, Dept of Health, Office of Insurance Commissioner and Governor consider the following points in the creation of new Laws for Insurance companies.

- By law establish the same clear definitions of terms for <u>all</u> health care in the state. MAA, State Purchased Health care, OIC and L&I.

    - Definitions of terms currently in WAC 388-xxx-xxx under the “definition” heading of each section should be applied uniformly and consistently.
    - Add additional terms that require definitions.

- Mandate by Law that clear un-ambiguous criteria be used by all agencies, and insurance carriers for determination of experimental or investigational drugs devices and treatments. Existing WAC 388-051-0550 is satisfactory adding EBM data as it comes on line.

- Create Laws that compel the collection of anonymous data on patient treatment outcomes. Evidence Based medicine (EBM)
    - Within these laws would be methods to transition to actual EBM as data becomes sufficient and credible.
    - Establish guidelines that doctors could and should use EBM data as first line treatment options for their patients.
    - Establish by law statistical qualifications or credibility criteria levels for EBM data that must be achieved prior to mandating, recommending or limiting a treatment option.
    - These laws would require the compilation and dissemination of data into formats that the Health care professional will use to evaluate treatment effectiveness.
    - For new treatments, with insufficient EBM data, give preference to Institutions, Surgeons etc. that have actively participated in the FDA clinical trials. Establish that if the FDA documents demonstrate efficacy equal to or better than generally accepted treatment that insurers shall cover that new treatment at least at generally accepted treatment rate. Where a generally accepted treatment is not comparable to the new treatment, use the existing criteria as WAC 388-051-0550 provides.
    - As EBM data on new treatment becomes sufficient create a process that incorporates it and encourages/ requires insurers to adopt them into their actuarial formulas.
- Reward/ require insurers that use their negotiation skills and buying power to contract with suppliers for medication, and devices, and hospital services, etc.

Attachment to: Resolution of Health Care Availability
Subject: Definitions of Medical terms
From: Steve Critchlow

Intent:
Primary request:
Enact Law that requires all agencies in the state use a common set of the definitions of terms in regulating, or purchasing Health Care.
Make the definitions currently in WAC 388- consistent in all health care regulated by state agencies.

To satisfy the primary request the following is offered.
Using, as a bases, the existing definitions of terms in WAC 388- create law that defines all terms to be applied consistently. Additional definitions to be add to support existing Law. Some identified terms and definition are provided. Obviously a review and consolidation of all definitions used for medical care must be performed.

(New Law)
This Law shall be applicable to all State agencies under legislative authority including Medical Assistance Administration (MAA), Department of social and Health Services (DSHS), Office of Insurance Commissioner (OIC), Labor and Industries (L&I) Health Care Authority (HCA) (add any not listed)

All agencies, commissions, authorities, or state departments given authority by Legislation within Washington State to promulgate code (RCW) for the regulation of business for medical services, medical insurance, or administer law (WAC) for medical services, medical insurance, or any health care related activities shall use a single common set of definitions for all terms within those Codes and Laws.

- A common set of definitions to satisfy the above requirements shall become effective on June 1 2007.
- Where existing definitions occur under in different sections, resolve discrepancies to adopt the definitions applicable with preference in the following order the patient, medical professional, medical clinic or hospital.
- When new definitions are deemed necessary, temporary authority is granted to the applicable state agencies to adopt and submit new definitions as needed pending approval at the next regular session of the legislature.
- Definitions used by insurers in contracts including subscriber benefit books shall conform to definition provided in (approved new law -WAC) and not subject to the discretion of the insurance company.

Current Law (In force, Existing)
WAC 388-531-0050 (Include all definition of terms included in all other WACs (LAW) applicable to health care.)

(Modified)(Only the word <u>expert</u> to be replaced as indicated)

Peer-reviewed medical literature, defined as medical literature published in professional journals that submit articles for review by ~~experts~~ Medical Professionals who are not part of the editorial staff. It does not include publications or supplements to publications primarily intended as marketing material for pharmaceutical, medical supplies, medical devices, health service providers, or insurance carriers.

(New) (Undefined term)
Medical Profession or Professional, defined as a physician licensed under chapter 18.71, or 18.57 RCW and actively practicing and Board Certified and member in good standing of national association of medical physicians in the discipline applicable to service or treatment under review and is not affiliated or employed by any *insurance company, affiliate, or agent*. A physician licensed under similar rules or laws within another State and actively practicing shall satisfy this requirement.

Example:
A Physician or surgeon reviewing a device for bone prosthetics as experimental or investigational shall be licensed in a US state and be a fellow in good standing of the American Academy of Orthopedic Surgeons (AAOS)

(New) (Undefined term)
Generally accepted, within a document is defined to mean knowledge or information on a surgical method, device, treatment, or pharmaceutical, reported in a peer-reviewed literature for treating a condition or disease, available to the majority of medical professionals meeting the Medical Profession or Professional definition.

(Existing WAC 388-531-0050) (Currently not applied to Private insurers)
"Experimental" means a term to describe a procedure, or course of treatment, which lacks sufficient scientific evidence of safety and effectiveness. A service is not "experimental" if the service:

(1) Is generally accepted by the medical profession as effective and appropriate; and

(2) Has been approved by the FDA or other requisite government body, if such approval is required.

(Existing WAC 388-531-0050) (Currently not applied to Private insurers)
"Investigational" means a term to describe a procedure, or course of treatment, which lacks sufficient scientific evidence of benefit for a particular condition. A service is not "investigational" if the service:

(1) Is generally accepted by the medical professional as effective and appropriate for the condition in question; or

(2) Is supported by an overall balance of objective scientific evidence, in which the potential risks and potential benefits are examined, demonstrating the proposed service to

be of greater overall benefit to the client in the particular circumstance than another generally available service. Satisfaction of this criterion shall be given to medical professionals (see Definition) and Medical centers were the development of the technology and treatment has taken place for that otherwise and Meet the FDA approval requirements. i.e. satisfactorily completed clinical trial process.

(New)
"Off-label use" In the United States, the regulations of the Food and Drug Administration (FDA) permits physicians the discretion to prescribe approved services as treatment for conditions not specifically identified within the FDA approval or intended indications. This practice is known as off-label use. (New Definition from FDA and other sources)

The use of a service, drug or device as "Off Label" in reference to an otherwise FDA approved service shall NOT be considered Experimental or Investigational.

(The following section is modified from WAC 388-531-0550 with a suggested changes or additions in blue).
(1) ~~When MAA makes a determination as to whether a proposed service is experimental or investigational, MAA follows the procedures in this section.~~ When a service or treatment does not meet the requirements of definitions for Experimental or investigational the following criteria shall be used such determination for the service in question: The policies and procedures and any criteria for making decisions are available upon request.

(2) The determination of whether a service is experimental and/or investigational is subject to a case-by-case review under the provisions of WAC 388-501-0165 which relate to medical necessity. MAA also considers the following:

a) Evidence in **peer-reviewed medical literature**, as defined in WAC 388-531-0050, and pre-clinical and clinical data reported to the National Institute of Health and/or the National Cancer Institute, concerning the probability of the service maintaining or significantly improving the enrollee's length or quality of life, or ability to function, and whether the benefits of the service or treatment are outweighed by the risks of death or serious complications;

(b) Whether evidence indicates the service or treatment is more likely than not to be as beneficial as existing conventional treatment alternatives for the treatment of the condition in question;

(c) Whether the service or treatment is generally used or generally accepted for treatment of the condition in the United States;

(d) Whether the service or treatment is under continuing scientific testing and research; The collection of clinical data for use in ongoing effectiveness studies for a particular service shall not be construed to mean the service is experimental or investigational.

(e) Whether the service or treatment shows a demonstrable benefit for the condition;

(f) Whether the service or treatment is safe and efficacious;

(g) Whether the service or treatment will result in greater benefits for the condition than another generally available service; and

(h) If approval is required by a regulating agency, such as the Food and Drug Administration, whether such approval has been given before the date of service.

(3)MAA applies consistently across clients with the same medical condition and health status, the criteria to determine whether a service is experimental. A service or treatment that is not experimental for one client with a particular medical condition is not determined to be experimental for another enrollee with the same medical condition and health status. A service that is experimental for one client with a particular medical condition is not necessarily experimental for another, and subsequent individual determinations must consider any new or additional evidence not considered in prior determinations.

(4) ~~MAA does not determine~~ An *Insurance company* may not determine a service or treatment to be experimental or investigational solely because it is under clinical investigation when there is sufficient evidence in peer-reviewed medical literature to draw conclusions, and the evidence indicates the service or treatment will probably be of greater overall benefit to the client in question than another generally available service. (WAC 388-531-0550)

(5) All determinations that a proposed service or treatment is "experimental" or "investigation" are subject to the review and approval of a physician who is:

(a) Licensed under chapter 18.57 RCW or an osteopath licensed under chapter 18.71 RCW; and actively practicing and Board Certified and member in good standing of national association of medical professionals in the discipline applicable to service or treatment under review and is not affiliated or employed by any *insurance company, affiliate, or agent*. A physician licensed and actively practicing under similar rules or laws within another State shall satisfy this requirement

(b) Designated by MAA's medical director to issue such approvals; and

(c) Available to consult with the client's treating physician by telephone.

Tab 12

Washington State Blue Ribbon Commission on Health Care Costs & Access

Proposal

Submitted by:
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In the United States affordable healthcare is a huge issue. *"In 2003, an estimated 18 million adults ages 19-64 were not working because of health reasons. Sixty-nine million workers reported missing days due to illness. Fifty-five million workers reported a time when they were unable to concentrate at work because of their own illness or that of a family member. Together, labor time lost due to health reasons represents lost economic output totaling $260 billion per year".*

—The Commonwealth Fund: Health and Productivity Among U.S. Workers.

The staggering statistics of skyrocketing health care costs are infecting business and government like a virus. The nation has spent more than $300 billion a year on stress-linked illness from heart attacks and stroke to diabetes as sixty-two percent of American workers report an increase in work loads, while more than half feel "overtired and overwhelmed."

"Health care is a major reason why employment growth has been so sluggish." — Sung Won Sohn, chief economist at Wells Fargo

"Health premiums are sapping corporate balance sheets even more than the rising cost of energy." —Eduardo Porter, Rising Cost of Health Benefits Factor in Slump of Jobs, CAL/AAEM Aug 24, 2004

Because of the per worker health insurance sticker price of $3,000 a year, there's a reluctance to hire full time employees.

A 2004 study over a four and a half month period tracked and classified 344 errors in 42 "primary care" clinics (primary care is fancy for doctor's offices, as opposed to the ER or hospital) published in the journal, *Quality and Safety in Health Care.* Jonathan Wright, MD of Tahoma Clinic, suggests more errors appear to occur when there is a large staff. He draws on the assembly line industrial model for reference as proof that when the employee base is doubled there's a four-fold increase in errors, i.e., medical mistakes, in this case. Undermining confidence, 13% are due to a lack of knowledge in the doctor's education and/or experience. More importantly, 82% were caused by "system malfunctions", meaning that either office administrative mistakes and/or miscommunications played a large part in the patient's receiving proper health care. In one case, a patient died due to lack of relaying a message. This study was but a small sampling of clinics nationwide over a four and a half-month period that either detected or admitted to patient errors.

In Minnesota's 2005-hospital report, half the mistakes occurred during surgery, including one death. Of the 106 "adverse health events", up from 99 the previous year, 16 surgeries were performed on the wrong body part, 2 were done on the wrong patient, while 8 patients received the wrong procedure. In 26 instances, foreign objects were left inside the patient.

Estimated medical error-related costs to the nation reach a burdensome $37.6 billion each year, with $17 billion of those costs associated with preventable errors, according to IOM. They conclude: "hospitals commit 400,000 preventable drug errors each years, that is US$3.5 billion — not counting lost productivity and other costs — from hospitals alone."

Many people feel betrayed by conventional medicine disappointed by inadequate care, misdiagnosis, an intolerable drug, failed surgery, and the lack of careful attention by practitioners. In addition, insurance companies' haggles over what's covered and what's not, conflicting reports from medical studies, deception by drug manufacturers and personal experiences that leave much to be desired, feed their discontent. Government estimates that millions of people annually spend more than $27 billion on alternative and complementary medicine, rather than on traditional health care.

Forty-Eight percent of American adults chose one or more alternative or complementary therapies in 2004. This number will increase as more and more people realize they have been giving their power away to traditional healthcare allopathic practitioners, who in some cases don't even know your name, removing the responsibility to control your own health. Webster's Unabridged Twentieth Century Dictionary defines the term, allopathic, meaning, "to suffer", and suffering is exactly what people are doing,

Our medical care system is still based on Newtonian physics, mechanistic viewpoints shared by science in general, which stated: if by reducing the body to a bunch of parts like a mechanic analyzing your automobile, that science could determine the body's behavior, i.e. performance, and would know how to predict and control Mother Nature. When the machine is broken, all they had to do was just replace the parts, or treat the parts as individual components. In other words, you end up in the hospital with an enormous medical bill that costs you an arm and a leg to pay off.

A holistic approach is where the whole is the sum of the parts, and when one part ails, it affects the whole. The physical body's system has innate intelligence, and drives behavior through perceptions.

The issue of healthcare costs and access could be easily solved if the *Problem Statement* were worded to assist state residents in maintaining a healthy body and lifestyle, by whatever means necessary.

That disease is inevitable and a funded healthcare infrastructure essential, are both assumptions that miss the point. This notion undermines the body's innate intelligence to heal itself, given the right environment. Jesus said, "*Heal thyself*". To Lazarus, he said, *"Pick up your bed and walk"*. That belief plays a part in healthcare must not be ignored, for if it worked in Biblical times, it still works today.

The definition of disease means “out-of-ease”, a sense of being out of control of one’s life, and is aligned with “stress”. Look to the drug industry, Big Pharma, as a huge player in advancing dependency on drugs. They are part of the problem, constantly bombarding the population’s psyche with advertising. The ads say: you’re not good enough, not slim enough, not smart enough, not sexy enough, and on and on. The commercials “program” the population, not for their health, but to satisfy corporate profits. The accumulation of wealth at the expense of state and private insurers is dependent on a programmed populace who believe the commercials have their best interests at heart. They assume people are incapable of making intelligent decisions for themselves.

Seeing the results of this phenomenon is when patients demand their doctor prescribe specific advertised drugs, and threaten to go to another doctor who *will* give them the prescription. The doctors are often caught in the middle - serving their patients health, and keeping them happy. Advertisers seek only self-serving bottom line numbers that bring investors lucrative benefits. What is at stake here is a condition of mental gymnastics, drawing on the “belief” that the drugs will work. Applying that same belief to wellness will improve the quality of health in Washington State by emphasizing self-responsibility.

Drug research is divided into 2 camps to measure a drugs’ effectiveness. One gets the drug, the other, called the control group, gets a placebo, generally a sugar pill. Results show that the placebo success rate is 70%, which means that merely the *belief* is sufficient evidence of a drug’s success. Given this fact, we could save a lot of money by *thinking* healthy thoughts, and cut healthcare cost by 70%. This means that drugs are only effective 30% of the time, not a winsome margin for investing. Misplaced confidence is costing people and governments untold billions of dollars.

Giving people the emotional support to help themselves stay well and to heal faster, will reward the population at least 70% of the time with success. Supporting wellness by positive reinforcement will help lower the high costs of healthcare, strengthening peace and happiness as desired goals. The benefits far outweigh the expense of establishing a politically justified, expensive healthcare system built on dependency that cripples business and government with high rates of absenteeism, temporary hiring and undermines worker productivity.

- Consider building a governmental healthcare model where wellness is expected, curtailing drug advertising, even though it generates a lot of money.
- Encourage nutritionally balanced diets throughout the state, in school lunch programs, emphasizing physical and mental exercise as a necessity. Be a guiding light.
- Use the power of positive thoughts as a guiding principle. Wellness is everyone’s birthright and should be encouraged.

1.*What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access?*

To envision a healthcare system where every Washingtonian can obtain needed services at an affordable price seems reasonable. Since the backbone of every successful country and government is the health of its citizenry, (the worker-bees that maintain it’s

functionality), helping them in time of need is simply paying them back for their service and loyalty. A unified healthcare system for everyone is taking care of the human family in the most productive way, and it's bigger than Washington State.

In our nation's capitol, lobbyists on Capitol Hill, who work for the health care industry, were paid $183.3 million in 2005, according to PoliticalMoneyLine.com. In the 2003-2004 election cycles, they paid $123.7 million on election campaigns, according to the Center for Responsible Politics. Add to this health care industry's corporate bureaucracy. CEO pay and benefit packages are in the million-dollar range and $30 million a year salaries, while amassing billion-dollar stock options; all at the expense of taxpayers who only want the best healthcare possible for their hard-earned money. Health care is big business.

Self-preservation is the law of nature, and if the persistence of nature to survive is doubted, we have only to look at the blackberry vines, the dandelions and various weeds whose growth we attempt to stave off with chemicals and mowing, only to return each year as a blessing of renewal. Nature's system for regeneration is normal. Healing is normal, given the right environment. The human body has a regenerative system and it does the healing, providing there's a favorable environment and not too much intervention thwarting the body's ability to do so.

2. *How will implementation of your proposal enhance the vision?*

Energy medicine, common in Eastern cultures, is better than chemical drugs, as energy travels faster than the speed of light. If healthcare is to be effective and efficient, these forms of healing modalities must be included in any healthcare coverage, otherwise it appears that special interests are controlling the State's decision-making. They need to be encouraged in healthcare practices as a quicker method of healing, greatly reducing costs by drawing on the natural electromagnetic energy field of the physical body.

We have only to look at the success of Ayurveda with Deepak Chopra, M.D. and Virender Sodhi, ND, MD in Bellevue, WA who both share the same credentials and are proponents of these disciplines. Much research supports this methodology.

Medical schools shy away from energy medicine, because pharmaceutical companies whose vested interests in continuing the monopoly of traditional medical practices fund them and must be protected.

3. *A new model includes* Complementary and Alternative medicine, combined with exercise, nutrition and vitamin supplements is to be encouraged, allowing people to be the best judge of their use. Too much government intervention removes the self-responsible action essential for a populace to accept control of their body and their health. Andrew Weil, M.D. teaching at the University of Arizona brings levity to health care, offering wisdom and knowledge to the healthcare field in plain talk that people can understand. He may be one of the most significant individuals reshaping the way we view self-care for healthy living. Dr. Weil's health plan boasts conscious awareness of health issues, healthy weight and ways to increase your creativity, while providing exciting challenges for your mind and body that will, effectively, change the way you approach life.

Christiane Northrup, MD, who uses common sense and alternative solutions in her practice, shares her wisdom on PBS specials best stating common sense for women's health. She is a light shining brightly in the field of medicine.

Healthy living criteria and practices cut across race, gender and income levels throughout the population. Everyone wins. Healthcare knows no skin color. All human bodies function the same, all else are artifacts of separation.

Encouraging self-responsibility for personal healthcare is essential to living a long life in good health, and goes a long way toward cutting the high costs of healthcare, a very desirable outcome for all concerned.

Educating government workers and the public about the way the physical body works at a cellular level is my forte. Governor Gregoire recognized my ability to benefit her initiative when I explained to her the new science of biology discovered in 1985 by B. H. Lipton, Ph.D. while Senior Research Scholar at Stanford's School of Medicine. Applying this new biology to heal myself from neurotoxin poisoning that nearly killed me in 1992, I know that it played a huge part in the healing process. To inspire others, I authored the handbook on self-healing, *If You Make The Rules, How Come You're Not Boss? Minding Your Body's Business (Hampton Roads, 2003)* endorsed by a former Washington State Chief of Public Health, as well as by the Head of Biology and Pre-Health at St. Martin's University.

The physical body's 50-70 trillion cells interpret signals from the environment instinctively and enact or deny signal's entry at the membrane level. Germs, bacteria, for example, are part of our biological system, and function in a way that supports the organism. When a signal from the environment triggers stress, fear, internal anxiety, and/or anger, then germs, as opportunistic organisms, take advantage of the vulnerability and advance their influence.

Most of the problems with health and attitude begin as an individual response to fear-based news that continues to bombard the psyche, keeping people on edge about whether they're going to live or die. If it were possible to shut off the valve of constant fear-based programming in the media, it would go a long way toward reducing the health care costs in Washington State, as well as throughout America.

R.T. Trall MD wrote in *The True Healing Art or Hygienic vs. Drug Medication* insisted, and rightly, that it is the body that acts and the drug that is acted upon. He proclaimed the obvious fact that the truth about the so-called "action of remedies" is the exact contrary to what medical men teach.

In 1860, Trall said, "I have myself, through Natural Hygiene, over 16 years, treated all forms and hundreds of cases of typhus and typhoid fevers, pneumonia's, measles and dysentery's, and have not lost a single patient. The same is true of scarlet and other fevers. No medicine whatever was given."

"These diseases (typhoid and pneumonia) are nothing more nor less than a cleansing process - a struggle of the vital powers to relieve the system of its accumulated impurities. The causes of the diseases are constipating foods, contaminated water, atmospheric miasmas, and whatever clogs up the system or befouls the blood. And the day is not far distant when a physician who shall undertake to aid and assist (suppress)

Nature in her efforts to expel impurities, by the administration of poisons (drugs, medicines, shots, radiation, etc.) will be regarded as an insane idiot. But now this practice is called medical science."

Trall declared, "It is the living system which acts" and not the lifeless drug. He also declared that, "the 'property' is in the living system; and that property is not 'affinity' but antagonism." Medical authors, he said, by their theories and terms "endow these dead (lifeless), inorganic, and actionless substances (actionless except in the mechanical or chemical sense) with instinct, if not with intelligence." Further, "Such teachings reverse the order of Nature. There is no affinity between poisons and the living system." He affirmed that any "relation of affinity" in "any approved or conceivable sense of the word between a vital structure and a poison," [INHS] Hygienic Review Vol. IV April, 1943 No. 8 Vital Action vs. Drug Action Herbert M. Shelton

4. *Regarding evidence-based healthcare* dependent upon recent external clinical tests may have value, but danger lurks when they become the deciding factor, for tests are only as good as the individual who reads them. Multiple factors must be considered to assess the physical state of being, and some factors may not be obvious. Consider the mental hygiene and what's going on in a person's personal life. These are not always obvious. Having a practitioner, who knows you as a person and not as a number on a file, will be better able to assess the condition, regardless of clinical evidence. The mind is in control of it all, and it doesn't always reveal its secrets openly.

Given the variability's testing and potential for false results, no diagnosis should ever be made solely on the basis of a single lab test. Medical tests are not foolproof and can present an incomplete picture when not put into proper context. To reduce the chance of medical errors, test findings must be scrutinized carefully to increase the reliability of a diagnosis. However, each individual remains responsible for monitoring their own care, asking questions, being attentive to detail from the beginning to the end, following up when needed, and *not allowing the system to make decisions for them*. Individuals must retain control of their life and be the final determinant of any outcomes.

Relying too much on technology as a determinant in assessing health conditions may not be the best choice, as it is not intuitive and cannot read the emotional slide rule that often colors a physical condition. I, myself, had such an experience, and know that human assessment and interaction often reads signals missed by technology. In addition, an element of spirituality must be considered in the mind/body/spirit triune.

Remaining focused on the optimal goal of health is essential, because not everybody in the system can be counted upon to do so. Though doctors may be competent professionals, they may not question the work of others in the system. That, in the end, may be the biggest threat to anyone's health.

5. *Improving affordability may be the greatest advantage* to adopting a more liberal model of healthcare. Including a broad spectrum of alternative healing modalities will appeal to those who want to stay out of the traditional medical model of "doctor dependent" healthcare. When all people have access to health care, regardless of its discipline, there is more choice, and better attitudes exist to support well-being practices.

Washington State has the ability now to move into being a progressive state, willing to allow broader application, recognition and payment for complementary and alternative medicine. The broad swath of offerings opens the field of self-healing and self-responsibility for one's own care. Those in need of specialists, emergency care and traditional medicine will also have what they need. In today's world, there are many choices, and adopting a more open attitude empowers the people. There is little to prove that the high costs of healthcare have anything to do with keeping people healthy. When retirees spend their savings on expensive healthcare, there is little left to enjoy the fruits of a long life.

About a decade ago, doctors began to be trained in what health guru Dr. Andrew Weil dubbed "integrative medicine," a new kind of doctoring that combines Western medicine with the best, most evidence-based alternative therapies. In Southern California, Western medicine teams up with acupuncture, yoga and herbs to fight both disease and pain. Finally, this hybrid is going mainstream. [MEDICINE AND THE NEW AGE Twice as Strong By Hilary E. MacGregor Times Staff Writer August 7, 2006]

Last, but not least, is the amount of stress people of this country endure. Bombarded daily by fear-based news about the fighting and war's on everything from peanut butter to pretzels facetiously, from oil, nuclear power plants to religion (belief) seriously, the last thing people need are pharmaceutical advertisements that feed more uncertainty into their lives. All this is doing is repressing society, and feeding the coffers of people and companies who profit. The more this continues the sicker will be the population.

So long as fear has a hold, expect healthcare costs to soar. Fear increases the cost of healthcare, exponentially. When the level of threat is high, the screws tighten on personal safety and sanity. The human cells in the body are like children, all 50-70 trillion of them, and they listen to all our conversations, spoken or not. When the outside is scary, emotions are high for fight or flight, and cells respond in an instant. Maintaining high alert on a constant basis thwarts cells ability to thrive and heal, as they would in a relaxed state. Translating that to the atrocious costs of healthcare insurance and healthcare in general, it means that as long as a state of emergency exists, pending security risks will produce more illness higher costs and increased demand for services, leaving scars on the minds of humanity for decades to come.

To be happy and healthy is to feel safe. Trusting is a strong component. When the news reports keep everyone on pins and needles, there's even more stress. Subsequently, more demands for s*omeone* or some*thing* to make the fear and hurt go away. The body can only take so much of this kind of thing before it suffers from the strain and breaks down.

The rule is that society and creativity flourish in a safe environment. It's true now and since the beginning of civilization. The economy grows when the environment is safe, plain and simple. People relax when peace prevails. Knowing that healthcare will be affordable eases some of the stress. But, putting people in charge of their life choices is all part of the wisdom of a caring society, compatible with accepting responsibility for his or her own health and life choices. Of course, emergencies will happen, and that must

always be taken into account with competent practitioners and life-saving processes, perhaps the best use of the medical profession as a whole.

6. *Marketing ideas for a new model.* Washington State, with Governor Christine Gregoire at the helm, has the opportunity to set the pace for a new vision of healthcare by adopting the ways of the wise.

—Allow availability to necessary facilities and competent care for those who need it.

—Encourage preventive measures to assuage illness.

—Alternative, Complementary, and Integrative Medicine becomes the norm. Energy, the unseen quantum energy field which Einstein formulated in his famous equation, $E=mc^2$ accepted as a healing modality and welcomed with open arms.

—Spearhead a campaign for wellness.

—Use Billboards and signage as a great way to promote wellness, with positive slogans, such as these:

I love life (use the red heart symbol) like in I love NY
Look for the good in your life.
I love to live in Washington State
Be happy. Stay well. You are loved.
Let your smile be your umbrella
Think Wellness
Love yourself into Life
We Are One!

Empowering the people with wholesome statements lets them know they have value, and can make a difference in their lives and in those around them. This will improve attitudes and act as positive reinforcement to automatically reduce dependency on needless healthcare services that balloon's costs. This one alone will go a long way toward building a friendlier, happier and healthier populace; lowering healthcare costs and improving the quality of life, the desired goal! Isn't it?

—Spearheading this positive reinforcement campaign among state residents is Great PR. Results will speak for themselves, reducing demand for medical services, thus lowering costs.

—Invite business to join the campaign and help promote healthy attitudes by following the same trend. They will be happy to spend money on this, because they stand to benefit.

—T-shirts could also reflect the wholesome slogans, coffee mugs, tags on advertising, pens, label buttons and other venues, including banners on Washington Transportation Dept. vehicles.

—Use the slogans everywhere, and build the momentum.

7. *I am willing to be a part of the solution.* Developing a curriculum grounded in the new science of biology understanding, training government workers in the empowering secrets of how the mind/body/spirit works together to maintain their life,

how they get sick and how they can heal, will shift the balance on worker absenteeism, improve job efficiency and increase profitability, thus cutting the State's high cost of health care. Collaboration with alternative practitioners, integrative medicine balancing with preventive healthcare measures, enhances the offering.

8. *Obstacles to implementation* are the limited views of the current vision. The pharmaceutical companies may not be easy to deal with, yet someone must make the hard decisions if there is to be any movement in the right direction of reducing the high costs of healthcare and improving the quality of life for all. Special interests have their own agenda, and it is all based on profits and satisfying the bottom line for investors. Washington State must be strong enough to take the lead toward making a significant difference in peoples lives, and for the health of the state itself. When people are empowered as a unified force, then powerful positive change is possible. Washington State must be strong and flex its muscles on keeping the home front sturdy and economically sustainable.

The residents of the state must be of strong constitution. One step is to encourage preventive care, like cell phone protection for elementary school children 9 years and older. Youngsters 3-8 should not come near a cell phone, for the radiation will adversely affect their brains. The Aulterra product is acclaimed in this department.

The challenge for the Blue Ribbon Commission on Health Care Costs & Access is to design a new way of doing things, like the green movement in architecture is doing in recycling building materials. Ask the people what they want. Utilizing the excellent generic version of the Forum Foundation's Opinionaire, questions can be designed to feedback valuable insights about how and what people feel is important for Washington State's future in healthcare. The Opinionaire is better than taking a vote. Oregon is using this now to assess the direction of their healthcare focus in the coming years. This empowers the people, asking them to express their opinion, and it can be done simply and less expensively than trying some unknown approach that wastes a lot of money and gets poor results.

Obviously, the current system is broken and can't be fixed. Otherwise, Governor Gregoire would have no need to make healthcare reform a pivotal part of her platform.

Drastic measures like banning all pharmaceutical advertising in the media would go a long way toward improving health and well being. Let them advertise to the medical profession, not bypass them to sway the patient. Whose side are they on, anyway?

Other ideas to reward people to stay well …

- Offer a bonus or discount for insurance premiums,
- A holiday event, picnic or concert with the Governor
- A contest to see how few days are taken off for illness with prizes
- Free license plates for 5 years
- Other incentives meaningful enough to engage the spirit of living a long life in good health.

These suggestions are germinating seeds, a beginning of what could generate a cohesive force of commonality for the people of this state, bringing to the fore a real unifying principle of caring and concern. No coercion, no threats or punishing behavior. How refreshing!!! And, the likelihood of a positive outcome is better than average.

-Unify the people of the state with positive reinforcement

-Give people pause to contemplate their choices

-Inspire people with a higher purpose

-Reward those who take charge of their lives in a positive way.

The reward system works so much better than punishment, as every parent knows. Everybody wins and this move encourages people to think more about their personal benefit, by accepting responsibility for right thinking, the way they eat, care for their bodies, and how little they complain about workplace conditions, or the people with whom they work. Prevention costs less than repairing the body after abuse. Plenty of rest nourishing meals and exercise builds strong bodies, while monitoring our thoughts for those that are self-deprecating. Encourage grocers and restaurants to eliminate GMO foods that corrupt the body's natural state of being, affecting the genetic integrity of the body adversely.

The idea here is to be happy, for when you're happy, you're in love with life, and when you're in love with life, you're healthy, and costs to the system are minimal. This is not rocket-science, but common sense. Cutting healthcare costs begin at home.

The urgency of medical care and all that it represents is appropriate for emergencies and critical care, and that's where it shows up best. No one will deny the blessing of the medical doctors and their skills in time of need. Every society needs this kind of critical care, and that's where it counts the most.

Unnecessary procedures, experimental surgeries, the preponderance of inefficiencies, and needless tests that pay for high-tech, high-ticket equipment sold to the doctors and hospitals as the latest greatest tool for diagnosis and profit, mostly the latter.

Einstein said that problems couldn't be solved using the same consciousness that created them. Which implies that a new vision is needed, that blindfolds be removed from the eyes of those guarding the safety of position, and that fresh ideas from outside are better positioned.

Most people in healthcare are sincere in their desire to help others, and they are to be honored, but when the FDA approves viral adulteration of our food supply, see http://www.newswithviews.com/Richards/byron7.htm then there's good reason to suspect foul play. What is the agenda? Where are the ethics? Certainly, it is time for the people to rise up and shout, *Foul Play*. With egregious actions like this, who needs enemies? We, as a people of this country, must give serious consideration to the intent behind this kind of malignant thinking. It's war on people.

I will continue to help people learn about the innate intelligence of the physical body from a cellular perspective, how physical bodies communicate at a cellular level to create the reality we call life. It is my mission to make a positive difference in the world, by empowering people to accept their innate power to rule themselves, and to know what is best for them in their given situation.

There's more to this issue than taking an aspirin and calling the doctor in the morning. It's going to take a courageous commission to sweep the halls of closed-door policy makers and open the minds to realize that all our decisions are based on perceptions of the environment, internal and external, alike. To improve healthcare, and cut costs, we must begin seeing ourselves as healthy. It's an inside job, after all.

Accompanying this Proposal is a chart comparing the features of Conventional Medicine and Wholistic/Integrative Medicine. Clearly, there is a significant difference in approaches to well-being health care. With the current failed system representing Conventional Medicine, it is clear that Wholistic/Integrative Medicine has a lot to offer and is worth serious consideration in any healthcare plan Washington State considers.

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Conventional Medicine	Wholistic/Integrative Medicine
Based on Newtonian and Cartesian philosophy, the hard laws of science, such as cause and effect, linearity and polarity.	Integrates Einsteinian, Cartesian and Newtonian principle. Actively incorporates energy, electricity, and constant movement. All matter is perception.
Breaks the body down into individual organs that can be surgically removed without affecting the rest of the body.	Treats the whole person. Each organ is part of a diverse and complex system, interacting and related to other organs. The health of one organ affects the health of the entire system.
Health is a one-way street headed towards deterioration and death.	Health is a two-way street, either moving towards health or disease depending on the conditions.
Wellness is simply the absence of disease. Unconcerned about poor system function unless a specific disease is identified.	Wellness is about improved function of the whole person (biological, physiological and psychospiritual) whether or not they have an identified disease.
Physician is the body-mechanic and healer.	Physician is the teacher, guide and facilitator or the healing process. Self-healing is encourages as an integral part of the therapeutic process.
Focuses treatment on the symptom, lab tests or pathology.	Primarily treats the person with the disorder.
For every diagnosis there is a specific treatment.	Uses a wide variety of healing treatments, philosophies and approaches.
The symptom is the problem.	The symptom represents an underlying cause.
Each body is biochemically identical. Assumes treatment will work the same on all people.	Honors biochemical individuality. Not all treatments will work in every person in the same way. Practitioner should individualize strategies.
Dependent on the result of standardized testing (blood, urine, etc.) to diagnose. If the results are normal then the illness is all in the patients head.	Disease manifests individually in people. If the patient says that something is wrong, then something significant should be acknowledged.
Look for a single factor for any particular	Multiple factors come together to overwhelm

disorder.	the bodys natural ability to defend and repair itself.

Tab 13

Health Care Costs and Access Improvement Proposal
Health Care Institute

1. What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access? The State should establish a non-profit institute to support payer, provider, and supplier efforts to improve the delivery of health care in Washington. The institute would be a small organization of 10-20 individuals who would work with interested stakeholders to increase access and improve outcomes through health care process improvement. Washington State would give the institute the mission of applying proven process improvement techniques to our health care delivery system and grant the institute a special charter, giving it authority to represent the State in this effort. The institute would identify processes that offer the greatest potential for cost savings and quality improvement, work with providers to establish best practices suited for broader application, and assist small providers that could not afford to staff their own process improvement office or hire consulting agencies. The institute would assist in the expanded application of evidenced based medicine as an integral part of process improvement. The institute would also organize an annual state-wide health care process improvement conference. The conference would serve as a forum to share lessons and best practices, and stimulate growth in the process improvement program. This institute could become a force for change, a model for other states, and a source of pride.

2. How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? The institute would enhance achievement of the vision and goals by operating as a non-partisan agency committed to the objectives identified by the State. It would involve providers, patients, government, businesses, insurance companies, suppliers, and other stakeholders interested in transforming health care for the citizens of Washington. The institute would tap decades of process improvement experience in the private sector and in health care to eliminate waste and improve quality in all critical processes. It would encourage the application of tools like Lean and Six Sigma which have dramatically changed operations in selected health care activities within the state and across the country. It would identify key processes within the delivery system most capable of affecting the cost and quality of delivery.

The institute would consist of a small staff of process improvement experts. The State would resource a core team. Major local employers, with recognized Lean programs and internal expertise, would be encouraged to each provide a process improvement expert to the institute. The State could also authorize an advisory committee or board consisting of leaders from stakeholder groups. The institute would examine the delivery system and identify processes where improvement could impact cost and quality for major portions of the patient population. The institute would examine the complete delivery system from the patient's perspective. It would also involve all agencies responsible for provision of health care in this review of the system to identify improvements that could actually affect bottom-line costs. The institute would then facilitate the improvement of these processes state-wide.

How do you know? There are many examples of providers improving the quality of processes greatly, while lowering costs significantly. They include Virginia Mason Medical Center, Children's Hospital, and Group Health Cooperative.

3. Is your proposal modeled after an existing policy or program within Washington or elsewhere? Yes.

If so, describe the policy or program and its outcomes. The proposed institute would apply the techniques practiced in the process improvement programs found in a number of major hospitals in Washington and across the country. The institute would deliver this approach to cost reduction and quality improvement state-wide. The Pittsburgh Regional Healthcare Initiative is an example worth considering. That organization has helped providers achieve exceptional results by applying Lean techniques in areas of great waste and unacceptable safety and quality.

This initiative is also modeled after the application of Lean and Six Sigma to a wide range of activities in the private and public sectors. The Automation Research Corporation Advisory Group reports that 35% of manufacturers employ Lean or Six Sigma tools as their main process improvement method. Lean, which represents Toyota developed techniques for eliminating waste and improving quality, is the most comprehensive process improvement approach and is best suited for attacking costs and most quality problems in the health care delivery system. Six Sigma tools are best applied to processes involving the production of a large number of identical products, when high degrees of precision are required (less than 3.4 defects per million); the production of vaccines would be a good example. Lean is very complementary to the State's mandate to focus on the patient, in that value, as perceived by the customer, guides Lean process improvement.

Lean techniques have produced exceptional results within manufacturing and other industries. In numerous cases, process owners have reduced defects significantly by building quality into every step in a process, while reducing costs. These costs are those associated with unnecessary processing steps, over production, unnecessary motion and transportation, waiting, and a number of other wasteful activities found in almost all processes. Lean manufacturing techniques allowed Boeing to reduce assembly time for the 737 by 50%. Automobile industry parts manufactures have reduced throughput times by up to 90%. Toyota is requiring it suppliers reduce parts costs by 10% a year for three years and assisting them in apply Lean continuous process improvement to achieve this goal.

The Department of Defense (DoD) offers an example of the application of Lean process improvement outside the manufacturing industry in an environment where government is driving the requirement for change. The Navy, Army, and Air Force have applied Lean and Six Sigma to supply and maintenance operations for a number of years. Recently, Defense agencies recognized Lean's potential to eliminate waste in areas outside logistics. In the last 12-18 months, the Secretary of the Army has expanded the use of these to tools

to include the entire institutional side of his Service. Likewise, the Secretary of the Air Force launched a service-wide program called Air Force Smart Operations for the 21st Century (AFSO21) a few months ago to help control costs and improve quality by applying these tools to a wide range of activities. Agencies across the Air Force are demonstrating great success in attacking cost and quality issues through the use of consultant contracts, by applying in-house process improvement experts, and by involving managers and workers throughout organizations.

4. *Will your proposal impose costs on individuals, businesses or government?* This initiative would impose limited costs on the State and on the few businesses that choose to provide an expert to the institute.

Will those costs be time-limited or on-going? Government costs could be time-limited. The State could provide operating costs and pay salaries for the core group for limited time period. The State might fund the program for five years, after which the initiative would be assessed to determine if an additional five years of support was required and warranted. The goal would be to have the institute to fund the core team's salaries in subsequent years from a portion of the savings generated for providers and payers. To have a major impact, this proposal must save millions of dollars annually. The cost of a handful of continuous process improvement experts should equal only a fraction of the potential savings.

Major employers supporting the proposal, would accept a continuing requirement to provide a process improvement expert to the institute. If the State empowers the institute to help payers and providers share cost savings, businesses should see savings or smaller increases in health care costs across their workforce that more than offset the cost of their team member's salary.

Can you estimate how much these costs will be, or suggest how such an estimate could be made? The costs would be largely personnel costs. Operating costs should be kept to a minimum, as the institute should be a model of frugality. This initiative will fail if it creates another bureaucracy. The State would provide approximately five full-time equivalents (FTEs) and the supporting group of major employers would provide one FTE each. These businesses would be encouraged to detail one of their employees with the institute rather than pay the salary of one of team members.

How much, if any, of these costs will be offset by corresponding savings? The goal would be for all of the costs to be offset, as described above.

5. *How does your proposal reflect collaboration among various stakeholders?* This proposal grew from observation of the first commission meeting and informal discussions among a handful of participants. It offers tremendous potential for future collaboration among providers, payers, suppliers, health care professionals, unions, associations,

businesses, government, and others by focusing all stakeholders on improvement activities.

Which stake holders have endorsed it? No stake holders have endorsed this proposal, but a number of Washington hospitals have established process improvement programs. Through their actions, they endorse the concept of applying continuous process improvement theories and techniques to health care. Additionally, the Healthcare Forum, Medical Association, and Hospital Association have all discussed large-scale process improvement and would likely support this initiative if it was properly developed and presented to them.

6. What are the obstacles to implementing your proposal? There are at least three obstacles. First, ongoing commitment of support by the State, as well as major employers providing process improvement experts, may be an issue. Second, competition among providers and provider groups could limit the extent of cooperation. And, lastly, the related notions that our health care problems are too large to solve and that health care costs cannot be lowered, must be overcome.

Who will object to it and why? Large hospitals and provider groups with well-developed process improvement programs may balk at sharing lessons learned with the institute and other health care providers. Today, they share limited lessons. They compete with other providers and may not feel comfortable with the level of collaboration necessary to meet state vision and goals.

Likewise, health care providers may not embrace the goal of using process improvement to lower payer and patient costs. Efficiencies gained through process improvement often help the providers overcome fiscal challenges and do not always produce savings for payers or patients. The effort will not get provider support if hospital fiscal considerations are overlooked and the initiative fails to provide “win-win” solutions for all involved.

How do you suggest these objections be addressed? Convince providers that we can lower costs without sacrificing their fiscal stability if all stakeholders work together to achieve the state’s goals through aggressive continuous process improvement. This could be done through a combination of presentations of transformation results by Washington providers experienced in Lean process improvement, as well as information sessions by consultants.

Tab 14

September 1, 2006

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The Honorable Christine Gregoire
The Honorable Pat Tribaudeau
Blue Ribbon Commission on Health Care Costs and Access of Washington
Mod 2 -229 B
310 16th Avenue SW
Olympia, Washington 98504

Dear Governor Gregoire, Senator Tribaudeau and Members of the Commission:

GlaxoSmithKline welcomes this opportunity to submit a proposal to the Blue Ribbon Commission on Health Care Costs and Access of Washington. We are recommending two strategies for meeting the Commission's goals of making Washington "one of the top ten healthiest states in the nation" and improving adherence to evidence based treatment. Our proposals include:

- A partnership with GSK to analyze Washington state employee claims data for adherence to evidence-based treatment. This will give the state a baseline for current interventions and compliance, and will provide valuable information on the direction and focus of the state's future efforts in chronic disease management. GSK has entered into a similar partnership with the state of Ohio.

- Implementation of an Asheville diabetes disease management program to create incentives and eliminate barriers to diabetes control for state employees, by participating in the American Pharmacy Association Foundation's Ten City Challenge or similar effort.

GlaxoSmithKline believes that the state of Washington can be a role model for local governments and private employers by setting targets and pioneering successful disease management programs. Research and experience tells us that bringing health care costs under control requires more than shifting costs to patients or rationing care; it requires better preventive care, early and appropriate medical interventions and adherence to evidence-based treatment guidelines. As a major employer itself, GlaxoSmithKline applauds the Commission for its vision and willingness to tackle the challenge of the decade – improving quality, affordability and access to health care for all.

Please don't hesitate to call if you have questions about our proposal. We are excited about the possibility of working with you and your staff.

Sincerely,

Jody D. Fischer
Regional State Government Affairs Manager

GlaxoSmithKline

PROPOSAL TO THE
BLUE RIBBON COMMISSION ON HEALTH CARE COSTS AND ACCESS

GlaxoSmithKline welcomes this opportunity to submit a proposal to the Blue Ribbon Commission on Health Care Costs and Access of Washington. GSK proposes two strategies that we believe will assist the Commission in meeting three of its key goals:

- Making Washington one of the top ten healthiest states in the nation in key categories such as diabetes prevention & control, immunization, heart disease prevention & control, obesity, asthma prevention and control, and smoking cessation;
- Ensuring that Washingtonians get the evidence based standard of care 70% of the time; and
- Achieving 100% compliance with evidence based guidelines for the management of chronic illness.

The first proposal is to analyze state employee claims data to determine the levels of evidence-based care currently being provided to patients with a variety of chronic conditions in Washington in order to establish a baseline so the Commission can better set priorities for interventions and program development that will do the most to achieve its stated goals.

The second proposal is to implement an Asheville model of diabetes management for state employees that includes financial incentives to patients who participate in diabetes counseling as a strategy for improving patient A1C levels, reducing overall medical costs and reducing absenteeism.

PROPOSAL I

Establish a Baseline of Washington Adherence to Evidence Based Treatment

Poor adherence to EBM clinical practice guidelines and patient medication compliance is a national problem that has been shown to increase health care spending and negatively affect patient health, quality of life and productivity. One well-recognized study found that evidence-based care was delivered to patients only about 55% of the time. Patient lack of compliance with treatment and medications has also been shown to increase hospital, emergency room and physician visits, and lower quality of life and productivity.

GSK proposes to partner with the state in conducting a Washington-specific analysis of patient compliance to EBM treatment guidelines. The results will reveal the magnitude and relative importance of the disease groups affecting citizens of Washington, adherence to clinical practice guidelines, and patient medication compliance. Developing a current baseline of compliance is a

critical tool for planning specific interventions and will enable the Commission to target public and private resources more efficiently to improve Washingtonian's health, quality of care, access to care and to reduce increases in health care spending. A baseline will also serve as a benchmark for evaluating the results of the interventions and the state's progress towards meeting the Commission's dual goals of 70% EBM treatment and 100% compliance with evidence based guidelines for the management of chronic illness.

A. Summary:

In order to meet these goals, we recommend that the first step be to conduct a Washington-specific analysis of

(1) The ten most prevalent diseases among Washingtonians;
(2) The ten most expensive conditions in the state;
(3) Adherence to clinical practice guidelines;
(4) Patient medication compliance;
(5) Use of potentially inappropriate medications; and
(6) The health care expenditures of patients with certain diseases.

We propose that the analysis be conducted using state employee health plan data. Three of the possible approaches are:

1. State government conducts the analysis internally with expert methodological support from GSK.
2. GSK conducts the analysis by licensing HIPAA compliant data
3. A third party (e.g., research consulting firm) conducts the analysis with expert methodological support from GSK.

As state government employee data should be available from the employer plan administrator, the costs to the State would be primarily overhead relating to the collection, de-identification and/or analysis of data (depending on which approach is taken). These costs should be limited to the project, rather than ongoing, and should pave the way for implementation of programs that improve the health, quality of life and productivity of Washingtonians and lower long-term spending on health care.

GlaxoSmithKline has experience developing and conducting similar studies. Recently, in Ohio, GSK developed the methodology and used clinically-based measures of adherence to clinical practical guidelines and patient medication compliance to calculate Ohio-specific rates and costs. Ohio chose to use this data to kick-off a "Health Ohio" month which included a broad educational campaign and a proclamation by the Governor of Ohio.

In Washington, the results of our proposed study would allow the Commission to set priorities for interventions and program development that will do the most to meet the Commission's goals.

B. Research: Adherence to EBM treatment impacts health outcomes and costs

Two key factors that affect the health outcomes of patients with chronic conditions are the receipt of appropriate, evidence-based care and patients' compliance with prescribed medications. Evidence-based care, also called evidence-based medicine (EBM), is defined as "the conscientious, explicit and judicious use of current best evidence in making decisions about the care for individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research."[1]

Research demonstrates that adherence with practice guidelines and medication compliance is suboptimal. McGlynn et al's article on quality of care found that in a random sample of adults living in 12 metropolitan areas, evidence-based care was delivered approximately 55% of the time.[2] Noncompliance with medications is also a common occurrence which has a negative impact on health outcomes. In a survey of 10,000 patients, 30% reported taking their medications less other than prescribed, 26% delayed filling a prescription, and 21% prematurely stopped taking their medications.[3] Noncompliance with medication can contribute to an increase in the number of acute care visits and emergency room visits, increased complications and decreased quality of life and productivity.[4-7]

Given the significant impact of adherence with practice guidelines and medication compliance on patients' health outcomes, there is a need to conduct baseline assessments to determine the levels of evidence-based care being provided to patients with a variety of chronic conditions in the state of Washington.

C. Key Research Questions:

The goal of the research we are proposing is to document the current health status of individuals residing in the state of Washington and to identify areas for quality improvement and answer the following questions:

1. What are the top 10 most prevalent disease conditions?

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[1] D.L. Sackett, W.M.C. Rosenberg, J.A.M. Gray, R.B. Haynes, and W.S. Richardson. Evidence based medicine: what it is and what it isn't. BMJ. 1996;312:71–72.

[2] McGlynn EA et al. The quality of health care delivered to adults in the United States. *New England Journal of Medicine.* 2003; 348:2635-2645.

[3] BCG analysis; Harris Interactive Patients Survey, 2002.

[4-7] Melfi CA, Chawala AJ, Crogan TW, et al. The effects of adherence to antidepressant treatment guidelines on relapse and recurrence of depression. *Arch Gen Psychiatry.* 1998;55:1128-32. 5. Kim MT, et al. Development and testing of the Hill-Bone compliance to high blood pressure therapy scale. *Prog Cardiovasc Nurs. 2000;15(3):90-96.* 6. Nichols-English G, Poirier S. Optimizing adherence to pharmaceutical care plans. *J Am Pharm Assoc.* 2000 40(4):475-485. 7. World Health Organization. Adherence to Long-Term Therapies: Evidence for Action. [World Health Organization Web site]. 2003.
Available at: http://www.who.int/chronic_conditions/en/adherence_report.pdf. Accessed March 16, 2004.

2. What are the top 10 most expensive disease conditions?
3. What is the adherence rate to clinical guidelines for various chronic conditions?
4. What is the compliance rate to medications for various chronic conditions?
5. What is the rate of potentially inappropriate use of medications
6. What is the health resource use and expenditures for various chronic conditions?

D. Proposal Methods:

Study Design

- Cross-sectional analysis of administrative claims data from health plan(s)

Data Source

- Administrative eligibility files, medical claims, and pharmacy refill claims
- Laboratory claims and/or electronic records contingent upon data availability

E. Study Outcomes:

Study outcomes include the following:

- *Prevalent disease conditions* (based on the International Classification of Diagnoses – 9th revision (ICD-9) codes): Prevalent cases are defined as the number of patients with a diagnosis of a disease, at a given time, divided by the number of persons in the population at a given time. Prevalence of disease conditions can be stratified by age, race, gender, geographic regions, employee status and other variables.
- *Top expensive disease conditions*: The most expensive disease conditions can be identified with medical and pharmacy claims.
- *Adherence rate to clinical guidelines*: Adherence with EBM clinical guidelines for various chronic conditions include, but not limited to, the following:
    - I. Childhood/Adolescents
        - Percentage of children two years of age with recommended immunizations
        - Percentage of adolescents 13 years of age with recommended immunizations
        - Percentage of children between the ages of 15 months and six years of age with recommended number of well-child visits
        - Pediatric asthma: percentage of persistent asthma patients filling a controller therapy. The measure will calculate a rate for each controller therapy (e.g., inhaled corticosteroids) and combination rates.
        - Pediatric asthma: percentage of persistent asthma patients filling a short-acting beta agonists (rescue therapy) to identify potentially uncontrolled asthma.
    - II. Chronic Conditions
        - Adult asthma: percentage of persistence asthma patients filling a controller therapy.
        - Congestive heart failure (CHF): percentage of patients filling a beta-blocker; percentage filling an ACE-inhibitor
        - Coronary artery disease (CAD): percentage of patients filling an ACE-inhibitor; percentage filling a statin
        - Depression: percentage of patients filling an antidepressant medication(s)

- Diabetes: percentage of patients filling oral diabetes medications.
- Diabetes: percentage of patients with at least 2 A1c tests
- Hyperlipidemia: percentage of patients filling a statin/acceptable alternative
- Myocardial infarction (MI): percentage of patients filling a beta-blocker post MI

III. Women's Health

- Osteoporosis: percentage of women 67 years of age and older who suffered a fracture who had either a bone mineral density (BMD) teat or filling a drug to treat or prevent osteoporosis in the six months after data of the fracture
- Cervical cancer: percentage of women 21-64 years of age who received one or more PAP tests to screen for cervical cancer

- *Medication compliance*: Patient compliance with medications for various chronic conditions include, but not limited to, the following:
  - Asthma patients compliance with controller therapy
  - CHF patients compliant with ACE, Beta-blockers, digoxin, diuretics.
  - CAD patients compliant with CAD-related medications (e.g., ACE, beta-blockers, calcium-channel blockers)
  - Depression patients with SSRIs, venlafaxine, bupropion
  - Diabetes patients compliant with oral diabetes medications (e.g., biguanides, TZD, sulfonylurea)
  - Hyperlipidemia patients with statins, niacin, fibric acid derivatives
  - Hypertension patients compliant with hypertensive medications

- *Potentially inappropriate use of medications:* Patient utilization to include but not limited to the following:
  - High utilization of short-acting beta-agonist for asthma
  - High utilization of oral corticosteroids for asthma
  - Narcotic usage for migraine
  - Usage of updated Beers medication list within patients ≥ 65 years of age

- *Health resource use and expenditures*:
  - Health resource use: 1) Outpatient office visits; 2) Inpatient hospitalization; and 3) Emergency room
  - Health care expenditures: 1) Pharmacy; 2) Medical; and 3) Total = sum of pharmacy and medical.
  - Resource use and expenditures can be stratified into disease-related and all-cause.

GlaxoSmithKline

PROPOSAL II

Create Incentives and Eliminate Barriers for Diabetes Control Using the Asheville Model

As a step towards meeting the Commission's goal of achieving 100% compliance with evidence based guidelines in the management of chronic illness, GSK proposes that the state of Washington join in the *Diabetes 10 City Challenge* effort, or implement its own Asheville model of diabetes management as part of the benefit plan for state employees in a self-insured plan.[4]

Demonstration projects using the Asheville model have been initiated by state and private employers across the country and have shown that by eliminating or reducing out-of-pocket costs to patients for diabetes medications and supplies as an incentive to entering and completing a program of diabetes counseling and management, employers can improve the A1C levels of their employees with diabetes, reduce overall medical costs, and reduce absenteeism. Programs like the *Diabetes Ten City Challenge* where pharmacists partner with public and private employers are getting good and consistent results. As a result, the Puget Sound Health Alliance (PSHA) and organizations like it are taking notice. PSHA specifically recommends that health plans and employers consider implementing pilot projects like the Asheville Project and *Diabetes Ten City Challenge* to improve quality and reduce costs. We believe that the state, as a major employer, can be a role model in implementing innovative diabetes management strategies with its own employees.

A. The High Cost and Prevalence of Diabetes Makes It an Appropriate Target for Intervention

Because of the social and economic impacts of diabetes, employers, health care providers and collaborative organizations such as the Puget Sound Health Alliance, have made it a high priority to define strategies to improve the quality of care and optimize outcomes for people with diabetes. In its March 2006 Final Report, the Diabetes Clinical Improvement Team of the Puget Sound Health Alliance reported that 4.5% of Washington adults age 20 or older—218,215 people—had diagnosed diabetes; another 106,000 were estimated to have undiagnosed diabetes. [5] The report went on to say that in King County, 5.1% of adults age 18 and older - 70,000 people - had

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[4] www.aphafoundation.org/programs/diabetes_ten_city_challenge/62.cfm

[5] *(WA DOH estimate: Washington State Diabetes Statistics, 2002. www.doh.wa.gov/cfh/diabetes/publications/2002_county_profiles/state2002.pdf.)*

diagnosed diabetes in 2002, [6] and that diabetes is the fifth leading cause of death in both the U.S. and Washington State among adults age 20-74. [7]

Complications from diabetes include heart disease, stroke, kidney disease, high blood pressure, blindness, lower-extremity amputations, dental disease, and complications of pregnancy In Washington, diabetes annually accounts for nearly 1,000 amputations of lower extremities, nearly 300 cases of kidney failure requiring lifelong dialysis or kidney transplant, and over 49,000 hospitalizations. The hospitalizations account for nearly half a billion dollars in annual hospital costs. The estimated direct and indirect financial costs associated with diabetes in 2005 were $132 billion nationwide, and $2 billion in Washington State. They include disability expenditures, work loss (including absenteeism and reduced productivity on-the-job), and premature mortality.[8]

PSHA specifically recommends that health plans and employers implement pilot projects such as the Asheville Model and *10-City Challenge* that reduce out-of-pocket costs for diabetes medications and supplies as a way to improve adherence to evidence-based treatment guidelines and reduce overall health care costs. We concur.

B. The Asheville Experience: Improved A1C Control and Lower Medical Costs

The Asheville project is a disease management program initiated by the city of Asheville, North Carolina, in 1997. As an employer struggling with the high treatment costs and lost productivity associated with diabetes, Asheville implemented a strategy of improving access and compliance to appropriate treatments, including prescription medicines, rather than the traditional approach of limiting access to treatment or cutting benefits. The City waived co-pays on diabetes medications and supplies for those employees who agreed to meet regularly with a pharmacist for counseling on drug adherence, diet and exercise and monitoring of blood sugar levels. The results were dramatic for the city and employees – better diabetes control, lower healthcare costs, fewer employee absences, and greater employee satisfaction, as the chart below demonstrates.

In the first year alone, average insurance claim costs dropped 41% to $3,596 per patient; in the fifth year the average insurance claim declined to $1,584 per patient.[9] The city also realized significant reductions in overall, annual direct medical costs, dropping more than 34% from an average of $7,082 per patient before the program to $4,651 in the fifth year. Employee

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[6] *(Public Health - Seattle & King County. Health of King County 2006, Chapter 6: Chronic Disease. www.metrokc.gov/health/hokc/index.htm)*

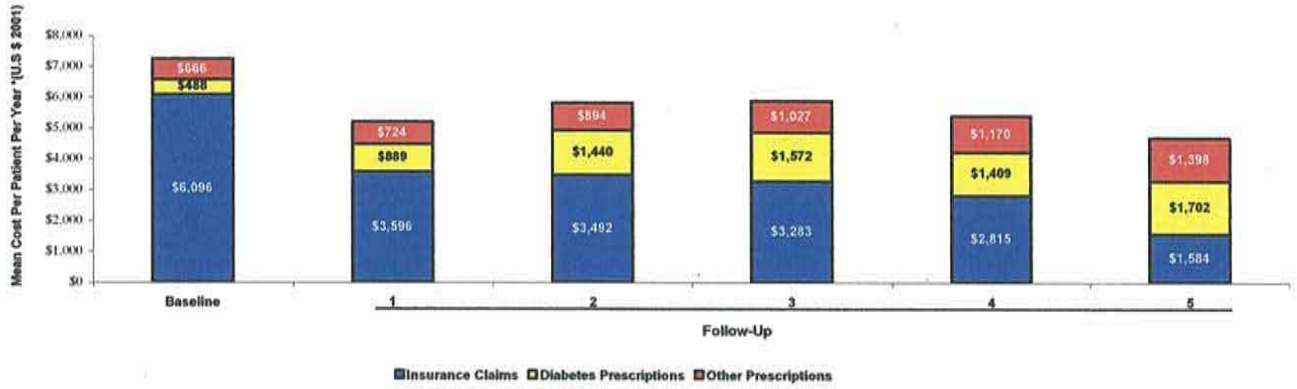
[7] (WA State Dept. of Health. The Health of Washington State, 2002 and 2004 Supplement. www.doh.wa.gov/HWS/CD.shtm.)

[8] *(Washington State Collaborative. The Washington State Collaborative 4: Diabetes and Cardiovascular Disease. www.doh.wa.gov/CFH/WSC/default.htm).*

[9] Cranor CW, Bunting BA, Christensen DB, "The Asheville Project: Long-Term Clinical and Economic Outcomes of a Community Pharmacy Diabetes Care Program." J. Am. Pharm. Assoc. 2003; 43(2):149-59.

absenteeism was cut by more than half. The city valued the increased productivity achieved at $18,000 a year. As the appropriate use of medicines and patient compliance with treatment increased, so did the pharmacy costs, but the overall savings from lower insurance claims was more than double the increased prescription spending. Most important, patient health improved as their A1c (glycosylated hemoglobin) concentrations, the key indicator for diabetes management, decreased (improved) at every follow-up for more than half of the patients, and the number of patients with optimal A1c levels increased over time as well.

The Ashville Project: Direct Medical Costs Over Time[10]



C. APhA's *Diabetes Ten-City Challenge:*

Several Asheville initiatives have now been launched by public and private employers across the country as part of the American Pharmacists Association Foundation's innovative *Diabetes Ten City Challenge Program,* as a strategy for improving diabetes management and controling health care costs. GlaxoSmithKline is proud to have provided technical and financial support for the program. GSK proposes that the State of Washington solicit the APhA to become a partner and one of the selected employers in the *Ten City Challenge* with a defined group of state employees.

How the Program Works:

1. **Specially trained community pharmacists** "coach" people on how to manage their diabetes, including setting goals, using medications properly, and tracking their condition

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10 Cranor CW, Bunting BA, Christensen DB, "The Asheville Project: Long-Term Clinical and Economic Outcomes of a Community Pharmacy Diabetes Care Program." J. Am. Pharm. Assoc. 2003; 43(2):149-59.

consistently with indicators such as cholesterol tests, blood pressure, foot exams and eye exams.

2. **Collaborative care teams** — including pharmacists, diabetes educators and physicians — are assembled in the community, educated about the program and are compensated for their involvement. Team members communicate regularly to optimize patient care.
3. **Employers contract with APhA Foundation** to establish the program in their community, and align employee benefit incentives to encourage success (co-payments for diabetes medications and related supplies typically are waived for patients who participate). Cost to employers is waived-co-pays and negotiated fee for counseling services.

4. **Employees choose to participate** through a voluntary benefit offered by their employer

5. **Success is measured** with clinical assessments including:

    - improvement in A1C concentrations (blood sugar control)
    - increased patient satisfaction with pharmacy services
    - decreased costs of medical care

Demonstrated Results:

The American Pharmacists Association reports that the benefits to employers nationwide from implementation of an Asheville-type management program for diabetes include an estimated $918 per participant, the first year, in total health care costs (overall annual medical costs per patient decreased $1,622-3,356 each year in Asheville); a 50% reduction in absenteeism; a reduction in workers compensation claims; high employee satisfaction with pharmacist care; and a savings to patients of between $400-$600 in waived co-pays. APhA reports that after eight years, employers using the Asheville program pay less to insure program participants than people without diabetes! [11]

We believe that Asheville-type diabetes management programs can produce the same benefits for many Washington public and private employers as well.

CONCLUSION

GlaxoSmithKline is pleased for this opportunity to strategize with the Commission on ways to improve health care delivery. We believe that the state of Washington can lead the way for local governments and private employers and pioneer changes that will make the Blue Ribbon Commission's vision of Washington as "one of the top ten healthiest sates in the nation" a reality. From experience we know that bringing health care costs under control requires more than shifting costs to patients and rationing care; it requires better preventive care, early and appropriate

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[11] www.aphafoundation.org/programs/diabetes_ten_city_challenge/62.cfm

medical interventions and adherence to evidence-based treatment guidelines. As a major employer and a health care company, GlaxoSmithKline applauds the Commission for its vision and willingness to tackle the challenge of the decade – improving quality, affordability and access to health care for all.

Contact Information

We would be pleased to provide additional information and discuss this proposal with the Commission. Please contact:

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jody.d.fischer@gsk.com I

Tab 15

Group Health Cooperative
Public Policy and Government Relations
521 Wall Street
Seattle, WA 98121

September 06, 2006

The Honorable Christine Gregoire
The Honorable Pat Thibaudeau
Blue Ribbon Commission on Health Care Costs & Access

Sent via email to hcca_brc@leg.wa.gov

RE: Blue Ribbon Commission Request for Proposals

Dear Governor Gregoire, Senator Thibaudeau, and Members of the Commission,

Group Health Cooperative, the largest non-profit, integrated health care system in Washington, strongly supports the vision and goals of the Blue Ribbon Commission—to assure improved health and affordable coverage for all Washingtonians.

We commend Commission members for recognizing that overall health, access to care and affordability of coverage are inextricably linked. Group Health's own vision and goals are predicated on this truth.

Meeting the challenge set forth by the Commission will require significant change. Change on this scale is never easy, and rarely comfortable; it demands shared responsibility and vision. Citizens, communities, employers, insurers, providers, elected officials and many social institutions have important roles and responsibilities in this endeavor.

Roadmap for Change
Achieving the Commission's goals requires a roadmap for change that all can clearly read and follow—a shared path to progress. We recommend the collaborative creation of a roadmap by all stakeholders as the Commission's over-arching priority.

In this document, we offer initial thoughts on critical elements of such a roadmap, as well specific ideas for improving Washington's health system.

We Can Build on Our Strengths through Partnership and Collaboration
Many of the recommendations in this proposal call for partnerships – between government and employers, between purchasers and payers, between providers and patients and so on. We can look at many of the strengths of our health system and see at their beginning an innovative partnership. Together, our community has created the Basic Health plan, OneHealthPort, the Puget Sound Health Alliance, Project

Access sites, and quality improvement efforts such as the Diabetes Collaborative. Group Health itself is the result of such a partnership between visionary physicians and nurses, community groups, healthcare leaders and patients.

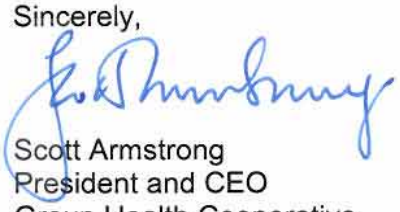
Group Health's Responsibility
Because we wear many hats, Group Health is uniquely positioned to help.

- We provide health care to nearly one in ten residents of Washington, directly and through our select community partners.
- We've created and applied a robust electronic medical record and health information system that's become a national, and even international model for supporting patient centered care and empowerment.
- Our research institution, the Center for Health Studies, is among the most respected in the country and is the birthplace of the Chronic Care Model.
- Our true, multi-disciplinary group practice, focuses on population and evidence-based care, and emphasizes coordination of care over a patient's lifetime and is focused on strategies that should serve as guideposts on the road to success.
- We work everyday in close collaboration with community providers, ranging from hospitals and Skilled Nursing Facilities to physicians, nurses and social service agencies.

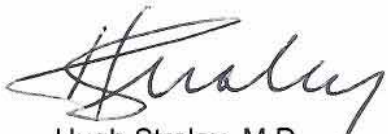
Group Health stands ready to fulfill our role and responsibilities as we work with the Commission and all stakeholders to meet the challenge of change.

We'll back our words with action, and with leadership. We are pleased to do so, not only because it's good business, but because it is our purpose: transforming health care to improve the well-being of the people in this state.

Sincerely,



Scott Armstrong
President and CEO
Group Health Cooperative



Hugh Straley, M.D.
Medical Director, and President
Group Health Permanente

Attachment

GroupHealth

Response and Recommendations
Washington State's Blue Ribbon Commission

Overarching Recommendation: Create a Roadmap for Change

The Blue Ribbon Commission has put forward ambitious, but achievable goals for Washington. In order to achieve these goals, we need a common roadmap for change that aligns our efforts, and a step-by-step program for moving everyone toward meeting the goals. Group Health therefore recommends that the Commission engage stakeholders in designing a roadmap for change to better enable all of us to help create a new, higher performing health system and better health. In this proposal, we set forth what we view as some critical elements of that roadmap, and some ideas for how we can make progress towards a healthier Washington. Group Health intends to follow up with the Commission in October with more detailed proposals for suggested first steps.

This document is organized by the Blue Ribbon Commission goal areas of Improving Access, Improving Health, and Improving Affordability, followed by responses to the questions set forth by the Commission.

I. IMPROVING ACCESS TO COVERAGE

BRC Goal: "All Washingtonians will have health coverage that provides access to effective care by 2012, with all children having such care by 2010."

Group Health's Position

The Commission's goal for access is ambitious, yet ultimately achievable, particularly if we all join together to create a sustainable plan for change. We have an access problem because we have an affordability problem. We have an affordability problem because we have quality problems, poor health status, and a payment/regulatory system that fail to address avoidable administrative overhead and overuse, underuse and misuse of healthcare.

Recommendations

1. Take steps now to meet the longer term goal of covering everyone for effective care.

We can make real progress now towards coverage for everyone. Our proposal sets out a number of steps we can take to meet these objectives. We can begin by addressing specific populations, such as children, young adults, and those who purchase in the individual and small group markets. We must also develop a shared understanding of our current tax structure and how healthcare is currently financed We need to re-engineer healthcare to drive better performance on a host of dimensions, including quality, efficiency, safety and patient satisfaction. No healthcare organization is optimizing performance, in part because the market and the public simply haven't demanded it, don't reward it, and sometimes undermine it. Payors must focus on driving performance while reducing the "hassle" for providers and patients.

As we make progress on our immediate objectives, we can also begin to build a state plan for covering everyone. Group Health believes we can and should build on our existing mixed system of employer, individual and public coverage. We encourage the Commission to engage stakeholders in a collaborative process to develop this longer range plan. Payors must assume greater accountability for supporting effective care, including prevention and improving chronic illness care rather than avoiding risk via underwriting strategies that simply move risk elsewhere. If we are to continue to have a system that is in largest part employer based, then

employers must have affordable options, and consistently exercise stewardship for their employees, encouraging health and offering choices that are affordable and targeted at use of effective care. Similarly, it is reasonable to expect that all who can afford it get and maintain affordable coverage and manage their health. State programs should focus on assisting those who cannot afford coverage on their own, and we should support effective community health centers; they form part of a vital safety net in our state.

As much as we would all agree that "there's enough money in the system now", we can't simply take from the parts we might perceive as over financed and give it to others. For both the short and the long term, everyone should work as a team to assure that Washington State gets its fair share of federal revenues to support healthcare access and delivery. We may also need to consider additional financing options, even in our highly tax averse environment. Group Health favors building on existing sources of coverage, but we would like to change the ongoing pattern of spending more state resources to prop up the status quo. We should aim for access and financing strategies that support the end goal of coverage for *effective* care for all.

2. Make children our first priority.

Covering children first is more than the right thing to do; it's the smart thing to do. The costs of failing to treat childhood health problems ripple through the economy and multiply beyond health care, to social services, business productivity and even criminal justice. Children, therefore, represent one of our best opportunities for reducing future costs by improving access to early intervention and effective prevention of chronic health conditions.

Group Health is prepared to commit people, time and financial resources to help design, implement and participate in a children's health initiative centered on providing a medical home to our state's low income children.

As a start, we favor increasing capacity in basic health and children's health insurance programs, and raising eligibility for children to 300% FPL. We encourage funding efforts to reach out to underserved populations through use of school nurses, public health nurses, other community health outreach workers, and by leveraging public service campaigns already underway. All stakeholders should work to have a coordinated strategy to assure our state both receives its fair share of federal SCHIP matching dollars (a 65% federal match!), and doesn't return available funds back to be used by other states as is now the case.

3. Emphasize coverage options for young adults.

State policymakers should work with purchasers and carriers toward a requirement that all health carriers offer extended eligibility for unmarried dependent children up to the age of 25. Even as a 100% self pay option for families, this would enable parents to keep young adults on their policies as they move into the working world. Additionally, the State and carriers should work collaboratively to develop approaches to assure coverage of all college students.

4. Improve the marketplace for individuals and small employers.

We may be able to significantly improve the market for buying health care and create new opportunities for individuals and small businesses to purchase affordable coverage through a "health connector" similar to what has been adopted in Massachusetts. A health connector is a marketplace mechanism—-similar in concept to a stock exchange or the Federal Employees Health Benefits Program—-that allows individuals and workers in small businesses to purchase personal, portable health insurance coverage from competing carriers. Such a program could leverage technology to reduce overhead, make available any state subsidies, and give individuals better information, more choice and incentives for choosing higher value health plans. Importantly, a connector model could be used to support quality and efficiency goals. The program, for example, could favor "next generation" health plans offered through accredited carriers committed to performance measurement, quality and price transparency. Participating employers could retain existing federal tax breaks for employer-group insurance, and workers could receive favorable federal tax treatment for their contributions, cost-shares and out of pocket expenses too.

Either as part of a health connector, or as a stand alone initiative, affordable buy-in options for small employers, with a focus on low-income employees, can be successfully implemented. We recommend modest adjustments to the recently passed Small Employer Health Insurance Partnership Program. Current legislation could be

clarified to enable some variation from strict actuarial equivalency. This would enable benefit designs that are on the comprehensive end of small group market offerings to be offered. Even Group Health's richest product designs cannot be offered without increased flexibility. If this pilot program is successful, it could be expanded to broaden access and participation.

5. Assure adequate reimbursement with accountability in state programs.

Inadequate reimbursement in state programs such as Medicaid leads to lack of access to care for low income families, and also to higher rates of uninsurance as costs are shifted to individuals and employers who purchase coverage in the private market. Enhanced reimbursement should be implemented in tandem with performance accountability measures and policy initiatives that are aligned with the overall roadmap for change.

6. Study and recommend appropriate healthcare tax reform.

The Department of Revenue should complete a study of health care taxes and assessments, and recommend healthcare tax reform options that help foster an improved health and a high performing health system. The current system has evolved as a patchwork over the years, and needs review. It imposes heavier tax burdens on small employers and individual policy holders. Self funded and regulated health plans carry very different tax and assessment burdens, with little understood implications for public programs, public health and risk pool funding as the prevalence of one form over another shifts. State tax benefits accruing to non-profit organizations are misunderstood. Our state healthcare tax structure may fail to maximize opportunities for federal matching funds. Over time, taxes initially earmarked for health care have been diverted to the general fund, while more programs have been shifted to the health services budget, straining financing sources for programs like the Basic Health plan. We need to ask how our healthcare tax and assessment structure could be changed to align with a roadmap for change.

II. IMPROVING OVERALL HEALTH

BRC Goals: "Washington will be one of the top ten healthiest states in the nation. Population health indicators will be consistent across race, gender and income. Increased use of evidence based care brings better health outcomes and satisfaction to consumers."

Group Health's Position

The overarching goal of long, healthy and productive lives for everyone means our view of change must encompass the broader dimensions of wellness and population health. Many of the decisions we make as individuals and communities negatively affect our health in ways that can only be addressed at far greater expense in our health care systems. Many of us lead high stress lives, eat badly, smoke, or "self medicate" in a variety of harmful ways. Many of us don't exercise. We're not connected with our communities, and we aren't as well prepared as we could be to address crises, such as pandemics and natural or man made disasters. This must change.

Healthcare itself should be re-engineered with people in mind. Patients should be able to assume that treatments offered to them are effective and safe, but we have problems on both these dimensions. Patients need to be in control of their healthcare to a greater degree, and be empowered to make smart decisions that are cost effective and improve their health care. Currently, consumer tools that enable comparisons on important dimensions of cost and quality at the health plan and provider level are not sufficiently developed, nor are the right incentives in place. Patients should be able to choose care that is efficient, coordinated over time and delivered by prepared, proactive professionals who work together as a team, but in general we don't train, pay, or provide the necessary infrastructure to achieve these results.

Recommendations

1. Give individuals new tools for health.

As a powerful purchaser and employer, the State should continue to focus on providing individuals tools to make health and lifestyle improvements. These include: health risk assessments, nutrition, and healthy lifestyle information and support. Research demonstrates that tools such as health risk assessments are most

effective when integrated in an overall approach to health and healthcare. Group Health is interested in partnering with the state to implement and evaluate the effectiveness of integrated wellness/health strategies. The state could also consider piloting programs that reward people who maintain good health or work to achieve health improvements with discounts on health care, lower premiums, or other benefits.

2. Leverage our statewide health improvement campaign – targeting obesity and smoking.

All stakeholders need to align much more aggressively around a statewide health improvement campaign targeted at obesity. Successful efforts to curb tobacco use should also be continued.

State strategies could include:

- Give public recognition to businesses and communities that adopt programs to encourage better nutrition and physical activity. State government could pilot ideas such as financial incentives for effective worksite health promotion programs and could fund research and demonstration programs to establish the business rationale for such efforts.

- Discourage the marketing and sale of sugary drinks and junk food in all schools, and support school physical education. State education strategies could be strengthened to assure children have more of the building blocks for healthy eating, activity and risk reduction.

- Identify the State's possible role in promoting healthy, sustainable communities. Land use, funding and tax policy, for example, could encourage improvements for pedestrian and bicycle facilities and corridors, as well as other activities that promote health and a higher quality of life.

- Design strategies to support local farmer's markets to make affordable fresh, healthful foods more accessible and to foster a sense of community.

3. Adequately fund an accountable public health system.

Since a cornerstone of public health is a healthy environment, many prevention investments are leveraged through a well-aligned public health infrastructure. This enables communities to collectively promote healthier behaviors and risk reduction, in addition to the myriad essential functions associated with protecting public health, including:

- Preparation for catastrophic events such as earthquake or flu pandemic
- Preserving the universal vaccine supply system to assure access for all children
- Disease tracking and surveillance for notifiable conditions
- Focus on prevention with a special attention on youth obesity and smoking

4. Understand and act on unwarranted variation in Washington.

Local communities have strikingly different rates of use of medical care. Sometimes, variation reflects underlying differences in the incidence of disease, or preferences of patients. *Unwarranted* variations cannot be explained on the basis of illness or patient preference, and often relate to practice styles and payment incentives. They reflect under-use, mis-use, and over-use of treatments and technologies. Some of the most significant variation that needs to be urgently addressed is the inequity of care delivery to vulnerable populations. Members of some racial, ethnic and sexual minority groups are more likely to have poorer health status and receive fewer needed services, suffer major illnesses and to die sooner.

If we are to substantially reduce unwarranted variation of all kinds, we must have an accurate picture of what patterns exist in Washington, because the remedies differ and can be targeted at our biggest problem areas. The best way to do this is to fund a Dartmouth Atlas of Health Care (or similar tools) specifically tailored for Washington State. This likely would be relatively inexpensive and a good use of scarce resources, and would guide collaborative efforts targeted at our state's most pressing problems.

State agencies, providers and payors should collaborate on strategies to increase information to patients and clinicians about therapies, targeted toward known patterns of overuse, misuse or underuse in our communities. Research is increasingly showing that regular and effective use shared decision-making tools can help patients understand treatment options can lead to better outcomes and more efficient use of scarce resources.

5. Promote effective care for chronic illness.

We need new tools and methods in an age of increasing chronic illness, and we need to focus on improving people's health in systematic ways. We need to look at the needs of individuals in the context of different groups in which they belong – such as those with certain chronic conditions. This allows health teams to identify the most effective preventive care and treatments options for each person in a thorough way, and to plan for the human and information and capital resources necessary to support improved health.

For those with chronic diseases, the ability to obtain the right services at the right time and right place is critical. When barriers exist, needed care is often delayed until conditions further deteriorate and the cost of treatment rises. Because a high percentage of health care costs are generated by a small percentage of people, our ability to assuring access and cost effective care for individuals with chronic disease and disabilities is extremely important. Improving chronic illness care and focusing on prevention presents our greatest opportunity to help people live longer, healthier lives, and reduce healthcare costs. We recommend Washington's stakeholder community rigorously align its improvement efforts around the now widely used Chronic Care Model, and consider new initiatives for Medicaid and the Washington State Health Insurance Pool (WSHIP),

In January 2006, the American College of Physicians released a policy monograph "The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care" to address what it sees as the looming crisis in primary care in the United States. Among their chief recommendations is the reorganization of care as outlined in the Chronic Care Model. As the report states:

> "The American College of Physicians believes that the CCM can be equally applied across all clinical situations and offers a valuable framework for the redesign of the care delivery system. Therefore, this monograph will subsequently refer to the CCM as simply the "Care Model" to emphasize that the elements of the model can apply to all patients, not just those with a chronic illness."

Group Health is increasingly organizing around the "planned care model" for all services, including prevention.

6. Focus on care delivery systems and approaches that encourage patient-centered team care.

Integrated group practices and aligned networks of high performing providers are well suited to delivering patient centered care, and should have the ability and the expectation that they will live up to their potential. We believe more integrated approaches need to earn the right to grow and avoid the deficiencies identified during the managed care backlash era. However, loosely knit fee for service health plans should not become the only model, particularly if we are to move to a more patient centric approach focused on quality, evidence, and the type of teaming of providers necessary to effectively prevent and manage chronic illness. The state can help assure different, competing models are available, with the patient understanding and experiencing the benefits and costs of different options. This is why it is important that policy makers consider the extremely negative impact that proposed legislation, such as "any willing provider" mandates, have on creating integrated, high performing health care delivery and financing systems that hold enormous potential for achieving the vision set out for the advanced medical home and the planned care model.

7. Change financial incentives.

We must work to change the way health care organizations and providers are evaluated and paid. Current methods often do not support the concepts of medical home and the planned care model, and do not address over-use, under-use and mis-use of healthcare services.

Coverage policies have a direct connection that must be considered. State legislative and regulatory bodies should develop strategies to assure that all benefit and provider mandates are rigorously reviewed prior to passage, so that only those that are aligned with criteria for a high performance health system, including proven effectiveness, are adopted.

The state should further strengthen its efforts to become a model health purchaser across all programs, rewarding plans and providers that achieve higher quality and value, and effectively care for the chronically ill. Strategies to improve reimbursement in Medicaid while demanding better accountability for performance should be implemented.

8. Support effective transparency and reporting initiatives.

Public reporting of reliable information on performance of health plans and providers can promote improvements in quality and efficiency. Public reporting, done right, can promote higher performance and help patients and purchasers make more informed decisions.

Performance measurement and transparency efforts are in a highly developmental and evolutionary state. Group Health believes it is too soon to employ a regulatory approach, but this does not mean the state should not be strongly involved. We believe the principal role of state government is to lead though example in its purchasing activities, and to assure its regulations promote rather than frustrate health plan and purchaser efforts to drive better performance, accountability and transparency into health care while reducing administrative cost. Until a national infrastructure can be established, we recommend that the state lend its considerable weight as purchaser to collaboratives such as the Puget Sound Health Alliance in efforts to align performance measurement and transparency on both a regional level and with emerging national "best practices".

The State can and should team with others to support development of more advanced performance measures at the national level. Those outlined by the Institute of Medicine are a great place to start, but current performance measures are inadequate to judge efficiency, equity and patient-centeredness, key features of a high performing health system. Most assess care only at one point in time, in one setting. They fail to measure systems-level performance that impacts efficiency through time (e.g., chronic disease complication rates).

The state as purchaser can favor organizations and providers that are willing to be more transparent, that meet agreed performance targets, and support development of tools that make cross comparisons more accessible and useful to other purchasers and to consumers. The state can also work in collaboration with other stakeholders to provide financial and technical support for organizations and smaller practices that are willing to invest in the systems and skills necessary to drive greater transparency and create the conditions for creating the advanced medical home.

9. Focus on new priorities in medical education.

Washington needs a focused policy agenda for re-supplying its medical workforce. We must act now to improve the supply of health care practitioners/specialties experiencing shortages, and those that have a demonstrated impact on efficiency and cost. Particular emphasis should be placed on primary care specialties, nursing and midlevel practitioners.

Research has demonstrated that health care outcomes are improved and cost of care reduced in areas with robust primary care. Despite this known correlation, family practice residency programs in Washington are not at capacity. Graduates are choosing other specialties.

One concrete step to encourage more students to enter primary care practice would be to increase state loan forgiveness and scholarship opportunities for primary care/family medicine residents who commit to practicing in Washington for a designated period. Washington stakeholders can also work together to advocate for continued funding of federal Title VII programs.

We need clinicians knowledgeable about teamwork, processes of care and how to improve them if we are to create the capacity for patient centered chronic care. Traditional medical education does not focus sufficiently on these necessary underpinnings of planned care practice. Group Health is interested in and willing to build its efforts to train new physicians, nurses and mid-level practitioners through programs such as the Group Health Family Practice Residency.

10. Focus on high cost/low benefit technology dissemination.

Some technologies help to produce medical miracles. Others may produce marginal benefits at significant cost. Last legislative session, the state took an important step by creating a technology assessment program for its self funded programs. At present, however, neither the State nor federal government has the institutional capacity to assess all new high cost technologies. While Group Health also has widely respected technology assessment program, no one player can act in this area alone with optimal results. The market, consumer

expectations and threat of liability limit unilateral action in this area. The Commission should encourage the State to continue to support the technology assessment program and encourage greater collaboration and shared learning in this area. The state's certificate of need (CON) program may also be an appropriate mechanism for addressing costly new technologies with unproven benefits and potential high costs, particularly if market strategies prove insufficient.

11. Continue to encourage patient centered information technology.

So much of what we need to do in healthcare rests on improved information flow. Information is key to safe and effective care for all patients, and for the teaming and rapid learning that are essential for effective healthcare delivery. It is also one of the keys to enabling patients to take control of prevention, their conditions and care. Information technology should be used to help optimize the total care experience, with the patient at its center.

The state should continue and expand efforts to foster more wide-scale use and dissemination of information technology. For example, the state can offer financial incentives that are equitable among providers, including early and late adopters. The state should also consider the recommendations of the health information advisory board, authorized by the legislature in 2006, with particular focus on local infrastructure for interoperability, and reimbursement and investment strategies that reward adoption and use of digital health platforms. The State should also assure that we protect the privacy of individually identifiable information, but not in a manner that erects barriers to the flow of information needed to assure provision of coverage, health services, quality assurance and research.

12. Commit to patient safety and fairness as the guideposts for liability reform.

Group Health strongly believes that we must address the fundamental dissonance between the medical liability system and the patient safety movement. We believe we must pursue patient safety and liability reform initiatives, with the goal of assuring faster, fairer compensation for injured persons, and for improving health outcomes as outlined by the Institute of Medicine.

III. IMPROVING AFFORDABILITY

BRC Goal: "Reduce the annual rate of increase in total health care spending to less than the growth in personal income."

Group Health's Position

Too many Washingtonians are losing access to affordable health care, and few, if any, have a good idea of how money is spent in health care. Many of the changes essential to improving overall health, healthcare and access are essential to bend down the cost trend, and assure we are getting value for every healthcare dollar. We have an access problem because we have an affordability problem. We have an affordability problem because we have quality problems, poor health status, and a dysfunctional payment system. We can't fix the problem without a shared understanding of how we spend our healthcare dollars, and how federal programs and policies affect our state.

Further Recommendations

1. Conduct a health care cost study.

Where are the costs in our health care system? Government, purchasers and health plans should work together to provide comprehensive information on costs (and quality) at both the individual and system levels. We recommend a well designed health care costs study in 2007 to describe the current financing and payment system. It should describe where the money comes from and where it goes in the current health care financing system. The study should include administrative costs, taxes and profits among all the constituent parts of our health care and financing system. It should also identify and compare inequities in pricing, payments and quantify any cost shifting, including federal and state programs. The study could lay the groundwork for financing, taxation and reimbursement reforms in later years.

2. Engage communities with a public awareness campaign.

Engage communities in efforts to explain costs and responsibilities. We recommend the State develop a public awareness campaign to increase knowledge about the costs of health care. This would include information on what people really pay for health care, the cost drivers, cost trends and the consequences of rising costs.

3. Pilot and evaluate new health benefit designs.

Patients need to be in control of their health care, and have the tools and accountability to make smart, cost effective decisions. Few supports for this kind of empowerment are now in place, and those that are, such as many current high deductible designs, are "first generation" and not sufficiently tailored to encourage a high performing health system and sound healthcare choices. Health carriers and major purchasers should be encouraged to pilot and evaluate benefit structures that both encourage effective care, and involve patients more directly in choosing between care options that have different costs and benefits. Ultimately, we may need to move to greater uniformity in coverage offerings that support affordable and effective care, but "one size fits all" strategies should be avoided.

4. Streamline insurance and health care administration and regulation.

Streamlining and standardizing administrative procedures and government regulations can achieve savings and bolster performance. We need to build on and support current collaborative efforts to devise creative, cost effective solutions to increase the efficiency of the health care financing and delivery system. The Washington Healthcare Forum, for example, has successfully focused on two key areas to decrease aggravation and non-productive work between providers and health plans: administrative simplification and electronic solutions for the secure exchange of information. These focus areas represent significant opportunities to dramatically reduce unnecessary paperwork and improve cash flow to health care facilities and providers.

We may also gain from examining some current regulatory practices. Extensive regulatory reporting requirements, for example, cost money but often produce data that is seldom if ever used. The State can also adopt win/win strategies that encourage innovation, transparency and reduce regulatory costs by tailoring regulatory requirements for organizations that are willing to be publicly accountable for performance and achieve and maintain accreditation with recognized, high caliber bodies such as the National Committee on Quality Assurance.

IV RESPONSES TO BLUE RIBBON COMMISSION QUESTIONS

Questions 1 and 2: What do you propose be done to realize the vision and goals for Washington State? How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

Response: The preceding sections of this proposal address questions 1 and 2.

Question 3: Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.

Response: Yes. This proposal begins to set forth a roadmap for change. The outlines for the roadmap are based upon the work of the newly established Commonwealth Fund Commission on a High Performance Health System. The commission draws from all parts of the health care system—from health care delivery to health insurance—as well as the state and federal policy arena, the business sector, professional societies, and academia. Their framework charts a course for a health care system that provides significantly expanded access, higher quality, and greater efficiency for all Americans, especially the most vulnerable members of society. [1]

Specific elements of the proposal are drawn from a variety of sources and models: The proposal builds off some of the existing successes and promising work in Washington state, such as SCHIP, Basic Health programs, One Health Port, and the Puget Sound Health Alliance and various collaboratives modeled on the Chronic Care Model developed by Dr. Ed Wagner and colleagues at Group Health's Center for Health Studies MacColl Institute for Healthcare Innovation. It suggests elements from promising innovations in other states, such as the Massachusetts HealthConnector model. It includes approaches for addressing underuse, overuse and misuse of care driven by a variety of research findings from sources such as the Dartmouth Atlas Project based at the Center for the Evaluative Clinical Sciences at Dartmouth Medical School.

> **Question 4.** Will your proposal impose costs on individuals, businesses or government? Will these costs be time limited or on-going? Can you estimate how much these costs would be, or suggest how such estimates be made? How much, if any of these costs will be offset by corresponding savings?

Response. Many of the elements of this proposal will impose additional investment costs on some individuals, businesses and government. Some will be limited, and some will be ongoing. We likely will have to invest in our future to save over the long term. Group Health has not developed reliable cost estimates for these recommendations; many require as much or more in terms of in-kind investment of time and expertise than outlays of additional capital. Many of the elements in this proposal, however, can be piloted or implemented at low to moderate cost, and all are directed at producing better healthcare value.

Group Health itself is investing in its people, its infrastructure and its ability to measure its performance so that it can meet the challenges of transforming health care, and our challenge is to channel these investments to assure they help us reduce cost trends in the face of increasing demands, and a greater burden of chronic illness. We are interested in pooling additional resources towards a collaborative effort for change.

> **Question 4.** How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

This proposal has been developed with the idea of forging sustainable consensus among disparate interests and stakeholders, and across traditional political divides, but we are sharing it with the Commission as a first step. Certainly many of the elements are under discussion by a variety of stakeholders.

> **Question 5.** What are the obstacles to implementing your proposal? Who will object to it and why? How to you suggest these objections be addressed?

Response:
Obstacle #1. *Resources.* Washington is both benefited and burdened by the relative efficiency of its healthcare system, and early advances in addressing the problems of lack of coverage. We do not have the readily identifiable pools of resources to redirect towards change, as do states like Massachusetts, nor do we appear to have a public that is interested in paying new taxes to fund health care expansions. While this is an enormous challenge, it can sharpen our thinking, and drive Washington to a position of real leadership in innovation in care delivery and efficiency in order to find the resources to assure everyone has coverage for efficient care. It is also in everyone's interest to have a common strategy to assure Washington gets its share of federal resources.

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[1] Citation The Commonwealth Fund Commission on a High Performance Health System, Framework for a High Performance Health System for the United States, The Commonwealth Fund, August 2006. http://www.cmwf.org/usr_doc/Commission_framework_high_performance_943.pdf

Obstacle #2 *Win/lose potential.* Comprehensive changes in the health care system are likely to result in winners and losers. Even those who are uncertain about how reform will affect them may oppose it because the stakes are high for organizations and individuals for whom they have stewardship. The challenge here is to mitigate or avoid the unfavorable effects on potential losers while creating major gains for our state as a whole.

Obstacle #3. *Single issue advocacy*. Single issue groups press for better coverage for particular demographic groups or treatments, or particular approaches aimed at benefited their constituencies, sometimes in ways that have harmful effects on others. We suggest legislators and stakeholders call a moratorium on special interest or single focus health care legislation that is highly divisive and disrupts the ability of parties to focus on the bigger picture, and begin to work together as a community to build trust and consensus.

Obstacle #4. Leadership and collaborative spirit. It is easy to politicize the deficiencies of our approach to health and health care, and this is sure to occur with particular intensity in the period leading up to the next Presidential elections in 2008. We believe that the public is hungry for public servants and leaders that can reach across traditional lines and forge a new consensus. In our state we have genuinely different views on how to reduce total spending, improve the quality and efficiency of care, and reduce health disparities, and a real opportunity to demonstrate leadership. The challenge is whether we can build solutions that are politically and economically sustainable over time, putting the greater good for everyone in the state front and center.

Overall, we need to create an environment within and among all stakeholders in which it is second nature to share our successes and failures and what we have learned from them. We must always remember that our common aim is to produce health and heal the sick.

Tab 16

UNIVERSAL HEALTH CARE COVERAGE PROPOSAL
BY HEALTH CARE FOR ALL--WASHINGTON

II. ONE PAGE SUMMARY
HIGHLIGHTS OF THE WASHINGTON HEALTH SECURITY TRUST PROPOSAL

The Problem

Based on the 1992 Washington Health Care Commission Report, econometric consultations commissioned for Health Care 2000[1], and a continuing litany of governmental, news, and anecdotal reports, Health Care for All-Washington finds that there is a health care financing crisis in the state of Washington. Health care economist Frank Fox estimated total health care spending in Washington for the year 2000 at $20 billion[1]. In 2002, Boeing official Bob Watts made the same estimate of $20 billion per year[2]. About 45% of that comes from employment-based health coverage, 40% from existing state and federal government programs, and 15% from out-of-pocket individual payments for premiums, deductibles, co-payments, and non-covered items like prescription drugs.

More than 600,000 residents of Washington have no health coverage at all. Many others are underinsured or fear they will lose whatever coverage they have. Individual health insurance is increasingly unaffordable, if available at all. Employers are reducing health benefits as insurance rates skyrocket. Costs of the state's health care obligations are increasing faster than any other budget item and are a large part of state budget deficit. The Basic Health Plan has been forced to reduce enrollment. Doctors and hospitals go out of business, operate at a loss, merge and downsize at a pace never seen before. 80% of surveyed Washington voters and doctors blame the mess on insurers[3]. However, many insurance companies and HMOs also cannot survive in the present chaotic market environment.

The Health Care for All-Washington Proposal

Health Care for All-Washington has calculated that the same amount of money, from the same categories we use now can be used to fund health coverage for every resident. This proposal creates the **Washington Health Security Trust, a single public trust fund dedicated to the financing of a defined set of health services for all state residents.**

Highlights

All residents are covered for defined benefits regardless of health or employment status. Residents choose their providers. Providers and patients make the medical decisions. Doctors and other providers work in the private sector, just as they do now. They are **not** employees or agents of the trust. Physicians, clinics, hospitals, and other providers negotiate the terms of their participation with the trust. A public board of trustees governs the trust. The initial appointed board, using citizens' and technical advisors, defines the benefits package, establishes a simplified claims processing system, and creates scientifically based tools for monitoring performance. The subsequently elected board of trustees and its advisory committees monitor operations, financial performance, the benefit package, quality of health services, and public satisfaction. They are directed to seek public input for trust policies over time. The initial appointed board is accountable to the governor and the legislature. Once the trust is up and running, elected trustees replace the appointed trustees in an orderly sequence and are directly accountable to the voters in their congressional districts.

How the Trust is Financed

The Washington Health Security Trust is funded by a combination of sources chosen to resemble current health spending patterns and to work with specific limitations and unique provisions of the Washington tax system.

- Employers pay a health security assessment of 10% of payroll above a threshold of $125,000 per quarter.
- Residents 18 and over pay a health security premium of $75 per month.
- Medicare enrollees pay a premium of $50 per month to add trust benefits beyond their Medicare benefits.
- State funds for health programs are transferred to the trust. Whenever the trust obtains federal waivers, funds for federal health programs will also be transferred to the trust. Until then, federal coverage remains in effect.
- Patients will pay small co-payments for outpatient and emergency visits, and prescriptions.
- Certain exemptions are included for low income families and employers facing financial hardship.
- Employers **may** purchase private health coverage for their employees. However, the trust benefits package is intended to give employees better coverage than even the best current health benefit plans, which now cost employers 12-14% of payroll.
- Pooling the funds for health services across the state and spreading the risk across the entire state population provides a stable mechanism to finance quality care for every resident.

[1] Health Trends/ Frank Fox Associates, 1998-2000
[2] Watts, Bob, Report from Facing the Future Conference (DSHS), 12/06/2002
[3] Elway, Stuart, Elway Research, Inc., WSMA Polls, 1999

UNIVERSAL HEALTH CARE COVERAGE PROPOSAL
BY HEALTH CARE FOR ALL--WASHINGTON

The Health Security Trust is a simple, fair, accountable, and affordable system to fund necessary health care for all residents of the state of Washington.

[1] Health Trends/ Frank Fox Associates, 1998-2000
[2] Watts, Bob, Report from Facing the Future Conference (DSHS), 12/06/2002
[3] Elway, Stuart, Elway Research, Inc., WSMA Polls, 1999

Blue Ribbon Commission on Health Care Costs & Access

Proposal for Achieving Goals over 5 Years

Submitted by Health Care for All - Washington (HCFA-WA)

Sarah K. Weinberg, MD, Vice President, (HCFA-WA)

Summary of Proposal

Because we believe that affordable universal access to quality health care is only achievable through a centralized source of funding, standard-setting, allocation of resources, and use of advanced information technology, we propose that Washington State adopt a public tax-funded system to finance health care for every Washington resident. ("Universal coverage" means coverage for everybody, not for everything.) Such a system need not prohibit the private purchase of health services outside the system, but the publicly financed system needs to provide sufficiently comprehensive coverage of medically necessary health services for all residents who choose to use it to avoid the creation of a two-tiered system (a lousy public one for the poor, and a better private one for the rich).

The current non-system in effect in the U.S. cannot provide affordable health care for everyone because of the truly stupendous amount of money wasted in administrative costs incurred by all participants, corporate insurer costs of being in business, and shareholder profits. These costs are inherent in a system with multiple payers, and cannot be changed in any significant way with various cost control strategies, as more than ten years of such efforts have shown. We cannot emphasize strongly enough how badly the current financing mechanisms are failing.

In addition, the failure to use evidence-based standards of care, especially for the management of chronic diseases, results in additional high costs of avoidable acute care, never mind the suffering of the patients involved.

The Commission does not need to invent a publicly financed universal coverage system de novo, as much work has already been done, especially in California, where the legislature just passed SB 840 that will create, if implemented, a single-payer publicly financed system for all Californians (see summary at www.healthcareforall.org/summare840.pdf). Actuarial studies have been done in California and in other states (most recently the Thorpe study in Vermont - see www.leg.state.vt.us/CommissionOnHealthCareReform) that consistently show that adoption of a single-payer health coverage system would provide a comprehensive package of benefits for all residents at a cost below what is currently being spent in those states. The overall savings are usually predicted to be about 5%. Additional ongoing savings can be expected through increased efficiency in the choices made in preventive care, in acute care, and in management of chronic diseases.

Future choices necessary as technology advances can be made on the basis of evidence that shows (or fails to show) efficacy and cost effectiveness in appropriate clinical settings. Experience in other nations with universal coverage systems shows that these choices are difficult as new, expensive treatments or medications are created, but centralized coverage decisions are at least perceived as fair. All centralized systems (even Canada, recently) allow those with means to buy whatever non-covered care they wish outside the publicly financed system.

The remainder of this Proposal, then, will address how to achieve a single-payer universal health coverage system in Washington State.

1. What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs & Access (BRC)?

The very first step is to stop assuming that a single-payer system (SPS) is "politically not feasible". There have been several national polls showing that over 60% of Americans favor a government-guaranteed, tax-funded health coverage system that would cover everyone. The most recent of such nation-wide polls (with three different approaches) were conducted by the Citizens' Health Care Working Group established by the Medicare Modernization Act of 2003. All three polls showed that over 70% of participants favored the "creation of a national health plan, financed by taxpayers, in which all Americans would get their health insurance". Taking the health insurance portfolio away from the private insurance industry will not be popular with that industry, but a large majority of other Americans will appreciate the resulting affordability of their health care. It is time to listen to public opinion that has not been influenced by deceptive media campaigns by those profiting hugely under the current non-system.

Once the BRC decides to move toward a SPS, we think the first step would be to consolidate all of the health coverage funded by the state into one program. For state employees, this can be accomplished with strong financial incentives. For Medicaid, Labor & Industries, the incarcerated population, etc., this can be done by executive decision. The covered population would be sufficiently large to realize savings rapidly through decreased administrative costs, ability to negotiate favorable prices for drugs and medical devices, ability to negotiate favorable payment rates for providers' services, and the ability to implement payment schedules based on evidence of efficacy and cost-effectiveness.

While this step is implemented, a continuation of the BRC should be defining the ultimate SPS to be available to any Washington resident within 5 years. California's SB 840 can be the model, but the hard part is devising a fair mechanism to tax the population specifically to fund the system. We think it can be done with a combination of premiums paid by all residents, payroll taxes on employers (who will no longer need to fund employee health benefits on their own), continuation of state general fund support for those with incomes too low to afford premiums, and continued federal financial support at the current level. Two vital ingredients:

- Setting up a completely separate fund for health care that cannot be raided for other state expenses
- Commissioning an actuarial study to determine the specific premiums, payroll taxes, and state general fund commitments needed to give the health care fund an adequate amount of money to work with. (See the Thorpe study in Vermont referenced above.)

A completely universal health coverage system for all residents of Washington State cannot be achieved without the cooperation of the federal government. Medicaid, Medicare, Indian health programs, the ERISA law, the Federal Employees Health Benefits Program, the military, veterans, and the Taft-Hartley trusts all have federal protections that must be dealt with. Forward-thinking members of Congress are thinking about a health partnership approach in which the federal government and state governments cooperate to try reform approaches to decrease the number of uninsured and control costs. The BRC should endorse this concept, which could make a positive impact on the fate of legislation currently pending:

- S. 2772 "Health Partnership Act" (Sens. Voinovich and Bingeman)
- S. 3776 "State-Based Health Care Reform Act" (Sen. Feingold)
- HR 5864 "Health Partnership Through Creative Federalism Act" (Reps. Baldwin, Price, Tierney, and Beauprez)

2. How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

Establishing a state-wide SPS will definitely "provide every Washingtonian the ability to obtain needed health care at an affordable price." This can be accomplished by 2012 for everyone. Children could be added into the state-sponsored program earlier, if desired.

Improving the health of the population will take longer than 5 years. Even immediate implementation of coverage for everyone's health care will not change health-related behaviors or repair already-damaged bodies in that short a time. That said, implementing health coverage for all residents sets the stage for providing consistent, evidence-based care for residents of every background and socioeconomic level. When everyone is covered by the same program, it is MUCH easier to implement programs to:

- Immunize all children and adults as recommended by medical organizations
- Set up systems to provide consistent, cost-effective management of chronic diseases
- Provide educational programs for everyone about preventive care and lifestyle choices related to health
- Provide support for people who want to make healthy lifestyle changes, but need help doing so
- Set up specialized programs to work with populations with special needs or ethnic considerations

Implementing these programs, assuming other states do not all do so as well, should lift Washington into the top ten healthiest states in the nation.

Creating a SPS for Washington is the only way to limit health care spending without denying necessary care to some residents. Only by tackling the elephant in the living room - the huge administrative expenses of the private insurance industry that are not paying for anyone's health care - can health care spending be brought down to the level of inflation (or nearly so). Experience in other nations with national health insurance systems proves that quality health care for all residents can be accomplished at much lower cost than in the U.S. currently.

3. Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.

This Proposal recommends using California's SB 840 as a model, which we think is the most recent detailed SPS system ready for implementation if it can be funded. (The funding problems do not relate to higher costs of the program, but to political requirements for a supermajority to pass funding legislation.) HCFA-WA drafted a complete system, including a funding mechanism, for Washington State in 2000 as an initiative. A summary of this initiative is appended to this proposal. The monetary amounts surely need to be updated - again, we recommend strongly that any complete plan be studied by a competent actuarial group to determine the adequacy of the proposed funding. No state has implemented a SPS. Three states have passed legislation that is designed to decrease the number of uninsured (Maine, Massachusetts, Vermont). None of these is adequately funded to provide <u>affordable</u> coverage for necessary care for everyone.

However, the U.S. is the only industrialized nation without some kind of national health program that provides decent health coverage for everyone. Pick any one of the systems out there and the U.S. (or Washington State) would be much better off. Ours is the only industrialized nation with 50% of personal bankruptcies caused by medical bills. All of these nations have better population health statistics than the U.S. Even wealthy Americans with health insurance are worse off health-wise than their counterparts in other nations, a fact that counters the popular myth that we have "the best health care in the world".

A whole paper could be written on this subject, but suffice it to say that treating quality health care as a necessary infrastructure of society and making it available to everyone leads to better health outcomes at lower cost, as demonstrated by the health statistics in all these other nations.

4. Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?

Health care is not free anywhere on the planet. The challenge is to require contributions to support the financing of health care in a way that is perceived as fair. In Washington State, the easiest way to do this is with a combination of individual premiums, employer payroll taxes, and government contribution to cover those who cannot afford to contribute. These are roughly the sources of funding for health care currently. Implementing a SPS will involve some transition costs (amount unknown), but then the cost of running the financing system should settle down to 8% or less of total health care spending. Once a specific system is designed, it should be evaluated by an actuarial group to get a better estimate of start-up cost and ongoing cost.

Since the new SPS system ultimately will be less costly than the current mess, there will be savings. These savings will be noticed by providers who will have much reduced administrative costs, employers who no longer have to wrestle with the whole health insurance industry, and individuals who will be able to count on having adequate coverage for a reasonable premium. Payments to providers can take these savings into account, so that the SPS does not become a major income booster for them. Again, past studies of proposals in other states have estimated an overall savings of around 5% as compared with continuation of the present "system".

5. How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

Implementation of a SPS will require cooperation among government officials in charge of the health care fund, citizens and employers (who need to pay what they are supposed to without major enforcement efforts), and health care providers (who need to negotiate payment rates and participate in coverage decisions).

The concept of a SPS has been endorsed by Physicians for a National Health Plan (representing 14,000 physicians), the National Hispanic Medical Association (representing 36,000 licensed Hispanic physicians in the U.S.), the Washington State Democratic Party, some chapters of the League of Women Voters, Universal Health Care Action Network, Health Care for All (with organizations in many states), the California State Assembly and the State Senate, and many, many labor unions.

6. What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

Implementing a SPS requires setting up a system that will take virtually all the health insurance business away from the private insurance companies. These companies are profitable (or, in the case of "non-profits", accumulating large surpluses), have hundreds of employees, and executives earning monumental salaries and other perks.

The pharmaceutical industry will also use all of its money and power to try to block a SPS because a unified system obviously will drive a tough bargain regarding pricing of prescription drugs (as have all the other nations with national health programs), lowering the profitability of the industry. Since this multinational industry has ranked at or near the

top in profits as compared to other industries in the U.S., there is room for lower profits without putting them out of business, no matter how much they complain.

Obviously, both these industries are going to fight SPS tooth and nail, and will be willing to pursue any means, fair or foul, to try to block reform. Both industries have already demonstrated this willingness in derailing past efforts at reform.

However, these industries do not own the United States or the State of Washington. Our elected officials must find the fortitude to face them down and unmask the self-serving nature of their objections to a SPS. Our elected officials have sworn to serve the public as a whole, and need to be willing to do without some very large campaign contributions if necessary.

Employers are aware of how unaffordable it is becoming for them to provide decent health insurance for their employees, but they are not well educated about how much of that cost is due to clinging to the multiple private insurer model of financing health care. Dumping employee health care costs on the public, as some employers are doing, is an inappropriate response to this problem. However, many employers have ideological blinders that prevent them from appreciating what their fellow business people (and their employees) in other nations gain from tax-supported national health programs.

Myths about the "excellence" of U.S. health care and the "inferiority" of single payer systems need to be dispelled:

- "We have the best health care in the world." We do not have the best health, as measured by standardized population health statistics. We have the most expensive acute care in the world, but we lag far behind other nations in preventive care and management of chronic diseases. We routinely overtreat the well insured (sometimes causing harm by so doing), and undertreat those without insurance (causing untold suffering and impoverishment).
- "Single payer systems will result in long delays in getting treatment." Some other nations have or have had problems with underinvestment in the resources needed to provide timely care for their populations. These nations are hard at work trying to correct the problem, but none are even thinking of abandoning the commitment to provide affordable health care for every resident. It is important to note that many nations with national health insurance systems do NOT have any wait lists for procedures. In the U.S. there are so many high tech facilities and providers already in place that there is no danger of wait lists as long as the payment system appropriately reimburses necessary care.
- "Drug prices have to be so high to cover research and development (R&D) costs." Most of the pharmaceutical industry is in the form of multinational corporations. They are managing to do quite well despite much lower prices for their drugs in other developed nations. In the U.S., the industry's costs for advertising drugs directly to consumers as well as to providers are larger than their R&D costs. Much of this advertising is first convincing gullible consumers that they have a disease that needs treatment, and then informing them of the most expensive way possible to treat their non-disease. If the ideal health care system prioritizes

prevention, and deals with treatment only when real disease occurs, advertising expensive drugs for non-disease is supremely counterproductive by wasting the time of both the consumer and the provider, driving up costs, and creating misery where none need exist.

- "Americans want free choice…." This is an essential part of the American character. However, with regard to health care, Americans want the freedom to choose their providers. What they want from their health insurance is coverage for the care decided upon by the patient and the physician working together for the best outcome possible for the patient in a given situation. Currently the health insurance industry places as many obstacles as possible between the patient and the physician on the one hand, and payment for the health care provided on the other hand. Consumers are discovering that all the "choices" offered by the insurers are inferior (or very expensive) - probably the reason behind the poll results showing that over 70% want the government to create a national health plan to cover all Americans.
- "Market forces should be allowed to fix the health care system." Competition among health insurers, hospitals, free-standing surgical clinics, drug companies, and others, has failed to control costs or provide affordable health care to many, but rather has added the costs of marketing all these entities to consumers. Market forces are not the appropriate way to handle every need in society. The obvious efficiency and lower cost of providing fire protection by a public fire department, public safety by a public police department, national defense by a public defense department, public roads built by public transportation authorities, and education for everyone by a public education system are clear examples. (Just stop for a moment and imagine the chaos and skyrocketing costs in competing private fire departments or police departments!) The financing of quality health care for everyone should be regarded as the kind of infrastructure needed to improve our nation as a whole, by improving the health (and peace of mind from knowing that care of illnesses will be available when needed) of every citizen.
- "People should be responsible for their own health." A common human failing is the inability to make tough choices that require avoiding something comfortable or fun now in order to prevent disease or trouble much later. In a way, most of us remain permanently in the adolescent mindset and ignore the long term consequences of today's choices. Rather than punishing Americans for bad choices, we need a health care system that encourages good choices AND provides support for making those good choices. Good population-based preventive care and health education can help. We also need to remember that bad things do happen to good people. It is much more compassionate for our society, as well as more cost effective, simply to contribute to the necessary health care of all those who need it and not get side-tracked into arguing about whether the patient "deserved" to get sick.

To quote Gov. Gregoire: "We cannot afford to fail to solve this problem… and by afford I mean the costs to the state and our people."

Our thanks to the BRC for taking on this tough public policy problem, and for soliciting solutions from any citizen or group of citizens. May you find the strength of purpose to complete your charge.

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Tab 17

Health Care That Works

An Overview Of Our Recommendations To The *Blue Ribbon Commission*

Health Care That Works **shares with the** ***Blue Ribbon Commission on Health Care Costs and Access*** **its statements of the Problem, the Vision and Goals.**

In its RFP, the ***Commission*** **asked that the answers to six questions accompany each proposal.**

BRC Question #1.

What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access?
Briefly summarize your proposal.

HCTW's **proposal has five components. The** ***Commission*** **can choose to embrace all, parts, or none of these proposal components. What follows is an overview of those components.**

First, ***Health Care That Works*** **recommends that The Governor establish a Task Force with the authority, responsibility and staff to draft legislation that provides every citizen with affordable universal access to health care, with fair reimbursement to providers, and guide that legislation through to enactment.** ***Health Care That Works*** **recommends that the Task Force use California SB 840 as its model for the legislation.**

Second, ***Health Care That Works*** **recommends that, as a part of that responsibility, the Task Force collect data that will help define the problems and facilitate the design of the system that will meet those challenges.**

Third, ***Health Care That Works*** **recommends that, as a part of that responsibility, the Task Force create an informed and educated base of voters, the business community and legislators and, in so doing, motivate them to demand the creation of a health care system that provides universal coverage.**

Fourth, ***Health Care That Works*** **recommends that, as a part of that responsibility, the Task Force create and guide, through to enactment, legislation that provides every citizen with a system of health care which uses evidence-based medicine as a protocol to deliver cost effective treatment outcomes of the highest quality.**

Fifth, ***Health Care That Works*** **recommends that, as a part of that responsibility, the Task Force create and guide, through to enactment, legislation that provides every citizen with an electronic medical record that enables providers to have access to such medical information as may be necessary to provide medical care with safety and thoroughness.**

Pages 5 through 8 describe our proposals for each of these elements.

BRC Question # 2.

How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

The HCTW Proposal provides specific recommendations, which, if adopted, will provide a well-defined set of guides for the creation of enabling legislation incorporating all of the

elements that *HCTW* believes are essential components of a successful plan.

There is a long road to be traveled between having created a vision statement and having a 24/7 operating Health Care System providing affordable quality care for all our citizens with fair reimbursement to our providers. *Health Care That Works* believes that its proposal provides a road map with a path outlined to take Washington citizens to the BRC goal.

To the question "How do you know?" For many questions we don't know. We believe. We desperately need corroborated data in order "to know."

BRC Question #3.

Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.

- ***HCTW* supports the enactment of a Washington version of California SB 840. We have reviewed the several other pending pieces of national legislation addressing universal coverage, notably HR 676, HR 1200, and S 2772. All of these have elements worth considering as possible enhancements. In our opinion, presently only SB 840 has the scope, depth, and detail to provide a working system. It still requires a funding plan, presently under development by the Kuehl team as CA SB 1764. They are interested in our "Calculated Disposable Income" as a mathematical basis for a progressive funding plan.**

- **An educational media campaign has been widely used as a technique for getting legislative approval and community support for and against upcoming legislation. *HCTW* believes that money to fund such a campaign might be obtained through a combination of grants from State and Federal sources and charitable foundations such as the Robert Woods Johnson and Bill and Melinda Gates Foundations in addition to funds raised by our State's health care advocacy groups, all working as a coalition to effect change. We can almost guarantee a vigorous media campaign to defeat such legislation by groups in opposition.**

- **Evidence-Based Medicine (EBM) has an impressive list of worldwide supporters. *HCTW* is not aware of any corroborated data to support an estimate of the reduction in the cost of health care if it were in broad use throughout the Washington medical community. To us, it makes sense that it would. We need numbers to prove that it would and provide an estimate of the likely savings.**

- **The use of the Electronic Health Record system is just beginning to find applications in the United States. It clearly prevents errors where used. Again, we need data.**

BRC Question #4

- **Will your proposal impose costs on individuals, businesses or government?**
- **Will these costs be time-limited or ongoing?**
- **Can you estimate how much these costs will be, or suggest how such an estimate could be made?**
- **How much, if any, of these costs will be offset by corresponding savings?**

If fully implemented, the *HCTW* Proposal will reduce the overall cost of health care in Washington and provide a means of controlling those costs.
It will impose costs on those who presently do not presently have health insurance.

It will impose costs on those businesses that do not presently subsidize their employees' health insurance.
It will reduce costs for some citizens and businesses.
It will raise costs for some citizens and businesses.

The *HCTW* Proposal will eliminate private insurers from operating in the state.

Premiums for health care are an ongoing cost.

If HCTW's "Calculated Disposable Income" program is used to compute premiums, it is possible to calculate the premiums necessary that, in its opinion, will equitably provide an income stream that will fully fund the costs of health care for all.

In our Proposal we address the issue of providing corroborating data for those decisions that will have to be made in drafting legislation.

We believe that the present expenditure of $32 Billion for health care will be reduced by eliminating the variously quoted 30% to 38% overhead expenses associated with the private health insurers and replacing their benefit management operations with those of a company such as Noridian that provides those contract services for Medicare at a rate variously quoted at 2% to 5%. This might then save 30% of $20.4 Billion (the private insurer share of the $32 Billion) or $6 Billion. This could pay for insurance coverage for our estimated 600,000 uninsured citizens and leave somewhere between $1.6 Billion and $4 Billion as additional savings. These additional savings would be used to reduce the $32 Billion figure and thus reduce premium expenses. Again, all these figures need corroboration.

The adoption of Evidence-Based Medicine can be expected to reduce the cost of health care. Estimates abound. Pick a number… 10%, 40%? Studies will support your choice.
The extension of EBM into the area of "End-of-Life" care can be expected to reduce the cost of health care. Salt Lake City Hospitals spend 30% less than the rest of the United States.
The reduction in the practice of "Unnecessary Medicine" can be expected to reduce the cost of health care. Again, pick a study, pick a number. We like 20%
By moving previously uninsured patients out of the Emergency Room and into the offices of Primary Care Physicians we believe we will significantly reduce the write-off losses of our hospitals. Our local hospital's finance officer tells us they wrote off almost $6 Million in 2005 in uncollectible ER treatment of uninsureds. This is a small local hospital with 57 beds serving a community of approximately 30,000 in rural Clallam County.

***HCTW* prefers not to quote savings percentages for these four areas because, while we have seen many quoted figures in the literature, we do not have corroborating data to support those figures.**

BRC Question #5

How does your proposal reflect collaboration among various stakeholders?
Which stakeholders have endorsed it?

Physicians for a National Health Plan and *Health Care That Works* both support the adoption of CA SB 840 as a model for the Washington State Health Plan. We have worked closely with The League of Women Voters, UHCAN, Health Care For All and the offices of California Senator Kuehl, Representative Conyers and Representative McDermott. HR 676 and CA SB 840 staffs are interested in our "Calculated Disposable Income" approach.

BRC Question #6.

What are the obstacles to implementing your proposal?
Who will object to it and why?
How do you suggest these objections be addressed?

The obstacles to the implementation of the *Health Care That Works* Proposal are formidable. The words "Single Payer" and "Universal Coverage" arouse strong feelings, pro and con.

Here are a few of the contentious issues that have to be dealt with…

- **There are voters and legislators who are opposed to <u>any</u> change in the *status quo.***
- **There are the private insurers who will be put out of the health insurance business in Washington.**
- **There are the young, healthy uninsureds who "don't need health insurance" and "have more important things to spend their money on than paying for health care for old folks who are really sick."**
- **There are companies that are self-insured that may resist any change in their control over their businesses by the State.**
- **There are the citizens with high incomes who will pay more for their health insurance than they do at present.**
- **There are businesses who will pay more for their health insurance than they do at present.**
- **There is ERISA, which regulates legislation affecting self-insured plans and private insurance plans.**
- **There are HIPAA rulings whose intent are to protect the privacy of medical information but are now obstructing the development of an electronic health record system.**
- **Lobbyists will assuredly direct millions of dollars to be used to convince voters and legislators to oppose any meaningful change in the health care insurance system in this state.**
- **There are voters and legislators who equate universal access health care with "socialized medicine" and its attendant unacceptable waiting periods for treatment.**
- **There is the 1933 State Supreme Court "*Culliton"* ruling that "income is property" which is still believed, by many, to block the passage by the Washington State Legislature, of any progressive tax for any purpose.**

The conventional wisdom for a proposal such as ours is "Political Suicide."

By doing nothing we will still spend $32 Billion Dollars on health care with that cost going up 9% a year, still leave 600,000 citizens without health care insurance, and have outcomes that trail 36 other OECD nations.

When do we have the courage to say "Enough!!"?

***Health Care That Works* believes that only the education of our voters, our business owners and our Legislators will create a groundswell of public support for our Proposal. We believe it is the essential element that has been missing from every prior attempt to solve the health care problem in this country.**

Give them the facts and the choices and then let the people speak through the ballot box.

The *Health Care That Works* Proposal Elements

1. Create The Health Care Task Force

Health Care That Works **believes that the most effective way to enact a health care system that will meet the BRC goals and timeline is to establish a task force whose sole mission is to create, and guide through to enactment, such enabling legislation.**

For the salaried position of Task Force Director, we believe that the BRC should nominate no less than three candidates. From that list, The Governor should appoint the Task Force Director.

The Task Force Director will recommend an initial operating budget to cover the first year's operations within 120 days of being appointed by the Governor. This budget will cover organization, recruitment and operate as it implements the *Health Care That Works* proposals.

An initial operating fund of $5,000,000 should be made available to the Task Force Director, pending the development and approval of the operating budget for the first year of Task Force operations.

We propose that the provisions of California SB 840 be used as general guidelines for the creation, organization and subsequent operation of the Washington Health Care System. The link to the full text of California SB 840 will be found on Page 7 of this Proposal.

We propose that the funding for the Washington Health Care System use a progressive premium plan such as is described in the *Health Care That Works* "Calculated Disposable Income." Links may be found on Page 8 of this Proposal for legal opinions supporting the enactment of progressive taxation for this purpose as well as an explanation and examples of the concept of "Calculated Disposable Income" as a means of favoring our lower income citizens.

Once enabling legislation is enacted, The Task Force Director will transfer operational authority and responsibility to the duly elected Commissioner of the Washington Office of State Health Care. The Washington Office of State Health Care will be organized and staffed in general compliance with CA SB 840 guidelines. The transition process from enacted legislation to full operation is well described in CA SB 840.

Cooperation in this effort will be made available, as required from the Governor's Office, the Legislature and such other government agencies as are deemed necessary by the Task Force Director.

2. Collect Accurate Data, Develop Accurate Projections and Forecasts

Statistics abound for prior years. Growth rates abound for prior years. Not all questions have answers.

The Task Force Director needs numbers we can all believe and use as a basis for planning.

- **We have been told that $32 Billion dollars is currently spent on health care in the State of Washington.**
- **We have been told that some of that is "unnecessary" overhead.**

- **We have been told that "unnecessary" overhead costs Washington citizens $6 Billion dollars a year.**
- **We have been told that eliminating that "unnecessary" overhead by going to single payer would more than cover the cost of insuring our 600,000 uninsureds.**
- **How much money can be saved by the use of evidence-based medicine?**
- **How much does it cost to install, start up and maintain an electronic health record system for a physician? For a town? For a state.**
- **After deducting current income from Medicare and Medicaid, we still have some $20 Billion for which to account. Where does that money come from now?**

These are but a few of the questions that need hard numbers to aid in the design and funding for a Health Care System that provides universal access with fair reimbursement to Providers.

There should be an ongoing operation to maintain and expand our health care database. Intelligence that is not shared by those who need it is a wasted effort.

The Task Force Director and staff should have priority access to the use of this resource.

3. Creating the Public Demand, Motivating the Legislature, Converting the Opposition

In its Request For Proposals, the BRC asked its stakeholders …

"What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?"

Health Care That Works **suggests that the Task Force Director select, by open competitive bidding, one of the top advertising agencies in the United States and one of the leading Opinion Survey companies, a team to run a combined campaign to define issues, educate our voters, business owners and legislators to the advantages of universal access health care, evidence-based medicine, and an electronic health record. As a part of this campaign, the ongoing impact of the campaign would be continuously measured and points requiring additional attention would be addressed.**

Health Care That Works **believes that this campaign should be professionally produced, using multi-media resources, with prime time and space placements. Funding for and the duration of this program should be professionally advised and judged adequate to the task.**

Health Care That Works **believes that an important part of the contract negotiations should be a substantial incentive payment paid to the selected agencies if resulting legislation is successful in creating a Universal Access Health Care Plan for the State of Washington.**

4. Implementing Evidence-Based Care

Health Care That Works **joins with almost every health care advocacy group in the United States, major medical associations, physicians' groups, hospital associations and many members of the BRC in support of the adoption of evidence-based medicine for those disease groups for which peer group EBM procedure acceptance exists.**

Concurrent with the adoption of rules implementing the use of EBM as a working protocol for all Providers, is the obligation to assure the solvency of those groups of Providers who may be impacted by unforeseen developments as a result that EBM implementation.

We all heard the "Back Pain" example so forcefully delivered by Dr. Mecklenburg.

***Health Care That Works* believes that there are reimbursement revisions that may have to be made in order to deal, for example, with the likely loss in ancillary services billings as a result of that reduction in "unnecessary medicine."**

There are likely to be major lobbying efforts to prevent EBM from being enacted because of the increased risk of malpractice litigation resulting from Providers not ordering every possible diagnostic procedure as a result of EBM being in place. This may require enabling legislation.

***Health Care That Works* is prepared to provide the BRC with specifics on EBM validation, implementation and reimbursement philosophy should that be needed by the BRC. These considerations are available on dozens of web sites. The UW EBM link is on Page 8.**

5. Providing Electronic Health Records

***Health Care That Works* proposes that the Task Force Director create and enact legislation to create a Continuity of Care-based Electronic Health Record system for every Washington citizen.**

The advantages of such a system are well known.

- **Accuracy of describing existing medical conditions to Emergency Providers**
- **The ability to deliver electronic prescriptions avoiding errors**
- **The ability to confer remotely with specialists out of the region**
- **Prevent drug interactions through multiple sourcing of prescriptions**

The objections to the implementation of an HER are

- **HIPAA Privacy issues**
- **Costs, including equipment, loading patient data and continuous updating**
- **Interoperability**

Because of the many unknowns to be dealt with in the implementation of an Electronic Health Record system, *Health Care That Works* proposes that a trial system be installed (obviously we would recommend Port Angeles as that test site.) This system would meet the specifications of the Washington Health Information Infrastructure Advisory Board (HIIAB) and the upcoming specifications of the federal American Health Information Community (AHIC).

Questions and procedures involving installation, training, data loading, patient and provider acceptance, real-time privacy issues, software debugging, all could be evaluated in a small controlled environment. As the system matured, additional providers and patients could be added to the system.

Working with Dr. David Kibbe, of AAFP, we have been advised that grants are available for this type of system development activity.

The privacy issue with HIPAA is going to require cooperation from our US Senators and Representatives.

***Health Care That Works* believes that the time for an electronic health record system has come.**

Education is required to create a demand for this desirable tool and the improvement in quality of care and patient safety that it will bring to our health care system.

*** * * * ***

This is the *Health Care That Works* Proposal. We believe it is a plan that will meet your vision and goals for Washington. It calls for BOLD ACTION.

We wish you well as you pursue this vital challenge.

You have our hearts, minds and wallets.

Serve us well.

Health Care That Works
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Contact Person: Larry Howard

Links to Supporting Documentation

A thorough review of the history behind the Washington Supreme Court Rulings concerning the constitutionality of a progressive tax on income by Hugh Spitzer and his conclusion, based on many rulings since 1935, that such legislation can now be enacted. (56 Pages)
http://www.olympicuu.org/BRC/PugetSoundLawReview.pdf

The Final Page of the Hugh D. Spitzer Review. (1 Page)
http://www.olympicuu.org/BRC/SpitzerLawReviewSummary.doc

The California Kuehl SB 840 Health Insurance System (91 Pages)
http://www.olympicuu.org/BRC/CASB840.pdf

How is *HCTW's Calculated Disposable Income* Calculated? (17 Slide Presentation)
http://www.olympicuu.org/BRC/CDI.ppt
(Use your Page Down key to change slides)

How can I find out how much my premium will be using CDI? (Interactive 1 Page)
http://www.olympicuu.org/BRC/HCTWCDIFunding.xls

The *Health Care That Works* Mission Statement (1 Page)
http://www.olympicuu.org/BRC/HCTWMissionStatement.doc

A link to the UW "HealthLinks" web site home page on Evidence-Based Practice.
http://healthlinks.washington.edu/ebp

A link to the *Search the Trip Database*. "Turning Research Into Practice" This will demonstrate the power of the EBM technique. An incredible tool, in use every day at UW Hospital in Seattle
http://www.tripdatabase.com/index.html

Tab 18

BLUE RIBBON PROPOSAL: HEALTH COALITION FOR CHILDREN AND YOUTH

The Health Coalition for Children and Youth (HCCY) is a group of health care providers, advocates and stakeholders representing the health care needs of all Washington's children and youth. We are convened by the Children's Alliance and have been a voice for the health care needs of Washington children for the past decade.

This document presents the overview of our proposal to achieve the vision of the Blue Ribbon Commission (BRC) for the health of Washington's children and youth. Our proposal will be submitted for the October 1 deadline. The long-term goal of this proposal is to improve the health of Washington's children and youth. Achieving this broad long-term goal will require a policy proposal with the following specific goals:

- Increase health care coverage for children
- Increase access to health care services for children through an improved delivery system that incorporates the medical home model
- Emphasize and reward the delivery of preventive health care and improve the quality of health care received
- Secure a sustainable funding source

By focusing on these priorities as a state, Washington will greatly improve the affordability of health care for children and improve their overall health status. Children with health coverage are more likely to have access to a medical home (a regular source of health care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective). Access to a medical home increases the likelihood children will receive preventive services such as developmental screenings and fluoride varnishes known to improve health and lower costs.

This proposal will further efforts to achieve the three-part vision of the BRC to cover all children by 2010 or sooner, improve the health of Washington's children and youth through improved quality and delivery of effective care, and improve the affordability of health care for children and youth by lowering preventable costs.

Our proposal will build on Washington's current programs that provide health coverage to children including Medicaid, the State Children's Health Insurance Program (SCHIP), the Children's Health Program and Basic Health. It will also seek to replicate successful program models such as Kids Get Care and the Children's Health Improvement Collaborative, and evidence-based initiatives that improve both access to services and the delivery system itself. We will also incorporate models from other states such as a North Carolina program to incent preventive services for children. Research shows that children are more likely to access coverage if their parents are covered; we therefore also seek innovations that encourage coverage for the whole family, including support for the Small Business Assistance Program. We also seek the maximization of available federal SCHIP funds.

Washington's education system guarantees the right to a basic education to all residents. We must acknowledge that successful achievement of this right is in jeopardy without basic health care for children. When a child cannot see the blackboard, hear the teacher, or is in pain because of untreated dental caries, the opportunities afforded by this right are for naught.

The public understands the fundamental link between health and education, and that prevention is effective. Polls and focus groups conducted both in Washington State and nation-wide consistently show strong support (upwards of 80%) for efforts to cover all children. Our proposal to improve the health of Washington's children is fundamental to our state's future ability to serve its residents. It is a practical part of a broader BRC proposal.

Tab 19

"Washington's only exclusive representative of small businesses"

INDEPENDENT BUSINESS ASSOCIATION

August 19, 2006

The Honorable Christine Gregoire, Governor
The Honorable Pat Thibaudeau, Co-Chair
Blue Ribbon Commission on Health Care Cost and Access
Olympia, WA 98504

Dear Governor Gregoire, Co-Chair Thibaudeau and Members of the Commission:

On behalf of the small business owners who are members of the Independent Business Association, we want to thank the Blue Ribbon Commission on Health Care Cost and Access for soliciting our recommendations on how to improve access and affordability to health care in Washington State. Unlike larger businesses and labor unions who have many options for health care beyond the laws of Washington State (i.e. self-funded ERISA plans, Taft Hartley trusts, etc.), small businesses are captives to the laws of Washington State in order to access affordable health care insurance. IBA members are very frustrated with their inability to access affordable health care coverage in Washington State. Many tell IBA of small businesses they know in other states that have far more affordable health care than is available to them here in Washington State. Making affordable health care insurance available to small businesses in Washington State is and has been their highest legislative priority for the past three years.

Following are recommendations proposed by the Independent Business Association on behalf of its members to the Blue Ribbon Commission on Health Care Cost and Access:

1. <u>Private Market System</u> – Small business owners want a private market health care system, not a government-run health care system like the state's current Industrial Insurance program. Small business owners know and fully understand the benefits of a true competitive private market system, they deal in it every day. They know there is no better system to assure maximum value for every purchasing dollar – provided there is real and true competition. Thus, small business owners feel that the Commission must focus on creating a truly competitive private marketplace for health care insurance and health care service delivery in Washington State. IBA has been often asked to recommend states to look at. In 2003, IBA did substantial research on this question and at that time came up with the following recommendation for states to further research: (in order of priority) Iowa, Kansas, Virginia, Minnesota, Michigan, Wisconsin, South Dakota, Idaho, Ohio, Oregon and California. This list was based on the cost of individual health care insurance in those states, number of insurers and the percentage of uninsured in each state. IBA has limited ability to fully research the insurance markets in other states and would urge the Commission to seek input from other stakeholders for recommendations also.

   How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

   The private market system operates in every other state in the U.S. No state has successfully implemented a government run health care system.

16541 Redmond Way #336C Redmond, Washington 98052 (425) 453-8621 Email iba@isomedia.com

Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.

The private market system is operating in every other state in the U.S. It has proven more successful than other highly controlled state run approaches like that attempted in Kentucky, Minnesota, New York, and in other states. The private market approach works better in some states than others.

Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?

This proposal will impose the least costs impacts on individuals, business or government if true and effective competition exists. It will not require the government set up a very costly infrastructure to operate and manage a state-run health care system. The more competition truly exists, the lower the costs for individuals and businesses.

How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

Most business health care purchasers and a substantial number of individual health care purchasers support a private market system to maximize their choices.

What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

Some feel a government run health care approach is better than a private market approach. In response, there has never been a successful government run health care plan in the U.S. The Medicare and Medicaid programs are not operating efficiently and are actually cost-shifting their costs onto other health care purchasers. Washington State is not in a position financially to attempt to create a totally new government-run health care insurance system.

2. <u>Focus on Price Points Not Health Care Services and Benefits</u> – Small business owners and their employees want health care insurance they can afford. Over the past decade, far too much focus has been placed on what services are delivered and who can deliver them. Small business owners want state laws to establish affordably priced health care plans based on price. We recommend that all insurers be allowed to offer one plan with an average cost of $100 per person per month, another plan at $150 per person per month and any other health care plans that insurers want to offer in addition to those two plans. Insurers should not be constrained by benefit mandates or types of providers who can deliver what services. In offering these plans, insurers must use a standardized state form indicating which currently mandated benefits are included and not included in their plan. The standardized form would also include other basic elements of the plan like coverages, deductibles, co-pays, exclusions, etc.

How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

High cost is the primary reason small business owners and others do not buy health insurance. Most health care plans offered in Washington State are far more costly than the price-points recommended in this proposal. Establishing health care plans using affordable price points is critical in enabling more people and small businesses to access health insurance in Washington State.

Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.

We are not aware of this proposal being applied in other states. There are states with much more affordable health care insurance than in Washington State. This proposal expands consumer choice and access to more affordable health care insurance in Washington State.

Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?

This proposal will make more affordable (lower cost) health care insurance available to far more small businesses and individuals. The cost impacts on government will be negligible.

How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

This proposal is consistent with recommendations from the Health Care Authority's Small Business Experts meeting held earlier this year. While not all stakeholders will necessarily agree with this proposal, those truly seeking affordable health care solutions for small businesses without regard for their own special interest will generally support this proposal.

What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

The primary obstacle to this proposal is political. Those who want to ensure their health care services are covered through benefit or provider mandates. In response, the need for affordable health care for small business and individuals clearly transcends the special interests of those who advocate for a level of coverage these purchasers cannot afford.

3. <u>Use Rating Mechanisms Proven To Work In Other States</u> – Washington State has one of the most unique health insurance rating laws for small businesses in the nation. Many insurers do not offer health insurance to small businesses in Washington State due to the uniqueness of Washington's rating laws. Washington's unique rating laws are hurting Washington consumers by dramatically reducing competition among insurers. The earnings of health insurers doing business in Washington State are notably high – higher than industry averages. In a truly competitive health insurance market, competition would reduce such profit margins and result in greater value for consumers. Consider looking at the rating systems in the states listed in our recommendation #1.

How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

Washington's health insurance rating system is hurting Washington consumers by limiting competition in the health insurance market. Most states in the nation have far more health insurers competition for business. Competition controls market prices.

Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.

Most other states have insurance rating programs that are effective but that facilitate a much more competitive market with more insurers participating. The Commission needs to research the laws in other states and bring to Washington State the laws that are proving to work best to facilitate competition while also assuring affordable access to health care for all applicants.

Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?

This proposal will make health care insurance more affordable for more people by increasing competition which result in reduced profit margins as compared to a less competitive market as now exists in Washington State. The costs to government will be effectively the same as they are now. It is important that a revised rating system not unfairly disenfranchise those with chronic health conditions but rather find a fair balance between their needs and all other health care purchasers.

How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

This proposal was on the list of strategies proposed at the Health Care Authority's Small Business Experts meeting held earlier this year. This proposal will be endorsed by small businesses generally.

What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

The obstacles are primary political. Opposition will come from those who generally oppose a private market system, possibly from some who have chronic health conditions, and possibly from some insurers. In response, this proposal must find a balance between the needs of the 80+% of those without any health insurance who cannot find affordable insurance, and those with chronic health conditions to avoid imposing excessive cost increases on them. The bottom line, it is critical to revise Washington's rating laws in order to increase the number of health insurers doing business in Washington State in order to reduce costs and increase access through effective market competition.

4. **Worker Education** – Too many employees working for small businesses ask their employers to NOT provide them health care insurance but instead to provide them the value of the health care insurance in take-home pay. For all but the lowest income workers, buying health insurance as an individual with after-tax dollars costs the individual worker about $1.23 for every $1 in coverage they purchase because of the federal taxes they must pay on their take-home pay. Most workers do not understand this and state officials and business owners need to engage in an active education plan to educate workers about the money-saving benefits of employer-paid health care benefits.

How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

This proposal will reduce overall costs for health care insurance for workers who purchase health care insurance on their own. It is simple to prove comparing the cost using before tax earnings and compared to after tax earnings.

Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.

We are not aware of this being done in other states.

Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?

There will some initial cost to government to implement this proposal but in the long run, when more workers agree to employer provide health care than higher take-home pay this proposal will actually reduce the amount of uncompensated care state government and other insureds end up paying.

How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

We know of no opposition.

What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

Funding this proposal from state revenues. In response, the long term savings will clearly offset the initial costs.

5. **Focus On Individual Responsibility Not Employer Responsibility** – Only individuals are and can be responsible for their health. Government cannot transfer that responsibility to any other party, including the individual's employer. The Commission and the Legislature must focus on individual responsibility and incentives. Some stakeholders have proposed that employers be mandated to provide health care coverage for their employees. Such a mandate attempts to transfer the responsibility for an individual's health to their employer. As stated above, this is not possible to do. With respect to an employer mandate to provide health care coverage to the employer's employees, the courts have held numerous times that an employer mandate is illegal under the federal ERISA laws. Thus, the Commission and the Legislature need to spend their limited time and resources on proposals to ensure individuals exercise their responsibility for their own health and provide incentives to do so.

How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

It encourages individuals to take more responsibility for their health care which is essential to a successful and effective health care system..

Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.

No, but some states are like Massachusetts is now attempting to implement an individual mandate based health care plan.

Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?

This proposal will primarily benefit individuals by helping them improve their health status by being more responsible and being more active in protecting their health. If effective, this approach will actually reduce costs by reducing the number and severity of health conditions among our state's citizens.

How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

We believe all stakeholders generally agree in having individuals taking more responsibility for their health care.

What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

The costs of health care services and access to affordable health care are obstacles. Some who believe that an individual's responsibility for their health care can be transferred to their employer may also object. In response, the other proposals we have made will make health care services and insurance more affordable to citizens of Washington State. For those who object because they believe an individual's responsibility can be transferred to their employer, their position is unrealistic and not achievable, and it is time too move forward on solutions that will work.

6. <u>Provide Incentives For Cost Effective Health Care Delivery</u> – The current health care delivery system in Washington State is backwards. It rewards providers for excessive use of the system and penalizes efficient use of the system. The Commission has been provided information from the health care delivery system of this situation. One estimate was that 41% of the health care purchasing dollar was wasted. Another suggested that as much as 50% of every health care dollar spent is wasted. There must be incentives created to reward cost-effective service delivery. This can be done in at least two ways. First, state purchasing of health care services needs to be made an incentive-based system that rewards cost effective health care service delivery and penalizes inefficient health care service delivery. The Department of Labor and Industries has proven successful in implementing a system of incentives and the result has been a far lower rate of health care inflation for their program as compared to other state health care purchasing programs. Second, provide incentives using state tax incentives to providers who can demonstrate cost-effective health care service delivery. We at IBA are not knowledgeable enough in the intricacies of the health care service delivery system to provide a detailed recommendation, but we are confident that the Commission has access to experts who can help with this.

How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

Incentives for cost effective health care delivery will reduce costs for Washington citizens, business, state government and taxpayers.

Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.

The presentation to the Commission by the Puget Sound Health Alliance and Dr. Mecklenburg provided a good base to work from.

Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?

This proposal will result in savings if designed properly. It may result in some loss of tax revenues to the state of Washington that will be more than made up for by reduced costs from expenditures for health care by the State of Washington with additional savings for Washington citizens through their health care purchases. It should be reflected in lower health insurance premium costs also.

How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

We believe this proposal will have wide spread support.

What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

There may be some provider interests who have objections to change. In response, there is strong citizen support for reducing the cost of health care and reducing the rate of health care inflation. Achieving those results through incentives rather than regulatory directive is the best approach.

7. <u>Provide Consumers Far Better Health Care Information</u> – One of the keys to improving Washington's health care system is through consumer-based health care where consumers actively make health care purchasing decisions. In order for consumers to effectively make informed health care decisions, they must have access to data and information to make those decisions. That data and information is not currently accessible in most cases. The Commission needs to develop mechanisms to make such data available to consumers. We would prefer private entities, not state government, be the sources of this information.

How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

Providing consumers with useful health care information is very important to maximizing the benefits of consumer-driven health care. Most citizens have little to no knowledge of where the access such information

Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.

Not that we are aware of.

Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?

We believe this information can be provided by private entities at little to no cost for consumers because of its high potential for marketing medical services and associated products and services. Otherwise, we believe that can be made available on a subscription basis through private not-for-profit entities.

How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

We believe there is broad based support for making useful health care information available to Washington citizens.

What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

There will be concerns of costs and additional reporting by health care providers. In response, if this proposal is implemented correctly, those who provide quality health

care services will be eager to participate in a relatively simple reporting system. Their costs will be far outweighed by the benefits and revenues from new clients.

IBA is eager to work with the Commission to further research these and other ideas that will make affordable health care more accessible to small businesses in Washington State. We thank the members of the Commission for their consideration of our recommendations and we look forward to working with you in developing meaningful workable solutions to improve access to affordable health care in Washington State for all.

Sincerely,

Gary Smith
Executive Director

Connell Sand & Gravel, Inc.

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August 23, 2006

The Honorable Christine Gregoire, Governor
The Honorable Pat Thibaudeau, Co-Chair
Blue Ribbon Commission on Health Care Cost and Access
Olympia, WA 98504

Dear Governor Gregoire, Co-Chair Thibaudeau and Members of the Commission:

As a small business owner in Washington State, I can speak from direct experience; Washington State needs major health care reform. I know small business owners in other states who have access to much more affordable health care insurance not available in Washington State. There are more small businesses not offering health care to their employees than are, a monumental turn-around from just 10 years ago. Bold action is needed now to make health care affordable and accessible to small business employees and owners in Washington State. It is time to put politics aside and focus on solutions that really work. We are sick and tired of this issue not being addressed due to political games.

I have reviewed the comments submitted by the Independent Business Association and we support their recommendations to you. Specifically:

- We strongly support a private market system, not a government-run or government managed health care system like the state's current Industrial Insurance program. We fully understand the benefits of a true competitive private market system because we deal in it every day. We know that the private market system is the best system to assure maximum value for every purchasing dollar – provided there is real and true competition.
- We strongly support making affordable health care plans available to Washington small business owners by setting at least two target price points for health care plans with one having an average cost of $100 per person per month, and another plan at $150 per person per month. Insurers can also offer any other health care plans they want, but they must be allowed and encouraged to offer plans in the lower price ranges. We also support the IBA proposal that insurers use a standardized state form indicating which currently mandated benefits are included and not included in their plans, and the standardized form would also include other basic elements of the plan like deductibles, co-pays, exclusions, etc.
- We support changing Washington insurance rating mechanisms so they are more like insurance rating systems used in other states. Washington State has one of the most unique health insurance rating laws for small businesses in the nation and many insurers do not offer health insurance to small businesses in Washington State due to the uniqueness of Washington's rating laws. This is dramatically reducing competition among insurers, significantly reducing the benefits of a private, competitive market to control costs. Thus, we are paying more for health insurance in Washington State than in other states. We truly need to foster much greater competition among health insurers in Washington State.
- We agree in IBA's proposal to educated workers on the benefits of enrolling in employer provided health care plans with before-tax-dollars rather than after-tax dollars. We are well aware of many workers who refuse health care coverage in order to increase their take-home pay. That is "penny wise and pound foolish."
- Health care is the responsibility of each individual. State government can only help facilitate access to affordable health care insurance and affordable health care services. We strongly agree with the IBA, the Commission and the Legislature must focus on individual responsibility and incentives, not on employer mandates.
- We support the proposal to provide incentives to health care providers for providing cost effective health care services. We agree with the IBA, the current health care delivery system in Washington

State is backwards. It rewards providers for excessive use of the system and penalizes efficient use of the system. We urge you to create incentives to turn-around this backward health care delivery system.

- We support the IBA's proposal to improve access to health care information about the effectiveness of health care providers. As consumers, we need this information to make informed health care decisions. When consumers have the information they need to make informed health care decisions, they can and will help reduce the costs of health care in Washington State.

Thank you for carefully considering our comments and those submitted by the Independent Business Association. The IBA truly understands the needs of small businesses with respect to health care and has proven over the years to be a very constructive stakeholder in developing constructive and workable solutions.

Sincerely,

Toni M. Hille

Toni M. Hille
Connell Sand & Gravel, Inc.

Schaff, Randi

From: Gregg S Grattan [gregg@omakace.com]

Sent: Thursday, August 24, 2006 7:58 AM

To: Blue Ribbon Commission on Health Care Costs and Access

Subject: Health Care costs

August 24, 2006

The Honorable Christine Gregoire, Governor
The Honorable Pat Thibaudeau, Co-Chair
Blue Ribbon Commission on Health Care Cost and Access
Olympia, WA 98504

Dear Governor Gregoire, Co-Chair Thibaudeau and Members of the Commission:

I would like to take a moment to let you know that I feel Washington State needs major health care reform. As a small business owner, this is one area of necessary expense that is getting harder to deal with each year due to increasing costs. As a background, I offer to pay for the full amount of health insurance for my employees. As costs rise, I have looked at a partial payment system but many of the employees state that if they have to pay for any of the insurance they will not take it. This is not a good situation for the employee nor the employer. The employee needs health insurance and the employer gets people back to work faster if their health care is taken care of. Also, the only way we can afford insurance at all is through group rates and if enough employees drop off, we no longer qualify for group rates. My buying group (Ace Hardware) has initiated some very good rates for health care in other states nationwide but they say time and time again that "Washington State just is not a state that allows for this type of negotiation – they have us over a barrel". Individual insurance is too costly. Add this to the fact that we are paying the highest minimum wage in the nation which has hurt my business more each year, but I will save that discussion for another time. It has become very necessary for the system to be fixed.

I would like to let you know that I support the recommendations of the Independent Business Association. Those recommendations are as follows:

- We strongly support a private market system, not a government-run or government managed health care system like the state's current Industrial Insurance program. We fully understand the benefits of a true competitive private market system because we deal in it every day. We know that the private market system is the best system to assure maximum value for every purchasing dollar – provided there is real and true competition.
- We strongly support making affordable health care plans available to Washington small business owners by setting at least two target price points for health care plans with one having an average cost of $100 per person per month, and another plan at $150 per person per month. Insurers can also offer any other health care plans they want, but they must be allowed and encouraged to offer plans in the lower price ranges. We also support the IBA proposal that insurers use a standardized state form indicating which currently mandated benefits are included and not included in their plans, and the standardized form would also include other basic elements of the plan like deductibles, co-pays, exclusions, etc.
- We support changing Washington insurance rating mechanisms so they are more like insurance rating systems used in other states. Washington State has one of the most unique health insurance rating laws for small businesses in the nation and many insurers do not offer health insurance to small businesses in Washington State due to the uniqueness of Washington's rating laws. This is dramatically reducing competition among insurers, significantly reducing the benefits of a private, competitive market to control costs. Thus, we are paying more for health insurance in Washington State than in other states. We truly need to foster much greater competition among health insurers in Washington State.
- We agree in IBA's proposal to educated workers on the benefits of enrolling in employer provided health care plans with before-tax-dollars rather than after-tax dollars. We are well aware of many workers who refuse health care coverage in order to increase their take-home pay. That is "penny wise and pound foolish."

- Health care is the responsibility of each individual. State government can only help facilitate access to affordable health care insurance and affordable health care services. We strongly agree with the IBA, the Commission and the Legislature must focus on individual responsibility and incentives, not on employer mandates.
- We support the proposal to provide incentives to health care providers for providing cost effective health care services. We agree with the IBA, the current health care delivery system in Washington State is backwards. It rewards providers for excessive use of the system and penalizes efficient use of the system. We urge you to create incentives to turn-around this backward health care delivery system.
- We support the IBA's proposal to improve access to health care information about the effectiveness of health care providers. As consumers, we need this information to make informed health care decisions. When consumers have the information they need to make informed health care decisions, they can and will help reduce the costs of health care in Washington State.

Thanks for your time! Please consider the IBA's comments as well as my own very carefully.

Sincerely,

Gregg S. Grattan
Omak Ace Hardware #4226Y
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Omak, WA 98841
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gregg@omakace.com

Tab 20

Schaff, Randi

From: Warren Hand [whand@iha4health.org]
Sent: Tuesday, August 29, 2006 12:02 PM
To: Blue Ribbon Commission on Health Care Costs and Access
Subject: Washington State--Proposal 8-2006

Blue Ribbon Commission

I respectfully submit the Institute for Healthcare Advancement's proposal for your review. IHA would be honored if our proposal becomes a part of the solution to provide accessible, affordable, quality health care to all of Washington.

Regards,

Warren Hand
Sales and Marketing
Institute for Healthcare Advancement
501 S. Idaho St.
Suite 300
La Habra, California 90631
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562-690-4001 x **205**
562-690-8988 Fax
800-434-4633

Washington State: Blue Ribbon Commission on Health Care Costs & Access

1. What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access? Please provide a brief summary of your proposal.

The Blue Ribbon Commission on Health Care Costs & Access is looking to establish a system to provide every Washingtonian the ability to obtain needed health care at an affordable price. During the last six years, the Institute for Healthcare Advancement (IHA), a not-for-profit 501 (c) (3) private foundation, has been providing a proven solution for lowering healthcare costs for states, health plans, and various organizations.

The solution is in the form of a book series, published by IHA, entitled "What To Do For Health". The books in the series provide valuable, easy-to-read, easy-to-use, in-home healthcare information designed for use by parents or caregivers. The books are written at a third- to fifth-grade reading level, and are available in both English and Spanish. The best selling book, *What To Do When Your Child Gets Sick*, is also available in Vietnamese, Chinese, and Korean.

The books deal with common health topics and are written by experienced health educators to enable appropriate healthcare decisions, ultimately lowering healthcare costs. The ability of a family to manage their healthcare, at-home, is one important factor toward Washington state being able to provide accessible, affordable, quality health care to all Washingtonians by 2012.

IHA's proposal would be for the state of Washington to purchase books and distribute them through

agencies dealing with the birth of newborn babies such as hospitals, in-home visitations, first check-up visits, community clinics, adult education classes, urgent care centers, local WIC centers, woman's shelters, or healthcare professional's offices. The distribution points are only limited by the imagination. One of the most successful methods of distribution is by the "parent kit" method used by other states.

What To Do When Your Child Gets Sick is the book in the series that would have the most immediate impact on improving Washington's health care.

2. How will implementation of your proposal enhance, hinder, or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

Distribution of the books is linked to appropriate utilization of healthcare services with numerous benefits including: a decrease in inappropriate use of Emergency Departments and Doctor/Clinic visits, lower employer premium costs, reductions in employee absenteeism, and fewer missed days at school. Reducing costs in any of these categories results in huge across the board savings for Washington.

It is estimated that as much as $73 billion dollars is wasted annually on inappropriate healthcare spending in the United States alone.

When a parent receives *What To Do When Your Child Gets Sick* and resolves, at-home, the problems of a bloody nose, fever, diaper rash, toothache, or any of the 50+ ailments found in the book, and they do not visit the ED, their confidence grows. Once they have the confidence, the corresponding ED use drops. Using an average of $200 per ED visit and $30 per clinic visit (low estimates) the resulting savings by families not using the services of the ED would be substantial for Washington.

Research through organizations, including UCLA, has shown positive outcomes derived through the use of the books by Head Start parents.

What To Do When Your Child Gets Sick has proven to be the deciding factor in reducing unwarranted Emergency Department visits and Doctor/Clinic use by Head Start parents who were given the book to keep at-home. Those parents who received the book reported a 48% reduction in unwarranted ED use along with a 37.5% reduction in Doctor/Clinic visits.

3. Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, please describe the policy or program and its outcomes.

The distribution of books from the "What To Do For Health" series comes in many different forms. The states of California and South Dakota each distribute the books in a "box" that is given to each new parent in their respective states. South Dakota has been distributing their *Bright Start Gift Box* for the last five years. California will begin distribution of their *Kit for New Parents*, which contains *What To Do When Your Child Gets Sick*, in October 2006.

Molina Healthcare of Michigan's outcome study, *Emergency Room Utilization Reduction Project*, has shown that parents who have the book at home reduced their ER visits by 14.6% and their "treat at home" response increased by 9.6%. Parents reported increased confidence levels for caring for their children, and. confidence levels translate into cost savings through fewer visits to ER, Doctor's offices and clinics.

Health plans like Neighborhood Health Plan (NHP) in Boston and Molina Healthcare of Michigan use *What To Do When Your Child Gets Sick* as incentives for their enrollees to stay healthy. Molina and Neighborhood Health Plan also use *What To Do When You're Having a Baby* in their programs. NHP distributes *What To Do For Teen Health* in return for parents bringing their teenagers in for regular check-ups. NHP feels that the book is a good intervention tool for teenagers.

4. Will your proposal impose costs on individuals, businesses, or government? Will these costs be time-limited or on-going? Can you estimate how much threes costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?

IHA's proposal will impose costs on the businesses and the government of Washington. BUT, the initial outlay for the purchase of books can be justified/offset by proven reductions in ED and Doctor/Clinic visits. Cost reductions are realized each time *What To Do When Your Child Gets Sick* is added to a state or health plan's program.

Initial costs would be based upon the annual birth rate in Washington state if each new mother were to receive a copy of the book. The discount pricing structure in place at IHA for quantities between 75,001—100,000 is $4.50 per book plus shipping and the price for 100,001—150,000 is $3.95 per book plus shipping. In calculating totals, multiply the number of births per year times the cost per book and add shipping. Shipping can only be determined around the time of the actual shipment based upon the constantly fluctuating "fuel surcharges".

On-going costs would depend upon the additional purchases of books for Washington state families.

If Washington were to decide to purchase the *Sick Child* book for state agencies that work with at-risk populations who have children enrolled between the ages of birth and eight years, but do not fall under the "newborn" category, additional cost would be incurred. The cost would vary by the number of books purchased with shipping charges being the fluctuation factor.

When evaluating the ROI, the $4.50 price vs. one ED visit of $200 produces a savings of $195.50 for <u>each time</u> the parent uses the book instead of going to the ED for an unwarranted visit. How many times this scenario plays out over a year's period depends on the individual parent or caregiver, but if just ONE unwarranted visit to the ED per family is averted, the trade-off savings are huge.

5. How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

Distribution is the key to the success of the books making a difference in reducing healthcare costs in Washington state and collaboration among stakeholders would be seen as an essential part of the success of distributing the books to those who really need them.

The stakeholders would need to be identified as those who see the books making a difference in the lives of Washingtonians. These distributors can come in a variety of agencies without much of a cost factor as in the example of a hospital distributing the books on the day the baby leaves the hospital, when the home visitation nurse goes to see the new mother, the book can go along.

6. What are the obstacles to implementing your proposal? Who will object to it and why? How do you

suggest these objections be addressed?

Obstacle: The most common obstacle is for the decision makers in any organization to embrace the idea of spending money to save money.

Answer: Reductions in ED use and Doctor/Clinic visits occur in the agencies that have made the commitment to improve the lives of new parents or underserved populations. It has been shown that parents want to take care of their families but most often do not have access to healthcare information they can read or understand. When no materials are available to explain how to manage their family's healthcare, parents visit the ED unnecessarily. It is estimated that 90 million Americans do not read beyond a fifth-grade reading level which makes them functionally literate and a burden to the country's healthcare system, including Washington state.

What To Do When Your Child Gets Sick is a solution to the overcrowding in the ED. The resulting dollar savings per ED visit alone overshadows the per book cost.

Obstacle: How would the state distribute 100,000 books?

Answer: The distribution structure is already in place through Washington's existing healthcare agencies, even though it might not see obvious at first blush, it just needs to be mined, organized, and implemented.

Tab 21

Schaff, Randi

From: Maureen Scott [maureens@ichs.com]
Sent: Friday, September 01, 2006 1:33 PM
To: Blue Ribbon Commission on Health Care Costs and Access
Cc: Shin-Ping Tu; Teresita Batayola; Michael McKee
Subject: Proposal: BRC on HCCA

Importance: High

Attachments: ICHS BRC-HCCA Proposal '06.doc

ICHS BRC-HCCA Proposal '06.doc...

TO: Honorable Members of the Blue Ribbon Commission On Health Care Costs & Access:

On behalf of our Executive Director, Teresita Batayola (teresitab@ichs.com), I am pleased to attach the proposal submitted by International Community Health Services (ICHS) for your consideration towards achieving the Commissions stated mission and goals.

We wish to acknowledge the significant participation of Shin-Pin Tu, MD, MPH of Harborview Medical Center, the Department of Medicine, University of Washington, and Director of the Asian Health Promotion Project as the medical consultant and contributing author for this proposal.

ICHS looks forward to following the Commission's process and receiving information as you go forward.

Maureen K. Scott, M.S.
Grants and Communications Associate
International Community Health Services (ICHS)
206.788.3675
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PROPOSAL: BLUE RIBBON COMMISSION ON HEALTH CARE COSTS AND ACCESS

Introduction

The information immediately following is offered to establish the context and relevancy of the proposal presented herein as well as the credibility of the proposing organization, ICHS.

Background

Founded in 1973, International Community Health Services (ICHS) is a 501(c)(3) community-based health care center committed to providing linguistically appropriate, culturally relevant, accessible, affordable and comprehensive quality primary and preventive medical and dental care to Asian/Pacific Islanders (API) and other members in the communities of Seattle and King County. Since 1994, our unduplicated patient population has increased by 360 percent (from 3,133 to 14,398), and more recently, between 2002 and 2005 it has increased by over 40%.

Population(s) Served

Our Asian/Pacific Islanders (API) constituency is primarily low-income and one of the most racially, ethnically and linguistically diverse in the State. ICHS's 2005 utilization data revealed a patient population comprised primarily of Asian/Pacific Islanders (API), at 83.2%, and with 4.8% African/ African-American, 3.4% White, .6% American Indian/Alaska Native, 1.4% self-identified as Hispanic and Spanish-speaking, and 6.6% were not self-identified as any ethnicity or as "other."

Patient Barriers to Accessing Care

In 2005, 67% of all ICHS patients reported income below 100% percent of the Federal Poverty Level - FPL - ($19,350 for a family of four) and 87% of all dental patients reported income below 200% of the FPL. Many ICHS patients have no health insurance - in 2005, 27% had no health coverage and 34% had no dental coverage.

Beyond financial obstacles, APIs face a number of cultural, linguistic, and societal barriers to accessing medical and dental health care. Immigrants and refugees tend to have little or no experience with the American health care system. In addition to possibly distrusting unfamiliar Western medical practices, APIs with limited English proficiency have difficulty communicating their concerns to medical providers who do not speak their language or understand their cultural beliefs, practices and obligations. ICHS has the capability of providing services in over 29 different languages and dialects to assure effective and culturally competent health care. The linguistic and cultural appropriateness and effectiveness of our services are demonstrated in the ever increasing numbers of patient encounters and unduplicated patients seen at ICHS.

Summary

1. ***What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access?***

Goal: Improve constituent health by increased use of evidence-based care resulting in better health outcomes and consumer satisfaction.

Objectives: 1.) Improve screening rates for cancer, oral health, diabetes, heart disease and hypertension among non-English speaking members of our API communities.

2.) Develop and disseminate research tested intervention materials promoting evidence based preventive care to limited English speaking Chinese, Korean and Vietnamese consumers.

Need: The findings of a comprehensive community needs assessment, "Asian and Pacific Islander Health," conducted for ICHS during 2006 included identification of the five most prevalent health concerns among various API communities and their providers (cancer, oral health, diabetes, heart disease and hypertension) and the language/ethnic groups with the highest consumer populations [Chinese (spoken, Cantonese), Korean and Vietnamese].

A major challenge encountered in providing quality medical care across different cultures and languages is the time and appropriate channel to inform patients of the rationale and availability, in terms relevant to the patient, for such evidence-based care within a 15-20 minute primary care medical visit. Without active measures to disseminate new medical knowledge, it takes 17 years on average for that information to be adopted into practice.

Methods:

1.) Conduct a search of federal funding agencies (e.g., Centers for Disease Control and Prevention) for research tested intervention materials that promote evidence based preventive care (e.g. cancer, oral health, diabetes, heart disease and hypertension).

2.) Procure and/or produce in-language materials in the research recommended media, e.g., videos, DVD's, pamphlets, etc.

3.) Provide dissemination orientation and training for bi-cultural family/ community health workers/educators bi-lingual in one of the target languages and English.

4.) Disseminate the research tested and procured/developed in-language intervention materials through agencies serving limited English speaking patients (e.g., community health centers, public libraries, health fairs, religious and ethnic cultural centers/events, ESL programs, hospitals, pharmacies, etc.).

Impact

2. How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

Decision-aids (e.g., videos, DVD's, etc.) have been shown to be effective in the general population. Research studies also support such approaches to reach patients of different cultures and with limited English speaking skills: outreach, mass media, videos plus pamphlets.[1, 2] A recent study underscores the importance of including patient education in achieving blood pressure control.[3] In fact, providers' prescriptions/referrals/ recommendations of evidence based care are futile unless patients are engaged and follow through with such prescribed care.

Through the procurement/development and dissemination of linguistically and culturally appropriate health education materials, limited English speaking consumers gain access to evidence based care and interventions. They are thereby empowered to assimilate the necessary information, engage meaningfully in their health care and follow-through with the evidence based recommendations and prescribed care.

Model

3. Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.

Promoting cancer screening through a health educator has been previously tested in a community setting focusing on Pap testing in Native American women.[4] A recently completed collaborative study by the University of Washington, Fred Hutchinson Cancer Research Center and International Community Health Services demonstrated that a multi-component intervention consisting of education through a health educator, culturally and linguistically appropriate materials (video and pamphlet), and a simple screening tool (Fecal Occult Blood Test) is extremely effective at increasing colorectal cancer screening by limited English speaking Chinese patients. The remarkable impact of this study's intervention offers a profound rationale for the use of linguistically and culturally appropriate health education strategies among populations with limited health information. Results from other cancer control intervention trials with limited English speaking populations also support this finding.[5]

Cost

4. Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?

The effectiveness and cost efficiencies of preventive health care are so well established as to be among the cornerstones of the best practices in contemporary medical and dental health care. The

intent of this proposal is to assure access to limited English speaking API consumers of linguistically and culturally appropriate health education materials specifically pertaining to evidence based screenings and care for cancer, oral health, diabetes, heart disease and hypertension.
In the collaborative study mentioned above[5], an in-clinic health educator assured successful screening by addressing many of the challenges to providing cancer prevention education confronting busy primary care practices. The health educator utilized the primary care encounter to provide cancer prevention education and adapted the process to the specifics of each patient encounter to prevent disruption of clinic flow. Further, screening promotion and education by an in-clinic health educator did not increase medical encounter time. Additionally, the costs associated with such promotion and education activities performed by a health educator are significantly lower than when provided by a primary care nurse and dramatically lower than when they are required of a physician.

Expected costs will be associated with the procurement or development of linguistically and culturally appropriate materials as they pertain to the specific media documented in research to be most effective [re: Methods, 1)]. Accordingly, that activity would be required to generate realistic budgets. Such costs may vary widely from the direct purchase of consumer-ready materials to actually covering expensed to produce the needed materials in the recommended media format, e.g., DVD production (script, director, actor(s)/narrator, technical supplies and equipment, editing, etc.), pamphlet (text, translation, graphic artist, technical equipment, supplies, printing, etc.), and so on. In-kind supplies, equipment use or pro-bono services may be possible, even likely, for some of these expenses. Although the research project budget to produce the video for the reference collaborative study (2004)[5] was in the range of $30,000, that may in fact not be a reliable estimate of costs for what is currently needed.

On-going costs would be associated with the continued purchase or reproduction of the specific materials, the percentage of the health educator's time devoted to these activities, and the possible updating of materials so that they remain consistent with new, evidenced based protocols and interventions as they are established over time.

Stakeholder Collaboration

5. How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

Shin-Ping Tu, MD, MPH of Seattle's Harborview Medical Center; the Department of Medicine, University of Washington, and Director of the Asian Health Promotion Project was the medical consultant and contributing author for this proposal.

Institutionally, ICHS is a participating member of the Asian Pacific Islander Coalition (APIC), the Community Health Network of Washington (CHNW) and the Washington Association of Community & Migrant Health Centers (WACMHC) where the need for current culturally and linguistically appropriate health education materials has long been recognized.

Additionally, ICHS is a widely recognized community resource for culturally and linguistically appropriate health education and medical services and is relied upon by many other agencies serving similar populations because of the great need for these services. Because of this, our staff and programs routinely participate in inter-agency collaborations, community forums, task forces, coalition, etc., such as the Diabetes REACH Coalition, the Children's Health Improvement Collaborative, Asian Counseling and Referral Services, The Center for Career Alternatives, Refugee Women's Alliance, Mutual Assistance Associations, and certainly the Crisis Clinic, Department of Social and Health Services, the Social Security Administration, and the numerous community agencies and associations serving refugees and immigrants: International Rescue Committee, World Relief, Catholic Community Services, Lutheran Social Services, area Community Colleges and ESL/LEP (English as a Second Language/Limited English Proficiency) programs, Harborview Medical Center, University of Washington Medical Center and Swedish/Providence Hospital.

A strength of this proposal is the broad applicability of the objectives and principles of the methods for all ethnic, cultural, racial and/or non-/limited English speaking consumer groups and their primary care providers, and more specifically, non-profit primary health care providers. It relies on identifying specific evidence based, culturally and linguistically effective health education materials and dissemination strategies which enhance health outcomes and customer satisfaction without putting additional demands on primary care providers and patient encounters.

Implementation Obstacles

6. What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

The need addressed by this proposal being apparent and the effectiveness of the methods being established, it is reasonable to question why such activities have not already been undertaken to the extent needed.

Consumers targeted by this proposal for preventive health education and screenings are predominantly low-income. They often must rely on non-profit health care organizations that receive funding restricted to the delivery of primary care services - typically, health education personnel and activities are not allowable expenses.

The most imposing obstacle to improve screening rates for cancer, oral health, diabetes, heart disease and hypertension among non-English speaking members of our API communities is the allocation of funding. **Specifically, adequate funding is necessary for:**

1.) **Bi-cultural and bi-lingual health educators, and**
2.) **Procurement/production of linguistically and culturally relevant health education materials.**

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1. Taylor VM, Jackson JC, Pineda M, Pham P, Fischer M, Yasui Y. Hepatitis B knowledge among Vietnamese immigrants. *J Cancer Educ.* 2000;15:51-56.
2. Taylor VM, Jackson JC, Yasui Y, et al. Evaluation of an outreach intervention to promote cervical cancer screening among Cambodian American women. *Cancer Detect Prev.* 2002;26(4):320-327.
3. Roumie CL, Elasy TA, Greevy R, et al. Improving blood pressure control through provider education, provider alerts, and patient education: a cluster randomized trial. *Ann Intern Med.* Aug 1 2006;145(3):165-175.
4. Dignan MB, Michielutte R, Wells HB, et al. Health education to increase screening for cervical cancer among Lumbee Indian women in North Carolina. *Health Educ Res.* Dec 1998;13(4):545-556.
5. Tu SP, Taylor V, Yasui Y, et al. Promoting culturally appropriate colorectal cancer screening through a health educator: a randomized controlled trial. . *Cancer.* In press (rev. 2004).

Tab 22

Jefferson County Committee for Health Care Access is a group of health care professionals, lay people, and representatives of community agencies who have come together to work on improving access to care for all people of our community. A roster of our members is included at the end of this statement.

Problems:
We see many problems with the current health care system, including, but not limited to the following:

- Inadequate management of chronic illnesses
- Use of the hospital emergency room in lieu of primary care providers by the uninsured
- A high percentage of health care dollars spent on end-of-life care that does not improve quality of life, due to unrealistic expectations from families and to the focus of our system on cure rather than providing compassionate care of those in the final stage of their lives
- Defensive medicine due to the risk of malpractice litigation.
- High administrative costs due to multiple insurers and their demands
- Risks distributed unequally with public insurers caring for the higher risk patients and private insurers caring for healthier people
- Lack of preventive care
- Inadequate patient education and empowerment in the prevention of illness and in their own self-care
- Inequitable coverage
- Excessive profits by insurers and pharmaceutical companies who also influence the care that is given
- Fragmentation of care with lack of communication between providers and community agencies

We recommend, in order to improve health care for all, a system that provides

- Universal health coverage, publicly funded with health care privately delivered
- Universal coverage all at once, rather than incrementally
- All people covered under the same system and mandatory
- Coverage should be individual rather than employer-based in order to be totally portable and equitable
- If financed by premiums rather than tax dollars, they should be based on the concept of Calculated Disposable Income with government subsidy for individuals and/or small businesses who cannot afford health insurance
- Coverage of reasonable and proper expenses for all medical care including health care providers, hospitals, prescription drugs, mental health, long-term medical care, dental care, vision care, and medical equipment. Such a system would include no deductibles, co-insurance, or exclusions for pre-existing conditions, and would have modest co-pays.

- Inclusion of preventive care and emphasis on wellness, prevention of disease, and support of people to practice healthy behaviors
- Patient-centered, with adaptability according to patients needs as determined by patients and caregivers, with case managers for those with chronic illnesses
- Oversight by health professionals and lay people, making use of evidence-based protocols and measurement of outcomes
- Implementation of a state-wide information technology program to reduce errors and improve medical communications
- Transparency among practices of healthcare providers with patient protection against healthcare accidents and egregious mistakes
- Fair reimbursement for health care providers

It should also be noted that a strong base of primary care is essential for any universal healthcare plan to be successful. Therefore, monetary and/or other incentives should be developed to encourage physicians and other caregivers to consider a career in primary care.

Cost:
The cost of such a system would be no more than what is now being spent on public programs, "uncompensated care," and private insurance. With the removal of the profit and the excessive administrative costs, everyone can be covered for less than is currently being spent on healthcare.

Obstacles to implementation:
We recognize that the barriers to implementing such a system include the powerful lobby of private insurers and national rules concerning Medicare and Medicaid. We encourage the BRC to study the previously proposed initiative, Health Care 2000, since much thought was put into it concerning cost and implementation of such a system. We also suggest that Washington support Senator Russ Feinfold's *State-Based Health Care Reform Act* and, if passed, become one of the states to pilot a universal health coverage project.

As we improve our health-care system, it is also important that we work to make our communities more supportive of good health practices, such as decreased reliance on the automobile and improved access to walking/biking trails, and improved nutritional practices in our schools. Recognition of the role that mental health plays in individual and community health is also essential.

Thank you for allowing our input. We eagerly await the recommendations of the commission.

Diane Bommer, RN, CDE (retired)
Julia Danskin, Public Health Nursing Director,
Jefferson County Public Health
Rebecca Kimball, ARNP, Jefferson Healthcare
Mack Boelling, MD (retired)
Beth Wilmart, Executive Director,
The Women's Health Project
Bob Peden, UGN, Jefferson County
Bonnie White, Olympic Community Action Programs
Timothy Hockett, Executive Director,
Olympic Community Action Programs (OlyCAP)
Cyndi Newman
Gail Wood, MASH clinic
Judy Tough, NAMI

Susan O'Brien, ARNP, Family Planning Clinic,
Jefferson County Public Health
Jean Baldwin, Director, Jefferson County Public Health
Laurie Strong, Jefferson Mental Health Services
Phil Peet, DSHS
Roy Walker, MS, Executive Director, Olympic Area Agency on Aging
Paula Dowdle, Chief of Operations, Jefferson Healthcare
Suzy White, Jefferson Healthcare
Sheila Lauder, NAMI
Ron Nelson
Vicky Lowe, Jamestown C'llalam Tribe
Jenifer Taylor
Joe Wagner, citizen, Community Roundtable
Linda Kay Smith,
Local 20/20 Health and Wellness Action Team
Nell Altizer
Pat Teal
Ron Tacker, MD

Tab 23

August, 2006

The Honorable Christine Gregoire
The Honorable Pat Thibaudeau
Blue Ribbon Commission on Health Care Costs and Access
Olympia, WA 98504

Dear Governor Gregoire, Senator Thibaudeau and Members of the Commission:

On behalf of the undersigned organizations, we would like to introduce you to our newly formed coalition, the "Jobs and Health Care Coalition." This coalition is made up of groups who are committed to being proactive and solution-oriented to solve the health care problems in our state.

From our perspective, the best solutions will not involve mandates on employers. Instead, we feel that the solutions involve leveraging the best of the private sector through more options and incentives while allowing the public sector to take care of those who need help. We are open to all ideas and solutions that meet the following principles:

- Establish an appropriate balance and blending between public programs and the private market to meet the diverse coverage and financing needs of our citizens. The coalition supports utilization of private plans and financing mechanisms as the primary arena with public programs serving as a safety net.

- Efforts that reduce the cost of health care both short term and long term by controlling underlying cost drivers in the system and reducing the upfront cost of insurance premiums and/or access to care.

- Proposals that remove regulatory barriers in the current system to reduce the cost of health insurance premiums and increase the number of private insurers willing to do business in our state;

- Creating a greater variety of choice in products and prices;

- Move us toward a system designed to educate individuals about the costs of health care, how they impact those costs and increase their responsibility for their health care.

- Clearly defining the role of employers in the health care system as a financing mechanism available to assist individuals in meeting their responsibility in health care on a voluntary basis as a means to attract and retain employees while still being able to provide jobs, wage increases and other benefits.

Since the employers in this state – both small and large – are an integral part of our state's health care system as both purchasers and consumers, we have a very strong stake in the outcome of the Blue Ribbon Commission. We look forward to working with you to help meet the goals you would like to achieve.

Feel free to lean on our coalition as a resource for you. Our hope is that by having the employer community working together, you will find greater efficiency in getting the information you need to make appropriate decisions in this arena for the state.

If you have any questions, please feel free to contact any of the representatives of our member organizations.

Sincerely,

Trent House, Dir. Government Affairs
Washington Restaurant Association

Carolyn Logue, Washington State Director
National Federation of Independent Business

Gary Smith, Executive Director
Independent Business Association

Gary Chandler, VP Government Affairs
Association of Washington Business

Jan Teague, President/CEO
Washington Retail Association

Laurie Kirkland, President
Washington Assoc. of Health Underwriters

Jan Simon, President/CEO
Washington St. Hotel & Lodging Assoc.

Kathleen Garrity, President
Associated Builders & Contractors of W. WA

Tom Kwieciak
Building Industry Association of WA

Jennifer Holder,
Wal-Mart Corporation

Kerri Lonergran
Lombardi's Neighborhood Italian

Jobs and Health Care Coalition
Principles

The ***Jobs and Health Care Coalition*** has developed a set of principles for coalition members and policymakers to use when evaluating future health care proposals. The coalition will oppose attempts to impose “mandates” on employers because of the risk this creates for jobs, economic development, and business survival.

The Coalition supports:

- Establishing an appropriate balance and blending between public programs and the private market to meet the diverse coverage and financing needs of Washington state citizens. Utilization of private plans and financing mechanisms as the primary arena with public programs serving as a safety net.

- Reducing the cost of health care both short term and long term by controlling underlying cost drivers in the system and reducing the upfront cost of insurance premiums and/or access to care.

- Removing regulatory barriers in the current system to reduce the cost of health insurance premiums and increase the number of private insurers willing to do business in our state;

- Creating a greater variety of choice in products and prices;

- Moving toward a system designed to educate individuals about the costs of health care, how they impact those costs and increase their responsibility for their health care.

- Clearly defining the role of employers in the health care system as a financing mechanism available to assist individuals in meeting their responsibility in health care on a voluntary basis as a means to attract and retain employees while still being able to provide jobs, wage increases and other benefits.

Tab 24

In 2007:

- Declare all **children** covered for all **outpatient** office visits, including well-baby care; pre-natal care; post-natal care; mental health; yearly physicals; illness visits; dental care; vision care; and prescription drugs.
- Establish a **reasonable** rate of payment to providers – possibly different in rural/urban areas. Pay it to any licensed provider who provides primary care to children, e.g., a general practitioner, family practice physician, pediatrician, ARNP, or others. Solicit the participation of providers on a committee to establish a fair rate of pay.
- Allow any child to go to any primary care provider (PCP). If the child has insurance, the office can bill it. But any child will be covered for outpatient care by the state at the established rate, if there is no other source of coverage.
- Providers will not be able to restrict the number of state-insured children as they often do with Medicaid.
- Referrals to specialists should be processed through a managed care matrix. The reimbursement rate should not be dramatically higher than that established for primary care providers. It is possible that co-pays or deductibles might be part of the payment arrangement for specialists.

The rationale for this plan:

- The state has a strong interest in assuring the healthy development of children. There should be no barriers in the way of children getting the prevention and early health care they need, so there would be no need to "enroll," no co-pays, no deductibles, and no premiums for parents of children to pay for routine outpatient care. And, we would waste no money or resources on promoting enrollment, checking eligibility, etc., but would simply provide services.
- Providers need to be part of the decision-making process about reasonable rates of payment so that does not present a barrier to care.
- I suspect that some working families who may be buying family coverage through work, even though it is a serious strain on their finances, might drop the coverage for children, and move the children into this state plan. This probable increasing reliance of families on state insurance for outpatient care for children will substantially decrease the administrative burden and cost in outpatient offices for billing numerous different insurance companies.
- Providing outpatient care can be a relatively predictable and manageable expense. I would assume that when a bill for a child first comes to the state for payment, someone in DSHS would contact the family to determine if they might be eligible for the more comprehensive benefit package available through Medicaid, and encourage/assist the family to apply.
- In essence, I would process the payments for these children as if they were part of the Basic Health Plan, but with the benefits indicated above specifically for children.

In 2008

- Extend the same level of outpatient primary care to all adults, including ob-gyns and internists in the PCP coverage group.

During 07 and 08

- Leave Medicare and Medicaid intact as they are – the huge bulk (probably 90% of spending) of those programs go for the care of the elderly, disabled, chronically ill, etc

Funding

Although political leaders whom I approach say the state isn't ready for it, I think citizens are – a state income tax. An initiative (perhaps organized/sponsored by Wm. Gates, Sr.) to the citizens to establish a state income tax should be started immediately, and should be used to provide the above level of healthcare funding for the next 10 years. After 10 years, the income tax revenues would go into the general fund. I don't like designated funds, but think this package of healthcare coverage for all outpatient care of children, paid for by an income tax, will be a very attractive package to most voters. I also think the healthcare savings generated by establishing readily-available outpatient care will save enough money that the designated fund can be moved into the general fund in 10 years.

- I'd use the federal tax return to determine the total amount of gross income on which any individual would be responsible for paying state income taxes.
- I would allow no deductions - not for donations, for medical expenses, for mortgage expenses, for children in the home.
- I would set a rate of 5% of all income, after allowing everyone who had any income to take a deduction of $25,000 or 200% of poverty, whichever is higher. This would allow those with barely enough income to meet daily needs to avoid paying this tax – including, probably, some of the elderly with lower incomes. I would tie the deduction to 200% of poverty so that it could continue to increase as the cost of living increases.

By 2009

I would have established a payment priority for higher-cost procedures; inpatient care; etc. I'd look to something like the Oregon model for determining priorities, but would apply those designated care/procedure/treatment priorities evenly across the board to anyone, regardless of the payment source.

Tab 25

King County

Proposal
Not Available
At This Time

Tab 26

KING COUNTY HEALTH ACTION PLAN

COLLABORATIVE PARTNERSHIPS IMPROVING COMMUNITY HEALTH

The King County Health Action Plan, a public-private partnership with Public Health-Seattle & King County and over three dozen collaborating members, welcomes the opportunity to respond to the invitation to submit ideas to the Blue Ribbon Commission on Health Care Costs & Access that will assist you in your work to achieve the vision and goals as articulated in your statement of July 27, 2006. We will respond to each of the six questions set forth and attach contact information. Thank you in advance for this opportunity.

1. What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access?

Thinking of two tracks within the overall health care system, one for children and one for adults, we will set forth the foundational opportunities for an approach to achieve an improved system for children.

In 2007 we can start taking the steps necessary to cover all children in Washington and assure their access to services by 2010. By starting with children we will be well on the way to setting the stage for a future healthier Washington. Building and spreading evidenced-based strategies and programs which improve access and health, increase quality and decrease costs, we can create a foundational template to reach the Commission's goals for children across the state. This is an approach also supported by the Health Coalition for Children and Youth (HCCY).

Our proposal for children will address the key elements of coverage and access to services, improved quality and decreased costs by expansion of evidenced-based programs in three areas.

I. Integrated Preventive Healthcare for Children
Expand the Kids Get Care Program (KGC) statewide
Annual Cost: $1,750,000 for 25 sites
Annual Savings: $1,775,679 statewide for Medicaid children 1-3 years old, potentially more for other populations

Kids Get Care is a program to ensure that children, regardless of health insurance status, receive early integrated preventive physical, developmental, mental health and oral health services through attachment to a health care home. This program is now in 24 sites in King, Pierce and Snohomish counties with a five year track record including having attached over 23,000 children to health care homes, and improved the rates of two year olds up to date with well child checks by 41% from 53% of these young patients to 75%. If spread to all counties in the state Kids Get Care has the potential over five years to save the state at least $9 million by reducing avoidable hospitalizations and other unnecessary services improve the health status of 50,000 children and connect them to health care homes. KGC is an example of a best practice as endorsed by the Communities Connect coalition.

See Appendix A for further program description and accomplishments as well as costs for spreading this program state-wide.

II. Making Sure Best Practices Are Not Best Kept Secrets
Expand the statewide reach of the Children's Health Improvement Collaborative (CHIC)
Annual Cost: State funds: $200,000; Federal Match: $200,000
Annual Savings: Supporting medical practices' participation in quality improvement projects like this learning collaborative disseminates best practices in the delivery of preventive care and chronic care management. Substantial literature documents the cost and health improvement benefits of improving such care. (See Appendix B)

Based on the successful State Diabetes and Cardiovascular Disease Collaborative, the purpose of the CHIC is to use quality improvement (QI) methodology and the Breakthrough Series Collaborative (BTS) model to improve the delivery of care for low income children by rapidly disseminating evidence-based care for specific chronic illnesses and preventive care. In the first two years, the CHIC focused on spreading the learnings from KGC, especially in the areas of well-child checks, early developmental screening, integrated oral health including fluoride varnishes and attachment to a medical home. Now in its third year, the CHIC is focusing on improvement of three specific chronic childhood illnesses: asthma, attention deficit/hyperactivity disorder (AD/HD), and overweight which also includes the relationship between nutrition and oral health. Not only does CHIC help medical practices improve care around a specific topic area, once a practice has learned the basic QI tools, they can apply them to any aspect of their practice, which provides them with the basic building blocks of improving their Medical Home capabilities.

By utilizing the CHIC as a vehicle with which to connect both the State's purchasing arm to its quality hand and to focus on targeted health indicators in the future (such as immunizations, premature delivery, etc), the State can drive health status and quality up and costs down. By expanding the ability of the CHIC to offer financial incentives to clinic teams for attending the CHIC, by tying participation in the CHIC to a requirement for contracted heath plans to achieve quality improvement goals in targeted areas, and by choosing key measurable quality indicators, such as those population based measures referenced in the Washington Health Foundation's Healthiest State in the Nation policy paper, the state can tangibly move forward to decrease disparities, improve the health of the state and decrease costs.

See Appendix B for further program description and accomplishments as well as costs for spreading this program state-wide.

III. County Innovations and Expansion of Coverage and Access to Services

Pilot Expansion of Children's Health Initiatives in County "Incubators"

Annual Cost: $3,000,000 (based on the proposal to King County, cost would be lower for a smaller or rural county

Annual Savings: Improved access and coverage is associated with early detection and intervention and less costly treatment. In San Mateo County, California, the Child Health Initiative program was associated with a 58 percent decline in uninsured hospital stays for children in nearby hospitals.

A Children's Health Task Force (CHATF) convened by King County Executive Ron Sims has recommended that King County move ahead with a three phased approach to improve the coverage and access for low income uninsured children in King County. Implementation of the recommendations requires legislative and budgetary action by the Executive and the King County Council. Information regarding membership and the announcement of this CHATF is available at: http://www.metrokc.gov/exec/news/2006/0522children.aspx

Phase One

The Task Force recommends investing funds to identify low-income children eligible for existing publicly funded insurance programs by implementing a targeted access and outreach program, beginning in Fall 2006. Strategies include funding new outreach staff and community health workers who are trusted communicators to help sign up the estimated 8,000 children for the coverage they qualify for, and to connect them to comprehensive preventive services including oral and mental health and a medical home. Over time, this investment is projected to connect the majority of children eligible for Medicaid and SCHIP to a medical home and health insurance.

Phase Two

Beginning in 2007, the Task Force recommends creating a gap insurance program that would be offered to 5,000 children in families under 300 percent of the FPL or children who are not eligible for existing public or private programs. Children in families over 300 percent of the FPL are not eligible for this gap insurance program. Final enrollment targets will be determined by the level of funding available to the new program.

Phase Three

Governor Gregoire has set a goal for the State of Washington that all children in the state will be covered by health insurance by 2010. By 2010, the King County program should either be consolidated into the state's coverage programs or the state should provide the financial resources to King County to continue this program as a component of the state's overall strategy.

By incubating ideas and spreading evidenced-based strategies to innovate and improve the delivery of services (such a placing behavioral health specialists in clinics to foster an early integrated and preventive approach to mental health), improvements at a county level are right-sized to fund, manage, evaluate and spread. Funding innovative and replicable approaches such as King County's and "growing" CHI's across the state is an idea that has been successful in other states such as California and Vermont.

In addition, the organization of Communities Connect provides the structure to reach into multiple counties for distribution of outreach funding and to capture and share best practices, evaluate the success of new ideas and align this statewide yet locally implemented collection of efforts with the goals of the Commission.

2. ***How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?***

The focus of this proposal is to help achieve the Commission's vision and goals they as relate to children's health. By relying on the spread of evidence-based programs, approaches and strategies with documented improvements, we know that implementation of this proposal will help achieve the Commission's vision and goals.

3. ***Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.***

Yes, our proposal contains elements that exist both in Washington and in other states. For example:

Kids Get Care is currently in three counties and displays an established track record of improving quality while decreasing costs and achieving impressive outcomes as displayed in Appendix A.

The **Children's Health Improvement Collaborative,** now in its third year, is modeled after the extremely successful state Diabetes and Cardiovascular Disease Collaborative which has demonstrated improved quality outcomes while decreasing cost. These targeted approaches utilizing proven QI methodology drive measurable achievements as displayed on the website at http://www.doh.wa.gov/cfh/WSC/.

A series of **Children's Health Initiatives designed** to achieve the same outcomes yet utilizing the strengths and assets differently at the county level is based on successful programs of a similar nature in California and Vermont. Documented success of these programs is available at www.ihps-ca.org and www.med.uvm.edu/vchip/. The Communities Connect organization of county level innovations and achievements in eight critical areas is also representative of national approaches present in 600 communities across the country with information available at: http://www1.leg.wa.gov/documents/joint/HCCA/CommunitiesConnect_7-27.pdf#search=%22communities%20connect%20health%20care%22.

4. ***Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?***

As stated in each of the three sections of our proposal, the cost investments by government to spread an existing program with proven outcomes is matched by an even greater return on investment through cost savings to Medicaid. Implementing meaningful incentives to measure and improve quality throughout the state can produce both program savings and improved health outcomes.

- **Expand the Kids Get Care Program (KGC) statewide:**
  Annual Cost: $1,750,000 for 25 sites
  Annual Savings: $1,775,679 statewide for Medicaid children 1-3 years old, potentially more for other populations

- **Expand the statewide reach of the Children's Health Improvement Collaborative (CHIC):**
  Annual Cost: State funds: $200,000; Federal Match: $200,000
  Annual Savings: Supporting medical practices' participation in quality improvement projects like this learning collaborative disseminates best practices in the delivery of preventive care and chronic care management. Substantial literature documents the cost and health improvement benefits of improving such care. (See Appendix B)

King County Health Action Plan Proposal to the Blue Ribbon Commission on Health Care Costs & Access

- **Pilot Expansion of Outreach and Coverage Children's Health Initiatives in County "Incubators"**
  Annual Cost: $3,000,000 (based on the proposal to King County, cost would decrease for a smaller or rural county)
  Annual Savings: Improved access and coverage is associated with early detection and intervention and less costly treatment. In San Mateo County, California, the Child Health Initiative program was associated with a 58 percent decline in uninsured hospital stays for children in nearby hospitals.

5. How does your proposal reflect collaboration among various stakeholders? Which stakeholders endorsed it?

This proposal represents the collection of three programs. Two of them, KGC and the CHIC were endorsed and launched under the umbrella of the King County Health Action plan, a public-private partnership with Public Health–Seattle & King County and three dozen collaborating members a listing of whom is available at: http://www.metrokc.gov/health/kchap/haproster.htm.

6. What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

The main obstacle to these program improvements is funding and some resistance to developing local responses to outreach gaps. However, investing in evidence-based ways to connect children systematically to preventive services and coverage and to support physicians in their provision of high quality care to young people has the highest return on investment since these children can grow up to lead healthy and productive lives. A relatively small investment relative to overall health care spending can yield substantial future financial and health rewards for Washington State. Tapping into local commitment to carry out outreach and linkage activities and supporting quality improvement efforts are innovative ways to improve health status measures among children that have been stalled at less than optimal levels for many years.

For Additional Information Contact:

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APPENDIX A

Kids Get Care

www.metrokc.gov/health/kgc

Kids Get Care (KGC) is a program to ensure that children, regardless of health insurance status, receive early integrated preventive physical, developmental, mental health and oral health services through attachment to a health care home. To assure access to services, children need both health care coverage and a coordinated delivery system that will assure they get preventive services. The Kids Get Care model contains three basic elements:

1. COMMUNITY ENGAGEMENT: Kids Get Care community health educators train community agency staff (typically child care agency staff) and parents about the importance of prevention, using oral health and developmental red flag identification tools. These staff form a web of community connections around participating clinic sites to support parents and funnel children to services.

2. LINKAGE: Children are linked to a medical and dental home. The prevention messages emphasize the importance of getting services from a regular source of care.

3. SEIZE THE MOMENT: The Kids Get Care case manager helps assure that comprehensive preventive services are provided during the visit, i.e. oral health and developmental screening occur during a regular medical preventive visit. Using quality improvement tools, doctors, dentists, and mental health staff are cross trained to recognize and refer children for needed services in all areas, preferably in the same visit; e.g., dentists ask whether immunizations and well child visits are up-to-date and send kids across the hall to the doctor and physicians do oral health education, screening and apply fluoride varnish. Once the children are getting services, good coverage is critical and the case manager and clinic eligibility workers help the family enroll if needed.

KIDS GET CARE ACHIEVEMENTS 2001-2006

OVERALL PROGRAM ACHIEVEMENTS

Cumulative outcomes, 2001 to 2006	**Total**
Children connected to medical and/or dental homes (a usual source of care)	**22,800 children**
Children scanned for developmental milestones and oral health by community agency staff	**88,000 children**
Community agency staff members or parents trained to provide developmental and oral health surveillance and health care home linkage	**9,300 staff or parents**
Applications of fluoride varnish applied to children 0-5	**7,400 fluoride applications**

INDIVIDUAL CLINIC RESULTS

Outcome	**From**	**To**	**Increase**
Two-year-olds up-to-date with well child checks at three clinics	53% in '01	75% in '03	41%
Children under five assessed by a structured developmental questionnaire in eight clinics	5 in '04	363 in '06	72-fold
Pregnant women and women with young children assessed for maternal depression at one clinic	33% in '04	72% in'06	118%
Women identified with maternal depression connected to appropriate mental health interventions and/or access to appropriate resources	88% in '05	100%	14%
Children under 18 months who received a dental visit in eight clinics (in one clinic **72 %** of 15 month old medical clinic patients had received a dental visit)	337 in '05	688 in '06	104%
Kids and families seen by a Behavioral Health Specialist who are adhering to treatment plans	0 in '03	80% in '04	NA

PARTNERSHIPS AND PRODUCTS

- Partnered with the Access to Baby and Child Dentistry (ABCD) program which recruited and trained 172 dentists and clinics in three counties from July 2002 to February 2006 to treat Medicaid-eligible children under five. ABCD focuses on preventive and restorative dental care for children with an emphasis on the first dental visit by first birthday.
- 603 community staff members and parents were trained on maternal depression and maternal-child oral health issues.
- Produced Developmental and Oral Health "Red Flags" checklists, and an educational video for parents in eight languages explaining Well Child Checks available at www.metrokc.gov/health/kgc.

EVIDENCE-BASED PREVENTION IMPROVES HEALTH AND IS COST EFFECTIVE

Measure 1*: *Children up-to-date with well child visits
Kids Get Care Results: 41% increase in two-year-olds up-to-date with Well Child Checks at 3 clinics, from 53% in 2001 to 75% in 2003.
Associated evidence of cost effectiveness: Medicaid children who are up-to-date with well child checks have a 48% lower chance of having an avoidable hospitalization. (Hakim, *Pediatrics*, 2001) A CHARS analysis shows this equates to annual Medicaid savings of at least $591,893 for two-year-olds only. (UW and KGC cost analysis, 2003)

Measure 2*: *Application of fluoride varnishes on young children
Kids Get Care Results: 7,400 applications of fluoride varnish were applied to children under five at eleven Kids Get Care participating clinical sites from 2003-2006.
Associated evidence of cost effectiveness: Fluoride varnish has been demonstrated to reduce caries by 38% (Centers for Disease Control and Prevention. Recommendations for using fluoride to prevent and control dental caries in the United States. *MMWR* 2001; 50 (No. RR-14):21.) A Washington Dental Service Foundation analysis shows potential savings of roughly $1.5 million statewide if fluoride varnishes were applied during well child visits for children ages under five instead of waiting to pay to fill the cavities that occur without this preventive treatment

Measure 3: First oral health screening by first birthday
Kids Get Care Results: 104% increase from 337 in '05 to 688 in '06 in children under 18 months who received an oral health visit in eight clinics (in one clinic 72 % of 15 month old medical clinic patients had received a dental visit).
Associated evidence of cost effectiveness: Children with early dental visits incur fewer subsequent dental costs. The age at the first preventive dental visit had a significant positive effect on dental-related expenditures, with the average dental costs being less for children who received earlier preventive care. (Savage, *Pediatrics*, 2004)

Measure 4: Use of structured developmental surveys, such as Ages and Stages Questionnaire (ASQ) or Parent Evaluation of Developmental Status (PEDS)
Kids Get Care Results: Three medical practices achieved an aggregate 46-fold in the percentage of children under five receiving a structured developmental questionnaire (the ASQ or the PEDS) during a well-child visit from 5 in 2004 to 238 in March-August of 2005.
Associated evidence of cost effectiveness: ASQs can detect 70 to 80% of children with developmental problems. By contrast, typically only 30% of children with developmental issues are identified before they reach kindergarten (Palfrey et al., *J Peds*., 1994 and Squires et al., *JDBP*. 1996) This detection and subsequent early intervention reduces need for special education and other services later in life–20% do not need special education services at 3 years of age (Washington State Infant Toddler Early Intervention Program (ITEIP) data system).

Kids Get Care Cost Analysis

KING COUNTY HEALTH ACTION PLAN

COLLABORATIVE PARTNERSHIPS IMPROVING COMMUNITY HEALTH

Strategic Pilot Projects

Innovative Policy Design

Convening for System Change

σ

Susan Johnson, Director
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Kids Get Care ensures that children, regardless of health insurance status, receive early integrated preventive physical, developmental, mental health and oral health services through attachment to a health care home. This hand-out presents the program's costs, benefits and potential to reduce health care costs.

PROGRAM COSTS and BENEFITS:

Start up costs: supported by U.S. Health Resources and Services Administration (HRSA) Community Access Program grant to design, develop, implement and evaluate program. $500,000 to $1 million per year over three years.
Short-term on-going costs: $38,400 to pay salary and benefits for one case manager at each site. Five to ten sites can share the services of one $48,000 per year community educator. Total annual case management and community education costs in 2002 at five sites were $240,000.

Table 1. Kids Get Care Costs and Activities, fiscal year 2002

	Number of children	Costs per child per year	Comparisons
Children screened by trained community staff	17,286	$14	
Children with a medical home	4,326	$55	$418 for *kids.health.2001* in Seattle and $268 for Healthy Spokane (Washington Health Foundation, *Kids Campaign Report*, 2002)
Children receiving case management services	1,849	$130	$300 to $500 per year are typical for case management interventions
Population of children at clinics	11,164	$21	Compare to $1.79 pmpm

PROGRAM SAVINGS

Kids Get Care increases the delivery of comprehensive well child visits. Three clinics participating for two years increased their overall rate of two-year-olds up-to-date with well child visits by 41%, from 53% to 75%, representing 291 out of 379 young children. Research shows that Medicaid children who are up-to-date with well child checks have a 48% lower chance of having an avoidable hospitalization (Hakim, *Pediatrics*, 2001). A simulation of what would happen to the number of avoidable hospitalizations for children if Kids Get Care were in place throughout the state was run with statewide CHARS data, see next page.

Table 2. Total costs of avoidable hospitalizations for two-year-olds in Washington State, 2002

	Total	Private insurance	Medicaid	Other
Number of two-year-olds in WA	78,369	48,891	27,492	1,986
Costs of avoidable hospitalizations	$4,984,591	$1,503,062	$3,120,671	$360,858
Number of avoidable hospitalization	1081	499	539	43
Number of admissions from the ER	586	256	306	25
Costs per avoidable hospitalization	$4,613	$3,015	$5,790	$8,392

Table 2 shows that in 2002, Medicaid covered 35% of the two-year-olds in the state, yet it paid 63% of the total costs of avoidable hospitalizations for two-year-olds. Avoidable hospitalizations and their associated emergency room visits are amenable to reduction with appropriate primary care.

Table 3. Simulation of savings if Kids Get Care were available statewide, 2002

	Total	Private insurance	Medicaid	Other
If Kids Get Care were statewide:				
Number of avoidable hospitalizations			442	
Number of admissions from the ER			251	
Savings from hospitalizations			$561,605	
Savings from avoided $550 ER visits			$30,288	
Savings from one- and three-year-olds			$1,183,785	
Total hospital savings for zero to three-year-olds			$1,775,678	
Number of additional Kids Get Care sites at $40,000 per site			44	

Note: A technical appendix is available showing how the simulation numbers were calculated.

In addition to the medical savings identified above, a Washington Dental Service Foundation (WDSF) analysis shows potential savings of roughly $1.5 million statewide if fluoride varnishes were applied during well child visits for children ages zero to five instead of waiting to pay to fill the cavities that occur without this preventive treatment. WDSF, the University of Washington and Medical Assistance are promoting early fluoride varnishes and oral health care through the Access to Baby and Child Dentistry program. Kids Get Care refers young children to ABCD providers at two of its seven current sites in King County.

In summary, it would cost the same amount to continue to pay for avoidable hospitalizations and caries treatment as it would to implement a Kids Get Care site at 44 additional locations and pay for fluoride varnishes throughout the state. Re-engineering the delivery of children's primary care services to provide greater support for preventive services can improve well child visits while reducing unnecessary hospitalizations and cavity treatment.

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

CHI
Child Health Institute
University of Washington

APPENDIX B

Children's Health Improvement Collaborative

OVERVIEW AND PURPOSE

The purpose of the Children's Health Improvement Collaborative (CHIC) is to use quality improvement (QI) methodology and the Breakthrough Series Collaborative (BTS) model to improve the delivery of care for low-income children suffering from specific chronic illnesses and preventive care. In the first two years, known as the Children's Preventive Health Care Collaborative, CHIC focused on spreading the learnings from KGC especially in the areas of well-child checks, early developmental screening, integrated oral health including fluoride varnishes and attachment to a medical home. Now in its third year, CHIC is focusing on improvement of three specific chronic illnesses: asthma, attention deficit/hyperactivity disorder (AD/HD), and overweight which also includes the relationship between nutrition and oral health.

The broader goal is to move from a completed successful pilot stage in 2005 and 2006 and statewide effort in 2007 to a long-term, sustained quality improvement effort in the state of Washington. This will be accomplished by linking to state health policies that pay for quality and enhancing relationships with local, county and state agencies and organizations to reach widely into the network of medical providers who care for low-income children across the state.

Building on the work of several other organizations: the King County Health Action Plan and its Kids Get Care program, the state Medicaid's Children's Health Improvement Collaborative, the Children's Hospital's Children's Obesity Action Team (COAT), the Washington Asthma Initiative and the National Initiative for Children's Healthcare Quality (NICHQ) collaborative work in all three chronic conditions this collaborative will be a quality improvement effort where approximately 8 to 10 medical teams per condition will work to measure and improve the quality of care delivered by their practices.

ACHEIVEMENTS AND COST SAVINGS

CHIC achievements include:

- 23 Clinics/practices participating in first two years
- Year one participants:
  - increased the percentage of children receiving fluoride varnishes from 21% to 42%
  - increased the percentage of children receiving structured developmental questionnaires from 10% to 38%.
- Year Two Year one participants:
  - increased the percentage of children receiving fluoride varnishes from 3% to 70%
  - increased the percentage of children receiving structured developmental questionnaires from 0% to 46%.

Examples from the literature include:

- A RAND Evaluation, Measuring The Effectiveness Of A Collaborative For Quality Improvement In Pediatric Asthma Care, (Schonlau,et al, Ann Fam Med 2005) showed positive impacts on important processes of care and patient self-management practices that have previously been linked to improved health outcomes.
- In another RAND evaluation, Improving Primary Care For Patients With Chronic Illness: The Chronic Care Model, Part 2. (Bodenheimer T, et al. JAMA, 2002), thirty-two of 39 studies found that interventions based on chronic care model components improved at least 1 process or outcome measure for diabetic patients. 18 of 27 studies concerned with 3 examples of chronic conditions (congestive heart failure, asthma, and diabetes) demonstrated reduced health care costs or lower use of health care services.

FUNDING

CHIC is funded by the Washington State legislature through DSHS with additional support from several local funders. The collaborative is staffed by Public Health-Seattle & King County and the Child Health Institute. The Child Health Institute is an inter-disciplinary research group comprised of faculty and staff from the Schools of Medicine, Dentistry, and Public Health and Community Medicine at the University of Washington. More information is available at: www.childhealthinstitute.org.

A sustainable state-wide quality improvement effort focused on children's preventive and chronic care will require an on-going annual base commitment from the Department of Health (DOH) or Health Recovery and Services Administration (HRSA) of $200,000 to be matched by Federal private dollars for a total of $500,000 - $600,000 annually. This level of funding will assure that smaller and rural practices throughout the state are paid for their travel expenses and substitute care and that practices receive the level of support required to assist them in making improvements.

Tab 27

King County
Medical Society

200 Broadway, Seattle, WA 98122-5323
206-621-9396 fax: 206-621-9455
www.kcmsociety.org

July 17, 2006

Washington State Blue Ribbon Commission
on Health Care Cost and Access
Governor Christine Gregoire and Sen. Pat Thibaudeau, Co-Chairs

Dear Commission Members,

On behalf of nearly 4,000 member physicians of the King County Medical Society, we are writing with the hope that you will take full advantage of the historic and timely opportunity you have been given to reshape health care in this state over the next several years. Moreover, we hope that you will take a truly bold course rather than rely on the piecemeal approaches of the past that have failed so abysmally to improve the health coverage and health status of the public.

In the Commission's initial, nine-point vision for the future, all but one item refers to cost in one form or another and it is easy to conclude that this is just another exercise that, despite the high-sounding rhetoric, is all about money. But the high level of health expenditure is important. It is severely straining business and government alike, driving families into bankruptcy and standing between citizens and the care they need with ever increasing frequency and costly results.

It is currently fashionable to talk about evidence-based medicine, pay-for-performance, electronic medical records, personal responsibility and other such ideas. In truth, many of them have merit and are worthwhile in and of themselves, especially for their potential benefits in the areas of quality and safety. Nevertheless, we fear that many policymakers will repeat the mistakes of the past by assuming that these disparate activities will save money on a grand scale. Many of these current trends have huge administrative costs associated with their development and ongoing maintenance and when these costs are taken into account, we believe that the savings realized, if any, will be meager indeed. It is unfortunate, therefore, that so much money and effort are being put into ideas that are likely to have relatively little return on investment. And we find it ironic and somewhat discouraging that no one in a position of influence has yet had the courage to address the single, largest contributor to the high cost of health care, namely, the vast sums of money consumed by the administrative overhead and profits inherent in our antiquated, employer-based, private insurance industry. Thousands of companies administering hundreds of thousands of similar benefit packages with incalculable variations in policies and procedures all siphon enormous amounts of money away from much needed research and patient care. At about thirty percent of the total health care expenditures, this large, untapped resource dwarfs any savings that might be found by tinkering with various bits and pieces of the current system but to date, it has been untouchable. Must we really wait for some unimpeachable corporate leader to stand up and tell us that the health insurance business model is no longer working before real issues are dealt with?

Ultimately, our state, and our country will tackle this issue which is unrivaled among developed nations. We believe that there will be no real progress toward finding an affordable way to improve the overall health of our citizens until such time as the United States makes a firm commitment to the health of its citizens through a well structured national health program that draws on the strengths of its public and private

sectors. Other modern nations spend proportionally much less on health care and get a much greater return on their investment in terms of healthier people. So can we if we put our minds to it.

However, until our society decides to deal with fundamental rather than peripheral issues, we will have to seek improvements incrementally rather than on a system-wide basis and it is with this in mind that we offer two possible ideas for your consideration.

Putting Children First

Our first proposal is that Washington commits itself to providing comprehensive health care to all children age 18 and under, not just poor children, but all children and, of course, this should also include maternity and dental care. The continuing deterioration of private insurance coverage and the many uncertainties facing public medical programs due to mounting federal deficits put children at great risk and, in our opinion, there is no compelling reason for allowing this to continue any longer. Apart from being universally sympathetic, youngsters are relatively inexpensive to care for and are not sufficiently numerous so as to overwhelm the health system. And it seems a good societal and business investment to usher citizens into adulthood with healthy minds and bodies. If we cannot find the wherewithal to do a good job in guaranteeing a high standard of care for our children, it is hard to be optimistic about what we will be able to accomplish for the population as a whole.

This is certainly not a novel idea. Many states are exploring myriad ways to expand health insurance coverage for children. But what we are suggesting that is unprecedented is that Washington becomes the first and only state in the nation to have a truly integrated, systematic and financially stable mechanism for the care of children. Therefore, we recommend creating a program that incorporates the following principles:

1. Universality: All citizens 18 and under will be included. A birth certificate will be the only document required for proof of eligibility.
2. Uniform Coverage Standards: Envisaged here is coverage for a comprehensive set of services similar to that typically found in the health plans of large employers, including dental care.
3. Standard Operating Policies and Procedures: To keep operating overhead to an absolute minimum level, all administrative requirements, e.g., forms, brochures, appeals practices, fee schedules, payment procedures, etc. should be common across all organizations, public and private, participating in the program. Common operating standards would also serve avoid a two-tiered medical system for children.
4. Administration: Similar to the oversight of our nation's financial markets provided by the Federal Reserve Board and the Securities and Exchange Commission, we urge the creation of a single entity, independent of government and the insurance industry, to set standards, monitor performance, enforce compliance, determine financial requirements, obtain federal waivers and make substantive alterations from time to time as necessary for the smooth functioning and integrity of the program. That the U.S. financial services industry is the most reliable, stable and innovative in the world is in no small part the result of the prudent and flexible oversight of publicly chartered, independent agencies. We believe that we should demand no less for the health care of our children.

Strengthen Primary Care

As a second alternative, should the Commission wishes to consider an option more expansive and commensurately more challenging, we would encourage you to think about using the abovementioned principles to provide coverage for primary health care services for all Washington residents. Primary care is where society can get the most value for money, or bang for the buck if you wish. This is where prevention,

health education and early detection take place. It is where physicians and other front-line practitioners can take the time to know their patients, coordinate their care and serve as their advocates in an increasingly complex, fractured, and chaotic system. But our health system is failing primary care by its unwillingness to pay adequately for it and to simplify this critical area of medicine. Fewer and fewer young physicians are choosing the field of primary care in favor of the more lucrative and less hectic specialties. And so devising an approach based on expanding primary care services might serve a dual purpose by raising standards of care generally and, at the same time, fortifying the important front line of health care.

In conclusion, we hope that you will avoid cobbling together the familiar band-aid approaches based on disparate components, leaps of faith regarding future federal participation and the various forms of budget gimmickry characteristic of current and earlier efforts to expand coverage. We hope that you will choose instead to move forward with imagination and courage. Our health system is crying out for orderliness, simplicity and stability and unless our elected officials and other leaders move us in this direction, in five years we will find ourselves continuing to ask why costs are so high and access so low. In the meantime, many ordinary citizens will continue to suffer death and serious illnesses that could have been avoided.

Systems work, chaos doesn't and if we can apply some of the basic principles of industry that have made our economy the strongest and most robust in the world - uniform standards of production, economies of scale, efficient allocation of labor and capital and the like - we will go a long way toward improving the health care and health status of all our citizens at an affordable price. Until we do, we cannot truly lay claim to having the best health care in the world.

There is ample money in our economy if it is spent wisely and there is certainly the skill and talent capable of performing to high standards. What we do not yet have is the political will to make the hard decisions that will be necessary if we are to reverse the downward spiral in our health services industry. In the end, it is more a matter of human values than cold statistics. Like the reasoning behind the laws governing public education, a healthy populace yields a more civil society, a more productive work force and a more reliable stream of taxpayers rather than tax users. And finally, we believe that it is no longer acceptable to ration health care on the basis of a person's employment or health status.

It is clear that our national leaders are not yet ready to take on this challenge and so, as with other complex aspects of our economy, it will fall to a few bold states to show imagination and fortitude in finding workable solutions that can stand the test of time. Starting with ensuring the proper care of mothers and children, or perhaps primary care in its entirety, we hope that Washington can again demonstrate the kind of leadership on health matters that it has in past decades. You have our full support in this very difficult and vitally important undertaking.

Sincerely,

Phillip Chapman, M.D.
President

William Watts, M.D.
President-Elect

Mike Kaminski, M.D.
Past President

Curtis Veal, M.D.
President, 2004

Edward North, M.D.
President, 2003

King County
Medical Society

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206-621-9396 fax: 206-621-9455
www.kcmsociety.org

August 31, 2006

Washington State Blue Ribbon Commission
on Health Care Cost and Access
Governor Christine Gregoire and Sen. Pat Thibaudeau, Co-Chairs

Dear Commissioners,

Shortly before the Commission's July 27 meeting, the King County Medical Society submitted a letter proposing two discrete and carefully defined measures that would go a long way toward meeting your primary objective of affordably expanding coverage to all citizens by 2012. One proposal called for the creation an integrated, comprehensive health system for all children eighteen and under and the other envisaged a similar system that would offer primary care services to all state residents.

While we offer some commentary below on the evaluation criteria for proposals, there cannot be enough emphasis placed on the need to create real systems if the Commission hopes to do anything meaningful over the next five years to increase access without adding burdensome expense and overhead. At the July meeting, the Commission heard from Mr. Porter, Mr. Malooly, and Dr. Mecklenberg of Virginia Mason. Each gave examples of how capacity and quality can be improved simply and inexpensively through the basic R&D and industrial design practices common to industry, but relatively new to health care. But again, these individuals represent organized medical systems that have well defined structures and operating procedures that allow them, like commercial enterprises, to continuously monitor and improve their products and services. These are not the characteristics of the health services industry through which most citizens seek and receive medical services.

The King County Medical Society continues to support the mission and objectives of the Commission and hopes that it will have the courage to break new ground and move this state forward in a manner that brings meaningful improvements to the health and well being of its citizens.

Sincerely,

Philip Chapman, M.D.
President

Charles T. Heaney, Ph.D.
Executive Director

KCMS Comments on Proposal Evaluation Criteria

1. **What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access? Briefly summarize your proposal.**

   While taking an incremental approach, the KCMS proposal goes a long way toward the goal of expanding coverage to all Washingtonians. The universal plan for children speaks for itself while the primary care alternative gives all Washington residents access to the basic services that have the greatest potential for improving health status across all sectors of the population.

   Should either of these two proposals be adopted in this state and result in the quality and efficiency gains that thoughtfully designed systems are capable of producing, it would likely spur whatever efforts are necessary in the future to incorporate any group of citizens left out of either system for one reason or another.

2. **How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?**

   It is hard to imagine how a systematic approach to a universal coverage scheme for children or for primary care would not advance the health status of state residents, reduce significantly the burdensome administrative cost of the present insurance system, and allow resources to be allocated to improving the overall quality and effectiveness of services delivered. Moreover, a major reason for the disparities in health status is the unavailability of medical care services across various sectors of the population defined by race, language, employment status, income and other parameters.

3. **Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.**

   The federal Medicare program for older citizens comes closest to exemplifying the type of system that KCMS has proposed for children and for adults. It is universal in that it covers everyone over the age of 65. It is supported financially through the combination of a dedicated tax, general tax revenues, and the financial participation of beneficiaries. Medicare has a defined benefit package and program-wide operating policies and procedures, all of which change over time as circumstances dictate. Finally, the program devotes considerable resources R&D efforts aimed at quality and efficiency improvements.

   While Medicare is directly administered by government through contracted private intermediaries, the proposals put forth by KCMS do not call for management by government. Instead, they advocate for direction and oversight by an independent, publicly chartered organization that can marshal the best capabilities of the public and private sectors of the health services industry.

4. **Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?**

   With respect to creating a universal health plan for children, there will, of necessity, be new expenditures associated with financing coverage for children who are not currently provided for. These outlays, however, will likely be relatively small and should be easily incorporated into the overall financing structure of the integrated system envisaged by this proposal. According to official state reports, there were about 1.7 million children at or below 19 years of age in 2004. Between the data available through private insurers and state programs, estimating the aggregate cost of caring for this age cohort it should be relatively straightforward.

Moreover, in recent years, thanks to new federal and state funds being made available, many children generally ineligible for basic state programs, have found health coverage. Then there are the children already covered through employer-sponsored health plans and plans purchased by individuals. And so there is already a considerable amount of money currently available for financing health care for children. Any additional expenditure, therefore, would go toward providing coverage for those youngsters who are left out of current public and private financing arrangements.

The same reasoning holds true for the primary care alternative. New funding would be necessary to the extent that individuals without primary care coverage were included or that such coverage that did exist failed to meet the requirements set out by plan specifications.

5. **How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?**

The Medical Society has not collaborated with any individuals or organizations in formulating its proposals. It is the position of KCMS that the systems approach reflected in both coverage strategies presented to the Commission stands on its own merits and reflects the growing sentiment in and outside of the health industry in favor of fundamental change in the manner in which medical services are financed and administered.

It should be pointed out, however, that in 2004, the Washington State Medical Association adopted a resolution sponsored by KCMS calling on the state to appoint a blue ribbon commission to assess the feasibility of achieving universal coverage in the state of Washington. Moreover, at about the same time, Group Health Cooperative also endorsed the principle of universal coverage.

6. **What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?**

There are several. First, as KCMS mentioned in its original proposal, there is lack of political will to confront the longstanding structural weaknesses of the health industry. Second, and closely related, is the predictable and formidable opposition of those interests whose autonomy, financial position or ideological orientation are threatened by the possibility of a stable, well-structured and adequately financed health sector. As in the past, the opponents of change will include certain segments of the provider community, various business interests, private insurers, pharmaceutical and medical device producers, others who fear a lessening of the rewards and influence they enjoy under current industry conditions.

To overcome these considerable obstacles, the essential first step is for state government to firmly commit itself to shaping the principles and priorities that will guide the future development of health services in this state. In the health arena, public policy should no longer be taken to be the collective decisions of numerous private entities guided by their own self interest. The public, through its representatives, must take the lead in this important process if the downward spiral in health care is to be reversed. If this process is undertaken in good faith, the medical community will be a willing participant.

With public priorities clearly identified, negotiations among the various stakeholders on how best to achieve the goals set can proceed with a common purpose.

Tab 28

LABOR READY

Dependable Temporary Labor.

August 31, 2006

VIA ELECTRONIC TRANSMITTAL

Blue Ribbon Commission on
Health Care Costs and Access
P.O. Box 40466
Olympia, WA 98504-0466

Dear Commission Members:

Thank you for the opportunity to contribute to the discussion regarding health care access. Like you, Labor Ready believes that healthy people lead to healthy communities and a healthy economy. Labor Ready thinks it is essential to keep Washington's residents working and to improve the affordability of and access to healthcare. When the Commission develops its recommendations for making healthcare more accessible, we hope that it also considers how the recommendations could impact our ability to put people to work—people who want and need temporary employment.

Labor Ready is a temporary manual labor provider. In 2005, we contributed more than $26 million to the state's economy through wages to our temporary employees. We value our employees, and safety is one of our primary concerns. Workers come to Labor Ready to learn new skills, to earn extra money, when they are in between jobs, or because they prefer the flexibility that temporary employment offers. Labor Ready dispatches workers primarily to customers in the construction, light-industrial, and manufacturing industries. Many of our customers are small businesses working on special projects, temporarily replacing absent employees, or looking for new employees through a working interview.

Labor Ready also employs more than 400 regular, full-time employees at its corporate office in Tacoma and our 28 state branches. Our staff members receive benefits, including health insurance, once they have worked for the company for 90 days—a typical probationary period established by many of the state's employers.

However, the average temporary worker remains with Labor Ready for only 150 hours before being hired permanently or moving on. A worker may stay for just a single day. Others may work for us for five days in January, three days in March, ten days in June, and ten more in December. Administering healthcare benefits for such employees would be nearly impossible and certainly burdensome, no matter how

those benefits are structured. Furthermore any increase in costs would simply be passed onto our customers, which would not only hurt small businesses who use temporary labor but also reduce the demand for temporary workers who need or want to work.

We ask that you consider the impact any proposals will have on the state's temporary workforce and include provisions that will allow us to continue putting so many people to work. We would be happy to discuss any proposals and the possible impact they could have on temporary employers and temporary workers.

Respectfully,

/s Lisa Lawrence
Corporate Counsel

Natalie McNair-Huff
Gov't. Relations Coordinator

Tab 29

Proposal to the Blue Ribbon Commission on Health Care Costs & Access
Lifelong AIDS Alliance
September 2006

Introduction

A growing body of research in the field of medical nutrition therapy (MNT) supports what families and caregivers have known for years—*good food is good medicine.*

Proper nutrition is essential for good health, and ignoring this simple preventative step carries enormous costs:

- Recent research by the national Association of Nutrition Service Agencies (ANSA) and the Congressional Hunger Center (CHC) shows that, for Americans living with diabetes in 2003, diet-related disease complications resulted in $2.2 billion charged to Medicaid, with an additional $419 million in hospital costs incurred by people without health insurance.
- Nationally, 29% of HIV/AIDS patients receive Medicaid, but these clients comprise the majority (53%) of AIDS-related hospitalizations. ANSA and CHC report that people living with HIV/AIDS have energy needs up to 30% higher than is normally required to maintain weight. Weight loss is linked to mortality in AIDS patients.
- The Centers for Disease Control and Prevention estimate the total direct and indirect costs of diabetes in the U.S. to be $132 billion—largely the result of disease complications related to diet.
- Poverty is linked to obesity, and people who are obese are at increased risk for heart disease, high blood pressure, diabetes, and some cancers. The CDC estimates that total direct and indirect costs of obesity to be $117 billion.

Access to healthy foods is often limited for people living in poverty. For those with diabetes and heart disease, prevalence and mortality are highest among Washington State residents living below the federal poverty level (Washington State DOH, *The Health of Washington State 2002 and 2004 Supplement*). Good nutrition offers a solution to many significant, costly, and preventable health concerns:

- A Department of Defense study of healthcare service utilization by military personnel and their dependents showed that, for patients receiving medical nutrition therapy, service utilization was reduced 9% to 17% for people with diabetes, 9% to 13% for people with cardiovascular disease, and 7% to 20% for people with renal disease.
- ANSA and CHC report that nutrition therapy can compensate for malabsorption of nutrients due to infections and medication side effects in people with HIV/AIDS.
- For diabetes patients, studies show that better blood sugar control reduces the risk for eye disease, kidney disease, and nerve disease by 40%.
- The CDC notes that good nutrition can have a dramatic impact on the prevention and control of obesity-related diseases, including heart disease, high blood pressure, diabetes, arthritis-related disabilities, and some cancers.

Since 1983, Lifelong AIDS Alliance has worked to improve access to health care for marginalized and impoverished populations affected by HIV/AIDS in the Northwest. Our nutrition program has been a powerful tool in this effort. *Chicken Soup Brigade: Lifelong's Food Program* has evolved from a palliative care program to a comprehensive nutrition therapy resource that produces measurable improvements in nutritional health and self-sufficiency for homebound, low-income individuals in

King County. In 2005, we expanded our nutrition services to people with illnesses other than HIV/AIDS. Now, working with partners such as Northwest Kidney Centers and the City of Seattle-Human Services Department, we work at the forefront of a new approach to improving public health while reducing overall health care costs. Through the production and delivery of medically-appropriate meals to poor, sick, and homebound King County residents, we use a system of outcomes measurement to document improvements to the health and self-sufficiency of our diverse clientele.

What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access?
We propose a collaborative research project that measures the health care benefit and savings produced in the course of administering medical nutrition therapy to low-income King County residents with chronic illnesses. Data from this study will show the public health benefit and Medicaid cost savings produced through application of MNT for low-income state residents with chronic illnesses. Results may suggest Medicaid coverage of nutrition therapy for Washingtonians, producing both improved health and substantial savings.

Chicken Soup Brigade: Lifelong's Food Program—in partnership with leading Northwest service providers— leads a regional conversation exploring the nexus between poverty, nutrition, and illness. Research continues to show causation between these crises:

- In February 2005, the Associated Press reported that 38% of those filing for bankruptcy had lost their job and insurance due to illness.
- The American Society for Nutritional Sciences reported in 2003 that "household food insufficiency was associated with higher rates of heart disease, diabetes, high blood pressure and major depression."

Most hunger relief resources in our region do not recognize the relationship between poverty and illness. Nutritional services are generally limited to several categories, most of which are geared towards ambulatory individuals or those with some financial resources:

- Food banks offer food but have limited capacity for delivery, no nutritional counseling, and often rely on donated products that exacerbate obesity prevalent in impoverished communities
- Meal delivery service through Senior Services' Meals On Wheels program charges a fee for customers under 60 years of age, and has limited options for specific dietary requirements
- Congregate meals at churches and community centers offer prepared lunches and dinners but offer little or no selection, and require diners to be mobile enough to attend

For people living with HIV/AIDS, chronic kidney disease, diabetes, cancer and other illnesses, adequate nutrition is essential for maintaining proper weight, good health, and a strong immune system. The challenges of battling chronic illness leave many people too tired or sick to manage a healthy diet. The need for good nutrition is exacerbated by diseases and medications that affect digestion, and by the financial hardship that often accompanies chronic illness.

Chicken Soup Brigade is the only nutrition program in the Puget Sound region that delivers nutrition therapy free of charge to people living in poverty with life-threatening illnesses. With broad support from corporations, foundations, and individuals, we serve people with needs unfulfilled by conventional hunger-relief efforts. In 2005, we expanded our nutrition program to serve people with

illnesses other than HIV/AIDS. Now, with new collaborations and an increasingly diverse core of supporters and clients, our nutrition program is setting new standards for hunger relief organizations in our region. We work to achieve outcomes rather than outputs, tracking clients' progress and ensuring that our services improve their lives. As a result, our data confirm that our services make a real difference in our clients' health and well-being:

- 73% of clients report that our food program helps them live more independently
- 82% report eating more nutritious meals as a result of our program
- 71% report reduced household financial anxiety
- 60% demonstrate improved nutritional health as determined by our team of registered dietitians

While we demonstrate programmatic effectiveness through outcomes measurement, more research is needed to definitively show that MNT reduces the rate of preventable, diet-related disease complications and corresponding health care costs. We propose utilizing one full-time researcher to compare one year's health care costs for approximately 300 low-income people receiving MNT, compared with to the health care costs of 300 similar individuals without MNT.

Washington State deserves a comprehensive research project to measure health care savings produced in the course of medical nutrition therapy. In the service of our state's effort to produce affordable, effective health outcomes for all state residents, we hope you will consider this proposal, and join us in further study of this important preventative tool.

How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

With our attention to measurable outcomes and our knowledge of preventative dietetic care, Lifelong AIDS Alliance and *Chicken Soup Brigade* share the Commission's commitment to improving the quality, access, and affordability of health care in our state. While studies show the value of MNT in disease treatment as well as connections between diet and disease complications, there is little definitive data showing the direct benefit of MNT on Medicaid costs and other health costs in Washington State. With the support of the Commission, Lifelong AIDS Alliance will produce this data and help the Commission achieve their vision and goals.

With overwhelming evidence in favor of diet-related interventions for preventable illness, MNT will play a vital role in achieving the Commission's goals:

- Improved Access—by extending *Chicken Soup Brigade's* MNT to more low-income state residents, we will improve health care access and raise awareness of proper nutrition among a traditionally high-risk group.
- Improved Health—in 1999, coronary heart disease was the principal hospitalization diagnosis for 27,707 Washington residents—a rate of 511 per 100,000 people (heart disease is the leading cause of death in Washington and the U.S.). Diabetes was associated with 56,485 hospitalizations in Washington in 1999—a rate of 1,038 per 100,000. Washington State DOH reports that "many of these hospitalizations could have been prevented through early detection and appropriate management of diabetes" (Washington State DOH, *The Health of Washington State 2002*).
- Improved Affordability—a 1999 study of patients of Group Health Cooperative of Puget Sound showed that, for patients with diabetes or cardiovascular disease, MNT was

associated with a reduction in utilization of hospital services for patients with diabetes (9.5%) and for patients with cardiovascular disease (8.6%). Also, utilization of physician services declined by 23.5% for MNT users with diabetes and 16.9% for MNT users with cardiovascular disease.

Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.
We will model our research on recent work by ANSA and CHC (cited above) and on our pending collaboration with the City of Seattle's Medicaid Savings Project.

The city of Seattle is implementing a Medicaid Savings Project to explore appropriate service interventions for medically complex patients with high Medicaid utilization. City staff will identify and implement preventative services—including MNT—that match the client's chronic care needs. The goal is to ensure that available Medicaid resources are being used in a cost-effective manner in order to obtain optimum value for both the client and the State of Washington DSHS. The result will be healthier clients of Seattle's Aging & Disability Services—and significant Medicaid savings for Washington State.

Will our proposal impose costs on individuals, businesses or government? Will these costs be time limited or ongoing? Can you estimate how much these costs will be, or suggest how such an estimated could be made? How much, if any, of these costs will be offset by corresponding savings?
With the cost of *Chicken Soup Brigade's* nutrition services currently less than $2,000 per client annually, MNT is likely to be a highly affordable alternative to costly diet-related complications of diabetes, HIV/AIDS, chronic kidney disease, and other diseases. The long-term savings and health benefits produced by both this research project and subsequent application of preventative nutrition therapy to high-utilization Medicaid patients would easily justify the initial cost of this research.

Washington State DSHS has a history of success with preventative treatments that reduce Medicaid spending. A 1997 briefing paper by DSHS, *Cost Savings in Medicaid Medical Expenses: An outcome of Publicly Funded Chemical Dependency Treatment in Washington State,* showed that chemical dependency treatment for indigent state residents—with an average cost of $2,300 per treatment episode—resulted in an average savings of $4,500 over a five year period and an impressive $7,900 average savings for clients with histories of Medicaid-funded care.

With your partnership, *Chicken Soup Brigade* would be honored to assist in measuring the cost savings produced through preventative MNT for low-income patients with heart disease, diabetes, HIV/AIDS, and other chronic illnesses. We are already starting this work. In collaboration with the City of Seattle-Human Services Department, *Chicken Soup Brigade* will provide MNT for the City's upcoming Medicaid Savings Project for their clients with high Medicaid utilization.

How does you proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?
The successful expansion of our food program's services has resulted in powerful collaborations with Northwest Kidney Centers, Seattle Housing Authority, and City of Seattle-Aging & Disabilities Services. Also, key funders have supported our work and celebrated our success, including the Paul G. Allen Family Foundation, The Foster Foundation, the Boeing Employees Community Fund, The Seattle Foundation, MAC AIDS Fund, and Microsoft Corporation.

What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?
Challenges to completing this research include identifying appropriate research partners, providing clients with incentives to participate, and securing funds for research and service implementation to appropriate subjects. But with *Chicken Soup Brigade's* fully-equipped production facilities and our staff of experienced dietetic professionals, costs of service implementation to study subjects would be minimal, and many of our new and ongoing clientele would be likely candidates for this project.

Thank you for the opportunity to submit this proposal. We look forward to working further with the Commission, and using our dietetic expertise to help achieve our shared goal of accessible, affordable, quality health care for all Washingtonians. If you have any questions or require additional information, please do not hesitate to call. We look forward to hearing from you.

Sincerely,

Tina Podlodowski
Executive Director, Lifelong AIDS Alliance
1002 E Seneca St
Seattle, WA 98122

Phone: 206-957-1600
E-mail: tinapo@llaa.org

Tab 30

September 1, 2006

TO: Members, Blue Ribbon Commission on Health Care Costs & Access

FROM: Carolyn Logue, Washington State Director
National Federation of Independent Business

RE: Submission of Proposals and Concepts for Consideration by the Commission

For the nearly 15,000 small business members of the National Federation of Independent Business (NFIB) in Washington State, health care is a top concern. Often these small business owners cannot find health care for themselves and their own families, but more frequently they cannot find or afford health insurance for their employees. This leaves them struggling for good employees as they compete with larger companies. It also pains them as they watch good employees (who are often friends) struggle with health problems.

However, the reality for small business is that even in a perfect environment, many would not be able to afford health care for their employees. The profit margins in these businesses are low and labor/other fixed costs are high resulting in situations where there will never be enough money to add in another cost without impacting wages paid to employees or even the ability to keep the job in the business. It is for this reason that NFIB continues to OPPOSE any proposals that require employers to pay for health insurance, we firmly believe that whether or not health insurance is provided by the employer is part of the overall compensation package – a package that must be flexible to meet the needs of both the employer and the employee.

Below are several ideas that we would like the Commission to consider as it evaluates proposals and plans. We feel strongly that these ideas will help formulate a direction towards cost savings in our health insurance system. They will achieve the goals and vision of the Commission in that the lower the cost, the more access small business and their employees will have in the system and fewer people will be uninsured. With fewer uninsured, more people (both children and adults) will have access to the health care system and thus a healthier population should result. We do believe, however, that no one of these ideas will solve the problem on its own. They, along with ideas from others, must be put into a menu from which multiple selections should occur.

- **Focus on the private sector**: From a small business perspective, the first priority should be to look at cost reductions in private sector insurance rather than simply layering public programs on top of the current system or putting public and private programs in competition with one another. According to NFIB surveys, while public programs are viewed as a safety net or last resort, the private sector is where small business owners want to purchase health insurance. We need to look at other states that have more private health insurance companies in their market and attempt to mirror regulations in those states in order to attract additional companies to the state. It should be a priority of the Office of Insurance Commissioner to increase the competitiveness of our market place since this competitiveness can benefit citizens as insurance companies vie for their health insurance dollars. Competition spurs innovation and creativity which can only benefit our health care system. Also, by building up the competition in the private sector and revitalizing all of our private health insurance markets, the state should not have to spend a dime other than potential staff costs for reviewing and revising regulatory requirements. In addition, a stronger, more affordable private market should reduce pressure on public programs as more people are able to find health insurance without help. An added benefit is that the more families are able to afford health insurance in the private market, the more children will be covered.

- **Change Our Rating Laws**: In order to make our state more attractive to other insurance companies and to allow more diversity in the premiums available to small businesses and individuals, we must look at how we determine insurance rates. The state should focus on other states that have a large number of health insurance plans along with a greater range of price options for individuals and small businesses. Our community rating laws, while helping some individuals, have helped increase our number of uninsured by increasing the price for young, healthy people to a point where they no longer see a benefit to justify the cost of having insurance. Allowing additional rating factors or allowing an insurer more ability to deviate rates within small group plans based on additional factors would help ensure lower cost plans are available to encourage younger, healthier people to get into the market – and a socialized system like health insurance needs more young, healthy people in it. One suggestion comes from Wisconsin which allows some variation for health status within a band similar to the age band we have now. This allows variations in price to reflect the actual costs driven by the group or individual but keeps limits and boundaries on the top and bottom numbers.

- **Prioritize existing public sector spending**: With the goal to cover all children by 2010, it is imperative that the state get its own house in order before requiring any additional spending. A complete review of state priorities in health care spending must be done quickly. This would include all spending in health care from all areas of government with a goal of maximizing existing dollars to meet priorities. If covering all children is a priority, then the spending plan using existing dollars should reflect that priority. A thorough discussion of the "what" government should pay for also must be done. No additional state health care programs should be set up and no additional spending should be done until this task is complete, reviewed and fully vetted.

- **Determine Plans by Price**: The state should contract with a certified actuarial firm to provide the legislature with five plan designs, not subject to any coverage, service or administrative requirements in Title 48 RCW. These plan designs will include cost-effective coverage at the following price points:

  $50 PMPM
  $75 PMPM
  $100 PMPM
  $125 PMPM
  $150 PMPM

  The report will include a detailed listing of the covered services, providers and conditions for each plan, deductible amounts, co-pays, and other out of pocket costs. The report will also include a listing for each plan of the statutory and regulatory requirements in Title 48 that would have to be repealed or revised to allow each plan to be sold in the private insurance market. This can be used to determine minimum coverage requirements in the state based on price rather than benefits or providers. The idea would be to see how the best coverage could be obtained for an affordable price.

- **Focus on individuals**: One of the best ways to meet the Commission's visions of improving health and improving affordability is to make it easier for individuals to obtain their own health care and insurance rather than creating dependency on employers or government. The more individuals are responsible for their own costs, the more thought will be given to lifestyle choices and the price of goods and services. The more individuals have access to their own health insurance, the less government will have to spend on uncompensated care and the less dependency there will be on an employment-based system. It is also much more preferable, according to NFIB members, for the government to serve as a safety net for individuals in health care, not businesses.

- **Make it a priority to bring more competition back to the individual market**: We need more than just three or four carriers to ensure the number of plans that would truly make our individual market competitive. To increase access, there need to be hundreds of plans available to individuals. To reduce costs, these plans must compete with each other for the same pot of money. To improve health, these plans must compete with each other to provide the best benefits for the least amount of money in order to attract the larger customer base. This should be a focus of the Office of the Insurance Commissioner. It is imperative that he bring back a vibrant and healthy private individual insurance market.

- **Strengthen the ability for individuals and small businesses to have Health Savings Accounts:** These accounts can help people better afford good catastrophic care and avoid bankruptcy. They also are the best way currently that individuals can obtain tax savings for purchasing their own health care. By helping small businesses purchase these types of plans for employees through removing the attached high deductible plan from

our existing small group rating pools, the plans will become more affordable and the small business owners will be better able to help with deductibles. In addition, the more employers are able to get help get employees started with HSAs, the more individuals will be able to afford their own health insurance once they leave that employer.

- **Allow Limited Benefit Plans:** Offered in other states, such as California, these plans provide first dollar coverage with caps rather than catastrophic coverage. They are very affordable ($35-$40) and can be a means in which an individual can provide up front coverage for themselves to enhance an employer's catastrophic plan. Or, the small business can offer the Limited Benefit Plan to enhance and help the individual who has an HSA. They can also be a great way to cover children who often just need basic preventive care. Many parents would be able to afford this coverage and reduce dependency and cost for government programs.

- **Allow Subsidization of Deductibles, Not Just Insurance:** The state should explore the cost of assisting individuals with the deductibles in HSAs rather than always subsidizing the total insurance package. Many individuals may be able to afford a high deductible premium but would have trouble with the upfront deductible costs. If the state looked at the cost of allowing the individual to buy their own HSA and then helped with a Limited Benefit Plan and the deductible amount, it may actually end up with reduced government costs while providing the same benefit for the individual. With the caps on both Limited Benefit Plans and HSAs, the government would have more surety in its cost projections. In addition, by building up the HSA, more people may be able to migrate out of state programs and not need the subsidies after a few years. In addition, they would have more incentives to save their deductible amount since it would build. The Limited Benefit Plan would cover the preventive care. (Another benefit is that the subsidy would actually go to the needy family, not the insurance company).

NFIB is constantly surveying its members to determine their positions on health insurance issues and the above ideas are just some of the suggestions that have come forward. We appreciate the opportunity to have input into the Commission's discussions and will continue to survey our small business members to determine their positions on other suggestions as they arise.

Please feel free to contact me if you have any questions at 360-786-8675.

Tab 31

A Washington State Plan to Reduce Avoidable Falls Injuries and Deaths

Among Older Adults

for the

Washington State Blue Ribbon Commission on Health Care Access & Cost

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1. Proposal Summary and Background

Summary

Falls are a major health problem among older adults.[1] Falls injuries in older adults are the leading cause of injury hospitalization in Washington State,[2] as well as nationally.[3] These preventable injuries create a financial and utilization burden on all segments of our health care system, and threaten the independence and quality of life of our aging population. Many falls in older adults can be prevented.[4] Washington State can help empower our aging population to stay healthy, safe, active and independent for life by implementing a strategic plan which facilitates and funds effective, sustainable falls reduction interventions. This plan will create the sustainable state and local infrastructures, interventions and system changes needed in our health care and aging services systems to contain falls-related costs and improve the quality of and access to health care for all citizens. Reducing falls injuries in older adults will also be an important step towards helping Washington become one of the top ten healthiest states in the nation.

The purpose of this proposal is to demonstrate that a statewide falls reduction plan meets the goals of the Washington State Blue Ribbon Commission on Health Care Costs and Access. By providing evidence based falls prevention best practices and lessons learned from community-based research conducted by the Washington State Department of Health's Injury and Violence Prevention Program in partnership with the NorthWest Orthopaedic Institute, health care costs to Washington State for older adults can be contained, and possibly reduced. The two key elements to ensure the success of this proposal are to:

- Ensure that best practices and evidence based interventions are applied
- Increase collaboration of agencies and organizations at state and community levels to capitalize on, mobilize and maximize existing resources

This proposal is designed to strengthen systems development for cross-program, cross-agency and cross-organizational work at state and community levels for reducing avoidable falls among older adults. This goal is in support of the Blue Ribbon Commission's initiatives to reduce costs in health care, and provide evidence based best practice care standards, and involve the patient in their individual care.

The goals[5] of this falls reduction plan are to:

- Reduce the hospitalization rate for falls among adults age 65+ by 10% from 1,667 per 100,000 in 2004 to 1,500 per 100,000 by 2010.
- Reduce the death rate for falls by 10% from 8.8 per 100,000 population in 2004 to 7.9 per 100,000 population by 2010.

Background

Falls and fall-related injuries have a significant negative impact on individuals, communities, and our health care system. The major risks for falls are related to many modifiable factors associated with health and aging, such as medication side effects, weakened balance and muscle strength which affect mobility, and changes in vision and hearing. As the population ages, this problem will only become more prevalent. However, many falls and fall-related injuries can be prevented. According to the Centers for Disease Control and Prevention:[6]

- More than one third of adults age 65 or older have suffered a fall in the last year
- Among older adults, falls are the leading cause of injury deaths and are the most common cause of injuries and hospital admissions for trauma

- 90% of all hip fractures result from a fall; 20% of those individuals who survive a hip fracture are never able to regain independent living
- By 2020, the estimated national annual cost for fall-related injuries for people age 65 and older is expected to reach $43.8 billion.

Washington State data on falls among older adults

Washington has one of the most rapidly aging populations in the country. In the past decade, the state's population of people age 65 or older increased by 15 percent. Washington's population age 65 and over, estimated at 711,810 in 2005, and is expected to reach 1.2 million by 2020. The population age 75 and over is expected to show the most rapid growth after 2015 when the Baby Boom generation reaches this age.[7]

Falls among older adults are the leading cause of injury-related hospitalization in Washington State, with 11,615 hospitalizations in 2004.[8] The hospitalization rate for falls among adults age 65 and older increased 12% in Washington since 1994.[9] In Washington State, there are four times as many hospitalizations due to falls among older adults than hospitalizations to motor vehicle occupants *for all ages combined.* Yet, while there are substantial resources devoted to the prevention of motor vehicle accidents, resources for preventing and reducing falls in older adults have been very limited and difficult to access.

Because falls and falls injuries often reduce mobility and independence, they are a common reason for admission to long term care facilities. Among Washington older adults who were hospitalized due to a fall in 2000, less than a quarter (22 %) was able to be released to their home under self-care. Nearly two-thirds (64%) were transferred to skilled nursing facilities or intermediate care facilities for additional care. While many skilled nursing facility admissions are short-term, falls remain a strong predictor of long-term placement in long term care facilities.[10]

Health care cost impact of falls injuries

Falls and falls injuries have a significant cost impact on all segments of the health care system, from emergency medical systems to long term care. The emergency medical system is especially increasingly overburdened.[11] Reducing falls and thus falls injuries in the growing aging population must be addressed in order to contain health care costs, and improve quality of care. Containing and reducing health care utilization for falls can increase access to health care for all Washingtonians.

Nationally, at 34% or $26.9 billion in 2000, falls represent a greater percentage of injury-attributable medical costs than any other injury mechanism, even exceeding the medical costs due to motor vehicle accidents. By far, the greatest costs are incurred among the 65-year old and older group. By themselves, females aged 75 years and older represent approximately 26% of the total medical costs of all fall-related injuries. By 2020, the estimated annual cost for falls-related injuries for people age 65 and older is expected to reach a staggering $43.8 billion.[12] If Washington State can save even a fraction of that $43.8 billion, there will be a significant reduction in health care spending, including long-term care costs.

Expenditures for falls include health care provided by emergency medical systems (EMS), transports, emergency departments, hospitals, skilled nursing facilities, home health and hospice care, in-home chore services, physician offices, ambulatory surgical centers, rural health clinics, durable medical equipment and prescription medications, and hospital re-admissions. The primary health care cost data currently available for falls-related injuries is on injury hospitalizations; this data does not include health care costs for care required after initial hospital discharge, costs for injured older adults who require EMS care without transport to

emergency departments, or costs for those who independently seek care in ambulatory care settings.

Hospitalized injured older adults accrue 15% more trauma care costs and need longer hospitalizations than younger adults.[13] Health care costs after hospital discharge, as described above, can equal or exceed initial hospitalization costs. According to the Northwest Physicians' Network in Tacoma, in Pierce County in 2005, the average cost to their Medicare managed-care enrollees for one falls injury hospitalization was $17,741; this does not include any after-discharge care costs. Projecting this cost figure for Washington State's 11,615 falls injury hospitalizations in adults age 65 and older in 2004 results in a 2004 initial hospitalization cost of $206,061,715 for these falls injuries, and falls injury hospitalizations are increasing yearly.

Washington State falls reduction efforts

In the past five years, Washington State has been involved in a number of initiatives to raise awareness regarding the problem of falls in our state and to implement falls reduction strategies with best practice interventions. The progress made in addressing this issue with these initiatives has now positioned Washington State far ahead of most states in the country.

In April 2006, in recognition of the seriousness of this problem for older adults, Governor Gregoire issued a proclamation declaring September 21, 2006 "Falls Prevention Awareness Day." This proclamation is currently being used to raise public awareness and facilitate the development of community partnerships to sponsor health and safety events in communities around the state.[14]

In 2001, the Washington State Department of Health's (WA DOH) Injury and Violence Prevention Program began to seriously address this critical problem with two Centers for Disease Control and Prevention and Control (CDC) funded grants. The first grant was used to research, identify and publish evidence-based falls prevention best practice strategies in the report "Falls Among Older Adults: Strategies for Prevention" which was published in 2002.[15]

The second CDC grant (a four year grant which ends October 31, 2006)) was used to design, implement and evaluate a community-based targeted injury prevention intervention for falls in older adults. This resulted in the Senior Falls Prevention Study, a randomized, controlled trial conducted in partnership with the NorthWest Orthopaedic Institute in Tacoma and the Spokane Regional Health District. The intervention strategy included implementation and evaluation of the evidence-based, best practice public health falls prevention interventions of individual risk assessment, education and strength and balance group exercise classes. Study participants included 453 community-dwelling older adults (age 65-96 years) in Pierce and Spokane Counties. This study showed that over a 12 month period, those who participated in these interventions significantly improved their strength, balance and mobility ($p<.05$), reducing their risk for falls; and had 25% less falls than the control group ($p>.05$). Additionally, 78% of all study participants were empowered to modify one or more of their modifiable individual falls risk factors by receiving evidence-based falls prevention information.

The CDC grant-funded research also included falls prevention knowledge, attitude and practice studies of key informants in health care and aging service organizations[16] and older adults[17]. Focus groups of older adults were also conducted to explore falls prevention exercise program motivators, barriers and key messages.[18] Using this data, an exercise program, education and individual risk assessment tools,[19] and marketing messages have been developed for dissemination, along with public and professional education presentations. A geographic information systems approach for older adult community falls prevention program site selection planning has also been developed.[20]

Based on data obtained in the study from the collaboration of state and local organizations, implementing falls prevention best practices at the local level improves health outcomes in older adults. The WA DOH Senior Falls Prevention Study demonstrated a need for statewide infrastructures for a sustainable falls prevention plan to reduce falls injuries in the growing Washington State aging population.

Proposal timing and opportunities

The proposal timing seeks to extend and broaden the impact of the WA DOH Senior Falls Prevention Study to seniors throughout the state by building on the research that has been accomplished in the past five years and the resulting rapidly growing interest and momentum in this area in Washington State. This falls reduction plan reflects the next steps in implementing the lessons learned from the WA DOH Injury and Violence Prevention Program's research and community partnerships in the area of falls prevention since 2001.

In March 2006, a reorganization of the Department of Health placed the Injury Prevention Program into the Office of Emergency Medical Services (EMS)/Trauma Systems. This reorganization provides a tremendous opportunity to enhance linkages of the public health injury prevention program and the EMS/Trauma system. By statute, Washington's trauma system continuum spans prevention, emergency medical services, acute care and rehabilitation. Falls among older adults was identified by the EMS/Trauma System Technical Advisory Committee for Injury Prevention and Public Education as one of its two main priorities, with the other being motor vehicle crashes.

In addition to the tremendous opportunity that Washington State now has to integrate falls risk assessment and prevention into the EMS/Trauma system, it is clear from the work accomplished over the past four years that the path to sustainability is to integrate falls prevention best practices for falls prevention into a spectrum of existing organizational structures. In addition to the EMS/Trauma system, these primarily include:

- Area Agencies on Aging and aging services, including senior centers and meal sites
- Trauma, acute, subacute, home health and ambulatory health care systems
- Public health departments
- Parks and recreation organizations
- Residential facilities for older adults (independent and assisted living)

State level strategies now needed to reduce falls injuries in older adults

Building on national and international research findings, along with the results of four years of research conducted by the WA DOH and the NorthWest Orthopaedic Institute, the Pierce and Thurston County Falls Prevention Coalitions and the Physical Therapy Association of Washington recommend and submit the following strategies:

A. The development of a statewide falls prevention campaign to reach the systems and professionals who serve older adults, and their families and caregivers. This campaign would be implemented through state and local infrastructures, and should include the following elements:

- A social marketing campaign to increase public and professional awareness that in Washington State the health, safety and independence, and active aging in place of older adults is valued and supported, and that many falls in older adults can be prevented
- The development and integration falls reduction strategies into the emergency medical system by exploring alternative health care transportation options, prevention, and

health care reimbursement strategies and options to reduce emergency room utilization for falls injuries in older adults

- The implementation of evidence-based best practice exercise (strength and balance) programs for community-dwelling older adults at all senior centers, senior meal sites, parks and recreation facilities, independent living facilities, and for homebound frail older adults receiving in-home care, in assisted living residential facilities, and adult group homes so that all older adults have access to this intervention
- The integration of falls prevention best practice education, information and resources into ongoing training programs for home care workers, senior service professionals and case managers, health care providers and allied health professionals
- The integration of falls prevention risk assessment screening and education into all points of contact for older adults in the health care system and senior services, and into health care electronic medical records systems

B. The development of falls prevention infrastructures at state and local levels:

- The state level through creating state funding for a formal joint position between the WA DOH Injury and Violence Prevention Program, (which is based in the WA DOH Health Systems Quality Assurance Division, Office of Emergency Medical and Trauma System), and the Washington State Aging and Disability Services Administration. This position is specifically needed to establish a state-level collaborative infrastructure to facilitate and support the local level infrastructures needed to create linkages for evidence-based best practice dissemination and prevention-based system changes. Linkages that need to be formally created at the state level through this joint position to contain falls-related health care costs include:
    - Area Agencies on Aging* (13 are in Washington State that cover our 39 counties)
    - Emergency medical and trauma systems
    - County public health departments
    - Acute, ambulatory care, home health and long term health care systems
    - State associations for health care providers, allied health care professionals, pharmacists, senior centers, parks and recreation organizations, and assisted and independent living residential facilities
    - Businesses and non-profit organizations that meet the needs of older adults

  *Washington State Area Agencies on Aging, as the community gateways for senior services, are the best positioned community agencies to coordinate aging services and system changes from the state to the local level.
- The local level through creating funding for Area Agencies on Aging in Washington State to convene regional or county falls prevention coalitions. Community falls prevention coalitions (as currently evidenced in Pierce and Thurston counties), adapting identified state and national strategies,[21,22] have proven to be essential and successful in forming local level collaborative partnerships and for create new linkages for the dissemination of evidence-based falls prevention interventions, which include:
    - Exercise (strength and balance) programs for older adults
    - Individual falls risk assessment
    - Public and professional education needed to address falls in older adults
    - Home safety modification programs

2. The Falls Reduction Plan Achieves the Commission's Vision and Goals

This falls reduction plan addresses the long term core issues needed to reduce falls injuries and realizes the vision and goals of the Blue Ribbon Commission in several ways:

First, the plan provides the education to health care providers and professionals that is necessary for evaluating and managing falls risks in older adults. Unfortunately, most health care providers treat patients for injuries after a fall has occurred, instead of educating patients on how to prevent falls from taking place. All Washington consumers would benefit from improving the quality of health care by creating access to falls prevention information and resources.

Second, this proposal improves the health and quality of life of Washingtonians by reducing falls-related injuries. Many older adults are aware of and concerned about balance, strength and health issues which can negatively impact their quality of life, as well as lead to falls. Many health care providers, such as physical therapists, have extensive knowledge of balance and mobility science, and interventions. However, consumers do not have adequate access to falls prevention information and these health care resources, resulting in unnecessary and preventable injuries.

Third, evidence-based falls prevention interventions have shown good health outcomes in older adults. The WA DOH Injury and Violence Prevention Program's CDC-funded research has already demonstrated the effectiveness of implementing best practices at the community level in our state. Implementation of the model WA DOH Senior Falls Prevention Study program is cost effective, patient centered, efficient and prevention oriented.

3. The Falls Reduction Plan is Modeled after National and International Strategies

National efforts to reduce falls in older adults

The Centers for Medicare and Medicaid Services, as part of its Healthy Aging Project, commissioned the Rand Corporation to conduct an evidence-based systematic review of interventions in the prevention of falls[6]. Findings from that review, published in 2002, include the following:

1. There was a clear trend that a multifactorial falls risk assessment and management program appeared to be the most effective intervention. However, falls risk assessments must be coupled with individually-tailored follow up interventions to be successful in reducing falls risks. The most commonly assessed risks in such programs were medication review, vision, environmental hazards, and orthostatic blood pressure.
2. Exercise was the next most effective intervention component.
3. The best approach to preventing falls is likely to use both a multifactorial falls risk assessment and management program along with exercise.
4. Home assessment and modification are most useful when combined with other strategies, and have not been demonstrated to be effective as an independent component.
5. Successful falls prevention interventions have been delivered by a variety of providers, including exercise instructors, nurses, physical therapists, social workers and teams of multiple providers.
6. Falls prevention programs, as a group, were shown to reduce the risk of experiencing a fall by 11% and a monthly rate of falling by 23%.
7. While not conclusive, the evidence suggests that falls prevention programs provided to seniors have the potential to be highly cost-effective, compared with current practice.

8. In the absence of new resources, it seems unlikely that much progress will be made in getting seniors to receive the benefits of falls prevention activities.

In the U.S., falls reduction plans have begun nationally and in several individual states. Because falls among the elderly are a nationwide problem, two important national initiatives have been established to address the issue. In December 2004, the National Council on Aging, in conjunction with the Home Safety Council and the Archstone Foundation, brought together 60 national experts to develop a national blueprint designed to reduce falls among the elderly in the United States (Anne Shumway-Cook, PhD, PT, University of Washington Department of Rehabilitation Medicine was an invited participant). "Falls Free: Promoting a National Falls Prevention Action Plan" was then published in March 2005.[23] The action plan identifies best practices related to falls prevention, including individual risk identification and management, exercise, and home safety evaluation. The National Council on Aging will be publishing a follow-up report in 2007 to measure the success of this action plan.

The National Council on Aging also created and sponsors the National Falls Free Coalition,[24] which consists of more than 40 partner organizations, including the Home Safety Council, Centers for Disease Control and Prevention, Centers for Medicare & Medicaid Services, American Society on Aging, American Geriatrics Society, National Indian Council on Aging, American Physical Therapy Association, American Board of Internal Medicine, National Association of Emergency Medical Service Physicians, and the American Academy of Orthopaedic Surgeons.

Several states have recently created coalitions and campaigns (California, Maine, Minnesota, New Hampshire, and Wisconsin); however, data is not yet available on their outcomes. The State of California published a "Creating a California Blueprint for Fall Prevention: Proceedings of a Statewide Conference" in February 2003. [25]

Two "Keeping Seniors Safe From Falls" bills that direct the development of a national falls prevention initiative are pending in Congress, HR 5608 and S 1531 (co-sponsored by Washington's Senator Patty Murray).[26] This initiative includes public information strategies, demonstration and research projects, falls prevention services, and outcome measures relating to reducing health care costs through falls prevention.

In March 2006, the Maine Legislature passed legislation "Directing the Commissioner of Health and Human Services to Develop Strategies To Keep Senior Citizens Safe from Falls" which specifically funds the creation of a statewide coalition, a statewide demonstration project, intervention approaches and programs that encourage partnerships. This successful legislation was modeled after the federal "Keeping Seniors Safe From Falls" House and Senate legislative bills.

In October 2005, recognizing the impact of falls on health care costs and quality of life in seniors, the Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services (CMS) implemented a new medical billing (ICD10) code, V15.88 History of Fall. The new falls "V" code is to be used to identify patients at risk or with a history of falls, and justify a provider's decision to order referrals and interventions. Institution of the new fall code is serving to heighten awareness among health care practitioners and increase services related to falls prevention, as well as providing a mechanism for falls health care cost data collection.

International efforts to reduce falls in older adults

A recent review of population-based falls prevention intervention studies published in 2006 by the Cochrane Collaborative,[27] an internationally recognized public health evaluation group, found that four countries (Australia, Norway, Denmark and Sweden) have begun to show a significant decreases or downward trends ranging from 6 to 33% in injury or fracture hospitalizations, and injury-related mortality rates in older adults. These results are being achieved by implementing policy-level changes in the area of health promotion and public health that include engaging local community agencies and services, direct service delivery, media advocacy, and public and professional education. These findings "support the preliminary claim that the population-based approach to the prevention of fall-related injury is effective and can form the basis of public health practice."[28] Other countries that are now addressing falls include Canada, Hong Kong, Japan, New Zealand, Singapore, South Africa, Taiwan, and the United Kingdom.[29]

4. Falls Reduction Plan Costs and Savings

This plan would require an initial investment of at least several hundred thousand dollars to effect the sustainable longterm changes needed in our health care and aging service systems. It is estimated that many of these changes could be accomplished in three to five years if initial funding is aggressive. One percent of the current yearly cost of $200 million for falls injury hospitalizations in Washington State could lead to a decrease in 10% of these health care costs for injured older adults if this plan is implemented and supported. Plan costs would then decrease over time as system changes and interventions become embedded and integrated into health care and aging services at state, local and systems levels.

Falls prevention interventions have been found to reduce falls, which correlate to health care cost savings. If all older adults in Washington State had access to best practice falls prevention interventions, information and resources, health care costs could be contained and reduced over time, and the quality of health care for older adults would improve.

Falls among older adults is one area of prevention in which "an ounce of prevention is worth a pound of cure" with an investment in prevention funding. The savings to the emergency medical services and the health care system that will be realized have the potential to grow exponentially in the future as our aging population increases in size.

While CDC funding to the WA DOH has accomplished much of the needed research regarding implementing and evaluating evidence-based falls prevention strategies and created community partnerships in a small number of counties, a statewide Falls Reduction Plan requires state funding to achieve the longterm sustainable goals of reducing falls injuries by increasing access to prevention best practices to contain health costs. The WA State Legislature has approved similar funding in the past. As an example, in 2001, Senate Bill 5898 was approved for $136,000 per biennium for a comprehensive campaign to alert parents to dangerous recalled juvenile consumer products.

<u>The Falls Reduction Plan funding would specifically need to provide for:</u>

- A staff coordinator (1.0 FTE) in a joint position Washington State Department of Health Injury and Violence Prevention Program and theAging and Disability Services Administration to establish a state-level falls reduction infrastructure
- A staff coordinator (0.5 FTE) at each of the 13 Washington State Area Agencies on Aging to create regional and county-level infrastructures for implementation of the Falls Reduction Plan and coalition building

- A social marketing campaign
- Increasing access for all older adults to best practice (strength and balance) exercise and education at the local level in senior centers, meal sites, and parks and recreation sites, assisted and independent living facilities, and for homebound older adults
- Professional education initiatives for health care providers, allied health care professionals, case managers, home care workers, and aging service professionals
- Identifying, developing and evaluating effective prevention, response, alternative transportation, and case management strategies in the emergency medical system
- Improving emergency medical and health care data collection systems to monitor and evaluate falls injury-related health care and outcomes
- Identifying strategies to integrate falls risk assessment tools into health care electronic medical records systems

5. The Falls Reduction Plan Reflects Active Collaboration Among Key Stakeholders

The coalition approach to address falls prevention is a very effective public health strategy that is now being widely used at local, state, national, international levels for building partnerships, creating needed linkages, implementing prevention strategies, identifying policy needs.[30] Building coalitions supported by a formal, funded state infrastructure is effective for funding streams, such as charitable foundations, and for mobilizing community organizations to fund and support local initiatives.

In Washington State, local falls prevention coalitions are now in place in Pierce and Thurston counties to address falls at the local level; King, Lewis, Mason, and Walla Walla counties are also now expressing interest in developing similar coalitions. The Pierce and Thurston County Falls Prevention Coalitions are successfully demonstrating that the strategies identified in the National Falls Free Action Plan and the California Blueprint for Fall Prevention are adaptable at the local level.

<u>Washington State Stakeholders</u>

Many state and local stakeholders are collaborating to address falls prevention in older adults, and support a Falls Reduction Plan to improve the quality of life for Washington's older adults. They include:

State level stakeholders:

- WA DOH Injury and Violence Prevention Program, Office of Emergency Medical Services & Trauma System
- Physical Therapy Association of Washington
- Washington Alliance for Healthy Aging
- Comprehensive Health and Education Foundation
- Service International Employees Union 775

Local level stakeholders:

- Pierce County Falls Prevention Coalition
    - NorthWest Orthopaedic Institute (501c3 non-profit) - lead agency
    - WA State Dept. of Health Injury & Violence Prevention Program – sponsor
    - Pierce County Aging and Long Term Care (Area Agency on Aging)
    - Franciscan Health System
    - MultiCare Health System
    - Gentiva Health Services
    - Good Samaritan Community Healthcare

    - Northwest Physicians Network
    - Tacoma Trauma Trust
    - Tacoma Fire Department
    - Gig Harbor Fire Department
    - Tacoma-Pierce County Health Department
    - Lifeline (personal emergency response system)
    - Pierce County Physical Activity & Healthy Eating Coalition
    - MetroParks Tacoma
    - Rebuilding Together South Sound
- Thurston County Falls Prevention Coalition
    - Providence St. Peter Hospital - lead agency and sponsor
    - Group Health Cooperative
    - Providence Home Health
    - City of Olympia Senior Services
    - Lewis Mason Thurston County Area Agency on Aging
    - Olympia Fire Department

6. Falls Reduction Plan Implementation Obstacles

The obstacles to implementing a falls reduction plan are insufficient funding, the lack of policies to create and sustain formal infrastructures and system changes at state and local levels, and therefore a lack of resources to implement effective strategies. State and local level organizations are increasingly ready and willing to address falls prevention, but are constrained by these barriers.

Conclusion

Washington State has already laid the groundwork and developed much of the collaboration necessary to take the next steps to formally implement effective falls reduction strategies for older adults at the state and local levels. This work has uniquely positioned Washington far ahead of most states in this area, and is already looked to as a model by the National Association of Area Agencies on Aging.[31] By taking the next steps of creating state policies and funding to reduce falls, the core related issues can be actively addressed to create sustainable systems and interventions for active, healthy, safe and independent aging. Five years from now, these steps will help contain health care costs and improve the access to and quality of health care for all Washingtonians.

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Tab 32

Getting Well by Doing Good: Single Payer as the Prescription for a Washington State's Sick Health Care System

Prepared for *Olympia Movement for Justice and Peace*

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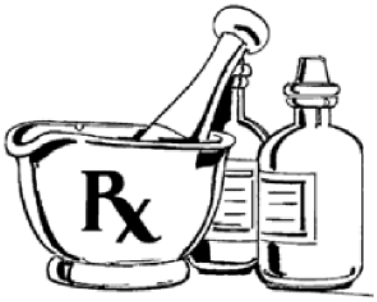
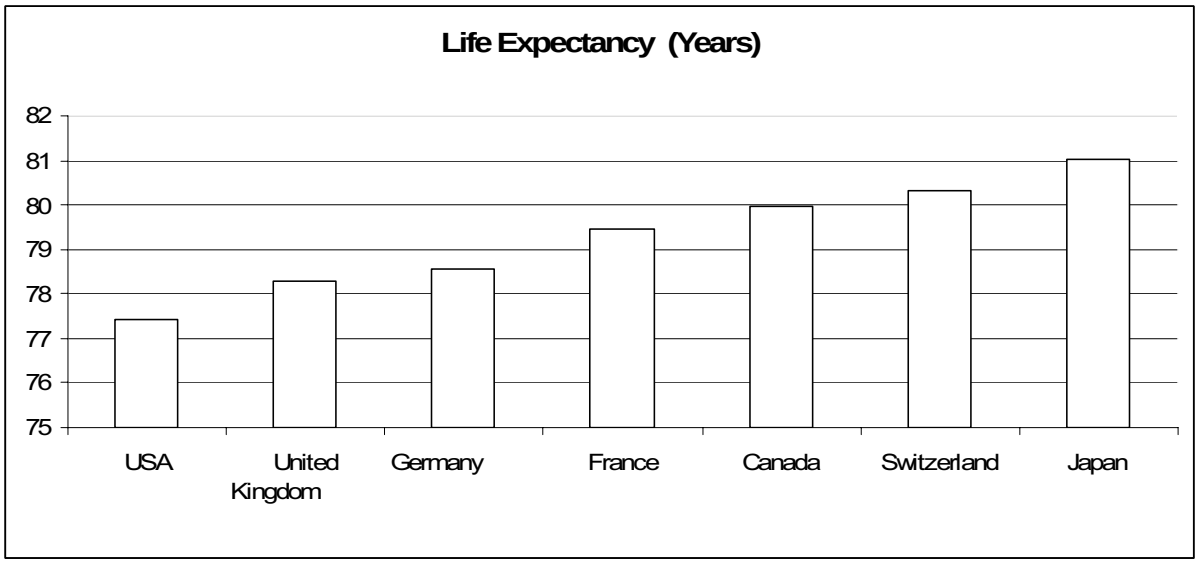


Healthcare is a right, not a luxury like caviar. Healing the sick is a moral obligation. But, the Washington State health care system, like the USA health care system is broken for all of us – not just for the uninsured. Yes we have too many people without insurance being denied vital care.

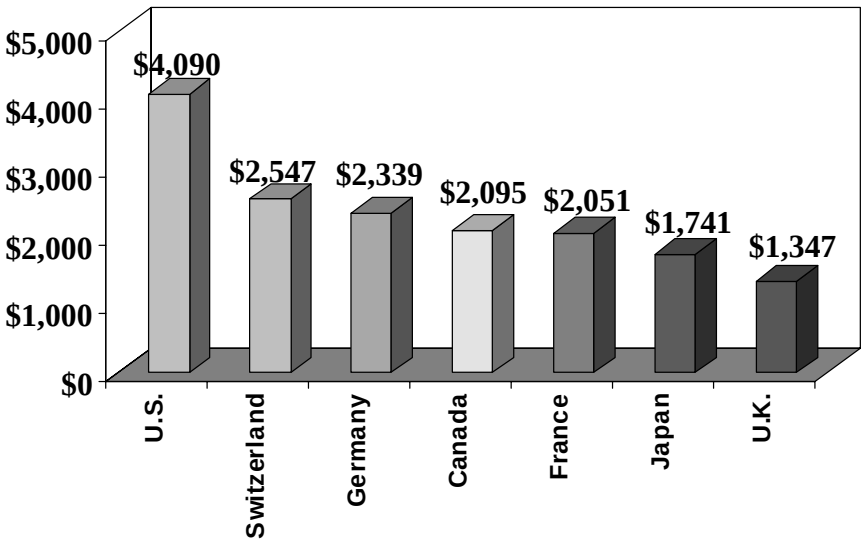
But the statistics are not good for the insured either. People in more than forty nations live years longer than we do, and see fewer of their babies die[1]; people in twenty are ill fewer days[2]. We have fewer doctors, nurses and hospital beds per patients than many other rich nations[3]. In high tech medicine, where we used to excel, France and Japan have more access to advanced devices such as MRIs than we do, without wait times[3]. Most U.S. patients treated for serious illness receive around half the procedures high quality treatment would require[4]; this applies not only to poor and middle class patients, but even to wealthy ones. Private health insurance does not provide Americans with the high quality health care most other rich nations routinely receive[5].



For this lower quality care, we pay more than any other nation on earth[3].

Private Health Insurance - The 800 Pound gorilla

The difference – we rely more on private insurance than everyone else; in other nations, the government or some other non-market entity is the primary insurer.



Thanks to private health insurance U.S. medical administration costs about one third of every U.S. health care dollar[6] (double other nations). We pay 40% more for the same pharmaceuticals[7], and receive less preventative care. Insurer and pharmaceutical profits, and especially medical provider compliance with insurer made red tape soak up money that should provide high quality health care to all Americans. Private health insurers have invented a form of bureaucracy that is less efficient than the IRS, the Pentagon and the Post Office combined; like cockroaches, the problem is not just what they eat, but what they spoil.

If we want to meet the goals the blue ribbon commission has outlined, the single biggest available source is to tap the huge pool of money wasted by private insurers.

Replace all or most private insurance with one publicly funded, publicly administered insurance plan. This would provide high quality health care for everybody by the licensed providers of their choice. Such a system would improve health care for all of us – both the uninsured, and people currently covered by health insurance.

How could we fund this?

Replace the money businesses currently spend on premiums and workman's comp with a payroll tax. (You can exempt very small business with five employees or fewer.) Replace the money individuals spend with a wealth tax on people and businesses with a net worth of over ten million dollars. We could seek waivers for Medicare and Medicaid. Failing that we could allow Medicare and Medicaid patients the option of retaining their current conventional coverage or switching to the statewide system. Thus Medicare patients could be covered under the same exemption that allows them to join HMOs. Similarly the plan could simply accept Medicaid compensations as provider.

Could this be done legally?

Yes - by organizing the plan as a non-profit, non-governmental insurance provider with an elected board the state simply bought services from. As condition of buying those services the

state could insist on negotiating standards, not only of services provided but of compensation paid to medical providers

What about various spending limitations?

Fortunately most of the spending limitations are laws, not constitutional provision - and thus could be repealed by the legislature or the referendum. Politically, the way to do this would be to replace current supermajority requirements with a simply majority requirement (other than certain bond and property tax requirements which are constitutional provisions).

What about the constitutional provisions forbidding income taxes in Washington State?

The don't apply to either wealth or payroll taxes. (If they applied to wealth taxes, then the property tax would be unconstitutional).

OK, so we could do it legally. What about political feasibility?

The question is whether you are interested in solving the problem or not. There are not going to be politically easy solutions to this problem. But if there was real leadership and education going on you could win support of a majority for this.

Single Payer FAQ

Q) How can private health insurance be less efficient than a program run by the <flinch> government?

A) Efficiency in markets, to the extent it exists, comes from competition. But insurers don't provide health care; medical practitioners do. Health insurers secure competitive advantage by paying fewer health care costs. They do this either by insuring as few sick people as possible in the first place, or by simply not covering the needs of their sickest customers. If it were legal every health insurer would locate on the tenth story of a building with no elevator. They would only accept or renew your policy if you could walk in the door without being out of breath.

There are limits to how blatantly insurers can deny care. So they use subtle means. For example, insurers may pay low fees for certain tests needed by people with very expensive illnesses. While a doctor with a healthy clientele may be able to accept this insurance and earn a living, a doctor who treats an illness either refuses to take it or loses money. The insurer is not turning down, say kidney patients. It is just that if you have a bad kidney no area nephrologist will accept that particular plan - so, given a choice, you will seek some other insurer. This works even if the insurer is not allowed to turn you down; they've provided an incentive for you to turn them down. As long as either the insurer has a choice of customers, or the customer has a choice of insurers, the single most profitable move an insurer can make is to drive the most expensive customers to the competition. This is known as "adverse selection".

Q) Why would that produce bad health care for everybody? No one in my family is chronically ill. Why do those statistics you cited earlier show that we will get poor or mediocre treatment?

A) Because health care is a system – like a car. If something goes wrong with your car it affects everybody riding it - not just people in the back seat. If one third of the health care dollar is spent on administration that robs health care from everybody – not just the uninsured, or people with poor quality health insurance, not just people with chronic illnesses.

Q) How does denying people care drive administrative expenses up to highest rate in world?

A) There are several factors in private insurance that drive administrative costs up. Thousands of health care plans, each with their own rules and regulations adds to the paperwork and red tape.

But more that this, a system that exists to prevent doctors and nurses from treating patients is going to be very expensive to administer. Medical practitioners want to cure sick people. It takes quite a lot of work to stop them.

That is the key reason modern health care organizations have extensive administrative structures, and multi-million dollar CEO's. Helping doctors and nurses care for patients is a skilled and difficult job; getting in their way even more so. It is not a one-time job either; doctors and nurses over time will find ways to work around a system that tries to reduce the care they can give – which is why a you need a highly paid CEO to constantly develop new obstacles to put in their way.

Q) Are administrative costs the only way private insurance robs health care of resources?

A) No – though they are the single largest chunk. Here are others:

Dividing pharmaceutical purchases between thousands of plans ensure they are bought retail. That is why the U.S. pays 40% more than nations who negotiate volume discounts[7].

For the same reason, U.S. health information technology (HIT) lags about dozen years behind Europe[8].

Since most people change insurance companies every seven years or sooner, insurers have an incentive to under-provide preventative care. There is a good chance another insurance company will reap many of the benefits. The uninsured mostly receive emergency care only – which further lowers preventative spending and increases costs.

Q) Aren't our health care costs higher because we eat too many cheeseburgers? It's the fat!

A) A recent study compared British health with U.S. health; it limited itself to white middle aged men of comparable weight. It still found that the British (who have one of the worst health care systems in Europe) are healthier than the U.S. Rich U.K. white males are healthier than rich American white males, middle class white Englishmen healthier than middle class white American men, and so on for working classes and the poor[9]. Bear in mind that we may be fatter, but we are also younger and smoke less than other rich nations. Other

studies have confirmed that demographic facts do not explain the differences between us and other rich nations.

Q) Does racism play a role in the quality and cost of U.S. health care?

A) Definitely. Regardless of income non-whites receive worse medical treatment than whites[10]. This does not explain the difference though. If you take white American life expectancy, and treat it as a separate country, white U.S. still ranks 20th[11].

Q) What about malpractice insurance? Isn't the problem that doctors are being sued frivolously, and so have to pay huge premiums and order unnecessary tests to defend themselves from false accusations? It's all the lawyers fault!

A) Malpractice payouts and legal costs in malpractice cases combined add up to less than half a percent of the health care dollar[12]. "Defensive medicine" is harder to estimate, but according to the Congressional Budget Office the most that could run is 2%. More to the point U.S. malpractice payouts and legal costs are not out of line with other nations; they are slightly lower than Canada. If malpractice premiums are too high it is the fault of the insurance companies; U.S. doctors pay higher premiums than other nations to insure against claims that are lower. The difference again is that other countries also provide single payer malpractice insurance.

Q) What will it cost to switch to single payer?

A) Switching to single payer won't cost a dime. It will save money. Right now, around 16% of the U.S. population is uninsured at any one time. Between savings in administrative costs, eliminating insurer profits, reducing pharmaceutical prices, and funding more preventative care, switching to single payer would reduce overall costs by 25% per person. So that saves 9% even after every uninsured person is covered; ideally we would use this savings to increase quality, rather than lower prices.

Q) But you are talking about learning from foreigners. Why do you hate America? Are you French?

A) Taking other people's stuff is an old U.S. tradition. Ask any American Indian. Log cabins were invented in Sweden. Hot dogs, hamburgers, and covered wagons were German. Apple pie is Egyptian. We stole the steam engine that powered our industrial revolution from England when they still were trying to re-conquer us. Much of our constitution came from the Iroquois.

The French health care system costs around half ours per person, and is rated by the World Health Organizations as the best in the world. The French spend less than we do per person on health care, live longer, stay healthier, go to any doctor they like, and have no more waits for elective care than we do. It would be un-American not to adapt their methods.

Q) But won't we end up waiting for care like they do in the failed Canadian health care system?

A) In spite of serious problems the Canadian system is not a failure; it is more successful than ours[1]. It is myth that huge numbers of Canadians cross the border to use U.S. medical services. The single most common reason for a Canadian to seek health care in the U.S. is that they are here on vacation or for business and get sick[13]. But it is also true that Canadians do have to wait for some elective procedures – something that is not true in about half of single payers systems[14]. The difference is that Canada runs most of their system like a giant HMO – paying per doctor, per clinic or per hospital, not fee for service. The best single payer systems like France and Japan pay per procedure, rather than using capitation systems.

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More Information on Single Payer

Physicians for National Health Care Program
(http://www.pnhp.org/ 312-782-6006 info@pnhp.org pnhp@aol.com)

Health Care for All Washington
(http://www.healthcareforallwa.org/ 877-903-9723
info@healthcareforallwa.org)

Olympia Movement for Justice and Peace
(http://www.omjp.org 360-867-6513 omjp@omjp.org)

Washington State Citizen Action
(http://www.wacitizenaction.org/ 206-389-0050
info@wacitizenaction.org)

Tab 33

Doula Services for Low-Income Women
An Open Arms Perinatal Services Proposal

In 2004 a total of 81,404 births in Washington State were recorded. The associated healthcare costs are tremendous. Of these births at least 11% are in families with incomes that fall below the poverty line. In addition to being least able to afford the high costs of perinatal healthcare, these families are also challenged by a variety of much higher risk factors than normal. These families are also the ones who receive the least support in our society, and instead often face the most discrimination and have the least access to health services.

If we do not support poor and minority women during their birth experiences, we send a message that they are not worthy of support, that their babies are not as important. There are good reasons to empower the next generation's mothers. These mothers will raise their children in confidence and power, advocating for their children's education and health needs, in a world that seems to increasingly deny them this. Strong women grow healthy children. That's what every community needs.

This proposal presents information and options for low-income women to have access to quality, culturally appropriate perinatal care through ***doula services.*** The benefits of doula services are well documented and include several short- and long-term benefits in regard to overall improvements in the health of the mothers and babies; increased familial bonding and reduced abuse and neglect; improved school readiness of the children; reductions in health disparities and discrimination within the health service community; and dramatically reduced health care costs.

Open Arms Organizational History

Open Arms Perinatal Services is a community-based nonprofit organization that has been dedicated to providing **doula services** to low income pregnant women and their infants since 1997. ***Doulas*** are women who are trained, experienced, and certified to provide caring support to women before, during, and immediately after birth. They provide emotional and physical support; information and educational materials; and support the decision-making and self-advocacy of the women they serve. Doulas are committed to helping women have satisfying birthing experiences.

The mission of Open Arms is to provide services that support, educate, respect, honor and empower women in need and their families throughout the childbearing year.

Open Arms fulfills an essential role in Washington by working to match low-income women with a doula appropriate to their particular circumstances, considering their social, cultural, and economic circumstances. By matching low-income women in need of birthing assistance with appropriate doulas, Open Arms is able to provide services to women that give them a safe and nurturing environment that also respects the diversity of their background and life experience, and enables and empowers them during the childbearing experience. The doulas that we provide are bilingual and bicultural. Community-based doulas take a culturally sensitive approach childbirth, infant development, and family support.

As a provider of doula services to several counties in Washington, Open Arms has developed strong collaborations with service professionals, local health and social service organizations, community residents, and health care providers. Of our current clients, at least 40% speak a first language that is not English. We provide bilingual and bicultural doulas when possible, and women trained in cultural sensitivity and communication at all times. We actively recruit low income women and minorities, educate new doulas and provide professional development, and advocate for better healthcare for mothers and babies.

Open Arms has a twelve-year history of working effectively with the state to provide perinatal services to low-income women. During our first three years we operated as a program of the Pacific Association for Labor Support (PALS) before becoming an independent nonprofit organization in 1997.

In 2004, federal funding for doula services was cut, dramatically impacting our ability to serve low-income women. Because of these funding cuts, we have been operating on a volunteer basis, serving 140 women annually. However, the need for perinatal services among low-income women is much greater.

Open Arms is now in the process of developing an expanded and diversified funding base, including individual donors, as well as corporate, foundation, and city, county, and state government support. Over the next three years we plan to increase our capacity to serve at least 1,000 women directly with doula services, and provide education and outreach to at least 4,000 women. In 2006 and 2007 we are expanding our programming to better serve our community and region, launching a new community-based Outreach Doula project, developing new doula training programs, and providing continuing education for certified doulas. Specifically this year we are expanding our doula services to provide support to three of Washington's highest-risk minority and immigrant populations:

1. **The Asian and Pacific Islander Refugee and Immigrant Doula Service.** We are collaborating with International Community Health Services to provide doulas to low-income Asian/Pacific Islander immigrant and refugee women. This outreach is unprecedented, while doula care has been available to all low-income women through Public Health, immigrant and refugees have not been specifically targeted for this service.
2. **Next Generation.** We are collaborating with the Children's Health Society of Washington to serve Latina teens by providing outreach to the Latina community, and recruiting more women of color into the doula apprenticeship program.
3. **The Otter Women Project.** We are collaborating with Indigenous Birth Workers Network and the South Puget Intertribal Planning Agency (SPIPA) to provide perinatal outreach and education to Native American women of childbearing age, and will provide a community assessment of the need for perinatal services for the tribes of southwest Washington.

The Need for Perinatal Services

Many low-income women do not have adequate access to healthcare, and their corresponding risks are higher than the median population. Insuring good healthcare for women during and after pregnancy includes education and nutrition, well baby checks, vision screenings, monitoring for mood disorders, and more.

Many new parents are also unaware of what constitutes normal newborn growth and development, and normal postpartum recovery for the mother. The physical or mental health of the new mother or baby can be compromised, and the parents need more help at home than they had expected. At least one in 10 new mothers experiences various degrees of postpartum depression, but low-income and minority women are at higher risk of depression prior to birth or post-partum depression after birth. A study conducted by Chicago Health Connection revealed that fully one-half of the at-risk young and low-income women participating in the program displayed significant symptoms of depression.

The Need for Minority, Immigrant, and Refugee Perinatal Services

Immigrant and refugee women often face greater challenges because they're in a strange land, with strange customs and unfamiliar environments, and possibly don't even understand the language. Immigrant needs have been obscured because of aggregated data that lumps new immigrants in with others in the same racial group. According to Children's Home Society of Washington, Seattle and King County have higher concentrations of minority and immigrant families compared to other areas of Washington, and more immigrants fall within poverty risk factors and poor health outcomes. A significant majority of these immigrants are Asian/Pacific Islander, one of the largest and fastest growing minority groups.

The Need for Teen Perinatal Services

The risks for teens of minority or recent immigrant backgrounds are even worse. Teen pregnancy is one of the biggest challenges facing youth today. In addition to the challenge of birthing and raising a child, teen mothers also face severe challenges in completing their education, are at higher risk of severe health problems, and are much more likely to be reduced or confined to poverty, to name just a few of the associated challenges. One of the populations at highest risk is Latina teens. Latina teens have one of the highest rates of teen pregnancy at 34.2%. Compounding the problem, teen mothers in King County are significantly more likely to receive late or no prenatal care, smoke, and be anemic during their pregnancy. One third of mothers in King County, ages 15 to 17, receive inadequate prenatal care, and young mothers are significantly more likely than their older counterparts to have pre-term deliveries and low birth-weight babies.

The Need for Regional and Native American Perinatal Services

One of the most marginalized populations of women of child-bearing age is women living in Native American communities scattered across southwest Washington, including the counties of Grays Harbor, Lewis, Mason, Thurston, Pacific, Kitsap, Pierce, Wahkiakum, and Cowlitz. Tribal community members living in or near southwest Washington reservation boundaries are marginalized from larger communities and cities due to geographic isolation, and due to negative social, ethnic, and economic perceptions of their culture, traditions, and worldviews. Most of these women are economically disadvantaged. In 2005 SPIPA, in collaboration with the U.S. Department of Health and Human Services, conducted an assessment of women's health services in southwestern Washington tribal communities. The assessment revealed that there is no prenatal, delivery, or postpartum care for these communities.

It is clear that perinatal services and culturally competent healthcare for low-income women, minorities, immigrants, and regionally isolated and marginalized populations are desperately needed.

The Role of the Doula

The emotional, social, economic, and cultural experiences that all women bring to the birth setting influence the way in which they will labor and birth their children. Certified doulas are trained to serve women who have cultural backgrounds different from their own, are experiencing perinatal mood disorders or drug-impacted pregnancies, or have prior life experiences which may significantly impact the ways in which they birth their child.

Doula support is intended to fill the gaps left in our customary perinatal practices, which usually include only medical procedures, occasional checkups, and the purchase of baby-related paraphernalia. Doulas provide the education, quiet support, and guidance of traditional perinatal support that our society is missing.

This support can include a wide range of issues. For example, doulas are trained in postpartum adjustment, newborn characteristics, care, feeding, and development, and the promotion of parent-infant bonding. They are experienced in supporting families through their postpartum experience. During the fourth trimester following birth, the doula's role is to provide education, nonjudgmental support, and companionship, and to assist with newborn care and family adjustment, meal preparation and light household tasks. Doulas offer evidence-based information on infant feeding, emotional and physical recovery from childbirth, infant soothing and coping skills for new parents, and can make appropriate referrals when necessary.

Doulas are trained to recognize signs of depression, and will make referrals to appropriate clinicians or support groups as needed. Unlike therapists or psychiatrists, doulas do not treat postpartum depression. However, they will help by creating a safe place for the mother emotionally. The doula will provide a cushioning effect by accepting the mother within each stage that she passes through. They relieve some of

the pressure on the new mother by helping her move into her new responsibilities gradually. By mothering the mother, doulas make sure that the mother feels nurtured and cared for.

Doulas also make sure the mother is fed, well hydrated, and comfortable. Doulas make sure mothers follow their care provider's instructions regarding diet and the management of any complicating factors such as diabetes.

There are two types of doulas that Open Arms provides to low-income women: *birth doulas* or *outreach doulas.*

Birth doulas
Birth doulas are trained to focus on the immediate needs of pregnant women just prior to, during, and after birth. Their services are limited to two prenatal visits with the mother, being present and working with the mother during labor and delivery, and two postpartum visits.

Outreach doulas
Outreach doulas are ***outreach workers*** who have doula training. Outreach doulas work with birthing mothers for a longer period of time, from as early in the pregnancy as possible to up to six months after delivery, and in some cases longer. Outreach doulas receive an additional 48 hours of in-class training beyond that of birth doulas, and the out-of-class training for outreach doulas is double that of birth doulas.

Outreach doulas are recommended in cases of higher risk when extended services are required; cases where cultural or language barriers are more prevalent; and cases where women are more isolated or marginalized due to geographic isolation, or due to negative social, ethnic, and economic perceptions of their culture, traditions, and worldviews.

Open Arms is working with Chicago Health Connection to educate and train our outreach doulas. We are modeling our outreach doula program on the Chicago Health Connection's community-based doula model, which establishes a culturally sensitive approach to pregnancy, childbirth, infant development, and family support.

A compete description of the Chicago Health Connection model of community-based outreach doulas is provided in answer to question 3 on page 8 in this proposal.

How Open Arms Can Help the Blue Ribbon Commission Realize Its Vision and Goals

1. **What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access? Briefly summarize your proposal.**

   In 2004 a total of 81,404 births in Washington State were recorded.[1] The associated healthcare costs are tremendous. Of these births at least 11% are in families with incomes that fall below the poverty line. In addition to being least able to afford the high costs of perinatal healthcare, these families are also challenged by a variety of much higher risk factors than normal. These families are also the ones who receive the least support in our society, and instead often face the most discrimination and have the least access to health services.

   Open Arms Perinatal Services addresses the needs of low-income pregnant women in disadvantaged communities. By matching low-income, minority, and immigrant women with appropriate doulas, Open Arms provides services to women that give them a safe and nurturing environment that respects their diversity, background, and life experience, and enables and empowers them during the childbearing experience. Certified doulas are trained to serve women who have different cultural backgrounds, are experiencing perinatal mood disorders or drug-impacted pregnancies, or have prior life experiences which may significantly impact the ways in which they birth their child. Our doula

[1] http://www.doh.wa.gov/ehsphl/chs/chs-data/birth/2004/2004c6.htm

services are founded on strong partnerships that include service professionals, local health and social service organizations, community residents, and health care providers.

Our goals are to:

- Provide women with access to quality, culturally appropriate perinatal care.
- Significantly reduce the costs of perinatal health care due to lowered intervention rates.
- Expand and deepen current doula services to all low-income women who need these services.
- Reduce infant mortality rates for Native, Latina, and African American women.
- Encourage stronger, healthier families through increased mother-child bonding.
- Provide the opportunity for more women to initiate breastfeeding.
- Provide mothers with satisfying birth experiences.

Currently Open Arms services are limited to low-income women in King County and a few surrounding counties. We have already developed short-term goals during 2006 and 2007 of expanding our services for low-income women. We are also targeting three of the highest-risk, highest-need minority and immigrant communities through three focused programs: The Asian and Pacific Islander Refugee and Immigrant Doula Service, Next Generation., and the Otter Women Project.

Our current activities provide a perfect "test-case" opportunity for the Blue Ribbon Commission and the State of Washington to support and evaluate Open Arms programs and our ability to help meet the commission's vision and goals. Our proposal to the Blue Ribbon Commission is to work with us in supporting our current services; and over the course of the five-year timeline proposed by the commission to bring our services to other high risk communities, and eventually to all low-income women throughout Washington State.

Measurable objectives

The Otter Women Project will:

- Reach 4,000 women in 2007 with education and outreach materials on perinatal support and doula care.
- Research and document chronic conditions in perinatal issues within these communities.
- The tribes will have access to culturally relevant doula services.

The Next Generation program will:

- Provide doula care to Latina and African American teens.
- Strengthen mother-infant bonding and delay subsequent pregnancies for teens.
- Educate teens about their choices during and after birth.

The Asian and Pacific Islander Refugee and Immigrant Doula Service will:

- Provide culturally appropriate doula care for Asian American and Pacific Islander refugee and immigrant women.
- Recruit and train Asian American and Pacific Islander refugee and immigrant women to become doulas.
- Educate new mothers about their choices during and after birth.

Program impacts

The impacts that Open Arms programs will have for low-income women include:

- **Removing barriers to service.** Doulas serve as ***cultural navigators,*** functioning as culturally competent links from the community to the health system. Perinatal care information is provided to women from within their communities through their natural social and communal networks. Information is provided through methods that are relevant to the women's cultural worldview. Communities that need the support of bicultural, bilingual doulas will have access to them.

- **Increasing awareness and supporting the individual's right to make active, informed choices about their healthcare.** Women are educated on their choices in birth and are able to actively make their own choices. Their right to feel supported in birth, and their interest and right in having cultural traditions supported in the birth setting will be respected and affirmed.
- **Providing education about perinatal services and birth options.** Choices in birth options are offered. Information about doulas and how they assist in culturally relevant birthing is provided.
- **Reducing repeat pregnancy rates.** The number of repeat pregnancies is reduced, especially for teens who first became pregnant at an early age.
- **Offering women professional training and a career path as a birth or outreach doula.** By recruiting from and for the communities who most need doulas, we are able to provide quality, culturally appropriate perinatal care to low-income women. At the same time, we are helping to reduce the economic disparity of these women by offering a career path and professional training.

Ultimately, Open arms programs will reduce the disparities in health outcomes for the low-income women, minorities, immigrants with language barriers, and women who have been marginalized due to negative social, ethnic, and economic perceptions of their culture, traditions, and worldviews.

Monitoring and evaluating success

We'll measure success by tracking the number of women served, and the quality of service. We'll track the increase of referrals, the increase of follow up contact, and the level of quality through doula report forms and client feedback forms. We'll also enhance and track training for doulas, and increased cultural competency by providing doulas with language and cultural backgrounds that better match our clients.

Our success in meeting our objectives can be measured by:

- Comparing number of women reached to the total number of women in the target audience.
- Providing an assessment of community needs along with concrete solutions to meet these needs.
- Establishing accessible doula services and support for low-income and high-risk communities.
- Comparing breastfeeding and qualitative evaluation of mother-infant bonding rates to general population of mothers.
- Tracking the number of women who chose to enter the doula training program, and who complete the program.

2. **How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?**

The birth and outreach doula services that Open Arms provides address the vision and goals of the Commission at every level: improved access, improved health, and improved affordability. Our services are provided to low-income women, minorities, and marginalized populations that have limited access, restricted or no health insurance, and much higher rates of risk.

Doula care during the birthing period results in significantly improved health outcomes at a much lower cost than other medical interventions, such as operations or the increased use of medication. The positive impact we provide to low-income women and minorities in terms of improved health outcomes and lowered costs also provides benefits to the state of Washington by reducing the burden of high health care costs.

Improving Access

Open Arms specifically serves the communities that have the greatest need and are least able to afford perinatal services and other medical care. We bring our services to low-income women and have programs that are designed to reach out to marginalized communities. Fifty-five percent of our overall client base is made up of women minority backgrounds.

In addition to our doula services for low-income women, Open Arms currently has three programs that reach out to minority populations that demonstrate both the highest need and highest risk. These programs are:

- **The Asian and Pacific Islander Refugee and Immigrant Doula Service.** We are collaborating with International Community Health Services to provide doulas to low-income Asian/Pacific Islander immigrant and refugee women. This outreach is unprecedented; while doula care has been available to all low-income women through Public Health, immigrant and refugees have not been specifically targeted for this service.
- **Next Generation.** We are collaborating with the Children's Home Society of Washington to serve Latina and African American teens by providing outreach to the community, and recruiting more women of color into the doula apprenticeship program.
- **The Otter Women Project.** We are collaborating with Indigenous Birth Workers Network and the South Puget Intertribal Planning Agency (SPIPA) to provide perinatal outreach and education to Native American women of childbearing age, and will provide a community assessment of the need for perinatal services for the tribes of southwest Washington.

Improving Health

The benefits of doula services are recognized by the World Health Organization, the Medical Leadership Council, and others. Personalized doula services can provide the following benefits for women, babies, and their families[2]:

- **Birth outcomes** can include shorter labors, fewer complications, reduced cesarean section rates, and reduced need for medication and epidurals.
- **Mothers** express greater satisfaction with their birth experience; have more positive assessments of their babies; and experience less postpartum depression.
- **Babies** have shorter hospital stays, breastfeed more easily, and experience more affectionate mothers.
- **Subsequent pregnancies** are delayed or reduced.

Additionally, doula programs benefit and serve the needs of the larger community by[3]:

- **Reducing the cost** of obstetrical care dramatically.
- **Increasing family attachment** and stronger mother-infant bonding, which leads to increased school-readiness and lower rates of child abuse and neglect.
- **Decreasing health disparities and discrimination,** by enabling women to serve other women from their own communities and to bridge language and cultural barriers when assisting families in meeting health needs.
- **Supporting** medical providers by bridging barriers as clients stay in care longer, show greater compliance, and have more positive outcomes.
- **Providing an entry-level training program** in health care for unskilled women who become doulas.

Improving Affordability

Doulas are a very cost-effective solution in the area of perinatal services. Several studies have shown dramatically reduced costs in the use of pain medications and medical procedures such as cesarean sections, shorter hospital stays, and overall improvements in the long-term health of the mother and baby—all of which contribute to reduced medical costs.

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[2] Altfeld, Susan, Ph.D. *The Chicago Doula Project Evaluation Final Report.* 2003. (www.rwjf.org/portfolios/resources/grantsreport.jsp?filename=029806.htm&iaid=144&gsa=1#RESULTS)

[3] Ibid.

In comparing births in which a birth doula was present and those in which no doula was present, DONA International[4] presented findings from North American trials and a meta-analysis of all trials of continuous labor which showed that women who had a birth doula in attendance were:

- 26% less likely to give birth by cesarean section.
- 41% less likely to give birth with a vacuum extractor or forceps.
- 28% less likely to use any analgesia or anesthesia.
- 33% less likely to be dissatisfied or negatively rate their birth experience.

The potential cost savings are significant. For example, a cesarean section costs an average of $11,361 versus $5,574 for a vaginal birth. There is a savings of $5,787 for every cesarean section that does not need to be performed.

3. Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.

Open Arms programs and services are based on established best practices for doulas. We are working with Chicago Health Connection to educate and train our outreach doulas, and we are modeling our outreach doula program on the Chicago Health Connection's community-based doula model, which establishes a culturally sensitive approach to pregnancy, childbirth, infant development, and family support. This model is effective because:

- **Outreach doulas are of the same background as the women they serve.** Outreach doulas are laywomen who understand the community and culture because they are from and of the community where they provide services. They have the same racial and socioeconomic background as the women they support. They provide effective nurturing, serve as role models, act as teachers, and become liaisons to local health care systems.
- **Outreach doulas are passionate about their work.** Successful doulas share certain qualities: a commitment to helping women own their births; a capacity to form strong, trusting relationships; and an ability to listen and respond to a mother's needs. These women are committed to giving back to their communities and strengthening the resources of other community members.
- **Outreach doulas provide extended support and involvement with families.** Outreach doulas foster relationships with families from as early in pregnancy as possible to well into the postpartum period. Both before and after childbirth, doulas offer direct support through home visits and center-based contacts. These opportunities are used to build a trusting relationship and enhance the knowledge of the mother and family about proper prenatal care, early brain development, and the critical role parents play in shaping the emotional, social, and cognitive development of their children.
- **Outreach doulas receive thorough training.** Chicago Health Connection has developed an intensive training curriculum for doulas. Their approach, based on Paulo Freire's "empowerment education," is similar to that used to train community health workers worldwide. The format is personal, interactive, and reinforces self-esteem and empowerment. Group discussions, role-play, presentations by speakers, and in-depth curriculum materials are all used in the training program.
- **The model develops community partnerships.** The community-based doula model relies on partnerships to promote better health. We believe that professionals cannot ignore the needs, perceptions, and strengths of communities if we are to make meaningful inroads into improving community health. We collaborate with community partners including service professionals, local health and social service organizations, financial donors, community residents, and health care providers.

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[4] http://www.dona.org/publications/position_paper_birth_table1.php and http://www.dona.org/publications/position_paper_birth.php#

4. **Will your proposal impose costs on individuals, businesses, or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?**

   Open Arms is a 501(c)3 nonprofit organization. As such our funding is received from individual donors and corporate, foundation, and local and state government grants. **Our services are provided for free to low-income women; there are no costs to the clients served through our program.**

   Our cost for a birth doula is $675 per individual, and the cost for an outreach doula is $3,500 per individual. This is a one-time cost per person per birth.

   To illustrate the potential cost versus savings benefits provided by having a birth doula present, we will provide a conservative estimate of the savings involved in cesarean section births using the statistics reported by DONA International, and using 2004 data from the Washington State Department of Health Center for Health Statistics[5], which is the most recent data available. In 2004 a total of 81,404 births in Washington State were recorded. Of these births 22,166 births were primary or repeat c-section births.

   In Washington State, it is estimated that 11% of the population is living in poverty, so approximately 2,438 c-section births in 2004 might have been within the Open Arms target population of low-income women. The actual number of low-income women giving birth is probably higher, but we will remain conservative in our estimate. When a birth doula is present c-section rates may drop as much as 26%, giving 634 potential births in which a c-section is not needed. A c-section costs an average of $11,361 versus $5,574 for a vaginal birth, so there is a savings of $5,787 for every cesarean section that does not need to be performed.

   The cost of a birth doula attending these 634 births is $427,950. The potential savings in the reduction of c-sections is $3,668,958. The overall savings in reducing c-section rates after taking into account birth doula costs is still over $3.2 million. An investment of less than half a million dollars leads to a savings of more than three million dollars.

   The potential savings in medical costs for c-section births alone is tremendous. Similar estimates and comparisons can be made for the savings gained by reducing other interventions such as using vacuum extractors or forceps, using analgesia or anesthesia, shortening the length of labor and hospital stays, and other interventions.

   Cost comparisons can also be made between the use of birth doulas and outreach doulas. Although outreach doulas are more expensive than birth doulas, they still provide an overall cost savings. The service goals of outreach doulas are much more extensive and comprehensive than birth doulas, but they are focused on a smaller, higher-risk target population than birth doulas in general.

   This example focused on only the 11% portion of low-income women giving birth. Clearly, if doula services were provided to women at all economic levels the cost savings statewide would be much larger.

5. **How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?**

   Open Arms fulfills an essential service in Washington by specifically working to provide low-income women with appropriately matched certified doulas. There are, however, a number of other service organizations with missions that compliment the mission of Open Arms, and with which we collaborate with on a variety of programs. These collaborations also provide opportunities for ongoing training and education.

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[5] http://www.doh.wa.gov/ehsphl/chs/chs-data/birth/2004/2004c6.htm

Open Arms collaborates with:

- **County health departments and maternal support services.** These providers and clinics refer women to our hotline, and help to inform pregnant women that doula care is available to everyone.
- **Organizations that help us to provide opportunities for ongoing doula training and education.** Examples of such collaborations include:
  - The Pathways to Birth program, a unique apprenticeship/service-learning program that recruits and serves low income women and provides a career path, with the Pacific Association for Labor Support (PALS).
  - Doula training and education with Chicago Health Connection.
  - Outreach doula training with the Infant the Infant Mortality Prevention Network (IMPN).
  - Cosponsoring the Birth Matters lecture series, an educational series addressing different aspects of birth, with the Seattle Midwifery School (SMS).

  Open Arms is also part of the Community Coalition for Healthy Babies along with organizations such as the Infant Mortality Prevention Network, Children's Home Society, and several others.
- **The Bill & Melinda Gates Foundation on the *White Center Early Learning Initiative.*** Open arms is participating in the Perinatal and Home-based Infant/Toddler Services Workgroup, one of 14 workgroups developing service recommendations for the goals of this initiative.

Open Arms stakeholders also include individual donors, city and county government agencies, and foundations. Past and current supporters include the Anthony Maymudes Fund, the March of Dimes, the Noel-Shoemaker Family Foundation, the Office on Women's Health, and the United Way.

Open Arms Perinatal Services has been formally endorsed by the Seattle/King County Public Health Department, International Community Health Services, and Children's Home Society of Washington.

The benefits of doula services are endorsed by the World Health Organization, the Medical Leadership Council, and others.

6. What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

The greatest obstacle Open Arms faces is in educating communities and raising their awareness of the support, access, and benefits that doulas can provide to women, babies, and families. This obstacle can be overcome by continuing to work with public health nurses and clinics to have them refer their cases to Open Arms when in need of support during pregnancy.

Another obstacle is that our outreach doula program might overlap in some cases with other services that provide home visits; for example nurse/family partnerships. To avoid potential conflicts, Open Arms can provide birth doulas instead of outreach doulas. For example, the Next Generation program that we collaborate on with the Children's Home Society of Washington already has home visitors, so they don't need our outreach services. However, they still need birth doulas because outreach workers and public health nurses are not available to attend labor and delivery. They cannot take that much time away from their regular duties, so Open Arms provides birth doulas for the time just prior to, during, and immediately after birth rather than the extended services of an outreach doula.

Outreach doulas can have an advantage over other home visit services because they are recruited from the same community of people that they are serving, and they have a common understanding of the challenges facing the mothers. Outreach doulas also have more credibility with the mothers when they come from the same community and have the same cultural background. For example, the reason that it is crucial we provide outreach doulas in our Otter Women Project is that there is a huge need for bringing native culture back into the birth setting for the members of the tribal communities of southwestern Washington. Native American women are often very isolated, and no other service can address their needs.

Tab 34

General Information:

a. Partners with Families & Children: Spokane
613 South Washington
Spokane, WA 99204
509-473-4810 Phone
509-473-4840 FAX
partners@inhs.org
www.partnerswithfamilies.org

b. Type of entity: private non-profit tax exempt organization,
Federal Tax ID Number: 68-0576560

c. Contact person:
Mary Ann Murphy, Executive Director
509-473-4827 Phone
509-473-4840 FAX
murphym@inhs.org

1. What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access? Briefly summarize your proposal.

We propose to organize the response and treatment for child victims of crime in a way that is BOTH cost-effective and efficacious in breaking the cycle of violence that can otherwise seriously compromise their development. This paper describes the experience and results in Spokane and urges the Blue Ribbon Commission to examine the work of the Washington Association of Child Advocacy Centers as a model for funding communities.

From unexpected quarters, the Federal Reserve Bank of Minneapolis, Art Rolnick (Senior Vice President and Director of Research) and Rob Grunewald (Regional Economic Analyst), have articulated an innovative argument for economic development. Their analysis concluded that the millions spent annually in communities for Economic Development Councils, focused on recruiting corporations from one community to another, was a zero sum game economically---a sheer waste of money. Which led them to pose the question: what WOULD be the single best investment communities could make in their health and well-being? Their conclusion: "dollars invested in early childhood development yield extraordinary public returns." Their advice to communities?
Find your highest risk children at the youngest ages and provide ***whatever it takes*** to them and their families to interrupt the trajectory that would otherwise bring them to school unable to learn, introduce them to drugs, alcohol and violence at early ages, leading to early pregnancy, school dropout and involvement in the criminal justice system.(Grunewald &Rolnick, 2004).

Admittedly, this proposal does not articulate a comprehensive solution for achieving the $17 for every $1 invested posited by the Federal Reserve Bank economists,

but it does tell the story of one community in Washington state, how we have organized our resources to treat our most vulnerable children---those who are abused, neglected and endangered by exposure to drugs and violence----in a way that saves health care dollars and produces better results.

In 1988, this program began as a clinic of Deaconess Medical Center, focused at that time on a multidisciplinary approach to child sexual abuse. Partners is now a hospital-based children's advocacy center, accredited through the National Children's Alliance and is both a licensed mental health provider and licensed chemical dependency treatment agency for outpatient and intensive outpatient in Washington state. Partners has five service lines addressing all forms of child maltreatment: physical and sexual abuse, neglect, and exposure to drugs and violence. Exclusively the state child welfare agency, law enforcement and/or other medical providers make referrals to us. Social workers from Child Protective Services have been co-located in our agency for the past 18 years. For the past two years, we have a Drug Endangered Children Liaison (our employee) outstationed at Division of Children & Family Services (DCFS) Intake and since last November, a Chemical Dependency Professional performing outreach services at DCFS. We also have a Children's Legal Advocate outstationed at the Prosecutor's office to provide education and support to child victims of crime and their families who must testify in criminal justice proceedings.

The five service lines and number of children served in 2005 are:

1. Expert multidisciplinary diagnosis of child physical and sexual abuse and endangerment through exposure to drugs and violence (Medical exams, forensic interviews, multidisciplinary case planning).	**397** children
2. Foster Care Assessment Program	**28** children
3. Children's Legal Advocacy	**93** children
4. Safe Start, crisis intervention for children exposed to violence	**422** children
5. Family-centered teams for comprehensive intervention with children referred for high-risk neglect from DCFS (integrating health, mental health, child welfare and chemical dependency treatment). Gender-specific behavioral health services are provided to pregnant and parenting mothers and for fathers (Dads Track).	**283** children
Total children served in 2005	=**1223**

In the past eighteen years, we have developed this model in Spokane so it is now addressing even more high risk children as well as their family members and is sponsored by both Deaconess and Sacred Heart Medical Centers. These hospitals might compete on other service lines, but they combine their resources for this needy population because they recognize that these families will incur enormous recurring costs---not only to the health care system, but to all systems in the community. Better to treat them, giving them the family-centered care they require and forming the collaborations necessary to achieve better results. Three federal outcome studies have demonstrated program effectiveness: *Starting Early Starting Smart*, 1998-2003*; Safe Start*, 2000-2006*; Drug Endangered Children*, 2003-present. Partners has applied to National Registry of

Effective Programs and Practices (SAMHSA) for designation as a promising practice on the strength of the first randomized clinical trial in the *Starting Early Starting Smart* study.

Summary of Outcomes: *Starting Early Starting Smart*

Partners with Families & Children: Spokane (formerly named Casey Family Partners) was one of twelve sites participating in the *Starting Early Starting Smart (SESS)* national outcomes study. 159 families with multiple needs, evidence of chronic neglect, with at least one child under 30 months of age were referred for baseline assessment in the research project; half were then referred to Partners and half to existing community services (Standard Care). Notable results sustained over 12 months were:

- Partners' families demonstrated improved health care utilization and housing stability and reduced need for domestic violence and legal services.
- Partners' families reported higher levels of satisfaction with services and reduced barriers to accessing and remaining in services.
- Partners' families showed reduced levels of severe, potentially lethal physical violence in relationships.
- Partners' families reported less parenting stress and reduced child behavior problems.
- Videotapes of parent-child interaction viewed by independent raters showed Partners' parents with improved positive regard for their children and ability to teach their children.

PARTNERS FAMILY TEAM COSTS COMPARED TO PUBLISHED INTENSIVE SERVICES RECOGNIZED AS BEST PRACTICES.

Program	**Focus**	**Child Age Range**	**Duration of Services**	**Cost per Child**	**Year of Report (Dollars for that Year)**
Partners Family Teams	Chronic neglect for the SESS project	0-30 months	6-12 months for most families	$ 3,134	2002
Multisystemic Therapy[1]	Juvenile offenders	Teens	4 months	$ 4,000	1996
One SESS Early Education Site[2]	Children in poverty	3-5 years of age	1-2 Head Start academic years	6,633	2001
Prenatal/Early Infancy Project (D. Olds)[3]	First-time pregnant women	Newborns	two years (birth - age 2)	$6,100	1996
Perry High Scope Head Start[4]	Children in poverty	3-5 years of age	1-2 Head Start academic years	$12,000	1996
Chicago Child-Parent Centers[5]	Children in poverty	5-6 years old	K thru 3rd Grade	$10,000	1996

[1] Multisystemic Therapy Home page http://www.mstservices.com/
[2] Personal communication Eileen O'Brien, March 29, 2002.
[3] Karoly, L.A. et al.(2001). Assessing Costs and Benefits of Early Childhood Intervention Programs: Overview and Applications to the Starting Early Starting Smart Program. Seattle: Casey Family Programs' Santa Monica: RAND.
[4] Ibid.
[5] Ibid.

Safe Start: crisis intervention and brief treatment for young children exposed to violence, 2001-2005; WSU, fiscal agent with Partners as the lead clinical agency in collaboration with NATIVE Project and Spokane Mental Health. Spokane was one of 12 sites funded by the Department of Justice and contributed over half of the clinical data collected in the study. Final reports are in preparation (Dr. Christopher Blodgett, Principal Invesitigator, blodgett@wsu.edu)

Drug Endangered Children (DEC): A Collaborative Community Response, 2003-present, Spokane County Sheriff's Office, fiscal agent; Partners provides multidisciplinary facilitation, forensic interviews, medical examinations, developmental assessments, liaison to Child Protective Service sand children's legal advocacy. Subject of a published article "Drug endangered children need a collaborative community response." (Altshuler, S., 2005)

2. How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

This proposal affects all three goals of access, improving health and improving affordability set by the Blue Ribbon Commission.

Felitti, et al, in 1998 published the Adverse Childhood Experiences (ACE) study following the health history of 17,421 adult clients of Kaiser Permanente's Dept. of Preventive Medicine in San Diego, who voluntarily reported about 8 categories of their experiences as children: (1) recurrent physical abuse (2) recurrent severe emotional abuse (3) contact sexual abuse (4) growing up in a household with someone in prison (5) growing up with domestic violence (6) growing up in a home with a parent who abused substances or who was (7) chronically mentally ill, depressed or suicidal and (8) the loss of at least one biological parent during childhood regardless of cause. Felitti's study then tracks the health consequences and costs throughout life, for example, "Persons who had experienced four or more categories of childhood exposure, compared to those who had experienced non, had 4-to12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt; a 2- to 4-fold increase in smoking, poor self-related health, more than 50 sexual intercourse partners and sexually transmitted disease; and a 1.4-1.6 –fold increase in physical inactivity and severe obesity. The number of categories of adverse childhood exposures showed a graded relationship to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease." (Felitti, et al, 1998, p. 245)

Most children in foster care have been exposed to at least four of these categories and many foster children---and their parents---have been exposed to 5-8 categories.

In the three decades since passage of the federal Child Abuse Prevention and Treatment Act (1974) a large body of literature demonstrates that child maltreatment has long-term negative impacts on children's physical and mental health and that it may be associated with a host of other social problems including juvenile delinquency and adult criminality. The estimated costs to society from child abuse and its related sequelae are

enormous and continue to climb. A report from the Urban Institute recently estimated that costs of government spending on child welfare activities alone were in excess of $22 billion annually and this figure does not take into account government spending on criminal justice, medical, or mental health services related to child maltreatment. (Shaidon, et al, 2006)

Thus, intervention as early as possible with children at risk of these adverse exposures matches the Commission's goals of:

1) Improving access to health care coverage, in this case, health care that is linked to behavioral health and social services, and that seeks justice for these child victims of crime and holds their perpetrators accountable.

2) Improving health by increased use of evidence-based care available to all children across race, gender and income levels.

3) Improving affordability: see initial cost-benefit evaluation (Shadoin, et al, 2006) described in section 4 below.

3. Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.

The Children's Advocacy Center (CAC) Model nationally

Since 1985, at least 600 communities in the United States have initiated investigation and treatment programs based on the Children's Advocacy Center (CAC model) developed in Huntsville, AL.

The Children's Advocacy Center (CAC) model is a child-focused, facility-based program in which representatives from many disciplines -- law enforcement, child protection, prosecution, mental health, medical and victim advocacy - work together, conducting joint forensic interviews and making team decisions about the investigation, treatment, management and prosecution of child abuse cases. CACs are community-based programs designed to meet the unique needs of a community, so no two CACs look exactly alike. They share a core philosophy that child abuse is a multifaceted community problem and no single agency, individual or discipline has the necessary knowledge, skills or resources to serve the needs of all children and their families. They also share a belief that the combined wisdom and professional knowledge of professionals of different disciplines will result in a more complete understanding of case issues and the most effective, child and family-focused system response.

The primary goal of all CACs is to ensure that children are not further victimized by the intervention systems designed to protect them. Program objectives include:

- Developing a comprehensive multidisciplinary, developmentally and culturally appropriate response to child abuse which is designed to meet the needs of children and their families in a specific community;

- Establishing a neutral, child friendly facility where interviews and/or services for abused children can be provided;
- Preventing trauma to the child caused by multiple, duplicative contacts with different professionals;
- Providing needed mental health treatment and other services to children and families;
- Maintaining open communication, information sharing and case coordination among community professionals and agencies involved in child protection efforts so that case decision-making and policy development are enhanced;
- Coordinating and tracking investigative, prosecutorial, child protection and treatment efforts so that cases do not "fall through the cracks";
- Holding more offenders accountable through improved prosecution of child abuse cases;
- Enhancing professional skills necessary to effectively respond to cases of child abuse through cross-disciplinary and cross-cultural training and support;
- Enhancing community awareness and understanding of child abuse.

The Children's Advocacy Center (CAC) model in Washington State

The Spokane program was modeled from that developed at Children's Hospital in San Diego, now named the David Chadwick Center for Child Protection and opened in 1988 and sought accreditation from the National Children's Alliance in 2000.

The Washington State Association of Children's Advocacy Centers was accredited as a state chapter of the National Children's Alliance in 1999. The Spokane program is a member, but this proposal has not yet been submitted to the state organization for endorsement (the press of time to meet the deadline for the Blue Ribbon Commission and current staff turnover for our state association Executive Director).

Therefore, this proposal speaks only to the Spokane experience, but we would encourage the Blue Ribbon Commission to further explore how these resources are developing throughout Washington State and can contribute to the Commission's goals.

The Washington State legislature recognized the value of this community resource and passed legislation in 2003 supporting the concept; followed in 2004 to provide some funding for the seven accredited centers in Washington state and the 5 centers seeking accreditation (see www.wsacac.org). The purpose of this proposal is to advocate for more robust funding, given the significant benefits from these collaborative community efforts.

Benefits

Communities that have developed a Children's Advocacy Center (CAC) experience many benefits: more immediate follow-up to child abuse reports; more efficient medical and mental health referrals; reduction in the number of child interviews;

increased successful prosecutions; and consistent support for child victims and their families.

Professionals involved in multidisciplinary work report greater appreciation and understanding of the mission of other disciplines; better access to cross-disciplinary training, and more informed decision making. This comprehensive approach, with follow-up services provided by the CAC, ensures that children receive child-focused services in a child friendly environment - one in which the needs of children and families come first (National Children's Advocacy Center, 2006).

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) in the Department of Justice has funded a multi-year, multi-site evaluation study by The Crimes against Children Research Center (CCRC) at the University of New Hampshire. Preliminary results on more than 1,000 cases of child sexual abuse from four CACs and from comparison communities without CACs highlight the following benefits:

- **Coordination of investigations:** Police in CAC communities were involved in 81 per cent of child protective services investigations of sexual abuse, compared to 52 per cent in other communities. Team interviews (two or more observers) were more common in CAC cases (28 per cent) than non-CAC cases (6 per cent).
- **Medical exams:** In the CAC sample, nearly half (48 per cent) of child victims received a forensic medical examination compared to less than a fourth (21 per cent) of non-CAC cases.
- **Mental health services:** Sixty percent of the CAC children received referrals for mental health services (compared to 22 percent in non-CAC communities). Of the CAC children referred, 31 per cent were counseled onsite by a therapist specializing in the treatment of child sexual abuse victims.
- **Parents and caregivers in the CAC sample were more satisfied with the investigation than in the comparison sample.**
- **All of the CACs in the study were regarded as community leaders and experts in the area of child abuse,** providing education, consultation and prevention activities in their communities.

The findings begin the process of establishing research-based support for the CAC model and suggest areas for improvement of the CAC response to children.

4. Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?

In 2005, the National Children's Advocacy Center (NCAC) in Huntsville, AL completed work on the first economic evaluation of children's advocacy centers. (Shadoin, et al, 2006). Highlights from the findings of this first study include:

- On a per-case basis, traditional joint investigations by Child Protective Services and law enforcement were 36% more expensive than CAC investigations. The average per-case cost of a CAC investigation was $2902 compared to $3949 for a non-CAC investigation, generating a savings of more than $1,000 per case.

- The total annual operations budget for CAC investigations was 45% higher than that of the total annual operations cost in the non-CAC community. However, on that budget, the CAC multidisciplinary team processed 202% of the average annual investigation caseload compared to the caseload processed in the non-CAC community.
- Annual investigation costs per 1,000 children were 41% lower in the CAC community than in the non-CAC community.
- CAC style investigations result in higher perceived public benefits (The study examines taxpayer willingness-to-pay in some detail—see http://www.nationalcac.org/professionals/research/CBA%20Executive%20Summary.pdf)

Combining these findings with those from the Felitti study on health costs through the lifespan of adverse childhood experiences, the Blue Ribbon Commission is well advised to consider the wisdom of the earliest possible treatment of child sexual and physical abuse and neglect. (Felitti, et al, 1998)

5. How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

Collaboration is the key to the success of these model community responses and the collaboration extends beyond health care disciplines. At the heart of this model is the multidisciplinary team of professionals with expertise in medicine, mental health services, child protection, law enforcement, prosecution and victim advocacy. In Spokane, this collaboration is vigorous, having developed over the past eighteen years since the establishment of the Deaconess clinic.

The Washington state legislature charged each county's prosecuting attorney with the task of convening all stakeholders to articulate a county protocol for child sexual abuse investigations. In Spokane, the protocol was developed in 2000 and updated in 2003, and represents the agreed practice for all stakeholders: Spokane County Prosecutor, Public Defenders, Child Protective Services, law enforcement, FBI, US Attorney, Washington State Attorney General, Spokane Community Sexual Assault Program at Lutheran Community Services, Spokane Victim Witness Unit, Deaconess and Sacred heart Medical centers, Department of Developmental Disabilities, school districts, Martin Luther King Family Outreach Center and Partners with Families & Children, which played a major role in facilitating the agreement.

Partners also facilitates a monthly forum of supervisors from the collaborating systems (affectionately termed "Critique Group"), which functions as a vehicle for joint and cross-training in state-of-the-art techniques as well as a mechanism to trouble-shoot the inevitable difficulties that arise from this multi-system model.

6. What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

This proposal suggests that the Blue Ribbon Commission explore the development of a statewide system of children's advocacy centers, offering the Spokane experience as one example. The Commission is urged to further explore the Washington Association of Children's Advocacy Centers and greatly expanding an integrated

structure of children's advocacy centers throughout the state to allow access for every child victim of crime. The attached posters about the experience of "Robin" graphically portray the promise of the revised model. Such a system, however, cannot be dictated and designed from Olympia and imposed on communities; each community or region has to utilize its own resources and coordinate them in ways that work locally. The county protocols developed through Prosecutor's offices offer a good foundation. Certainly, the state's medical centers have a stake in the provision of this care as an alternative to their emergency departments, but they are not accustomed to begin their health care planning at the local prosecutor's office. The issue is not so much one of overcoming objections as it is finding incentives to do business differently and leadership in cross-system analysis and planning.

Resources

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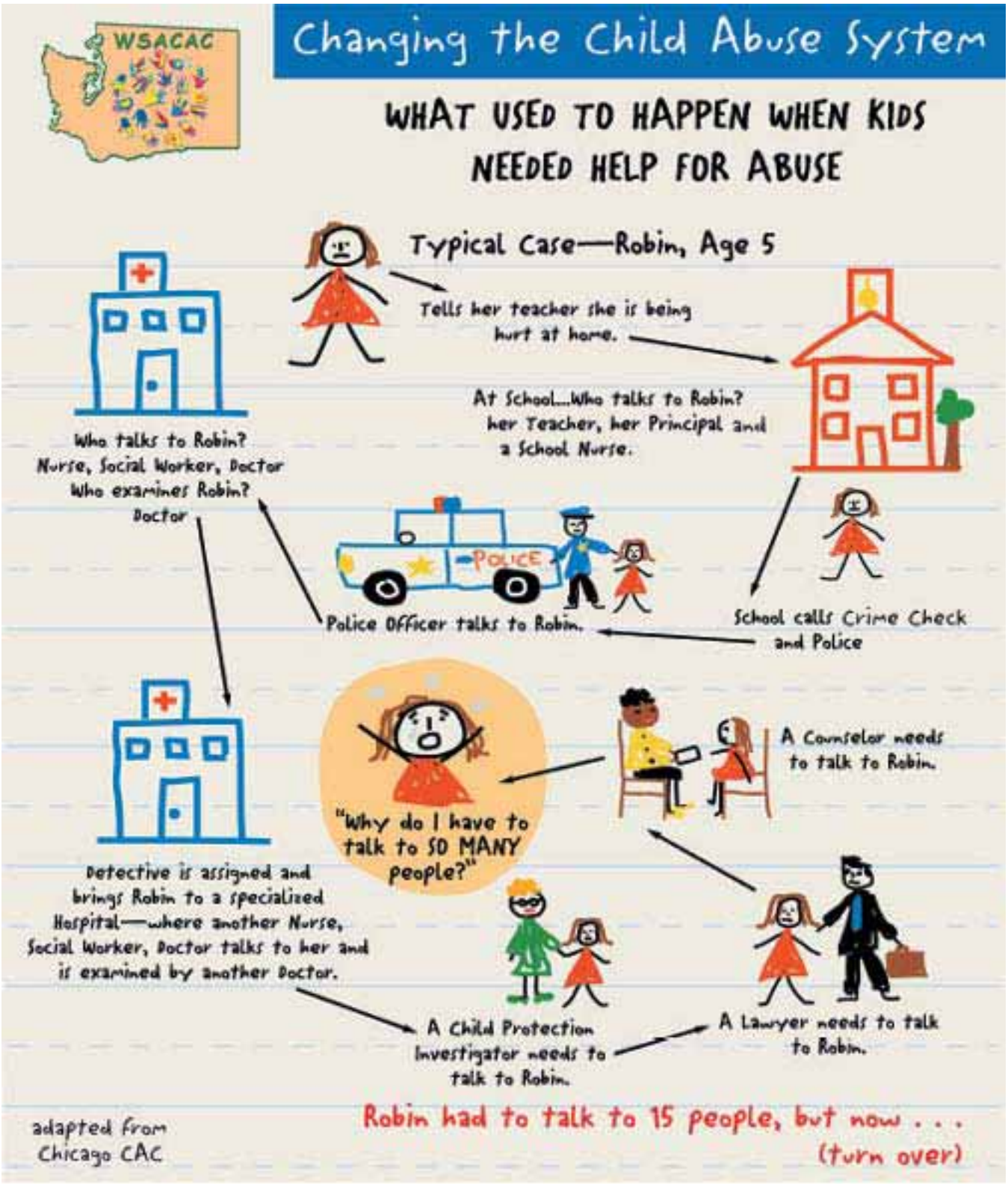
WSACAC
Changing the Child Abuse System
WHAT USED TO HAPPEN WHEN KIDS NEEDED HELP FOR ABUSE
Typical Case—Robin, Age 5
Tells her teacher she is being hurt at home.
At School...Who talks to Robin? her Teacher, her Principal and a School Nurse.
Who talks to Robin? Nurse, Social Worker, Doctor
Who examines Robin? Doctor
POLICE
Police Officer talks to Robin.
School calls Crime Check and Police
"Why do I have to talk to SO MANY people?"
A Counselor needs to talk to Robin.
Detective is assigned and brings Robin to a specialized Hospital—where another Nurse, Social Worker, Doctor talks to her and is examined by another Doctor.
A Child Protection Investigator needs to talk to Robin.
A Lawyer needs to talk to Robin.
adapted from Chicago CAC
Robin had to talk to 15 people, but now . . .
(turn over)

WSACAC
Changing the Child Abuse System
WHAT HAPPENS TODAY WHEN KIDS NEED HELP FOR ABUSE
"This Place is Great"
Robin tells her story, while a detective and CPS worker, Listen as a team
Robin can see a doctor.
Robin is referred to a counselor, who will help her heal.
Robin's mom talks to an advocate to help her understand the system.
Robin comes to the CCAC with her mom.
Tells her teacher that she is being hurt by her mom's new boyfriend at home.
Start Here
. . . Robin talks to 3 people

Tab 35

Blue Ribbon Commission
On Health Care and Costs

August 31, 2006

Proposal for Competition

This proposal will finally bring long sought for competition into health care. The central focus for competition is between traditional primary care and a new entity established to promote health and well being. Many studies and reports clearly indicate primary care is near collapse. (See notes) The recent study comparing cost and health status of US citizens and British citizens shows in a dramatic way the disparity between the two nations. We spend substantially more and are substantially less healthy. (See note 1.)

1. What is to be done. This proposal brings into being a new entity with the primary mission being to promote health in contrast to traditional primary care mission of seeking to find something wrong and fixing it. The first step in "health' is assessing risk of disease due to genetic factors, behavior and life style issues. This will be done by carefully designed risk assessment tools such as the "Diabetes Risk" test designed by the Finns. A ten year review of this tool proved it to be very accurate in predicting who will become diabetic. There are many others that have been developed but are seldom used.

   This would be done by a new entity whose sole mission is risk assessment, counseling patients on risk reduction, and encouragement for better health. Now such counseling consists of "drop a few pounds and get more exercise." In a world where we are constantly bombarded with enticing ads for all things good to eat and drink and "take the easy way" such simple admonishments are seldom effective. Therefore weight control and exercise will be key components that are stressed.

   Such risk assessment can be done on a personal one on one level or be done for whole groups of people such as all employees and family members of a business or governmental entity or a single location of such an entity. Counseling also can be done on an individual or group level. Doing it on a group level provides opportunity for group support and encouragement.

   An important function of these entities would be patient and public education. Now written material for patient understanding of disease is uneven at best. As they develop and establish associations, advocating public policy would become important

   Such entities would render no therapeutic services nor would they prescribe drugs. While supervision by a physician may be necessary, much of the work

could be done by a professional "personal trainer." These entities should not be under the control of any presently established provider of services.

Competition would be on the basis of value of the services provided. As these new entities proved they had a positive impact on the health of their customers, more individuals and employers would seek their services.

2. This proposal will help achieve many of the nine vision goals.

3. I am aware of many risk assessment tools and several wellness clinics, but am not aware of any formal linking them into a single entity that would offer services to individuals and groups.

4. Start up costs and operating costs could be minimum or substantial depending on the scope and size and the number of the entities created. I am aware that some business corporations are now investing in on site clinics for such things as wellness and diabetes. Having worked with many benefit managers, I am aware they keep up with current trends and the report of the disparity between the English and the US must have been disturbing to them as it was to me. In time, a short time I suspect, these services would become part of the benefits offered employees. These services should be eligible for payment from Health Savings Accounts. In addition there are both governmental entities and Foundations that would award grants for start up and operating costs. As such entities proved their worth, a more stable source of funding would emerge.

5. This proposal is from an individual with substantial experience in the health insurance business and more recently as a patient representative with Peace Health with hospitals in Oregon, Washington and Alaska. In a project to improve care of chronic disease of diabetes and congestive heart failure I made a number of proposals to improve care including exercise programs. These were ignored. I was told by one in a leadership position that I should not expect adoption of my suggestions as they would harm hospital revenue. I would not expect any components of the present stakeholders presently delivering services to endorse this proposal. Those who pay for the care would endorse this proposal. And as a parent and grandparent, it is important to me that my family have better care than I receive.

6. The obstacles can be overcome. Enabling legislation would be necessary. That would include licensure, accreditation, regulation and supervision as are present for other service providers. The traditional primary care and intuitional care providers would object. These objections should be addressed by telling them "you failed us." This would further spur competition to be the best in leading patients to the best state of health possible.

Notes

1. See "Disease and Disadvantage in the US and in England." Journal of the American Medical Association, May 24, 2006. This article reports US spends $5,274 and England spends $2,164 per capita per year on Health Care. The conclusion is that US citizens are "much less healthy than their English counterparts and these differences exist at all points of the SES distribution."
2. See "Effective Care" from Dartmouth Atlas Project. This indicates that patients with hypertension, coronary heart disease, pneumonia and colorectal cancer received about 50 percent of the recommended care.
3. See "Insulin Resistance" from the American Heart Association, July 4, 2006. This release indicates 60 million Americans have insulin resistance and that leads to type 2 diabetes, and an increased risk of stroke and heart disease. This is largly ignored by the traditional primary care establishment.
4. See "State of Diabetes in America: A New Report Reveals America's Diabetes Health is in Jeopardy." May 18, 2005. American Association of Clinical Endocrinologists. This reports on the dismal state of care of diabetes in the US.
5. See "Reforming Primary Care: a Comprehensive Strategy From The American College of Physicians." Richard Glickman-Simon, M.D. This report indicates the "collapse" of Primary Care is imminent. See also editorial in NYT on August 30, 2006 regarding the same subject.

Summary comment. I have been involved in health care since 1960. During those 46 years, I have seen costs increase and quality suffer. The exception is of course, in the development of life saving procedures when extreme conditions are present. But our overall health status has suffered. During those 46 years only one change has had any material impact and that is the introduction of the use of DRG's for payment of hospital services. This resulted in a substantial reduction of use of in patient hospital services. Now we have patient centered care, seamless care and evidence based medicine. While these are worthwhile ideas, in my experience with Peace Health and my personal experience as a patient, they are largly ignored.

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360 383 0331

Tab 36

Peter Anderson
Director
State Policy

PhRMA

September 1, 2006

Washington State Blue Ribbon Commission
on Health care Costs and Access

Re: Proposals

Dear Commission Members:

The Pharmaceutical Research and Manufacturers of America (PhRMA) supports the efforts of the Blue Ribbon Commission on Health Care Costs and Access and appreciates the opportunity submit proposals regarding what to do to realize the vision and goals to develop "a sustainable five-year plan for substantially improving access to affordable health care for all Washington residents."

PhRMA is committed to ensuring that all patients have access to affordable medicines. As such, we are submitting for your consideration three proposals. The proposals address the following: tax incentives to encourage physicians and other healthcare providers to provide treatment for the uninsured; promote reauthorization and enhance the outreach and enrollment of the State Children's Health Insurance Program (SCHIP); and greater use of lower cost, more affordable limited healthcare benefit policies.

While we did not address the Washington Basic Health Plan in our proposals, we recognize the valuable services that it has provided for nearly 20 years. Accordingly, we would support efforts to build upon the existing program and would assist in that endeavor. PhRMA stands ready to work with the Commission in order to examine these as well as other opportunities to improve access to affordable health care for all Washington residents.

Thank you for the opportunity to submit comments to the Blue Ribbon Commission and please contact me at (916) 233-3480 if you desire additional information.

Sincerely,

Peter C. Anderson

Pharmaceutical Research and Manufacturers of America

1215 K Street, Suite 970, Sacramento, CA 95814 • 916-233-3480 • Fax 916-233-3488
mjacobs@phrma.org www.phrma.org

Pharmaceutical Researchers and Manufacturers of America (PhRMA) Proposals to the Washington State Blue Ribbon Commission on Health Care Costs and Access

In order to reach the Commission's goal of developing a system which provides every Washingtonian the ability to obtain needed health care at an affordable price, PhRMA is submitting three separate proposals: tax incentives to encourage physicians and other healthcare providers to provide treatment for the uninsured; promote reauthorization and enhance the outreach and enrollment of the State Children's Health Insurance Program (SCHIP); and greater use of lower cost, more affordable limited healthcare benefit policies.

Proposal 1.

1. What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access? Briefly summarize your proposal.

The proposal is intended to provide a business and occupation (B&O) tax credit or deduction for physicians and other healthcare providers for the cost of treatment for the uninsured. The B&O tax is imposed on the gross receipts of business activities conducted within the state, without any deduction for the costs of doing business. The tax is imposed on the gross receipts from all business activities conducted within the state.

2. How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

Access to medical care and healthcare services is directly correlated to an improvement in long-term patient health outcomes and health costs. Preventive services both postpone and/or eliminate the development of high cost conditions such as diabetes, asthma and hypertension.

Tax incentives can be important tools in assisting the uninsured by encouraging healthcare providers to provide treatment for which they otherwise would be uncompensated. It is important to support tax incentives at the state level that provide the greatest utility to uninsured consumers.

3. Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.

Washington is one of two states that utilize a B&O tax, and neither state currently provides a tax deduction for the treatment of the uninsured. However, generally, states with income taxes provide deductions for losses and charitable contributions such as those that may result from charitable care as characterized in this proposal.

4. Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?

Implementation of a B&O tax credit or deduction will result in a loss of General Fund revenue to the state. However, this could be offset by a reduction in state costs of treating the uninsured in hospital emergency rooms for conditions that would have been more easily treated weeks before the emergency room visit.

5. How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

The problem of the uninsured will not be solved in a vacuum. It will take concerted efforts and cooperation from all the stakeholders involved in the every aspect of healthcare, business and state government communities. Patient advocates will need to support this effort and convince policy makers that this will result in necessary care for individuals who otherwise would go without medical treatment.

6. What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

Everyone involved in creating a solution and behaving in a cooperative manner. There are numerous groups that could hold up the design of such a program or limit their cooperation. Pro-tax organizations may object to the proposal or special interest groups may be concerned that this may be funded at the expense of their favorite government program.

Proposal 2.

1. What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access? Briefly summarize your proposal.

Enhance the Healthy Kids Now! (Washington's SCHIP) so that it continues to provide coverage to uninsured children of low-income working families. This can be accomplished in two ways:

- The SCHIPs federal reauthorization is in 2007 and opportunities exist for the state to take a leading role in encouraging reauthorization and a higher level of funding.
- Partner with various state and national groups to promote enrollment in these program to ensure childhood access to care and preventive medicine.

2. How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

Existing programs for children's health insurance have been utilized extensively since 1998 and have proven to be very successful at covering the uninsured. Reauthorizing the program at higher funding levels, or at least maintaining current funding levels, could be an effective tool in securing the gains on child health coverage made over the past ten years. Possible funding increases may be important to factor in the measures of healthcare inflation that have occurred since the creation of SCHIP. In addition, partnering with a state or national organization would promote children's health overall, and would help reach the goal of outreach and enrolling those children at greatest risk of falling through the healthcare safety net.

3. Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.

All states are concerned with the about the reauthorization of the SCHIP program, its authorized funding level, and how to best outreach to those most at-risk in the community.

4. Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?

Reauthorization of the program will result in continued federal costs, state matching costs, and successful additional enrollment will result in new costs at both levels.

5. How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

Stakeholders involved in all aspects of both the SCHIP programs and healthcare overall will have to active in lobbying for SCHIP reauthorization. Patient and child advocates will need to support this effort at the state and national levels and convince policy makers that reauthorization of this program will result in necessary care of children who otherwise would go without medical treatment.

6. What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

The existing federal budget deficit and competing federal programs will be obstacles to obtaining additional funding or even maintaining existing funding levels.

Proposal 3.

1. What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access? Briefly summarize your proposal.

Maximize the use of limited benefit plans, which provide primary or preventive services, which are less costly and more affordable for lower income uninsured individuals and families.

2. How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

Access to medical care and healthcare services is directly correlated to an improvement in long-term patient health outcomes and health costs. Preventive services both postpone and/or eliminate the development of high cost conditions such as diabetes, asthma and hypertension.

In an effort to improve access to health coverage and preventive healthcare services in the low-income and uninsured populations, more affordable limited healthcare benefit policies should be promoted as long as they include adequate pharmaceutical services that demonstrate the importance of drugs in the healthcare continuum.

- Limited benefit plans are designed to provide a finite set of health benefits generally focused on preventive care and some basic level of health services.
- Pharmaceuticals must play a key role in all acceptable limited benefit plans.
- Limited benefit plans should be targeted to uninsured individuals who cannot afford existing health insurance policies and should not be used in the broader population.
- Limited benefit plans should not be advocated as a replacement for comprehensive health insurance.

In addition, the expansion and improved access to insurance programs may help improve the overall health insurance market by expanding population risk-pools and decreasing the need for uncompensated care and cost-shifting. In the scope of overall healthcare transformation, insurance reform and new product development will serve both the uninsured and healthcare stakeholders overall.

3. Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.

Limited benefit plans are currently available in Washington and in some other states to varying effect.

4. Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?

There would be a cost to individuals or families who are otherwise uninsured. However, the cost would be far less than the cost of standard, comprehensive health insurance. Both the state and counties may witness savings by limiting the number of uninsured and reducing the amount of uncompensated medical treatment.

5. How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

Creation of an equitable and functional limited benefit policy will take considerable cooperation on the part of insurers, patient advocates, and the state insurance commission who ultimately approves of state insurance offerings. Patient advocates will need to be involved to ensure that any products are of substantive value and address the most identifiable health cost drivers.

6. What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

Patient advocates may demand only comprehensive coverage for the uninsured. They may contend that these policies only include primary or preventive services and individuals would have to pay for necessary specialty coverage out of pocket. Limited benefit plans are not full health care coverage, could be viewed as a “band-aid” and not a long-term solution.

Tab 37

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August 28, 2006 Contact: David McLanahan, MD, PNHPWW Coordinator

PNHPWW Recommendations to the Governor's Blue Ribbon Commission on Health Care Access and Costs

First and foremost, PNHPWW recommends and works toward a national single-payer health program as the only sustainable solution to our national health care crisis in access and costs affecting all the states. Given that implementation of such national legislation is at least 3-5 years away, we are submitting our recommendations for a single-payer plan for Washington State. We believe that such a program, apart from being of benefit to our residents, would encourage the passage of national legislation.

The task of the Commission is to recommend to Governor Gregoire and the Legislature by December 1, 2006, a sustainable five-year plan to substantially improve access to affordable health care for all Washingtonian residents. Our recommendations in response to the six questions posed by the BRC are as follows:

1. What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access? Briefly summarize your proposal

Set up a single health care plan that guarantees quality health care to every resident of Washington State.

We outlined the crisis in access and costs and arguments for a single-payer system in our ***Statement by the Western Washington Chapter of Physicians for a National Health Program*** previously submitted to the BRC. In summary, single payer advances the Commission's goals of increased access and controlling costs by:

- providing high quality, comprehensive health care to every resident of Washington State
- saving the State expenses by significantly lowering administrative costs, giving leverage to control costs of purchases such as drugs and medical devices; minimizing wasted health care dollars through enhanced public health, self-care, disease prevention, and strong primary care; identification and elimination of unnecessary care and procedures; global budgeting based on prior experience and need

- facilitating allocation of resources to provide more uniform care helping to eliminate gaps and disparities across all sectors of our population
- facilitating implementation of electronic medical records and providing a State data base on health service utilization and health outcomes, thereby facilitating quality control and implementation of evidence-based medicine
- fostering transparency in coverage decisions giving greater accountability to the public
- improving the outlook for Washington State business by ensuring a healthy workforce, decreasing overall average costs, thereby enhancing its comparative position in the global market.

If we had had a single-payer health insurance program in 2003, out of total health spending of about $30 billion, Washington State would have saved $5.3 billion in administrative costs according to estimates by the leading researchers in the field. That was $6,735 dollars for each of our 780,000 uninsured residents, more than enough to provide comprehensive coverage for all. (Woolhandler S, Campbell T, and Himmelstein DU. "Administrative Waste in the U.S. Health Care System in 2003: The Cost to the Nation, the States, and the District of Columbia, with State-Specific Estimates of Potential Savings", *International Journal of Health Services*, 34:1, 79-86, 2004).

A. PNHPWW Recommendations for BRC study and analysis

The BRC action plan includes analyzing submitted reform proposals from stakeholders in our current system, consumer advocacy groups, and doing its own independent research. We recommend study of California Senate Bill SB 840. This single-payer legislation would provide access to quality health care for all residents of California. It has been carefully formulated with input from health policy experts, provider groups, advocacy groups, and politicians. Details of its administrative setup and accountability, mechanisms for quality improvement and control, etc, are too extensive to be detailed here but are easily available to the BRC. This discussion will focus on funding options and impacts, always the most difficult and controversial aspects of reform legislation. California SB 921, the precursor to SB 840, was critically analyzed in the Lewin Group report "The Health Care for All Californians Act: Costs and Economic Impacts Analysis," dated 1/19/2005. This study specifically examines SB 921's cost impact on statewide health spending, program costs and revenues, and impact on state and local government, private employer and family health spending. These evaluations would be generally applicable to Washington State.

In California, the Lewin study found that single-payer bill SB 921would cover everyone, including undocumented immigrants and the uninsured, and still reduce health spending by $8 billion in the first year. This is especially remarkable given that California has a much larger undocumented immigrant population and nearly 18.7 percent of their population uninsured, compared with 13.0 percent in Washington State (2004 data, from the Census Bureau).

We recommend that the BRC study SB840 and invite The Lewin Group to make a presentation to the BRC about their study and how it would apply to Washington State. This independent, highly regarded economic analysis firm has over 20 years experience studying the impact of health reform initiatives on major stakeholder groups including governments, employers, providers, and consumers. As noted in response to Question 2 below, the Lewin Group's experience includes analyses and comparison of many different types of reform initiatives in at least 8 different states.

B. PNHPWW Recommendations for the BRC to present to the Legislature.

PNHPWW advocates that the BRC recommend to the Washington State Legislature that it formulate health care reform legislation based on California SB 840 with modifications as necessary to adapt to specific conditions in Washington State. SB 840 provides for a state Health Insurance System administered by an independent Health Insurance Agency, directed by the Health Insurance Commissioner (appointed by the Governor and confirmed by the Senate). Its intent is to establish a system of universal health insurance that covers all residents with comprehensive health insurance benefits, guarantees a single standard of care, and improves the quality of health care. Apart from establishing a carefully integrated and responsive system, the new program stabilizes and constrains the growth in health care spending by linking it to GDP growth.

On a single-payer basis, the Agency would negotiate for or set fees for health care services provided through the system and pay claims for those services from the State Health Insurance Fund established in the State Treasury. SB 840 would prohibit health care service plan contracts or health insurance policies from being issued for services covered by the state Health Insurance System.

SB 840, as passed by the full California Senate May 31, 2005, did not detail how revenues would be collected other than require the Commissioner to seek all necessary waivers, exemptions, agreements, or legislation to allow various existing federal, state, and local health care payments to be paid into the Health Insurance Fund, which would then assume responsibility for all benefits and services previously paid for with those funds. SB 840, as amended and passed by the California Assembly Appropriations Committee on August 22. 2006, would create the California Health Insurance Premium Commission to determine the cost of the California Health Insurance System and to develop a premium structure for the system that complies with the following criteria:

(1) be means-based and generate adequate income
(2) to the greatest extent possible, ensure that all income earners and all employers contribute a premium amount that is affordable and that is consistent with existing funding sources for care in California.
(3) maintain the current ratio for aggregate health care contributions among the traditional health care funding sources, including employers, individuals, government, and other sources.
(4) provide a fair distribution of monetary savings achieved from the establishment of a

universal health care system.

In SB 840's precursor, California SB 921, state health care costs in excess of the amount collected from existing funding sources and paid into the Health Insurance Fund would be raised through new dedicated taxes created to replace what business and families were currently spending on health insurance premiums and out-of-pocket expenses eliminated under SB 921. Of the many possible options, SB 921 included a payroll tax of 8.17% on employers and 3.78% on employees ($7000 floor; $200,000 ceiling), self-employment business tax of 11.95% ($7000 floor; $200,000 ceiling), non-wage/business tax: 3.5% ($7000 floor; $200,000 ceiling), and a surcharge of 1% of taxable income above $200,000. These taxes would be adjusted automatically each year to the level required to pay for the program.

The Lewin Group estimated SB 921 would save the state of California $8 billion in 2006. A partial summary of their findings follows:

Increased program costs due to *additional utilization* of services:

- by individuals previously uninsured: $5.9 billion
- by individuals "underinsured" compared to new plan: $4.5 billion
- for increased home and community-based services: $1.5 billion
- increased utilization due to elimination of patient cost-sharing: $9.5 billion

Net program savings due to:

- increased use of primary care: $3.4 billion
- bulk purchasing of drugs and durable medical equipment: $5.2 billion
- decreased administrative costs (including insurance, hospital, and physician costs): $19.9 billion
- improved fraud protection: $765 million

Economic Impact on Stakeholders

- employers currently providing insurance coverage would have a decrease in average cost per worker by $775. The biggest savings would be for firms with under 10 workers and greater than 500 employees.
- employers not currently offering insurance coverage would have an average cost per worker of $2,290.
- average family health spending would be reduced for families earning under $150,000 per year. Average family spending would increase somewhat for families earning over $150,000.

Since Washington State doe not have a state income tax, there will need to be other ways to make up the shortfall between program costs and revenues. PNHPWW recommends that such measures should not inhibit access and should be progressive. We recommend payroll taxes rather than premiums, deductibles, or co-pays. A payroll tax should be compatible with ERISA restrictions as this tax can be considered not as a tax for an employer mandated health benefit but as a tax collected by the employer and passed on to the Health Insurance Fund in the same way that employers now collect Medicare taxes.

2. How will the implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission. How do you know?

BRC Goal of Improving Access

Guaranteed insurance coverage for all residents under a single comprehensive program will insure access.

BRC Goal of Improving Health

Barriers to receiving quality care will be eliminated. Ensured access will improve disparities in health care statistics across race, gender, and income levels. A single plan will facilitate coordination of care, evidence-based medicine, electronic medical records and many other major improvements. These measures will assure that Washington State will be one of the top 10 healthiest states in the nation.

BRC Goal of Improving Affordability

By eliminating the wasted health care dollars spent on administration in our current multi-payer arrangement, introducing economies of scale and bargaining power, and resources saved by improving the health of our citizens, a single state insurance system will reverse the rate of increase in total spending.

Many independent studies of options for state health care reform have concluded that a single-payer system is the best way to cover everyone and decrease overall costs, the only plan that does so when different reform models were compared:

•New Mexico 1994 – Lewin Group looked at single-payer, managed competition, employer-mandates
•Delaware 1995 - by Solutions for Progress
•Minnesota 1995 – Lewin Group -VHI
•Massachusetts 1998 - Lewin Group/Boston University School of Public Health
•Maryland 2000 - Lewin Group study comparing single-payer and “Pay or Play”
•Vermont 2001 - Lewin Group
•Massachusetts 2002 – Lewin Group studied 3 models
•California 2002 - Lewin Group looked at 9 models
•Maine 2002 - Mathematica Policy Research
•Rhode Island - 2002 Boston University School of Public Health/Solutions for Progress
•Missouri 2003 - Missouri Foundation for Health
•Georgia 2004 - Lewin Group
•California 2005 - Lewin Group
•Mississippi – Lewin Group
•Connecticut 2006 - Economic and Social Research Institute/Urban Institute

A recent study conducted for Connecticut by the Economic and Social Research Institute/Urban Institute in 2006 compared three health care reform models:

1. State single-payer plan
2. State pool with competing private plans for uninsured
3. Expanding health coverage safety net for low & moderate income adults & all children

The models compared were measured by the criteria of "universal health care" set by the Institute of Medicine (100% coverage and affordable). The single-payer model (100% coverage at 16% reduced cost) was the only model to fully satisfy the Institute of Medicine criteria.

3. Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program or its outcomes

There is no existing state program insuring access to all its residents. The most prominent, detailed, and researched current legislation is California SB 840 SB as introduced by Senator Sheila Kuehl and described above.

4. Will your proposal impose costs on individuals, businesses or government? Will these costs be time limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?

A single-payer program for Washington State would pay for all medically necessary health services, with total expenditures set at the same proportion of state GDP as in the year prior to implementation of the program. Federal, state, and local public monies now spent directly on health care or insurance as well as public funds routed through private insurers would be paid into the program. Employer and employee contributions to current health plans would be eliminated and could be replaced by payroll taxes as described above or in some other fashion. The mix of taxes used by the Legislature to raise funds is a matter of tax policy separate from the organization of health care but should be on a progressive basis.

The above-mentioned state studies of state single-payer health insurance plans concluded emphatically that any increased costs would be offset by corresponding savings and would be sustainable.

Funding for the new Washington State plan would require waivers or federal legislation to allow federal, state, & local health care payments to be paid into the state insurance

system. There are currently three bills introduced in Congress that would enable states to use currently federal funds:

1. Health Partnership Act (S.2772) *Senators George V. Voinovich (R-OH) and Jeff Bingaman (D-NM)*
2. State-Based Health Care Reform Act *Senator Russ Feingold (D-Wisc)*
3. The Health Partnership Through Creative Federalism Act [2] (HR 5864*) Reps. Tammy Baldwin (D-WI) and Tom Price (R-GA)*

5. How does your proposal reflect collaboration among the various stakeholders? Which stakeholders have endorsed it?

All of the necessary stakeholders could easily collaborate on the new Washington State program. Their expertise is very important. Hundreds of organizations have endorsed national and state single-payer health insurance plans. Of course, the multiple insurance plans would no longer be necessary.

Current insurance industry personnel with qualifications required by the new plan could be absorbed. Help finding new employment or retraining for those displaced would be a priority. There is a great need for additional workers in long-term care and home care for our aging population. Retraining workers to work in long-term care would be very helpful. Also, many utilization review and other administrative staff are nurses - returning nurses to the bedside would help with the nursing shortage. There are also shortages in residential supportive services for the mentally ill - another area where displaced workers could help improve the quality of care and reduce the need for hospitalization. These needs are much more pressing than maintaining an insurance bureaucracy.

6. What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

The opponents to fundamental health care reform have power, money, and media, and, therefore the ear of many politicians. The insurance companies who would lose a share of their health insurance business would present the biggest obstacles. The pharmaceutical industry would have to bargain drug prices and would see decreased profits. Many providers fear change and decreased income (especially specialists). Many small businesses and others that do not now pay for employee health insurance would have to pay a share. Also, banks and the credit industry would see HSA account profits disappear. Their objections need to be addressed by putting the good of society as a whole ahead of special interest groups.

On the other hand, the potential supporters of fundamental reform are vast. The uninsured all would be covered. The elderly & middle class would not worry about underinsurance

and financial ruin. Medicaid recipients would be assured of access and one standard of care. Big Business would find a way to contain rising health costs and improve its position for international competition. Physicians would cut their administrative costs and time wasted on paperwork. Union workers would not need to bargain for health benefits and could focus on other issues.

Most national polls, the CHCWG experience, and initiatives such as the one recently passed overwhelmingly in Seattle indicate the public is ready to back legislators taking a stand for guaranteed health care access. The impediment to fundamental reform in health care is not economic, but political. Political will, not economic expertise, is what will bring about this important change. Many BRC members have expressed "off the record" that they favor a single-payer health insurance program, that it is the only rational solution to our crisis in access and costs, that it will, *eventually*, come to pass, but that it is not now politically feasible. Washington State needs leadership *now* from the BRC to "do the right thing."

Tab 38

Planned Parenthood Public Policy Network of Washington

2001 E. Madison • Seattle, WA 98122

August 31, 2006

The Honorable Christine Gregoire
The Honorable Pat Thibaudeau
Co-Chairs, Blue Ribbon Commission on
Health Care Cost & Access
By email: Hcca_brc@leg.wa.gov

Dear Governor Gregoire, Sen. Thibaudeau, and Commission Members:

Thank you for this opportunity to participate in the Commission's effort to achieve its vision of a health care system that provides every Washingtonian the ability to obtain needed health care at an affordable price.

We write today on behalf of Planned Parenthood and other community-based family planning agencies, which serve as the point of entry into Washington's health care system for thousands of of individuals. Each year, 3.1 million women, men, and adolescents enter a Planned Parenthood center in nearly 1,000 American communities and leave treated and better educated about themselves, their bodies, and their health needs.

In 2005, Washington Planned Parenthood staff members, interns and volunteers provided approximately 215,000 people with sexual and reproductive health services. Planned Parenthood and other publicly funded family planning agencies helped prevent 23,000 unintended pregnancies in Washington in 2005 (WA Department of Health).

The range of health care services offered by community family planning clinics include:

- a complete medical history and physical examination;
- screening for cervical and breast cancer;
- testing for anemia, sexually transmitted diseases and pregnancy;
- education about pregnancy prevention, STDs, birth control methods, infertility, prenatal care, nutrition and other related health issues;
- provision of medically approved birth control methods;
- pregnancy termination;
- referral to other health and social services as needed.

Planned Parenthood health educators provided a wide variety of educational programs to over 51 thousand people of all ages and in a variety of settings—from middle schools and universities to non-English speaking and homeless populations, from prisons and social service programs to religious institutions and civic organizations. Programs focused on 25 content areas including teenage pregnancy, abstinence, contraception, family planning, sexually transmitted infections, HIV/AIDS, rape and sexual abuse, parent-child communication, women's health, sexual orientation and family life education.

Family planning providers understand the crisis in America's health care system because our clients, especially young, poor women, are those whose needs have been all but ignored by that system. We are committed to helping shape a reformed health care system that is truly responsive to the needs of women and men of reproductive age, adolescents, communities of color, and vulnerable populations.

1. **What do you propose to be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access?**

As community safety-net providers, our message is straight-forward: the best chance to improve health care outcomes and control costs is for Washington State to redouble its efforts to prevent unintended pregnancy by providing access to contraception, family planning services and medically accurate sexual health education.

Access to preventive reproductive health services is a linchpin, not only for women's health, but also their economic security and family well being. Unintended pregnancy is a risk factor for inadequate prenatal care, low birth-weight, and exposure of the fetus to tobacco, alcohol and other substances. It is also a risk factor for neonatal death, domestic violence, and child abuse. It is associated with economic hardship, failure to achieve educational and career goals, and the failure of marriages.[1]

Policymakers in Washington State have grappled with the issue of unintended pregnancy as a health care system cost driver for years.

In 1998, the Department of Health submitted a report to the legislature about insurance coverage of contraception. At that time, data showed that 57% of all pregnancies were unintended, and half of those pregnancies ended in abortion.[2] In its findings, the department noted: "[t]here is a wealth of literature on unintended pregnancy and contraception. The literature almost universally calls for increased access to comprehensive contraception, including reducing financial barriers…" The department cited numerous studies, including:

- The *Health of Washington Women*, published by the Washington Women's Education Foundation in August 1997, which recommended that "all health plans in Washington cover the full range of FDA-approved contraceptive methods [and that] state policy should increase funding for subsidized contraceptive services for low-income uninsured women. Access to reproductive health services should be comprehensive, culturally appropriate, and include both medical services and related counseling and patient education. Services should be provided in a variety of settings, including health plans, community clinics, public health departments and districts, and school-based clinics. And, Washington women should have access to a 24-hour statewide clearinghouse for information on family planning information and services."

- The 1998 *Washington State Public Health Report*, which recommended assurance of confidential access to family planning and other reproductive health services, especially to teens and other at-risk populations. The report also recommended working to increase public awareness of the incidence, costs, and consequences of unintended pregnancy.

[1] Federal Title X Family Planning Program.
[2] *Contraceptive Services Sunrise Review Report*, Department of Health, 1998, pg. 3.

The Contraceptive Services Sunrise Review Report highlighted the cost savings: "[o]ver the course of five years, a sexually active woman who does not use contraception will cost private insurers a total of $14,500 for pregnancy related care. According to a report entitled *Contraceptive Technology, 17th Revised Edition*, in a single year 85 out of 100 sexually active women not using a contraceptive method will become pregnant."[3]

Since 1998, Washington State has become a national leader on pregnancy prevention efforts, but its progress is threatened by budget cuts and bureaucratic red tape.

We were on the right track with *Take Charge*, Washington's Medicaid Section 1115 Waiver Family Planning Program.[4] Now in its sixth year, the program provides free family planning services for one year to low-income women and men with no health insurance. The *Take Charge* program has been overwhelmingly successful.[5] Despite increases in population growth, the program has contributed to a 3.5% decrease in the state's abortion rates and a 2.5% decrease in the state's birth rates. According to the Department of Social and Health Services, for every dollar spent on *Take Charge*, Washington saves approximately $3.30 in future care and services, and four of five program objectives described in the initial application (December 1998) have been achieved, or exceeded:[6]

- An estimated 21% of the women eligible under the waiver, who would have had an unintended pregnancy, remained pregnancy free.[7]
- The proportion of clients using a more effective family planning method increased from 53% at enrollment to 69% one year later. The proportion that reported using abstinence in the prior two months increased slightly, from 10.8% to 11.2%.
- The number of Medicaid women who received services from family planning clinics increased from 22,850 during the baseline year to 85,607 in year one, 108,253 in year two, and 121,997 in year three.
- The number of Medicaid men receiving family planning services increased from 850 during the baseline year to 3548 in year one, 4384 in year two, and 5018 in year three.

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[3] *Id*. at 6

[4] The waiver program was supported by the WA. St. Council on Family Planning, the WA. St. Association of Local Public Health Officials, the American College of Obstetricians and Gynecologists, the WA. Federation of Business and Professional Women, the Washington State Labor Council, the Parent-Child Assistance Program (P-CAP), the American College of Nurse Midwives Washington Chapter, the League of Women Voters of Washington, the National Council of Jewish Women, the American Society of Sexuality Educators and Trainers (ASSET), the Children's Alliance, the Health Coalition for Children and Youth, the March of Dimes, the American Association of University Women, the Northwest Women's Law Center, ARNPs United, Washington State Community and Migrant Health Centers, the National Organization of Women, and the Washington State Women's Health Care Coalition, Washington Women United and Women In Unity/Puget Sound Chapter and Planned Parenthood.

[5] According to the Department of Social and Health Services, "the decrease in Washington birth and abortion rates, especially for young women, implies that many unintended pregnancies have actually been averted." "The statewide birth rate for women 15-44 decreased by 9% from 66.4 per 1000 in 1991-92 to 60.5 per 1000 in 2001-02. The birth rate for young women, age 15-24, decreased by 24%, from 85.7 per 1000 in 1991-92 to 64.9 per 1000 in 2001-02. In 2001-02, birth rates for older women, 25-44, both low income and higher income, were essentially the same, at 58.7 and 58.4 per 1000. By 2001-02, the birth rate for young higher-income women (50 per 1000) was lower than that for older higher-income women (58.4 per 1000) while the birth rate for young low-income women (84.4 per 1000) remained higher than that for older low-income women (58.6 per 1000)." CSO Profiles, Birth & Unintended Pregnancy Statistics for Community Service Offices, 1991-2002, The Department of Social and Health Services Management Services Administration, Research and Data Analysis Section.

[6] The fifth objective about raising provider awareness of unintended pregnancy prevention represents a long-term goal and a number of initial steps to facilitate this objective have been completed. http://www1.dshs.wa.gov/rda/research/9/72.shtm

[7] *Id*.

But the program's success is at risk. Inadequate reimbursement rates, bureaucratic red tape and benefit cutbacks threaten to derail the entire program.

***Impact of Inadequate Rates**:* Some small, independent family planning providers in rural, underserved communities with high unintended pregnancy and STD rates are struggling so severely with inadequate Medicaid and *Take Charge* reimbursements that they are unable to purchase needed contraceptive drugs and devices and are, instead, sending patients to pharmacies as their only alternative. Rising costs and flat Title X family planning funding only exacerbates the problem.

***Benefit Cutbacks*:** The State Department of Health (DOH) and the Centers for Disease Control (CDC) strongly recommend that clinics test and treat all sexually active women under 25 years of age for Chlamydia—largely because this sexually transmitted disease (STD) has no symptom and can have devastating life-long consequences. As of 2004, STD testing and treatment is no longer a covered service under *Take Charge*, despite the fact that many men and women obtain family planning counseling and contraceptives during an STD-related office visit. Family planning clinics and local health departments are relying almost entirely on the DOH Infertility Prevention Project (IPP) to try to provide Chlamydia testing, but that program is now overwhelmed and has capped the number of Chlamydia tests that a family planning clinic may do under the project. Despite alarming increases in gonorrhea, syphilis, and other STDs in Washington, there are no other state or federal dollars available to local family planning clinics for the testing and treatment of these diseases. As a result, many family planning providers are seeing sharp decreases in the numbers of men and teens coming into their clinics, which undercuts our efforts to provide them with pregnancy prevention counseling and contraceptive methods.

In addition, DSHS is implementing new federal restrictions that prevent a person who has private insurance of any kind from accessing family planning services under *Take Charge*, even if their insurance does not cover contraceptives or the contraceptive method they need. This includes minors who are covered by their parents' insurance, but are unable to use that insurance without compromising their right to privacy and confidentiality under state law.[8]

***Bureaucratic Red Tape**:* Onerous new eligibility criteria, such as requirements for social security numbers and proof of citizenship, are significant obstacles for patients--especially young, minority, and vulnerable patients--who lack access to necessary documentation and/or social security numbers. Unnecessary regulations, frequent changes to billing requirements and reimbursement rates and excessive paperwork requirements place enormous burdens on health care providers. Today, family planning clinics spend hours of staff time filling out paperwork and working with young, at-risk clients to navigate cumbersome eligibility processes and comply with government regulations. These valuable staff hours could be better spent providing direct health services.

To get *Take Charge* back on track, improve the health of Washington residents, and contain health care costs, state policymakers should ensure that:

- Family planning services and STD testing and treatment are available at no cost to uninsured and underinsured individuals with incomes at or below 250% of the federal poverty level.

[8] The state may grant exceptions for confidentiality reasons only on a case-by-case basis.

- Medicaid and *Take Charge* program requirements and reimbursement rates are reasonable so that local county health departments and local non-profit health care providers – who are the backbone of these programs – can continue to be community partners. While the majority of providers are capping the number of Medicaid clients they will see, family planning clinics are not. Medicaid and *Take Charge* clients make up approximately 73% of the clients served by family planning providers. Unreasonably low Medicaid reimbursements threaten our continued ability to serve Medicaid and Medicaid waiver clients.
- Recognize and treat family planning services as an appropriate entry point into the health care system. More than 70 percent of all women who see a gynecologist or a women's health care specialist do not see any other health care provider. It's their primary point of entry into the system.
- Family planning services are convenient, confidential, and sensitive to the individual's cultural background.
- Services emphasize the prevention of illness and consumer education, not just treatment of disease and pain. And patient education must be a priority. A Harris poll on women's health found that many American women were not receiving basic preventative health care services. One of the main reasons reported was the lack of information from their physician, including the absence of counseling.
- In order to help control costs and increase access to care, the role of nurses, midwives and physician assistants should be expanded. With the present shortages of health care providers in underserved communities, our state must do everything it can to expand access into the health professions, promote efforts to recruit culturally and geographically diverse students, and increase support for financial assistance programs to help low- and middle-income students pursue health care training.
- Community safety net providers—community clinics, migrant clinics, tribal clinics and family planning clinics, are supported and integrated throughout the health care system. These organizations have a demonstrated ability to reach traditionally underserved groups with cost-effective, culturally appropriate health services. Washington should examine the Minnesota model, which required health plan networks to include community safety net providers to ensure timely access to essential public health services, including family planning.[9]

2. How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission?

Ensuring access to family planning and STD services to insured and uninsured persons across all income levels will ensure that population health indicators are consistent across race, gender and income levels. Family planning *is* evidence-based care that ensures better health outcomes by permitting women and men to plan the number and spacing of pregnancies. Providing access to family planning services helps reduce the risk factors identified by above (inadequate prenatal care, low birth-weight; and exposure of the fetus to tobacco, alcohol and other substances; neonatal death, domestic violence, and child abuse). Washington's *Take Charge* data shows that every dollar spent on preventive family planning services saves the state $3.30 in future health care costs.[10]

[9] Minnesota Statues (2006) 62Q.19 Essential community providers.
[10] DSHS *Take Charge* Interim Evaluation

3. **Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the program and its outcomes.**

Our proposal is modeled after successful public health programs in Europe and Canada. These countries have rates of unintended pregnancies, abortion and sexually transmitted diseases that are a fraction of the rates in Washington and the United States. But we need not look beyond the borders of Washington to see the benefits that family planning brings. We urge state policymakers to recognize the success of the *Take Charge* program, and family planning programs, in general.

4. **Will your proposal impose costs on individuals, business or government. Will these costs be time-limited or on-going? Can you estimate how much of these costs will be, or suggest how such estimates can be made? How much if any, of these costs will be offset by corresponding savings?**

Washington's *Take Charge* data shows that family planning services save the State millions of dollars. DSHS estimates that publicly funded maternity care for unintended pregnancy costs the state approximately $116,000,000 in 2004. Meanwhile, every dollar spent on family planning saves the state $3.30 in other health care costs. The cost of providing a patient family planning services under *Take Charge* is $311 per year, compared with the average cost of a pregnancy termination at $497, or the average cost of prenatal care and delivery at $6,849 per baby.

State funding of STD testing and treatment also averts long-term health care costs. According to the American Public Health Association (APHA), every dollar spent on prevention of Chlamydia, saves $12 in complication-associated costs.

5. **How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?**

See footnote 4, identifying the organizations that provided support for the family planning waiver proposal in the late 1990s.

6. **What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?**

The main obstacle to implementing this proposal is the commitment to fully fund family planning and STD prevention and treatment services. Access to reproductive health care services and sexuality education improves the health of the community, reduces unintended pregnancy and abortion, improves educational attainment, reduces violence against women, and saves millions of dollars. Funding family planning and STD services is one of the wisest investments our State can make.

Sincerely,

Elaine Taylor Rose	**Theresa M. Connor**	**Amy Luftig**
Executive Director	Director of Public Policy	Deputy Director of Public Policy

Tab 39

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September 1, 2006

The Hon. Christine Gregoire, Co-Chair
The Hon. Pat Thibaudeau, Co-Chair
Blue Ribbon Commission on Health Care Costs & Access
Office of the Governor
PO Box 40002
Olympia, WA 98504-0002

Dear Governor Gregoire and Senator Thibaudeau:

In response to the Blue Ribbon Commission's recent request for input, I am writing to offer for your consideration Premera's perspective on ideas the Commission could pursue to progress toward its vision and goals for the future of Washington state's health care system.

Much of the testimony before the Commission and its subsequent discussions reflect broad-based interest in:

- Evidence-based, high quality and cost-effective care
- Personal responsibility for health status improvement
- Relevant, accessible information for consumers and caregivers to make appropriate choices
- Elimination of waste that does not add value for the consumer the system is designed to serve.

We want to share with you some of the initiatives Premera has pursued in these areas, as well as related suggestions, which have delivered positive outcomes in our region and may serve as models in the future.

Sincerely,

H.R. Brereton Barlow
President and CEO
Premera Blue Cross

cc: Blue Ribbon Commission members

PREMERA | BLUE CROSS

September 1, 2006

A proposal to realize the vision and goals for Washington state established by the Blue Ribbon Commission on Health Care Costs and Access.

To achieve the Blue Ribbon Commission's vision for 2012, the private and public sectors should jointly accelerate efforts that will recognize and reward healthy and cost-efficient behavior, and create incentives to encourage more informed and cost-effective health-care decisions.

The challenges are formidable and no entity can achieve these goals alone. The ability of Washington state to achieve the vision and goals articulated by the Blue Ribbon Commission will be dependent on specific, measurable improvements in the following areas:

1. **A greater focus on improving health** versus the "episodic" care model treating sickness -- specifically, a shift in emphasis toward preventing costly and traumatic medical conditions that can be avoided via lifestyle changes.
2. **Advances in evidence-based medicine** -- driven by collaborative efforts to learn what works and shaping the delivery of medicine to reduce variation from evidence-based guidelines.
3. **Greater transparency** -- related to healthcare quality, clinical performance and relative cost-effectiveness of treatment options -- providing consumers with information to make better choices and health-care professionals with information to deliver the most cost-effective care.
4. **Better accountability across the healthcare system** -- including a more involved and accountable consumer -- equipped with better information and incentives (a) to modify lifestyles where possible, and (b) when medical care is needed, to make more informed treatment decisions.
5. **Greater collaboration** between payers, providers, purchasers and government -- from healthcare delivery (e.g., sharing of data and accelerated adoption of best practices) to public policy (e.g., recent collaborative efforts among business, medical and hospital associations, and health plans to understand the impact of health-care cost shifts from public programs to the private sector).

State government can play a central role in promoting a broader understanding of current efforts by different stakeholders to promote these values, and by creating incentives that accelerate innovation and adoption of best practices. The state could also play a significant role by supporting uniform federal standards in specific areas such as evidence-based medical quality guidelines, information-technology standards, and cost-benefit analysis for new medical treatments.

Existing models in Washington state

In recent years, initiatives have emerged that are aligned with the vision and goals of the Blue Ribbon Commission, delivering positive outcomes, which should be considered as models. A short list of examples follows:

- The ***Puget Sound Health Alliance*** is a regional partnership involving employers, physicians, hospitals, patients, health plans, and others working together to improve quality and efficiency while reducing the rate of health care cost increases across King, Kitsap, Pierce, Snohomish and Thurston Counties. Alliance participants agree to use evidence-based measures to identify and measure quality health care, then produce publicly-available comparison reports designed to help improve health care decision-making.

- Premera's ***Quality Score Card*** initiative, built collaboratively with prominent medical groups throughout the state, has demonstrated dramatic improvement in quality and health outcomes since 2002 (see Appendix A and www.premera.com/qsc). Premera's Quality Score Card has been endorsed (and co-designed) by 13 major medical groups statewide and used as an example by the Puget Sound Health Alliance. In 2002, Premera invited medical groups across Washington to identify which quality indicators they wanted to measure; then participants worked collaboratively to agree on quality standards and how to assign responsibility where multiple physicians treated a given patient. Results were initially presented to each medical group confidentially; by 2004 these groups endorsed online publication of what became the first public scorecard developed in a non-HMO environment. Since that time medical groups representing hundreds of thousands of Washington patients have agreed to participate in the scorecard. Since 2002, aggregate performance in low-scoring areas has improved by more than 50 percent. Particularly exciting about this work is the enhancements in health outcomes. Last year a subset of participating medical groups began publishing medical outcomes in certain categories; key indicators of diabetes health have improved by up to 87 percent in a single year. Evidence-based standards, ability to compare clinic performance to a community benchmark, and innovations arising from this collaboration have been the keys to success.

- ***Washington State Health Care Forum***, is a coalition of health plans, physicians and hospitals that joined together to improve health-care efficiency and effectiveness by applying collaborative information technology solutions. The Health Care Forum has delivered a successful model through OneHealthPort ("OHP") of how technology can be implemented on a shared basis to improve administrative efficiency with a goal of improving delivery of care. At this point more than 20,000 individual subscribers in the medical community are registered to use OHP as a single-sign-on gateway to the web capabilities of local health plans and provider organizations. By sharing investment in technology, OHP provides a common technology infrastructure to improve health-system efficiency (see Appendix B).

- Premera's ***Springboard® health-risk management*** and personal coaching initiative, broadly endorsed by benefit consultants, major employers, and state health officials, was launched this year following demonstrated success by Washington employers that health-risk management programs can significantly reduce employees' excess health risk in as little as

one year. Peer-reviewed national research correlates lower health risk with lower health-care costs. By paying program costs for Washington employers, Premera is collaborating with businesses to explore the impact of personal health assessments and professional health coaching on employee health, productivity and health costs (see Appendix C.)

- ***Subimo Healthcare Advisor and Hospital Advisor online transparency tools,*** available to Premera members facing medical decisions, estimate treatment costs and compare hospital performance and quality for a range of specific conditions (see Appendix D). The hospital quality indicators are subject to verification by the hospitals themselves. Additional information is available online to support members with questions they may have and questions they may wish to ask as they evaluate treatment options and prepare for care.

Challenges to be addressed

The Commission's goals face an environment where health care cost trends have been rising in the 10-14 percent range since the late 1990s -- at least triple the rate of growth in personal income. This presents a huge challenge to meeting the Blue Ribbon Commission's goal of holding health-care cost trend to the rate of personal income growth within five years. As the Commission develops its recommendations, it should be aware of and address factors which can exacerbate these already high cost trends:

- ***Changing demographics and health status.*** As baby boomers age, the cost impact of an aging population adds about 1-2 percent to annual medical cost trends. At the same time, declines in health -- from epidemics of obesity and diabetes to alarming projections that this generation of children for the first time in two centuries may live shorter lives than its parents -- will continue to drive more costs into the health-care system.

- The threat of ***medical malpractice lawsuits*** has a dampening effect on efforts by providers to increase transparency.

- ***Government cost-shifting--***the impact of federal and state program payments on health-care costs paid by employers and individuals. Low public program payments create cost pressures on physicians and hospitals that are in turn shifted to the private market, impacting affordability of employer-based and individual insurance (see Appendix E), and the uninsured. Based on a report prepared by Milliman USA, Washington employers and individuals paid an estimated $738 million (2004 dollars) to cover shortfalls incurred by Washington hospitals serving Medicare and Medicaid patients. The resulting burden on employers was estimated to be $490 per family health insurance contract. This cost-shift accounted for 29.9 percent of the 2004 increase in hospital costs paid by people with private insurance or no coverage -- and the magnitude of cost shifting has been growing. An analysis based on the results of the Milliman study concluded that the corresponding cost-shift for physician services added $412 per family contract, or $620 million statewide. Total burden on Washingtonians: $902 per family insurance contract, or a $1.4 billion statewide. A broad range of business, provider and payer groups is collaborating to understand and address this issue. Organizations interested in participating in a coalition together to address the issue include the Greater Seattle Chamber of Commerce, the Spokane Chamber of Commerce, the Inland Northwest Business Coalition on Health, the Washington State Hospital Association, Regence Blue Shield, the Association of Washington Business, the Washington State

Medical Association, Group Health Cooperative, the Washington Health Care Forum, the Snohomish County Economic Development Council, MultiCare Health System, the Polyclinic, Planned Parenthood, and Premera.

Given these issues, meeting the Blue Ribbon Commission's goal of holding total health-care spending to the rate of growth in personal income would require that health-care cost trends be held *below* the rate of general inflation.

Opportunities for public/private collaboration

The public and private sector, working together, should collaborate to:

- ☐ Showcase quality performance
- ☐ Encourage innovators and achievers in health care quality and efficiency based on evidence-based criteria
- ☐ Collaborate with stakeholders to avoid duplication of efforts and unintended results
- ☐ Establish State workforce as a model for personal health management
- ☐ Provide consumers with the information they need to make better health-care decisions.

Appendices

Appendix A: Premera Quality Score Card

Appendix B: Washington State Health Care Forum - OneHealthPort

Appendix C: Springboard® Health Risk Management Program

Appendix D: Subimo Healthcare Advisor and Hospital Advisor online transparency tools

Appendix E: Milliman USA cost-shifting study

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PO Box 327
Seattle, WA 98111-0327

PRESS RELEASE

FOR IMMEDIATE RELEASE

Premera and Clinic Media Contacts are attached

PREMERA BLUE CROSS 2005 QUALITY SCORE CARD: AN UPDATED SNAPSHOT OF HEALTH CARE QUALITY IN WASHINGTON

Results range from dramatic improvement in diabetes control to a decline in prescribing practices that minimize antibiotic resistant bacteria

MOUNTLAKE TERRACE, WA – (Dec. 14, 2005) –Premera Blue Cross and prominent medical groups across Washington today announced results of the 2005 Premera Quality Score Card, a collaboration supporting better health and more sustainable costs by providing information health-care professionals and consumers can use to improve the quality and cost-effectiveness of health care.

Preventive screenings, diabetes monitoring and treatment, use of cost-effective generic drugs, and satisfaction with thoroughness of treatment were among the 19 variables measured by Premera's 2005 Quality Score Card. Results are published online at www.premera.com.

For the first time, the 2005 Quality Score Card includes performance on a group of important health outcomes -- revealing potentially dramatic improvements in control of diabetes.

In 2005, medical group participation in this collaborative effort nearly doubled, creating a robust view of health-care quality in Washington. Participating medical groups reach an estimated one third of Premera's Washington members. Every participating medical group was among the top three performers in at least one area. The Score Card also estimates performance for physicians statewide.

Participating medical groups include Columbia Medical Associates; The Everett Clinic; Minor and James Medical; MultiCare Health Systems; Pacific Medical Centers; Pediatric Associates; Physicians Clinic of Spokane; The Polyclinic; Puget Sound Family Physicians; Rockwood Clinic; Virginia Mason Medical Center; Swedish Physicians; and Wenatchee Valley Medical Center.

Diabetes control improving

New to the 2005 Quality Score Card are three scores that reveal not just how often patients receive evidence-based standards of care, but also the resulting impact on health.

In 2003, a subset of participating medical groups began tracking key diabetes health indicators -- specifically, control of cholesterol, blood pressure, and ongoing blood sugar -- all highly correlated with better long-term health and lower medical costs. All participating clinics have been tracking these scores in 2005 for clinic-by-clinic publication next year.

"The Washington clinics chose to measure themselves against a higher level of performance than the minimum 'control' standards published by the National Committee for Quality Assurance (NCQA)," noted Dr. Mark Sollek, Premera Medical Director heading up the Quality Score Card project.

The results reveal dramatic improvements for these clinics' Premera patients from the previous year:

- 51.3 percent of diabetic patients had well controlled hemoglobin A1c levels (at or below 7), nearly doubling the previous year's performance.
- 41.6 percent of diabetic patients had well controlled cholesterol levels (below 100), improving previous year's performance by more than half; and
- 38.6 percent of diabetic patients had well-controlled blood pressure (at or below 130), improving previous year's performance by nearly half.

"This is an early but exciting indicator," noted Dr. Sollek. "If this improvement can be sustained, it has the potential to reduce heart attacks, hospitalizations, amputations, strokes, blindness, kidney failure and premature deaths -- and represent significant savings in health-care costs."

Studies have shown that every 1 percent drop in "A1c" levels reduces by 40 percent the risk of blindness, kidney failure and nerve disease and other vascular complications. Health care costs are up to 32 percent higher for diabetic patients with A1c levels greater than 10 compared to those whose A1c levels are 7 or lower.

Patients with well-controlled LDL cholesterol have 20 percent to 50 percent fewer strokes, heart disease and other cardiovascular complications. Blood pressure control reduces the risk of cardiovascular disease among people with diabetes from 33 percent to 50 percent, and the risk of vascular complications by 33 percent.

Quality Improvement: Patterns of Performance

Most participating medical groups in Washington state posted at least minor improvements on a majority of quality and satisfaction measures last year.

Quality Score Card participants tended to post performance scores 3 percent to 6 percent higher than the average of all other Washington State practices seeing Premera members last year.

Some of the greatest single-year improvements by individual participating clinics include:

- 34 percent improvement in the recommended rate of well-child visits for infants in the first 15 months of life.
- 33 percent gain in use of appropriate blood pressure medications for diabetes.
- 14 percent improvement in the rate of generic prescribing where a generic is available.
- 12 percent improvement in the recommended rate of cholesterol screenings for people with diabetes.

In most cases, declining performance reflected minor fluctuations in already high-scoring quality areas. One exception involved patterns of antibiotic usage. Recommended management of ear infections declined by 9 percent from the previous year, and for acute bronchitis, by 12 percent. Participating medical groups are using these results to examine why performance has declined and to determine what steps should be taken to address it.

The Quality Score Card also measures how much health-care practices vary clinic by clinic and doctor by doctor. While recommended treatment of acute bronchitis occurred 34 percent of the time overall, some physicians may have delivered recommended care only 12 percent of the time, while others did so 74 percent of the time.

Building on a solid foundation

Participating medical groups say the Quality Score Card works because it was developed in a collaborative, trusted environment and tested with physicians for two years before the first results were published by Premera in 2004. In 2005, the collaborative approach used to develop Premera's Quality Score Card was recognized as a national best practice by the Blue Cross Blue Shield Association.

Using a collaboratively developed set of quality measures and measurement method, participating medical groups and Premera continue to work with other organizations in Washington state and nationally to drive to a more consistent "core" of set quality measures.

About Premera Blue Cross

Our mission is to provide peace of mind to our members about their health-care coverage. We provide health insurance and related services to more than 1.3 million people. Premera Blue Cross has operated in Washington since 1933, and Alaska since 1957. Premera Blue Cross is an independent licensee of the Blue Cross Blue Shield Association.

Premera Blue Cross is a member of a family of companies based in Mountlake Terrace, Washington, that provide health, life, vision, dental, and long-term care insurance, and other related services.

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Well-Child Visits

2005 Quality Score Card

2005 Score Card Average:

- 67% of children ages of 31 days to 15 months, received at last 6 well-child visits within first 15 months of life.

2005 Range of Recommended Visits:

- Rates of recommended visits among participating medical groups ranged from 22% to 79%.

2006 Opportunity:

- Well-child care accounts for 22 percent of all average family practice physician's and pediatrician's patient contacts and an unknown, but no doubt substantial, part of child health care expenditures
- Well-Child Visits can help children stay healthy because each visit includes a complete physical examination to assess growth and development, which may reveal potential problems early.
- Well-Child Visits are key opportunities to communicate with your child's health-care provider.

Overview – 2005

Overview – 2004

Quality Leadership Awards

2005 Quality Score Card Measures

Breast Cancer Screening

Cervical Cancer Screening

▶Well-Child Visits

Diabetes

Asthma

Ear Infections

Acute Bronchitis

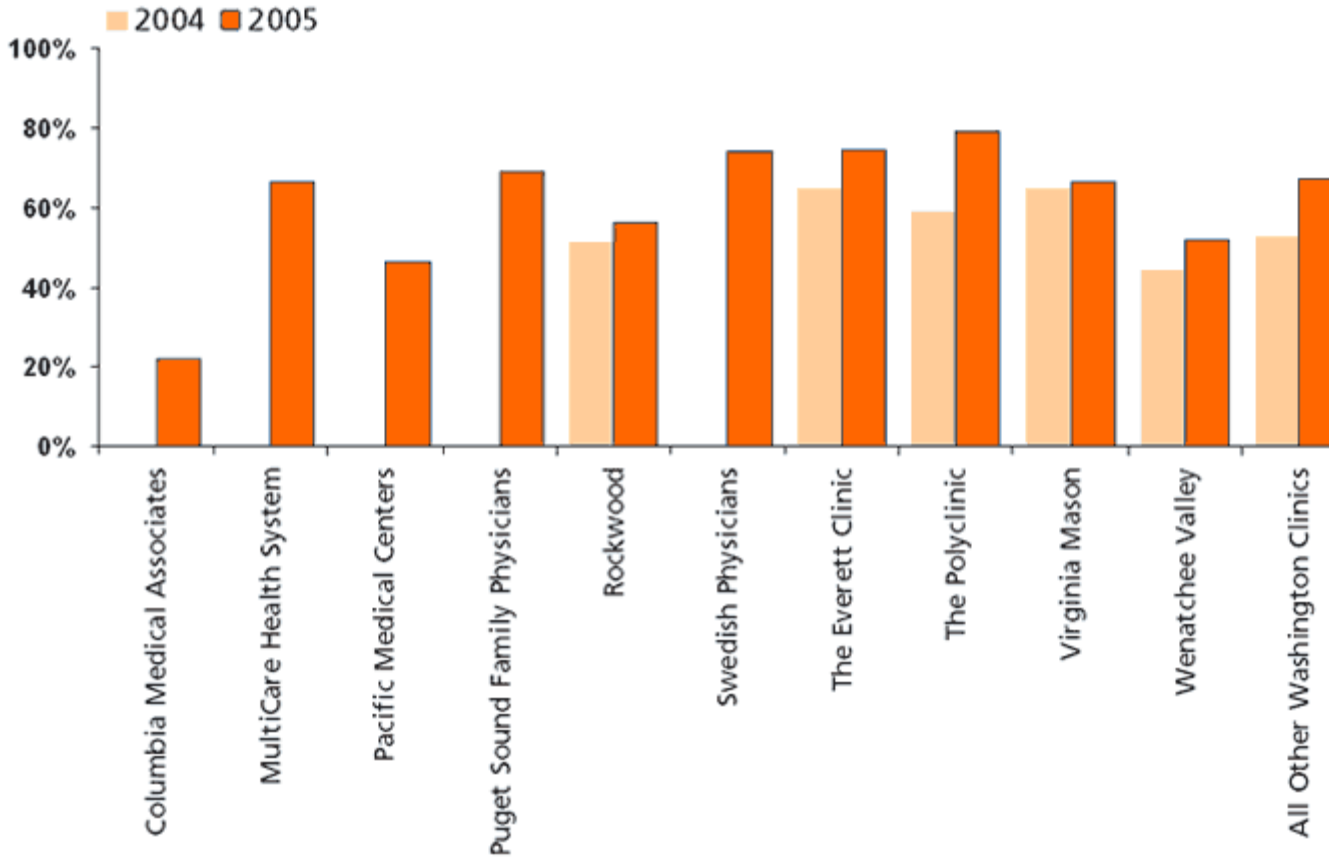
Preferred Drug List Compliance

Use of Generics

Patient Satisfaction

2005 Premera Quality Score Card

Age 0-15 Months with 6 or more Well Child Visits



The Seattle Times
seattletimes.com
Saturday, December 17, 2005 - 12:00 AM

"Score Card" rates clinics' health care

By Carol M. Ostrom
Seattle Times staff reporter

All doctors would like to believe they're taking good care of their patients.

So when major medical groups across the state first compared scores a few years ago to see how often they provided patients with the recommended screenings, treatment and monitoring, some were shocked to see they weren't doing so well.

What happened after that, you might say, was competition-driven cooperation.

Sharing tips for improvement as part of their participation in the "Quality Score Card" project, a joint effort with insurer Premera Blue Cross, has been a culture change, doctors in those groups say. And according to figures released Wednesday, it has dramatically improved the health of diabetic patients.

The participating medical groups care for about 40 percent of all of Premera's members.

When the project began in 2002, clinics received their own scores, but scores for other groups and clinics were "blinded." Almost instantly, low scorers demanded to know the identities of clinics at the top, and how they scored so high.

At clinics' insistence, those identities were revealed, and with them some formerly proprietary secrets of success.

Medical groups whose doctors control patients' asthma well, for example, shared winning strategies in exchange for tips on ensuring that women get yearly cervical-cancer screenings.

"No doctor likes to be second-best," said Dr. Rick Ludwig, chief medical officer of Pacific Medical Centers, one of the score-card clinics.

The notion that others were doing better "gets docs' attention," said Dr. Warren Fein, medical director for Swedish Physicians. "Doctors are inherently competitive."

The "score card" rates clinics in a variety of health-care areas, such as asthma control, for example, but it doesn't rank the clinics against each other with overall scores.

Premera's Dr. Mark Sollek said making scores public was a "gutsy move" on the part of the medical groups. But other doctors said they believe such public accountability is inevitable.

"It's becoming more and more important for the community to know how we're doing," Ludwig said.

For diabetic patients, such attention to good care helps improve their health, according to the yearlong tracking by Premera and some of the larger clinics.

The percentage of diabetic patients who met target levels of blood pressure, cholesterol and long-term blood-sugar control rose dramatically in 2005 compared to 2004, according to the results. For example, there was an 87 percent increase in patients whose tests showed three-month blood-sugar control.

Studies have indicated that every 1 percent drop in a patient's long-term blood-sugar control translates to a 40 percent reduction in the risk of blindness, kidney failure, nerve disease and blood-vessel complications in diabetics.

Despite the encouraging statistics, there's room for improvement. This year, only 59 percent of Premera members with diabetes were tested for long-term blood-sugar control. In a couple of categories, such as the optimal care of ear infections and bronchitis, clinic performance in general declined from 2004 to 2005.

Carol M. Ostrom: 206-464-2249 or costrom@seattletimes.com

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THE SPOKESMAN-REVIEW.COM

Health notes

Score Card shows area diabetics in better control of disease

Megan Cooley
Staff writer
December 20, 2005

WASHINGTONIANS WITH DIABETES are making dramatic improvements in their control of the disease. That's one of the results of the 2005 Premera Quality Score Card, a collaborative effort between Premera Blue Cross and doctors to share information and improve the quality and cost-effectiveness of health care.

The Score Card, available at www.premera.com, rates clinics using 19 variables such as how many patients undergo preventive screenings and the use of generic versus brand-name drugs.

This was the third year that data was collected and the first time the Score Card included not just how often patients are treated using the best method available, but also the result of that care on patients' health.

Diabetic patients were tracked on how well they controlled their cholesterol, blood pressure and blood sugar levels.

Among the results:

•Slightly more than 51 percent of diabetic patients had well-controlled hemoglobin A1c, or blood sugar, levels, nearly doubling 2004's performance.

•Almost 42 percent had cholesterol levels below 100, improving last year's performance by more than half.

•Nearly 39 percent had well-controlled blood pressure, improving last year's performance by almost half.

That's good news because for every 1 percent drop in A1c levels, a diabetic's risk of blindness, kidney failure and other vascular complications reduces 40 percent, according to Premera.

And patients with well-controlled cholesterol have 20 to 50 percent fewer strokes, heart disease and other cardiovascular problems.

Premera spokesman Scott Forslund gives a lot of credit for the improvements to the Washington State Diabetes Collaborative, a six-year-old effort by doctors to improve the way they treat diabetic patients.

The Score Card showed improved care for other patients, as well as a reduction in the cost of health care. At one clinic, the rate at which infants were getting well-child visits grew 34 percent between 2005 and 2004. At another clinic, the prescribing of generic drugs versus brand-name ones grew 14 percent.

Three of the 12 clinics that participated in the 2005 Score Card are in Spokane: Rockwood Clinic, Physicians Clinic of Spokane and Columbia Medical Associates. The participating clinics reach about one-third of Premera's Washington members.

Poison helpline available

When it comes to holiday eating, fruitcake isn't the only hazard.

So far this Christmas season, at least nine children have eaten holiday decorations and gift wrap, 17 have tasted candles or lamp oil, 34 consumed plants and 30 drank perfume or cologne, two common holiday gifts, according to the Washington Poison Center.

"It's amazing that they eat what they do," said Kerri Booth, the center's education coordinator.

While most of those items don't pose a poisoning risk, they can be choking hazards. And other dangers lurk during the holidays.

For example, you visit the home of friends without children and, because their house hasn't been childproofed, your toddler swallows a small ornament or rummages through the cupboard with their cleaning supplies.

Maybe your child decides to explore your guestroom, where Grandma is staying, and the little one can't resist the pretty-colored pills your mom left on the nightstand.

Booth encouraged people to call the poison center when they have concerns.

"Oftentimes they call 911 when they really should be calling us," she said.

People should call 911, though, if someone can't breath, can't be woken up, is having a seizure or is clearly having some other medical emergency, she said.

The phone number for poisoning concerns is the same in any state: (800) 222-1222. Whether you're in Washington or Wisconsin, your call is directed to a local help center.

Grieving during the holidays

Hospice of Spokane offers tips for coping with sadness when the rest of the world seems consumed by joy:

•Decide to keep your regular traditions or plan something entirely different. Just remember that your choice is temporary and you can change your activities next year.

•Accept help. Ask friends to shop for or with you or do the cooking, if you choose.

•Light a candle, display a flower or create a special holiday decoration in memory of your loved one. Offer a dinner prayer, meditation or toast to them.

•Do an activity your loved one enjoyed to bring joy to others, such as caroling or serving meals to the homeless.

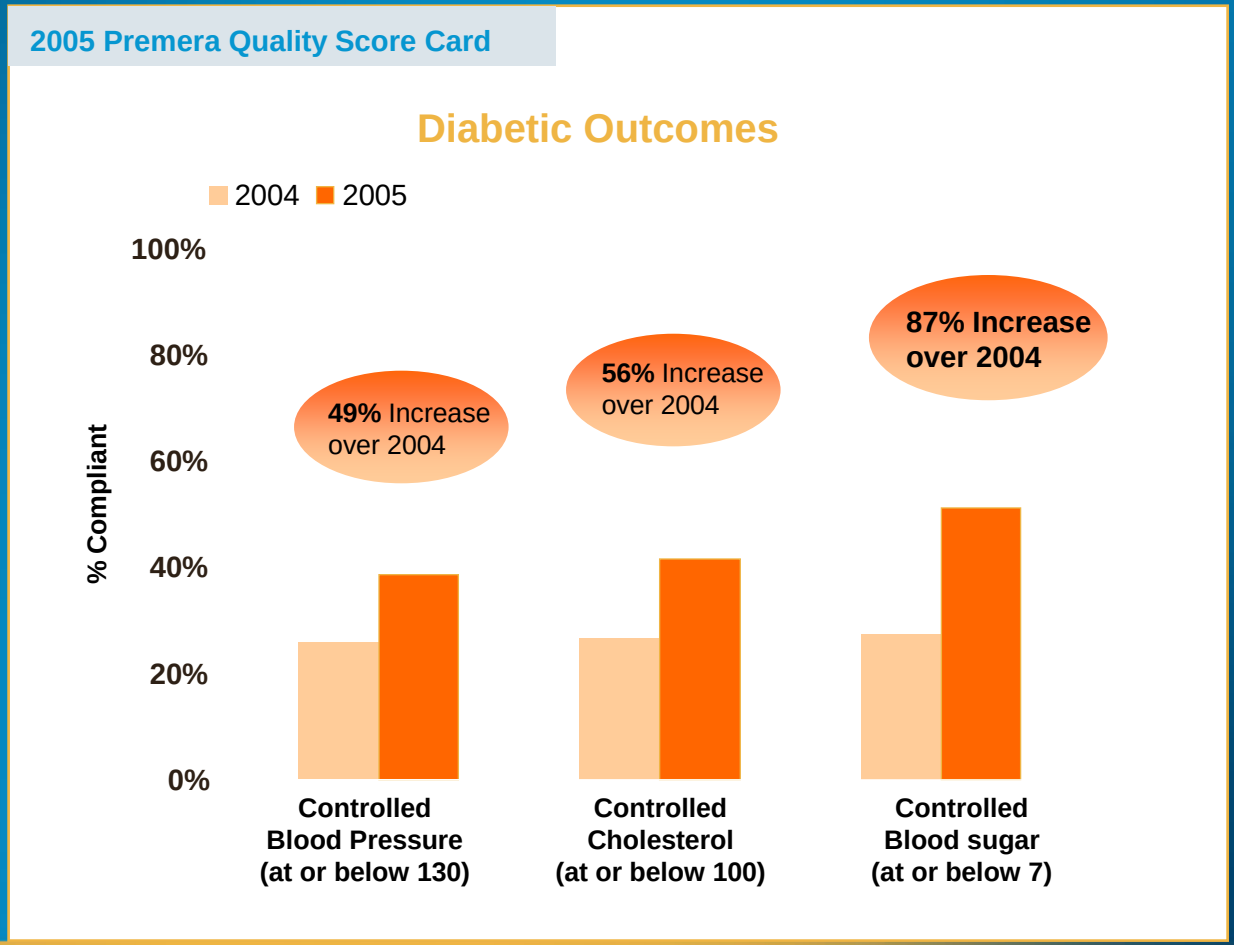
•And give yourself and others permission to remember happy times with that person.

Pharmacist honored

The Spokane Pharmacists Association named Brenda Bray 2005's community pharmacist of the year.

Bray is a clinical assistant professor of pharmacotherapy at Washington State University's Spokane campus. She was recognized for bringing real-world experiences to her students and for her work as an on-call pharmacist for Group Health Cooperative and Shriners Hospital for Children.

Specific Example
Diabetes Care: Blood Tests



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Customize My View

White Paper

Premera Health Risk Management: A Springboard™ to Success

Abstract

A health risk management (HRM) program helps employers improve the health of their employee population. Healthier employees translate to increased productivity, fewer sick days and a slowing of the rise in health care costs. With the proper employer commitment, HRM programs are an effective tool in the battle to improve health and control costs.

This paper describes results of Premera Blue Cross' first full year of HRM data from three Washington employers and introduces a new HRM program, Springboard™, designed to help more employers begin offering an HRM program to their employees.

The encouraging year one results have prompted Premera to take a leadership role in rolling out products designed to spur uptake of this effective health management tool.

Destination: Health

Premera's health risk management program is part of a portfolio of resources to support our members at every stage of health.

This supports a larger Premera initiative called Destination: Health, aimed at better health for our members and more sustainable costs. The challenge is formidable and no entity can do it alone. The key is education and collaboration with employers, brokers, providers, consumers and the extended health care community in three key areas: encouraging cost-conscious actions, improving medical quality, and supporting our members at every stage of health.

Washington's Workers

The health of Washington's workers is in crisis. Today, the rates of obesity, diabetes and other longer term debilitating conditions are fueling an even faster decline in the overall wellness of the state's population. Conversely, the cost of providing health benefits is rising rapidly, putting pressure on employers already struggling to continue offering health-care coverage to their workforce.

State statistics show how serious some of the trends have become:

- The rate of obesity among Washington residents has more than doubled in the past 15 years
- The prevalence of diabetes in the state's population has doubled since 1990

In 2004, Premera took a first step towards helping employer groups address the declining health of members and the rising cost of benefits with the introduction of a health risk management (HRM) tool for employers who wanted to begin building a culture of wellness among their employees.

HRM programs have three primary components:

1. A confidential personal health assessment that gives each member a personalized look at their overall wellness.
2. Confidential telephonic health coaching for those members identified as the highest risk for developing serious medical conditions.
3. Robust reporting that provides employers an aggregate snapshot of the health of their overall population.

At least 25% of health-care costs are linked to modifiable lifestyle choices including obesity, smoking and stress.

- Source: Anderson, et. al., (2000, Sept/Oct). The Relationship Between Modifiable Health Risks and Group-Level Health Care Expenditures, AJHP, 15(1), p. 45-52.

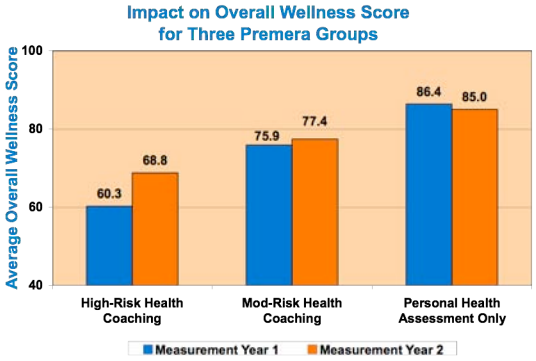
Members gain a better understanding of their own personal health and the risk factors that affect them now and into the future. Employers gather the information necessary to best manage the benefit packages they offer to their employees.

Cultures of Wellness

It takes more than a simple personal health assessment to make an HRM program successful. To achieve long term success, an employer must fully embrace the program and begin building a culture of wellness.

A look at three Washington employers who have completed one year in the HRM program shows some positive early signs. Overall, high risk employees enjoyed significant first year success, with average wellness scores increasing more than eight points or a 13 percent increase.

Moderate and low risk employees saw virtually no change in their overall wellness scores, another success because this group was able to maintain their health and stay out of the high-risk group.



A "Springboard™" to Success

The year one results have prompted Premera to take another step forward with the introduction of its Springboard™ program. The idea: encourage more employers to implement HRM programs by removing financial barriers to entry.

Premera will provide a two-year financial incentive to employers based upon the cost of the HRM product. Claims savings in year three and beyond are expected to offset the cost of continuing the HRM program.

Springboard™ at-a-glance:

Employer Requirements

- Fully-insured
- 200+ employees
- 40% minimum employee participation (may include enrolled spouses) in the Personal Health Assessment
- 50% minimum active participation in the coaching program (of those identified as high-risk)
- Employer-sponsored wellness incentive plan
- Medical and pharmacy benefits must be offered exclusively through Premera

Program Components

For employees:

- Personal Health Assessment and confidential participants' health report
- Telephone health coaching

For employers:

- High-quality management reporting
- Communication Kit to inform employees and promote participation

Program Costs and Savings

- Employer is responsible to pay for HRM services delivered by Summex
- Employer is responsible for the cost and administration of the wellness incentive plan
- In the first year, Premera adjusts projected claims based on estimated costs for HRM services
- In the second year, Premera adjusts projected claims to reflect actual costs for first-year HRM services
- Over time, upward trending of health care costs can be lowered and stabilized
- High-quality reporting allows employer to target risks and opportunities to drive down costs even further

About Premera Blue Cross

Our mission is to provide peace of mind to our members about their health-care coverage. We provide health insurance and related services to more than 1.3 million people. Premera Blue Cross has operated in Washington since 1933, and Alaska since 1957. Premera Blue Cross is an independent licensee of the Blue Cross Blue Shield Association.

Premera Blue Cross is a member of a family of companies based in Mountlake Terrace, Washington, that provide health, life, vision, dental, and long-term care insurance, and other related services.

PREMERA | BLUE CROSS

PRESS RELEASE

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NEW PREMERA DATA SHOWS WELLNESS AT WORK CAN BUCK THE TREND OF GENERAL HEALTH DECLINE

PREMERA ANNOUNCES NOVEL SPRINGBOARD™ PROGRAM -- INSURER WILL SUBSIDIZE UP TO TWO YEARS OF EMPLOYERS' PROGRAM COSTS FOR EMPLOYEES' PERSONAL HEALTH ASSESSMENTS AND PERSONAL HEALTH COACHING

Premera Introduces Health Risk Management Program at 10 a.m. on June 14 at News Conference being held at the Edgewater Hotel in Seattle

MOUNTLAKE TERRACE, WA – (June 14, 2006) – To help employers assist their employees in preventing poor health conditions that result from unhealthy lifestyles, Premera Blue Cross announced today encouraging results by Washington state employers adopting health risk management (HRM) programs -- and introduced a new program, Springboard™, designed to dramatically accelerate the rate at which employers can build a culture of wellness in their workplace and inspire their employees to adopt healthier habits.

"Employers increasingly are considering HRM programs to address declining workplace health and rising healthcare costs," said Gubby Barlow, CEO of Premera Blue Cross. "We're launching Springboard™ to enhance support for our members at every stage of health. This is part of a larger effort aimed at twin goals of better health and more sustainable costs for our members."

With Washington state health officials, prominent employers and consultants, Premera announced the Springboard™ program, which will subsidize up to two years of HRM program costs -- including annual confidential personal health assessments and personal health coaching -- for mid-size and larger employer groups in every state the company serves, as a way to jump-start efforts to improve employee wellness in the Northwest.

"The health challenges facing Washington residents have never been greater," said Maxine Hayes, MD, Washington State Health Officer. "Increased rates of obesity, diabetes and other

preventable conditions combined with decreased amounts of physical activity are putting more people at risk for fast declining health later in life."

Premera's analysis, involving results from three major Washington corporations, shows a clear opposite, positive trend. The first year HRM results from these employer groups demonstrate that every employer saw significant improvement in a single year for employees identified as high risk, while keeping moderate to low risk groups from moving into the high risk category.

"Personal health assessments and personal health coaching work. These results, in context with longer term studies, are exceptionally encouraging," said Dave Johnson, MD, regional medical director for Premera Blue Cross. "We're seeing a dramatic improvement in wellness in a short period of time."

Other studies show a strong correlation between improved wellness scores and fewer sick days, increased productivity and reduced health-care costs for the employer, Dr. Johnson noted. "We are hopeful these employer groups will take a similar track," Dr. Johnson said.

"Our employer groups using HRM programs in the past have already begun seeing the benefits of a healthier employee population," said Barlow. "We expect that Springboard™ will allow more employers to take the important first step to building a culture of wellness in their workplace."

For employers interested in a more intensive HRM program including components such as on-site biometric testing and participation in a multi-employer trust, ClearAdvantage (a Premera program) is offered through ClearPoint, LLC. The trust is expected to be formed by Fall 2006.

Premera will be holding a news conference to discuss the results and the new Springboard™ program. The conference will be held at the Edgewater Hotel in Seattle, WA (2411 Alaskan Way, Pier 67) beginning at 10 a.m. Members of the media may also listen to the news conference on the web at www.pugetsoundvideo.net. After entering the site, click on the Premera Blue Cross tab on the left. When the Premera logo appears at the top, click on it and that will open a windows media player showing the meeting live.

A white paper is linked to this news release at www.premera.com/newsroom.

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Presented by: PREMERA BLUE CROSS

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- Allergies and Asthma
- Bone, Joint and Muscle
- Brain and Nervous System
- Cancer
- Children's Health (Pediatrics)
- Diabetes
- Digestive/Gastroenterology
- Ear, Nose and Throat
- Endocrine, Nutritional and Metabolic
- Eye
- Geriatric (Senior) Health
- Gynecology (Female Reproductive System)
- Heart and Circulatory System
- Kidney and Urinary Tract
- Maternal and Childbirth
- Men's Health
- Respiratory, Pulmonary and Lung
- Skin/Dermatology
- Transplants
- Women's Health

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Estimate Treatment Costs

Estimate Treatment Costs:

> Choose Topic Area
> Customize Your Information
> **Estimate Costs**

Medical Encyclopedia Links:

- Mammography

For more information about **Breast Cancer**, visit the Topic Home page.

Provider Directory

Before deciding on a hospital, check the Provider Directory to verify participation with your health plan.

Quick Survey

Do you feel better informed about the health care decision you were researching?

Yes

Estimate Costs

Topic: Mammography

Summary

Mammography is an x-ray study of the breasts used to detect abnormal growths.

Note: Costs indicated below do not necessarily reflect what you will pay out-of-pocket or whether the service is covered by your health plan. Your out-of-pocket costs will depend on your health plan benefits and whether the service is covered under your plan. You should talk with your doctor about exactly what medication, test or service he or she recommends.

Mammography

	Typical Cost: In-Network‡
Estimated Cost Before Insurance Benefits	$172 - $240

‡Estimates for women of all ages in Seattle (King County)

Source: Subimo, PharMetrics, 2004

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Customize Your Information

- No
- Somewhat

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Healthcare Advisor™

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Find and Compare Hospitals

Find and Compare Hospitals:

> Choose Search Type
> Choose Topic Area
> Choose Comparison Topic
> Select Factors Important to You
> Input Search Radius
> View Search Results
> **Profile and Compare: Summary Report**
> Profile and Compare: Detailed Report

For more information about **Heart Bypass (Coronary Artery Bypass Graft Surgery)**, visit the Topic Home page.

Provider Directory

Before deciding on a hospital, check the Provider Directory to verify participation with your health plan.

Profile and Compare: Summary Report

Comparison Topic: Heart Bypass (Coronary Artery Bypass Graft Surgery)

Here is a summary report of information for the hospitals you selected. Click on factor names for more detailed explanations of the factors and why they might be important to consider.

Network Participation: Subimo's Healthcare Advisor includes all hospitals in a given area, not only those participating with your plan. Your benefits and out of pocket costs may vary depending on whether you see a participating provider. Please check the Provider Directory and your certificate of coverage before deciding on a hospital. To learn more about the hospital comparisons, visit Sources and Methodologies.

How Well Hospital Matches Your Selected Factors

	ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL	SWEDISH MEDICAL CENTER - PROVIDENCE CAMPUS	VIRGINIA MASON MEDICAL CENTER
Match Score	157	100	89
Distance from ZIP 98133	2391 mile(s)	10 mile(s)	9 mile(s)
Network Participation:	Check Provider Directory	Access / Foundation / Heritage	Access / Foundation / Heritage

Your Selected Factors

Heart Bypass (Coronary Artery Bypass Graft Surgery): Inpatient

Quick Survey

Do you feel better informed about the health care decision you were researching?

- Yes
- No
- Somewhat

Submit

Treated more patients (High Importance)	797	238	365
Had fewer patients with complications (High Importance)	Better than Expected	As Expected	As Expected ‡
Had fewer patients with infections (High Importance)	Better than Expected	As Expected	As Expected ‡
Had lower mortality rate (High Importance)	Better than Expected	As Expected	As Expected ‡
Patient ages included in above data	All Ages	All Ages	All Ages

Other Hospital Factors :

Follows recommended treatments and preventive practices (Medium Importance)	Above Average	Above Average	Above Average
Has many high technology services (High Importance)	Above Average	Average	Average
Has an intensive care unit (ICU) (High Importance)	Yes	Yes	Yes
Has a critical care unit for heart problems (CICU) (High Importance)	Yes	Yes	No

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View Search Results

Profile and Compare: Detailed Report

Notes:

Insufficient Data - Volume used to compute this result does not meet current patient confidentiality or other guidelines.

Does Not Apply - Data not relevant to particular hospital situation.

‡ See discussion about outcomes and major teaching hospitals.

Actual complication, post-operative infection, and mortality rates (where displayed) for each hospital are compared to **expected rates** for that hospital. Expected (or predicted) rates are determined based on the types of patients each hospital sees and how sick the patients are. Hospitals with sicker patients typically have higher expected rates, and our methodology accounts for this.

** - If ** appears for How Well Hospital Matches Your Selected Factors, there were no hospitals in the search area that met your criteria, and it is not possible to provide a relative match score.

Click here for more on how how match scores are calculated for hospitals with Medicare only data vs. hospitals with state data.

Please note that some information about hospital services may reflect the capabilities of a broader hospital system, and not just this hospital location. You should contact the hospital directly to confirm its capabilities.

Learn more about the data Sources and Methodologies.

A hospital's performance on any of the factors you see here is not a guarantee of a good or bad outcome for you. We encourage you to consider multiple factors when choosing a hospital for care. And, we encourage you to seek out additional sources of information in your decision-making process, including talking to your physician and contacting hospitals directly. In addition to hospital information, you should understand your physician's experience.

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The New York Times

Business Day

THURSDAY, JUNE 1, 2006

Low Payments by U.S. Raise Medical Bills Billions a Year

By MILT FREUDENHEIM

Employers and consumers are paying billions of dollars more a year for medical care to compensate for imbalances in the nation's health care system resulting from tight Medicare and Medicaid budgets, according to Blue Cross officials and independent actuaries.

A new study commissioned by Premera Blue Cross, based in Seattle, has found a rapid acceleration in higher costs to private payers in Washington State, for example, as hospitals and doctors grapple with constraints in the federal health insurance programs.

The study found that in 2004, the most recent year for which full data are available, hospitals in Washington State charged an additional $738 million — or 14.3 percent of their revenue — to private payers to make up for Medicare and Medicaid underpayments. Similarly, doctors shifted $620 million, or 12 percent, said John Pickering, an actuary at Milliman Inc., a consulting and actuarial firm that conducted the study.

A similar Milliman study in California for 2004 said that health plans and consumers paid an additional $4.5 billion for hospital care in that state to compensate for Medicaid and Medicare constraints. Milliman's California study, commissioned by Blue Shield of California, did not include physicians' charges.

Will Fox, a Milliman actuary, said California hospitals had been hit particularly hard by Medicare payment policies in the last few years, "and there is no reason to think this has let up."

Other research has come to similar conclusions across the country. Unpaid hospital bills, largely for the uninsured, are costing about $45 billion nationally a year and adding about 8.5 percent to the cost of health insurance for those who do pay, said Kenneth E. Thorpe, a health care economist at Emory University.

Employers said the rising cost trends were, in turn, adding to the growing numbers of people without insurance. And when those people check into hospitals, they generate even higher costs for those employers and consumers who pay insurance premiums.

"This is a serious national problem, and it is only going to get much worse," said Helen Darling, president of the National Business Group on Health, a research and trade group for large employers. "There are more uninsured, the hospitals are inefficient, and every year, Medicare and Medicaid hold down on increases to cover rising medical costs," she said.

Rich Maturi, a senior vice president of Premera, said the report would show "employers and policy makers that they needed to address an unsustainable trend in the growth of cost-shifting." Business leaders, health plans and groups representing hospitals and doctors plan to meet in July to review the report and make policy recommendations.

Although many state budgets are overwhelmed by rising Medicaid costs, health care reforms intended to reduce the ranks of the uninsured that were recently enacted in Massachusetts and Vermont include more state money for Medicaid. Blue Cross Blue Shield of Massachusetts and Partners Healthcare, the largest hospital group in Boston, jointly supported the Medicaid increases.

"That was a real-world example of hospitals and insurers seeing that they had common interests," said Paul Ginsberg, a health economist who is president of the Center for Studying Health Systems Change, a nonprofit research group in Washington.

Hospitals across the country lost money on Medicare patients in 2003 after at least six years of declining profit margins, according to the latest report by the Medicare Payment Advisory Commission, which advises Congress and federal officials.

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PAYMENT LEVEL COMPARISON BETWEEN PUBLIC PROGRAMS AND COMMERCIAL HEALTH PLANS FOR WASHINGTON STATE HOSPITALS AND PHYSICIANS

Presented by:
Will Fox, FSA, MAAA
John Pickering, FSA, MAAA

May 2006

A MILLIMAN GLOBAL FIRM
Milliman
Consultants and Actuaries

At the request of Premera Blue Cross, Milliman, Inc. has prepared this comparison of healthcare provider payment levels between public programs and commercial health plans in Washington State. Separate comparisons are presented for hospitals and physicians. For hospitals, we have analyzed financial statements for fiscal years 1995 through 2004, and quantified the cost shift from Medicare and Medicaid to other payers. For physicians, we have compared current fee schedules and quantified the payment level differences between public and commercial payers. We understand that this paper will be shared with hospitals, physicians, employer groups, legislators and others to support a constructive dialogue between all stakeholders regarding provider payment rates paid by public programs.

FINDINGS

In recent years, Washington hospitals have incurred increasingly large losses on Medicare and Medicaid business. At the same time, margins on commercial business have increased. This phenomenon can be thought of as a cost shift from the public programs to commercial payers. That is, if Medicare and Medicaid had paid higher hospital rates, commercial payer rates could have been lower with hospitals still achieving the same net patient service operating margins.

Similarly, Medicare and Medicaid fee-for-service physician rates are significantly lower than market rates paid by commercial PPOs in Washington. While publicly available financial statements that would enable quantifying gains and losses by payer type are not available for physician services in total, as they are for hospitals, the payment rate differences suggest a subsidization of public payers by those who pay commercial rates.

HOSPITAL PAYMENT LEVEL COMPARISON

Our hospital findings are based on analysis of Washington State hospital financial statements for fiscal years 1995 through 2004, as reported by the Washington State Department of Health. We have reviewed the data for reasonableness, but have not audited or independently verified the data. If the data is inaccurate or incomplete, the results of our analysis may likewise by inaccurate or incomplete.

The Department of Health reported financials are sufficient to separate Medicare, Medicaid, and all other payers into separate categories. The “all other” category is dominated by commercial insurance payers, but also includes payers such as self-pay, Workers’ Compensation, and other government programs. Throughout this paper, we refer to the “all other” segment as “Commercial.”

In order to focus on payment level differences by payer category, only patient related financial results are included in our analysis. Specifically, non-operating, tax, and other operating revenue and expense are excluded.

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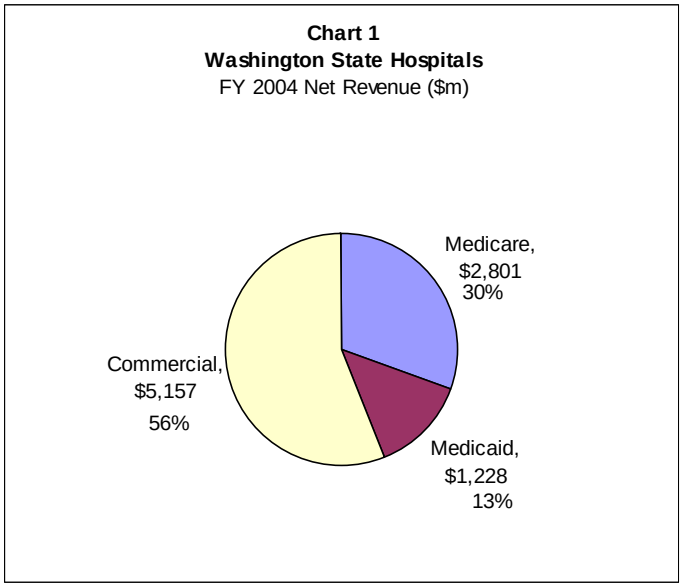
Charts 1 and 2 illustrate the cost shift from Medicare and Medicaid to Commercial payers in 2004.



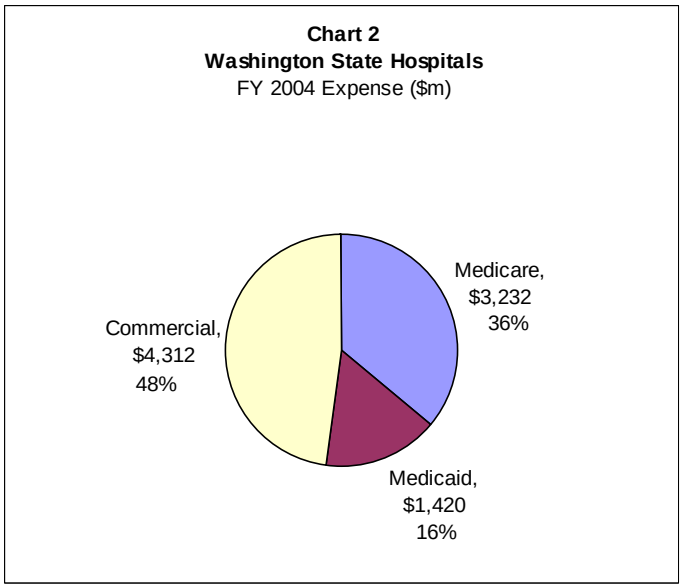


Chart 1 presents net patient service revenue by payer type in fiscal year 2004. Chart 2 presents expense by payer type. Notice that the Commercial segment generated 56% of revenue, but only 48% of expense. On the flip side, 30% of revenue was generated on the Medicare segment, but 36% of expenses were incurred. Likewise, Medicaid accounted for 13% of revenue, but 16% of expenses. If there were no cost shift, each segment's share of

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revenue would equal its share of expense. That is, the sizes of the pie pieces would not change between Chart 1 and Chart 2.

Attachment A, at the end of this paper, presents the detailed values underlying all charts presented in this paper.

Chart 3 presents the detail of the fiscal year 2004 cost shift.

Chart 3
Washington State Hospitals
Fiscal Year 2004 Cost Shift ($m)
Patient Related Services Only

	Net Revenue	*Expenses*	*Income*	*Margin*	*Cost Shift*	*Revenue without Cost Shift*	*Margin without Cost Shift*
Medicare	$2,801	$3,232	($430)	-15.4%	($510)	$3,312	2.4%
Medicaid	1,228	1,420	(192)	-15.6%	(227)	1,455	2.4%
Commercial	5,157	4,312	845	16.4%	738	4,419	2.4%
Total	$9,186	$8,964	$222	2.4%	$0		

Chart 3 shows that in 2004 Washington State hospitals, in aggregate, had a -15.4% margin on Medicare business, a -15.6% margin on Medicaid business, and a 16.4% margin on Commercial business, resulting in an overall patient related margin of 2.4%.

In terms of patient related operating income, Medicare resulted in a $430 million loss, Medicaid a $192 million loss, and Commercial an $845 million gain, combining to an overall gain of $222 million.

Chart 3 also shows that if each segment were to supply revenue in proportion to its expense, Medicare would have needed to supply an additional $510 million in revenue, and Medicaid an additional $227 million in revenue. The Commercial segment would have needed to supply $738 million less in revenue. If this cost shift had not occurred, each segment would achieve the overall margin of 2.4%.

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Chart 4 presents the fiscal year 2004 cost shift by segment as a percentage of net revenue.

Chart 4
Fiscal Year 2004 Cost Shift Percentages ($m)

	Net Revenue	*Cost Shift*	*Cost Shift Percentage*
Medicare	$2,801	($510)	-18.2%
Medicaid	1,228	(227)	-18.5%
Commercial	5,157	738	14.3%
Total	$9,186	$0	

Chart 4 can be interpreted to mean that Medicare revenue would need to increase by 18.2% in order to achieve the overall margin of 2.4%. Likewise, Medicaid revenue would need to increase by 18.5%. Commercial revenue could then decrease by 14.3% with hospitals still achieving the aggregate 2.4% margin.

Further, losses on the public programs were widespread among Washington hospitals. Chart 5 presents the percentage of hospitals in Washington State with negative patient related margins by payer segment in 2004.

Chart 5
Hospitals with Negative Patient Related Margins
FY 2004

	Hospitals Analyzed	*Hospitals with Negative Margin*	
		#	*%*
Medicare	92	74	80%
Medicaid	92	75	82%
Commercial	92	25	27%
Total	92	38	41%

Chart 5 shows that 80% of Washington State hospitals lost money on Medicare and 82% lost money on Medicaid in 2004, compared with 27% losing on the Commercial segment.

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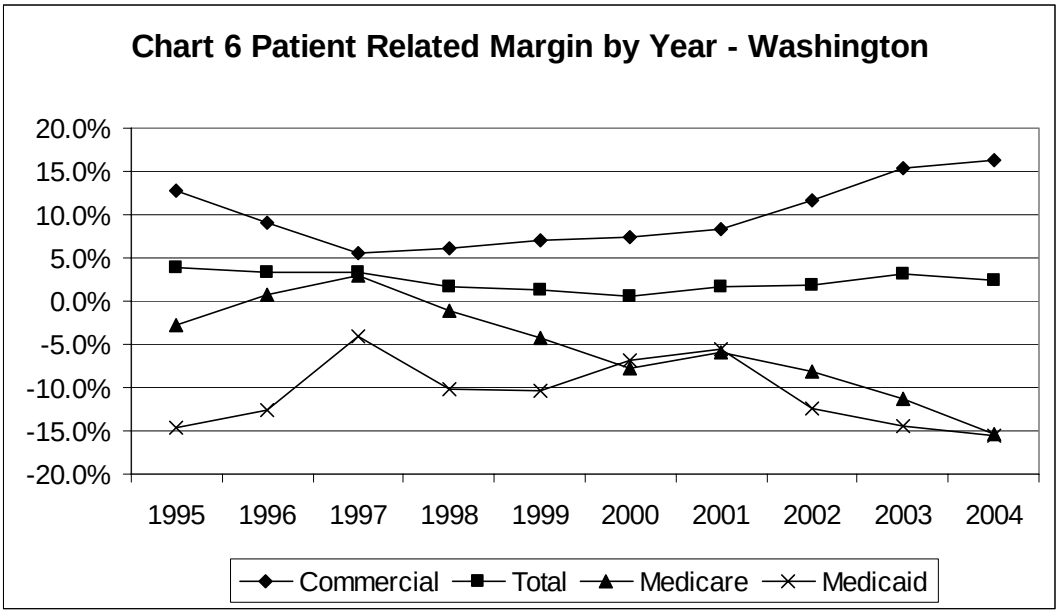

Chart 6 shows that while total patient related margin has remained in the 0% to 4% range from 1995 through 2004, it has been achieved through increasingly large margins on the Commercial segment in order to offset increasingly negative margins on the public segments. Public margins peaked in 1997 and have declined significantly since then. Commercial margins show a reverse mirror image of the public margins, bottoming in 1997 and growing since then.

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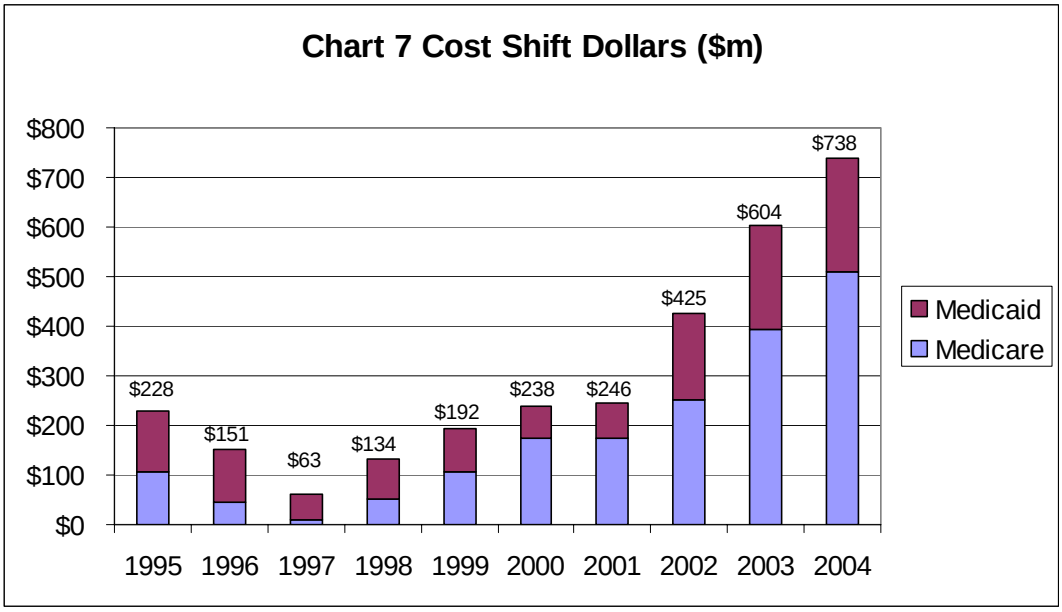
Chart 7 quantifies in dollar terms the trend in cost shift that was clear in Chart 6.



From a $63 million dollar cost shift in 1997, the shift has grown to $738 million in 2004. The cost shift escalated beginning in 2002, with average increases of $164 million per year between 2002 and 2004.

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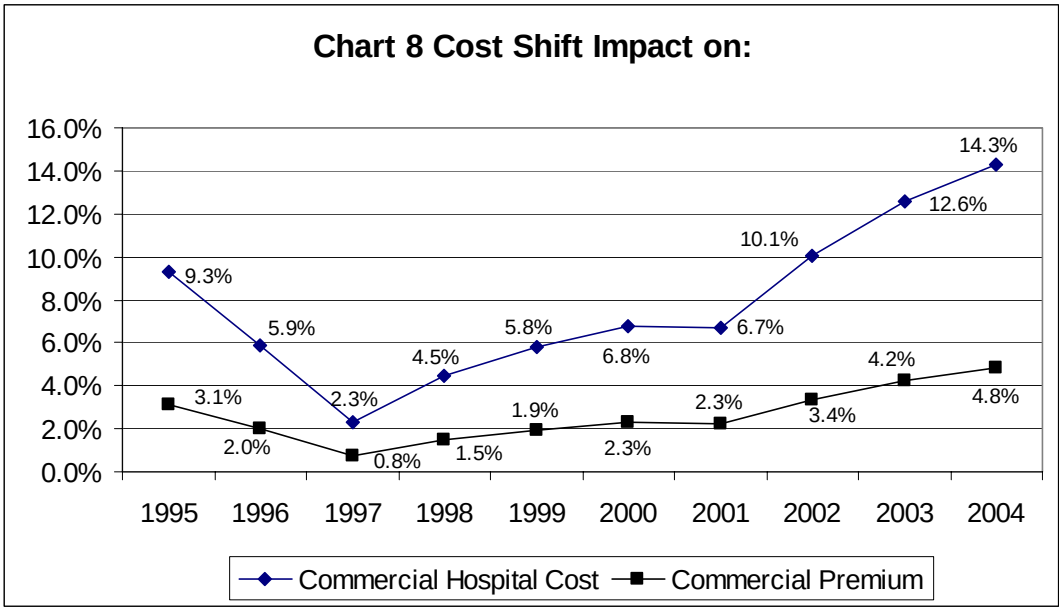
Chart 8 displays the impact of the cost shift on Commercial hospital costs and premium.



In 2004, the cost shift amounted to 14.3% of Commercial hospital cost. With the assumptions that hospital costs represent 40% of medical costs and an 84% loss ratio, the 2004 cost shift amounts to 4.8% of Commercial premium (4.8% = 14.3% x 40% x 84%).

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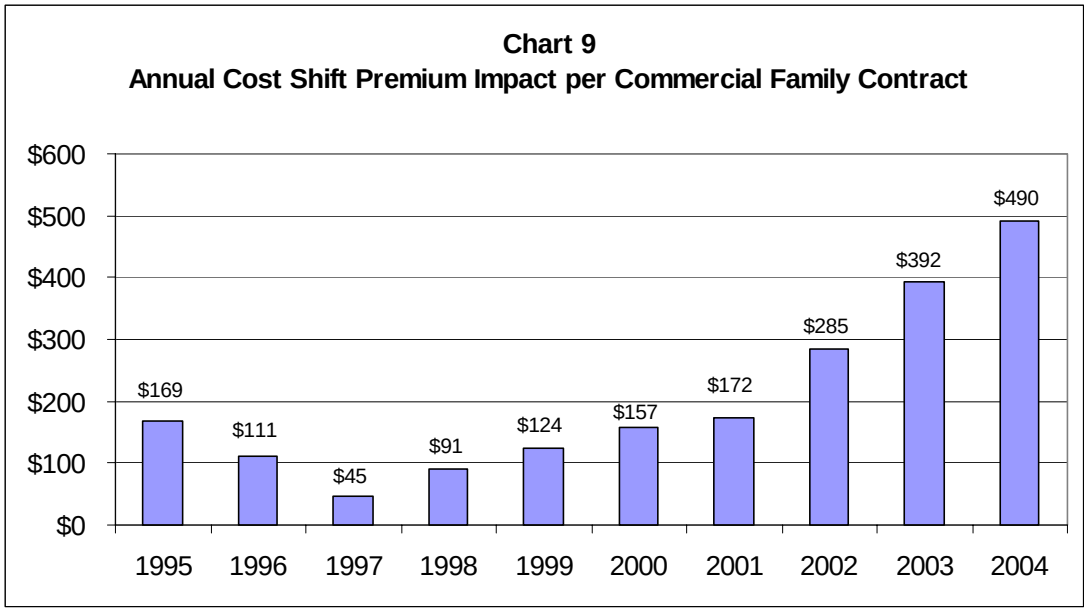
Translating the premium impact into dollars, with typical commercial premium around $850 per family contract per month in 2004, the cost shift amounts to an annual cost of $490 per commercial family contract ($490 = $850 x 4.8% x 12 months). Chart 9 presents the annual premium impact of the cost shift per commercial family contract.



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PHYSICIAN PAYMENT LEVEL COMPARISON

As with hospitals, commercial health plans in Washington pay considerably higher rates, on average, to physicians than do Medicare or Medicaid. In order to assess physician payment level differences, we have compared physician fee schedules in effect as of March 2006. Chart 10 presents the schedules.

Chart 10
Washington State Physician Fee Schedule Comparison
Schedules in Effect March 2006

	Conversion Factor	*RVU Basis*	*Geographic Adjustment*
Medicare	$37.8975	2006 RBRVS	King & Rest of State
Medicaid	CF varies by service: $44.99 Maternity $34.56 E&M - Children $24.82 E&M - Adult $22.71 All Other	2005 RBRVS	Statewide
Commercial	Fee schedules vary by payer. Typical schedule: $50.00 - $54.00	2005 RBRVS	None (area differences accounted for in conversion factor range)

Physician allowable fees are typically calculated as a dollar conversion factor multiplied by a relative value unit (RVU) and perhaps further adjusted for geographic area. In practice, there are many variations on this theme. In order to compare fee schedules, each of these components should be considered.

The commercial schedule represents what we believe to be typical commercial payment levels for fee-for-service PPO payers. Commercial payment levels vary by payer, and further may vary by geographic area, physician specialty or other factors. We based this assessment on our market knowledge, information provided by Premera Blue Cross, and publicly available data.

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While conversion factors are easy to compare across the schedules listed in Chart 10, the comparison could be misleading because the schedules have different RVU bases and geographic adjustments applied. In order to facilitate an overall comparison, Chart 11 adjusts the conversion factors to a 2005 RBRVS with no geographic adjustment basis. That is, for each schedule, we have calculated an adjustment factor to shift from the actual RVU and geographic basis of the schedule to 2005 RBRVS with no geographic adjustment. Using Medicare King County as an example, we estimate that a $37.90 conversion factor on 2006 RBRVS with a King County geographic adjustment (the actual schedule) would produce the same payment amount, in aggregate, as a $40.19 conversion factor on 2005 RBRVS with no geographic adjustment.

Chart 11
Physician Fee Schedules Expressed on Consistent Basis
2005 RBRVS without Geographic Adjustment

	Unadjusted Conversion Factor	*Adjustment to 2005 RBRVS w/o Geo. Adj.*	*Adjusted Conversion Factor*
Medicare			
King County	$37.90	1.060	$40.19
Rest of State	$37.90	0.984	$37.28
Medicaid			
Maternity*	$44.99	0.985	$44.31
E&M - Children	$34.56	1.005	$34.74
E&M - Adult	$24.82	1.005	$24.95
All Other	$22.71	1.002	$22.75
Commercial			
High Typical	$54.00		$54.00
Low Typical	$50.00		$50.00

*Medicaid has an add-on payment for high risk deliveries of $282.81, which for the most common delivery procedure is worth an additional $6.56 on the unadjusted conversion factor. On the other hand, Medicaid pays the normal delivery rate for cesarean deliveries (which have a higher RVU value), resulting in an unadjusted conversion factor for the most common cesarean delivery procedure of $39.71. We have not made any adjustment for the additional payment or the policy of paying only for a normal delivery.

The adjusted conversion factors are then directly comparable, as all are expressed on the same underlying schedule basis.

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Chart 12 presents the commercial adjusted conversion factors as a percentage of Medicare and Medicaid.

Chart 12
Physician Payment Level
Commercial as a Percent of:

		Range		
		Low	*to*	*High*
Medicare				
	King	124%		134%
	Rest of State	134%		145%
Medicaid				
	Maternity	113%		122%
	E&M Children	144%		155%
	E&M Adult	200%		216%
	All Other	220%		237%

Chart 12 shows that typical commercial payments range from 24% to 45% above Medicare and 13% to 137% above Medicaid.

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Chart 13 presents a comparison of payment levels for anesthesiologist services. Anesthesia payments do not follow the same structure as the fee schedules discussed above, so the conversion factors in Chart 13 should not be compared to the earlier conversion factors.

Chart 13
Anesthesia Payment Level

	Anesthesia Conversion Factor	Commercial as a Percent of: *Low Range*	*to*	*High Range*
Medicare - King Co.	$17.99	258%		281%
Medicaid	$20.44	227%		247%
Commercial	$46.50 - $50.50			

Chart 13 shows that commercial payers pay between 158% to 181% more than Medicare for an equivalent anesthesia service, and between 127% to 147% more than Medicaid.

The commercial conversion factor range in Chart 13 represents our best estimate of typical commercial payment levels; actual payment levels vary by payer. The Medicare conversion factor shown is for King County. The Medicare conversion factor in the rest of the state is lower, at $17.44.

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METHODOLOGY

Hospital

The hospital analyses presented in this paper are based on the Year End Hospital Summary Reports for Washington State hospitals reported by the Washington State Department of Health. We have relied upon this data. We have reviewed the data for reasonableness, and in some cases have made adjustments to the data.

The data adjustments that we made were based on more detailed year-end financials also reported by the Department of Health. In two cases, the reported financials were internally inconsistent, with the inconsistency materially affecting overall results, so the hospital was excluded (excluded only for the year of the inconsistency).

The Department of Health data is sufficient to split billed charges and net patient service revenue between Medicare, Medicaid, and all other. The all other category includes commercial insurance payers, self-pay, Workers' Compensation, and other government programs. Throughout this paper, we refer to the all other category as "Commercial." The reported financial data does not split expenses into these payer segments, however. We allocated expenses to payer segment as described below.

The financials include gross revenue (billed charges) by payer segment. Deductions from gross revenue are reported for contractual rate agreements by payer segment and for charity care/other deductions. We removed the charity care/other deductions from the Commercial segment's billed charges. Total operating expenses were then allocated to each payer segment (Medicare, Medicaid, and Commercial) in proportion to the segment's billed charges. This was performed at the hospital level. In actual practice, the cost to charge ratio will vary by service within a given hospital. Our use of a constant cost to billed charge ratio is an approximation of the actual expense distribution.

The split between Medicare, Medicaid, and Commercial is based on each hospital's reporting of the split. It is likely that some Medicare and Medicaid payments for beneficiaries in health plan managed care programs are reported by hospitals in the Commercial segment, rather than the Medicare or Medicaid segments. To the extent that these managed plans apply payment rates similar to the fee-for-service government programs, this reporting issue serves to lower the cost shift identified in this paper, as the low payment levels for these patients are combined with the higher payment levels for other patients in the Commercial segment. That is, if all payments for Medicare and Medicaid beneficiaries were reported in the Medicare and Medicaid segments, the cost shift would likely be larger than presented here.

The results in this paper present only patient related financial results. Specifically, non-operating, tax, and other operating revenue and expense are not included. As total expenses were available only at the operating and non-operating level, we allocated operating expenses associated with other (non-patient) operating revenue by assuming the same margin between

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patient revenue and other revenue. Further, we did not allocate any expenses to tax revenue. All allocations were performed at the hospital specific level.

Group Health Central and Eastside hospitals were excluded from the analyses because they primarily treated only their own members and their summarized financials were not reported in a consistent manner with other hospitals.

Physician

The physician fee schedule analyses are based on the 2006 Medicare fee schedule after revision for the Deficit Reduction Act of 2005 (which served to maintain the same conversion factor Medicare applied in 2005, rather than decreasing it), the Washington State Medicaid fee schedule effective 7/1/2005, and our assessment of typical commercial fee schedules as of March 2006.

The Statewide geographic adjustment applied in the Medicaid schedule is equal to 30% of the Medicare King County adjustment and 70% of the Medicare Rest of State adjustment.

The Medicare, Medicaid, and assumed commercial fee schedules all apply the RBRVS site-of-service payment methodology.

In addition to fee schedule levels, claims editing rules applied by payers also affect the total reimbursement received by physicians. We have not attempted to compare or quantify claims edit differences between commercial payers and Medicare or Medicaid.

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Attachment A
Washington State Hospitals
Patient Related Financial Results

	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
Medicare										
Billed Charges	$2,248,609,742	$2,417,358,670	$2,626,507,446	$2,781,682,110	$3,119,753,970	$3,747,617,801	$4,302,226,836	$4,993,869,081	$5,815,307,513	$6,580,743,483
Net Patient Revenue	1,536,438,850	1,708,320,696	1,838,127,715	1,826,849,103	1,866,423,886	2,039,292,316	2,249,605,454	2,467,422,519	2,653,309,266	2,801,192,463
Allocated Expense	1,578,769,573	1,695,904,638	1,785,143,197	1,848,245,187	1,946,956,986	2,198,646,760	2,381,598,000	2,670,261,764	2,955,009,940	3,231,507,818
Operating Income	(42,330,723)	12,416,058	52,984,518	(21,396,084)	(80,533,100)	(159,354,444)	(131,992,546)	(202,839,245)	(301,700,674)	(430,315,355)
Margin (1)	-2.8%	0.7%	2.9%	-1.2%	-4.3%	-7.8%	-5.9%	-8.2%	-11.4%	-15.4%
Medicaid										
Billed Charges	$1,010,354,460	$997,751,086	$1,041,651,054	$1,092,855,314	$1,239,434,718	$1,526,721,157	$1,791,219,748	$2,335,673,061	$2,492,688,331	$2,782,712,122
Net Patient Revenue	633,890,955	629,871,946	701,309,988	671,885,554	727,242,497	869,991,688	984,415,659	1,184,696,251	1,163,504,550	1,227,773,606
Allocated Expense	726,288,304	709,469,891	729,721,483	739,876,995	803,099,804	929,049,613	1,039,273,573	1,331,517,814	1,330,685,702	1,419,726,087
Operating Income	(92,397,349)	(79,597,945)	(28,411,495)	(67,991,441)	(75,857,307)	(59,057,925)	(54,857,914)	(146,821,563)	(167,181,152)	(191,952,481)
Margin (1)	-14.6%	-12.6%	-4.1%	-10.1%	-10.4%	-6.8%	-5.6%	-12.4%	-14.4%	-15.6%
Commercial										
Billed Charges	$3,002,818,266	$3,276,586,033	$3,729,107,839	$4,218,867,148	$4,947,174,016	$5,526,701,075	$6,012,154,396	$6,950,924,890	$7,961,867,297	$8,679,514,563
Net Patient Revenue	2,443,586,857	2,548,908,059	2,709,892,133	2,990,102,561	3,319,610,865	3,519,184,802	3,659,672,836	4,217,157,009	4,792,023,366	5,156,917,356
Allocated Expense	2,129,205,709	2,317,649,788	2,558,262,861	2,808,695,623	3,087,530,760	3,260,567,265	3,356,043,279	3,722,407,231	4,059,317,482	4,312,338,637
Operating Income	314,381,148	231,258,271	151,629,272	181,406,938	232,080,105	258,617,537	303,629,557	494,749,778	732,705,884	844,578,719
Margin (1)	12.9%	9.1%	5.6%	6.1%	7.0%	7.3%	8.3%	11.7%	15.3%	16.4%
Total										
Billed Charges	$6,261,782,468	$6,691,695,789	$7,397,266,339	$8,093,404,572	$9,306,362,704	$10,801,040,033	$12,105,600,980	$14,280,467,032	$16,269,863,141	$18,042,970,168
Net Patient Revenue	4,613,916,662	4,887,100,701	5,249,329,836	5,488,837,218	5,913,277,248	6,428,468,806	6,893,693,949	7,869,275,779	8,608,837,182	9,185,883,425
Allocated Expense	4,434,263,586	4,723,024,317	5,073,127,541	5,396,817,805	5,837,587,550	6,388,263,638	6,776,914,852	7,724,186,809	8,345,013,124	8,963,572,541
Operating Income	179,653,076	164,076,384	176,202,295	92,019,413	75,689,698	40,205,168	116,779,097	145,088,970	263,824,058	222,310,884
Margin (1)	3.9%	3.4%	3.4%	1.7%	1.3%	0.6%	1.7%	1.8%	3.1%	2.4%
Cost Shift										
From Medicare to Commercial	$106,294,176	$46,499,138	$9,017,930	$52,909,921	$105,777,190	$173,191,845	$173,031,997	$252,996,697	$395,122,063	$510,461,899
From Medicaid to Commercial	121,822,737	104,244,706	53,756,531	80,606,847	86,270,235	64,904,990	72,766,569	171,832,422	209,250,217	227,163,951
Total	$228,116,913	$150,743,844	$62,774,462	$133,516,768	$192,047,425	$238,096,835	$245,798,566	$424,829,119	$604,372,280	$737,625,849
As a % of Comm. Hospital Cost	9.3%	5.9%	2.3%	4.5%	5.8%	6.8%	6.7%	10.1%	12.6%	14.3%
As a % of Comm. Premium Cost (2)	3.1%	2.0%	0.8%	1.5%	1.9%	2.3%	2.3%	3.4%	4.2%	4.8%
Annual Prem. Cost per Comm. Family (3)	$169	$111	$45	$91	$124	$157	$172	$285	$392	$490

Notes
(1) Margins and other values are patient related only. Other operating, tax, and non-operating revenue and expense are excluded.
(2) Assumes hospital cost = 40% of medical cost and an 84% loss ratio
(3) Assumes 2004 premium PMPM of $236 and family contract load of 3.6

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Tab 40

August 30, 2006

Proposal to Utilize the Proactive Health Professional Liaison/Consultation Call Center To Improve Health Outcomes and Decrease Healthcare Costs in Washington State

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Proposal to Utilize the Proactive Health Professional Liaison/Consultation Call Center To Improve Health Outcomes and Decrease Healthcare Costs in Washington State

Introduction:
Proactive Health Team (PHT) is a team of doctors, nurses, and pharmacists who are currently working in the medical community. We came together with one common goal, to improve the healthcare system by making it wellness driven rather than illness driven. As working healthcare professionals we have witnessed first hand the increasing problems of our healthcare system. We propose to strategically address each of these contributing factors by providing the consumer a resource of healthcare professionals that can act as a liaison for the consumer regarding healthcare decisions for a very nominal fee to the consumer.

Key factors contributing to the problems of the current healthcare system:

- Increasing insurance costs and larger co-pays. Small business and individuals are finding it harder to afford health insurance.
- Defensive medicine. Malpractice claims have escalated, which has contributed to over-utilization of healthcare services
- Poly-pharmacy (multiple medications, over-the-counter products and supplements). Poly-pharmacy is the greatest risk factor for adverse drug reactions, reduced compliance, increased emergency room visits, hospitalizations, and nursing home admissions[1].
- Escalating prescription drug and durable medical equipment costs.
- De-personalization of relationships with healthcare providers has contributed to patient non-compliance.
- Use of multiple doctors and pharmacies has contributed to the lack of continuity of care and to redundancies.
- Consumers are utilizing more alternative sources for health information, such as the television, Internet, and print media, which may not provide relevant or accurate information for their individual health situation.
- The pharmaceutical industry dictates what is considered the standard of care. The pharmaceutical industry pays for most of the medical research, which focuses on drug development, not cures for illness. The US uses more prescription medications and spends more of its gross domestic product on health care than any other country yet it is ranked 37th in the world in quality of health by the World Health Organization[2].

PHT recognizes all of the challenges facing the Commission in achieving its goals of improving access, health, affordability, and quality. PHT's proposed strategy addresses each of the questions of the Commission:

1. What do you propose be done to realize the vision for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access?

The most significant link and yet the weakest link in the healthcare dilemma is the consumer. The third party payor system has resulted in the consumer becoming impotent and apathetic. Our illness driven system has fed the consumers' apathetic behavior in regards to taking a proactive approach to their health and well-being. For the majority, a reactive approach is the norm and this results in greater co-morbidities and greater healthcare expenditures.

Consumers must take an active role and responsibility in their health decisions in order to resolve the current healthcare dilemma. In an attempt to lower healthcare expenditures, the health insurance industry is making consumers become more responsible for their healthcare spending by raising deductibles and implementing Consumer Directed Health Plans and Health Savings Accounts. The Carlson School of Management has evaluated the success of these efforts to lower healthcare expenditures and found that this was not effective. Yes, Consumer Directed Health Plans did decrease the number of doctor office visits and the number of prescription medications bought, but it increased

the number of hospital admissions[3]. So either, consumers waited too long to seek medical advice which resulted in a more serious illness or condition developing or they didn't have adequate information to know what warranted seeking medical advice early on.

The bottom line is that the consumer must be empowered with making informed healthcare decisions. PHT will provide the consumers with proven scientific research facts and a team of licensed healthcare professionals available to answer and discuss their health concerns that are not dictated by the pharmaceutical or health insurance industries. We believe that by communicating one-to-one with each consumer and actively involving each consumer in his or her healthcare decisions, an improved quality of life will be the result.

PHT proposes to provide the following services:

- **Comprehensive Health Screens.** Our nurses will contact consumers and offer to conduct comprehensive health screens that may identify health risks that are silently festering and if not attended to may result in the manifestation of illness in a few years. Although a person may feel fine today, certain stressors in life such as emotional, financial, diet, lack of exercise or too stringent exercise etc. may be silently eating away at a person's wellness. The body talks to us through symptoms and because the body is so resilient, these symptoms may come and go without a person giving them much thought. But these may be clues that a person needs to take some action to remain healthy in the years to come. Our very comprehensive health screen explores every system of the body looking for clues of anything lurking that may impede a person's health if not attended to early on.
- **Education and Consultation.** Our health professionals will provide education and consultation to the consumer as well as notify the consumer's Primary Care Physician (PCP) of these possible health risks. Most people will take necessary steps to improve their health if they understand the relevance of the information. Our health professionals will provide the consumer with factual information in terms he/she understands.
- **Medication and Supplement Evaluation.** Our pharmacists will evaluate prescription medications and OTC supplements and medications for possible interactions, etiology of symptoms and cost effectiveness. Many people see more than one doctor or don't even have a primary doctor and they may purchase their medications from several pharmacy locations. This often results in taking medications that have duplicating effects or are not compatible with each other and this could result in unnecessary costs and worse yet—harm. Often medications are prescribed for symptoms that may be due to an interaction with another medication, an over-the-counter medication, a supplement, or a food that is incompatible. Our pharmacists will look at the whole picture so that such a scenario can be identified and corrected.
- **Provide Scientific Rationale.** Our medical researcher will research consumer inquiries regarding products and health information that the consumer may have seen in the media to provide factual answers to the consumer regarding health risks or benefits associated with such products. Consumers are bombarded with information regarding health issues on the television, Internet, and print media, all claiming to be the answer to one's health issues. Yet not all of this information is correct and some may be very harmful depending on an individual's health status.
- **Available 24 Hours a Day –7 Days a Week.** Our nurses and doctors are available 24 hours a day—7 days a week to provide triage or answer questions regarding one's health.
- **Person-to-Person Communication.** The PHT will provide person-to-person assessment and individualization of health protocols so as to increase consumer compliance and quality outcomes. Through interactive communication with the consumer, our trained healthcare professionals can get a clearer picture and help the consumer make decisions that will be more apt to accommodate his/her lifestyle.
- **Database That Keeps an Ongoing Medical History on Each Consumer.** PHT utilizes an extensive database that maintains an ongoing medical history on each consumer. This allows the consumer to shop their healthcare services without sacrificing continuity in care. The database helps to compile all of the consumer's information as it is gathered into one place,

which makes it very easy to send the information to the doctor of the consumer's choice. This allows the doctor to evaluate all of the pieces of the consumer's medical history in chronological order, which can be very revealing when trying to figure out the cause of a symptom. This also helps prevent duplication of lab tests and costs and stress that may be associated with redundancies.

- **Patient Advocate and Liaison.** The health professionals on the team will perform as a patient advocate and interact with the consumer's PCP to promote continuity of care. The PCP may have limited time per office visit due to scheduling and insurance limitations, so the consumer needs to provide the PCP with the best information during that limited time frame. Our health professionals can help the consumer develop a list of pertinent questions and information to give the PCP during the office visit, so that the PCP can provide the best health advice. Our doctors at PHT can even communicate the consumer's health concerns with the PCP if the consumer requests.
- **Preventative Lab Testing.** Upon completion of the Comprehensive Health Screen, certain high risk individuals may be identified and PHT will offer to pay for certain labs that can identify early precursors to some diseases such as homocysteine levels, lipid peroxidation levels, AMAS test for early detection of cancer.
- **Effectiveness Quantitatively Evaluated.** PHT utilizes Likert scales to quantitatively evaluate if the team's efforts were able to increase consumer compliance with preventative wellness protocols that in turn decreased the health risk status of the consumer. We have developed our Comprehensive Health Screen so that we can measure the consumer's health risk at the beginning and then again after we have helped the consumer make some changes in the management of their health. We can quantify if these changes were effective in improving the consumer's health outcome and if modifications should be made to the consumer's plan for health.

2. ***How will implementation of your proposal enhance, hinder or otherwise impact the achievement of each of the goals established by the Commission? How do you know?***

Implementation of the services offered by PHT will help the Commission achieve each of its goals:

Improving Access. Washingtonians face the same problems as those that were identified in the 2004 Survey of Primary Care and Health System Performance: Adults' Experiences in Five Countries[4]:

- Participating countries: US, UK, Australia, New Zealand, Canada
- US: 1 person in 5 have no regular doctor and only 37% of those that do had long-term relationships with their regular doctor.
- US reported most difficulty getting access to care after hours.
- US reported most likely to not see a doctor when sick, didn't get recommended tests or follow-up care, or went without Rx because of cost.
- 50% of ER visits in US were for care that their regular doctor could have provided.
- 1 in 4 adults reported problems with coordination of care due to:
    - Test results or medical records not available
    - Received duplicate tests or procedures
    - Delays in notification of abnormal test results
    - Received conflicting information
    - Failure to review medications and explain side effects
    - Failure to identify patients' preferences or concerns, to communicate well, or engage patient in care decisions
    - 50% reported failure in receiving reminders, and never received advice or counseling on weight or exercise, or if they had any emotional issues.
    - 1/3 reported not receiving information on how to manage their care at home regarding a chronic condition

- Among those with Internet access, more than 50% reported wanting to speak with a doctor rather than communicate via email

The services of PHT can improve the consumer's access to accurate information regarding their healthcare questions in that a health professional at PHT is available 24 hours a day, 7 days a week by simply calling a toll free number. Access to this health professional assistance at PHT is affordable because the consumer pays only $10.00 a month for a membership.

Improving Health. Health outcomes are dependent on more than just accurate information being provided to the patient. The patient must retain this information, be compliant in following the guidance of the health professional, and the health professional and patient must have a relationship conducive to the sharing of information so that modifications may be made to the plan of care that will accommodate the patients individualized needs. We are all individuals with different needs and a one-size fits all plan of care may not produce the most beneficial health outcomes. A study published in JONA February 2003, showed that the greater the requirement for nurses at call centers to use set protocols, the poorer the quality of outcomes[5].

PHT will provide one-to-one communication with each consumer in the comfort of their own environment so that they can take notes and have better retention of the information provided. This will foster a sharing relationship between the PHT staff member and the consumer in which the consumer will be encouraged to share and actively participate in making good healthcare decisions.

PHT has a researcher on staff to provide the latest information based on scientific literature. The health professionals at PHT will provide the rationale supporting the health information shared with the consumer, which will increase the percentage of compliance resulting in overall better health outcomes.

PHT offers a comprehensive health screen that inquires about every system of the body, looking for early precursors that may manifest into disease in years to come if not attended to. Unfortunately most of the common blood chemistry and urine tests used today are not preventative because they do not identify early precursors to disease, but rather only reveal an abnormal indicator usually after the disease process has been established. The comprehensive health screens utilized by PHT will enable health professionals to perform an ongoing evaluation of data from various populations and perhaps identify specific early indicators that can trigger a disease if present with certain coexisting factors. This information can then perhaps lead to better proven preventative testing in the future.

Improving Affordability. With the rising costs of healthcare and insurance premiums, many employers have had to discontinue health insurance benefits for their employees. This has resulted in an increase in the number of uninsured Washingtonians and has increased the burden on the state funded health plans. The insurance industry is attempting to accommodate the need to decrease or limit the amount of expense to small businesses so that employers can afford to provide health benefits for employees by offering Health Savings Accounts or Consumer Driven Health Plans (CDHP).

PHT can assist the consumers who are participating in a Health Savings Plan or a CDHP in making informed decisions regarding their health and the $10.00 per month cost for PHT's services can be deducted from the Health Savings Account or CDHP account, so that it is not an increased expense to the employer. Furthermore, if the consumer (employee) is able to decrease the amount of health expenditures from his/her Health Savings Account or CDHP fund by utilizing the services of PHT, then the employer will be able to roll these savings into the employees plan in the succeeding year.

Also plans such as the CDHP, may result in the consumer doing more shopping for the best price and not necessarily the best quality among healthcare entities and this can result in discontinuity in care and redundancies that will result in poorer health outcomes and unnecessary expenditures. PHT utilizes a database that keeps an ongoing medical history on each consumer that can track lab results, medications etc in chronological order. Many times a patient may see various doctors for a variety of complaints and many times the chief complaint at the time of the office visit may be related to a supplement or medication interaction which may not be revealed to the attending doctor. This could result in the attending doctor prescribing yet another medication, contributing to the growing trend of poly-pharmacy. By comparing the time of the onset of symptoms to the initiation of a new medication or supplement, the professionals at PHT may be able to identify the cause of a consumer's symptoms as a specific interaction and then report this information to the consumer's primary physician. This could result in a medication change and/or discontinuation of some medications that are not necessary.

Also PHT's database can track and flag labs that are due or results that have not been obtained and then notify the consumer and the consumer's doctor of such findings. This will decrease the expense of redundancies and errors due to lab results being overlooked.

Improving Quality. PHT can work with such organizations as the Puget Sound Health Alliance to help provide consumers with data regarding the healthcare entities that have the highest standards of quality. PHT's database can improve continuity in care, which has been shown to improve quality and decrease waste.

PHT's researcher will keep the team members apprised of the most recent evidence based healthcare findings. Unfortunately, much of the standard of care today is dictated by the pharmaceutical industry and it may not result in the best quality outcome. For instance, the MONICA study by the World Health Organization is the world's largest and longest comprehensive study on heart disease (21 countries, 150,000 patients, and 10 years duration). It revealed that patients using one of the statin drugs to lower their cholesterol had the poorest survival rate[6]. Despite this evidence, the U.S. has adopted the use of statin drugs as the standard of care for the prevention of heart disease.

3. ***Is your proposal modeled after an existing policy or program with Washington or in another state? If so, please describe the policy or program and its outcomes.***

Many insurance companies have implemented nurse call centers and health information websites where the consumer can direct their health related questions. Unfortunately these resources have not had a significant effect in improving overall quality of health or in significantly decreasing healthcare expenditures. A study published in JONA in February 2003, found that only 47% of a random sample of HMO members used the telephone nurse advice line in a 1-year period. Only 2% of this 47%, called the nurse advice line more than 2 times[5]. The under utilization of the nurse call centers is the due to the reactive approach of these existing systems. The effectiveness of these systems is reliant on the consumer taking the initiative to call the center and in most cases this was only during a health crisis and not for preventative information that could improve future quality of health.

Unlike the current health information call centers that utilize a reactive approach, PHT offers a proactive approach, which has the potential to greatly improve future as well as current health outcomes. PHT recognizes that consumers must be actively involved in their health, but in order for the consumer to do this, he/she must acquire accurate information to even know what questions to ask. PHT takes the initiative to get the consumer involved by calling the consumer and performing a comprehensive health screen. This provides the opportunity for the health professional of PHT to determine the consumer's current knowledge base regarding his/her health and to identify and apprise the consumer of potential risk factors that may be lurking. It

is imperative that this communication is on a one-to-one basis, not via a written questionnaire like some Internet based health information centers utilize because often-pertinent information is revealed in the tone of voice.

4. ***Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?***

   The consumer must become more involved in his/her health and share more responsibility for healthcare spending. This need has fostered the growing trend in such insurance plans as the CDHP. This shift of cost must not be too burdensome to the consumer or it could contribute to the growing population of uninsured Americans. PHT recognizes this and offers its services for $10.00 a month per member/family. This membership fee can be deducted from the consumer's CDHP fund or HSA so that it doesn't impact the employer's health benefits costs or the consumer's direct out-of-pocket expenses.

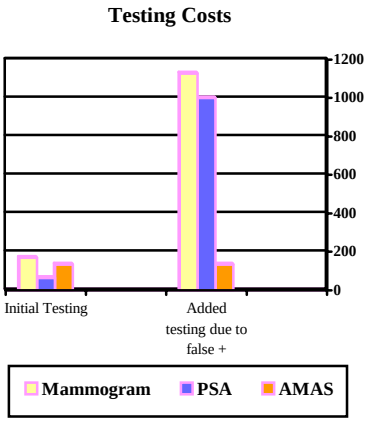
Triage Scenario of Potential Savings to Consumer

Monthly Membership to PHT	Costs	Savings
Monthly Deduction from CDHP fund or HSA or	$10	
Prevent one non-urgent ER visit & direct to PCP	$60	$883
Total costs for month	$70	
Total savings for month		$813

Furthermore, PHT realizes that many consumers may procrastinate in regards to some preventative testing as a means to save money at the present time, but this could result in very high healthcare costs and poor health outcomes in the future. Thus, PHT will pay for some preventative lab testing for consumers who are identified via the comprehensive health screen to be at high risk. For example, a consumer may have a history of being exposed to environmental toxins, a family history of cancer, and symptoms indicative of a suppressed immune system, which would put the consumer at increased risk for developing cancer. PHT then may offer to pay for the Antimalignin Antibody in Serum (AMAS) test, which is FDA approved as an early diagnostic test for cancer and has false-negative and false-positive ratings of less than 1%[7].

The following is an illustration of how such preventative measures such as the AMAS test can result in savings and better quality outcomes:

"More than 1.2 million breast biopsies are performed each year in the U.S.; about 20% turn out to be breast cancer." (*The American Journal of Managed Care*, 5/2001)[8,9,10,11,12]



1. ***How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?***

The services of PHT will not replace a consumer's current primary care physician/practitioner, but rather PHT is a medical/health information resource to which the consumer can direct his/her general health questions. Doctors have verbalized frustration that they aren't allotted enough time by insurance carriers to adequately assess and evaluate a patient's condition during an office visit. So the American Medical Association conducted a survey to evaluate how much time a doctor was allotted by an HMO insurance carrier to spend with a patient during an office visit and surprisingly the HMO allotted time was actually two minutes longer than office visits performed outside of the HMO network. But investigating the issue further, the study identified that the reason doctors felt pressed for time to adequately assess the patient's chief complaint, was that the first 20 minutes of the 30 minute office visit was spent answering general health questions the patient had pertaining to information they had read, heard, or saw in the media and then only the last 10 minutes was the doctor able to devote full attention to the health complaint at hand[13]. By utilizing the services of PHT, the consumer can direct these general health questions to us, so that when the consumer goes to the doctor, the entire office visit can be focused on the symptom or ailment that is chief complaint. In order for a consumer's doctor to gain a clear picture, ~~Furthermore,~~ the health professionals at PHT can help consumers detail the pertinent information ~~to discuss with their doctor~~ that may be related to their chief health complaint to take with them to their doctor's visit~~s.~~, ~~so that the doctor can get a clearer picture of what may be causing the symptoms or health concern~~ This could result in a more favorable health outcome.

PHT has doctors, pharmacists and nurses as well as researchers on staff whose expertise could also be utilized by the State of Washington Medicaid/Medicare program to perform drug/treatment utilization evaluations to assess whether a therapy or treatment is effective and cost efficient. This could result in better health outcomes, significant cost savings to the program and compliance with the OBRA 1990 regulations.

The services offered by PHT would provide synergy between achievement of the goals and the mission of Puget Sound Health Alliance, by empowering the consumer to make informed decisions regarding their health and by increasing consumer compliance.

6. ***What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?***

One or the obstacles we foresee is educating the consumer to see the value in subscribing to the services of PHT. The $10.00 a month charge is nominal for most, but it is an expense all the same. Thus, PHT proposes to offer a year pilot program to the State of Washington Basic Health Plan members to prove the cost effectiveness of this proposed program of involving and empowering the consumer in their healthcare decisions. In this pilot program, each Basic Health Plan member/family would be required to pay an additional $10.00 with their monthly premium for the PHT services.

PHT proposes the following service delivery models:

Triage Model:

Consumer Calls Toll Free Number (1-888-854-0288)

↓

Registered Nurse Answers Call and Performs Triage

↙ Or ↘

RN advises consumer of proper Care pathway

RN refers the call to PHT staff MD or pharmacist for consultation.

↘ ↙

RN, MD, or Pharmacist notifies consumer's PCP of results of triage via fax phone or email.

↓

All triage callers will receive a follow-up call by a licensed health professional within 3 days from the date the initial triage call was received.

Comprehensive Health Screen Model:

RN or other qualified health professional staff member calls the consumer and requests his/her voluntary participation in the conduction of a comprehensive health screen questionnaire via the telephone.

↓

Answers to health screen questions triggers the computer program or the RN to refer the consumer for further education and consultation by a qualified licensed health professional staff member i.e. a pharmacist to review current medications, or a physician to review identified potential health risks. The areas of concern in the consumer's comprehensive health screen are highlighted and the consumer is scheduled for follow-up education and consultation with one of the PHT's health professional staff members.

↓

For those consumers having potential risks, a PHT staff physician or ARNP will inform the consumer's PCP of the results of the comprehensive health screen. If the PCP chooses to order any laboratory tests, PHT may offer to pay for the testing (PHT budgets up to 10% if its monthly revenue for the laboratory testing it coordinates through the consumer's PCP).

↓

If the PCP orders laboratory testing, the consumer's file will be marked for follow-up to ensure that the lab was completed, the results were received by PHT for entry into the database and the results were forwarded to the PCP. If the labs were not completed, a PHT staff member will contact the consumer or the laboratory to determine the reason the lab was not completed and also inform the PCP. If appropriate, a PHT staff member will educate the consumer of the potential health implications of choosing not to have the lab test performed.

Conclusion:

PHT believes that unless consumers have an active role in their healthcare, the healthcare crisis will continue to grow to catastrophic proportions. Costs will continue to escalate to the point where employers will no longer be able to offer health insurance as an employee benefit and consumers will not be able to afford it on their own. The costs of caring for our citizens will fall more and more on state government and state government cannot afford this added expense. The PHT model and proposal is designed to empower consumers to be more responsible and involved in their healthcare decisions and solutions. Without the consumers involvement and participation, the healthcare system as we know it today will not survive.

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Tab 41

Blue Ribbon Commission

Proposal –
Project Access efforts in Washington State

Statewide Support

Project Access is a system of care that relies on the generosity of physicians, hospitals and other providers to donate care and services to the low income uninsured. It is a model of care that is currently working in over 50 communities across the country including six communities in Washington. Project Access is typically housed or closely related with the local County Medical Society, and relies on close working relationships with the safety net and private practitioners. Project Access aims to provide all care and services needed by a qualified uninsured patient; primary care, consultative specialty services, in and out-patient hospital services, ancillary services, medications and durable medical equipment.

There are six known Project Access efforts in Washington state at various stages of development and implementation.

- Spokane County Project Access – Sept. 2003
- Thurston County Project Access – May 2005
- King County Project Access – March 2006 (with 2 pilots since 2004)
- Whatcom County Project Access (a partnership between Whatcom Alliance for Healthcare Access and Whatcom County Medical Society) – September 2006 start date
- Clark County – developmental
- Benton/Franklin Counties – developmental

Most of the larger urban areas are included in these efforts. Additional other communities have had initial exploratory meetings.

Project Access is a compelling model for providing healthcare for low income uninsured patients; it builds on the strengths in the current system while minimizing the challenges, asks that various parts of the health care system provide care and services within their area of expertise, and shares the challenge of meeting the medical needs of the uninsured across a broad base of providers. Project Access is locally run , it streamlines, enlarges and improves the amount of charitable giving that physicians and other providers are already doing, it adds to the economic vitaility of the county by improving the health of the community – particularly the health of low income working adults.

While each Project Access is unique to the needs and strengths of its local community, each follows the basic guidelines initially developed in Buncombe County, NC twelve years ago:

- Project Access is a physician-led community partnership
- Project Access develops a coordinated charity care system by working with existing physicians, hospitals and other providers
- Project Access provides for the full continuum of medical care; primary care, specialty care, ancillary services, medications, and in and out-patient hospital services
- Project Access asks that each part of the system do what it does best
- Project Access provides needed access to care for the low-income uninsured while encouraging those who are eligible to enroll in state sponsored health insurance programs.

Project Accesses have in common a premise that coordinated care for the uninsured can provide better health at a lower cost than the current non-system that has patients delaying care and/or obtaining care via emergency rooms.

Project Accesses have a history across the country of improving access for the uninsured to health services, reducing inappropriate emergency department usage, lowering hospital admissions through the emergency department and reducing the hospital length of stay for the uninsured served through Project Access. Additionally, Project Accesses have shown to be a benefit to local businesses as the small employer has a healthier base from which to hire, workers lose less time due to illness when they have appropriate access to health care and the enrollees in Project Access are measurably healthier.

While each Project Access has its own eligibility requirements, typical requirements in Washington are that patient income be 200% Federal Poverty Level or below, uninsured (and not eligible for state sponsored insurance) and a Washington state resident.

1. What do you propose be done to realize the vision and goals for Washington State established by the Blue ribbon Commission on Health Care Cost and Access?

With the current efforts underway, state support to strengthen Project Access efforts could catapult these efforts to the next level of coordination and stability while providing expertise to other communities interested in this model.

Organization –
At this time, each Project Access effort initially learns what it can by word-of-mouth. Phone calls and web-searches provide a wealth of information, but are not as effective or rich as in-person site-visits and conferences. In Washington State many Project Accesses are members of Communities Connect, a statewide affiliation of community health care collaboratives where information and best practices are shared. State funding for coordination of these efforts and shared learning for Project Access programs could provide a cost-effective mechanism to grow these efforts. With support for semi-annual meetings and site-visits, current Project Accesses could learn and share best practices and new, developing Project Accesses would be able to move much quickly. This funding could be provided as a specific allocation to Project Access efforts exclusively or as part of a larger best practices support for community collaboratives through Communities Connect.

Coordination –
Each Project Access develops its own system, protocol, etc. While local autonomy is critical, some areas lend themselves well to cost savings if we had the ability to share infrastructures. Examples include; statewide software for client demographics and outcomes reports, common electronic medical records (EMR) for Project Accesses, and a state-funded, community-located Ombudsman to best connect low-income uninsured to medical care. This Ombudsman concept that the Blue Ribbon Commission is familiar with.

Financial Stability –
Project Accesses are a local solution to a much larger problem. With an expected minimum of $5 returned to the community in donated care and services for every $1 invested in Project Access infrastructure, Project Access is a very cost effective model of providing care to the uninsured. Yet the financial viability of each Project Access is an ongoing challenge. Some of the Project

Accesses had the advantage of early significant grant dollars (Robert Wood Johnson Foundation, HCAP Federal grants), others have not.Both of these fund sources are no longer available to Project Access programs. All Project Accesses work daily to assure that there are ongoing financial resources to continue to make Project Access services available to the low income uninsured.

State support for those components all Project Accesses have in common would stabilize current efforts and facilitate the growth of other Project Accesses. Interpreter services and medications are typically the two biggest financial commitments for Project Accesses. Access to medications will become less of a challenge with the full implementation of the program the Prescription Drug Assistance Foundation is developing. This is 2-3 years away from statewide implementation. State support to expedite the Prescription Drug Assistance's program development would have a huge positive impact on Project Accesses. Additionally, the work being led by HCA on the Drug Consortium has the potential to assist in addressing the challenge of low cost medications for the uninsured.

Strengthening and Replicating

Last year's passage of SB6459 which promotes the development of community healthcare collaboratives provides access to funds that can be critical to the developing Project Accesses. A similar grant program for existing efforts is also needed. In some communities, local governments have provided resources for Project Access – however with limited funds available to them, a local special tax district, such as a Community Medical Health District would expand the amount of dollars available. Community Medical Health Districts will be more fully described in another proposal being submitted to the Blue Ribbon Commission by Communities Connect.

Forming Project Accesses are relying on existing Project Accesses for technical advice and consultation. Supporting this sharing of expertise allows new efforts to develop the necessary community base and come on-line more rapidly.

2. How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

Project Accesses have a positive impact on the Blue Ribbon Goals.

With a disproportionate number of the low-income uninsured having limited English language skills and being racial or ethnic minorities, the uninsured are more at risk of having health indicators that are poorer than the general population. One of the challenges with this population is getting access to health services that would provide treatment and information to help patients health indicators better match the indicators of the general population. With a Commission goal of having consistent population health indicators across race, gender, and income in Washington, Project Access provides a local way to deliver medical care across those race, gender and income boundaries.

Some Project Accesses are providing a level of medical screening to assure appropriateness of referrals that guarantees that use of expensive physician and hospital services meet nationally recognized standards of care. This will both improve health outcomes and save money.

3. **Is your proposal modeled after an exiting policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.**

The Blue Ribbon Commission had a presentation on Spokane Medical Society Project Access at its July meeting. It is the oldest and most established Project Access in Washington. It currently returns over $9 in donated health care and services to Spokane County residents for every $1 spent in administrative support. The Commission presentation addressed issues of program and outcomes. The full presentation is available on the Blue Ribbon Commission web-site.

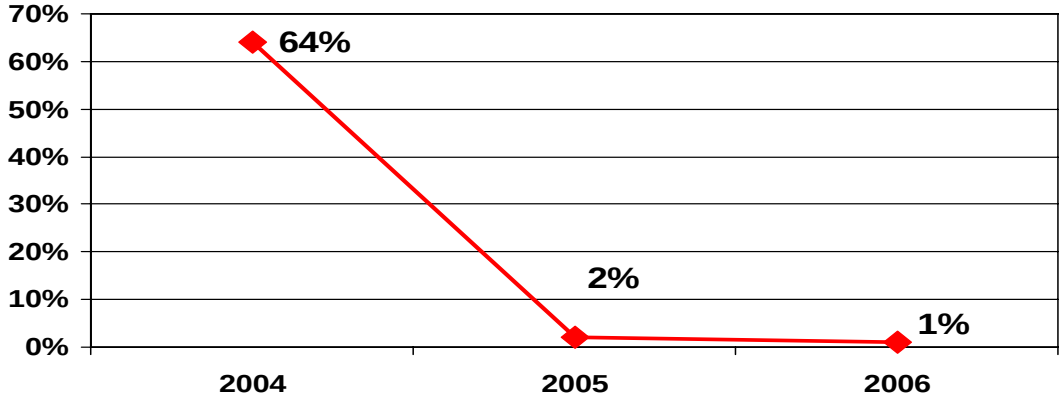
Project Access was initially founded in Asheville NC through the auspices of Buncombe County Medical Society. North Carolina has provided state money to replicate and coordinate Project Access efforts across the state. As the oldest of the Project Accesses, they have been wonderful stewards of their learning and have shared their expertise through site visits, reverse site-visits and phone consultations.

4. **Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?**

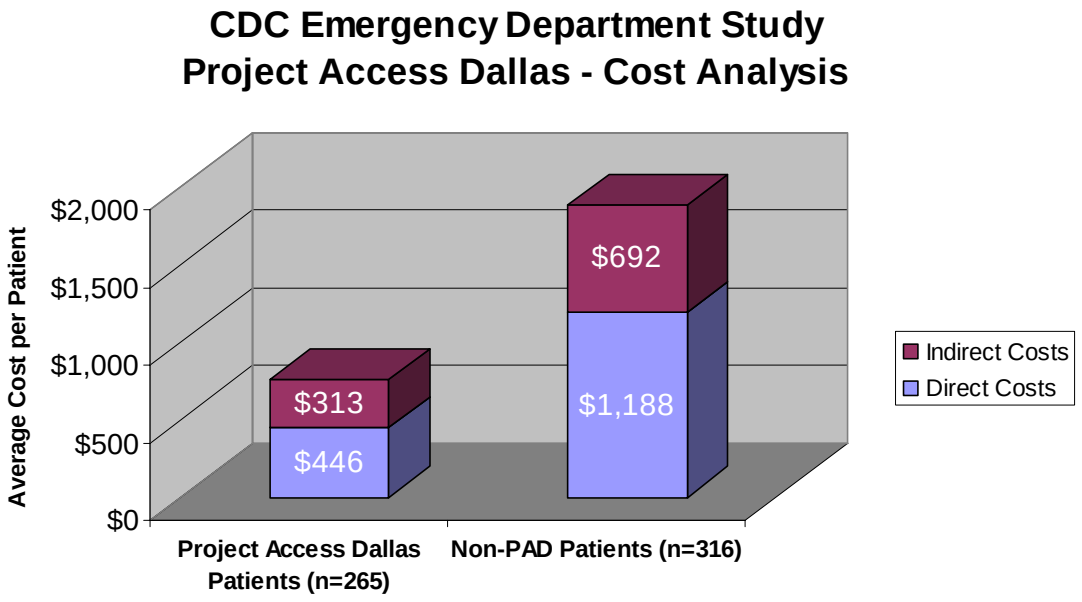
Project Accesses have a proven track record of providing timely health care at lower cost. While it requires the funding of administrative infrastructure, Project Accesses typically get at least a $5 to $1 return on investment, meaning that for every one dollar invested in Project Access infrastructure, the community receives at least $5 in donated health care services.

The graph below shows the decreased percentage of unnecessary emergency department use in the Project Access effort in Indianapolis, Indiana. With close relationships between Project Access and hospitals' Emergency Departments, it is possible to significantly reduce emergency department use and cost by the uninsured. This results in cost savings to the hospitals, more appropriate care to the uninsured and less burden to the physicians' on-call to the emergency rooms. In Wichita Kansas, the uninsured involved in Project Access have an Emergency Department utilization profile that matches the use profile for the commercially insured population.

Less Unnecessary Emergency Department Use
Indianapolis, In



Dallas Texas has invested in sophisticated evaluation mechanisms and has compelling data that supports the case for supporting Project Access efforts. The direct costs of serving Project Access patients in the study are 38% less than for the non-Project Access patients. Indirect costs are 45% of the cost of serving non-Project Access patients. With these kind of savings, it's good business to support Project Access efforts



5. Does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

Each Project Access has a different cadre of local partners based on the dynamics of its local community. While a very close tie to the medical community, typically through the County Medical Society, is critical, close partnerships have to exist with local community health centers, hospitals, public health departments and other providers of health care services as well as local funders such as United Way, local government, health plans, and foundations. See Attachment I.

6. What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

Project Accesses are a short-term solution to a community wide, region-wide and national problem. If and when universal access is adopted and successfully implemented, the need for Project Accesses will be greatly reduced.. We can not assume a long-term solution that relies on the generosity of physicians, hospitals and other providers. Until we have a state-wide or national solution, this is a low cost, community response to providing needed health services to our low-income uninsured neighbors.

With an improved reimbursement rate for Medicaid and Medicare, with more inclusive eligibility requirements for enrollment in state and federally sponsored/subsidized health insurance, the number of Washington residents that remain outside Project Accesses eligibility requirements would decrease. And this would be good.

7. Project Access Ask of the Blue Ribbon Commission

Project Access seeks two categories of support from the Blue Ribbon Commission; 1) support for system efforts that would provide tangential assistance to Project Accesses and 2) direct support to Project Access.

System efforts –

a. Fund SB 6459 each biennium. Broaden to include ongoing grant support to existing community efforts that improve local access to health care.
b. Fund the Ombudsman concept.
c. Support the further deployment of the Prescription Drug Assistance Foundation.

Direct support to Project Access

a. Provide $70k/year totalt o provide technical assistance to new and emerging Project Accesses.
b. Provide $40k/year total to facilitate communication and sharing of best practices through site visits and semi-annual meeting of all existing and developmental Project Accesses. This could be provided as a specific allocation to Project Access or as part of a larger best practices support for community collaboratives through Communities Connect.
c. Support Project Accesses in obtaining and using a common (EMR). We estimate the cost at approximately $30k/operational Project Access/year. The goal is for this EMR to link the local Project Access with local participating physicians and hospitals.
d. Provide $25 – 35k/operational Project Access/year financial support for interpreter services and/or durable medical equipment to local Project Access. Each Project Access needs the local flexibility to determine how best to spend these dollars.

Attachment I

Key Partners of Project Access efforts in Washington

	Collaborating partners*	**Key funding partners**
Spokane Project Access	Community Health Association of Spokane Christ Clinic Deaconess Medical Center Deer Park Medical Center East Central Community Organization Clinic Family Home Care Corporation Holy Family Hospital Inland Imaging Native Health of Spokane Pathology Associates Medical Laboratories People's Clinic Sacred Heart Medical Center Spokane Falls Family Clinic Spokane Physician Hospital Community Organization Valley General Hospital and Medical Center	Community Health Plan of Washington Empire Health Services Foundation Northwest Premera Blue Cross Robert Wood Johnson Foundation Providence Health Care Yakima Valley Farm Workers Clinic
Thurston Project Access	Thurston-Mason County Medical Society * Sea Mar Community Health Center (Olympia) Thurston County Public Health and Social Services * Providence St. Peter Hospital Capital Medical Center Group Health Cooperative (Olympia) Neighborhood Free Medical Clinic Planned Parenthood of Western Washington (Olympia) Evergreen State College Health Center CHOICE Regional Health Network Volunteer Center Immigrant and Refugee Center	City of Lacey City of Tumwater Thurston County United Way of Thurston County Providence St. Peter Hospital Providence Health Systems Providence St. Peter Hospital Foundation RGK Foundation Lassen Foundation Squaxin Island Tribe Nisqually Indian Tribe Community Foundation of South Puget Sound Group Health Cooperative Foundation Washington Health Foundation Combined Fund Drive

King County Project Access	Community Health Centers of King County Companis Country Doctor Community Health Centers Evergreen Healthcare Harborview Medical Center International Community Health Services King County Medical Society Mothr Joseph of Swedish Medical Center Pacific Hospital PDA Puget Sound Neighborhood Health Centers Seattle Indian Health Board Publid Health – Seattle & King County Pacific Medical Centers Sea Mar Community Health Centers	Community Health Plan of Washington King County Medical Society Pacific Hospital PDA Washington Health Foundation Washington State Hospital Association
Whatcom	Whatcom Alliance for Healthcare Access Whatcom County Medical Society St. Joseph Hospital	St. Luke's Foundation City of Bellingham St. Joseph Hospital
Vancouver		
Benton/Franklin Access to Care	Community Health Center La Clinica Grace Clinic Kennewick General Hospital Apria Helath Care Tri-Cities Endoscopy Center Cardiologists Kennewick Eye Clinic Pediatricians Wild Rose Clinic Pain Management & Rehabilitation Neurosurgeon Family Practice	HRSA – HCAP grant

* typically, provide in-kind resources

Tab 42

Providence Health & Services
Washington/Montana Region

August 30, 2006

Governor Christine Gregoire
Senator Pat Thibaudeau
Blue Ribbon Commission on Health Care Costs and Access
PO Box 40002
Olympia, WA 98504-0002

Dear Governor Gregoire, Senator Thibaudeau and Members of the Commission,

Providence Health and Services would like to take this opportunity to commend your efforts to develop an affordable, sustainable and quality health care system for all Washington residents. Providence also appreciates the opportunity to submit the attached information to the Commission regarding the Commission's vision and goals for Washington's health care system.

Providence has provided health care in Washington for over 150 years and brings a unique historical perspective to this reform effort. In addition, Providence operates an array of health care services in communities throughout Washington, including nine acute care hospitals, skilled nursing facilities, home health and hospice agencies, a statewide home infusion agency, low-income senior housing programs, assisted living facilities, adult day health care programs, out-patient clinics, and Washington's only Program of All-Inclusive Care for the Elderly (PACE).

Providence has a special calling and our mission holds us accountable to demonstrate a special concern for the poor and vulnerable, many of whom lack access to health care. Providence is committed to a core value of justice and we work to change the social structures that deprive people of elements that we hold to be part of the common good. While we are not in a position to propose a final reform package, we have developed the attached package of essential elements that we believe are important in reforming health care. Our goal in submitting these elements is to engage in a thoughtful discussion on the need to reform the delivery and financing of health care in a manner that controls costs, ensures access, and aligns provider and patient behaviors around a proper set of incentives to create high-quality outcomes at an affordable price.

Health care policy and systems are extremely dynamic. As such, Providence will continue its work to identify and address the needs, concerns and requirements of an effective health care system. Providence is deeply committed to our shared goal of improving Washington's health care system. We appreciate being involved in the conversation and working with you as you move forward. Should you require further information, please contact me at 425-687-3700.

Sincerely,

John Fletcher
Chief Executive
Washington/Montana Region

Attachment

Providence's Perspective On Effective Health Care Reform

The text below outlines Providence's perspective on what elements must be included in the shaping of any proposal to effectively reform the financing and delivery of health care in a financially sustainable manner. Each of these elements is organized around three basic goals: Access to Care; Affordability and the Cost of Reform; Accountability and Transparency. As an organization with a special concern for the poor and vulnerable and with a core value of justice this document represents the position of Providence and will be used to advocate for change and evaluate competing proposals. Informed by 150 years of service to our communities, we offer this perspective in an effort to engage and encourage others so that together we can ensure affordable, high quality, efficient, and effective health care for all Americans.

Access to Health Care

1. **Reform must achieve universal coverage for all.**
   The Census Bureau estimates that over 46 million Americans lack health insurance coverage. The lack of coverage for such a vital part of the common good is inconsistent with our core value of justice and cannot be defended. Any reform proposal must include processes to ensure that individuals are actually enrolled.

2. **Coverage should be portable and not exclusively linked to employment.**
   Fifty-six percent of uninsured adults work full time and an additional seventeen percent are employed on a part-time basis. Sixty-three percent of uninsured workers are employed yet their employers do not offer any health insurance. A further seventeen percent are ineligible for the coverage that their employer does offer. Moreover, the percentage of employers that offer any coverage is declining and the type of coverage being offered is increasingly "thinning out." Consequently, it is important that coverage be de-linked from the individual decisions of employers if we are to achieve our goal of universal coverage. Portability is a feature that can add to consumer appeal by allowing individuals to retain their provider relationship.

3. **A basic benefits package is needed, developed through a public process that makes benefit decisions explicit and rational using evidence-based guidelines.**
   Providence believes in the notion of establishing an explicit ranking of services using evidence-based guidelines that are then used to design a uniform benefit package through a public process. This feature should be included in any reform proposal.

4. **Those currently covered by Medicaid should be included in the universal basic package. The state should purchase health care in the same manner as it is financed for other state residents.**

Medicaid funding and reductions in reimbursement rates have long been a major contributor to the cost-shift problem and the accompanying increase in the number of the uninsured. As a result individuals whose care is financed through Medicaid often have good coverage but lack access to services, especially with respect to primary care. Incorporating the Medicaid program into the basic plan for all residents will require the state to purchase health care on the same basis as the rest of society. It also will serve to create a broader base of support for the poor since all members of society will receive the same basic benefit plan unless they choose to exercise their right to buy additional coverage at their own expense.

5. **Insurers must continue to have a role and must participate in providing the basic plan.**
   Market forces and existing competition among competing plans is seen as the best way to establish networks, encourage needed innovation in the delivery of health care, enhance quality, ensure cost containment, and address a strong concern about concentrating too much power in a single government agency. Any plan wishing to offer supplemental coverage must first offer the basic package of services to consumers in order to provide any health insurance in the state.

6. **Consumers can choose from any basic plan offered by insurers, similar to the manner in which the Medicare Advantage program operates.**
   What one author describes as "Managed Consumerism" is intended to "blend the patient-centric focus of consumer-driven health care and the provider-centric focus of managed competition." We believe that promoting informed and cost-conscious choices of consumers - enabled by the criteria outlined in our accountability and transparency goal and in an environment of competing health plans - will support the efforts to reform the delivery of health care while providing needed elements of cost containment.

7. **Consumers can buy additional coverage beyond the basic package.**
   Reform proposals should allow an individual to purchase additional coverage beyond the basic package financed through the public system.

Affordability and the Cost of Reform

8. **Everyone must contribute: consumers, employers and government share costs.**
   The individual effects of any reform proposal on specific employers, consumers, and government will vary; nonetheless, there is a recognized need to engage all three groups in the financing of the program. While some individuals, employers, and governments may contribute more to the aggregate funding of the program efforts should be undertaken to maintain the existing

relative distribution of expenses among these sectors. Any proposal should seek to avoid massive re-distributional consequences among these groups.

9. **Employers' contribution to health care costs should be more predictable.**
Reform proposals must incorporate cost containment features that make all contributions more predictable – especially those for employers whose contributions represent the single largest source of funding for health care, and whose costs continue to rise dramatically. Responsibility for the financing of employers' share of health care cost must also be equitably shared: tax mechanisms should not allow some employers to avoid participating in the cost of health care. At the same time some protection must be available for small employers and those who are self-employed.

10. **Financing provided by consumers should be based on their income: only the lowest-income consumers would not share costs.**
Our core values of justice and stewardship requires that individuals participate in the cost of their care as a means of helping to pay for the system, encouraging appropriate and efficient utilization of services, and to educate consumers as to the cost of care. Additional subsidies would be provided to low-income individuals by the state to offset the cost of required co-pays and deductibles that are included in the basic package of services. Benefit design should also include incentives that encourage healthy lifestyles, the provision of preventative services, and participation in disease management programs where appropriate.

11. **Premiums should be community rated to broadly share risk with premium risk adjustments to prevent problems of adverse selection.**
There must be broad risk sharing among all members of the state and plans should not be allowed to discriminate against high-risk individuals who choose to enroll in their plan. At the same, premium risk adjustment factors must protect plans against the effects of adverse selection while encouraging plans to adopt delivery models that address the specific and unique needs of certain high-risk categories.

12. **The Medicare program should continue but be reformed so that it is financially sound for the future, and is not subsidized by the private sector.**
Medicare's payment formulas, benefit design, and relative size in the market collectively create incentives that frustrate the goals of any state-specific reform proposal. While this fact would argue for incorporating Medicare into state health care reform efforts, requiring this as a condition of any reform effort would likely derail needed changes.

13. **While moving to universal coverage may require an initial investment of additional funds, reform should lead to more predictable and affordable increases in the cost of care**

Recent analysis has demonstrated at a statistically significant level that a higher percentage of uninsured adults reported that they were in fair or poor health and had lower SF-12 physical component scores than their insured counterparts. Despite the fact that uninsured individuals typically access higher-cost emergency department and hospital care that over time may be replaced by a greater utilization of primary care at an overall lower cost, in the short term it might be expected that there will be a need for a greater infusion of funding until such time as these cost efficiencies are realized. Reforms must also anticipate an initial influx of people (the uninsured) into the health care system and the related administrative costs.

14. **Cost control is paramount and must be built into any reform proposal.**
These elements incorporate the following cost containment features:

- Use of a managed-competition model that requires health plans to compete for enrollment on the basis of being able to deliver a uniform benefit to all individuals choosing to enroll in the plan;
- Premiums that require individuals to participate in the cost of their coverage that are indexed to income;
- Requiring all individuals in the state to have a vested interest in the aggregate cost of the health care since it affects the benefit design and their specific premiums;
- Requiring consumers to fully participate in the additional cost of electing to choose a higher cost plan;
- Use of evidence-based guidelines to rank health care services and to decide on what services are included in the basic benefit package (the notion of "rational rationing") with a focus on prevention and health promotion; and
- A uniform benefit design and coordinated enrollment process that creates a cost-effective administrative structure and promotes a reduction in overhead expenses by insurers. Any reform proposal should also incorporate features that will lessen administrative burden on providers, insurers, and consumers while eliminating the waste associated with the current system of financing, delivering, and billing for health care services.

Accountability and transparency

15. **Consumers deserve quality care based on available evidence and best practice standards: health care providers and insurers should provide consumers with easy access to information about quality and standards of care.**
While insurance reform is necessary it also must be seen as an enabler to further reform in the delivery of health care services. If individuals are to be encouraged to choose health care services on the basis of good information then the competing and confusing standards for quality must be eliminated. Consequently, any reform proposal must require disclosure and public

exchange of certain defined measures of patient outcomes and satisfaction using evidence-based guidelines.

16. **Consumers also need and deserve easy access to information about cost of services and "plain English" pricing.**
    Health care pricing has been unduly influenced by cost-shifting and reimbursement incentives. Reform proposals should include features that require disclosure of price and cost information; especially since premiums are community-rated and risk adjusted.

17. **Hospitals, other providers, and insurers should collaborate and share responsibility for effective cost containment.**
    Payment methodologies, in addition to insurance reforms, should encourage the appropriate utilization of services and reform in the way that health care is delivered. Costs must be predictable and financially sustainable. Collaboration and innovation should be encouraged along with the adoption of appropriate technology that is proven to be cost-effective.

18. **Responsibility for improving the health of the community remains. If reforms result in lower rates of charity care and overall community benefit burden, providers and insurers should identify an alternative means of contributing to the greater good in health care.**
    If reform efforts are adopted and prove to be successful, windfall profits could occur, at least in the short term. Reform proposals should plan for this possible outcome so that the financial outcomes and benefits arising from universal coverage accrue to society and are not dissipated or mal-distributed. Providers and insurers should offer their proposals for mitigating windfalls as part of public reform discussions.

Tab 43

Puget Sound Health Alliance

Ideas for the Washington State Blue Ribbon Commission on Health Care Costs and Access

Submitted by:

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1. What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access? Briefly summarize your proposal.

To realize the vision and goals set forth by the Commission, all three problem areas of improving access, health status and affordability need to be addressed in an interconnected fashion. Rather than approaching each separately, we suggest that the Blue Ribbon Commission support the community-based effort already underway through the Puget Sound Health Alliance (the Alliance) that is fundamentally restructuring health care incentives to consistently recognize, encourage and reward effective and efficient health care.

All people should have access to services and treatments that are effective to improve and promote good health. Yet, even for those who have insurance or are able to get health care services now, research shows that over 40 percent of patients in this area don't receive care that is consistent with widely-accepted, national standards defining effective care (RAND, 2004). These standards reflect effective care patients ought to receive – such as mammograms, immunizations and other preventive measures, and services like blood glucose (sugar) tests and foot exams for people with diabetes. When care provided to so many falls so short of standards, that means a sizeable chunk of the health care dollar is spent on services that are ineffective or don't improve health. Through greater health care effectiveness and efficiency in improving health, public and private health care dollars can "stretch" further to provide health care access to all.

At this time, the work of the Alliance is focused on Snohomish, Kitsap, King, Pierce and Thurston counties, targeting four major stakeholder groups: physicians, consumers, purchasers and health plans. As a collaborative, our success is contingent upon the collective ability to coalesce stakeholders around common goals despite sometimes divergent interests.

Thus far, more than 110 organizations participate in the Alliance and many have an interest in expanding the efforts statewide, including the State of Washington represented by Steve Hill, Administrator of the Health Care Authority. We encourage everyone to join, including individual consumers. Private and public employers, consumer groups, physicians, hospitals, health plans and others are actively involved and support our work. Explore these links for more information:

- http://www.pugetsoundhealthalliance.org/join/participants.html for a list of Alliance participants
- http://www.pugetsoundhealthalliance.org/news/index.html for media coverage and editorials
- http://www.pugetsoundhealthalliance.org for general information about the Alliance

The Health Alliance is focused on defining, measuring, reporting and rewarding high quality, efficient care that promotes and improves health. Our initiatives include:

- **Producing a publicly-available report comparing the performance of medical clinics and hospitals** regarding quality, efficiency (i.e., value or cost) and patient experience. This report will be based on data compiled from all health plans in the state, many self-insured employers and the State of Washington, Medicaid and possibly Medicare. The purpose is to inform decision-making by patients, purchasers and providers. The report will also provide public recognition for those who provide higher quality, more efficient care, while creating an incentive for quality improvement across the entire system.

  The Alliance will base our initial public report on quality measures drawn from those published by the Institute of Medicine (IOM) in December 2005. Other measures to be included in the Alliance reports will address cost-of-care and patient experience. We expect to have the first quality performance report available for vetting by physicians, health plans, select purchasers and consumer representatives at the end of 2006. After honing the analytic approach, data presentation and format of the reports, based on feedback received during the vetting process, we expect the initial report to be available to the public by the end of the first quarter 2007.

- **Adopting evidence-based treatment guidelines,** in collaboration with physicians and other medical leaders in the region, for use when treating patients. These guidelines – initially for heart disease, diabetes, low back pain, depression, and appropriate prescribing of medications – will be consistent with national standards, reflecting generally accepted standards of care. This Alliance effort is led by our Quality Improvement Committee, comprised mainly of local physician leaders working with specialized Clinical Improvement Teams. The specialized teams are researching and recommending the evidence-based clinical guidelines and related quality measures for each chronic condition.

- **Recommending specific changes to align incentives** to encourage decisions – made by doctors, patients, employers, health plans and others – that improve personal health and treatment outcomes while rewarding quality, affordability and good patient experience. The Alliance has begun meeting with employers and unions who purchase health care on behalf of employees and their families, to share specific recommendations. The specific recommendations thus far focus on elements of health benefit plan design, workplace wellness and health promotion activities, and effective communication with individual consumers.

- **Supporting the adoption of interoperable health information technology, such as electronic medical records,** personal health records and patient registries to improve efficiency and enable more accurate ways to assess health quality outcomes. Increasing the use and interoperability of health care information technology not only increases efficiency through reduction in duplicative paperwork, but also improves the ability for providers to better manage the care for their patient populations by using the system reminders and other clinical support tools imbedded in registry software. Ultimately, as more electronic medical records and other health IT are used, the data currently "locked" in paper-based medical charts will be more accessible across the population to include in the public reports on health care quality. By tapping into chart-level data (de-identified to protect patient confidentiality) the public comparison reports will be able to include more accurate information about treatments actually provided and the resulting impact on improving health status.

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- **Providing a suite of useful informational tools to help guide health care decision-making** for each stakeholder, built on a common set of information, but customized for appropriate use by each group. Materials will be provided to individual consumers regarding about how to work with their doctors to prevent and manage chronic illness, in addition to suggestions for taking better care of themselves. Informational tools for use by employers and union trusts will support better health for employees through benefit plan design, worksite programs and communication suggestions. And, using consistent information, provider-oriented materials will also be developed for use within medical clinics and hospital settings, to help with clinical processes related to the evidence-based guidelines and to use as handouts to patients.

The ultimate long-term sustainability for quality improvement will occur within a health care system structured with incentives for physicians, consumers, health plans, purchasers and others. The incentives need to be aligned to support the ongoing process of measuring, reporting, and improving health care quality. It is this **structured system of aligned incentives** – one of which is a public report on health care performance – that will drive and sustain quality improvement over the long term. Vital to creating this structured system of incentives is the ability to **engage and activate consumers**. The key is to find effective ways to build awareness, deeper understanding, and then engage consumers so they choose to incorporate preferred behaviors into health-related decisions and activity.

The government can play a vital role in consumer engagement to promote and improve the health of our next generation in particular. A key question is how to ensure that we have healthy children who grow up into healthy adults. The rates of obesity among our young people are cause for alarm. In 2004, according to the Seattle-King County Department of Public Health, approximately 6.3 % of adults age 18 and older in the state had diagnosed diabetes and about 6% of adults in Washington state have been told by a health professional that they have heart disease. Based on the poor health status of so many people under age 18, a looming crisis in health care (and health care costs) is the upcoming increase in the number of overweight people likely to develop serious chronic illness. For each overweight child, the future is likely filled with health problems, expenses and quality of life limitations that cannot be ignored by the larger community.

Just as success has been achieved in reducing the rate of tobacco use and smoking in Washington state, there is an essential need for a coordinated effort to encourage better health among children, addressing nutritional choices and more physical activity in particular. There is no easy answer to this challenge, as it must involve taking a longer view and tapping into the influences that occur at home, through the schools, in daycare centers, wherever health care is provided and through other people and places of influence. Women are central figures and role models in so many of those environments, so a related issue is how to encourage and promote a healthy lifestyle for them as role models to children, particularly as mothers, teachers, and daycare providers.

The work of the Washington Health Foundation, a member of the Alliance and a close collaborator in our work to promote better health, is a strong place to start to engage in this long-term effort. Ultimately, such collaboration will need to create social change and build a cultural expectation of good health. Based on the experiences of many organizations in leadership roles at the Alliance, we recommend taking an aspirational approach to promote concepts such as “Fit for the Future” or “Eat Smart, Move More” rather than placing blame on those who are least healthy. Consistent with this are programs that provide support to individuals through personal health coaching and weight loss groups such as Weight Watchers™.

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In summary, under this proposal, the Blue Ribbon Commission can play a key role in expanding the effectiveness of the collaborative work of the Puget Sound Health Alliance. Specifically, we recommend that the Commission:

(a) provide multi-year funding to the Alliance to expand the reporting, quality improvement and consumer engagement efforts statewide;

(b) apply the power of the State in its purchasing behavior by continuing the work already underway to incorporate Alliance recommendations into health benefits, worksite wellness and health promotion, and communication directed at anyone covered through PEBB coverage, Medicaid, Basic Health, Workers Compensation / L&I and other government-based health programs;

(c) build on the Washington Health Information Collaborative award program and the work of the Health Information Infrastructure Advisory Board (HIIAB) by strongly promoting to providers greater use and interoperability of electronic medical records, patient registries and other health information technology (IT), which might include setting health IT expectations as a part of State program contracts, and providing multi-year funding to the WA Health Information Collaborative for awards given to medical clinics and hospitals to adopt and expand their use of health IT; and,

(d) engage in a long-term effort in collaboration with the Washington Health Foundation and others, to improve the health of children and youth across the entire state, through a coordinated system of policies requiring healthy nutrition and regular exercise in schools, in addition to promotional messages, positive support and incentives for children and the people who influence them.

2. How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

The Commission, in implementing this proposal, will directly address all three problems of access, health status and affordability in the current health care system. These problems are the result of existing incentives that are frequently inconsistent and often unintended. By supporting changes in health care system incentives, the Commission can directly affect decisions and behavior that determine the effectiveness and quality of care, the health status of the population and the affordability of care which leads to greater access.

The current lack of consistent information for all stakeholders regarding effective health care treatments and value received, for example, does nothing to ensure that every health care dollar spent provides the most effective care for the greatest number of people. For those who do have health insurance, reimbursement systems pay more to providers for “doing more” rather than getting people healthier. Promotional messages aimed at consumers to ask doctors for specific treatments, increase demand, whether or not the treatment is needed, and reinforce the notion that “more care is better.” The larger social environment in which the health care system operates does not effectively encourage good decisions about nutrition and physical activity, resulting in a growing population of overweight people living with chronic disease.

By supporting the work of the Alliance, the Commission will help to reduce barriers created by perverse incentives in benefit design and reimbursement structures, in addition to creating positive incentives through effective workplace programs, information, and health promotion activities. Each of these shape expectations and behavior through direct and subtle incentives influencing patients, physicians, health care practitioners, employers, unions, health plans and government.

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We know from experience that incentives impact behavior. The system we have today, with all of its problems, is a direct result of the financial incentives and other rewards and recognition currently in place. Logic dictates that by changing the incentives, behavior change will follow. For example, reports to the public that compare health care performance are far more likely to result in quality improvement than no reports at all, or reports that are only shared with providers. Regarding employee engagement in healthy activities, recent experience within King County as an employer illustrated the power of incentives: by offering a significant differential on the deductible level for employees who were willing to take a health risk assessment and get involved in healthier behaviors, about 90% of their employees chose to participate.

3. Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.

The proposal for the Commission is directly tied to activities already underway at the Puget Sound Health Alliance. Elements of the Alliance activities draw from best practices in other cities and regions around the country. Examples include public reporting occurring in Minneapolis/St. Paul, quality improvement efforts in Pittsburgh and other locations. The Alliance is collaborating nationwide, through groups such as the National Business Coalition on Health and the Robert Wood Johnson Foundation (RWJF), which provide technical support and access to national experts to enhance our capabilities in Washington state.

From the "other Washington," Secretary Mike Leavitt, head of the United States Department of Health and Human Services, met with Alliance leaders in Seattle last month to discuss shared goals and to deliver the great news that HHS wants to work with the Alliance to get us access to Medicare data for our public reports. Secretary Leavitt made it clear that HHS is interested in seeing that the Alliance is added to the growing national network of similar collaboratives working on shifting the incentives in health care toward higher quality, more efficient and affordable care.

4. Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?

From a system-wide perspective, this proposal focused on incentives to promote higher quality and better health will yield cost savings rather than increase costs. In the absence of the proposed activities, health care costs will continue to increase at an unacceptable rate for individuals, businesses and government. Interest in creating the Alliance in the first place was based in large part on the keen understanding that cost growth is not sustainable and that the focus on more effective and efficient care and better health outcomes is vitally important to being able to manage health care costs over time. This need is especially strong for the State of Washington, as it uses limited taxpayer dollars to provide coverage to State employees and their dependents, in addition to funding the array of health related programs and services.

Regarding the proposed activities specific to the Commission, we are very interested in receiving significant ongoing financial support from the State of Washington, in addition to the contributions already made by the Health Care Authority. The Alliance is building a key part of the health care information and quality improvement infrastructure to benefit everyone in the state. For example, the report comparing the performance of medical clinics and hospitals will be available to the public, and thus is a community asset. Strong credit should be given to the public and private employers and other organizations that have come to the table to fund the cost of building the Alliance foundation and

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"infrastructure" for producing the initial reports. However, over time, as these public reports are a public good which will benefit the entire community, we strongly encourage the Commission to consider ways that the State can provide long-term financial support for the Alliance and its work.

5. How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

The Alliance is unique in that all stakeholders have been represented at the table from the start. Everyone is welcome to join and participate in the Alliance as it continues to grow. Thus far, more than 110 organizations participate from the five counties of Snohomish, Kitsap, King, Pierce and Thurston. Every participating organization and individual consumer contributes to the Alliance financially, to support our work. And, while our initial focus is the Puget Sound region, many of our employer, union, provider, health plan, and consumer group participants have an interest in expanding the Alliance efforts statewide and ensuring that our work is coordinated with others on a national scale. For a list of participants, see http://www.pugetsoundhealthalliance.org/join/participants.html

Beyond funding the work, stakeholders across the community are deeply involved in the decision-making process of the Alliance, which takes place through a committee-based organizational structure. Over 150 physicians and other health care professionals, in addition to business people, and government and community leaders and individual consumers have and continue to contribute a tremendous amount of volunteer time to ensure that the Alliance meets its goals. In a recent calculation, total contributions to the Alliance were estimated to be worth over $4 million – including financial support, discounts on services, in-kind consulting and donated time from some of the areas top medical, technical and business professionals. An additional indication of the support from physicians, hospitals and other providers involved in the Alliance is that many strongly endorsed our first two clinical improvement team reports. See http://www.pugetsoundhealthalliance.org/resources/CITHeartDiabetesSupport_000.html

6. What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

Based on the level of commitment and support for the Alliance, we see no obstacles to the work which is largely underway. We are not aware of any objections to the work that the Alliance is undertaking.

As leaders representing the State, the Commission has power to assist with the long-term challenge of securing financial support to ensure continued production of the public comparison report on health care quality, affordability and patient experience. Given that the reports are a community asset, it is possible that current and potential funders may decide over time simply to let others pay for it. This is the classic "free rider" problem, which is why government often funds items that provide a public good.

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Tab 44

REACH
Racial and Ethnic Approaches to Community Health

REACH COALITION

Aging and Disability Services

American Diabetes Association

American Heart Association

American Lung Association

Center for MultiCultural Health

Harborview Medical Center

International Community Health Services

Kin On Health Centers

National Asian Pacific Center on Aging

Northwest Urban Ministries

Pacific Northwest Research Institute

Public Health – Seattle & King County

Qualis Health

Sea Mar Community Health Centers

Seattle Indian Health Board

Senior Services

Univ. of Washington
School of Nursing
School of Nutritional Sciences
Health Promotion Research Center
School of Public Health

Washington State Department of Health

Public Health – Seattle & King County
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Principal Investigator

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REACH Evaluation Manager

Seattle & King County REACH Alliance Proposal
Blue Ribbon Commission on Health Care Costs & Access

1. What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access?

We propose that the Blue Ribbon Commission support the Seattle & King County REACH 2010 Coalition (REACH) in becoming the REACH Alliance in order to expand our efforts in providing innovative, culturally relevant diabetes education, social support, and self-management training in King County to all communities of color disproportionately impacted by this disease. In addition to individual level changes, the REACH Alliance will provide technical assistance and training to the health care community on culturally competent diabetes services and health behavioral change strategies. The REACH Alliance sees our approach as having long-range implications by providing accessible, culturally relevant, affordable, quality health care to King County residents. The approach we have taken can be replicated to ensure broader access to healthcare for all Washingtonians, particularly those most at-risk. The comprehensive diabetes services along with community and systems level changes will result in reduced incidence of disease and healthier communities. The Alliance requests support to triple, by the year 2008, the number of health agencies in King County that provide comprehensive, culturally relevant diabetes services to African Americans, Asian Americans and Pacific Islanders, and Latinos/Hispanics. The goal of the Alliance would be to provide all members of our focal groups with access to our diabetes services by 2012.

Providing accessible, affordable quality health care requires the collaboration of groups from diverse industries, occupations, and communities. The REACH Coalition (REACH) has created such a partnership. The REACH Coalition is a partnership of community based agencies, community groups, educational and research institutions, public health agencies, hospitals and health care providers, and people living with diabetes working together to reduce diabetes related health disparities in King County. The coalition believes that all of these groups and many more have to work together if we

are to realize the vision of all Washingtonians having access to affordable, quality health care. For this reason we are working to create the REACH Alliance that would include our current members and expand to include faith

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communities, policy makers, health insurers, foundations, and businesses. The uninsured are no strangers to the agencies that comprise REACH. Many of those most at risk for being uninsured (e.g., low income families, racial and ethnic minorities, part-time & seasonal workers, low-wage workers, and small business employees) participate in the diabetes services provided by the REACH Coalition.

Health disparities are the disproportionate burden of disease and death that impacts certain racial/ethnic groups. REACH has been working to reduce these health disparities by providing effective and culturally relevant diabetes services. Community and systems level changes focus on improving case coordination and information systems, developing stronger partnerships among community groups, and influencing organizational and legislative policies. These efforts are not only to improve the quality of life for people living with diabetes but to reduce the health care costs due to emergency room visits, hospitalizations, and preventable medical procedures. The data have shown that lack of access to care results in Washington residents delaying medical care. This behavior exacerbates and complicates the medical condition of people living with diabetes, thus increasing medical costs. The Alliance aims to reverse this trend.

2. How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

The REACH Alliance will make a significant contribution to the achievement of the Commission's mission and goals. We say this confidently, based on the six-year experience of the REACH Coalition, the demonstration project on which the REACH Alliance we are describing is based. REACH has served more than 1500 persons with diabetes in African American, Asian American and Pacific Islander, and Latino communities in King County. The REACH Alliance would have even broader impact.

Diabetes is one of the costliest chronic diseases facing this country, with direct and indirect annual costs now at $132 billion. (The annual health care cost burden of diabetes on the State of Washington has not yet, so far as we know, been calculated.) It is called a silent killer because its victims die not of diabetes itself, but of the ravaging complications it entails—especially kidney disease, heart disease, and stroke. Diabetes is also an inequitable disease—burdening communities of color at up to, and even more than,

twice the rate of white communities. Finally, the disparities in access to effective, affordable diabetes health care (not simply disparities in disease incidence but in access to care that could prevent or control it) are demonstrated by the fact that an African American man with diabetes in King County is twice as likely to die from a diabetes-related cause as his white counterpart.

The REACH Alliance, if fully implemented, will measurably advance the Commission's five-year vision as it pertains to King County, and thus serve as a model for similar or expanded programs in other areas of the State. It will also advance the goals of the Commission in the following ways:

- All communities of color in King County will have access to culturally competent diabetes education and self-management services by 2012.
- When people of color have less diabetes, and those with diabetes are empowered to control its complications more effectively, Washington State will be measurably healthier.
- Every patient and family that receives the culturally-competent diabetes services of the REACH Alliance will reduce the racial and ethnic disparities of diabetes in Washington.
- The chronic-care self-management model of REACH, delivered by peer providers, in language, within a culturally relevant and sensitive framework has been demonstrated to be effective. Its use by the broader constituents of the Alliance—to reach even more patients and communities—will extend effective health care that is evidence-based.
- The REACH Alliance will direct its energies at the most cost-effective early stages of diabetes—i.e., before it starts, in educational efforts to promote prevention; in self-management training, to promote good glucose control; even in late stages, to retard the development of additional or more severe complications.

Such benefits are unequivocal. They are already clear in the evaluation results from the REACH Coalition. Assistance from the State in developing the Alliance would therefore make an unprecedented contribution to achieving Washington's health goals, would have dramatic impact on the State's diabetes crisis, and would serve its citizens of color with health care that they are now too often excluded from.

3. Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.

The REACH Alliance proposal is modeled after the existing Seattle & King County REACH 2010 Diabetes Program. “REACH” stands for Racial and Ethnic Approaches to Community Health and is a CDC-funded nationwide demonstration program whose goal is to reduce and eliminate health disparities among communities of color. The Seattle & King County REACH program is specifically targeting the disparity of diabetes among African Americans, Asians, Pacific Islanders and Hispanic/Latinos within King County.
For more information about Seattle & King County REACH 2010, please see http://www.metrokc.gov/health/reach/index.htm. For more information about the REACH Program at the national level, please see http://www.cdc.gov/reach2010/.

Our confidence in The REACH Alliance’s future outcomes is based on the success of its predecessor, the Seattle & King County REACH Program. To date, over 1500 people have participated in REACH activities. Based on 772 matched pre and posttest surveys collected from REACH participants, the program has resulted in improvements in dietary behaviors, physical activity and diabetes knowledge. Participants also report greater confidence in managing their diabetes, particularly in keeping their blood sugar under control, and exercising healthy behaviors. Focus groups with participants generated overwhelmingly positive responses and confirm our survey findings. Participants across the board expressed great appreciation for having activities and materials in their respective native languages, tailored to their own cultures. They especially appreciated learning how to choose and eat healthy foods from their culture. Respondents felt that REACH provided them with helpful diabetes information and skills that they otherwise would not receive and linked them with invaluable peer and professional support.

Primary outcomes of The REACH Alliance will include: increased availability and improved access to culturally competent and tailored diabetes-related resources for people of color, increased diabetes knowledge among REACH participants, increased confidence in self-management of diabetes, other chronic diseases and overall health among REACH participants, improvements in significant diabetes health indicators among REACH participants (e.g., improved HbA1c and blood pressure levels), positive changes in organizational practices that promote health and diabetes care, particularly for people of color, and reduced health costs for organizations/institutions with clients who participate in REACH.

4. Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?

The REACH Program to date has engaged in extensive community outreach to create strong links in the community in order to recruit heretofore inaccessible participants for diabetes education, and self-management support. Since we are a research driven program, we have had a very strong evaluation component. We have also engaged in advocacy and dissemination. It is somewhat complicated to tease these activities out from one another. At best, we estimate that providing the initial twelve hours of diabetic education and ongoing monthly self-management support groups would cost about $600.00 per person for the first year of their care. Ongoing costs for each person would be less as they would include ongoing support groups and occasional refresher courses. The ongoing costs have not been determined. We have been providing population based care in collaboration with community health clinics.

For an example of a population based care that includes self-management support and a consideration of savings, review the chronic care model activities utilized by Group Health Cooperative. According to David McCullough, MD, from Group Health Cooperative of Puget Sound,* Group Health reduced the average cost per patient by $62.00 per month x 12 months x 20,000 patients. This reduction achieved a cost savings of $14 million. At Group Health the mean HbA1c was 7.5 in 2003 as a result of these activities. We believe that payment for the REACH Alliance initiative could be provided by a mix of individuals, businesses, health insurance providers, Medicaid, Medicare, and grants (Foundation & Government).

*footnote: McCullough is Clinical Professor of Medicine, University of Washington, and a diabetologist. He spoke at the 6th Annual Epidemiology, Biostatistics, and Clinical Research Methods summer session (2004) in Seattle.

5. How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

The work of the Seattle & King County REACH Coalition is grounded in collaborative principles, with a stress on community participation, a model to be continued through The REACH Alliance. Our collaborative principles stress equal power-sharing among all coalition partners, as demonstrated through decision-making by consensus, and recognition that each partner has distinctive assets to contribute to our mission. The Coalition is comprised of a wide array of public health experts, community organizations, community members and people with diabetes. The Coalition's lead fiscal agency is Public Health-Seattle & King County. Coalition research partners include the University of Washington (UW) School of Nursing, UW School of Public Health, the UW Health Promotion Research Center and Pacific Northwest Research Institute. Community-based organizations include the Center for MultiCultural Health (CMCH), serving African Americans; and Rainier Health & Fitness, a local gym in Seattle's Southend providing high quality, low cost physical fitness training to residents in the Rainier Valley area. Health centers include Harborview Medical Center - the local public hospital, International Community Health Services (ICHS), serving Asian and Pacific Islander Americans; and Sea Mar Community Health Centers, serving Latinos/Hispanics. Others include Aging & Disability Services (ADS), Seattle's local Area Agency on Aging, Qualis Health, a nonprofit healthcare quality improvement organization, the American Diabetes Association and the Washington State Department of Health. We are an active member of the Washington State Diabetes Network and also partner with King County Steps to Health, a US Department of Health and Human Services funded initiative that focuses on reducing the burden of diabetes, obesity, and asthma through prevention.

All of our Coalition members have endorsed the work of the Coalition, its mission to eliminate health disparities, and have expressed support for The REACH Alliance proposal. CMCH, ICHS, Sea Mar and ADS have expressed commitment to implementing REACH activities, such as diabetes education classes, support groups, self-management classes, and individualized care for elderly and homebound people with diabetes. Our collaborators at the University of Washington are dedicated to evaluating the methodology of our work and validating best practices.

We are working to establish and solidify new partnerships with local businesses, health care industry, pharmaceuticals, other community organizations and policy leaders in the region which will increase regional awareness, use and support of The REACH Alliance.

6. What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

Present funding for diabetes care does not recognize the value of the group experience in community settings rather than clinic settings or the value of peer educators. Current funding priorities and the established expectations of clinicians and other health care system entities are obstacles and may object to the implementation of this proposal. Our experience in REACH, documents the success of reaching people through community based interventions. Presenting data from other clinicians and other experts in the health care field could address these objections. For example, presenters from MacColl Institute for Healthcare Innovation, Center for Health Studies, and Group Health Cooperative of Puget Sound state that, “Diverse professionals and lay persons can effectively deliver self-management support if they have clearly defined tasks, roles, and are trained in evidenced based interventions. The credential is less important than what they are doing.” The Center for Disease Control also has a position paper supporting the use of peer educators. Good health care management requires enormous behavioral change, not just on part of the patient, but on part of clinicians and the health care system. Health care systems have begun to retool their approaches by participating in the various health care collaborative groups. The REACH Coalition has always worked by bringing the various partners to the table to create a system that is effective for participants and providers. The REACH Alliance will continue to develop that collaboration.

Tab 45

Regence BlueShield Recommendations to the Blue Ribbon Commission on Health Care Costs and Access

September 1, 2006

Regence

Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

REGENCE BLUESHIELD RECOMMENDATIONS TO THE WASHINGTON STATE BLUE RIBBON COMMISSION ON HEALTH CARE COSTS AND ACCESS

The number of Washingtonians without health insurance concerns all of us. While estimates vary, the best guess is that around 600,000 Washingtonians lack health insurance during a typical year.[1] The impacts of going uninsured are clear. The uninsured receive less preventive care, are diagnosed at more advanced disease stages and tend to receive less medical care and have higher mortality rates than insured individuals.

Health insurance also affects the financial well-being of individuals and families. Insurance reduces the financial uncertainty associated with health care, since illness and health care needs are not always predictable, and medical care can be very expensive.

Reducing the number of uninsured Washingtonians and keeping health care affordable is a top priority for Regence BlueShield. We must act now to make accessible, affordable, quality health care a reality in Washington. Ultimately, the private sector and government must work hand-in-hand to realize this vision and achieve our stated goals.

At the same time, we recognize that there is no magic cure. Research shows the uninsured are not a monolithic group, and there are many reasons why individuals and families are uninsured. The uninsured include:

- Low-income populations reachable through some public programs;
- Employees of small businesses and young adults who cannot afford coverage; and
- Those with higher incomes who can afford coverage but nevertheless choose to be uninsured.

Our proposal seeks to put into action initiatives specifically designed to meet the needs of these three groups, namely: more effective outreach for the first group, more affordable products available through the existing private market for the middle segment and communication and education about the importance of coverage for the third group.

We believe, working together on these three initiatives, that good progress can be made toward the Blue Ribbon Health Care Commission's stated goal: In five years, we will create a system providing every Washingtonian the ability to obtain needed health care at an affordable price.

[1] See 2004 Washington State Population Survey, U.S. Department of Health and Human Services, Health Resources and Services Administration's Bureau of Professions State Planning Grant #1 P09 HS 00002-02, 2004 Uninsured Population Under Age 65.

OUTREACH: Those Reachable Through Existing Public Programs

The 2004 Census Current Population Survey estimated that 44.7 million non-elderly uninsured individuals in the U.S. were reachable through existing government health programs, such as Medicaid or the State Children's Health Insurance Program (SCHIP).

Clearly, many of the uninsured in our state are not taking advantage of government programs designed to serve them:

- **In Washington, 69.9 percent of all uninsured children are potentially eligible for public coverage through Medicaid, SCHIP, or the Basic Health Program.[2]**

- **Additionally, 63.6 percent of all uninsured adults in Washington are potentially eligible for public coverage through the current Medicaid and Basic Health programs.[3]**

The lack of enrollment in public programs can be attributed to many variables. Some may be unaware they are eligible for these programs, or even that such programs exist. Others may perceive a stigma associated with government programs. Language barriers or other obstacles may also hinder enrollment of many demographic groups. Consider the following example:

Latinos represent the largest segment of the uninsured market: Nationally, nearly 4 in 10 Latinos are uninsured—the highest uninsured rate among all racial or ethnic groups. According to a September 2005 OFM report, Hispanics are more likely than any other racial/ethnic group in Washington to be uninsured. 18 percent of non-elderly Hispanics in Washington are uninsured compared with 10 percent of African Americans, 11 percent of non-Hispanic whites, 11 percent of Asians, 17 percent of Native Americans and 17 percent of Pacific Islanders.[4] These statistics suggest generic outreach programs may not be the best use of state dollars; targeted outreach programs to demographic groups with high uninsured rates would likely be most effective.

Any proposal addressing the uninsured in Washington must include a focus on those populations eligible for government assistance. Current state outreach efforts must be amplified. One option for increased activities would be for carriers serving Healthy Options and BHP populations to augment state efforts and assist in targeted outreach programs. In addition to participating in the Healthy Options Medicaid program which serves low-income populations including Latinos and others, Regence is developing a program of outreach to Latino populations

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[2] See id., Data for 2004 Children Age 0-18 Years.
[3] See id., Data for 2004 Adults Age 19-64 Years.
[4] Gardner, E., Washington State Population Survey, Research Brief No. 37, Health Insurance by Race/Ethnicity: 2004, Washington State Office of Financial Management (2005).

as part of a private-sector emerging markets strategy. We would be pleased to explore working collaboratively with the State on outreach projects for these populations.

We acknowledge that there is a cost to increase public safety net programs. Increased outreach implies a willingness on the part of the state to devote greater resources to these programs and not merely to exacerbate the current cost shift to the private sector.[5]

AFFORDABLE PRODUCTS: Those Ineligible for Public Programs Who Cannot Afford Coverage

Almost half of the uninsured nationwide struggle to find coverage they can afford.[6] This demographic group comprises many Washingtonians who are ineligible for government programs but are still unable to afford coverage. For example, small employers may not offer coverage to their employees due to cost pressures.

Young adults may go without coverage because they cannot afford an individual policy, and they are willing to accept the risks of being uninsured. Statistics reveal the vulnerability of this segment of the population:

Although young adults comprise 17 percent of the under-65 population, they account for 30 percent of the uninsured non-elderly population.

More than half (57 percent) of young adults in the U.S. who lack health insurance reported ***the cost of health care kept them from seeking needed treatment or services***— including filling a prescription or seeing a doctor or specialist when needed.

Yet failing to obtain health insurance can spell financial ruin for many young adults. A serious car accident or illness can result in thousands of dollars in medical bills and fees.

To address this segment of the uninsured population in Washington, Regence BlueShield suggests more affordable products be designed for young adults. These offerings should be tailored to meet the intense focus on cost concerns of this population by, for example, limiting or excluding some benefits such as durable medical equipment, complementary therapies, or brand-name prescription drugs.

In recent years, insurers in many states have created products following this model. BlueCross BlueShield (BCBS) of California reports that 70 percent of the people on one of their "Tonik" plans were previously uninsured.[7] Tonik and similar plans show great promise in reducing the number of uninsured young adults in California and elsewhere.

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[5] See Milliman, Inc. Study, Payment Level Comparison Between Public Programs and Commercial Health Plans For Washington State Hospitals and Physicians, May 2006, https://www.premera.com/stellent/groups/public/documents/pdfs/dynwat%3B5724_97223688_2320.pdf.

[6] See The Uninsured in America, BlueCross BlueShield Association, http://www.bcbs.com/uninsured/index.html, page 8.

[7] Laura Vanderkam, *Health Insurance Doesn't Have to Hurt*, USA Today, June 7, 2006.

With the support of the Health Care Commission, such policies designed to serve the uninsured young adult population could be made available in Washington. We believe these plans could make a real difference in the lives of our own uninsured young adults. The value of making lower cost "starter" plans available to young "immortals" is that it encourages these individuals to continue making responsible coverage decisions as they mature and become able to take on more comprehensive coverage.

With respect to whether government should design and implement such programs, Regence believes government's most appropriate role lies in the provision of "safety net coverage" and that government should not be competing with the private sector for solutions to private market problems. Government does have an important role in assuring a level playing field and allowing regulatory flexibility.

Carriers in many other states are now offering innovative plans designed to reach the uninsured. For example, short-term medical products are available in Idaho, Oregon, and Utah—the other Regence states—but have not been approved by the OIC here in Washington. These products can fill a niche for many people who are between jobs or waiting to be covered under a group plan. Recent graduates may also benefit from this type of temporary coverage.

Any proposal to help the uninsured in Washington must take into account these gaps in coverage. Allowing flexibility in product design to meet these categories of the uninsured would make coverage more affordable for a large segment of our population. These lower-cost plans may also be an option for part-time and temporary workers who do not have access to employment-based coverage. Based on internal research, the following are examples of lower-cost individual and small group products unable to be sold in Washington today, largely due to a lack of flexibility in insurance regulation:

Individual Products Targeted at Young Adults

- Tonik Calculated Risk Taker (BlueCross BlueShield of California)
- Young Adult Blue (BlueCross BlueShield of Michigan)
- Saver 80 (United Healthcare – Iowa)

Small Group Products Targeted at Maximizing Value For Cost

- Regence Now Select (Regence BlueShield of Idaho—Note: this is an individual product. A similar small group product is under development in Idaho, targeted to be launched October 1, 2006)
- Community Blue (BlueCross BlueShield of Kansas City)
- Group BasicBlue (Arkansas BlueCross BlueShield)

Medical Products That Can Fill A Temporary Need for Coverage

- InterM Medical Plan (Available through Regence Life and Health Insurance Company in Idaho, Utah, and Oregon)

Regence urges the Commission to allow carriers to offer at least one lower cost, mandate-light product in both the individual and small group markets. Along with evidence-based approaches to quality and transparency around costs, we believe there is a need in our market for coverage options along a spectrum from basic to comprehensive. We would be pleased to provide further information to Commission members about any of these ideas and products.

EDUCATION: Those Who Can Afford to Enroll

Twenty percent of the uninsured in America earn $50,000 or more annually.[8] Of those earning $50,000 or more, 40 percent are young adults, 12 percent are self-employed, and 40 percent are workers or dependents in small firms.

As with the low-income populations described above, there are several reasons why those who can afford health insurance choose not to purchase it – at great potential risk to themselves and their families. Anecdotal evidence suggests these higher-income individuals may believe they do not need coverage because they are young and healthy, or believe they can fund routine medical needs out of pocket. Others may not be aware of the existing coverage options available.

In this group as well, young adults in the 19-30 age range are particularly vulnerable. This group represents the largest and fastest growing segment of the population without health insurance; they are uninsured at twice the rate of adults ages 30 to 64.

Targeted outreach and education must be stepped up to educate young adults and others about the need for health insurance in the event of an emergency or catastrophic illness. Regence and many other carriers have products such as Medical Savings Accounts that appeal to consumers of all income levels, and particularly to this demographic group. Data suggests that thirty percent of new members on a Medical Savings Account were previously uninsured. There may also be tax incentives and credits that could be made available to support those who acquire this type of coverage.

We believe the three-pronged approach outlined here is one way that some immediate progress can be made toward the goal of securing coverage ability for the uninsured. By focusing our efforts, we can increase enrollment in state assistance programs, provide new, lower-cost health plans and educate people with resources to assume responsibility for their health and financial well-being.

[8] See The Uninsured in America, BlueCross BlueShield Association, page 6.

Tab 46

The Smiles for Life Project

Maintaining Oral Health throughout Life

A Proposal to the Blue Ribbon Commission on
Health Care Costs and Access

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INTRODUCTION

When the Governor's Blue Ribbon Commission asks the question, "How do we reach the goal of becoming one of the healthiest states in the nation in the next five years?" we know the answer must include oral health.

When the Commission asks for evidence-based care, cost-effectiveness and cost containment consistent with personal income growth, visionary utilization of the health care workforce, and universal access across race, gender and income levels, we know that we are already operating within the vision and goals of the Commission.

Our proposal would ultimately lead to the expansion of oral health care services to Washingtonians utilizing **teledentistry** and **professional and community partnerships**. This proposal focuses on one underserved population in two Washington counties to demonstrate how the utilization of new technologies and appropriate utilization of all oral health care providers will work in Washington.

The Alliance of Dental Hygiene Practitioners brings this proposal to the Commission. The Alliance is an organization of over 50 community-practicing dental hygienists and their supporters with the mission: "Improve the oral health of our communities by promoting evidence-based, cost-effective, oral health services, access to them and education, and to support consumer choice and community partnerships."

Our demonstration project would initially serve elders and their caregivers in Clallam and Jefferson Counties, which span the northern part of the Olympic Peninsula. Why? Because "affordable dental care" is the number one expressed need listed by elders in these counties who responded to a recent newspaper survey. Other top concerns were disease prevention services and education, information and assistance in finding services, finding a doctor who accepts new patients, health care product information, and meaningful volunteerism. The survey was conducted by the Community Advocates for Rural Elders (CARE) Partnership, formed with the help of a Robert Wood Johnson grant in order to assess the needs of older adults in an area of the state with an unusual demographic profile.

In 2004, the percent of people 65 years of age and older was 21.4 percent in Clallam County, and 21.8 percent in Jefferson County. According to the recent demographics cited in the CARE Projects Resource Manual, Clallam County has roughly twice the percentage of residents over age 64 than does the State (21.2% and 11.2% respectively). The median age of the population in Clallam County is 43.8 years, nearly a third higher than the state average. Approximately 60% of the population in Sequim alone is over the age of 55. Population forecasts for the State of Washington indicate that Clallam County's older adult profile foretells the State's older adult profile fifteen years from now. This demographic profile was one of the reasons the regional Area Agency on Ageing was awarded a planning grant to study the needs of the elders in Clallam County.

Both Clallam and Jefferson Counties are designated as rural. Both are designated as federally underserved, yet there are no Federally Qualified Health Centers (FQHCs) in either county. The closest FQHC is in Kitsap County. Because of the larger percent of the population 65 years of age and older, both counties have higher percentages of people on Medicare than the Washington or national average. According to the Centers for Disease Control Behavioral Risk Factor Surveillance System and other community health assessment references, both counties also have higher percentages of citizens on Medicaid. Clallam and Jefferson Counties are not unique in that there are few private dental practices that accept Medicaid coupons, and fewer that accommodate the special needs of elders and older adults with special needs. Travel for elders in this region is difficult, time-consuming, and hazardous because of the frequently rainy conditions. Few bus routes link the cities along the main east-west corridor of the northern Peninsula.

Members of the Alliance of Dental Hygiene Practitioners who are already serving elders and adults with special needs in Clallam County met recently with administrators of the CARE Partnership which focuses on elders in Clallam County, and the regional Area Agency on Ageing, which also serves Jefferson, Gray's Harbor and Pacific Counties. The meeting explored ways the oral health care needs of the region's elders might be met, particularly those who are homebound, on Medicaid or limited income, and have special needs.

SMILES FOR LIFE is based on the master's degree work of Cyndi Newman, the Oral Health Consultant/Program Manager for Clallam and Jefferson County Health Departments and the OlyCAP Oral Health Care Access Program, and on the success of a collaborative model of oral health services delivery pioneered by Apple Tree Dental, a non-profit organization that has been operating in Minnesota for over 20 years. Apple Tree Dental utilizes teledentistry and the judicious use of oral health care providers to reach very rural, underserved populations, especially elders and special needs populations. The CEO and one of four founders of Apple Tree Dental, Dr. Michael Helgeson, has agreed to serve as one of the consultants for this project.

The collaborative model, utilized in several states including Minnesota, links a community-practicing dental hygienist in a formalized relationship with one or more consulting dentists, without obligating those dentists to provide treatment services to the populations the dental hygienist is providing preventive services and education to. The dental hygienist and dentist collaborate on communication and practice protocols and procedures, and routes of referral for dental treatment. Together they develop preventive services plans, which the dental hygienist implements, then reports outcomes back to the consulting dentist and any entities or agencies the community-practicing dental hygienist has contracted with for each outreach program.

SMILES FOR LIFE

PROJECT GOALS, OBJECTIVES AND TIMELINE

The Smiles for Life Project will address four needs and part of the fifth expressed need of the elders in Clallam County. It aims at improving and supporting the general health of all elders with a focus on oral health issues. Through access to up-to-date oral health education and information, as well as preventive and restorative oral health therapies, senior citizens will be able to maintain good and affordable oral health throughout their lifetimes. The Smiles for Life Project is committed to working with community partners, such as the CARE Partnership, to ensure that older adults are able to access essential oral health services.

GOALS

The Smiles for Life Project, along with its community partners, will

- Increase the awareness of oral health and its importance in total health
- Collect and analyze baseline data related to the oral health status of older adults living in Clallam County
- Develop education and outreach strategies for oral health promotion and disease prevention that empowers older adults to take responsibility for managing their own oral health
- Integrate preventive and restorative oral health services for seniors who are living with low incomes and/or are homebound
- Collaborate with community partners to increase access to essential oral health services to all seniors living in Clallam County

OBJECTIVES and TIMELINE

Within the first month of the project research and development phase, the Smiles for Life Project planners will collaborate with known community partners, in particular with the CARE Partnership, to plan the design and implementation phases of the project, identify and recruit additional community partners, consultants, providers and volunteers to the project.

The project planner will immediately begin researching possible funding opportunities for the proposed project, and to gather community support for the project with media assistance, as well as recruit community stakeholders to assist with the search for funding opportunities.

Note: The Washington Dental Service Foundation has offered its support of Alliance of Dental Hygiene Practitioner programs that would focus on elders.

Within the first three months, the Project planner will consult closely with advisors to the Project. In particular, these will include experts in geriatric general and oral health care management, the use of telemedicine and teledentistry technology, data collection, management and analysis, and health care team management.

Within the first three months, the Project planner will recruit community stakeholders to serve as a planning and steering committee for the Project. In particular, the planner will begin to recruit dentists, denturists, dental hygienists and dental assistants who are interested in participating in the Project.

Within the first six months, the Project design will be finalized with input from the general community, elders and their advocates.

Once funding has been committed to the Project, implementation of the Project will begin with oral health education information being distributed via media and community partners to all areas of Clallam County.

Within three months of the start of implementation, at least two oral health education classes and oral health screening/exam clinics will be conducted at each Senior Center in Clallam County.

Within six months, clinical dental hygiene services will commence at residential sites and senior centers for program eligible clients who are 55 years of age and older, uninsured, low income and who have become immobile or are otherwise homebound. Elders with insurance or financial means will be referred to participating private practice dentists in the community who have committed to payment plans, senior discounts or other incentives that truly make dental care affordable to this population.

Within nine months, teledentistry will be utilized between field-positioned dental hygienists and one or more participating dentists to confirm and prioritize oral health treatment needs in program-eligible clients via digital radiography and intraoral camera transmissions, and clinical intake protocols agreed upon by the Project dental hygienists and collaborating dentists.

Restorative clinic days will be organized, sites located and coordinated, portable equipment located and committed, providers and clients scheduled. Each participating dentist’s expertise will be maximized and total services multiplied by utilizing dental hygienists for anesthesia and restorative procedures, with dental assistants and volunteer elders completing the on-site teams. The Project planner envisions two to four dental chairs being utilized for each portable restorative clinic.

Exit surveys will be conducted to assess client satisfaction with the care they have received, measure oral health outcomes, and direct improvements of the Project. Did the program provide "affordable dental care" that has met other expectations?

The overall timeframe for planning, implementation and adequate assessment of the SMILES FOR LIFE Project is 3 years. This would give time for replication in other counties to achieve at least partial statewide implementation within the Commission's targeted 5-year goal.

ADDRESSING THE COMMISSION QUESTIONS

1. **The vision of the Commission is to have a system developed in five years which provides every Washingtonian the ability to obtain needed health care at an affordable price.**
   The Commission's goals are the following:
   - **<u>Improve access</u> to health coverage that provides effective care by 2012, with all children having coverage by 2010**
   - **<u>Improve health</u> with Washington becoming one of the top ten healthiest states in the nation, with consistent population health indicators across race, gender and income levels throughout the state, and increased use of evidence-based care for better health outcomes and consumer satisfaction**
   - **<u>Improve affordability</u> by increasing total health care expenditures only as consistent with growth in personal income**

SMILES FOR LIFE focuses on the development of a system that ultimately will provide appropriate, effective, and affordable oral health care to elders and populations with special access needs. The project will be initiated in two Washington counties, serve as a demonstration model with refinements over three years, then begin implementation over the next two years in other Washington counties. The SMILES FOR LIFE Introduction summarizes the proposal, and the section on Goals, Objectives and Timeline explains the Project's realization of the vision and goals of the Commission.

2. The SMILES FOR LIFE Project implementation will address the vision of the Commission by developing an innovative delivery model that will provide oral health care most relevant and accessible to populations that are the least served by the current delivery system, and which have identified affordable oral health care as their number one health care need.
The SMILES FOR LIFE Project will <u>enhance</u> all the goals of the Commission by:

- Expanding the oral health care options available to a major and rapidly growing population sector in the state, retiring baby boomers
- Improving health indicators consistent across all <u>ages</u>, as well as across race, gender and income levels across the state

- Using and actually contributing to the body of evidence base upon which best practices are policies are built (the evidence-base relative to the elder population is almost non-existent at present)
- Increasing utilization of mid level oral health providers consistent with the medical health care delivery model expansion

How will we know if we are enhancing the vision and goals of the Commission?
The Project will demonstrate measurable outcomes through appropriate and consistent data collection throughout the implementation phase of its 3-year demonstration, and tracked through all subsequent years. Data collection will include outcome measurements in terms of services utilization, measurable improvements in oral health status, decreased reliance on the most expensive oral health care providers, cost analyses of the project on an annual basis to determine cost-effectiveness and efficiency, and consumer satisfaction surveys.

3. The SMILES FOR LIFE Project is modeled after existing programs both inside and outside Washington State. Within Washington State, the project is modeled after several mobile preventive oral health care services owned and operated by community-practicing dental hygienists, which specifically serve elders and adults with special needs. Additionally, there are several mobile dental practices in Washington State serving these populations, which also demonstrate the efficacy of providing oral health care services on-site in group homes and other residential centers. These models all take services directly to the consumers rather than asking the consumers to come to the service centers. Many of these models have been in existence for over 20 years. They have served many thousands of Washington State's most fragile and vulnerable populations. The numbers of community-practicing dental hygienists, particularly those serving Medicaid clients are steadily increasing, while the numbers of dentists serving the same populations have decreased. This fact points to the need to utilize the changing workforce to its best and most cost-effective capacity in order to meet the changing demographics and health care needs of all Washingtonians.

The Project is also modeled after the Apple Tree Dental organization, a non-profit established 20 years ago in Minnesota to meet the special access needs of low income children and their families, elders, especially those in nursing homes, and persons with disabilities. The vision, mission and goals of Apple Tree are entirely consistent with those of the Commission, and after 20 years the organization continues to expand to include more of the state's underserved populations. Details about Apple Tree's success can be found in its annual reports, linked to its website at appletreedental.org.

4. The Project will increase costs to the government by asking the state to expand funding to the aged and disabled populations who depend on Medicaid for oral and general health care services. Basic costs to Medicaid will be ongoing, increasing in direct proportion to the number of enrollees. Census data and socioeconomic demographics can be used to estimate the impact on Medicaid funding. There may be additions to services covered by Medicaid such as fluoride applications for elders and reimbursement increases, which would also increase costs to the state. The emphasis of government funding should be on

preventive dollars, as recommended to the states by the Robert Wood Johnson Foundation.

The Project will utilize both public and private partnerships and funding for fiscal sustainability. Medicaid funds will certainly be needed for the lowest income clients. Corresponding savings to the state will be accomplished by using a sliding scale for payment of services like that of community clinics and other health care programs. The sliding scale will be utilized for clients of the project that have incomes higher than Medicaid eligibility thresholds. The Project will seek grant funds for its startup and expansions. It will apply for non-profit status within the 3 year demonstration timeframe in order to position itself for broadest eligibility. The Project will utilize volunteers as much as possible. Cost containment will be a priority of the project in order that costs to the consumers will be as low as possible while allowing the project to be sustainable. The project will solicit bids for services included in order to allow and promote competition among providers. This will help to ensure the affordability of services to consumers, while maintaining the highest standards of quality, safety, and confidentiality.

5. The Project is based on collaboration with various stakeholders. At the time of this submission we have no formal endorsements, but meetings with stakeholders have begun and we are certain formal support is forthcoming. A strong coalition of stakeholders already exists on the Olympic Peninsula, which has been seeking solutions to the oral health dilemmas of its most fragile, vulnerable and poorest populations. Initial CARE partners included the Olympic Area Agency on Aging (O3A), Senior Information & Assistance (I&A), older adult representatives, Tribal leaders, Olympic Medical Center, United Way, Peninsula Community Mental Health Center, Clallam County Health Department, Forks Hospital and Outreach, and Olympic Medical Home Health.
The area hospitals are likely to endorse the proposal, since they are the most financially impacted by the lack of dental providers for Medicaid, low income and disabled populations. Likewise, advocate organizations of these populations are most likely to endorse the project. Finally, citizen organizations like AARP are very likely to support the SMILES FOR LIFE Project.

6. The legislature will be asked to remove the supervisory barrier in the dental hygiene practice act to allow dental hygienists to access elders wherever is most convenient to the elders themselves. This would include homebound elders, currently restricted from accessing preventive services, and elders living in retirement centers and assisted living facilities. Elders should simply have the right to access preventive oral health care services as freely as possible. In the long term, freedom to access preventive oral health services will result in lowered costs to <u>all</u>: the state, the community, and the consumers. The evidence-base is wide and deep in support of preventive services in relationship to cost savings.

The state dental association is likely to object to the Project because historically, they have been in opposition to any initiative to improve oral health care services coming from the dental hygienist community. They believe community-practicing dental hygienists

will take income away from private practices, rather than enrolling more of the community members into oral health care systems. They believe that dental hygienists might cause harm to the public. They believe the reports of need for oral health care services for low income individuals and families, elders and persons with disabilities are grossly exaggerated, and finally, they believe that they are doing their utmost to serve the needs of their entire communities. None of these beliefs are evidence-based.

In order to overcome the likely objections of the state dental association members, the SMILES FOR LIFE Project aims to overcome any arguments against the project with a pro-active approach. Community partnerships and collaboration among providers are its cornerstones. The Project will recruit community-minded dentists to serve on the steering committee, and will recruit dentists who are experts in geriatric and special needs care to serve as advisors to the project. It will recruit from the broad medical field as well, especially those with expertise in geriatric care. The Project will seek to become an externship site for the training of all dental health professionals, which would also contribute to the project's long-term sustainability. The Project has a faculty member from the University of Washington's Department of Public Health Sciences in the Dental School recruited as a consultant.

Finally, SMILES FOR LIFE will incorporate the following strategies offered as samples in the development of the vision, mission and goals of the Commission:

- Utilize prevention and health promotion
- Reduce health care administrative costs and pass savings to consumers
- Provide information and incentives to encourage personal wellness
- Utilize workforce and technologies to their best potential
- Allow and promote competition among providers to offer consumers the best price, quality and services

REFERENCES

1. **Apple Tree Dental** can be researched at appletreedental.org.
   Dr. Michael Helgeson, CEO of Apple Tree Dental, will serve as an advisor to the project and has stated he would be happy to provide expert testimony.

2. The **CARE Projects Resource Manual** and other resource materials can be requested from the CARE Partnership from:
   Sheryl Lowe, Director, loweshj@dshs.wa.gov
   Barbara Clarke, Community Coordinator, clarkbl@dshs.wa.gov
   107 E. 8th Street
   Port Angeles, WA 98362
   360-538-2456, extension 115

3. **About The Robert Wood Johnson Foundation® (RWJF)**
   RWJF believes that the best solutions to improve long term care and supportive service systems will originate through strong community partnerships. The **Community Partnerships for Older Adults** program supports communities in defining and preparing themselves for how best to care for their older adult population now and in the future. A maximum of $20 million will be made available to approximately 30 grantee communities over the life of the program. Grantees are provided financial and technical assistance to develop and implement community-generated approaches to long term care and supportive services system improvements for at risk older adults.

4. **Access to Oral Health Services for Low Income People: Policy Barriers and Opportunities for Intervention for the Robert Wood Johnson Foundation**, was published Oct. 2002 for the Forum for State Health Policy Leadership, National Conference of State Legislatures. The publication is included with this proposal submission in Adobe format.

5. The master's degree project, **The Smiles for Life Project, Maintaining Oral Health Throughout Life**, is available from Cyndi Newman at 360-808-4706 or mail to: cnewmanrdh@tenforward.com

Access to Oral Health Services for Low-Income People:

Policy Barriers and Opportunities for Intervention for The Robert Wood Johnson Foundation

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October 2002

Forum *for* State Health Policy Leadership
National Conference *of* State Legislatures

NATIONAL CONFERENCE
of STATE LEGISLATURES

The Forum for America's Ideas

The NATIONAL CONFERENCE *of* STATE LEGISLATURES (NCSL) serves the legislators and staffs of the nation's 50 states, its commonwealths and territories, and the District of Columbia. NCSL provides research, technical assistance and the opportunity for policymakers to exchange ideas on the most pressing state issues. NCSL is a bipartisan organization with three objectives:

- To improve the quality and effectiveness of state legislatures,
- To foster interstate communication and cooperation, and
- To ensure states a strong, cohesive voice in the federal system.

FORUM *for* STATE HEALTH POLICY LEADERSHIP

The Forum *for* State Health Policy Leadership is an entity within the National Conference *of* State Legislatures. The central mission of the Forum is to enhance the capacity for informed decision making and leadership within the state legislatures regarding the financing, organization and delivery of health care services to low-income and vulnerable populations. The Forum is designed to provide a range of information, training and technical assistance services to new state legislators who are potential future leaders in health policy and to serve as a mechanism for established leaders in state health policy to further develop and share their expertise.

Executive Summary

The National Conference of State Legislatures contracted with The Robert Wood Johnson Foundation (RWJF) in January 2002 to conduct a study of policy barriers to access to oral health care for low-income people and opportunities for the Foundation to address them. Over an eight month period, NCSL gathered and analyzed information, hosted meetings of national and state experts, and conducted site visits to five states (herein labeled States A through E). The site visits offer a rich portrait of the struggle to improve access in states and communities through conversations with nearly 75 people on all sides of the issue. Definite themes emerged from the site visits and the meetings about barriers that lead to three sets of opportunities for intervention by RWJF.

NCSL has documented multiple policy barriers to access to oral health services that are described in detail under the following sections:

- Supply, distribution and practice patterns of dentists
- Federal and state policy and programmatic barriers
- Dental education
- Research issues
- Leadership
- Advocacy, and
- Public education.

In general, it is much easier for people to identify and describe barriers and harder to generate creative solutions. Those who work on oral health issues seem very much "mired in the present" and are not thinking about bold new solutions. There were a number of things people interviewed for the study did *not* mention or request that seem like glaring omissions, such as foundation support to:

- Increase the supply of dentists
- Develop a new mid-level practitioner similar to a nurse practitioner or physician's assistant
- Explore the use of expanded function dental auxiliaries
- Research and report on scope of practice and supervision requirements for dental hygienists and dental assistants
- Research state dental practice acts for restrictions they impose on medical providers delivering dental screening and fluoride treatments, and for the impact of the corporate practice of dentistry
- Improve advocacy efforts on behalf of water fluoridation
- Research and write about dental economics and how they differ from medical economics
- Educate governors or governors' health staff on oral health
- Engage in leadership development among dental associations or dentists.

The three areas where RWJF investment would be most useful to breaking down policy barriers so states can move forward more forcefully to solve their access problems are:

Defining the Policy Problem

There is much disagreement in states about the nature and dimensions of the oral health access problem. States that have not moved forward need consensus-building activities such as oral health policy academies, task forces and commissions in order to develop a unified vision of the problem at hand. They also need help educating the media and working with the media to raise the visibility of oral health issues, and a broad public education effort aimed at the general public and high-risk groups such as immigrants, Medicaid and SCHIP recipients, low-income mothers and grandparents.

Developing Policy Solutions

Assuming that a common definition of the problem has been accepted, states lack realistic and achievable policy solutions. There are also big holes in the picture; information is not shared for political reasons, not available or not given to people who could use it to make a difference. States need the sort of information that has been available in great quantities to spur the debate over health care reform: policy analyses, program evaluations, cost-benefit analyses, reports on best practices, and surveys to gather state-specific and local information. In particular, they need policy work that can explore alternative practice and service delivery models, new providers and any new ideas that would help open up the dialogue into new ways to solve problems in oral health. This work needs to be coupled with a broad dissemination effort to people in all areas of the policy process.

Build Political Support

Oral health is a low priority for policymakers, most state health officials, advocacy groups and much of the general public. There are very few groups other than state dental and hygiene associations that work with the legislature on an oral health agenda, and they do not move forward together in any sustained fashion. Coalitions on oral health are either absent, missing members from key constituencies, weak, or poorly-funded and managed. Coalitions need training and tools to generate support for change in oral health policy. Even more serious, there is a dearth of consistent, strong leadership on oral health issues in legislatures and state agencies. There is a need for leadership development among legislators, education for legislative staff and support for state dental directors.

I. Supply, Distribution and Practice Patterns of Dentists

Barriers: Supply, Distribution and Practice Patterns of Dentists

Too Few Dentists or Just Enough?

One clear problem in states is the wide disparity of opinions about whether or not there is a shortage of dentists in their states. Most people, particularly those who work for state Medicaid agencies or health departments, safety net clinics or advocacy groups, feel that there is clearly a shortage of dentists in their state. Dental association officers and staff in the states we visited, on the other hand, generally say there is no shortage of dentists, although they are willing to admit there is a geographic maldistribution. State B's dental association president said "if there was valid scientific evidence of a shortage, we would support more students in existing dental schools, but no new schools." (The declining number of students admitted to dental school is further discussed in the "Dental Education" section.) In every state visited, people from all sides of the issue cited a maldistribution of dentists, with too few in rural, frontier, border and urban underserved areas to see patients regardless of income. State C has 25 counties without a dentist and State A has 3 counties with no dentists and 15 with fewer than five. About one-fifth of State E's counties do not have a dentist. It is particularly difficult to get specialty care in rural areas. There is also a tremendous problem attracting dentists to serve Native Americans on reservations.

According to states, any shortage that does exist is likely to be exacerbated in the coming years by the aging of the dental workforce. For example, 40% of State E's dentists will be retiring in the next ten years. This issue isn't uniformly understood by people within states as not every state collects this information and the dental associations, which receive the results of the annual American Dental Association surveys, don't generally release or share the information. State regulatory boards also may have the information but don't analyze or release it.

Enough Dentists for Whom?

Most people agree that there is a shortage of those who are willing to treat low-income clients, particularly those insured by Medicaid. Some dentists in State D resigned from the Blue Cross Blue Shield network rather than agree to take low-income patients paid for by a foundation's program. Part of the problem is that most dental practices are already full with patients who pay in cash or have private dental insurance so inadequate capacity exists to care for low-income patients. The president of one state dental association said "dentists don't feel like they need to see more patients" when asked if expanded function dental auxiliaries would be helpful to solve access problems. Another barrier is dentists' preconceived notions of what Medicaid patients are like. There is a stigma associated with this population and an assumption—often borne out—that there will be a high no-show rate. A number of people noted that dentists would rather donate care at a clinic than have "them" in their waiting rooms.

In every state, people said there are very few dentists who are willing and able to treat children or adults with special health care needs. Many dentists are taught in dental school to refer disabled patients and young children elsewhere, so they lack the training and comfort level to treat them. In State C, there is a three-week wait for oral health services for children with special health care needs. In State A, many families must drive long distances to the dental school so they delay care until the need is critical because access is so difficult. In State D, a few disabled patients can receive care at a city hospital through the WICHE program (multi-state exchange program that provides slots in professional schools for state residents from states without schools). A fiscal analyst at the legislature said "it would take four years for them to serve the whole disabled population with one dental visit."

Protecting a Cottage Industry

Another set of barriers is the way dental practices are organized. Dentists by and large are in solo practices. A large percentage don't accept any insurance, let alone Medicaid, on philosophical or practical grounds, and ask patients with insurance to pay in full and seek reimbursement on their own. A dental educator in State B said, "in continuing education 'management' classes, dentists are taught not to accept insurance." Many states have a ban on the corporate practice of dentistry in their dental practice act, which prevents dentists from working for any entity other than another dentist. This has been used to prevent the development of dental managed care and preserve the solo practice model. A state dental association president explained that in his view "the ban on corporate practice is because of quality of care. (Corporate practices) are mega-practices that operate faceless practices that aren't patient-oriented. (There is a lack of trust between dentist and patient so) patients don't know if care is really needed." This provision also erects a legal barrier to the development of public health dental clinics or the addition of dental components to community health centers unless exceptions are written into law or regulations. State B experienced this problem and had to get an amendment in the law during the 1999 legislative session to allow them to hire rather than contract with dentists. One health center official said "dentists don't want to care for poor people but they don't want us to either." State A also has a ban on the corporate practice of dentistry and allows exceptions only for unlicensed or foreign dentists, who can be employed by public health clinics or nonprofits to provide indigent care under the supervision of a licensed State A dentist.

Simmering Resentments Toward Dentists and Organized Dentistry

One consistent finding was that there is a steady undercurrent of negative feelings about dentists among many of the people interviewed such as employers, purchasers of dental services, policy makers, state officials, community program directors, educators and regulators. This is important to describe so it can be factored into potential solutions. People in each state made some potentially offensive and controversial comments about typical personality types of dentists: they are difficult to work with, extremely independent, resistant to change, and don't partner well with other professionals. Some of the same personal characteristics that make dentists capable of performing high-risk tasks that require extreme precision with little or no room for error may be what makes them difficult. In State A, one state official said: "Dentists are perfectionists, anal retentive. They are very high maintenance. Dentists are never really happy." In State D another state official said: "They're not willing to negotiate. I'm not as frustrated with them now, but I still think they could give a little bit more."

Few people understand the economics of dental practice that give rise to many of these complaints. Some people express resentment that dentists behave more like business owners than health care providers and should have more concern about needy individuals and the health of the public. There are legislators and state officials who view dentists as uncooperative, greedy and lacking in empathy. A State E official said, "Once a dentist has established a practice, they feel no obligation to the community." While there were differences between comments about organized dentistry and individual dentists, there were negative feelings and experiences expressed about both by a broad range of people interviewed.

Not Enough Clinics

In each state visited, people spoke of an inadequate public health infrastructure or safety net for dental care. The few community health centers that have dental clinics and the publicly or privately funded dental clinics are overwhelmed. According to the State C community health association, the pent-up demand is such that "whenever they open a dental site, the waiting list explodes" at *all* dental clinics in the state, after media report on low-cost dental services. However, State E's Medicaid director also cautions that support for safety net dental services should not "let dentists off the hook" for providing care. He sees the safety net as a backup rather than a primary source of care. In State A, the dental director estimated that maybe 3% of the dental care in the state is provided with public funding through their 67 county

health departments. The rest comes from private dentists. State E has only one community health center and it can't keep up with demand for dental care. In the absence of sufficient public clinics, many people without insurance or a usual source of care go to the emergency room. A foundation-supported project in one part of State E found 800-900 emergency room visits each year for dental problems; 47% of those were for Medicaid-eligible patients.

Part of the problem is the extreme difficulty in recruiting dentists to work in safety net settings. The State C community health association says they currently have 15 openings for dentists at their clinics and two clinics staffed only by hygienists. Hygienists are not sufficient because "in community health centers, 20% is preventive and 80% is restorative. New patients are often a heavy investment in time and resources." The dentists and hygienists who staff those clinics are personally and professionally challenged and need networking and support because of the high, unrelenting demands of the workload and the difficulties in caring for the population. Clinicians say that their patients have a high level of need and sometimes don't follow up or complete their care, leading to a lot of frustration and worry among their caregivers.

Other Dental Providers

In some states and in areas within states, there is a shortage of hygienists, dental assistants and dental lab technicians, although this comment cropped up less frequently than the similar comment about dentists. Since most dental hygienists don't work full-time, it is harder to interpret the numbers on supply. In at least one state, a university official said, "organized hygienists are the same as dentists in not acknowledging there is a shortage." Another factor that was not often discussed is that it's difficult to get dental hygienists to volunteer. Most hygienists are women who balance work and family obligations.

In State C, a community health center official bemoans the fact that opportunities for screening are being missed and wants to reach out to non-dentists. She noted that "pediatricians see children up to 15 times before age 3" and could provide dental screening. Whereas, "in our state, we have only 65 pediatric dentists and even they don't want to see children before 3 years."

Opportunities for Intervention: Supply, Distribution and Practice Patterns of Dentists

- To increase the number of providers willing to serve Medicaid patients, state and local officials all expressed a need for help in expanding the safety net for oral health services and recruiting full-time public health dentists.
- There is a need for funding to purchase equipment for offices or for outfitting mobile vans; one state suggested that matching funds be made available for this purpose. In State E, the Medicaid director wants funds to provide no-interest or low-interest loans to cover the capital costs of expansion for public health dental sites. State B community health centers need funds for capital expansions in underserved areas, but an even greater need is for funds to operate new clinics until they can become self-sustaining.
- There were also a few requests for assistance in expanding school-based dental services for children
- One person requested placing a dental chair in a public hospital if another setting is not available.
- It is clear that dentists prefer treating low-income patients in a setting other than their offices. For services outside the clinic or hospital setting, some communities, particularly in State D, want help in coordinating volunteer dentists to see low-income patients. There is also need for dentists to supervise hygienists (at whatever level is required by the state) who volunteer to provide screening and hygiene services in schools and other sites in low-income areas.
- In a comment related to dentists' attitudes, an administrator of the State C dental board said "a class by Ms. Manners" would be very useful for dentists.
- Only one person, an insurance company foundation executive, expressed the desire to have funds

to investigate training of a new type of mid-level dental provider, similar to a nurse practitioner or a physician assistant.

- The State C community health association wants help developing a program to train pediatricians to do screening for oral health problems in the 0 to 3 population and work with dentists to solve them. Similarly, an official at the dental school at a public university in State B wants funds to provide training for physicians, nurse practitioners and physician assistants in oral health screenings and application of fluoride varnishes.
- An advocate in State A suggested that a "medical home" model similar to the one the American Academy of Pediatrics developed for children would be helpful to link children and families with a dentist or clinic and to link together medical and dental care.
- Two dental schools expressed a desire for looser licensing requirements to allow foreign-trained dentists to pass exams and establish a practice or teach.

II. Federal and State Policy and Programmatic Issues

Barriers: Federal and State Policy and Programmatic Issues

Federal Policy Barriers

A number of people, particularly state officials, pointed to obstacles to access created by the federal design of Medicaid and SCHIP. For example, the optional nature of adult dental services in Medicaid and children's dental services in SCHIP undercuts the importance of dental care and makes it among the first targets for Medicaid or SCHIP cutbacks. Also, since SCHIP is not an entitlement, benefits can be capped. Low dollar caps ($500 in State C and $300 in State B) mean children with severe oral health needs don't have "meaningful" coverage and need to pay high out-of-pocket costs for care, seek a source of charity care or go without care over the cap. The federal law prohibiting enrolling children with health insurance in SCHIP has created access problems for children with health insurance but no dental coverage. State D expressed interest in creating a dental-only wrap-around plan for these kids if the law was changed to permit it. Also, many low-income people who need care but are unable to pay for it are not eligible for Medicaid. Safety net providers—already stretched treating Medicaid patients—treat these patients without reimbursement.

Another problem relating to federal law mentioned by several states is that the Federal Tort Claims Act—which protects most employees in community health centers from malpractice claims—does not extend to dentists. Some states have all but discarded certain options to increase the number of providers, such as employing volunteer or retired dentists in a clinic, because of the prohibitive cost of providing malpractice insurance for them.

Reimbursement Rates

Certain state policies adversely affect dentists' willingness to serve low-income populations (Medicaid, SCHIP, and uninsured). Dental associations in every state claimed that reimbursement is too low, although at least one dental association president noted that reimbursement has improved in the last several years, and States B and C raised reimbursement rates during the last legislative session. For the most part, the dental association message hits home with legislators and staff. A senator in State E remarked that "most procedures pay below cost." While this is true for the adult population, rates for children are actually in the 80-90th percentile—certainly not below cost—and Medicaid rates in some parts of the state are above private-pay rates. The State C dental association went so far as to say that inadequate rates result in "MASH dentistry" and a "double standard of care" with some profiteering dentists setting up Medicaid-only clinics and performing "factory dentistry." The representative went on to add that the "crisis in access would go away if dentists were paid at the 75th percentile." Some people suggested that the methods states use to calculate reimbursement are outdated and inadequate. (To this end, the Milbank Memorial Fund has developed an alternative reimbursement model using interactive actuarial software.)

Barriers to access also result when some procedures or services receive no reimbursement. For example, coordination between physicians and dentists is rarely funded, though some see the need for it. State C's SCHIP director believes that "whenever kids interact with the health care system, primary care providers should refer and link them to needed oral health services. Any case management or follow-up should include oral health." However, this type of coordination is rarely funded. Also, states rarely provide extra reimbursement for the elderly or people with disabilities, as State E does, though it is more difficult and time-consuming to treat these patients than to treat children.

Administrative Barriers and Patient Compliance

Other factors that make dentists unwilling to serve low-income patients are continuing administrative hassles, although some states have instituted electronic billing, begun using ADA billing codes and claim forms, and reduced or eliminated prior authorization requirements. State E's dental association remarked that the time required to receive payment has doubled to 6-9 weeks in 2002 for an unknown reason.

Failure to keep appointments is another factor that limits dentists' willingness to serve low-income patients. State officials agree with dentists that no-shows are problematic but have made little headway in addressing the problem. There are long waiting lists in both public and private care settings.

Limited Public Employee Benefits

Many feel that oral health is systematically undervalued. The low valuation of dental care is also reflected in the uneven benefit packages for state employees: dental benefits are not subsidized for State E's employees and dependents or most State A workers. If benefits are offered, the reimbursement levels are often low. Roughly 60% of full-time public employees have dental insurance, but the services covered, copayments, deductibles and dollar caps vary.

Fluoridation

Although each state we visited has some funds for them, programs to fluoridate water systems are generally small and on the defensive. During the last legislative session, State B cut its fluoridation budget by 80% to help offset a small part of the cost of the Medicaid reimbursement rate increase. The state dental director said the current state health commissioner does not believe fluoride is beneficial and has fears about its safety. Also in State B, one of the largest cities in the country without fluoride voted a few years ago to fluoridate after years of contentious debate and an enormous community coalition effort but has yet to implement it. In State D, legislative leaders had been working at the local and state levels to get communities funds to fluoridate water, but county boards voted it down for several years. A grassroots effort in State D won a referendum approving fluoridation in three cities last year, although implementing it has been stalled by court challenges and efforts among some smaller communities to opt out of the water system.

Scope of Practice and Supervision Battles

Persistent opposition by state dental associations to the attempts by dental hygienists to expand their scope of practice and loosen supervision requirements was mentioned in every state we visited. One community health center official said: "Dentists are the most territorial mammals on the face of the earth, except maybe dogs." This struggle is similar to others between professionals, such as physicians and nursing groups. These are very difficult issues for legislatures because they pit important groups against each other, involve complex technical issues unique to each profession and have the potential to hurt or help the public. Hygienists are trained to provide various preventive and "triage" services but are often prevented from doing so under state practice acts. Hygienists feel they can remedy access problems by going directly to underserved populations (thus removing transportation and outreach barriers and solving the no-show problem). In their own defense, dental associations disagree that changes in scope of practice or supervision are needed to improve access, arguing that most low-income patients need restorative care which can only be performed by a dentist.

In the states we visited, organized dentistry has consistently opposed hygienists' attempts to practice to the full extent of their training under any level of supervision and opposed attempts to perform services off-site that they can do under a dentist's supervision. There seem to be big disparities in practice acts governing hygienists and assistants between and within states. In State A, hygienists need direct supervision to apply sealants, while in other states, sealants can be applied by dental assistants. In State E, hygienists can perform a full range of services on reservations, but not in private dental offices a few miles away. In State C, hygienists can get their own Medicaid provider numbers and set up independent practices. However, the dental practice act in State C will be reauthorized next year and most people expect that independent practice and the ability to get separate Medicaid provider numbers will be challenged by the dental association.

There were several comments from hygienists, advocates and educators about the suspected presence of sexism and a "good ol' boys network," in keeping dental hygienists from expanding their scope of practice

or practicing more independently, since the great majority of dentists are men and hygienists are mostly women. A dental educator in State B said the newly enacted program that will allow dentists to provide clinical training to prospective hygienists is "a slap in the face of the hygiene profession and to women." There are also differences in practice between dentists and hygienists that deteriorate their working relationship and reduce mutual respect. For example, dentists believe in applying sealants only to healthy teeth, while hygienists in two states said they have been taught that sealing a decayed tooth prevents further decay and still allows a dentist to restore it.

State Fiscal Woes

All of these factors are overlaid by the fact that states are facing budget crises. New state-only initiatives regarding dental health—which many policymakers fail to recognize as an important health concern—are unlikely to be funded. The goal of most state officials is simply preservation of programs, rather than expansion. (In fact, since the beginning of this project eight states have cut back on or eliminated adult dental benefits in Medicaid and four more considered doing so.) Hiring freezes in at least two states we visited (States A and E) mean that open oral health positions cannot be filled. In the case of State E, the hiring freeze has blocked state agency officials from hiring a needed data analyst to complete an evaluation of a case management program, despite CDC funding for the position. (They will attempt to contract with someone for the life of the CDC grant to circumvent the freeze.)

Opportunities for Intervention: Federal and State Policy Issues

- A number of states said they needed funds to make existing programs, such as Medicaid or SCHIP, work better. State funds to maintain oral health program staff are insufficient. State agencies said they needed funds to increase reimbursement rates under Medicaid and SCHIP because revenues are too scarce and, in some cases, rates are so low that increases to a realistic level are simply unaffordable. Another state suggested that funds to provide incentives for dentists who treat disabled and low-income, high-need patients would be helpful. State A's dental association wants a small grant to conduct outreach to dentists to become Medicaid providers. An advocate for special needs kids in State A wants the state to establish a referral hotline that would provide information about which dentists are accepting new Medicaid patients.
- Fluoridation was a topic on many wish lists. Several states said they needed funds to expand fluoridation, specifically to buy equipment for communities to use to fluoridate their water supplies.
- There were a few ideas and requests for assistance to change the current financing or delivery system or experiment with new practice models. The State B dental director wants help establishing a non-entitlement dental care program for adults. Another state wanted seed money to establish or support "model practices" and demonstration programs to improve access. One state requested support for development of a dental HMO that uses evidence-based practices, focuses on prevention and evaluates outcomes.
- Finally, across the board, dental hygienists requested help in working to loosen supervision and expand scope of practice to the extent of their training so they can help improve access to care for low-income people.

III. Dental Education

Barriers: Dental Education

Other than Public Health Service Act provisions and the National Health Service Corps, which both offer limited support for dental professionals, there is **little federal support for dental education**. Federal support ended in the late 1970s in response to concerns about a potential glut of dentists and some reported difficulties by new dentists seeking to establish a practice. Other than general support for public universities with dental schools, **state support is limited** to loan repayment or scholarship plans. Though such programs exist in statute, they may be poorly funded by states and limited in number. For example, there are only five slots in State B. The State E legislature specified population ranges for each of the three loan repayment slots created in 2000; only the slot in the most populous area has been filled.

Eighteen states (soon to be 16 with new schools in two states) have no dental school. States that solve that dilemma through cooperative arrangements such as WICHE have increased opportunities for their students to receive a dental education, but have no guarantees that they will return to their home state. A **shrinking number of dental school applicants** are competing for a shrinking number of dental school slots. Even if a school acknowledges a shortage of dentists and wish to increase the number of graduates, expansions in class size are limited by a **shortage of dental school professors**. Dental schools have trouble recruiting faculty because salaries are much lower than a dentist can make in private practice. Furthermore, some people, such as the dean of a dental school in State C, believe the **lack of diversity in the dental profession** is detrimental to care of the underserved. According to a state official in State E, young dentists view their profession "as a business, not healthcare." Other people raised questions about the lessons students learn in dental school; one state official heard anecdotally from students that their dental school blatantly advised them not to treat Medicaid patients.

Opportunities for Intervention: Dental Education

In states with a dental school. . .

- Non-profit providers need funds to **hire dentists to provide supervision** for dental graduates and dental students who are doing residencies and externships in sites that provide care to underserved patients.
- A related request was for **changing dental education** so that rotations through community clinics are a condition of graduation.
- Several state officials also wanted funds to **promote the dental profession** to high schools students, recruit dentists to the state (particularly to rural and underserved locations) and recruit "a different type of student" into dentistry (particularly nontraditional students, minorities, women and people interested in public service).

In states without a dental school. . .

- States without a dental school have different needs than states with dental schools. For example, State E needs **funds to provide placements** for second and third year dental students. (They don't have the clinic infrastructure to house visiting dental students or the funds to pay someone to supervise them.)
- States without a dental school need help **developing a satellite school** with a neighboring state's dental school.
- These states also want help in **designing incentives to ensure that state residents return** to the state after attending dental school elsewhere.

IV. Research Issues

Barriers: Research Issues

In every state, people expressed the need for more information to help them do their jobs or move the policy process forward. There were two general types of requests: one for more data on the nature and extent of current access problems and the second for research, evaluation or policy analyses on financing or program models to fix access problems. State A's Medicaid director said they "need information to support state efforts to invest in dental services. It is very difficult to generate support for dental services in this state." One legislative staffer said he needed much more information about the exact nature of the access problem, asking, "how much is due to factors specific to low-income people and how much is due to the Medicaid system?"

A number of states want more current and detailed information about the prevalence of oral health problems and unmet need among different populations, not only to spur policy and program development but to develop realistic cost projections of new dental benefits in Medicaid and SCHIP. State A is piecing together small amounts of money from several sources to do a surveillance project on Head Start students, 3rd and 9th graders. The State C SCHIP director wants to know what true need is for dental services among children in the SCHIP program (between 133% and 185% of the FPL) once previous pent-up demand has been satisfied so accurate cost projections can be made. The State B dental director wants to collect and analyze data on what happens to children who need more care than the SCHIP benefits provide (over the $300 therapeutic cap), partly to spur changes in benefit design and partly to better assess the true costs of a comprehensive benefit.

A few states have studied, or wish to study, how much Medicaid spends on emergency care for dental pain and avoidable oral health problems that could be treated by a dentist. A related question was posed about the cost of hospital dental care for disabled patients for care that could be delivered in a dental office if qualified dentists were available. Another fact not available for states or localities is the number of school days missed by children due to oral health problems; this is seen to be key to spurring investment in oral health programs for children. A disability advocate in State B wants information about the impact of untreated dental problems and poor oral health on employability.

The questions on financing and program design either involve how to make the current system work better or ways to experiment with different models. A nagging question involves the need for research documenting the impact of raising reimbursement rates. According to the State A Medicaid staff, "legislative staff in State A believe that reimbursement rate increases are a waste of money because they don't increase dentists' participation." The State C Medicaid agency wants a detailed study to compare Medicaid and SCHIP oral health programs across states with respect to codes, reimbursement rates and administrative processes to help them better manage the program. Their second question involves how much of the capitated rate for dental should be spent on education of clients and their families about good oral health practices.

One person said, "new thinking is needed about how to get dentists to see low-income patients. Should it be a daily rate to see patients one day a week or one day a month?" Another asked, "what works to reach the low-income population who mostly don't get information through reading?" State E was in the midst of evaluating a case management program when the program director left her job and the project was left uncompleted. State A Medicaid would also like to test a prepaid dental plan for Medicaid beneficiaries on a voluntary basis in one county.

Opportunities for Intervention: Research Issues

- In every state, someone asked for state-specific data about unmet oral health needs in specific populations, including surveillance data for children at specific grade levels.
- Advocates, legislators and legislative staff need policy analyses to review data in the context of specific interventions and explore the costs and benefits of each.
- Many states want funds for demonstration or pilot projects to help states show what works to fix system problems and funds to produce objective evaluations to document lessons learned.
- Descriptions of best practices and dissemination of information about successful programs are lacking and very much needed, as well as funds to replicate successful programs once they are identified.
- Sharing information that now exists—such as program evaluations of state programs or national data sets—is important but is not being done. Information to move policy forward has not been made available or is not known to most people working on these issues at the state level.

V. Leadership

Barriers: Leadership

A problem consistently mentioned across states is the low level of education, awareness and interest among legislators about oral health issues. Advocacy groups expressed a need to have legislative champions in each chamber of their legislature. In the states visited, State B is losing both of its champions this year to redistricting, State D is losing one of its two champions to retirement, and State A has no champions on health issues at all, let alone on dental. At least one legislator in State E considers herself a champion of dental health, but with a legislature that meets for only 80 days every two years, she finds it difficult to devote too much energy to one of many pressing issues. In State C, a legislative leader pushed to allow independent practice dental hygienists to bill Medicaid; that leader is now the governor, thwarting the hopes of the dental association to repeal that law. However, there doesn't appear to be a current legislative champion in State C. While advocates see legislative awareness and leadership as crucial, not all legislators agree they need much education. One legislator suggested that broad education efforts shouldn't be more elaborate than bullet-point notes on a single page. Since State E's legislative session is so short, her colleagues rely heavily on the relevant committee's assessment of a bill; therefore, she doesn't think broad education efforts in the legislature need "glossy paper" presentations.

Education about the differences in the economics of dental versus medical practices is clearly needed to lend a rational underpinning to debates about raising Medicaid and SCHIP reimbursement rates. In the absence of more education on these issues, there are common misperceptions among legislators that give rise to sentiments such as "dentists are rich people who don't need more money in reimbursement rates." One State D senator allegedly asked at a hearing: "Did you know dentists make more than physicians?" Education about the importance of oral health, the need among specific populations, and gaps in services are also important.

Another related issue is the need for educating legislative staff about oral health issues. They are the "detail" people who work on bill drafting, cost estimates, program analysis, committee hearings, and executive branch oversight. Staff are particularly important in the 11 states where term limits have taken effect (there are 6 more where they have been enacted but not implemented yet), and other states with high political turnover because they supply the institutional memory lacking in the new crop of legislators. The level of awareness and knowledge in the legislative staff interviewed for this project was spotty.

In addition to leadership in the legislature, a number of people said it is important to have a full-time dental director in each state department to provide leadership on oral health issues. In California, Maryland, Nevada, Rhode Island, West Virginia and Wyoming, there is a part-time dental director. In 41 states there is a full-time dental director. Currently, Washington, Oregon and Michigan have vacant dental director positions. The dental director is generally the advocate within state government, sometimes in conjunction with a dental analyst or director within the Medicaid agency, for funding for oral health programs. They make budget requests and other recommendations to health commissioners and Medicaid directors, who in turn make recommendations to health and human service secretaries and to governors.

Many public officials and dental professionals remarked that consumers and policymakers do not understand that oral health is a part of overall health. As a result, oral health seems to be a low priority for some state health agency officials. Without consistent strong leadership within health departments and Medicaid agencies it is difficult to get support for oral health programs. Dental directors in States A, B, and D said they did not get support from the health commissioner or governor in asking the legislature for funding for health programs. Strong leadership may have a cost, however. The State B dental director told us that his two predecessors had been fired for being too "activist" and that he had not been consulted by

the Department of Human Services (which runs Medicaid and SCHIP) about the planning or implementation of the dental benefit. Since oral health is a small percentage of overall spending in Medicaid and public health, it doesn't garner much attention in the policymaking or budgeting processes.

Opportunities for Intervention: Leadership

- Throughout the visits, people spoke of the need to develop leaders among legislators. In each state, people said they needed education for legislators and legislative staff to elevate the issue of access to oral health care on the priority list and convince them of the need for investment in oral health programs. There was a particular sense of urgency for this task in states that were losing their leaders to redistricting or retirement. Special attention should be given to members and chairs of health committees since these legislators may have more power to move the debate and influence other members on health issues.
- Some states want funds to hire oral health staff due to state budget shortfalls and hiring freezes.

VI. Advocacy

Barriers: Advocacy

Lack of A Powerful Voice

A consistent theme in states is the lack of effective advocacy for oral health issues in general, and access to dental care for low-income people in particular. The State D legislative staff director for the appropriations committee said "there is no constituency for it. Because of the limited time legislators have during a session to consider specific populations or services, the burden to push an issue is on the advocacy groups."

State E expressed the need for a coalition or a "powerful voice" to speak out on behalf of oral health. State D, while it has a coalition, says "we are flying by the seat of our pants here," and they lack knowledge about how to operate it and funds to staff it. In State E, the maternal and child health director said the state lacks "funds for coalition-building." The State A health commissioner claims "the state needs funds for a staff person to support the coalition." State A has a coalition that grew out of its work with the NGA policy academy, but it lacks broad representation and political clout. State B has no oral health coalition. The maternal and child health coalition in State B does not lobby on oral health although it did work to get dental benefits included in SCHIP. The director of the coalition said, "oral health needs to get on the list of needs and become a priority." State C also lacks a coalition, although advocates did organize for a one-time push to add dental coverage to SCHIP.

Advocacy groups clearly need more and better information to be successful. An advocate in State A said, "there is no objective material available that we can use for advocacy on dental and we have no time to develop it." In States A and D, advocates pointed to campaigns on issues that were coordinated by a national office that could supply materials and data to state groups that can be tailored to their needs. They said there is nothing like it for dental access. A reporter for a local newspaper in State A pointed out that the advocacy groups that lobby for services for children and the elderly are different, and that "between older people and kids, kids rarely win. Children's issues are a low priority compared to senior citizens."

Oral health is also not a priority for advocacy groups in the disability or special needs kids communities. In States A and B, the disability community says that oral health is a "back burner issue" because access to health care can be a life or death issue.

Dental Associations are Not the Best Advocates for Low-Income Programs

In all the states we visited, the only or most visible group lobbying the state legislature is the state dental association. Organized dentistry is extremely powerful at the state level, second in influence perhaps only to physicians, and is seen as the main group that determines policy outcomes on oral health programs. In State A, a senior legislative staffer stated, without any awareness that her statement was controversial, that "my chairman won't support anything the dental association opposes." Dental associations are poor advocates for access to dental services for Medicaid and SCHIP beneficiaries because they are perceived as self-serving in seeking increased reimbursement rates. They are sometimes perceived as providing false leadership or "lip service" to access issues for low-income people.

Hygienists are Relatively Politically Inactive

On the contrary, according to the state officials we visited, dental hygiene associations are not powerful. Hygienists are less likely than dentists to belong to and be active in their state associations. This lessens the funding available for lobbying on their issues and lessens their clout. Their solutions to problems are not brought before the legislature as often, considered as carefully, and given the same weight as those brought by the dentists. Besides dental associations and dental hygienist associations, community health centers

were mentioned as meeting with legislatures occasionally on oral health issues, primarily to request funding for services.

Decisions are Made Out of the Public Eye

An important issue related to advocacy is that many decisions affecting oral health programs are made in isolation; there seems to be no consensus-building function within the states we visited. Information about the problem at hand (potential budget cuts, workforce shortages, etc.) is not shared, and decisions about how to solve them are made with no broad discussion involving different sectors of the policy community. For example, State D recently cut its dental benefits in SCHIP because of state budget shortfalls. Although there were unspent federal SCHIP funds, the state did not have the funds needed to match them. The decision to cut dental benefits, rather than cut other benefits or reduce costs in some other way, was made by the SCHIP director without consulting the legislature, dental association or advocacy groups. Similarly, legislative leaders made the decision to cut adult dental benefits in Medicaid in State D without consulting the health committee, the health department or advocacy groups.

The relative weakness of advocacy groups allows these important decisions to be kept out of the public eye. They seem ineffective at "spreading the word" to their members and the general public about a pending decision so they can attempt to influence it.

Opportunities for Intervention: Advocacy

- Advocates universally claimed they needed information and objective data on oral health problems in their state and an evaluation of policies tried by other states. Other people echoed the need for assistance in translating data and information into a form that motivates people to act.
- Advocacy groups also said they need financial support.
- Another theme was the need for support to develop coalitions, staff them and help them be effective in reaching their goals. A closer working relationship between the legislature, executive branch agencies, program level administrators, providers and advocacy groups can ensure an exchange of information and a discussion about the potential impact of a pending policy change, even if consensus is not possible.

VII. Public Education

Barriers: Public Education

The need for **educating the public** about the importance of oral health and its relationship to overall health was mentioned frequently by a wide variety of people. An advocate in State B said "lack of access to oral health services is not considered a health care crisis." Low-income people and immigrants in particular were singled out as in need of education because they don't practice preventive measures sufficiently and only seem to come in for care when they experience pain. Some low-income immigrants and certain cultural groups also feel that losing teeth is a normal part of aging. A legislative staffer to the appropriations committee in State D said, "lack of demand for oral health services is a barrier. If more people wanted the services, they would be willing to pay more taxes to make sure they get them." Older people with dentures don't realize they still need care and screening for oral cancer. The lack of education and awareness about what constitutes quality oral health care is pervasive.

Compounding this issue is a host of barriers to **enlisting the media** in the effort to educate the public. Electronic media rarely cover issues in oral health policy because they are too long and complicated to explain in the short segments reserved for news stories and aren't considered interesting enough for longer features. Print media reporters said that health policy issues in general are considered by editors to bore readers. Reporters interviewed said they can only write about health policy issues if they get a local angle to the story, such as a local clinic adding or losing a dental component, or if they can cover them as part of a story about state or local government. Occasionally, reports issued by national groups can be covered if they shed light on the state's performance on an issue or problem. A reporter in State D said he needs help finding "success stories and personal examples" in order to provide a local hook and make the story newsworthy or appropriate for a feature story. A State A reporter said "I need more national reports with state-by-state data so I can run state-specific articles; local information would also be helpful." With regards to educating the public about the importance of oral health care and the number of low-income people who can't get care, one reporter said, "unmet need is not newsworthy."

Opportunities for Intervention: Public Education

- People from all sides of this issue requested financial and operational support to **educate the general public** about the importance of oral health, particularly about disease prevention, fluoridation and the links between poor oral health and low birthweight babies, pre-term births, and cardiovascular disease. One coalition executive called for "a big public relations and awareness campaign similar to *Watch Your Mouth* targeted to legislators and the public."
- The State A disability community suggested that families needed education about what constitutes **quality oral health care.**
- Other suggestions or requests were to **educate specific patient groups** seen as key to improving access to oral health care or patient behavior. A foundation in State C feels that the group most important to educate are **parents and grandparents** of low-income children. State E requested help in providing oral health information to **low-income mothers** through their home-visiting program. State officials also called for support to educate **the Medicaid population** about how and when to seek care and how to prevent oral health problems.
- Finally, there were a number of requests to support **education for health care reporters**, primarily print media. Both reporters interviewed said they needed help building their knowledge base about oral health and the programs that are used to solve problems. Invitations to conferences on health policy issues were suggested as a good method to provide education. Reporters can't accept gifts, but waiving registration fees for conferences was one suggestion as a way to promote attendance.

VIII. What Didn't Surface on Wish Lists

Long on Barriers, Short on Solutions

One of the interesting things about the many interviews conducted as part of this study is the lack of a one-to-one relationship between barriers identified and requests for assistance or ideas for foundation investment. Frequently, people identified barriers but requested assistance to do something other than address those barriers. This may be because it is always easier to identify problems than to solve them. Also, some people interviewed had no idea how foundations work in terms of funding constraints or grantmaking goals; they had few or inappropriate ideas about how foundation support might help (for example, suggesting foundation funds could be used to pay for services or increased reimbursement rates). Other interviewees were simply giving "wish lists" without regard to a foundation's potential role or the financial or political barriers in achieving the change. However, it is very clear that most people are very rooted in the present. They acknowledge the power of the state and national dental associations and the current structure of dental care financing and service delivery in this country and have trouble looking beyond these institutions.

Some Important Omissions

Given the fact that people assume the status quo will prevail, it is not surprising that almost no one suggested foundation support to increase the supply of dentists even though many people feel there is a shortage in their states. Also, only one person suggested trying to develop a new mid-level practitioner such as nurse practitioner or physician's assistant which could extend the capacity of the existing dental workforce and help improve access in rural areas. This may be because of the difficulty dental hygienists have in expanding their scope of practice and loosening supervision; if an established profession has made no inroads, how could another a new type of professional hope to deliver any of the services dentists now provide? It was interesting that no one suggested researching and writing a report about or working to reduce the wide variations in scope of practice and supervision requirements for dental hygienists and dental assistants. For that matter, although the ban on the corporate practice of dentistry was mentioned as a barrier in several states, no one suggested doing a study on how many states have such a ban, what the impact has been and how states have fared without it. Another request notable by its absence is support for advocacy efforts surrounding water fluoridation. Many people asked for funds to provide equipment for fluoridation, but none for information or advocacy, although it could help make difference in these local decisions. No one requested a paper or other education effort explaining the differences between dental and medical practice, or "dental economics," to policymakers but it is clearly needed. Most people don't know or appreciate why dentists refuse to see patients for whom reimbursements are below cost. No one suggested education on oral health for governors or their health policy staffs to increase their support and involvement. Finally, no one suggested leadership development among dentists or dental associations even though many leaders on low-income access issues in states come from that community.

IX. Conclusion

Three Components for Policy Change

A well-known book, John Kingdon's Agendas, Alternatives and Public Policy, puts forward a simple framework for analyzing the components needed for policy change. He says that three things have to be present in order to move an issue forward. First, there must be a commonly accepted definition of the problem. Second, there must be a workable policy solution to the problem as it is defined. Third, there must be political support for the solution among all the relevant parties required to enact it. These three things must occur together in proportion to one another for policy change to take place. A huge problem coupled with a small solution without political support from all important actors will not work. A well-defined problem with an unpalatable solution will not get the political support to work. There are many examples of this framework from the site visits that explain why the states visited have not moved forward forcefully to solve problems and point to interventions that might break the logjams.

Defining the Problem

In the states NCSL visited, there was not a commonly accepted definition of the problem causing access difficulties. In particular, there is strong disagreement about whether there is a shortage of dentists or just a maldistribution and too few who are willing to see publicly insured patients and people with disabilities. There is also disagreement about how to define problems of access within Medicaid. Is it a problem of poor oral hygiene, cultural beliefs and compliance among patients? Do patients not want dental care? Is it a problem of low participation in Medicaid among dentists due to reimbursement rates and administrative hassles? Or are dental practices already at capacity and therefore acting as any business should to optimize profits by not substituting low paying patients for those who pay cash in full? Assuming that access problems are multi-dimensional and complex, there is little consensus among people working from different perspectives in states about which specific policies need to be changed—let alone what those changes should look like. The process of defining the problem is not simply one of obtaining information to answer a question, but of perception and momentum behind an issue generated by people working on it from all sectors.

Data that might be used to arrive at a common definition of the problem is either not available at all, not shared for political reasons or not understood by people who are in a position to make decisions. State agencies that might have useful data don't have the funds or staff to retrieve it or have not been asked for it. Dental associations view some data and information as proprietary and potentially harmful to their interests. In State B, the dental association is willing to support some new slots "if valid scientific evidence showed a shortage" but this evidence is unlikely to be available to a state agency, the legislature, or advocacy groups without dental association cooperation in obtaining it. One state dental director said he would have to file a Freedom of Information Request in his own state to get SCHIP utilization data, although he has Medicaid data and both programs are in his department. In State A, the state board of dental examiners claimed they didn't have personnel with the time or skill to retrieve information on the age of the dental care workforce from individual dental licenses, but they said the dental association had the information. The dental association said they don't have it but the health department does. The health department says they don't have it either. Therefore, the governor and legislature do not know that a large percentage of the dental workforce may retire in the next decade, without sufficient numbers of new dentists being trained to replace them.

The media—who often generate interest in an issue, broaden awareness of a problem and help shape the definition of the problem in its coverage—are largely silent on access to oral health care. For the most part, the public isn't hearing about these issues on television, radio or in newspapers and pressing policy makers for action. Television covers shorter stories and local print media rarely cover health policy issues, particu-

larly issues without a local angle. Political leaders aren't convening hearings or public forums to discuss access to oral health care because these problems aren't "on the radar screen."

In order the move the policy process forward, RWJF support could:

- Fund **consensus-building** activities in states such as oral health policy academies, task forces and commissions and provide ongoing technical assistance to ensure lasting results.
- Be used to **educate the media** and work with editorial boards on oral health issues.
- Help **educate both the general public and high-risk groups** such as immigrants, Medicaid and SCHIP recipients and low-income mothers and grandparents about prevention, the importance of oral health to overall well-being, and how to use services.

Formulating a Policy Solution

In the states we visited, there was no agreement about workable policy solutions, putting aside the lack of consensus about how to define the problem. For example, if a state has decided that its access problems are due to workforce shortages, there are a variety of potential policy solutions. One obvious solution might be to expand the number of dentists being trained in the state's dental schools, or, for states without a dental school, to buy slots in a neighboring state's school or establish a residency program to bring third-year students or graduates to the state. With the exception of State E's dental association, every state dental association we visited had already opposed that solution in recent years, saying the state had an adequate number of dentists and an increased supply would threaten the practices of currently licensed dentists. And, in an exercise of dental association power, a satellite residency program in State B that was passed and funded by the legislature over dentist opposition died in implementation. As a professor at the dental school said "we attempted to establish dental residences but the local dental societies ran us off."

Even if there is general agreement about expanding the workforce through dental education, a host of additional problems arise. How should the state address: a shrinking number of applicants for dental schools? Lack of diversity and a public service orientation among prospective dental students? Reduced state funding available for dental schools? The dental faculty shortage? A shortage of classrooms and dental chairs for teaching? In State E, there aren't enough state funds to establish residency slots for third-year dental students, although most people agree there is a shortage of dentists. In State C, the dental school feels that dentists' income of more than $160,000 a year attracts a certain kind of student (one who is interested in high earnings) and leads to dental faculty shortages. Nationwide, there are more than 300 dental faculty vacancies, 70% in clinical training.

Another potential solution for the problem of workforce shortages is enlisting other providers to deliver services. Dental hygienists have been working consistently in states to expand their scope of practice and loosen supervision requirements but have met with opposition from the dental association, which argues that hygienists' training cannot address the restorative care needs of low-income patients. Of the states visited, only in State C can hygienists practice independently and bill Medicaid directly. In State A, which has very tight supervision requirements, a state oral health council was asked to consider independent practice for hygienists and they said "over my dead body because…dental practices will go bankrupt." Objective analysts might look at the situation and see that dentists and hygienists each have training to improve access in two different but equally important ways, through restorative care and prevention, respectively. However, crafting a policy that reflects this has proven to be too tough to do in almost all states.

Another potential new source of care is pediatricians, pediatric nurse practitioners and other medical personnel who can be taught to screen for dental caries, apply topical fluoride, educate patients and parents about proper oral hygiene and make referrals to dentists for restorative care. In most states, dental practice acts define some of these services as the illegal practice of dentistry if performed by anyone other than a dentist licensed to practice in that state, punishable by fines and revocations of license. Potential

changes in the dental practice act are fraught with heated discussions about endangering the quality of care for patients. The dean of a dental school in State C has begun training ear, nose, and throat clinicians in the basics of oral health and wants to expand to other medical professionals, and in State B, a hygiene professor—quietly, to avoid being blocked by the dental association—is considering a similar effort

Each of these potential methods for expanding the workforce has been attempted in a site visit state. However, because of the dearth of data collection and evaluation resources, the innovative state and others considering modeling the policy are left with two unanswerable questions: Did the policy work?, and Why or why not? Consequently, though facing similar problems and considering similar solutions, each state is needlessly working in a policy vacuum. In order the move the policy process forward, RWJF support could:

- Fund policy analyses, program evaluations, cost-benefit analyses, reports of best practices and surveys to gather policy relevant state and local data;
- Fund some policy work that would explore alternative practice and service delivery models, new proproviders, and "out of the box" thinking;
- Support a dissemination effort targeted at people in every part of the policy process is needed.

The Politics

Finally, in the states we visited, there was not broad political support for policy change in oral health. There are few groups working on oral health issues, and they do not speak with one voice. State dental associations are among the two or three most powerful groups in state politics and are generally the only people speaking with legislators and staff about oral health issues. There were overt statements made by people interviewed about their strong influence in state policy matters; in most states at most times, dental associations can stop any initiative they oppose. Organized dentistry is not seen as effective in lobbying for increased reimbursement rates because they appear self-serving rather than interested in access for low-income people. However, in the states we visited, dental associations had not been active in seeking many other remedies for access problems. Hygienists aren't terribly active politically and have a difficult time pursuing their agenda with state legislatures to the extent that it conflicts with the dentists. Community health centers lobby but for many health issues, not just dental care.

Most state-based health advocacy groups are not active on oral health issues, and if they work on it at all, it's a low priority. The natural allies among advocacy groups are maternal and child health, disability, and poverty and welfare groups, but none work on oral health in any sustained fashion. Also, the leaders among state executive branch agencies do not place oral health high on the priority list. Health commissioners and Medicaid directors have many important issues on their plates, and dental directors do not generally have the clout to raise the profile of their issues any higher. This reflects the generally lower priority that the public places on oral health compared to physical health.

Finally, there are few champions for oral health in legislatures. Most legislators are not educated about these issues and many states don't have any that are committed and willing to push policy initiatives forward. Some states with knowledgeable committed legislators are losing them to redistricting or term limits with no one to fill the void. Legislative staffs also need education. Health and appropriations committees cover a broad range of issues during hearings and access to Medicaid or oral health may receive only a few minutes. In states with a history of low taxes and an emphasis on personal responsibility rather than government assistance, it can take extraordinary intervention, such as a lawsuit filed against the state, to spur policy action.

In order the move the policy process forward, RWJF support could:

- Be extremely useful in supporting coalition building and advocacy efforts, both outside of government and including government;
- Assist in educating legislators and legislative staff, and developing legislative leadership on oral health issues.

Appendix I. Methodology

There were three sets of activities involved in this study: data gathering and analysis; conducting a meeting of national experts and a focus group of state officials and advocates; site visits to five states.

NCSL gathered and analyzed a wide variety of reports, peer reviewed articles and other information about state dental programs in Medicaid and SCHIP, and oral health improvement efforts in general. Prior to the beginning of this contract, NCSL filed a Freedom of Information Request with the Centers for Medicare and Medicaid Services to obtain copies of reports filed with CMS by states about access to dental services for children. NCSL also collected dozens of reports produced in the last five years by state departments, commissions, coalitions and task forces about oral health. These included materials submitted to NGA by states applying for the oral health policy academies. NCSL prepared summary sheets with two pages of data about each state program. The goal was to collect in one place basic information about dental education, hygiene education, the dental and hygiene workforce, children's services in Medicaid, reimbursement rates and administrative simplifications in Medicaid, regulatory issues and state program leadership and interventions.

In order to select states for site visits, NCSL reviewed state documents, collected data and compiled two page summary sheets on each state. The goal was to identify states that are not considered the front runners in oral health programming, nor are they considered the least active and promising as sites for investment of RWJF resources. The five states with the highest reimbursement rates and three more that are considered "best practices" states with respect to the priority placed on oral health and the development of their programming were eliminated from consideration. NCSL then identified 11 states that fit the "middle" criteria and presented details on seven that represented a range of states geographically and politically. Two states were eliminated from this list for being too advanced. This yielded five states selected for site visits.

Visits were arranged for 2 ½ days of interviews with as many people as possible who could offer important information about policy barriers and opportunities for intervention. The goal was to include key legislators and legislative staff that chair or staff health committees or health appropriations, or who are leaders on oral health issues; maternal and child health, disability and/or oral health advocates; the state dental board; the state dental association; the state hygiene association; local or state executives from foundations that support oral health programs; community health center or dental clinic representatives; SCHIP and Medicaid directors and dental officers; the state dental director from the health department; and faculty from dental and hygiene schools. It wasn't possible to meet with every representative in each state given time restrictions and scheduling conflicts.

National Conference
of State Legislatures

The Forum for America's Ideas

October 2002

Tab 47

PROPOSAL SUBMISSION TO
THE WASHINGTON STATE GOVERNOR'S BLUE RIBBON COMMISSION FOR AFFORDABLE HEALTH CARE 2006

Problem Statement:

Our health care system does not provide accessible, affordable, quality health care to all Washingtonians.

Goals:

- All Washingtonians will have access to health coverage that provides effective care by 2012, with all children having such coverage by 2010.
- Washington will be one of the top ten healthiest states in the nation.
- Population health indicators will be consistent across race, gender, and income levels throughout the state.
- Increased use of evidence-based care brings better health outcomes and satisfaction to consumers.
- The rate of increase in total health care spending will be no more than the growth in personal income.

Definitions:
MEDICAL HOME
A medical home is where provision and coordination of a patient's health care is centered and is based upon the mutual commitment to a "doctor-patient" relationship.

EVIDENCE-BASED MEDICINE (EBM)
Evidence-based medicine is a classification system of medical care that ranks diagnostic and treatment recommendations through rigorous analysis of randomized controlled trials with statistical validation and controls for bias.

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1. PROPOSAL

Emphasis upon building trust for access, quality, and value in health care can best be achieved by preserving the interpersonal relationship recognized in the traditional doctor-patient relationship. Technological developments and reimbursement mechanisms have caused an erosion, if not the destruction, of a single base of operation for medical care in what can now be labeled a **Medical Home**. http://www.futurefamilymed.org/x26843.html

This Medical Home is no longer common with typical medical care today and its absence creates a residual of fragmented, duplicative care that is sometimes ineffective or harmful. In addition, the increasing significance of chronic illness underscores the value of longitudinal care over long periods of life illness.

Patients who have a regular family physician, internist, or pediatrician may have achieved a reliable medical home relationship with a provider. These providers could also include physician extenders, such as nurse practitioners and physician assistants. Where such care is

established, there exists a base of operation where complex medical care can be anchored, coordinated, expedited, and executed.

Any medical home can be adapted to introduce flexible electronic systems that employ the use of **Registry Systems** http://content.healthaffairs.org/cgi/reprint/20/6/64 which compel the implementation of evidence-based guidelines while the patient is being seen and treated. Registries do not require the presence of electronic health records. The presence of such registries will guarantee both the flexible employment of evolving standards of care and the tracking of performance accountability.

Washington State, through the Department of Health, has already invested in the development of the CDEMS (Chronic Disease Electronic Management System) http://www.cdems.com/ that is made available for free to Washington practitioners. Practitioners who do not have an electronic health records system have used CDEMS. In addition, a series of educational support for introduction and maintenance classes have already been prepared for the user.

The synthesis of all the transformational care components involving chronic care management, integrated care, community treatment, electronic health records, registries, and point of service web-based information has been packaged by the American Academy of Family Physicians (AAFP) as the **New Model of Family Practice** http://annfammed.org/content/vol2/suppl_1/index.shtml, http://www.futurefamilymed.org/x26823.html It was initiated in 2005 in Washington State and New Jersey as the Practice Enhancement Project (PEP), http://www.futurefamilymed.org/x28894.html with a pilot project for our state of ten medical practices.

The **Integrated Care** concept that consolidates mental health, substance abuse, and medical treatment at the clinical level, resurrects the failed holistic effort that became sidetracked and synonymous with alternative care interventions. The need for Integrative Care has been further highlighted by silos of funding streams that have perpetuated wasteful churning of reactive care in individual patients who suffer multiple categories of illness simultaneously. While Washington State has wisely initiated a pilot project to integrate care in Snohomish County, http://www.nsrsn.org/WMIP/Download/WMIP_White_Paper_Update_061404a.pdf#search=%22WMIP%22 that focus has been directed to integrating funding and employing nurse consultant case coordination. The Medical Home is the natural locus to coordinate necessary integrative care at the actual point of service by a provider who is committed to integrated multidisciplinary care.

The information technology component of the New Model includes **electronic health records** (EHR) that enhance an integrative approach to care. Medication monitoring and drug interaction checks to improve patient safety should be a functional feature of the software employed. Currently there is anticipation for the Avista software based on the VA Hospital system. Hillary Clinton and Newt Gingrich recommended its release as free software about a year ago. http://www.ihealthbeat.org/index.cfm?action=dspItem&itemid=115801

The Certification Commission for Healthcare Information Technology (CCHIT), as of July 2006, has certified 18 products. http://www.healthcareitnews.com/story.cms?id=5244. This certification, sanctioned by the HHS and Secretary Michael Leavitt, guarantees functionality, interoperability, and security and should be a factor in any state recommendation. Furthermore, the need for interoperability extends nationally and recommendations must be coordinated with national guidelines.

Implementation of Web-based **electronic information in the examination room** during the patient encounter will permit access to such valuable information as evidence-based guidelines, health plan formularies, and patient education material.

Evidence Based Medicine (EBM) has been highly exalted and praised in commission testimony for its cost saving potential, but its limitations need to be recognized. Medical Evidence systems find little in current standard of care that passes the rigor of EBM scrutiny. The basis for medical malpractice litigation is currently breach of standard of care, with no respect given for evidence based standards. The best example is the USPHTF (U.S. Preventative Health Task Force) that does not regard any treatment for cancer of the prostate as being effective. Without a statutory acceptance of an evidence-based standard as an alternative to current standard of care, any savings achieved by its adoption will be overshadowed by litigation costs. A transformed system for future health care must anticipate a **statutory change in tort law** to accept EBM as an acceptable standard of care.

Innovative detail within the New Model of care includes increased utilization of "group visits" involving more than just a traditional provider. One-on-one encounters between provider and patient will be gradually replaced by more interdisciplinary group visits employing **interactive group learning encounters.**

The above fundamental changes to the delivery system infrastructure for health care need to be supplemented with paradigm changes in the superstructure of health care financing. Currently, the highest prices are charged to the uninsured, which are charged the sticker price for services rendered. There is currently a lack of **price transparency** that would permit any meaningful price shopping by the consumer. Other states, such as Wisconsin, http://www.wipricepoint.org/ have implemented excellent web accessed hospital price disclosure. This was accomplished by the hospital association without mandatory legislation, as was required in California. If necessary, the state legislature could mandate hospital and outpatient care price transparency along with a requirement for **lowest pricing for the uninsured.** Medicare has initiated the posting of specific hospital Medicare payments to permit comparison shopping.
http://www.cms.hhs.gov/HealthCareConInit/01_Overview.asp#TopOfPage.

Well-intended mandates for inclusion into health insurance policies have increased the price http://www.ncpa.org/ba/ba237.html of individual policies http://www.rwjf.org/publications/synthesis/reports_and_briefs/pdf/no4_synthesisreport.pdf#search=%22New%20York%20%22standard%20plan%22%20individual%20health%20insurance%22 without regard to impact upon premiums. Each mandate has a purpose, but also a corresponding price. If the state Basic Health Plan is the only available individual policy

unencumbered by mandates, then **affordable intermediate plans** can be offered, and with full disclosure of mandated limitations. The OIC can be charged to evaluate plans and rates and then establish tiers of less than full mandated coverage for the affordable consumer plan choices.

Medicaid has experimented with managed care plans that almost always have the feature of designating a primary care physician. While some success of these plans has been attributed to the management component, they happen to feature the assignment of a semi-willing Medical Home. **Assigning a designated primary care provider** to Medicaid recipients can immediately place this program on a Medical Home platform.

The spectrum of the 9.8% uninsured population in Washington http://www.ofm.wa.gov/researchbriefs/brief031.pdf is dynamic but not necessarily based on poverty, since over 50% exceed 300% of the Federal Poverty Level. Some are uninsured by choice. A noticeable proportion is the young adult (college age) who finds little value in health insurance and has higher priorities for spending. There is always a segment that is eligible for Medicaid but chooses not to apply. One example in the Northwest is the fisherman who works in Alaska bringing home over $100,000 annually, but finding the premium price for health insurance to be excessive. Likewise those recently unemployed find the price of COBRA insurance to be excessive.

Most of those that are uninsured by choice regard the current premium rates to be unaffordable. This would be remedied by the availability of lower priced health insurance. For the young adult population, premiums could be cut in half if normal pregnancy, labor, and delivery were funded by an alternate mechanism. A strategy to reduce the uninsured would be to identify subsets and target the needs of each group. One proposed solution in the legislature last year was to cover young adults under parents' policies to a later age. This might eliminate a segment of the uninsured without disturbing the risk pool. Another idea - health-equity insurance - could be used to pay premiums during periods between employments, thus reducing another subset of the uninsured. Other identified groups, such as those released from prison, and might be specifically addressed as they are revealed in a detailed **analysis of the uninsured**.

The uninsured may be served with fortified charitable forms of free care. This would serve as a safety net when public and private insurance fails. Public policy and indirect support can insure the success of these programs. The current dilemma with the Medicare ruling that non-citizens are ineligible for coverage is a non-issue to the charitable free care clinics. A comprehensive transformation of the health care system for Washington State should support the momentum and beginnings of **charitable health care.** (ie., RotaCare http://www.rwjf.org/publications/synthesis/reports_and_briefs/pdf/no4_synthesisreport.pdf#search=%22New%20York%20%22standard%20plan%22%20individual%20health%20insurance%22 and Project Access http://www1.leg.wa.gov/documents/joint/HCCA/ProjectAccess_7-27.pdf#search=%22Project%20Access%22).

A specific beneficial partnership would be utilizing and defining a state emergency medication stockpile by its usage at free clinics, rather than to discard expired medications. Likewise free standing - free clinics could be designated in partnership to be first response disaster shelters or coordinators. Charitable care within existing practices may be instantly affected if a **tax credit mechanism for documented free care** is established.

Finally, it is extremely unlikely that the medical care system will ever be able to fully meet the healthcare needs of Washington's population unless the demand for healthcare services is reduced. This can be accomplished by creating a healthier population through community-based, primary prevention initiatives that are well funded and evidence-based. An example has been the statewide Tobacco Control and Prevention Program funded by the National Tobacco Settlement funds that started in 1999 and has successfully lowered tobacco use in our state and others with similar initiatives. Other initiatives directed at increasing physical activity, improving nutrition, and reducing obesity could have a major impact on the need for chronic disease healthcare.

2. GOALS

The implementation of the expectation of a Medical Home, along with registry-based care, is designed to achieve the three goals of improving health. Where Washington State may be lagging other states, or where population disparities are noted, the registry focus can be immediately adjusted to insure prompt intervention and results.

Improvement in access to health coverage to every Washingtonian must openly recognize the need to care for those state residents who are not United States citizens in order for that goal to be achieved. Currently there has been a surge of openings of "Free Clinics" of various sorts, including Rotacare, faith-based, and Project Access. Previous testimony to the Commission has indicated a high return on investment (ROI) of $9.75 for every dollar invested. In addition Community Connect has witnessed the power of charitable donation when the need exists. Physicians are likely to donate their efforts to a charitable need, but unlikely to donate time to the government. The RotaCare free clinics sponsored by Rotary would cease to receive donations if the funds were channeled to assisting government programs.

Access goals for health care (not insurance) would be met by creating an absolute safety net based on charity that has no expectations of citizenship. Existing efforts for free clinics can be enhanced by logistical and regulatory support by the government.

The increased rate of health care spending may be curtailed by replacing fragmented care with coordinated medical care anchored in a Medical Home. An additional opportunity to curtail cost escalation is curtaining the health care dollars spent on insurance overhead costs, or that portion which is not for health care itself.

While the insurance industry may pride itself in containing the rise of internal paperwork, there has been no curtailment of the indirect paperwork burden on medical providers who have witnessed a doubling of staff per provider required in the last ten years. By fiat, the state government may cap the percentage of the health insurance premium dollar that is consumed by direct insurance company cost and indirect obligatory costs imposed on providers.

3. MODELS

While the concept of a Medical Home was once exemplified by a small town general practitioner who delivered all the babies, cared for the children, young adults and the aged, this

concept has been lost in the modern world. The American Academy of Family Physicians (AAFP) has looked ahead to the future to design a New Model that is centered on the Medical Home. Washington State and New Jersey are the two first states to begin implementing this in 2004.

Within Washington State the Group Health organization has recognized the need to emphasize the Medical Home and has started a pilot project at their Factoria facility. This needs to be noted, since Group Health has long offered a strong primary care program with a named provider. The organization offers multidisciplinary care as well, but the substance of the Medical Home, where the coordination of responsibilities is needed, will now be included by definition. This highlights the need for substantive coordinated care over time, customized to the individual patient who is attached to his or her Medical Home.

The AAFP has assisted one of the Fortune 500 companies to design a new health care system for their employees to be centered on the Medical Home. http://www.aafp.org/online/en/home/publications/news/news-now/professional-issues/20060815aafpibm.html. This company understands the return on investment by defragmenting their employee health care benefits.

A model for the value of registries is the Diabetes Collaborative, which in Washington State, developed the Microsoft Access based registry program called CDEMS (Chronic Disease Electronic Management System). This system is made available for free, and can be utilized by a medical practice that has Microsoft Office Pro and does not require ownership of an electronic health records (EHR). The setup of CDEMS is such that it can be applied to any chronic disease.

4. IMPOSED COSTS

While there are costs for transforming health care to emphasize the Medical Home, some of the ongoing cost of continuing medical education itself can be conformed to the features contained in the more comprehensive New Model. For board certified family physicians, this is already taking place in the restructured cycle of board recertification examinations every seven years and in the adoption of annual Maintenance of Certifications. Other specialties are likewise adopting maintenance of certifications as well.

The current licensure requirements amounts to approximately two weeks worth of required continuing education, which in itself can be structured to incorporate transformation of the delivery of health care.

The Washington State Department of Health has an established training program to educate users of the CDEMS registry for chronic diseases. This has been developed in a general form to enable application to different chronic diseases. It has the flexibility to apply, adjust, and modify guidelines for standards of care. A $2 million budget allocation by the state to target registry development and application of chronic disease registries should be rapidly recouped while improving the delivery of care.

The insurance industry already has experience with manifestations of managed care that includes preferred provider panels, or case management, or preauthorization mechanisms. Reconfiguring these components to reimburse for simpler Medical Home concepts should dedicate the industry to reduce their contribution to the entropy of the health care premium dollar.

Interactive group learning may need to be taught with specific skills and techniques designed to coordinate the complexities of advanced integrated health care delivery. Investment in such training and implementation by the health care system, industry and government may be augmented by private grants to promote this form of real-time learning. The concept of navigators or coaches needs to be introduced into the reimbursement and volunteer mechanism, but this is fortunately being explored by HRSA (Medicaid) to address health care disparities. Likewise the integrated health care concept of unifying medical, mental health and substance abuse treatment is augmented with interactive group patient sessions during this form of patient encounter. The integrated health care and navigator concept can converge by implementing the interactive sessions. Funding of this can be from offsets of conventional patient interactions and the anticipated savings generated from efficiencies currently not possible with fractionated, disconnected care.

Much literature is available concerning the cost impact of electronic health records. There is certain data efficiency, clinical efficiency, and safety anticipated, but the implementation direct and indirect costs along with the maintenance expenses generally seems to run higher, not lower, than expected. The privacy liability may also overrun the economic savings unless security can be raised to higher levels. Likewise the liability cost of defaulting to a spartan EBM standard of care may totally engulf any anticipated savings unless EBM is required to be accepted as legally defensible in medical malpractice liability suits. The cost of implementing and maintaining EHR may eventually be offset by the reduction of error liability cost, but that assumes containment of the size of medical liability judgments, which is currently unlimited.

Initial EHR costs are substantial and proposals have been made for the government to bear the cost as they are collectively the largest customer of medical services. Others suggest that the insurance industry has the most to profit from EHR and should bear the expense rather than shifting further claims processing costs on providers.

The cost of structuring a low, affordable price to the uninsured should be minimal if that price were the lowest negotiated rate of a private health plan. In the absence of a single rate for all, that expected price would be below the average private plan rate, but above that of Medicare and Medicaid. Hospitals may see a lower total for uncompensated funds, but this would be equitably, or at least proportionally, applied to all hospitals. The cost for hospitals to display price transparency may help to contain and reverse the widening range of accepted payment for specific services, but the financial data is already there. It just needs to be reconfigured to display it in an open manner. The paradoxical result could be a higher collection rate when after-fact charges are regarded as fair and reasonable, as opposed to unreasonably high and inequitable.

The cost of providing regulatory and indirect support to “free clinics” that do not accept funds from the government would be offset by the diminished burden of urgent, but not emergent care, on the emergency system. Blending the dispensing of free medications with stockpiles of disaster medication would allow normally expired and discarded medications to be utilized on a rotating basis. The same free standing “free clinics” could also be designated and supported as disaster shelter clinics, which are free clinics during a disaster.

The simple measure of allowing **free care to receive a tax-credit** on the B&O taxes would be a mechanism of reimbursement without state funds in hand. While this may create angst with state revenuers, the objective of providing affordable care for all Washingtonians will be one step closer to being met.

5. COLLABORATION

Nationally**, internists** http://www.acponline.org/hpp/statehc06_1.pdf and **pediatricians** http://www.aap.org/advocacy/archives/julymedhome.htm have independently come to the same understanding on the importance of the Medical Home. Together with the American Academy of Family Physicians, they represent the majority of primary care physicians that support longitudinal and comprehensive coordinated health care to the individual.

Of note is the submission to the Blue Ribbon Commission by the **King County Medical Society** that narrows recommendations down to two: 1) Care for all children, and 2) Primary Care. http://www.kcmsociety.org/DocumentFiles/31.pdf. The KCMS proposal, supported by other county medical societies, is significant as it absolutely represents the necessary input from the practicing clinician that is notably underrepresented in much health care planning. The KCMS points out the failure in the past of unbridled enthusiasm for clever, fashionable ideas that have proved deleterious to the delivery of health care. Those concepts included managed care, nurse case management, holistic care, and HIPAA. Many of these ideas still have validity, but the methods of actual implementation have resulted in disappointing results. In a similar manner, the KCMS warns of embracing technological concepts such as electronic health records and information technology, or evidence based medicine, with all the advantages anticipated and none of the pitfalls foreseen.

If major changes in the delivery of health care are to be advocated by this commission, a more concerted effort must be made to query the physicians and physician extenders for an "environmental impact statement." Change is needed and inevitable, but unintended destruction of the medical eco-system and groundwater could be more irreversible as in land development.

While there are physicians who lead large organizations, they are often former practitioners who are now morphed into administrators. Input from actively practicing physicians is much needed but increasingly difficult to obtain due to workloads. Physician associations such as the WSMA and the largest component, the WAFP, are resources for such input and support.

6. OBSTACLES

The obstacle to changes inherent in the New Model with respect to providers is inertia - the resistance to change. Fortunately the need for this type of change is recognized by leaders in many fields, including family practice, internal medicine, and pediatrics, that represent the substantial part of primary care. Training for change may be funded by multiple sources and can be incorporated into existing continuing education programs. The University of Washington School of Medicine should configure its long range planning and curriculum to translate New Model concepts for all the affected primary care specialties.

There may be some anticipated objection to assigning primary care providers to Medicaid patients. Potential errors and mismatches must be considered with provision for adjustment of misassignments. Objection by the primary care providers may only be theoretical, since assignments seem to have worked well with Healthy Options.

Mental health and substance abuse treatment systems have been working at cooperative care for a number of years to address the "dual diagnosis" needs of patients with mental illness and substance abuse problems. They have met resistance, which has gradually been overcome. That momentum can be carried forward to integrate the medical field as well. The state has begun integrating care at the funding level and heralds a change of direction that needs to proceed to comprehensive integration of care.

The funding aspect of health care in recent history has emphasized insurance and pooling of risk to the degree that it paradoxically punishes the individual, such as the young adult or the worker in between jobs who has no affordable price options. If premiums could be reduced for those who are employed, innovative policies could be designed to accumulate days of health insurance to be usable when between jobs.

There is resistance and fear that, unless mandates are preserved, policies sold in this state will provide inadequate coverage. The resulting consequence of having no insurance, because it is unaffordable, is far worse than an insurance policy that fails to pay for full benefits. The argument needs to be communicated for this tradeoff. Full disclosure for absent mandates can be displayed in tiered categories for prudent purchasing.

Hospitals may object to open price disclosure, but hospital associations in other states have successfully posted user-friendly price comparisons. Mandatory legislation to display hospital pricing should not be necessary.

Objection may be raised by state revenue concerns for a tax credit mechanism in the B&O tax, but this apprehension needs to be held in abatement until the success of this innovation can be measured, as it has not been tried elsewhere. It would be a courageous innovative risk that has tremendous untapped potential.

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SUMMARY

Major transformation must occur in order solve the stated problem and to achieve the desired goals. This must extend from the infrastructure of medical care implementation, to the superstructure of medical care funding. This proposal emphasizes the multi-pronged changes in delivery of care presented in the New Model of care that has at its foundation the Medical Home.

With a Medical Home, high-touch interpersonal care is not lost to a high-tech impersonal delivery of care. Included is the recognition of the need to manage chronic illness in a multidisciplinary approach and to shift the reliance upon the one-on-one session to more group interactive learning, augmented by optimal use of electronic technology to minimize error.

Suggested changes to the increasingly failing reimbursement mechanism in this proposal focus upon making available more affordable individual health insurance premiums. Much of the dilemma of poor value results from the extensive list of insurance mandates. Many of these must be sacrificed as a tradeoff to permit bare bones, affordable private insurance.

Furthermore, the uninsured population may be systematically reduced by more detailed analysis and targeted solution for each root cause of their status.

We must not overlook the importance of reducing the community need for healthcare services through implementation of community-based primary prevention and improving the overall population health. Changes in medical systems alone cannot accomplish this.

Finally, it is incredible to note that with all the energy surrounding concern for cost of health care there is precious little good information estimating the average lifetime cost of

medical care to an individual. The fragmented health care we experience today may be just a reflection of the fragmented thinking about health care financing.

The overview of the recommendations in this report is designed to preserve maximum, necessary total system flexibility and sensitivity for response to future changes and adaptations that may be unforeseen. Respect for individual differences and needs, as well as population diversity, is fully appreciated. Any plan that lacks such flexibility may fit existing needs for a fleeting moment, but the absolute certain changes in health care may suddenly render it inappropriate or detrimental.

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Endorsement: Snohomish County Medical Society

Additional Suggested Links

Multistate Health Informanation Technology legislation http://www.ehealthinitiative.org/
State and Regional Free Clinic Associations http://www.rxassist.org/patients/res-free-clinics.cfm
National Association of Free Clinics http://www.freeclinics.us/
Physician Surplus now a shortage http://www.annals.org/cgi/content/full/141/9/705#R12-12
States with Medical Malpractice Caps Increase Physician Supply
http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.250
Immigrants Account for 26% of Uninsured in the US
http://www.californiahealthline.org/index.cfm?Action=dspItem&itemID=112092
64% of Illegal Immigrants Uninsured http://www.cis.org/articles/2004/back1204.html
RotaCare Free Clinics http://www.rotacare.org/about.htm
Neighborhood Free Medical Clinic Lacey http://www.nfreemc.org/
Trinity Free Medical Clinic Tacoma http://www.tpctacoma.org/outreach.htm
Core Safety Net Sites Washingtion http://www.doh.wa.gov/hsqa/ocrh/har/safetynet.xls
Interstate Insurance Options http://cdhc.ncpa.org/commentaries/interstate-competition-in-the-individual-health-insurance-marketplace
Mandates add 20-45%
http://www.cahi.org/cahi_contents/resources/pdf/TrendsEndsDec2005.pdf#search=%22cost%20of%20state%20mandated%20health%20benefits%22
Future of Health Care Spending http://www.ncpa.org/pub/st/st286/
Physician Shortage http://www.ncpa.org/sub/dpd/?page=article&Article_ID=3448
Medicare "Medical Home" http://www.acponline.org/college/pressroom/pilot_test.htm
Aetna Price Disclosure http://www.washingtonpost.com/wp-dyn/content/article/2006/08/21/AR2006082101103_pf.html

Tab 48

Spokane County
MEDICAL SOCIETY

Orange Flag Building • 104 S. Freya St., Suite 114 • Spokane, WA 99202-4868 • (509) 325-5010 • Fax (509) 325-5409

August 31, 2006

Blue Ribbon Commission on Health Care
Office of the Governor
P.O. Box 40002
Olympia, WA 98504-0002

Dear Governor Gregoire:

The Spokane County Medical Society would like to thank you, and the Blue Ribbon Commissioners, for your leadership to improving healthcare access to all Washingtonians. We believe that all people should have access to quality medical care.

An important point for healthcare access are the State Medicaid programs. To help improve physician, and other professional providers participation in Medicaid, we recommend the establishment of a Medicaid Ombudsman program within each community in Washington State. By creating this direct liaison between professional providers and the Medicaid department, satisfaction, efficiency and improved cost effectiveness would be achieved by all parties. The ombudsman system would provide the communication link to assist providers with medical coverage issues, claims processes and problem resolution. The result would increase provider participation as the improved efficiency of the system is demonstrated. The Spokane County Medical Society has established such a process with commercial medical insurance carriers in our area that has proven satisfactory to both organizations. Our Society would welcome the opportunity to serve as a pilot location to begin to implement a state-wide Ombudsman system.

Enclosed is the Blue Ribbon Commission Request for Proposal response for your consideration. We will be pleased to provide the Commission with additional detail should you request it.

Sincerely,

Janet L. Monaco

Janet L. Monaco, M.H.S.
Chief Executive Officer

Cc: Lisa Brown, Washington State Senator, 3rd Legislative District
Brad Benson, Washington State Senator, 6th Legislative District
Timm Ormsby, Washington State Representative, 3rd Legislative District
Alex Wood, Washington State Representative, 3rd Legislative District
John Serben, Washington State Representative, 6th Legislative District
John Ahern, Washington State Representative, 6th Legislative District

Blue Ribbon Commission Proposal
Spokane County Medical Society
August 29, 2006

1. What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access?

This proposal is to establish a Medicaid Ombudsman Program in Washington State. The location of the Ombudsman would be identified based on the need in each community. The Ombudsman, if located within the community, is able to serve as a liaison between the Medicaid program and the physicians in the community.

2. How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the commission? How do you know?

Implementation of a Medicaid Ombudsman program would help increase physician satisfaction and physician participation in the Medicaid program. With the ability to have provider issues, such as eligibility, claims, or care, resolved locally and quickly, confidence in the Medicaid program will increase. In Spokane County, the best location for the Ombudsman is within the Spokane County Medical Society to increase physician interaction. If the Ombudsman is affiliated with a medical society and not the government, they can serve as a bridge between government and the private sector.

3. Is your proposal modeled after an existing policy or program within Washington State or elsewhere? If so, describe the policy or program and its outcomes.

This proposal is modeled after a successful 10 year Buncombe County Medical Society program in Buncombe County, North Carolina. The Department of Social Services Managed Care Representative is housed within the medical society, and is recognized as a significant benefit to physicians and their offices. The Carolina Access ombudsman provides assistance to practices with Medicaid including retropay, access to Medicaid, assisting Buncombe County Project Access with patients who have applied for Medicaid but their status is unknown, and obtaining payment for physicians who have seen Project Access patients who subsequently received Medicaid. The ombudsman program has resulted in an increase in physicians participating in Medicaid and in an increase and consistently high percentage of physicians participating in Carolina Access, the managed care plan that provides a medical home for patients. Furthermore, this program increases plan/physician communication. The medical society has demonstrated a substantial increase in physician participation in other plans by developing close partnerships that lead to notable problem-solving.

4. Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?

Cost for an ombudsman program could be covered by the state with existing personnel. The cost can be paid by the state Medicaid program, utilizing available Federal matching funds. This cost can be offset by increased physician participation, more efficient patient scheduling and treatment, and decreased Medicaid overhead costs due to increased efficiency in problem resolution.

5. How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

A collaboration between the Medicaid program and physicians will lead to better care for Medicaid patients and increased physician satisfaction and willingness to participate. Sponsored by a medical society, it will give physicians additional incentive to actively participate in the program. The Washington State Medicaid program would benefit by having greater physician participation in Medicaid, which would then benefit Medicaid patients with an increased choice of physicians.

Spokane County Medical Society, Communities Connect, the Department of Social and Health services, and the Washington Health Foundation have expressed interest.

6. What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

The largest obstacle to implementing this proposal is funding. Spokane County Medical Society would like to launch a pilot of this program. Through installation at the Spokane County Medical Society, Medicaid materials could be included in the new physician packets that are distributed when new physicians are credentialed. One month after the receipt of the Medicaid packet, the Medicaid Ombudsman would visit the physician at their practice to answer questions. Members of the Spokane County Medical Society have consulted the medical society and Medicaid office in Buncombe County. A pilot project would be built upon their methods, reporting and accountability but adapted for differences in structure in Washington State. The results, lessons and best techniques of this pilot could then be used to replicate and answer possible objections.

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August 25, 2006

RE: Recommendations for the Reform of the Health Care System to the Blue Ribbon Commission

The Spokane Alliance, a countywide organization of 33 diverse religious institutions, education associations, unions, and other interested groups represents over 30,000 Spokane County residents. These member institutions are cornerstones of a vibrant democratic society and hold the key to mending and reweaving the social fabric essential for strong families and healthy communities. Health care access has been one of the principal foci for our organization since its founding in May, 2002. The Alliance recommends the following coverage principles be adopted by the Blue Ribbon Commission.

- Expand the Basic Health Plan and Medicaid to cover all uninsured residents under 300% of FPL by 2010, with coverage for children beginning in 2008.
- Expand the Small Employer Health Insurance Partnership to cover employees up to 300% of FPL by 2010.
- Give larger employers a choice of providing employee health insurance coverage or contributing to the cost of covering employees through state plans.
- Combine the private health insurance market pools for individuals, small business and association health plan coverage, and create a reinsurance market for the combined pool.
- Improve benefit design to include a core group of primary, preventive, emergency, catastrophic, mental health, dental and chronic care services.
- Implement existing legislative action plans to reduce health care disparities based on race and ethnicity.

Based on these principles, we propose the financing and quality, cost control and access elements be adopted by the 2007 legislature:

- The uninsured below 300% of FPL should be required to contribute to the cost of health insurance on a sliding-scale basis at affordable levels. The self-employed above 300% FPL must purchase insurance coverage. The state will ensure quality affordable health plans are available through regulatory oversight or by expanding existing public health plans to accommodate these people.
- Larger employers should have a choice of providing insurance coverage or paying a sliding scale premium tax based on employer size, phased in by 2010.
- Create risk-adjusted, value-based outcomes/results reporting and tracking for all providers and insurers. Establish or use an existing, independent group to collect, monitor and distribute the data.
- Encourage or model innovative benefit design with chronic care/disease management coverage.
- Ensure transparent pricing of health care services.
- Build incentives into all public programs that encourage best practices. Link provider pay increases to commitments to expand access and increase quality.
- Public/private Cost/Quality Oversight Commission, with representatives from government, business, labor and consumers, to implement cost control and quality measures, including recommendations from Certificate of Need (CON) Task Force.

The recommendations come from the work of our Health Team and their collaboration with the Fair Share Health Care Coalition. We encourage the BRC to work closely with them and others as you craft a comprehensive solution to the current crisis in our health care system. We look forward to offering our direct testimony to you regarding our recommendations for reform.

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Tab 50

September 1, 2006

TO: Blue Ribbon Commission on Health Care Costs & Access

FROM: Access Committee, State Board of Health

RE: PROPOSED STRATEGY TO MEET COMMISSION VISION AND GOALS

The following is a proposal to the Blue Ribbon Commission on Health Care Costs & Access from the Access Committee of the Washington State Board of Health (SBOH). The committee comprises Kim Marie Thorburn, MD, MPH, Ed Gray, MD, and The Honorable David Crump, PhD, and it is staffed by Craig McLaughlin, the Board's Executive Director. This proposal has not been reviewed or adopted by the full Board given that it has not met since the Commission issued its request for proposals, but the proposal is consistent with policy directions established by the full Board.

Summary

The Blue Ribbon Commission is interested in providing every Washingtonian with health care access by 2012. But one outstanding question is: Access to what? Governments exist to provide for the health and welfare of the populations they serve, but the state does not have the resources, nor does it necessarily have an obligation, to assure every resident has first- and last-dollar coverage for every medical service she or he desires. At the heart of this proposal, therefore, is a recommendation that Washington State identify a core set of health services to which everyone should have access, and then focus on ways to make it possible for every Washingtonian to obtain those services at an affordable price. This effort can build on the *Menu of Critical Health Services* developed by the State Board of Health and the Public Health Partnership (see attached).

The Board's Access Committee also is interested in providing adequate funding for public health activities and promoting greater utilization of preventive health care—two strategies that will avoid illness and reduce the need for expensive medical care. To further control costs, there should be a single administration for claims and payments, which would have the potential to reduce significantly wasteful administrative costs incurred by providers and insurers. An effort should be made also to consolidate as many covered lives as possible into a single risk pool. An entity should be established that plays the role of consumer in a more functional market. And finally, the system should not rely on maintaining or expanding the employer-based system, an anomalous and anachronistic system that employers are already abandoning (although it should ensure that current business investment in the system not be withdrawn).

Response to Commission Questions

1. What do you propose be done to realize the visions and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs & Access?

There are many ways to structure a health care finance and delivery system that would have many of the characteristics described above. All require a stronger role for government, but they do not necessarily require that government run the health care system (national health system) or become the insurer for everyone (single-payer). The following bullets describe one approach that would provide access to critical services, discourage overinsurance, eliminate "free riders," create market incentives to control costs, support quality initiatives, maintain a niche for private insurers, allow for consumer choice, and keep medical care delivery in the private sector.

- Washington State should establish a quasi-governmental entity—for purposes of this proposal, we will call it the health and wellness services board (HWSB)—whose governance structure includes representatives from health plans, consumers, providers, business and labor, along with state and local officials.
- HWSB should identify a core set of critical health services to which every resident of Washington State should have access. The Board's *Menu of Critical Health Services* could serve as a starting point for this effort.
- This list of core services should distinguish between services that should be financed using an *assurance* model (preventive services for which utilization should be encouraged) and those that call for an *insurance* model (services that are required only for some individuals, but the financial risk and cost of which should be shared across the entire population or a large subset).
- The list of core services should reintegrate the existing "silos" of health by including appropriate services considered to fall within the realms of public health, mental health and dental health, regardless of the delivery model.
- The state, in cooperation with the private sector, should guarantee, as a matter of policy, that every resident of Washington State will be able to obtain these core services, as well as catastrophic coverage, at an affordable price (in other words, services can by obtained for free or at an affordable rate or are covered by an affordable plan) by 2012 and for all children by 2010.
- Delivering on this guarantee would almost certainly require increased funding for many core public health services (see the work of the Joint Select Committee on Public Health Finance and the proposal submitted by the Washington State Association of Local Public Health Officials).
- Delivering on this guarantee would also require subsidization of premiums for low-income families and individuals (below 300 percent of the federal poverty level) not eligible for Medicaid or Medicare and expansion of state programs (see proposal submitted by the Fair Share Coalition for more specific suggestions).
- HWSB should serve as the sole broker of health care plans for the self-employed, part-time workers, employees of businesses under a certain size, employees of larger businesses that do not offer health insurance through their work, and government

employees, and retirees (exclusive of individuals who are eligible for Medicaid, Medicare, or SCHIP). It should also offer to serve as a broker for any other businesses that purchase health care for employees, regardless of size.

- HWSB should treat all individuals acquiring coverage through it as members of the same consolidated risk pool. It should not engage in risk selection or pursue policies or plans that will promote risk stratification.
- HWSB should allow individuals to choose among a state insurance program (i.e., the Basic Health Plan or Uniform Medical Plan) and plans offered by private (commercial or nonprofit) insurers under contract to HWSB. It should also serve as a one-stopping shopping source, capable of enrolling people in Medicaid, Medicare, SCHIP, etc.
- HWSB should also play an assurance function by funding population-based services and direct access to preventive services as warranted, and private insurers should be required to contribute to this effort out of their premiums.
- All private plans offered through HWSB must be open to all members of the consolidated risk pool regardless of preexisting conditions and must, at a minimum, cover all core services. These plans may provide additional coverage beyond the required core services.
- HWSB should require that the insurers with which it contracts:
    - Accept claims submitted through HWSB or another public or quasi-public entity using a standardized electronic form (the Utah Health Information Network provides a possible model).
    - Provide data necessary for quality measures specific to the insurer (such as the time it takes to pay valid claims, delivery of preventive services, quality consistency across racial and ethnic groups, etc).
    - Provide data it possesses that is necessary for tracking quality measures specific to providers that are part of its HMO or provider network.
    - Participate with HWSB in developing and implementing cost control and quality improvement measures targeted to providers (e.g., evidence-based coverage decisions, centers of excellence, pay-for-performance, and transparency in cost and quality).
    - Participate with HWSB as consumers directly involved in quality improvement partnership teams with HMOs, facilities, and provider associations.
- HWSB should identify a “base price,” which shall be the cost of the lowest-priced plan available through HWSB that provides the complete set of core services and meets established quality targets.
- Government subsidies should not be used to pay for anything beyond the base price.
- Premiums paid above the base price, whether by employers or individuals, should be taxed as sales, and premiums should not be deductible as a business expense.
- Business tax policies should seek to capture an established share of the base price for each employee of a business over a certain size that does not purchase insurance on behalf of its employees.
- Employers who wish to provide insurance to their employees may purchase insurance directly, purchase insurance through the HWSB, or deposit money in a pre-tax health savings account or flexible spending account; however, all payments above the base price

should be treated as a salary expense for the business and as income for the employee to the extent allowed by federal law.

- HWSB should be held accountable, using a GMAP-type process, for the state's performance against a set of established performance measures that would ensure its continuing, primary focus on population health and wellness and elimination of health disparities (see, for example, the Washington Health Foundation's Healthiest State in the Nation Campaign measures).
- State law should create a *de facto* mandate that individuals purchase insurance by creating incentives, removing disincentives and establishing "gateways," such as:
    - Requiring proof of health insurance coverage as a pre-condition for issuing or renewing a driver's license.
    - Requiring that all children demonstrate within one year of entering school for the first time that they have insurance and have completed a well-child visit in the last year that includes an immunization status check, an oral health screening, and vision screening to American Academy of Pediatrics standards (this would require additional investments in school nurses, public health nurses, provider access in rural areas, and possibly school-link clinic capabilities).
- The state should subsidize health information technology (interoperable electronic medical record systems) for small practices that agree to meet performance targets (e.g., percent of children receiving well-child visits and immunizations on time) and to participate in cost and quality initiatives such as transparent pricing and the tracking and reporting of risk-adjusted outcome measures. Failure to meet targets or to provide cost and quality data would require repayment for the amortized cost of the technology.
- As a major part of its work, the HWSB would serve as a "macro-consumer" that would be directly involved in quality improvement partnership teams with HMOs, facilities, and provider associations.
- HWSB should be integrated into the work of the Governor's Interagency Council on Health Disparities and the Council should continue its work on developing an action plan for eliminating health disparities.

2. How will implementation of your proposal enhance, hinder, or otherwise impact the achievement of the vision and the goals established by the Commission? How do you know?

This proposal would enhance the vision and goals of the Commission in several ways.

Improving Access: It is unrealistic to think that the state can guarantee unlimited access to coverage (first- and last-dollar coverage) for every Washingtonian. Many experts have argued that one of the reasons for rampant health care inflation is overinsurance. Consumers are typically not required to consider the cost implications of their health care decisions, and procedures and services that are not evidence-based, economical, efficient, warranted, or safe are readily paid for by insurers. A "defined benefits" approach, as proposed, will make it more affordable to provide access to the most necessary services. This proposal, however, stops well short of rationing. Any employer or individual can buy any type of health plan that is offered—but the government's responsibility to assure coverage is affordable, and to facilitate insurance purchasing through direct subsidies and through tax breaks and other incentives, is limited to the

cost of the least expensive plan that meets established thresholds for coverage and quality. The state must be strategic and selective about where it puts its next dollar to promote access—and to do so it must effectively address the question: Access to what?

Improving Health: This proposal attempts to integrate all aspects of health, not just the delivery of illness care. An emphasis on public health protections, prevention and primary care is essential if Washington hopes to be one of the top ten healthiest states in the nation. It would give the HWSB responsibility for funding (although not for administering) some critical public health services of statewide significance, and for engaging actively in an assurance function when it comes to providing proven, evidence-based preventive care of community-wide importance (as opposed to traditional insurance activities that attempt to avoid costs and spread any costs that are incurred across the risk pool).

HWSB's performance would be judged primarily on population wellness indicators, as compared to metrics related to the delivery of personal health services, on the assumption that what gets measured gets done. Presumably, some of those measures also could relate to how Washington compares to other states, and potentially to other nations or their political subdivisions (e.g., British Columbia). The work of the Washington Health Foundation and the Public Health Improvement Partnership could inform any effort to develop an appropriate set of measures.

Measures for judging HWSB's performance would include measures about disparities based on race, ethnicity, gender, and income. Work on developing a state plan for addressing health disparities through the Governor's Interagency Council on Health Disparities would continue.

There are several elements of the proposal that would drive adoption of evidence-based medicine, evidence-based mental health and evidence-based public health practice. These include: (1) incentives for adoption of health IT, which can include provider prompts tied to evidence-based protocols and can provide data for a host of other quality improvement activities; (2) development of an evidence-based set of core health services (defined benefits); (3) as macro-consumers, HWSB and insurers would be involved with providers in quality improvement teams that would promote evidence-based practices and streamline business processes.

Improving Affordability: The Commission has heard a lot of scary data, information and theories about the escalating cost of health care in this country (although per capita spending on public health has been declining). There are many different theories about why we spend twice or more what any other nation spends on care, yet have relatively poor outcomes. Many of these come down to the fact that most economic sectors in the country rely on the markets to drive decisions—we expect the "invisible hand" of Adam Smith to guide us—but in health care, there is no functioning market; the invisible hand is either absent from the picture, or as is more often the case, guides us in the wrong direction because of false incentives or disincentives.

There are several reasons given for this, but most of these come down to the fact that there is no effective consumer in the picture. In 1963 Nobel laureate Kenneth Arrow defined the causes of market failure and uncertainty as: inequity in information, inequity in resources (especially income), the ethical decision to separate treatment from ability to pay, the importance of trust in

a care relationship, the vulnerability and psychological state of patients, and the longer term implication of the physician-patient relationship.

As recently as this year, Michael Porter and Elizabeth Teisberg, in their book *Redefining Health Care: Creating Value-Based Competition on Results*, have argued that because there is no true consumer in the mix, major players in the health care system end up shifting costs, restricting services and acquiring bargaining power, rather than ensuring value.

Alan R. Hubbard, director of the National Economic Council and economic adviser to the president, argued in the May 3 *New York Times* that health care is expensive "because the vast majority of American consumers use it as if it were free." Several proposed health care reforms attempt to involve consumers in making economic decisions about their care. Perhaps the most popular of these policies currently is health savings accounts (HSAs) and other elements of what has been called "consumer-driven health care." These strategies, however, do little to address other causes of market failure, such as those identified by Arrow three decades ago. A Commonwealth Fund study published in December found that consumers on such plans were more judicious about their spending, but consumer satisfaction is extremely low. Such plans also result in missed health care and higher out-of-pocket costs. Insurers provided little health information, and consumers tended to mistrust the information they did receive. HSAs and related reforms also increase risk selection, which many analysts, including Porter and Teisberg, have identified as one of the cost-drivers of medical inflation.

Porter and Teisberg have argued that insurance companies should be persuaded to play the role of consumer, acting as a collective surrogate for consumers in advocating not only for cost containment, but also for quality. This committee is not convinced that this is achievable. Insurers would continue to have incentives to prioritize efforts to control their own costs over quality improvement and adoption of high-value, high-cost technologies. The Commission also heard of an example where a large employer—the City of Seattle—played the role of consumer while working as part of a business process improvement team and Virginia Mason Medical Center.

In this proposal, HWSB would serve as a macro-consumer, representing actual consumers in the aggregate on business process and quality improvement teams. It would also encourage insurers and large employers to be partners in this endeavor. At the same time, it would promote some market reforms designed to influence consumer demand.

The introduction of a "consumer with clout" is just one way this proposal would contain costs and make coverage more affordable. It would drive consumers to choose lower cost, streamlined, and more efficient plans—"base price" plans—for economic reasons. With defined benefits built around evidence-based medicine, these plans would make it less likely that consumers would choose unnecessary, uneconomical, or unsafe care.

The proposal would also result in administrative simplification. Estimates of the waste caused by unnecessary administrative overhead (mostly paperwork) vary. Methodologies that compare the efficiency of Medicaid and Medicare to private sector insurance suggest that unnecessary

overhead could easily account for as much as 30 percent of spending. Comparative studies looking at the British and Canadian systems suggest that administrative waste in the U.S. health care system is actually much higher, but it is unrealistic to expect that reforms at the state level could capture all potential savings.

Making insurance more affordable, creating strong incentives for individuals to obtain insurance and emphasizing the delivery of public health services and preventive care would also reduce the extremely expensive overutilization of emergency rooms. This proposal would also dramatically reduce risk selection.

3. Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the program and its outcomes.

This proposal emphasizes three goals—a defined benefit packet of core health services that incorporates public health activities, a single risk pool, and a combined administrative structure. The remaining specifics describe one model for achieving those goals. That model is based largely on the "managed competition" concept developed by the Jackson Hole Group in the early 1990s. There are many overlaps between the Jackson Hole Group's work and the Washington State health reforms enacted in 1993 and later rolled back. Managed competition was also at the core of the Clinton Health Security plan. Veterans of the health policy debate will recognize that the HWSB is similar to the "health insurance purchasing cooperatives" (HIPCs) that were proposed by the Jackson Hole Group and incorporated into the 1993 Washington State reforms. Under the Clinton plan HIPCs evolved only slightly into regional health alliances. There were extensive debates around this basic concept in the early 1990s and much can be learned about the strengths and weaknesses of managed competition by revisiting those debates. It should be noted, however, that this plan differs from previous plans in some significant ways—notably, there is no employer mandate. Also, the defeat of previous incarnations of managed competition were driven as much by partisan political considerations, misleading public advertising, and the lobbying and campaign funding activities of some vested special interests, as they were driven by considerations about whether they could effectively meet goals such of those adopted this Commission.

In some ways, this proposal is modeled after efforts and programs already in place in Washington State. It would rely on expansion of existing programs like the Basic Health Plan, SCHIP, and the Uniform Medical Plan, and on an agency much like the Health Care Authority (HCA), but responsible for many more covered lives, expanding many of the cost control and quality improvement activities it has already begun.

There are some parallels with recently enacted health insurance "mandates" in Massachusetts, except this proposal would use incentives and gateways to encourage coverage, rather than costs imposed through taxation. Some health policy tools are not available to Washington because the state does not have an income tax. It is too early to know what outcomes will result from Massachusetts' policy.

Finally, the "defined benefits" concept in this proposal suggests some similarities with the system in place in some Canadian provinces, where the government negotiates a capitated price for a defined set of services. The difference is that employers and consumers would be free to purchase coverage over and above the basic package. Canada's health care system has better health outcomes and better customer satisfaction than the U.S. system. There are longer waits for elective procedures, but for emergent conditions, delays are not a problem.

4. Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or ongoing? Can you estimate how much these costs would be or suggest how such an estimate should be made? How much, if any, of these costs will be offset corresponding savings?

This proposal assumes that health care is a shared responsibility of business, individuals, and government. The entire premise is that it would result ultimately in savings to individuals, business, and government by slowing medical inflation. There would be costs to individuals, business, and government, and the government costs would have to be picked up by individuals and businesses, but most of these "costs" would be the result of cost-shifting, not new overall system costs.

Some additional costs would stem from increasing funding to areas of health care that are currently underfunded to the detriment of population health. These areas include public health, reimbursement to primary care providers for preventive care, and administrative support services in schools (i.e., nursing and family outreach services).

We believe there is already enough money in "the system" and that the costs of adequately funding areas that are now under-resourced would be offset by significant reductions in administrative expenses, the number of medical errors, and the number of unnecessary procedures, as well as streamlined business processes, better management of chronic conditions, and prevention of avoidable illness and injury. Several studies suggest that it is cheaper to insure people than to pay for their care through unreimbursed care and inappropriate emergency room visits.

The greatest new costs would be to businesses and individuals that currently opt out of the health care system—individuals who are currently choosing not to purchase insurance and businesses that do not provide coverage for their employees. Individuals incurring new costs would include those who are uninsurable or for whom insurance is prohibitively expensive because they are high-risk, but who might be willing to pay for insurance if it were available and affordable, and those who simply cannot afford coverage because they are low income. Some costs for this latter group should be offset by government subsidization, either by direct subsidization of individuals and families under 300 percent of poverty or by subsidizing small businesses that would like to provide some insurance benefits to employees but cannot cover the entire cost, thereby leveraging their resources. The state might also want to look at the minimum wage and determine if it is sufficient to allow individuals to purchase insurance. Individual payments for coverage should be held to five percent of income.

Part of the challenge will be ensuring that businesses currently paying into the system do not withdraw existing funding. Businesses may choose to continue their current level of commitment, but regardless should not be allowed to drop below some threshold of support. The minimum threshold could be set at a percentage—say, 85 percent—of the base price. This minimal level of commitment could be maintained through tax policy. There are several suggestions in the literature for how this might be achieved. One example would be to charge a payroll tax (for example, $1 per hour worked) and allow deductions for premiums paid on employees' behalf, although deduction should not to exceed the base price.

This proposal would appear to shift costs from business to government and individuals, but it should be noted that those shifts are already taking place. This proposal would manage that shift and keep it within reasonable limits. If you consider entitlement programs, tax subsidies, and insurance for retired military and government employees, government already pays for some 60 percent of health care costs. Increasingly, the government has been left to cover the most expensive, most high-risk populations.

The most extensive actuarial work on the economics of managed competition was done by the U.S. Office of Management and Budget when the Clinton plan was under consideration. Costing out this specific proposal would require extensive actuarial work by HCA and tax policy choices that are best left to the Governor and the Legislature.

5. How does you proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

The time between when the Commission issued its request and the deadline submission made it difficult to both develop a proposal tailored to the Commission's goals and vision and to conduct the stakeholder work necessary to seek consensus or win endorsements.

Nothing about this proposal is inconsistent with the proposals submitted by the Washington Association of Local Public Health Officials or the Washington Health Foundation, and the Access Committee supports both of those proposals.

There is also considerable alignment between this proposal and drafts of Fair Share proposal, and we suspect there may also be considerable alignment with many of the suggestions that will come from the Office of the Insurance Commission. One difference that we do anticipate between this proposal and the Fair Share Proposal is that there is no explicit employer mandate or play-or-pay component. Business payments into the system would have to be maintained and businesses currently avoiding any contribution to health care costs for their employees would face additional payments in the form of business or payroll taxes. Labor contracts and competition for labor would ensure that many businesses would continue to offer health insurance as part of the compensation packages. Very large businesses could continue to self-insure under ERISA. But the system would allow for a transition away from an employer-based system. As noted above, this is already happening. Our employer-based system is an accident of history, and the system today is already more government-based than employer-based. A health

care financing system should provide continuity of coverage, and an employer-based system expands and contracts with fluctuations in the economy.

6. What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

Larger businesses that currently provide insurance would probably support efforts to control costs, to make their contributions more predictable, and to allow for a transition away from an employer-based system. Smaller businesses and some larger businesses that currently do not cover employees will object to being required to pay into the system through increased taxes. A recent survey of business leaders found that most prefer PPO systems over HMOs, but it is likely this proposal would drive purchasers toward HMOs. Individuals who are now free riders or who benefit from risk selection will object to returning to a true insurance model where risk is spread across the population. Hospitals will see some benefit to reductions in uncompensated care, although coverage for some technologies will drop. Smaller insurance companies that have built their business model around risk selection will object strenuously, although the larger, traditional insurance companies tend to favor the managed competition model. Providers will like some aspects of the proposal, but not others—for example, there are concerns that pay-for-performance and outcome tracking, even when risk-adjusted, hurts providers that treat sicker or more at-risk patients.

Addressing these obstacles will require building a strong coalition and framing messages in ways that resonate with people's closely held values. Public opinion tends to favor health care reform initially, but counter messages that appeal to closely held values, or "frames," can be very effective in turning the tide of public opinion. This proposal is also complex and supporters will have to find a simple and understandable way to present it to the public.

Washington State Board of Health

Access to Critical Health Services

Final Report

July 2001

Committee on Access:

Tom Locke, M.D., M.P.H.

Ed Gray, M.D.

This report describes the Washington State Board of Health's work on access to critical health services during the 1999-2001 biennium. It contains *Recommended Critical Health Services for Washington State Residents*, which the Board adopted on September 13, 2000, and *Critical Health Services Explained: A Guide to the Menu of Critical Health Services*, which the Board reviewed on July 11, 2001.

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Executive Summary

People's health suffers when they do not have access to the individual health services they need. Communities suffer when these services are not available to significant numbers of their residents. In Washington, state and local health jurisdictions monitor access to critical health services and work with the health care system—including insurers, medical facilities, and health practitioners—to identify gaps in access and find ways to reduce them.

This role, integral to public health's mission of preventing illness and promoting health, is explicitly included in the *Public Health Standards for Washington State* developed by the Public Health Improvement Partnership.[1] Those standards stipulate that information should be available at the state and local level about "a core set of critical health services that are necessary to protect the public health." They also call on public health jurisdictions to provide referrals for clients who need these services, and to mobilize their communities to reduce gaps in the availability of services.

The Washington State Board of Health has been serving as the lead agency at the state level in the development of public health standards relating to health care access.

The Board feels it is important to focus attention on a core set of critical health services because of growing financial pressures in the health insurance market and the health care delivery system. A consistent theme in public testimony to the Board in recent years has been that cost pressures are resulting in the elimination of third-party coverage for services that have important public health benefits.

To respond to the needs of the public health system, and to concerns about adverse public health impacts from cost-containment strategies, the Board created a Committee on Access that comprises two Board members, Tom Locke, M.D., M.P.H. and Ed Gray, M.D. During the 1999-2001 biennium, the committee identified a menu of core services. In doing so, it set out to answer the key question: Which health services are truly essential for maintaining individual and community health? The result is *Recommended Critical Health Services for Washington State Residents*, a menu of services adopted by the Board on September 13, 2000.

MCPP Consulting compiled the menu under contract to the Board, with funding provided by the Board and the Public Health Improvement Partnership. This list was assembled by a team of independent medical professionals and health care consultants using national research regarding the impact of health services on individual and community health without regard to funding or payment.

The two primary source documents were:

1. U.S. Department of Health and Human Services, *Healthy People 2010*, January 2000

2. United States Preventive Services Task Force, *Guide to Clinical Preventive Services, 2nd edition*, 1996

No service appears on the menu unless the provision and availability of the service is thought to have a predictable and demonstrated **benefit to the health status of the community-at-large**—or the absence of this service is thought to adversely affect the health status of the community-at-large.

Any health service that met this threshold condition was then measured against four criteria:

- This service addresses a health issue whose impact or potential impact on the population is known to be great—either in terms of relative prevalence/incidence or in terms of degree of risk for the community-at-large for events or conditions that occur less frequently.
- Key national research, standard-setting and policy-making bodies consider this service important and a relatively high priority.
- There is strong evidence, through national or state research and/or evaluation, that the service is safe, effective, and/or cost-effective.
- Policymakers, providers, and the public would agree (more likely than not) that the service is important and necessary.

Services included on the menu were judged to have met these criteria. The PHIP Steering Committee and the Board reviewed the menu before adoption.

The list specifically addresses personal health care services. The Board assumes, for the purposes of this menu, that the full set of public health services, as described in the PHIP standards, should be available in each community. These essential services include controlling the spread of communicable diseases, educating the public about healthy lifestyles, and ensuring the safety of the air we breathe, the food we eat, and the water we drink.

The Board intends that the menu be reviewed and updated periodically as new evidence and information becomes available. The Board approached this work from a population-based perspective. The need for specific services by individuals should be determined on a case-by-case basis, with consideration given to age, gender, risk factors, specific diagnoses, medical necessity, and potential risks and benefits.

The Board recognizes that a single, standardized list of health services would not serve the needs of every local jurisdiction. Significant local differences exist in community attitudes, population, geography, health service capacity, provider availability, and more. For this reason, the Board offers a true "menu" of services that can inform local efforts to develop lists that are responsive to local needs.

During 2001-2003, the Board will collaborate with local health jurisdictions to develop and use localized lists, explore ways to incorporate the menu into the creation of an insurance product, and develop a list of performance measures for assessing access.

[1] The Public Health Improvement Partnership is a collaboration of local health jurisdictions, the Board, the Department of Health and the Northwest Center for Public Health Practice at the University of Washington. The partnership was formed to develop and implement the biennial Public Health Improvement Plan passed into law in 1995

Critical Health Services Explained

On Sept. 13, 2000, the State Board of Health adopted *Recommended Critical Health Services for Washington State Residents*.[2] The following questions and answers explain the reasons for creating the menu, its content, and how it might be used.

What is the menu of critical health services?

These are health care services the Board has identified as essential to the health of the community at large. The Board believes that when health purchasers and policy makers decide which medical and public health services they will make available, they should consider the services on this menu as high priorities for all Washington communities.

Why a menu? Why now?

The Board has a longstanding interest in ensuring that all Washington residents have access to health care services that are necessary from a public health perspective. It is difficult to talk about promoting access without first being able to answer the question: Access to what? One reason the Board developed this menu was to encourage a dialogue—both within the public health community and among the regulators and purchasers of health care. It is the Board's hope that participants in that discussion will be able to articulate which of the many available health care services are truly critical to every community's health.

The Board also created the menu to support the efforts of more than 100 health professionals at the state and local level who have collaboratively developed the *Standards for Public Health in Washington State*.[3] The standards outline what our health officials believe must be in place everywhere in Washington to provide adequate public health protection. The standards detail the specific steps our state and local public health agencies should take to monitor and report on our entire population's health, to respond quickly and effectively to disease outbreaks, to protect us all from unsafe and unhealthy environmental conditions in our food, air and water, and to strengthen communitywide health promotion and disease prevention efforts.

A final section of the standards outlines public health's role in assuring access to "critical health care services." Again the question arises: Access to what? The standards call on the state and each community to determine a specific set of critical health services. Once a community-based set of services has been defined, the standards call on local health jurisdictions to maintain and disseminate information about the availability of these critical health care services, to provide referrals for clients who need these services, and to mobilize their communities to reduce gaps in the availability of services.

How does this relate to statewide public health improvement efforts?

Since the Legislature established the public health improvement process in 1995, the Board has been a member of the partnership that produces the *Public Health Improvement Plan* (PHIP).[4] The goal of the partnership is to create a public health system that will increase the level of protection from environmental and communicable disease health threats and improve the health of Washington state residents through effective use of health promotion, community assessment data, and personal health care services. One element of the PHIP work plan for 1999-2001 was to develop a "menu of critical services." The Board took on that project as its contribution to the PHIP. The Board's menu serves as a starting point for the state and local health jurisdictions to begin work on community-specific sets of critical health services. Those sets will then provide a framework for efforts to assess the availability of services and mobilize communities to improve access.

Who created the menu?

A team of independent medical professionals and health care research consultants produced the menu under the direction of the State Board of Health. The consultants relied on current research findings and the authoritative thinking of national experts who have analyzed public health priorities. The PHIP Steering Committee and the Board reviewed the menu before adoption.

What determined whether a service would be on the menu?

No service is on the menu unless providing that service would be expected to have a demonstrable benefit to the community at large—or its absence would be expected to harm the health of the community. Each service also had to have its effectiveness documented by scientific research and be broadly supported by health experts and professional organizations.

The following criteria were used to assemble the list:

1. The **degree of impact** or potential impact on the community's health.

2. The **level of agreement** among national research, standard setting, and policy-making bodies that providing the service is an important and relatively high priority.

3. The **strength of the evidence** that the service is safe, effective, and cost-effective.

4. The **likelihood that there would be agreement** among policy-makers, health providers, and the public about the importance of the service.

What types of services are included?

The services fall into eight general categories:

1. Making sure that people have **general access to health services** (for example, they are able to see a primary care physician and can get home health care if needed).

2. Preventing **risky behaviors** and encouraging healthy behaviors (for example, educating people about the dangers of smoking and encouraging healthy diets).

3. Treating and preventing the spread of **communicable and infectious diseases** (i.e., screening for tuberculosis and providing immunizations for vaccine-preventable illnesses).

4. Protecting the **health of mothers, infants and children** (for example, making sure pregnant mothers get good nutrition and providing well-child checkups for young children).

5. Improving **behavioral health** and caring for people with mental illnesses and disorders (i.e., preventing alcohol abuse and providing intervention services for people who are suicidal).

6. Detecting **cancer** early and treating it effectively (for example, providing screenings to detect breast cancer early and specialty care for treatment of people with various types of cancers).

7. Dealing with **chronic conditions** and improving **disease management** (for example, treating diabetes, asthma, and chronic heart disease).

8. Improving people's **oral health** (for example, screening children for oral disease and encouraging use of fluoride to prevent tooth decay).

So is this simply a list of critical health issues?

The menu goes beyond that.

First, it identifies target populations for each menu item. For example, it includes screening for serious mental illnesses only for people at high risk; screening the general population is not on the menu. And while the menu includes efforts to decrease tobacco use among the general population, it specifically includes prevention programs aimed at teens.

Second, the menu specifies the type of service that is needed—screening, education and counseling, or medical intervention. For example, it does not recommend screening or medical intervention for unhealthy dietary behaviors, but it does recommend counseling and education.

The menu also considers whether there is a need for infrastructure improvement or policy change. Infrastructure focuses on the availability and distribution of providers, facilities, and services throughout the state—are needed services available from qualified providers within a reasonable distance? Policy on critical health services deals with decisions made by elected officials,

public agencies, health care providers, and insurance purchasers that affect the availability and quality of needed services. For example, a law making it more difficult for minors to purchase tobacco products would decrease teen tobacco use. Similarly, requiring insurers to cover mental health visits would increase access to behavioral and mental health services.

Why are some services that seem important not on the menu?

Not everything that may be good for people's health is on this menu. For some conditions, the degree of risk for the entire community is relatively small. Or there may be some uncertainty about the safety or effectiveness of particular services. Just because a service is not listed on the menu does not mean it is lacking in benefit for some people, only that it did not meet the rigorous selection criteria used to determine the menu of critical health services.

For example, the menu does not include complementary and alternative medical care (such as naturopathic and chiropractic services). Remember that the menu is a starting point for setting community-specific priorities. Community leaders are free to add or subtract from this menu.

Is the menu prioritized?

No, though the four criteria listed above may be used in the future to rank-order the menu.

How might the menu be used?

- By **measuring access** to these specific services, researchers can determine the degree to which state residents have access to critical health services—and whether initiatives such as PHIP result in better access and better health.
- Policymakers can use this menu to **guide a community discussion** to reach agreement about which services, if any, should be uniformly available.
- Local health jurisdictions can use this menu as a model from which to **build local menus** of critical health services. Those community-specific menus could then inform efforts to mobilize the community to improve access.
- Policymakers may want to use this menu to help **set priorities and guide policy** choices.
- Public and private employers may want to use this menu to **shape the insurance coverage** they purchase for their employees.

[2] http://www.doh.wa.gov/sboh/Priorities/Access/CriticalHealthList.pdf
[3] http://www.doh.wa.gov/standards/default.htm
[4] http://www.doh.wa.gov/Publicat/2000_phip/2000_PHIP.htm

Recommended Critical Health Services for Washington State Residents

Topic, Target Population, & Service Type

Context

The *Proposed Standards for Public Health in Washington State*[5] include a section focused on Access to Critical Health Services. The intention of this section of the standards is to ensure that information is collected about a set of critical health services for purposes of monitoring, assessment of performance, identification of opportunities for improvement, and community mobilization efforts to ensure access to services and to address needs. In order to carry out the standards, it is first necessary to define a set of critical health services, which will become the platform for assessment and action. The following menu of critical health services has been adopted by the Washington State Board of Health and will serve as this set.

This menu is meant to be periodically reviewed and updated as new evidence and information becomes available. The perspective of this work is population-based. However, need for and access to any of the proposed services is determined by the individual patient/consumer circumstance—considering age, gender, risk factors, specific diagnoses, clinical appropriateness, and medical necessity.

Key Source Documents

Two sources provided the primary guidance for inclusion of items in this menu:

1. *Healthy People 2010*, U.S. Department of Health and Human Services, January 2000

2. United States Preventive Services Task Force, *Guide to Clinical Preventive Services*, 2nd edition, 1996

Contents

- **Adopted Menu of Critical Health Service Items:** Services are named by clinical or health topic in the left column. Other columns indicate whether the service is targeted for the general population and/or a sub-population with specific risk factors, and the type of service—whether screening/testing/assessment; counseling/education/support; or intervention.

- **Threshold Requirements and Criteria:** This is a summary of considerations and criteria that have been applied in the selecting services to be included in the menu.

[5] The *Standards for Public Health in Washington State* were finalized subsequent to the adoption of this document.

KEY for "Target Population": C = Children T = Teens/Adolescents A = Adults (Non-Senior) S = Adults > 65 W = Women
M = Men HR = At High Risk D = Diagnosed GP = General Population

Category & Service Item	Target Population	[.....Service Type.....] Screening / Testing	Counseling/ Education/ Support	Intervention	Infrastructure	Policy
General Access to Health Services						
Ongoing Primary Care	GP	√	√	√	√	√
Emergency Medical Services & Care	GP	√	√	√	√	√
Consultative Specialty Care	GP; D; HR	√	√	√	√	√
Home Care Services	GP	√	√	√	√	√
Long-Term Care	S; HR	√	√	√	√	√
Health Risk Behaviors						
Tobacco Use	T; HR; GP		√	√		√
Dietary Behaviors	HR; GP		√			
Injury & Violence Prevention (Bike Safety, Motor Vehicle Safety, Firearm Safety, Poison Prevention, Abuse Prevention, etc.)	HR; GP		√	√		√
Physical Activity & Fitness	GP		√	√		
Responsible Sexual Behavior	T; A; HR		√	√		√
Communicable and Infectious Diseases						
Immunizations for Vaccine Preventable Diseases	C; T; S; HR		√	√	√	√
Sexually Transmitted Diseases	T; A; HR	√	√	√	√	
HIV/AIDS	T; A; HR	√	√	√	√	√
Tuberculosis	GP; HR	√	√	√	√	
Other Communicable Diseases (i.e. Meningicoccal & Hepatitis C)	GP; HR; D	√	√	√	√	

KEY for "Target Population": C = Children T = Teens/Adolescents A = Adults (Non-Senior) S = Adults > 65 W = Women
M = Men HR = At High Risk D = Diagnosed GP = General Population

Category & Service Item	Target Population	[.....Service Type.....] Screening / Testing	Counseling/ Education/ Support	Intervention	Infrastructure	Policy
Pregnancy and Maternal, Infant, and Child Health/Development						
Family Planning	T; W; A	√	√	√		√
Prenatal Care	T; W; HR	√	√	√		
Women, Infants, & Children (Nutritional) Services	C; W; HR		√	√		√
Newborn & Early Childhood Services	C; HR	√	√	√	√	
Well Child Care	C; T	√	√	√		
Behavioral Health and Mental Health						
Substance Abuse Prevention & Treatment Services	T; A; HR	√	√	√		√
Depression	GP	√	√	√		
Suicide / Crisis Intervention	T; A; HR	√	√	√		
Other Serious Mental Illnesses / Disorders	HR	√	√	√		√
Cancer Services						
Cancer-Specific Screening (i.e. Breast, Cervical, and Colorectal Cancers) and Surveillance	A; S; HR	√	√		√	
Specialty Cancer Treatment	A; S; HR		√	√	√	

KEY for "Target Population": C = Children T = Teens/Adolescents A = Adults (Non-Senior) S = Adults > 65 W = Women
M = Men HR = At High Risk D = Diagnosed GP = General Population

Category & Service Item	Target Population	[.....Service Type.....] Screening / Testing	Counseling/ Education/ Support	Intervention	Infrastructure	Policy
Chronic Condition/Disease Management						
Diabetes	C; A; HR	√	√	√		
Asthma	C; A; HR	√	√	√		
Hypertension	C; A; HR	√	√	√		
Cardio-Vascular Disease	C; A; HR	√	√	√		
Respiratory Disease (other than asthma)	HR		√	√		
Arthritis, Osteoporosis, and Chronic Back Conditions	GP; HR	√	√	√		
Renal Disease	HR; D	√	√	√	√	√
Oral Health						
Dental Care Services	GP	√	√	√		
Water Fluoridation	GP			√	√	√

Services related to **Congenital and Injury-Induced Disabilities** (specialized therapies and assistive devices) were considered but not included on the adopted menu. Although critical for those individuals affected, such services did not meet the population-based threshold requirement of benefiting the health status of the community-at-large

Threshold Requirements & Criteria

Threshold Requirement
All services must meet this requirement for inclusion on the menu of critical health services.[6]

Community Health Status Benefit	The provision and availability of this service is thought to have a predictable and demonstrated benefit to the health status of the community-at-large. Or the absence of this service is thought to result in detriment to the health status of the community-at-large.

Criteria
Scoring against these criteria is more relative than absolute. However, services included on the menu strongly met most of these criteria.

Degree of Impact	This service addresses a health issue whose **impact or potential impact** on the population is **known to be great** - either in terms of relative prevalence/incidence, or in terms of degree of risk for the community-at-large for events or conditions that occur less frequently.
National Agreement on Priority	Key **national** research, standard-setting and policy-making **bodies consider this service important and relatively high priority.**
Strength of Evidence	There is **strong evidence** through national or state research and/or evaluation of the service's safety, effectiveness, and/or cost-effectiveness.[7]
Likelihood of Agreement (vs. Divisiveness)	This service **would be (more likely than not) agreed-upon** by policy makers, providers, and the public as important and necessary.

Measurement Considerations
The following should be considered as measurement planning proceeds for Access to Critical Health Services.

1. Practical feasibility of measurement given current realities.
2. Existence of a nationally defined, tested and accepted measure or indicator associated with this service.

[6] The potential for social and economic burden, if the service would be absent, was also considered as a threshold requirement. It was found not to be a discriminatory; all potential services met the requirement.
[7] There is agreement that cost-effectiveness evaluation of services should be considered in prioritization and resource distribution decisions, as an adjunct to evidence on effectiveness. Yet, methods of such analyses are not standardized & vary widely. Evidence on cost-effectiveness is therefore limited & likely not comparable across different studies and/or services . (Reference: American Journal of Preventive Medicine 2000; 19(1); pp 15-23; and Guide to Clinical Preventive Services; Second Edition; pp.lxxxv-xcii.)

About the State Board of Health

The State Board of Health serves the citizens of Washington by working to understand and prevent disease across the entire population. Established in 1889 by the State Constitution, the Board provides leadership by suggesting public health policies and actions, by regulating certain activities, and by providing a public forum. The governor appoints ten members who fill three-year terms.

Board Members

Consumers

Linda Lake, M.B.A, Chair, has 25 years of experience in the field of health and social services. She has directed several community health and social service organizations, including the Pike Market Medical Clinic.

Joe Finkbonner, R.Ph., M.H.A., is an independent consultant on Native American health issues. He has served as chair of the American Indian Health Commission and director of the Lummi LIFE Center.

Elected County Officials

The Honorable Neva J. Corkrum, Vice Chair, is a Franklin County commissioner and member of the Benton-Franklin Health District Board of Health.

Elected City Officials

The Honorable Margaret Pageler, J.D., is president of the Seattle City Council and a member of the Board of Public Health in Seattle and King County.

Department of Health

Mary Selecky is secretary of the Washington Department of Health and former administrator of Northeast Tri-County Health District.

Health and Sanitation

Charles R. Chu, D.P.M., a practicing podiatrist, is president of the Washington State Podiatry Independent Physician Association.

Ed Gray, M.D., is health officer for the Northeast Tri-County Health District and chair of the Basic Health Plan Advisory Committee.

Carl S. Osaki, R.S., M.S.P.H., former director of environmental health for Public Health—Seattle & King County, is on the faculty at the University of Washington.

Vicki Ybarra, R.N., M.P.H., is director of planning and development for the Yakima Valley Farm Workers Clinic. Much of her work is dedicated to supporting children and families.

Local Health Officers

Thomas H. Locke, M.D., M.P.H., is health officer for Clallam and Jefferson counties and medical director of the Port Gamble S'Klallam tribal health program.

Board Staff

Don Sloma, M.P.H., Executive Director

Craig McLaughlin, M.J., Senior Health Policy Manager

Doreen Garcia, M.P.P., Senior Health Policy Advisor

Marianne Seifert, M.A., Health Policy Advisor

Desiree Day Robinson, Executive Assistant to the Board

Jennifer Dodd, Assistant to the Board

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Tab 51

UW Medicine

VICE PRESIDENT FOR MEDICAL AFFAIRS AND
DEAN OF THE SCHOOL OF MEDICINE

August 22, 2006

Governor Christine Gregoire, Co-Chair
Senator Pat Thibaudeau, Co-Chair
Blue Ribbon Commission on Health Care Costs & Access
Office of the Governor
PO Box 40002
Olympia, WA 98504-0002

Blue Ribbon Commission on Health Care Costs & Access Members

Dear Governor Gregoire, Senator Thibaudeau, and Members of the Commission:

Thank you for the opportunity to provide our perspective to the 2007 Blue Ribbon Commission on Health Care Access and Cost. I have chief executive responsibility for UW Medicine that includes the University of Washington (UW) School of Medicine, University of Washington Medical Center (UWMC), Harborview Medical Center, University of Washington Physicians (UWP), and the UW Neighborhood Clinics. UW Medicine's many contributions to health care access include education and training of health professionals. UW Medicine has more than 3,500 students and trainees in the health professions. We also serve as a key provider of tertiary and quaternary care, and as the major safety net provider of hospital-based care for the uninsured and underinsured in Washington State. Our faculty and staff provide approximately 20% of the total hospital-based care in King County, but we provide more than 60% of the care for patients who are underinsured and uninsured.

Financial support for medical education and training has been seriously strained over the past decade due to pressures on the Medicare and Medicaid programs. At the same time, there are current and projected shortages of medical and health professionals particularly for the rural and urban underserved areas of the state. UW Medicine has an excellent track record of addressing these shortages by serving as a safety net provider and increasing the number of physicians electing to practice in rural and underserved areas in Washington and throughout the region. Maintaining support for UW Medicine's educational and research programs is essential if we are to continue to succeed in these areas.

Let me cite several examples.

- The state's endorsement for the Harborview Research & Training Building in 1995 provided vital research/work space for UW medical faculty who care for patients at

Paul G. Ramsey, M.D.

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HARBORVIEW MEDICAL CENTER / UNIVERSITY OF WASHINGTON MEDICAL CENTER / UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE / NEIGHBORHOOD CLINICS

Harborview Medical Center. This played a key role in attracting and retaining medical faculty who staff the inpatient services and outpatient clinics of Harborview.

- Passage of the medical faculty licensure act (SHB 1076) in 2001 helped prevent an anesthesiology faculty shortage at the UW.
- Support for the Family Medicine Residency and the Physicians Assistant training programs has made the State of Washington the premier site in the country for medical students and physician assistants electing to practice primary care.

The State can provide key financial and policy support that leverages UW Medicine's ability to attract and retain faculty and students who advance our academic mission and address critical needs of the State.

There is also a unique opportunity in the coming session. Primary care can enhance access and lower costs by managing medical conditions at the level most appropriate to the condition. The UW School of Medicine places emphasis on primary care education and training partnerships with community physicians and hospitals across the State. This has led to an emerging consensus to expand the WWAMI program and create a new regional dental program ("RIDE") at a new first-year site in Spokane for medical and dental students. This proposal will be advanced in the 2007 Session and represents a collaborative effort between the UW, WSU, EWU, and community leaders in business and health care.

Thank you for your consideration. We would be happy to provide you with more information or answer any questions.

Sincerely,

Paul G. Ramsey, M.D.
Vice President for Medical Affairs and
Dean of the School of Medicine

PGR:jd

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Tab 52

Washington Academy of Family Physicians

August 31, 2006

Governor Christine Gregoire, Co-Chair
Senator Pat Thibaudeau, Co-Chair
Blue Ribbon Commission on Heath Care Costs & Access
Office of the Governor
PO Box 40002
Olympia, WA 98504-0002

Dear Governor Gregoire, Senator Thibaudeau, and Members of the Commission:

The Washington Academy of Family Physicians (WAFP) represents the largest body of primary care doctors in the state. Our 2,600 members offer care to patients in communities in all parts of the state, bridging geographic, economic, social and racial differences.

The WAFP is pleased to have this opportunity to offer our views to the Blue Ribbon Commission on Health Care Costs and Access (BRC) on the critical issues related to health care reform in Washington State. In our view, the goals described in the RFP document are appropriate and desirable, but the complexity of the challenges in the present system facing patients, health care providers, and health care funders makes a single cohesive solution extremely difficult.

At least part of this complexity results from the interrelated nature of the current problems with the health care system. For instance, the inadequate levels of reimbursement for many preventive services dissuade physicians from offering these services while at the same time, restricted insurance coverage for these same services often means that lower-income patients cannot afford health care which would avoid or at least minimize future negative health outcomes, which in turn add to the cost burdens of the entire system. Similarly, low reimbursements and high liability insurance premiums discourage physicians, particularly in rural areas, from providing the level of access to care that would meet the goals defined by the BRC.

As primary care specialists, family physicians are uniquely positioned at the intersection of access and affordability issues for the basic health care needs of Washingtonians throughout the state.

The WAFP believes there are several problems or challenges that today exist as barriers to the attainment of the goals of Accessibility, Affordability and Quality health care:

- The myriad of insurance programs (government and privately purchased) increases the paperwork and obstacles between family physicians and our patients
- There are too few safety net slots for those patients who cannot afford insurance

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- Physician reimbursement is a significant barrier to access and quality of health care. Currently, preventive care and chronic disease management are not adequately funded by government or private payers. Inadequate reimbursements result in some physicians being unable to treat patients from the lesser-paying insurance programs.
- The system is fragmented by multiple care-givers without sufficient coordination or communication to provide efficient, effective quality care.
- Continuing high malpractice insurance costs constitute a burden to the system. Fear of lawsuits leads to "defensive medicine," causing unnecessary actions, such as additional testing, which further hinders efficient patient care.
- The future supply of primary care physicians is jeopardized by decreasing numbers of students entering family medicine due to being undervalued by the system and by payers.

The WAFP endorses the Future of Family Medicine Project recommendations for improved health care, recently published by the American Academy of Family Physicians:

- Taking steps to ensure every American has a personal medical home
- Advocating that every American have health care coverage for basic services and protection against extraordinary health care costs
- Promoting the use and reporting of quality measures to improve performance and service
- Developing reimbursement models to sustain family medicine and primary care practices

WAFP believes strongly that the solution to Washington's health care challenges must come from structural changes that will continue to facilitate access and higher quality health care. It is for this reason that our Academy has adopted the New Model of Care for family medicine specialists, featuring patient-centered care, open access scheduling, individual (in-person or phone/email) and group visits, multidisciplinary team care, and continuous quality improvement. It is important to recognize that innovation in technology and in the practice of family medicine will continue over time, and that the health care system must not only allow, but also enable these improvements. The health coverage that provides "effective care" in 2006 may not, and likely will not, be deemed to be effective care in 2012.

Recommendations

We believe the vision for Washington's health care must include the following:

1. **Create a plan to ensure that all Washingtonians have a medical home.** Numerous studies document that access to primary, preventive, and chronic disease care provided by family physicians and other primary care providers is the most cost-effective manner of improving health outcomes.

2. **Expand access to care for the uninsured and working poor through existing safety-net programs.** Cost savings through initiatives in preventive care, chronic disease management, and evidence-based medicine will allow these programs to remain affordable for the state and beneficiaries. Increased reimbursement for physicians will insure greater participation by physicians and access to care by beneficiaries. Reimbursement increases should be reasonably tied to physicians providing quality care.

3. **Continue current efforts to adopt evidence-based medicine guidelines, pharmaceutical use, technology assessments, and pay-for-performance that is based on physicians' input and expertise.** The WAFP supported the Governor in her initiatives this past legislative session, and strongly believes these efforts will lead to cost savings that preserve and expand access to essential medical services.

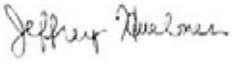
4. **All physician practices should adopt electronic health records.** However, proper funding and incentives for electronic medical records must be facilitated, especially for providers in small practices and communities that have more difficulty affording them. Studies document that increased use of EHRs leads to improved health outcomes, but that payers reap the benefits. We suggest increased grants for those who have not adopted EHRs yet and tax credits for those who have.

5. **Facilitate increased entry by medical students into family medicine.** In order for primary care to be the foundation of a new system, we must have the personnel needed. We recommend increased state support for the University of Washington's #1 ranked Department of Family Medicine, and medical student scholarships and loan forgiveness for students and residents who will become family physicians and work in this state, especially in underserved areas. More of our brightest and most compassionate medical students will enter family medicine as they see it rightfully valued in our improving health care system.

The WAFP would be pleased to provide further information on how the New Model practice might operate to achieve the goals for improved access, affordability and quality of health care in the state, and welcomes the opportunity to discuss these issues with the Blue Ribbon Commission. Thank you for your consideration.

Sincerely,

Stephen C. Albrecht, MD, Co- Chair
Commission on Legislative
and Governmental Affairs



Jeffrey A. Huebner, MD, Co-Chair
Commission on Legislative
and Governmental Affairs

Tab 53

Washington Association of Health Underwriters
Position Statement on Health Care

Background

Private employers, labor unions, public entities and individuals are all rightfully concerned about the increasing cost of health care coverage. In addition, these health care purchasers in Washington State suffer from inadequate market choices when compared with the options that are available in other states. Increased market competition resulting from the entry of new carriers into the Washington market would bring downward pressure on the cost of coverage. The entry of new carriers into the Washington market would also bring new coverage options for health care purchasers. Washington policymakers should create public policies that are designed to attract new carriers to enter the Washington market.

These factors—the high cost of health care coverage and limited market choices for Washington health care purchasers—are also impacted by benefit design and rating requirements. Increasingly, many health care purchasers are unable or unwilling to bear the costs associated with the comprehensive coverage plans that are required in Washington State. A long line of legislatively-mandated health care benefits prohibit the ability of carriers to offer lower-cost plans that provide meaningful medical benefits but are not subject to current mandates and other requirements. Washington's laws relating to the establishment of rates for health care coverage also impact the cost of coverage. Frequently the result of these laws drives costs higher for large numbers of lower-risk health care purchasers. Washington policymakers should create public policies that are designed to offer more coverage options with varying benefits that can be tailored to the needs of Washington consumers. Rating laws should be revised to allow lower costs where possible and justified.

Position

The Washington Association of Health Underwriters supports health care policy proposals that result in:

- Increased coverage choices for Washington health care purchasers, including the availability of limited benefit coverage plans and more choice of Health Savings Account options;
- Increased market competition through the entry of new carriers into the Washington market;
- Rating laws for health care plans that allow for lower premium costs where possible and justified, including rating laws that allow plans that include the use of Health Savings Account to be rated separately from other health insurance business;
- Educating consumers about the true costs of health care, how individuals impact those costs and increase their responsibility for their own health care;
- The private market place as the primary financing mechanism for health care and only using public programs as a safety net.

Washington Association of Health Underwriters
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Tab 54

washington association naturopathic physicians

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September 1, 2006

Honorable Christine Gregoire, Governor
Honorable Pat Thibaudeau
Co-Chairs
Blue Ribbon Commission on Health Care Costs and Access
Olympia, WA 98504

Dear Commission Members,

Thank you for this opportunity to submit a proposal to the Blue Ribbon Commission and participate in the achievement of the stated Commission goals. The following proposal, "Evidence-based, Chronic Disease Prevention (EBCDP) Programs: Access to Cost-Effective Care for Improved Health", is being submitted by the Washington Association of Naturopathic Physicians (WANP).

The State of Washington is committed to the provision of evidence-based health care and the promotion of prevention, healthy lifestyles, and healthy choices as demonstrated through the Blue Ribbon Commission's stated goals of Improving Access, Improving Health and Improving Affordability. Historically, commitments to evidence-based medicine and health promotion have remained separate in health policy discussions despite a growing evidence-base that demonstrates healthy lifestyles are imperative for both prevention and long-term outcomes in many chronic diseases. Washington State is uniquely positioned to combine these commitments by developing innovative programs that promote, create incentives for, and measure evidence-based chronic disease prevention (EBCDP) practices, thus improving Health care quality and rapidly demonstrating a positive return on investment.

To date our proposal has collected broad support from stakeholders, representing a willingness among provider groups and health organizations to cooperate for its implementation. We look forward to working with the Blue Ribbon Commission and all interested stakeholders to develop an implementation plan for this proposal. In brief, we believe Washington State can excel where others have fallen short in the creation of an environment focusing on Health care delivery.

Questions can be directed to Terry Kohl, Lobbyist at (206) 568-0991 (office), (206) 850-6030 (cell), or tkohl@comcast.net or Ryan Bradley, ND at (206) 778-1722 or ryan.bradley@bastyr.edu.

Sincerely,

Ryan Bradley, ND and Erica Oberg, ND
Washington Association of Naturopathic Physicians (WANP)

Proposal to the WA State Blue Ribbon Commission
on Health Care Costs and Access
September 1, 2006

Evidence-based, Chronic Disease Prevention (EBCDP) Programs: Access to Cost-Effective Care for Improved Health

Submitted by the Washington Association of Naturopathic Physicians (WANP)

Evidence-based, chronic disease prevention (EBCDP) programs will contain health care costs, improve health care outcomes and expand access. EBCDP program development is congruent with current WA State Blue Ribbon Commission goals and visions by combining evidence-based practice with chronic disease prevention. EBCDP includes guideline-directed, therapeutic lifestyle change including healthy eating, physical activity, smoking cessation, weight control, and stress reduction. EBCDP includes approaches for both primary and secondary prevention of chronic diseases and chronic disease complications. EBCDP programs must be developed to include performance measures and promoted in a manner that creates incentives for both patients and health care providers. Data collection shall be a requisite component of all EBCDP programs for self-critical performance appraisal.

1. What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access? Briefly summarize your proposal.

In response to the Blue Ribbon Commission's request for proposals, the Washington Association of Naturopathic Physicians (WANP) proposes the following strategies by which EBCDP can improve access, improve health and improve affordability:

a. **Development of performance measures,** designed by the State in collaboration with regional partners, for use in State-supported quality improvement programs that ensure the delivery of evidence-based, chronic disease prevention (EBCDP) services by all types of WA State health care providers. These performance measures shall be consolidated from current national guidelines, e.g. US Preventive Services Task Force, ATP-III, JNC-7, etc. and recommendations from national health associations, e.g. American Heart Association, American Diabetes Association, etc. Benchmarks shall be based on current evidence and consensus utilizing local expertise. Performance measures will be specific, yet tailored to meet the needs of individual health care provider types and health-care delivery facilities; the measures will be applicable to individual physicians in a primary care setting, public-health centers including support staff, and hospital-based programs with multiple provider types.

b. **Collection of outcomes and cost effectiveness data** to evaluate the impact of implementing the EBCDP performance measures on chronic disease risk factors, e.g. hypertension, and ultimately on the incidence of chronic diseases and disease-related events, e.g. diabetes, myocardial infarction. The collection of this data may initially occur in demonstration projects to ensure delivery optimization prior to large-scale implementation, at discretion of the State and the Department of Health. Because of EBCDP practices are already incorporated into naturopathic medicine as an element of routine care, demonstration projects with naturopathic clinics may provide an appropriate demonstration environment. Cooperation between naturopathic physicians, State-funded health insurance programs, and the public health sector is an achievable and powerful partnership.

c. **Development of provider and/or facility incentives**, designed by the State in collaboration with regional partners, for the provision of EBCDP education. Examples may include: health care provider recognition programs, pay-for-performance programs, increased eligibility for State funding and direct changes to regional reimbursement structure. Provider incentives may undergo testing in select demonstration projects with diverse types of health care providers to ensure optimization prior to large-scale implementation, at discretion of the State and the Department of Health. Provider incentives are critical for the delivery of EBCDP services due to current reimbursement challenges.

d. **Development of patient incentives**, designed by the State in collaboration with regional partners, to be funded by private payers, State-funded health programs and employers that encourage the receipt of EBCDP education from participating WA State health care providers and facilities. Examples may include: quarterly prevention visits with waived co-pay for high-risk patients; premium reductions or credits for patients who demonstrate reduction in chronic disease risk factors, adoption of healthful behaviors, and/or improvement in self-management of their health concerns; the provision of free community-based, educational programs and choice in the selection of health care providers who demonstrate a commitment to the provision of EBCDP education. Patient incentives may undergo testing in select demonstration projects with participating health care providers to ensure optimization prior to large-scale implementation, at discretion of the State and the Department of Health. The King County Healthy Incentives Program is a model for incentive development. In order to reach populations in which health disparities are common, incentives must anticipate common obstacles, e.g. transportation access.

e. **Focus on cooperative, critical mass delivery** of EBCDP services by a broad provider base, including physicians. Critical mass delivery requires health care facilities to develop systems to ensure all patients receive EBCDP services, regardless of facility-type. While primary care providers (MD, DO, ND, ARNP) may be positioned to deliver these recommendations efficiently for most patients, many patients do not have a single medical home. Community public health clinics and hospitals should also be seen as Health promotion centers.

2. How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

The Commission has a laudable vision of creating a system in which every Washingtonian will have the ability to obtain needed health care at an affordable price; this vision can and will be achieved within 5 years. The adoption of this proposal will achieve this vision in the following ways:

In Improving Health:

To become one of the top ten healthiest states in the nation will require shifting the Washington healthcare system away from disease-oriented, crisis care toward a preventive, Health promotion care. A consumer-driven, Health-oriented system can be created with wide provider inclusion and improve patient satisfaction with services and care.

Healthy state rankings include measures of obesity prevalence, lost work time, cardiovascular death, and cancer death among other measures; these scores are improved by the implementation of EBCDP services. By developing EBCDP programs we can create the infrastructure for the delivery of evidence-based care resulting in better health outcomes. By doing so across a wide base of all provider types, and by eliminating the barriers that reduce provider's ability to offer such care, population indicators of state health will become consistent across race, gender & income.

A few critical points are summarized below:

Adoption of a Health Lifestyle = Evidence-based, Chronic Disease Prevention (EBCDP).

- 62% of coronary events are preventable by following a healthy lifestyle (The Health Professionals Follow-up Study (n=42,847) (*Circulation* 2006; 114;160-167)
- 58% of Type 2 diabetes is preventable by lifestyle modification (Diabetes Prevention Program (DPP); (*New Engl J Med* 2002)
- Cardiovascular disease, diabetes, and cancer are all preventable through lifestyle practices (Preventing Cancer, Cardiovascular Disease and Diabetes: A Common Agenda American Cancer Society, American Heart Association, and the American Diabetes Association, *Circulation*, 2004)

EBCDP is more effective than early medication for disease prevention.

- Lifestyle (58%) was superior to early metformin (34%) for the prevention of diabetes (DPP, *New Engl J Med*, 2002)
- Lifestyle change is the *only* intervention proven to reverse coronary artery disease (Ornish et al., *JAMA*, 1998)
- Early TZD class medications were ineffective in diabetes prevention (Knowler et al. *Diabetes,* 2005)

Few WA State health care providers are making EBCDP recommendations in practice**.**

- Only 16% of adult respondents said they were advised by their doctor, nurse, or other health professional to eat fewer high fat or high cholesterol foods
- Only 20% were advised to eat more fruits and vegetables
- Only 23% were advised to be more physically active

Source: The Burden of Heart Disease and Stroke in Washington State 2004; WA State Dept. of Health

This summary of data provides rationale for our proposal. It is known that 1) health is improved and chronic disease is prevented through the adoption of healthy lifestyles 2) EBCDP is more effective than early prescription medication for prevention and 3) EBCDP is not currently widely offered in Washington State. The adoption of this proposal will improve the health of Washington citizens.

In Improving Access:

The focus on cooperative, critical-mass delivery of EBCDP services will ensure access. Consumer choice will drive the selection of primary care services to facilities that provide high patient satisfaction. Offering EBCDP services at a low, or reduced, cost to critical need populations and/or as a routine component for health program enrollment will also ensure access. In some populations, including those of low socioeconomic status, access is also limited by community factors such as transportation and neighborhood safety, which need to be addressed. With broad participation and provider inclusion, patients will have access to the necessary EBCDP services independent of their choice in medical home.

Chronic disease disproportionately affects people of lower socioeconomic status,

- These populations are most in need of EBCDP services and are most dramatically affected by barriers that limit providers ability to offer such care, including low reimbursement
- Once appropriate EBCDP recommendations are given by providers, they are low or no cost to implement

In Improving Affordability:

The cost effectiveness estimates of prevention programs range considerably depending on the analysis used. In general, primary preventive services are widely recognized as cost-effective, with secondary prevention programs considered to be more so. Yet EBCDP services apply to both primary and secondary prevention. Also a major influence on the cost of such programs is the lack of infrastructure and coordinated care delivery for EBCDP programs. Many economic analyses are limited in that they often only include data on the cost savings from preventing a single condition, when in fact the same EBCDP

services may reduce costs on multiple chronic diseases (cardiovascular disease, diabetes, cancer, depression, etc.) simultaneously. The implementation of broad-reaching EBCDP programs focusing on critical-mass delivery will overcome these obstacles through the development of infrastructure in multiple health care settings.

EBCDP programs are cost-effective.

- Preventive services are widely accepted as a cost-effective strategy to reduce disease. AHRQ-supported research shows that health education and lifestyle modification reduce the negative impacts, including costs, associated with chronic disease (Research News. *AHRQ No 02-0018* April 2002)
- A recent demonstration project implemented the Diabetes Prevention Program lifestyle intervention in adults age 50 and prevented 37% of expected cases of diabetes over 15 years at a cost of $1288 per QALY. Private insurer investments in this EBCDP program showed recovery of costs in the form of medical expenses avoided after three years implementation. (Ackermann et al., *Diabetes Care*, 2006)

Ignoring EBCDP is very costly.

- Almost 60% of Washington adults are overweight or obese. Obesity is one of the primary factors in many health problems, including diabetes and heart disease. In one year alone, diabetes-related hospitalizations cost about $1.27 billion
- Escalating costs of chronic disease nationwide despite higher priced treatments
- Avoidable medical costs of amputation, blindness, dialysis, kidney transplantation, cardiovascular surgeries, and long-term hospitalization
- Avoidable human costs of blindness, amputation, work-time losses, and depression

Chronic disease care is costly for patients and insurers and the costs are escalating. The advent of new medications and technologies has not reduced the cost or incidence of chronic disease. In fact both have increased and are expected to continue to increase. A new approach to Health care deliver is urgently needed in Washington State.

3. Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.

The proposed EBCDP strategies expand upon existing policies and programs. While numerous quality improvement efforts are being implemented throughout the country on local and national levels, efforts are largely being guided by national recommendations referred to as the Clinical Performance Measures "Starter Set" which has been put forth by the Ambulatory care Quality Alliance (AQA), the American Academy of Family Physicians (AAFP), American College of Physicians (ACP), America's Health Insurance Plans (AHIP), and Agency for Healthcare Research and Quality (AHRQ). The starter set does not include healthy lifestyle measures for most health behaviors- despite substantial evidence suggesting a healthy lifestyle is critical for prevention and also improves long-term outcomes. This proposal is in alignment with the national measures and expands upon them by proposing the development of measures to fill in the gaps in the current "Starter Set".

Additionally, EBCDP is similar to and congruent with programs both here and in other states. Local efforts with which the EBCDP strategies are congruent include the **Puget Sound Health Alliance,** which is promoting the use of the "starter set" measures and has committed to emphasizing health promotion and lifestyle interventions in response to the feedback of their membership. EBCDP strategies also parallel the **King County Healthy Incentives** program. State-wide adoption of EBCDP strategies could provide improved infrastructure and further development of incentive mechanisms which could increase the success of this innovative program. The **Department of Health** and the **Washington Health Foundation** (WHF) are working together to bring the Chronic Disease Self Management Program - CDSMP (a program developed and tested by Dr. Kate Lorig from Stanford University) - to Washington's

rural communities. WHF is working on health promotion and prevention in their Healthiest State in the Nation campaign and will be in need of mechanisms to measure their success. There will be a need for developing strategies like those in this proposal to ensure consistency in measures and data sharing as additional health promotion programs are created by health care leaders.

We commend the Governor's Washington Wellness Works program which states, "Government must play a leadership role to promote prevention and wellness. I believe Washington is especially well-suited to serve as a model by promoting healthy behavior among our own employees and retirees. We not only improve the health of state employees and retirees, but also enhance their ability to serve state citizens…State agencies are in a position to address the cost of health care. Washington state buys health insurance for 1.3 million people (Medicaid, Basic Health, Public Employees Benefits Board) at the cost of $8 billion each year; we're in a position to affect change in the area of health care."

Many elements of the delivery of the proposed EBCDP strategies are exemplified by the **Chronic Care Model**, developed by Ed Wagner, MD at the Group Health Cooperative. The Chronic Care Model incorporates cooperation between the community and the health care delivery system. The model implies patient empowerment, responsibility, and participation through the design of self-management programs and optimization of care delivery. The Chronic Care Model forms a valuable lens through which to design and implement EBCDP strategies, including critical-mass delivery.

Examples of other state programs and policies where EBCDP-type approaches are being introduced include new **Medicaid Reforms in Kentucky, West Virginia, and Idaho**. These states have been the first to use new benefit design and cost-sharing options created by the Deficit Reduction Act (DRA), to restructure Medicaid programs. The goals of such programs are to make patients more responsible for their own care which will save money for the state; this portion is congruent with part D of the proposal which creates patient incentives. West Virginia's plan includes a program by which Medicaid beneficiaries who adhere to a responsibility contract will receive credits that they can use to purchase additional benefits. While there is a punitive component to the West Virginia model (which we do not advocate replicating), the incentives provide an example which, to date, has not increased costs (N Atkins, commissioner of West Virginia's Bureau for Medical Services 2006).

An additional example is **Florida's Healthy State Program.** The Healthy State Program provides a personal, technology-enabled approach to address the critical health care needs of Medicaid patients while reducing the state's health care cost. The program will ultimately improve access to care for approximately 50,000 Medicaid patients suffering from four difficult-to-manage chronic illnesses -- asthma, diabetes, heart failure and hypertension. The program facilitates access to providers to "proactively address health issues and learn to maintain healthy behaviors".

The experience of these individuals and organizations is congruent with the proposed approach for implementation of EBCDP service delivery. Representatives from these regional organizations and other experts should be brought forward during the design of specific EBCDP demonstration projects.

4. Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?

EBCDP program costs will be shared by public and private stakeholders. This proposal suggests relevant parties, including providers, purchasers, payers, consumers, and policy makers can come together to form consensus on the best cost sharing strategies. Published analysis suggests at-risk individuals are willing to pay for risk reduction programs, especially if these programs are subsidized; high-risk individuals were more likely to pay, and would pay more, depending on the design of the program (Johnson FR, et al. *Diabetes Care*. 2006).

However, regardless of the selected strategy health promotion programs such as EBCDP have been proven cost effective demonstrating a return on investment within 3-5 years for reduced medical costs associated with prevented chronic disease. Additionally, models of EBCDP in conditions such as diabetes, which currently accounts for 12% of all health care expenditures (Hogan, Diabetes Care 2003), show impressive cost-effectiveness. Analysis of the Diabetes Prevention Program (which compared with early prescription drug treatment, placebo, or diet and physical activity) found that providing the lifestyle intervention at age 50 years could prevent 37% of new cases of diabetes before age 65, at a cost of $1,288 per Quality Adjusted Life Year (QALY) gained. A private payer could reimburse $655 (24%) of the $2,715 in total discounted intervention costs during the first 3 intervention years and still recover all of these costs in the form of medical costs avoided. If Medicare paid up to $2,136 in intervention costs over the 15-year period before participants reached age 65, it could recover those costs in the form of future medical costs avoided beginning at age 65 (Ackermann, *Diabetes Care*. 2006). Additional cost analysis of the Diabetes Prevention Program in high-risk populations resulted in a cost of $1,100 per QALY for the lifestyle program versus $31,300 per QALY for early prescription drug therapy (Herman, WH. *Ann Int Med* 2005).

5. How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

EBCDP has been formally endorsed by:

Bastyr University; Gannady Raskin, MD, ND; Dean of Naturopathic Medicine
The American Association of Naturopathic Physicians; Jane Guiltinan, ND; President

The proposal has been circulated to the following individuals and organizations:

Individuals and Health Organizations:
Dan Rubin/Kristen West, Choice Regional Health Network
Brooke Bascom, King County Benefits Healthy Incentives Program
Don Sloma, WA Health Foundation
Robby Stern, Fair Share Health Care Coalition
Melanie Stewart, American Cancer Society
Nick Federicci, American Lung Association
Mike Shaw, American Heart Association
Donna Christensen, American Diabetes Association
Bruce Reeves, Washington Senior Citizens' Lobby
Rick Mockler, Washington State Public Health Association (WSPHA) and the Washington State Association of Local Public Health Officials (WSALPHO).

Hospitals
Lisa Thatcher, Washington State Hospital Association

Private Insurers:
Ken Bertrand, Group Health
Rick Wickman, Premera
Nancee Wildermuth, Regence, Pacificare of WA
Davor Gjurasic, Molina Health Care
Mel Sorenson, American Health Insurance Plans

Health Care Provider Associations:
Len Edinger, WSMA
Kathleen Collins, WA Academy of Family Physicians
Melanie Stewart, WA Osteopathic Medical Association and American Massage Therapy Assn- WA Chapter
Tamara Warnke, WA State Nurses Association and Advanced Registered Nurse

6. What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

Obstacles to implementation are few. Common critiques and possible solutions include:

1. Critique: Decreased utilization of hospitals may result, creating hardship on funding of hospitals.

Possible solution: Development of EBCDP programs within hospitals for those patients who chose the hospital as their medical home; redistribution of hospital resources toward mental health and urgent care services.

2. Critique: Few third party payers allow reimbursement for provider time discussing EBCDP. Prevention-based service descriptors, i.e. current procedural terminology (CPT), are consumed by vaccinations and screenings, evaluation and management (E&M) services are disease-focused and adjunctive care services, e.g. dieticians, are also coupled to disease diagnoses.

Possible solution: Increase reimbursement for current health counseling, self-management education, and nutrition education to all trained providers. Develop specific codes and/or policy surrounding existing codes for the delivery of EBCDP services to high-risk patients. Expand preventive visits to include EBCDP services. Develop pay-for-performance and other provider incentives based upon performance measures to be paid for by cost-sharing arrangements between patients, purchasers, and payers.

3. Critique: The proposal does little for chronic disease treatment.

Possible solution: The proposal is prevention focused. However EBCDP services apply to both primary and secondary prevention and are critical to successful long-term management and improved outcomes in chronic disease. Similar services can and should be applied to treating those with existing disease, however we suggest it be developed in a different proposal. We are supportive of a hierarchy of therapeutics beginning with EBCDP services, proceeding to non-drug therapies, and then finally to drug therapy and surgery, yet the evidence available for non-drug treatments remains limited. We are supportive of an evidence-based initiative and feel EBCDP services are desperately needed for both prevention and treatment.

4. Critique: The proposal is being submitted by naturopathic providers. Does this mean the intent is for EBCDP to be performed only by naturopathic providers?

Response: We use naturopathic physicians as one example provider group for implementation of this program. However, this proposal is broadly inclusive and includes all trained providers in a wide array of health delivery environments. Health promotion and lifestyle recommendations are included in all major national guidelines for chronic disease care- but are not being delivered according to the guidelines in Washington State.

5. Critique: Costs increase when EBCDP-programs are initiated.

Response: This is true. As lack of infrastructure for EBCDP services contributed to the cost of implementing the programs. This fact further illustrates the services are not currently present in routine health care delivery. The cost of infrastructure development, as well as the cost of convening regional

expertise for the development of the proposed performance measures, incentives, and data collection infrastructure, will be required prior to wide-spread initiation. The development of demonstration projects confirming benefit may be a short-term tactic to ensure benefit prior to wide-spread implementation. Also, the long term cost savings are notable and substantially less costly than drug therapies. Also, current economic analyses are limited in that they often only include data on the cost savings from preventing a single condition, when in fact the same EBCDP services may reduce costs on multiple chronic diseases (cardiovascular disease, diabetes, cancer, depression, etc.) simultaneously.

Summary

The development of performance measures and incentives for both patients and providers for the delivery of evidence-based, chronic disease prevention (EBCDP) services using a cooperative, critical mass delivery model will assist the Washington State Blue Ribbon Commission in reaching its goals of improved health, improved access, and improved cost for the citizens of Washington. The collection of data on EBCDP programs will ensure critical self-appraisal of the resulting programs. The delivery of these services in all State-funded programs by trained providers will improve chronic disease incidence in at-risk populations reducing health disparities. The proposed strategies are broadly inclusive to provider types and are relevant in a wide variety of Health care delivery environments. Adopting the strategies outlined in this proposal will aid in the development of a Health-oriented care delivery environment in the State of Washington and reduce dependence on expensive medication and surgical intervention.

This proposal was drafted by Erica Oberg, ND and Ryan Bradley, ND on behalf of the Washington Association of Naturopathic Physicians (WANP) and has been submitted to the Washington State Blue Ribbon Commission on Health Care Costs and Access.

Dr. Erica Oberg is naturopathic physician at the Institute of Complementary Medicine in Seattle and a researcher at the Health Promotion Research Center in the School of Public Health and Community Medicine at the University of Washington. She has collaborated on several federal research grants including investigations of dietary composition in weight loss and multifaceted lifestyle interventions in type 2 diabetes. Dr. Oberg recently served on the Cardiovascular Disease Clinical Improvement Team as a Bastyr University delegate to the Puget Sound Health Alliance. Dr. Oberg is currently a consultant to the WA Department of Health on a project to revitalize cardiovascular disease prevention in WA State.

Dr. Ryan Bradley is clinical faculty for the Diabetes & Cardiovascular Wellness Program at the Bastyr Center for Natural Health. He also works as a research fellow at Bastyr University where he is currently conducting clinical trials of nutrients in type 2 diabetes. Dr. Bradley is published in the field of evidence-based, chronic disease prevention (EBCDP) service delivery, specifically looking at the delivery of these services by naturopathic physicians. He is committed to improved quality improvements and serves as Chair of the Clinical Guideline Development committee for the American Association of Naturopathic Physicians. Locally active, he recently served on the Diabetes Clinical Improvement Team as a Bastyr University-delegate to the Puget Sound Health Alliance.

Tab 55

Washington Coalition for Insurance Parity
300 Elliott Avenue West, Suite 300 ◆ Seattle, WA 98119-4118

Date: August 31, 2006

To: Blue Ribbon Commission on Health Care Costs and Access

From: Randy Revelle, Chair
Sean Corry, Public Education Chair
Washington Coalition for Insurance Parity

Re: Parity Coalition Proposal

The Washington Coalition for Insurance Parity, representing 145 organizations, is pleased to assist in the work of the Blue Ribbon Commission on Health Care Costs and Access. The coalition looks forward to collaborating with commission members to make full mental health parity a reality in our state.

Mental health problems are common throughout the state and nation. Each year, one in ten Americans suffers from a severe mental illness and one in five experiences a diagnosable mental illness. Mental illness is the second leading cause of disability and premature mortality. On the other hand, mental illnesses are generally as treatable as physical illnesses. Most mental illnesses improve with treatment, and early intervention yields the best results.

The mission of the Washington Coalition for Insurance Parity is to end discrimination in mental health insurance by pursuing legislation that would provide full mental health parity in Washington State. During the 2005 Legislative Session, the Washington State Senate and House enacted mental health parity by large, bipartisan majorities. The parity law, signed by Governor Gregoire on March 9, 2005, accomplishes three goals:

- Extends comparable mental health insurance to more than ***1.5 million*** residents;
- Reduces insurance discrimination against people living with a mental illness; and
- Helps thousands of people with a mental illness and their families overcome the stigma.

Insurance discrimination continues in our state within the small business and individual insurance markets; a total of almost ***540,000*** residents are excluded from the parity law. The individual insurance market currently provides no mental health coverage.

To increase access and promote healthy recovery from mental illness, any recommendations by the Blue Ribbon Commission should include a commitment to full mental health parity. ***The commission has the opportunity to end insurance discrimination against Washington State residents living with a mental illness by recommending mental illnesses be treated in a manner comparable to physical illnesses in the small business and individual insurance markets.***

Attached to this memorandum are the coalition's answers to the Blue Ribbon Commission's questions. Our representative to the commission is Sean Corry, Public Education Chair. Sean can be reached at Sprague Israel Giles, Inc., 1501 Fourth Avenue, Suite 2000, Seattle, WA 98101, (206) 957-7070, or scorry@sig-ins.com.

WASHINGTON COALITION FOR INSURANCE PARITY
Answers to Commission Questions

Question 1: *What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access? Briefly summarize your proposal.*

Question 2: *How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?*

The Washington Coalition for Insurance Parity recommends the Blue Ribbon Commission on Health Care Costs and Access extend Washington State's mental health parity law to include the small business and individual insurance markets. Mental health parity means mental health services are covered by insurance in a manner comparable to other health services. The extension of parity to these markets enhances access and increases affordability of mental health care to 540,000 Washington residents still experiencing discrimination.

In a 2006 study, the Substance Abuse and Mental Health Services Administration concluded that state parity laws have succeeded in expanding access to mental health care for those with relatively moderate and mild mental health problems. The Washington Coalition for Insurance Parity recognizes the need to improve access to affordable health care for all Washington residents and believes that providing mental health services comparable to physical health services is a crucial step toward that goal.

The cost to businesses of absenteeism, lost productivity, and claims for disability and unemployment insurance due to untreated mental illness is ***greater*** than the cost of mental health parity. In 1999, the U.S. Surgeon General reported that the indirect costs of mental illness imposed an estimated $79 billion loss on the U.S. economy in 1990. According to the U.S. Department of Labor, the $79 billion would be worth at least $120 billion today.

Question 3: *Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.*

The coalition's proposal to expand mental health parity is modeled after Washington State's 2005 mental health parity law enacted with strong bipartisan support from the state Senate, the state House of Representatives, and the Governor. The 2005 parity law will end insurance discrimination against people living with a mental illness in the large group insurance market.

Many states and the federal government have enacted mental health parity. At least 12 states have documented that with appropriate care management, parity results in ***less than a one percent*** increase in premiums. No state has repealed or weakened its parity law. Comprehensive parity has also been provided to nine million federal employees at a premium increase of ***less than one percent.***

The cost of expanding mental health parity would be minimal. In November 2004, PricewaterhouseCoopers published an actuarial analysis of the parity legislation enacted in Washington State. The analysis concluded the legislation would increase premiums by ***less than one-half of one percent!***

The coalition has collected numerous studies documenting that mental health parity results in minimal increases in insurance premiums. Ronald Bachman, a nationally recognized health care actuary, analyzed the results of parity and concluded in the *Evaluation of Parity in the FEHBP: Final Report*, "…the cost of the [Federal Employees Health Benefits Program] implementation of mental health parity only ranges between 0.24 percent and 0.87 percent." A March 2006 New England Journal of Medicine article, *Behavioral Health Insurance Parity for Federal Employees,* analyzes the costs and benefits associated with the federal parity law:

> "When coupled with management of care, implementation of parity in insurance benefits for behavioral health care can improve insurance protection without increasing total costs. *** The primary concern has been that the existence of parity would result in large increases in the use of mental health and substance-abuse services and spending on these services. With respect to the seven [Federal Employees Health Benefits] plans we studied, these fears were unfounded."

In the March 30, 2006 edition of the *Washington Post*, Ralph Ibson, president of the National Mental Health Association, said, "This study, which is certainly enormous and robust, very decisively puts to rest some of the major myths that opponents have brought to this debate, the principal myth being that to enact and implement parity is to increase health care costs."

Question 4: *Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much if any, of these costs will be offset by corresponding savings?*

Extending the state's mental health parity law to the small business and individual insurance markets would require no funding from the state's budget. In fact, mental health parity would reduce state government costs for imprisonment, hospitalization, homelessness, and public assistance. Mental health parity will also improve the overall health of the community. Providing appropriate and effective mental health treatment can reduce total health care expenditures for persons with a mental illness. Such treatment reduces the need for costly medical services (such as hospital and emergency room services) and improves outcomes for people with other chronic disorders.

Extending mental health parity would result in minimal cost increases to insurance premiums for small businesses and individuals. ***These increases, however, would be more than offset by the benefits to businesses through increased productivity, less absenteeism, and fewer claims for disability and unemployment insurance due to untreated mental illnesses.*** Psychiatric disorders are the most frequent cause of disability and lost work productivity among working adults. Working people with a depressive or anxiety disorder miss at least twice as many days of work due to illness as those without.

In a February 2006 interview for *Employee Benefit News*, Helen Darling, president of the National Business Group on Health, notes, "Mental health and substance abuse disorders currently cost U.S. employers billions of dollars annually in lost worker productivity. All will

benefit if we reduce the terrible burden of depression and other serious mental health problems that sap strength, productivity and a decent quality of life out of employees and their families."

Echoing the National Business Group on Health's comment relating to lost productivity, the Institute of Medicine's 2006 *Quality Chasm Series* reported: "Indeed, workers with depression have been found to lose 5.6 hours a week of productivity as compared to 1.5 for workers without depression."

Question 5: *How does your proposal reflect collaboration among various stakeholders? Which stake holders have endorsed it?*

The proposal to expand mental health parity is supported by 145 organizations of the Washington Coalition for Insurance Parity. (Please see the coalition's attached membership list.) These organizations represent a broad cross-section of the community, including consumer groups; non-profit organizations; hospitals, physicians, nurses, and other providers; labor unions; an insurance provider; trial lawyers; several businesses; religious organizations; and local governments.

Mental health parity also has broad statewide and nationwide support. A January 2005 poll of 750 likely voters in Washington State showed that ***86 percent*** of them supported mental health parity, while ***79 percent*** of those polled supported parity even if they would experience an increase (less than one percent) in premiums. In 2002, a poll by the National Mental Health Association showed that an overwhelming majority of Americans ***(79 percent)*** supported parity legislation, even if it resulted in an increase in their health insurance premiums.

Question 6: *What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?*

While many small businesses support the coalition's proposal to expand mental health parity, the coalition believes small business associations would oppose the expansion. Some health insurance companies would also oppose expansion of the parity law. The opposition falsely claims that parity would increase premiums between five and 10 percent. The opposition has yet to produce any study confirming their allegations.

When making a decision on mental health parity, the coalition respectfully urges the Blue Ribbon Commission to follow the overwhelming amount of research, experience, and studies that support parity. Numerous experts cite extensive research supporting the fact that parity does not cost too much, and it actually saves money. ***Most important, mental health parity is simply the right thing to do!***

Washington Coalition for Insurance Parity

August 30, 2006

The following 145 organizations support enacting mental health parity legislation in Washington State:

- AARP Washington
- Affiliated Mental Health Programs
- African American Mental Health Professionals of Western WA
- American Academy of Pediatrics, Washington Chapter
- American Civil Liberties Union of Washington

- American College of Physicians, Washington Chapter
- ARNP of Washington State
- Association of Advanced Practice Psychiatric Nurses
- Association of Washington Cities
- Association of Washington Public Hospital Districts

- Behavioral Health Resources
- Ben Bridge Jewelers Inc.
- Catholic Charities, Diocese of Spokane
- Catholic Community Services of Western Washington
- Catholic Family and Child Service, Diocese of Yakima

- Children's Alliance
- Children's Home Society of Washington
- Children's Hospital and Regional Medical Center
- CHOICE Regional Health Network
- Church Council of Greater Seattle

- Columbia River Mental Health Services
- Common Ground for Children and Families
- Community Advocacy Coalition
- Community Health Network of Washington
- Community Psychiatric Clinic

- Compass Health
- Crisis Clinic
- Family Medicine of Yakima
- Family Services of King County
- FareStart

- Fremont Public Association
- Good Samaritan Behavioral Health Care
- Grant Mental Healthcare
- Greater Lakes Mental Health Care
- Green Party of Seattle

- Harborview Medical Center
- Health Care for All/Washington
- Healthy Mothers, Healthy Babies
- Intercommunity Peace and Justice Center
- Japanese American Citizens League - Pacific Northwest District

- Jewish Family Services
- Jewish Federation of Greater Seattle
- King County Project Access*
- League of Women Voters of Washington
- Lutheran Community Services Northwest

- Lutheran Public Policy Office of Washington State
- MCPP Healthcare Consulting, Inc.
- Mental Health Association of Washington
- Minority Executive Directors Coalition
- MultiCare Health System

- NAMI Citizens Guild of Western State Hospital
- NAMI Chelan/Douglas Counties
- NAMI Clallam County
- NAMI Clark County
- NAMI Cowlitz County

- NAMI Eastside
- NAMI Greater Seattle
- NAMI Jefferson County
- NAMI Kitsap County
- NAMI Kittitas County

- NAMI Lewis County
- NAMI North Sound
- NAMI Palouse
- NAMI Pierce County
- NAMI Skagit County

- NAMI Snohomish County
- NAMI South King County
- NAMI Spokane
- NAMI Thurston/Mason Counties
- NAMI Tri-Cities

- NAMI Wahkiakum
- NAMI Walla Walla
- NAMI Whatcom County
- NAMI Whidbey Island
- NAMI Yakima

- National Alliance for the Mentally Ill of Washington
- National Association of Social Workers, Washington Chapter
- National Eating Disorders Association
- Northwest Alliance for Psychoanalytic Study
- Northwest Federation of Community Organizations

- Northwest Health Law Advocates
- Northwest Women's Law Center
- Okanogan Behavioral Health Care
- Older Women's League, Seattle/King County Chapter
- Partners with Families and Children: Spokane

- Peninsula Community Mental Health Center
- Piano and Organ Moving Company, Inc.*
- Plymouth Housing Group
- Seattle Education Association
- Seattle Human Services Coalition

**** Indicates a Small Business***

- Seattle Mental Health
- Seattle Psychoanalytic Society and Institute
- Senior Citizen's Lobby
- Senior Services of Seattle/King County
- Service Employees International Union/1199NW

- Snohomish County Labor Council, AFL-CIO
- Sprague-Israel-Giles, Inc.*
- Tacoma Area Coalition of Individuals with Disabilities (TACID)
- Timberlands Regional Support Network (RSN)
- Timberlands RSN Advisory Board

- Transitional Resources
- Valley Cities Counseling/Consultation
- Volunteers of America, Spokane
- Washington Academy of Family Physicians
- Washington Academy of Physician Assistants

- Washington Association for Marriage and Family Therapy
- Washington Association for Substance Abuse and Violence Prevention
- Washington Association of Area Agencies on Aging
- Washington Association of Churches
- Washington Association of Community/ Migrant Health Centers

- Washington Citizen Action
- Washington Community Mental Health Council
- Washington Federation of State Employees
- Washington Food Coalition
- Washington Health Care Association

- Washington Health Foundation
- Washington Mental Health Counselors Association
- Washington Protection and Advocacy System
- Washington Public Employees Association
- Washington Re-Education Association

- Washington State Association of Counties
- Washington State Catholic Conference
- Washington State Coalition of Mental Health Professionals/Consumers
- Washington State Council of Child and Adolescent Psychiatrists
- Washington State Council on Aging

- Washington State Developmental Disabilities Council
- Washington State Hospital Association
- Washington State Labor Council, AFL-CIO
- Washington State Medical Association
- Washington State Nurses Association

- Washington State Parent Teacher Association
- Washington State Partners in Crisis
- Washington State Pharmacy Association
- Washington State Psychiatric Association
- Washington State Psychological Association

- Washington State Public Health Association
- Washington State Society for Clinical Social Work
- Washington State Special Education Coalition
- Washington State Tourette Syndrome Association
- Washington State Trial Lawyers Association

- Whatcom Counseling and Psychiatric Clinic
- Wyeth Pharmaceuticals
- Yakima County Health Care Coalition
- YFA Connections
- Youth Suicide Prevention Program

**** Indicates a Small Business***

Tab 56

DELTA DENTAL

Washington Dental Service Foundation

Community Advocates for Oral Health

August 22, 2006

Comments for the Blue Ribbon Commission on Health Care Costs and Access
Tracy Garland President & CEO, Washington Dental Service Foundation

Thank you for the opportunity to provide input regarding how to develop a health care system that provides every Washingtonian the ability to obtain needed health care at an affordable price. I attended the Blue Ribbon Commission meetings on June 22 and July 27, and I want to reiterate the importance of including oral health in your work. Oral disease is a major health problem in our state, and prevention and early treatment needs to be an integral part of any effort to address health care access and affordability.

The Washington Dental Service Foundation is the state's largest foundation dedicated to improving oral health. We support innovative oral health programs focused on preventing oral disease, expanding access to dental care and increasing awareness of the importance of oral health.

Despite the fact that it is almost entirely preventable, dental disease is a serious and growing problem in our state. It affects all ages, harming the health of seniors and the ability of children to do well in school; it even affects the readiness of our soldiers. Consider the following:

- About 30 percent of Washington's National guardsmen called to active duty had dental problems so severe they could not be sent overseas.
- A recent state study found that the rates of decay among children are increasing. Forty-five percent of preschool children and 60 percent of elementary school children have decay, numbers that are higher than the national average.
- Between 2002 and 2004, Children's Hospital and Regional Medical Center experienced an astonishing 54 percent increase in the number of children seeking expensive emergency room care for problems that started with dental cavities — cavities that could have been prevented.
- Nearly one-third of seniors (about 218,000 in our state) have untreated dental cavities.

Oral disease can be intensely painful, costly and lead to other serious health problems. There is also a significant cost to society in terms of higher health care expenses, reduced productivity, and missed school and opportunities for children. It is well documented that poor oral health interferes with early childhood development and learning.

It is much more expensive for families — and taxpayers — to pay for dental disease treatment than to pay for prevention. Annually more than $50 million is spent in this state treating children for oral disease. Medicaid accounts for about half of this spending. If you add adults

and especially seniors to the equation, the costs become enormous. Many of these costs could be avoided if prevention and early treatment were higher priorities.

2007 policies

There are several policies that can be adopted in 2007 to prevent dental decay and improve access to dental care.

- We should engage more primary care medical providers to provide preventive dental care services during well-child checkups. This intervention will catch at-risk kids early when the opportunity for prevention is greatest. The evidence shows this approach is cost effective because typically primary care providers see a child about eight times for well-child exams before a child's fist visit to the dentist.

- We must ensure more people receive the health benefits of fluoridated water. Almost half of Washington residents do not have fluoridated water, even though 60 years of evidence proves it is a safe and effective way to prevent oral disease. More than 170 million Americans drink fluoridated water every day. Studies have shown that every dollar spent on fluoridation saves about $140 in dental care costs.

- We should devote more resources to seniors' oral health. Dental disease is linked to diabetes, heart disease and stroke. Increasing access to preventive and restorative dental care will help keep seniors healthy and reduce overall health care costs.

- We need to address disparities in health care by adopting approaches that encourage ethnic minorities to pursue health care careers. A diversified workforce is essential to improve oral health in minority communities.

- We need to take action to encourage good nutrition. In addition to causing obesity, today's sugar-filled diet today is a major contributor to the decline in children's oral health. The state needs to examine its policies to make certain they do not inadvertently encourage poor nutrition, which leads to dental decay.

Five-year vision

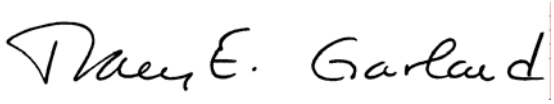
In five years we can significantly reduce dental disease among children and seniors and improve oral health in Washington. The five-year vision should accomplish the following:

- Dental disease prevention is identified as an important **health** priority.
- By 2010 all kids are covered for dental preventive services and early treatment.
- Workforce diversity is increased improving access for underserved populations.
- Dental care is easily accessible and delivered in a culturally competent manner in dental, medical and community settings.
- Dental, medical and community providers are appropriately reimbursed for delivering cost-effective prevention services.
- Seniors receive comprehensive preventive and restorative care.
- State policies reflect and reinforce the importance of good nutrition.

These are simple steps that can and should be taken to protect the oral health of Washington residents. When we make oral disease prevention a priority in this state, the health dividends and cost-savings will be significant.

We look forward to working with the Blue Ribbon Commission and others to address this important health issue.

Sincerely,



Tracy E. Garland
President & CEO
Washington Dental Service Foundation
(206) 528-7388
tpgarland@deltadentalwa.com

Tab 57

Washington Fair Share Health Care Coalition

WA State Labor Council
WA Community Action
WA for Health Care
UFCW International Union
SEIU State Council
WA Federation of State Employees
Brown & Cole Corporation
Joseph & Associates, P.S.
WA State Hospital Association
Community Health Network of WA
WA State Chapter NOW
Don Barbieri, Chairman of the Board, Red Lion Hotels (affiliation noted for identification purposes only)
Terry Gardiner, Former CEO, Norquist Seafood
Western Council of Industrial Workers
WA Society for Clinical Social Work
Spokane Alliance
Lutheran Policy Office of WA
Planned Parenthood Affiliates of WA
IUPAT District Council #5
Laborers District Council
WA Machinists Council
Teamsters Joint Council #28
Center for a Changing Workforce
AFT Washington
WA Building & Construction Trades Council
Labor Roundtable of SW WA
UNITE/HERE #8
SPEEA/IFPTE #2001
WA Alliance for Retired Americans
Pierce County CLC
UFCW, WA State Council
WA Senior Lobby
WA State NOW
Snohomish County LC, AFL-CIO
League of Women Voters of WA
River Run Venture, LLC
BLET/WA State Legislative Board
USNU/UFCW #141
UFCW #21
UFCW #44
UFCW #81
UFCW #1439
WPEA/UFCW #365
CWA State Council
Sheet Metal Workers #66
IUOE #612
Pacific NW DC of Iron Workers
Cowlitz/Wahkiakum CLC
Longview/Kelso BCTC
ATU Legislative Council
ATU #587
ATU #757
ATU #758
ATU #843
ATU#1015
ATU #1576
Laborers #276
Roofers #153
SEIU #775
SEIU #925
SEIU #1199NW
IFPTE #17
NW Women's Law Center

PROPOSAL TO
THE BLUE RIBBON COMMISSION ON HEALTH CARE COST AND ACCESS

FROM THE FAIR SHARE COALITION
August 30, 2006

Introduction

This proposal was developed by the organizations of the Fair Share Coalition of Washington, which includes major health care provider, labor, community, faith-based, and senior citizen organizations. This proposal is different in part from the Coalition's 2006 legislative proposals; addresses the goals developed by the Blue Ribbon Commission; and is based on existing programs.

Proposal Overview:

This proposal is based on the desire of the people of Washington to be healthy and to have a high-quality health care system in which affordable health services are available for everyone. We want a health care system that prepares the next generation for school and allows us to lead productive lives. We want people to take responsibility to improve their own health and to pay what they can reasonably afford to support their health services. We support the present goal of all children having health coverage and achieving that goal by 2008. In addition, health care coverage of adults should be expanded using current effective and proven health care programs.

Proposal Outline

The major goals of this proposal are 1) to provide coverage for all Washington residents; 2) share health care costs equitably across government, employers, and individuals; 3) increase access to health care for low-income residents; 4) create high-value health care outcomes; 5) increase financial security for state residents.

Fair Share Plan Coverage Elements:

- Expanding the Basic Health Plan and Medicaid to cover all uninsured residents under 300% of FPL by 2010.
- Providing coverage for all children beginning in 2008.
- Expanding the Small Employer Health Insurance Partnership (SEHIP) to cover employees up to 300% of FPL by 2010, to reduce economic impact of health care costs on small businesses.

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- Giving larger employers a choice of providing employee health insurance coverage or contributing to the cost of covering employees through state plans.
- Combining the private health insurance market pools for individuals, small business and association health plan coverage, and create a reinsurance market for the combined pool.
- Improving benefit design to include a core group of primary, preventive, emergency, catastrophic, mental health, dental and chronic care services, and maintaining or improving benefits in existing public programs.
- Implementing existing legislative action plans to reduce health care disparities based on race and ethnicity.

Fair Share Plan Financing Elements:

- Require uninsured individuals and families below 300% of FPL to contribute to the cost of health insurance on a sliding-scale basis at affordable levels. Self-employed individuals above 300% FPL must purchase insurance coverage, (provided the state certifies that affordable plans are available.) The state will ensure quality affordable health plans are available through regulatory oversight or by expanding existing public health plans to accommodate these people. Cost sharing levels in existing public programs should not be increased.
- Larger employers have choice of providing insurance coverage or paying a sliding scale premium tax based on employer size, phased in by 2010. This feature is necessary to end cost-shifting by and public subsidization of some large employers.

Fair Share Plan Quality/Cost Control/Access Elements:

- Create risk-adjusted value-based outcomes/results reporting and tracking for all providers and insurers. Establish or use an existing independent and trusted group to collect, monitor and distribute the data.
- Encourage or model innovative benefit design with chronic care/disease management coverage.
- Ensure transparent pricing of health care services, with episode and care-cycle pricing and limits on pricing discrimination.
- Build incentives into all public programs that incentivize best practices. Link provider pay increases to commitments to expand access and increases in quality.
- Public/private Cost/Quality Oversight Commission, with representatives from government, business, labor and consumers, to implement cost control and quality measures, including recommendations from Certificate of Need (CON) Task Force.

Proposal Narrative

The Fair Share proposal expands the current employer-based health insurance system, using the existing Medicaid and the Basic Health Plan to initially cover all children by 2008; to cover uninsured employees and other residents, with coverage phased in by 2010; and expanding the Small Employer Health Insurance Partnership, to reduce the economic impact of health care costs on small businesses with low-wage workers, with coverage also phased in by 2010. The proposal would also assist small business by creating a common health insurance risk pool for small business, associations and individuals, followed by creation of a reinsurance mechanism for the combined market. The proposal calls for a minimum level of coverage for state residents, to include basic primary, preventive, emergency, catastrophic, mental health, dental and chronic care services.

To finance the expansion of coverage, the Fair Share proposal envisions contributions from government, employers, and individuals. Individuals would contribute on sliding-scale basis below 300% of FPL at affordable

levels, considering their limited income. To reduce cost shifting from uninsured individuals who can afford insurance, individuals over 300% of FPL would be required to purchase coverage, provided that the state certifies that affordable coverage is available. To reduce cost-shifting and public subsidy of large employers, these employers who choose not to provide insurance to some or all employees would be given a choice of contributing to the state's health care purchasing fund, using a sliding-scale payroll tax based on size of employer.

The Fair Share Coalition seeks to improve health care quality and value in part using proposals from a recent Harvard Business School book by Michael Porter and Elizabeth Teisberg, *"Redefining Health Care: Creating Value-Based Competition on Results"* (HBS 2006). Porter and Teisberg propose encouraging providers and insurers to compete on the basis of value (as measured by health outcome per dollar spent). The key to competing on value is to measure risk-adjusted health outcomes, and make this information available to consumers, employers, insurers, and government. This builds on current efforts to promote evidence-based practice guidelines and health outcomes data by the Puget Sound Alliance and similar efforts. We believe state government can play a critical role in setting standards for measurement, and requiring providers and insurers to collect and disseminate this information.

To further expand value-based competition, purchasers need transparent pricing information, including prices for episodic and cycle-of-care costs, and some protection from the current price discrimination that currently benefits only the largest health care purchasers.

Plan designs and coverage should be modified to cover chronic care and disease management services, to encourage consumers to seek needed care and allow providers to intervene appropriately, while reducing hospitalization and overall costs. On the provider side, we need incentives in all public programs that incentivize best practices, including linking provider pay increases to commitments to expand access and increases in quality. Residents who take steps to improve personal health should also be rewarded through financial incentives in plan design and out-of-pocket costs.

Finally, to implement this legislation, Washington needs an ongoing public/private Cost/Quality Oversight Commission, with representatives from employers, labor, government and consumers. Such a Commission would set and review standards for coverage, financing, data collection and dissemination, and implement the recommendations of the Certificate of Need (CON) Task Force for a strategic health planning process.

Responses to Commission Questions

1. The proposal realizes the Commission's vision by providing access for all residents, making significant changes in benefit design and outcomes measurement to ensure residents get "needed" care as currently defined, and will significantly reduce costs from projected levels through provider and insurer competition based on value, transparent pricing, reduced cost-shifting, and better disease management.

2. The proposal enhances the chances of achieving the Commission's goals by providing a realistic path, using existing state programs, broad-based financing mechanisms, and existing health improvement plans. More specifically:

    a. Goal 1. Provides phased in access for all residents by 2010. Provides for effective care by developing system of health outcomes reporting and chronic care management.

    b. Goal 2. Moves Washington towards leading the nation in health by covering chronic care, by rewarding providers of superior care, by promoting practice guidelines, and by providing incentives for state residents to improve their health.

c. Goal 3. Delivers more consistent health indicators by implementing existing action plans to reduce disparities based on race and ethnicity, and by providing affordable access to primary, preventive and chronic care for low-income residents.

d. Goal 4. Incorporates evidence-based medicine and calls for value-based competition among providers and plans, using risk-adjusted outcomes data.

e. Goal 5. Strategy of value-based competition combined with state oversight provides best model for controlling cost increases, along with promotion of evidence-based medicine, chronic care management, transparent pricing, and establishing a strategic health planning process, including a more effective certificate of need process.

3. The Fair Share proposal is based on the existing Medicaid, Basic Health Plan, Puget Sound Alliance, and Certificate of Need task force recommendations. These programs all have a track record of increasing health care access, improving quality, or reducing costs. The proposal for equitable sharing of employer costs shares features with Hawaii's employer-based health insurance system, which has reduced cost-shifting and increased access.

4. The proposal would share costs of an effective state health care system equitably among individuals, employers and government. These costs would be phased in by 2010. The employer share of these costs would be less than large employers currently pay for employee health insurance, adjusted for medical inflation. The individual share would based on a sliding scale for low-wage workers, and would be less than the current trend line for employee contributions to health insurance, adjusted for medical inflation. For employers who currently provide insurance to most employees, there will be significant savings, not the least of which would be a savings of 25-30% in the share of premiums currently going to uncompensated care. Some of the initial cost to employers not currently providing insurance would be offset by quality improvements and reductions in unneeded health care expenses. The proposal's costs also could be subsidized from federal grants and assistance available to states for innovative health care reforms, if the Health Partnership Act (S.2772) or similar legislation passes in the next session of Congress.

5. This proposal reflects significant collaboration among a large number of participants, including major health care providers, business leaders, unions representing nearly half a million employees, consumer organizations, and others. The proposal was developed over the past six months, the result of numerous meetings, conferences and discussions. This proposal is endorsed by the Fair Share Coalition, which includes the organizations on the attached list.

6. Possible obstacles and responses:

a. The proposal may result in a challenge of the employer choice standards to the federal courts. Any state proposal that includes an employer role may face a legal challenge. It is possible that financing and risk-sharing components may need to be adjusted by future legislative action, depending on federal court action.

b. Some organizations will object to any proposal that includes an employer financing component. The response is that employer participation is necessary to equitably finance health care, to reduce cost-shifting, and to ensure a level playing field between similar sized employers.

c. Some individuals will object to any provision that requires individuals above 300% of FPL to purchase health insurance. The response would be that this provision is essential to prevent cost-

shifting between individuals who can afford health insurance and other purchasers. Individuals would be protected by a state guarantee that such coverage must be affordable.

d. The proposal is subject to changes in Medicaid funding by the federal government. The extent of state funding for health insurance coverage may need to be adjusted by future legislative action, depending on federal legislative action.

e. Some insurers and employers will object to creating a pool in the private insurance market for individuals, small businesses and association plans. The response is that pooling risk and creating a reinsurance mechanism is necessary to make insurance more affordable for many small businesses, older individuals, people with chronic conditions, and families.

f. Some providers and insurers will object to collecting and disseminating risk-adjusted health outcomes data. The response is that results-based competition between providers and insurers won't work without providing accurate outcomes data to purchasers, and feedback to providers and insurers.

g. Some providers and insurers might object to encouraging value-based competition. The response is that the current competition serves only to shift costs, get more bargaining power, and limit services.

h. Some purchasers and insurers might object to the concept of a Cost/Quality Oversight Commission. The response is that some entity must set the ground rules and make policy adjustments for outcomes data standards, for effective competition, including ensuring transparent pricing, improving benefit design, and implementing a strategic health planning process with input from all purchasers.

The Fair Share Coalition looks forward to working with the Blue Ribbon Commission in meeting its goal of providing needed health care at an affordable price. If we can be of assistance, please contact us.

Tab 58

PROPOSAL TO THE BLUE RIBBON COMMISSION

THE WASHINGTON HEALTH FOUNDATION PROPOSAL:

As the architect and administrator of Washington's Healthiest State in the Nation Campaign, the Washington Health Foundation (WHF) proposes to work with the Blue Ribbon Commission to advance health and health care. Specifically, we are proposing:

1. To use our Healthiest State Report Card database to help identify measures that offer the greatest potential to improve Washington's health so that we move into the Top 10 in state health rankings over the next 5 years;
2. To partner with the Blue Ribbon Commission on our long term plans to educate consumers about the health system and their need to take personal responsibility for their health (e.g., in the upcoming Governor's Community Health Bowl, televised health tips, radio and print publications, health advice to our 23,000 and growing individual Champion list, our website's free personal health tracking system for use by Washingtonians, etc.);
3. To incorporate specific prevention messages into the Governor's Community Health Bowl based on areas that the Blue Ribbon Commission would like to prioritize (through paid media, earned media, our website and materials, *thrive!* magazine, etc.);
4. To provide advice or further analysis on priority issues or specific ideas identified by the Blue Ribbon Commission, including the identified Top 10 health targets, specific policy proposals regarding how to achieve universal access to coverage and care in our state, or specific approaches for incorporating evidence-based medicine into state health strategies.

Our shared goals include:

- To move Washington from #14 into the Top Ten in state health rankings;
- To see that all Washingtonians have access to health coverage that provides effective care, with all children having such coverage by 2010; and
- To see that key health indicators are consistent across race, gender and income levels throughout the state.

The Healthiest State in the Nation Campaign sets forth a broad and balanced set of proposals that echo many of the State's interests as articulated through the State's Priorities in Government measures. (Please see Comparison Matrix below.)

States like Massachusetts have demonstrated that progress in health and health care can be made when diverse interests and political philosophies find common ground. We believe a similar approach in Washington State can result in the collaborative effort required to create effective change in health and health care.

Our view regarding health care costs is similar to the Commission's in that we believe universal access to needed care and significant health improvement should be achieved without increasing total health care spending per person more rapidly than the growth in personal income. We agree that this can be achieved in part, by increasing the use of evidence-based care to bring better health outcomes and satisfaction to consumers. What is more, we believe health care financing reform is essential to enable state government to increase investment in non-health care spending that holds even greater promise for improving our state's health. Such investments include public health infrastructure, early learning and basic education.

WHF's attached *2006 Report Card on Washington's Health* summarizes the action areas our Campaign is using to measure progress toward becoming the Healthiest State in the Nation. The Circle of Health portrays the message that building Healthy Systems and promoting Healthy Living are the keys to health improvement. WHF developed this by working directly with the people of Washington from 2001-2003. WHF heard time and again that the public wanted a comprehensive solution to health problems that embraced both the need to address our social systems for health and the need for greater responsibility on the part of individuals.

Within Healthy Systems and Healthy Living, WHF defined a set of action areas to explain how Washington could become healthier. The following action areas are included in the Circle of Health: *Promoting Community Health, Investing in Prevention, Increasing Value in Health Services, Protecting Against Injury and Disease, Avoiding Addictions, and Engaging in Healthy Habits*. These action areas within WHF's Circle of Health are a guide to WHF and to our more than 550 Participating Organizations for how Washington can become the Healthiest State in the Nation. The Circle of Health also frames our own strategic intent and application of resources in terms of programs, grants and policy leadership.

But to make these improvements real and lasting we must "go to the next level" – using specific health measures. So WHF constructed a measurement system for our Circle of Health. At the big picture level, we used the United Health Foundation's annual publication of state health to determine our current state rank, though now WHF's own *2006 Report Card* provides an alternative for making this determination.

More important for this proposal, WHF has selected a series of measures within our action areas that can be measured over time. The attached draft *2006 Report Card* identifies the 12 measures. For each, it provides the current numbers and state ranks. Note that many of the measures relate strongly to measures used by others in the state, including the Washington State Department of Health. One important difference is that WHF's measures were selected because of the need to make comparisons to other states, rather than at the county and local public health jurisdiction level. The *2006 Report Card* has been distributed throughout the state in draft form since May, and we believe it has proven to be a solid analytical approach for measuring Washington's health relative to other states.

While the core message of the Healthiest State in the Nation Campaign is one of action (designed to bring our now more than 550 Participating Organizations and 23,000 individuals into doing their part to make Washington a healthier state), a strong analytical base helps to leverage our work. The database for our *2006 Report Card* was designed to allow "what if" propositions to be tested to tell us how certain changes to programs, policies, timelines and resources might improve our measures.

The Executive Summary of the draft *2006 Report Card* offers what WHF considers a fruitful and achievable proposal to attain a top ten ranking for Washington State. Washington could advance into the Top 10 by:

- covering all our children for health care;
- increasing our rate of children's immunization (now #42);
- increasing our rate of timely prenatal care (now #37);
- increasing our rate of timely mammography (now #35);
- increasing public health system investment (now #44);
- increasing high school graduation rates (now #35); and
- reducing binge drinking (now #20).

One key objective under this scenario is to increase Washington's public health investments to the national average. This includes investments in infectious disease control (including HIV treatment and prevention), food and water safety, maternal and child health, immunizations, mental health, substance abuse, and community health center services. To our state's credit, some such increased investments have recently been made. Investments in mental health, for example, were made during the last legislative session but are not yet reflected in our data. Investments in public health preparedness for avian flu were also made, but have also not yet been included.

If the Commission would like to explore the impact of other health improvement scenarios to move our state into the Top 10 in state health rankings, WHF is willing to assist. In addition, WHF stands ready to work with the Commission in developing a set of action strategies to achieve these ends. To make real progress we believe an effective long term health improvement effort will require a variety of policy, programmatic and personal behavior change strategies. Some WHF might lead. For others, WHF might enlist the help of our Participating Organizations. Still others might be achieved solely by action by the Blue Ribbon Commission.

Our goal is that this proposal initiates a dialogue between the WHF and the Commission. To that end, we are fortunate that among the members of our Policy Advisory Council is Christina Hulet, Health Advisor to Governor Gregoire and staff to the Commission. Her active engagement in our deliberations holds the promise of expanding and deepening this dialogue. We hope she, on behalf of the Commission or the Commission members themselves, will let us know any specific topics within our broad areas of agreement they believe would be most beneficial for us to develop first. As we finalize our own policy agenda for 2007, we plan to deliver more detailed recommendations later this fall, if not in time for the Commission's very ambitious timeline, then at least in time for the state's consideration during the 2007 legislative session.

While there may be other groups or government agencies that are better positioned to work on particular action areas or issues in health or health care, our Healthiest State in the Nation Campaign has already created the potential for a new and broad base of public-private support and action. Since we view the Blue Ribbon Commission as an important part of moving to achieve the Healthiest State aims based on your Vision

Statement & Goals, we would be interested in exploring further your ideas for a direct link to our work.

IMPACT ON THE VISION AND GOALS OF THE COMMISSION

Rather than identify a specific policy or program proposal at this time, we offer the example discussed above, and propose working with you to discern the specific possibilities associated with the Commission's Vision Statement & Goals statement that "Washington will be one of the top ten healthiest states in the nation." WHF's work and proposal also relate strongly to other points in the Improving Health section of your vision statement. The elimination of health disparities is a core and cross-cutting issue in our Campaign. We understand it to be a shared focus with the Commission which identifies the goal: "Population health indicators will be consistent across race, gender and income levels throughout the state." Also note that while WHF guides action through process measures, our *2006 Report Card* includes a strong outcome approach to health. Last but not least, the individual Champions we are recruiting to join the Campaign, backed up by our multiple year effort to understand public values and attitudes regarding health and health care, (through polling, focus groups, and community roundtable meetings across the state) provide an excellent means to test whether Commission approaches truly offer "satisfaction to consumers."

IS THIS MODELED AFTER ANOTHER PROGRAM?

Our research indicates that the scope and design of the Healthiest State in the Nation Campaign program are unique. While there are other states that have stated - through both private and public organizations and leaders - that they want to be the "healthiest state in the nation," no other program exists with the breadth of our efforts. In particular, there is no other program that aims to educate and engage the public in such an effort, let alone link this to the Healthy Systems and personal responsibility that are necessary to really improve <u>health</u> outcomes.

A multitude of private and public organizations are working on specific projects or studies on topics within our areas of action and measures. Their programs are in many cases more robust than what WHF may offer in specific action areas, measures or issues.

Our goal has been to include these organizations in our Campaign to recognize this work and provide it even greater value as part of a more comprehensive effort; many have already chosen to create this linkage and are part of our more than 550 Participating Organizations.

An important counterpart and relationship with respect to our work is the State Department of Health and the Public Health Improvement Partnership. Many of our measures, though not all, are part of their fine work to improve health. Again, our intent

has been to connect our work to theirs, through both a partnership with DOH and our active involvement and support of PHIP.

WHF is also beginning to work with other states who are initiating Healthiest State in the Nation efforts. We believe this is an important part of the potential of our Campaign; that is, the potential for competition among states that will lead to a race to the top of health rankings, rather than a race to the bottom on issues that are framed purely around cost.

COSTS TO INDIVIDUALS, BUSINESSES OR GOVERNMENT

While the Healthiest State Campaign does cost money to operate, WHF is currently financing the vast majority of this effort through our own reserves. We anticipate, at a minimum, continuing this Campaign at a very active level for three years through our reserves. We are fundraising to extend this timeline and to expand our activities.

WHF is offering to do the basic work described above through our current budgets, i.e., "what if" modeling for the Commission through our *2006 Report Card* database and working with the Commission to identify key target areas for improvement in the next five years. If the Commission were interested in a more extensive analysis on these matters, or organizing specific reports, meetings, or action programs, WHF would request funding support for these.

From a broader point of view, you should note that our framework presumes that we can advance health in this state by reallocating current resources rather than finding new money. To this extent, we find generally common ground with the Commission's goal of holding health care spending increases to the rate of increase personal income. This WHF system change value comes from our Community Roundtables and Health Leadership Summit of 2003. Our core values, based on public dialogue and voting by more than 400 leaders at our Summit states that Washington should: *assure fairness to a redesigned health system through reallocation of existing health resources*.

Thus, at a basic level, WHF's view is that investments and improvements in health can be achieved by reprioritizing and shifting the use of current public, private and personal resources rather than additional costs. The only way to achieve this is over a multiple-year time period of at least five years, and this is part of our interest in the Blue Ribbon Commission. WHF is also working with our Policy Advisory Council on the principles of what a state budget would look like based on becoming the Healthiest State in the Nation - both growth of current health expenditures and general areas of investment of savings over time to a "redesigned health system."

COLLABORATION AMONG VARIOUS STAKEHOLDERS

WHF's fundamental strategic intent has been to create a new community of action around an area of agreement for the leaders, organizations and people of Washington: that we can, and should be, the Healthiest State in the Nation. This began in 2004 as a vision proposition, but has over the past 18 months moved to more actionable levels through inviting organizations and individuals to join the Healthiest State Campaign. WHF has already created the largest civic engagement project for health in our state's history, with the involvement of more than 550 Participating Organizations, 125 schools, and 23,000 individuals. And the Campaign is still growing.

Our 550 Participating Organizations includes representation from all major sectors engaged in health, including health providers, government, private non-profit organizations, business, labor, community organizations, schools, public health and more. Over 150 of these organizations are not only participating, but deeply engaged in our Campaign, which provides a strong collaborative base for action.

Key Leading and Contributing Partners in the Campaign, who are providing explicit resources to the Campaign (cash or in-kind) include:

American Heart Association/American Stroke Association
Association of Washington Public Hospital Districts
AstraZeneca
Children's Hospital & Regional Medical Center
Comprehensive Health Education Foundation
First Choice Health Network
Greater Seattle Chamber of Commerce
Group Health Cooperative
Multicare Health System
Phrma-Rx Help for Washington
Providence Health System- Washington Region
Service Employees International Union District 1199NW
Swedish Medical Center
University of Washington, including UW Medicine
Washington State Department of Health
Washington State Health Care Authority
Washington State Hospital Association
Washington State Medical Association
Washington State Nurses Association
Washington State Pharmacy Association

Uniquely, WHF has set out to ensure the public is directly and substantively involved in our efforts. While this is a long term proposition to build, we intend to do this through far more than a consumer advisory committee. Rather, we are recruiting individual Champions to join the Campaign. To date, we have recruited over 23,000 Washingtonians into the Campaign, and our target for this year is 50,000. We expect this

will give us a representative base to work directly with the public, even as we recruit more into the Campaign.

OBSTACLES

While there are many challenges to making the Healthiest State in the Nation Campaign a success, the major obstacle to our specific proposal is the suggestion that WHF should set our sights on more simple and "achievable" targets. We believe that this is part of the reason our health system is where it is today - a tendency toward too many incremental programmatic efforts that attack specific issues and problems at the unwitting expense of further fragmentation and loss of effectiveness for the overall health system. While we applaud and support many of these efforts, it is imperative for our state, through a blend of public and private leadership, to keep its eye on the prize - and to state this as the outcome of better health, indeed, making Washington the Healthiest State in the Nation.

Greg Vigdor
President & CEO
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COMPARISON OF HEALTHIEST STATE IN THE NATION MEASURES AND OUTCOMES FOR PRIORITES OF GOVERNMENT

The Washington Health Foundation (WHF) created the *2006 Report Card on Washington's Health* as part of its Healthiest State in the Nation Campaign. The *Report Card* provides a comprehensive focus for the Campaign, which is the largest civic engagement campaign for health in state history—so far involving more than 550 Participating Organizations, 125 schools and 23,000 individuals.

The *Report Card* reflects the Campaign's key message that it will take both Healthy Living and Healthy Systems for Washington to reach number one. It measures Washington's ranking in12 health indicators and six health outcomes, and includes graphs showing where Washington stands among all 50 states. While it is unique as a comprehensive measurement and planning tool, many of the individual measures and outcomes in the *Report Card* are either the same as, or point to elements similar to, those in report cards prepared by other health-oriented organizations.

Of most importance for state policymakers, though, is that many of the Priorities of Government (POG) measures set forth by The Office of Financial Management mirror WHF's *Report Card* measures. Both organizations rely on the existing body of evidence to support their investment decisions. It is important to note that several of the POG measures that are similar to WHF's measures are not from the "health" POG. WHF and its partners selected these same measures as health indicators because the health of Washington is strongly associated with them, including areas such as education, safety and economic vitality.

The table below pairs the *2006 Report Card* measures and outcomes with similar POG measures.

WHF believes this pairing demonstrates how closely the priorities of Washington State government already match those needed to make Washington the Healthiest State in the Nation.

Washington Health Foundation's *2006 Report Card on Washington's Health*	**The Office of Financial Management Priorities of Government**
PROMOTING COMMUNITY HEALTH Economic Well-Being (a blend of median household income, unemployment, child poverty and poverty rates)	Percent of State Population Living Above the Poverty Level (Indicator #1 under "security of Washington's vulnerable children and adults" POG) *And* Median Household Income and Change in the Poverty Rate (Indicators #2a and #2b under "economic vitality" POG) *And*

	Percent of State Labor Force Employed (Indicator #5 under “economic vitality” POG) *And* Washington Average Annual Wage and Washington Median Hourly Wage (Indicators #6a and #6b under “economic vitality” POG)
High School Graduation Rates (Percentage of persons who graduate in four years from a high school with a regular degree)	Increasing the high school graduation rate (Indicator #3 under “student achievement” POG)
INVESTING IN PREVENTION Insuring for Prevention (Percentage of the population that does not have health insurance privately, through their employer or through the government.)	Health Insurance Coverage by Age Group (Indicator #3a under “health” POG)
Public Health System Investment (Dollars per person spent in 2003 on public health)	
INCREASING VALUE IN HEALTH SERVICES Health Home (Percent of adults who answered “in the past year” to the question: About how long has it been since you last visited a doctor for a routine checkup?)	Unmet Healthcare Need (Indicator #3b under “health” POG)
Medical Care Quality (Average rank across 14 key health care measures for hospitals, nursing homes and home health care)	

PROTECTING AGAINST INJURY & DISEASE Receipt of Proven Preventive Care (Average state ranks for receipt of prenatal care, children's immunization, mammography, cholesterol screening and colorectal cancer screening combined)	
Seat Belt Use (Percent of adults observed using shoulder belts)	
AVOIDING ADDICTIONS Smoking Rates (Percentage of the population over age 18 that smokes on a regular basis)	Rate of Tobacco Use Among Adults (Indicator #1a under "health" POG)
Binge Drinking Rates (Percent of adults who report having five or more drinks on one occasion during the past 30 days)	Drinking Driver Fatalities per 1 Billion Vehicle Miles (Indicator #1b of "safety" POG)
ENGAGING IN HEALTHY HABITS Physical Activity (Percent of adults who report 30+ minutes of moderate physical activity five or more days per week or vigorous physical activity 20+ minutes three or more days per week)	Obesity Among Adults (Indicator #1b under "health" POG)
Proper Nutrition (Percent of adults who report consuming five or more servings of fruits and vegetables per day)	Obesity Among Adults (Indicator #1b under "health" POG)
OUTCOMES Premature Death Rate (Number of years of life lost per 100,000	Average Years of Healthy Life Remaining at 20 (Indicator #2a under "health" POG)

population)	
Select Mortality Rate (Combined mortality rate includes: Infant mortality, accidental deaths, cancer deaths and cardiovascular deaths per 100,000 population)	Infant Mortality Rate (Indicator #2b under “health” POG) *And* Incidence of Property and Violent Crimes per 1,000 population (including accidents) (Indicator #1a under “safety” POG) *And* Unintentional Non-Fatal Injury Hospitalizations and Fatal Injuries per 100,000 Population (Indicator #1c under “safety” POG)
Limited Activity Days (Number of days in the previous 30 days when an adult’s activities are limited due to physical or mental difficulties, self-reported)	
Emotional Well-Being (Percentage of adults with 14 or more of the previous 30 days that were mentally unhealthy days, self reported)	
Infectious Disease Rate (Number of AIDS, tuberculosis and hepatitis cases reported to the Centers for Disease Control and Prevention per 100,000 population) Health Disparities (Disparities in health risks, opportunities or outcomes for African-Americans, Hispanics, American Indian/Alaska Natives, and Asian/Pacific Islanders)	

Tab 59

The Center for Health Care Reform's Proposal to the Blue Ribbon Commission

What Should Be Done?

Washington needs to do three basic things to improve the health care of this state: 1) increase access to health care insurance; 2) determine a baseline of what insurance should cover and what an individual should be responsible for; and 3) restructure the health care delivery system to deliver value to the patient in terms of health outcomes per dollar spent. All three of these items are interconnected; access to health insurance and the coverage terms of that insurance policy impact the cost and ultimate value of the delivery of health care. Moreover, all three items will encourage market competition based on results that would improve the value of the health care delivered to Washingtonians.

Increase access to health care insurance

There is no one-size fits all solution to increasing access to health care insurance because the goal is to create a vibrant market with different products available to consumers. This can be accomplished in different ways, each of which merits closer consideration. The rationale for opening the market is to encourage competition based on value to the consumer, not promote a race to the lowest-cost bare bones package.

Allow insurance carriers to offer reduced mandate insurance plans

State mandates add to the cost of insurance policies, although it is not clear by what magnitude. Regardless of the precise cost associated with each mandate, cumulatively they increase costs, which are passed on to purchasers. By removing at least some of the restrictions to coverage, carriers should be able to offer more economical policies that meet the fundamental benefit needs of the consumer, including small businesses. Given the number and breadth of the mandates in Washington, it is reasonably foreseeable that carriers will continue to offer coverage that includes those mandates that they consider valuable to a purchaser of a health plan. Moreover, by offering some plans with reduced mandates, it does not mean that other plans will not still contain the full number of mandates or have a richer benefit package.

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Encourage insurance carriers to offer health care plans that shift away from first dollar coverage

First dollar coverage can contribute to rising health care costs because the consumer is unaware of the cost associated with a given diagnosis and treatment. Thus, first dollar coverage can result in an overuse or inefficient use of health care services. When the consumer has a higher level of responsibility for routine health care decisions, they have greater incentive to include the expected value received per dollar expended in their decision making process. Health savings accounts (HSAs) combined with high deductible health plans (HDHPs) are one mechanism of encouraging movement away from first dollar coverage. However, reform efforts in this direction should have a systematic focus, not merely favor one type of product.

Consider implementing a "Connector" similar to Massachusetts

Massachusetts recently enacted legislation creating a "Connector." The Connector serves to connect individuals to insurance. The Connector creates a marketplace in which consumers can purchase health care insurance plans from competing insurers. Washington Policy Center would be happy to work with the Commission and others to look more closely at the Connector and how a similar market mechanism could be implemented in Washington.

<u>Determine what insurance covers and what individuals should pay for themselves</u>

As a matter of policy, discussions should be had regarding what insurance should cover and what individuals should be responsible for and how such decisions should be made in the future. Ideally, a minimum standard will be developed at the federal level. Although this is outside the jurisdiction of the Commission, efforts can be made to better define minimum coverage. This discussion should be focused on the health value of each insurance benefit. Hopefully, this discussion would help move Washington State away from the conflict over mandates and towards a basic affordable plan that ensures high value care. Presumably, such a plan would include preventive care benefits and primary care.

Once a minimum standard is accomplished there would be a coverage floor which health insurers are required to meet but could voluntarily exceed. Insurers could still offer a variety of plans with coverage above the minimum, for which they could charge a higher premium or have a higher deductible. Additionally, services that were not covered in the minimum plan could be covered through supplementary insurance policies. Essentially, defining a minimum standard would permit the market to meet consumer's demands for additional coverage while permitting more Washingtonians to have valuable insurance coverage.

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Restructure the health care delivery system to deliver value to the patient

The health care delivery system needs to be restructured to focus on providing the best value for a patient's health rather than focusing on how to reimburse for treatment of a particular medical condition. Competition needs to be encouraged in terms of results. Such results based competition will promote improvement in the areas of diagnosis, treatment, disease management, and prevention and will ultimately provide patients with high value.

A patient's health is unique in many ways and the best measure of quality is better patient results in terms of health outcomes versus cost. Simply put, how do services and technologies compare in addressing specific medical conditions over the complete care cycle for a patient. This type of competition will encourage accountability and effective care. Because results are measured and compared, providers have incentive to maintain knowledge of current best practices while having the flexibility to deviate in order to provide better results for a given patient.

Of course, for this results based competition approach to succeed, results information must be collected and disseminated. This type of transparency in the medical system is becoming increasingly desired by consumers. Priority should be given to devising universally accepted outcome measures that are meaningful and agreed to by most participants. Additionally, price information, at least an estimate or range, should be made available to the consumer prior to utilization. Perhaps the ideal starting point for such price information is in routine medical services such as office visits, imaging, and laboratory services.

How Will This Impact the Blue Ribbon Commission's Vision and Goals?

This proposal will meet the Commission's vision by providing more access to health insurance coverage, defining what such coverage should include, and restructuring the delivery system to focus on value to a patient's health in terms of health outcome versus cost (i.e., quality).

This proposal will also satisfy most of the Commission's goals as described below.

- Improving access: By increasing access to health care insurance through market competition based on value to the consumer, determining what valuable, yet basic, health care coverage means, and restructuring the delivery system to focus on delivering value to the patient, more Washingtonians will have access to health care coverage providing quality care in 2012.
- Improving health:
    - By focusing the health care delivery system on value to the patient's health, Washingtonians will have the opportunity to become one of the healthiest states in the nation. Essentially, Washington's goal of a healthier state population will also be the

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goal of the health care delivery system, on a patient-by-patient basis.
    - Measuring results for patients in terms of value to them based on health outcome versus cost and making such information accessible should ultimately enable many health disparities to be lessened or eliminated.
    - By promoting competition based on results, providers will be motivated to know the current best practices and to apply them in a fashion that provides the best outcomes for their patients. This approach will not necessitate implementing state wide best practices which could have a negative outcome for some patients, discourage physicians from using their best judgment, and increase the number of medical malpractice lawsuits. Rather providers will have an incentive to use best practices to yield the greatest health outcomes per cost for their patients.
- Increasing affordability: Increasing access to health insurance coverage and determining what insurance should cover are closely linked to increasing affordability. Valuable insurance coverage could be available at an affordable cost to Washingtonians. Limiting the rate of increase in total health care spending to no more than the growth in personal income, however, seems to be artificially limiting the options available to Washington. Focusing on a delivery system that provides value to the patient based on health outcome versus cost addresses the issue of health care inflation without creating artificial barriers to improvement. The actual cost of care should be measured over the full cycle of care, from prevention through long-term management, and such measurements do not fit well into a calendar year. Limiting the amount of total spending increases may be acceptable in regards to affordability of access to coverage, but acute spending for a prescription drug or medical procedure might be cost beneficial in the long run. It should be up to the individual to choose how much of their income should be spent on total health care costs.

Modeled on an Existing Policy or Program?

Some of the concepts incorporated in this proposal are drawn from "Redefining Health Care, Creating Value-Based Competition on Results" by Michael Porter and Elizabeth Teisberg and published by the Harvard Business School Press. Many of the concepts are being pursued by other states. For example, Arizona exempts small business health insurance plans from complying with some of the state mandates. (Arizona HB 2698). Massachusetts is in the process of implementing their "Connector." And transparency and outcome measures are becoming more prevalent. South Dakota requires that prices for hospitals' commonly performed procedures be published. And efforts have been made to collect results information. Washington Policy Center is available to work with the Commission to examine related policies and programs already in place more closely, and what this might mean for Washington.

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What Are the Costs?

It is foreseeable, that the short term costs would be outweighed by the long term savings both in dollars and the health of Washingtonians. Washington Policy Center is willing to work with the Commission and others to determine the costs imposed and saved by this proposal.

Collaboration Among Stakeholders?

Pending.

What Are the Obstacles?

One obstacle to this proposal is creating a neutral environment in which to discuss mechanisms for increasing access to health care insurance and determining what insurance should cover. Perhaps the most difficult obstacle, however, is that of accomplishing a culture shift in the health care delivery system. Although it sounds simple to shift from a reimbursement based system to one focused on providing the best value for a patient's health, it requires a different approach to the system, the development of different tools to aid in the system's success, and consumer education. For a system like this to function well, there must be consumer engagement and informed consumers.

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Tab 60

Insurance Coverage for the Treatment of Hearing Loss
Proposal to the Blue Ribbon Commission on Health Care Access & Cost
Submitted by the Washington Speech & Hearing Association
September 1, 2006

"Among the five senses, people depend on vision and hearing to provide the primary cues for conducting the basic activities of daily life…These senses provide the portals for language, whether spoken, signed, or read. They are critical to most work and recreation and allow people to interact more fully. For these reasons, vision and hearing are defining elements of the quality of life." (From Healthy People 2010, National Institutes of Health)

Background

28 million Americans, or approximately 10% of the total population, have some degree of hearing loss. In fact, hearing loss is the number one birth disorder in the United States. In Washington, this means 650,000 children and adults have a moderate to profound hearing loss.

As the nation's population ages, the need for hearing aids increases. Hearing loss is now the third most prevalent chronic condition in older Americans. An estimated 23% of individuals between the ages of 65 and 74 have a hearing loss. 31% of those over age 74 have a hearing loss. It is predicted that hearing and related speech impairments will continue to rise.

Studies show that 95% of hearing impaired individuals can improve their communication by using hearing aids. Unfortunately, only 20% of Washingtonians with hearing loss have hearing aids. Children with hearing loss can miss up to 50% of classroom speech, making it likely that they will need special education classes. Adults with hearing loss are also at a disadvantage for education and employment opportunities.

Currently, most insurers do not provide any coverage for hearing aids. Without this coverage, most individuals simply go without. Hearing aids are expensive; typically, a pair of hearing aids costs $3,000-$4,000. This puts an undue financial hardship on individuals and families to buy these necessary instruments.

To address this issue of access to hearing aids, the Washington Speech & Hearing Association (WSHA) proposes that Washington state require all insurers that provide coverage for prosthetic devices also include coverage for hearing aids, if so recommended by a qualified health care provider.

Insurance Coverage for Hearing Aids Achieves the Commission's Vision and Goals

Insurance coverage for hearing aids realizes the vision and goals of the Blue Ribbon Commission in several ways. First, it realizes the Commission's vision of providing every Washingtonian the ability to obtain needed, affordable health care. This proposal

ensures that individuals with hearing loss have access to affordable hearing aids through their insurance policies.

Second, this proposal improves the health of Washingtonians by providing treatment to a very treatable condition. As stated above, 95% of individuals with hearing loss can improve their communication through the use of hearing aids.

Third, the science behind hearing aids shows that they are an effective form of treatment for individuals with hearing loss. It has been shown that older adults who receive treatment with hearing aids significantly improve their emotional and social functioning, as well as their communication abilities. The same holds true for children. Treating hearing loss in children improves speech, language, social, and emotional development.

Insurance Coverage for Hearing Aids Modeled after Legislation in Other States

Eight states require insurance coverage for hearing aids: Connecticut, Kentucky, Louisiana, Maryland, Minnesota, Missouri, Oklahoma and Rhode Island. Most states with this requirement have limited the amount of the benefit, the frequency of the benefit, or the population who can access the benefit (i.e., children only). In 2005, there were approximately 13 other states contemplating legislation to mandate insurance coverage for hearing aids, as well as efforts on the national level.

California's Legislature has just passed legislation requiring insurers to help pay for hearing aids for deaf or hard-of-hearing children. This bill awaits Governor Schwarzenegger's signature.

Insurance Coverage for Hearing Aids Costs and Savings

Fiscal notes on past legislation mandating insurance coverage for hearing aids has stated that the cost to state purchased health care would be approximately $1.5 million per biennium. Premium increases would be $.13 to $.30 per member per month. The addition of coverage for hearing aids would be an extremely small part of any premium.

In fact, some insurers have been taking steps to offer limited hearing benefits. In Washington, Regence offers a "value added" program that gives discounts to their members for hearing exams and hearing aids. Premera and Pacificare also offer similar programs. Clearly, these insurers recognize that these hearing benefits create value for their subscribers.

The cost of adding coverage for hearing aids is outweighed, however, by the savings to our state's health care and education systems. According to the American Speech-Language-Hearing Association, hearing loss intervention before six months of age results in significantly better language skills than intervention after six months. Children receiving early intervention are likely to develop on par with their peers, while children with untreated hearing loss are ten times more likely to be held back a grade in school or enter special education. Studies have shown that children who do not receive early

intervention cost our educational system an additional $420,000 in special education costs and classroom modifications.

Insurance Coverage for Hearing Aids Stakeholder Support

There are many supporters of insurance coverage for hearing aids, from very diverse backgrounds. These supporters include the Department of Health, the Governor's Committee on Disability Issues and Employment, the Washington State Self-Help for Hard of Hearing People, the Listen for Life Center at Virginia Mason, the Washington Grange, the Rotary Club of Clover Park-Lakewood, the Washington State Special Education Coalition, The Washington Association of Area Agencies on Aging, the Tacoma Area Coalition of Individuals with Disabilities, and the Washington Speech & Hearing Association, among others.

Insurance Coverage for Hearing Aids Implementation Obstacles

Predictably, insurance carriers have opposed past legislation calling for coverage for hearing aids. They cite general concerns for the costs that mandated benefits add to premiums, but they have never cited any specific costs for a hearing aid mandated benefit. Business organizations have also opposed this legislation stating that hearing aids are not medically necessary, can be purchased over time on credit, and are "generally affordable."

These objections can be addressed by applying a cost-benefit analysis similar to the one conducted by the Department of Health in its sunrise review. That analysis showed that the cost of providing coverage for hearing aids is offset by the savings that can be achieved, including savings to our health care system and education system.

Conclusion

Hearing loss is an illness that needs treatment. Many diverse organizations and individuals have already acknowledged the importance of this treatment through access to hearing aids. It is time that the state of Washington recognizes the issue of hearing loss as a disease and provides access to the necessary treatment for its hearing impaired citizens.

Tab 61

WASHINGTON STATE ASSOCIATION OF LOCAL PUBLIC HEALTH OFFICIALS

AN AFFILIATE OF WASHINGTON STATE ASSOCIATION OF COUNTIES

August 31, 2006

Honorable Christine Gregoire, Governor
Honorable Pat Thibaudeau
Co-Chairs
Blue Ribbon Commission on Health Care Costs and Access
Olympia, WA 98504

Dear Commission Members,

Thank you for the opportunity to submit a proposal to help achieve the Blue Ribbon Commission's July 27, 2006 Vision Statement and Goals. I am writing on behalf of the Washington State Association of Local Public Health Officials (WSALPHO), a non-profit organization whose membership is comprised of all 35 local public health jurisdictions in Washington State. Public Health's mission of improved health status cannot fully be realized without access to critical health services and disease prevention and health promotion activities. This fits well with the vision and goals of the Commission.

We recognize that the Commission's work is focused on finding solutions to our health care access crisis and the skyrocketing costs of medical care provision. As the Commission members are aware, health cannot be achieved through access to "illness care" alone. We must strengthen the ties between medical services and population based services if we are to be successful in achieving affordable care and healthier citizens. Local public health is charged with the responsibility for and uniquely positioned to assure medical care access and provide health promotion and disease prevention in our communities so that the vision and goals of the Commission can be achieved. In addition, we must all work together to provide the physical and social environments that promote healthy behaviors.

Attached is a proposal from WSALPHO that we believe to be critical to the ability of the Blue Ribbon Commission to achieve their goals. We have chosen to use the format requested by the Commission of answering the specific questions about our proposal.

Sincerely,

Janet Davis

Janet E. Davis
Chair

206 Tenth Avenue SE, Olympia, WA 98501 Telephone: (360) 753-1886 (360) 753-2842

PROPOSAL TO BLUE RIBBON COMMISSION ON HEALTH CARE COSTS AND ACCESS
WASHINGTON STATE ASSOCIATION OF LOCAL PUBLIC HEALTH OFFICIALS

1. What do you propose to be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access? Briefly summarize your proposal.

WSALPHO requests the Blue Ribbon Commission support the forthcoming recommendations of the Joint Select Committee on Public Health Financing. The Joint Select Committee has carefully examined the role, the priorities and the capacity of the local public health system and is working on specific funding recommendations that will be finalized in October 2006.

By supporting the Committee's forthcoming recommendations, the Commission can foster formation of local collaboratives of health care partners to solve local access to care issues. This will allow Local Public Health and the provider community to proactively address preventable chronic diseases like diabetes and heart disease that result in major medical care and hospital costs. These activities are further described in the WSALPHO plan, *Creating a Stronger Public Health System: Statewide Priorities for Action,* that was presented to the Joint Select Committee on May 25, 2006. It is available at: http://www.wacounties.org/wsalpho/Workbook 7 - Final.pdf (pages 1-13 are an overview).

2. How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission?

Commission Goal: Access to healthcare –

Public health has a unique point of view in that we look at health issues not in terms of any particular disease or interest group, but from a population-based perspective. As a result, we believe that local public health has an important role to play regarding affordable and accessible health care. One of the key areas listed in the *Standards for Public Health in Washington* is Access to Critical Health Care. The Standards include a list of critical health services that should be readily available to all citizens. Public Health's role is not to necessarily provide such medical care for those who can't afford to pay but to assure that people have access to those critical health services when they need them.

Local public health understands and sees on a daily basis the impact that lack of access to critical health services has on the health of our community. We see children in schools with rampant tooth decay, pregnant women with no prenatal care, people who have to choose

between food and needed medication and people on our streets and in our jails with mental health or substance abuse problems. These are public health issues that can be addressed if everyone had access to critical health services. Public health can help because we are in an ideal position to make a difference. As people visit our clinics and WIC programs and as public health nurses make home visits, we help needy families get access to medical services and to programs such as Medicaid or Basic Health Plan.

Unfortunately, at the local level there is often no system in place to bring community partners together around access issues. Public health is and should be a part of the solution. We work at the community level to resolve access issues and can act as the interface between populations in need and medical and social care partners.

Access to medical services will improve if public health is provided the capacity to achieve the following:

- **Document local problems in access to health care.** We have the expertise but lack the data to fully document and understand the complexities of the problem at a community level. Today, communities may know they have a problem with lack of access to critical health services, but they do not know why, or the extent of the problem. Public health can play a key leadership role in addressing access problems by using specialized skills in collection and analysis of available data.

- **Build coalitions for policy development, pilot programs, advocacy and leadership.** Communities need to come together and develop strategies to address their specific local access issues. Public health has the data, education and facilitation capability to bring to the table. We can convene stakeholders and build coalitions to make a locally designed difference. The Commission has heard about the difference local access coalitions are making. Programs such as Choice Network and Whatcom Alliance for Healthcare Access should be replicated in communities across the state. Local public health is a key player in making this happen.

- **Help people find medical and dental homes.** Public health workers see on a daily basis the impact that lack of access to critical health services has on families and individuals in our communities. Local public health workers are well positioned to help find medical and dental homes for the clients they serve and provide case management for individuals needing a variety of other health and social resources.

Commission Goal: Improving health –

Another key area listed in the *Standards for Public Health in Washington* is Promoting Healthy Living. Many people think of being healthy only in terms of access to illness care, but an understanding of the causes of medical care inflation makes it clear that chronic disease

prevention is also important. Clinics and hospitals see many patients currently who are suffering from preventable diseases. And for the future, it is clear that our aging population has increasing rates of obesity, sedentary lifestyles and other chronic disease risks. These trends will lead to a population with high rates of expensive chronic diseases that must be treated over longer and longer lifetimes and are the greatest driver of health care costs. How healthy we are in the future depends on investments we make now to prevent diseases like diabetes from developing. Public health has a key role to play in helping initiate and sustain such programs.

Overall health in Washington will dramatically increase if public health is provided increased capacity to:

- **Promote healthy behaviors:** The role of public health is to promote health behaviors aimed at the real causes of premature death and illness. People must be provided with the knowledge and support needed to pursue healthy lifestyle choices, including changes to the built environment. The reduction in smoking rates seen in Washington State is evidence of the effectiveness of this approach. Research has shown that reductions in smoking rates save money. The Campaign for Tobacco Free Kids estimated that reducing the adult smoking rate by one percentage point in Washington state:
  - Reduces the rate of smoking related deaths by 9,400,
  - Saves $14.3 million dollars over 5 years through fewer heart attacks and strokes,
  - Saves $4.5 million dollars over 5 years through fewer smoking-affected births and
  - Saves $62.6 million dollars over 5 years in Medicaid costs.

  The California Department of Health has estimated that for every $1 spent on its comprehensive tobacco control program between 1990 and 1998, an estimated $3.62 in <u>direct</u> medical costs was avoided.

- **Establish linkages with medical providers:** Medical care providers can play a key role in helping individuals know and understand the impact of their lifestyle choices on their health. However, physician time is limited and often focused on treatment. Public health prevention experts can provide information and techniques to physicians that have been shown to increase their focus on prevention.

- **Emphasize self-care strategies for chronic disease prevention.** Public health can help shift the model from expert care only to appropriate self-care as a major part of prevention. We can provide educational programs and motivational interventions that help people to take some responsibility for their own health rather than to only rely upon the “illness care” system to treat them. We can promote changes in how planners develop neighborhood so that the residents can safely walk, ride bicycles and take their children to parks to play and exercise.

WSALPHO strongly urges the Commission to make these activities an important part of its eventual recommendations. Health promotion aimed at chronic disease prevention is one of the few measures, short of reorganizing the entire health care system, which can directly address the causes of our medical care cost and access problems.

Commission Goal: Improving affordability –

Promoting healthy, prevention-based behaviors are at the core of public health's work. These activities and services are demonstrated to be cost-effective strategies that save money that would otherwise be spent later on medical, social and other community services. One well-researched example of a public health intervention program that works, especially for young children, is the Nurse-Family Partnership (NFP). NFP is an evidence-based home visitation service by public health nurses that serves low-income, first time mothers of any age. The outcomes of this program include:

- improved prenatal health,
- fewer childhood injuries,
- fewer subsequent pregnancies,
- increased intervals between births,
- increased maternal employment,
- improved school readiness,
- reductions in child abuse/neglect,
- fewer arrests and convictions of mothers and their children as teens.

The Washington State Institute for Public Policy estimated the implementation costs (in 2003 dollars) of the program at $9,118 per child with the benefits estimated at $26,298 or in other words – every $1 spent produced a benefit of $2.88. This did not take into account any savings from decreases in low birth weight, child injuries or increases in immunization rates.

The 1998 Rand Study which reviewed the Nurse-Family Partnership identified at least four types of significant savings to government:

- increased tax revenues from increased employment,
- decreased welfare costs,
- reduced expenditures for education, health and other services and
- lower criminal justice costs

They also estimated that the net reductions in public costs begin to accrue by the time children in the program are four years old.

3. Is your proposal modeled after an existing policy or program within Washington or elsewhere?

This proposal is consistent with the current role of public health in Washington State. The key areas defined in the Public Health Standards developed in accordance with RCW 43.70.520 clearly address public health's role in:

A) Promoting healthy living:

The best examples of what public health activities and programs target are tobacco cessation, physical activity, dietary habits, oral health, injury prevention and responsible sexual behavior. One example of public health's role in health promotion is the Washington State Nutrition and Physical Activity Plan that promotes environmental and policy changes to encourage healthy eating and physical activity. The executive summary can be found at:
http://www.doh.wa.gov/cfh/NutritionPA/publications/npe_exec_summary.pdf

B) Helping people get the services they need:

This means general access to medical services, maternal and child health and development, behavioral and mental health services, chronic disease and conditions management and dental services. One local example of access initiatives supported by local public health is the Whatcom Alliance for Healthcare Access (WAHA). WAHA is a nonprofit organization dedicated to ensuring access to healthcare services for all members of our community. It is composed of a wide range of partners including leaders from the nonprofit, business and governmental sectors, as well as many local health care organizations and is dedicated to solving community healthcare problems. More information at:
http://www.whatcomalliance.org/

4. Will your proposal impose costs on individuals, businesses or government?

WSALPHO estimated the cost of addressing gaps in public health services so that reliable and similar services can be offered statewide. This information was presented to the Joint Select Committee. The cost associated with fully funding the existing gaps in Public Health exceeds $200 million annually with approximately $30 million funding Health Promotion and approximately $29 million funding Access to Critical Health Services. The full recommendation can be found at:
http://www.wacounties.org/wsalpho/FINAL%20Additional%20Investment%20Spending%20Plan_detailed%20plan_v1%20(3).doc

5. How does your proposal reflect collaboration among various stakeholders?

All 35 local health jurisdictions reached consensus on the gaps and priorities for public health as presented to the Joint Select Committee. Other partners who provided assistance or endorsement were the WA State Dept. of Health, WA State Board of Health and the Public Health Roundtable that includes the Washington Health Foundation, the Washington State Nurses Association, the Washington State Medical Association, the Washington State Public Hospital Association, the Washington State Hospital Association and the Children's Alliance.

Public health directly involves collaboration with the medical care providers, community organizations, other government agencies and the community at large. Health is not just about access to appropriate "illness care", but it is also about societal and political will to address the leading determinants of health, such as income, housing, family protective factors and individual lifestyle choices. Good health is provided through a continuum of activities, ranging from primary prevention (the public health model) to treatment (the medical care model). Both must be present to improve a community's health status and reduce costs.

6. What are the obstacles to implementing your proposal?

We believe many of the possible objections to increasing public health funding have been addressed during the Joint Select Committee process and will be identified in the report issued by the Committee.

In closing, WSALPHO strongly supports the Commission's goals of improving health care access, improving the population's health, and improving health care affordability. However, without a strong public health system, the medical care system and the Commission will be unable to deliver on its goals of improving health to become "one of the top ten healthiest states in the nation" and to have population health indicators that "will be consistent across race, gender and income levels." To do this, WSALPHO requests that the Commission support the reversing of the decay of the public health system by supporting public health funding as recommended by the Joint Select Committee on Public Health Financing.

Tab 62

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August 28, 2006

The Honorable Christine O. Gregoire
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P.O. Box 40002
Olympia, Washington 98504-0002

The Honorable Pat Thibaudeau
Washington State Senator and Co-Chair
Blue Ribbon Commission on Health Care
P.O. Box 40443
Olympia, Washington 98504-0443

Dear Governor Gregoire and Senator Thibaudeau:

The Washington State Medical Association (WSMA) is taking this opportunity to share – for the consideration of the Blue Ribbon Commission on Health Care in its deliberations – our vision of tomorrow's medicine and the features it should exhibit to provide cost-effective, care-effective services and better access to affordable health insurance.

The WSMA commissioned the enclosed report, *Tomorrow's Medicine: A Report on the Future of Health Care Delivery in Washington State*, in part, to assist the Commission with its work.

The first section of the report outlines in considerable detail where health care is today – and includes some data, which sheds new light on commonly held assumptions. The information was compiled by the WSMA's Health Care Economics Department.

The second segment of the report is unique. Based on work of the Washington Research Council (which interviewed 36 key stakeholders), it identifies eight consensus themes that should be adopted by the Commission as part of its report to the Legislature. They are:

- *"Excellent Health Care Will Reduce Costs, Increase Access, and Improve Lives"*
- *"Universal Access - Laudable Goal, but Difficult to Achieve"*
- *"Toward a Seamless, Collaborative Health Care System with Physician Leadership"*
- *"Electronic Medical Records: Valuable, Inevitable, and Worth the Cost"*
- *"Implemented Wisely, Guidelines and Evidence-based Practice Offer Promise"*
- *"Increased Patient Responsibility for Health Care Will Reduce Costs and Improve Quality"*
- *"When Consumers Embrace Healthy Lifestyles, Everything Gets Better" and,*
- *"To Maintain Quality and Access, There Must Be Financial Stability"*

The "treatment plan" outlined in this report points the way to practical solutions. Past research, objective appraisal of the impact of potential major reforms, and appreciation of the politics and role of health care in our society clearly show that there is no "silver bullet" solution to the problems of the system.

In addition, the WSMA firmly believes the Commission needs to recommend to the 2007 Legislature that additional enrollment be funded for the Basic Health Plan (BHP). The BHP is in place with a track record and requires no fundamental policy debate, and it can be the mechanism to increase access to affordable insurance. All that is necessary is a commitment of resources by the Legislature. A five-year commitment to funding the BHP can greatly reduce the number of uninsured citizens in our state.

The Commission should also commit to the goal of providing health care coverage to all children by 2010, a goal adopted by the legislature in 2005 (and which the WSMA supports).

The Commission cannot ignore public health. The public health system in our state is a silent partner in achieving the goals of being the healthiest state in the nation. Over the years, public health resources have been trimmed to the point where it is becoming difficult to provide basic preventive services, and prepare for disasters. The WSMA supports any efforts to identify a specific source of funding for public health services. We are part of a coalition dedicated to this end.

Another area that the Commission must attend to how programs like Medicaid and the BHP pay physicians for the services they provide. It matters little to create more eligibility when payment levels do not cover the cost of providing the services and medical practices cannot afford to take care of the people covered by either Medicaid or the BHP. The WSMA will be recommending to the 2007 Legislature that these programs pay for medical services to low-income pregnant women and children at the same level that is used in the Uniform Medical Plan (UMP). In addition, all other services in the Medicaid program and the BHP (such as adult primary and specialty care) should be paid at 80% of the UMP. Such funding will stem the current – and rapidly worsening – constriction of access to medical services for these program enrollees.

The WSMA looks forward to hearing from the members of the Commission regarding the recommendations of this report and letter. For additional information or so set up another venue to discussion please feel free to contact Len Eddinger in our Olympia office at (360) 352-4848.

Sincerely,

Peter J. Dunbar, MD
President

cc: WSMA Board of Trustees
Thomas J. Curry, Executive Director/CEO
Len Eddinger, Senior Director, Legislative and Regulatory Affairs

Enclosure

Cover ltr to blue ribbon commission

TOMORROW'S MEDICINE

A Report on the Future of Health Care Delivery in Washington State

Tomorrow's Medicine assembles data from a number of reputable sources and opinions from a variety of health care stakeholders to outline the current status and desirable future course of health care in Washington state. The objective is to foster reasoned discourse on the preferred state of tomorrow's medicine, and to outline the leadership responsibilities of physicians as the health care system continues to evolve.

Tomorrow's Medicine was commissioned by the Washington State Medical Association (WSMA). The first section of this report, *Where Are We Today?,* was derived from quantitative data and analyses provided by the WSMA's Health Care Economics Department.

In the second half of this report, we took a different approach.

Every conversation touching on health care quickly comes down to a few common questions like these: What's the best way to make sure everyone has access to good health care? Can we bring costs under control without sacrificing quality? What kind of health care system do we want? How do we pay for it?

Physicians share many of the public's concerns. We want to increase access to treatment, to use technology to reduce costs, and to assure consistent, high quality care. We know that people without adequate insurance coverage often wait too long to see a doctor, increasing their health risk and further driving up costs. And we realize that current policy debates – in legislative chambers, boardrooms, and lecture halls – often simply re-plow familiar ground.

To inject a fresh perspective, the WSMA chose to look beyond the immediate horizon. We wanted to know what key stakeholders envisioned for our state's health care system five years from now.

- What should we expect?
- What should we be planning for?
- Where will the practice of medicine be?
- How will we work together to provide high quality, accessible care?

In the section titled, *What Should Tomorrow's Medicine Look Like?,* the Washington Research Council asked physicians and university faculty, business and labor, hospitals, insurers, and government leaders to share their views with us. [1] And despite their various professional interests, they emphasized remarkably similar themes.

This report outlines how we can move forward, taking medicine and health care into the future in a productive way that benefits patients, physicians, and purchasers alike – a goal that cannot be achieved without collaboration. This report also includes plans for collaborating with the stakeholders who helped define the issues, and inviting others to join this effort.

Where Are We Today?

The Role of Medical Care in Washington's Economy

The health care industry and physicians' practices play a prominent role in the national and Washington state economies.[2] Beyond providing care and saving lives, medical practices generate jobs and economic development and are integral to the economic health of their communities. The cost of health care, medical services, and the administration of the financing and delivery system also are felt throughout the economy.

The Economic Impact of Physicians' Practices in Washington State

More than 12,000 men and women worked as physicians (either Doctors of Medicine or Doctors of Osteopathic Medicine) in Washington state in 2003. While physicians were employed in a broad range of settings, including nursing homes, medical schools, research laboratories, and government, the vast majority (about 10,700) provided direct patient care in offices, clinics, and hospitals.[3]

More than 115,000 jobs economy-wide, 3.2 percent of total employment, were directly or indirectly created by physicians' practices.

A 2005 study by the Washington Research Council quantified the economic impacts of these 10,700 physicians and their practices on the Washington state economy in 2003, focusing on four indicators — business revenue, employment, personal income, and taxes.[4]

For each indicator, practices have both direct impacts (which occur within the practices), and indirect and induced impacts (which occur elsewhere in the economy).

***Business Revenue* -** In 2003, physician practice revenue totaled an estimated $5.97 billion (the direct impact). This revenue was re-injected into the state's economy via spending by the practices and their employees. That spending generated an additional $5.83 billion in revenue for other businesses (the indirect and induced impacts). Thus, the total business revenue attributable to physicians' practices was almost $11.80 billion, nearly twice the direct impact.

***Employment* -** Physicians' practices provided jobs for 10,700 physicians and 48,000 staff. The spending by practices and their 58,700 physicians and employees is responsible for creating 57,000 jobs in other sectors of the economy. Thus, more than 115,000 jobs economy-wide, 3.2 percent of total employment, were directly or indirectly created by physicians' practices.

***Personal Income* -** The compensation of those working in physicians' practices - wages, salaries and benefits - totaled $3.5 billion in 2003. The economic activity of physicians' practices and their employees resulted in $1.7 billion in personal income for people who worked in other industries, an average of $29,960 for each indirectly created job.

***Taxes* -** Physicians' practices generated significant tax revenue for state and local government. The state collects Business and Occupation (B&O) tax at the rate of 1.5 percent on most practice revenue, in addition to some minor excise taxes. Practices generated $79.7 million in B&O and other state excise revenue in 2003. The indirect and induced activity generated by the practices generated additional tax revenue totaling $127.4 million. Physicians' practices also generated local sales taxes of $32.8 million. Thus, the total tax revenue generated by physicians' practices in 2003 was $239.9 million.

Health Care Spending – Where does it come from; where does it go?

The United States continues to experience a steady increase in spending for health care services, rising from $1.310 trillion in 2000, 13.3 percent of the Gross Domestic Product (GDP), to $1.937 trillion in 2005, 15.6 percent of the GDP.

Those expenditures are projected to reach over $2.7 trillion, about 17 percent of the GDP (see Appendix A) by 2010. Other estimates place the percent of GDP lower at about 11 percent (see Appendix A), but still well ahead of expenditures in other sectors including housing, food, and national defense.

Critics take issue not only with US spending levels for health care but also with the value and health outcomes realized for such expenditures, noting that other nations spend far less, yet receive better health outcomes for their citizens.[5]

Contributing factors most commonly cited for the rise in health care spending:

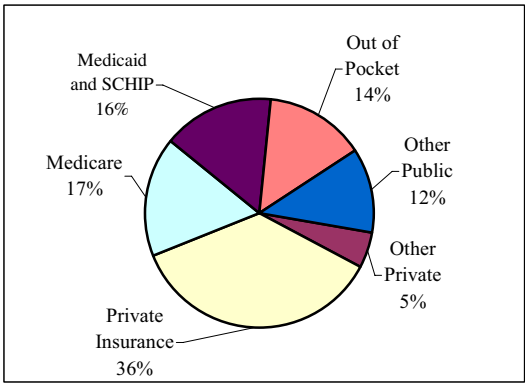
- The highly fragmented financing structure of the delivery system.
- Administrative complexity and associated overhead costs of operating that system.[6]
- The degree to which there are variations in the appropriateness, level and type of care provided from region to region, within communities and even within large medical groups.
- The degree to which the system must treat chronic disease, much of it resulting from Americans' lifestyle (e.g. diabetes and obesity).

Of the revenues that underwrite the delivery of US health care, private health insurance pays for 36 percent of those services, while publicly funded government sponsored programs, primarily through the Medicare and Medicaid programs, account for 45 percent of those dollars

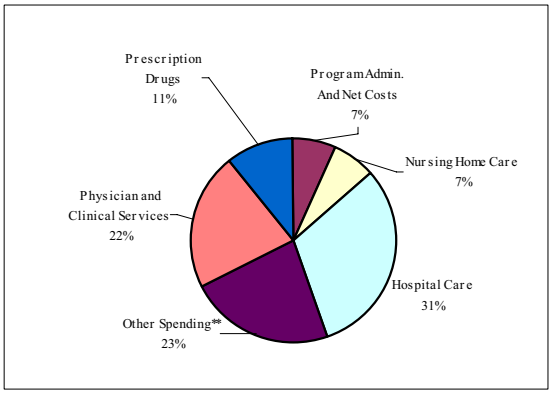
Chart 1

The Nation's Health Care Dollar - 2003[7]

Where it Came From



Where it Went*



* Numbers do not add up to 100 percent due to rounding. SCHIP is State Children's Health Insurance Program
** Other spending includes dental services, other professional services, home healthcare, durable medical products, over the counter medicines and sundries, public health activities, research and construction.

Chart 2 **The Nation's Health Care Dollar Percentage of Revenue 2001-2004[8]**

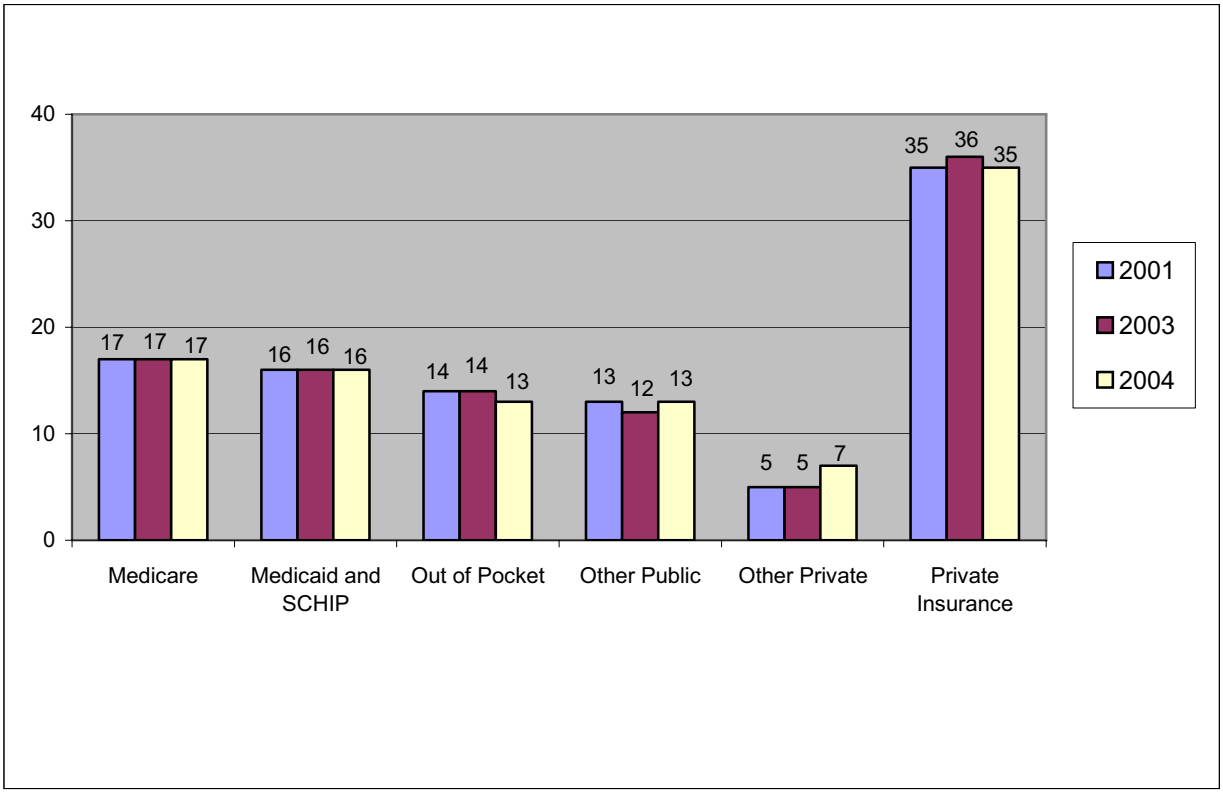
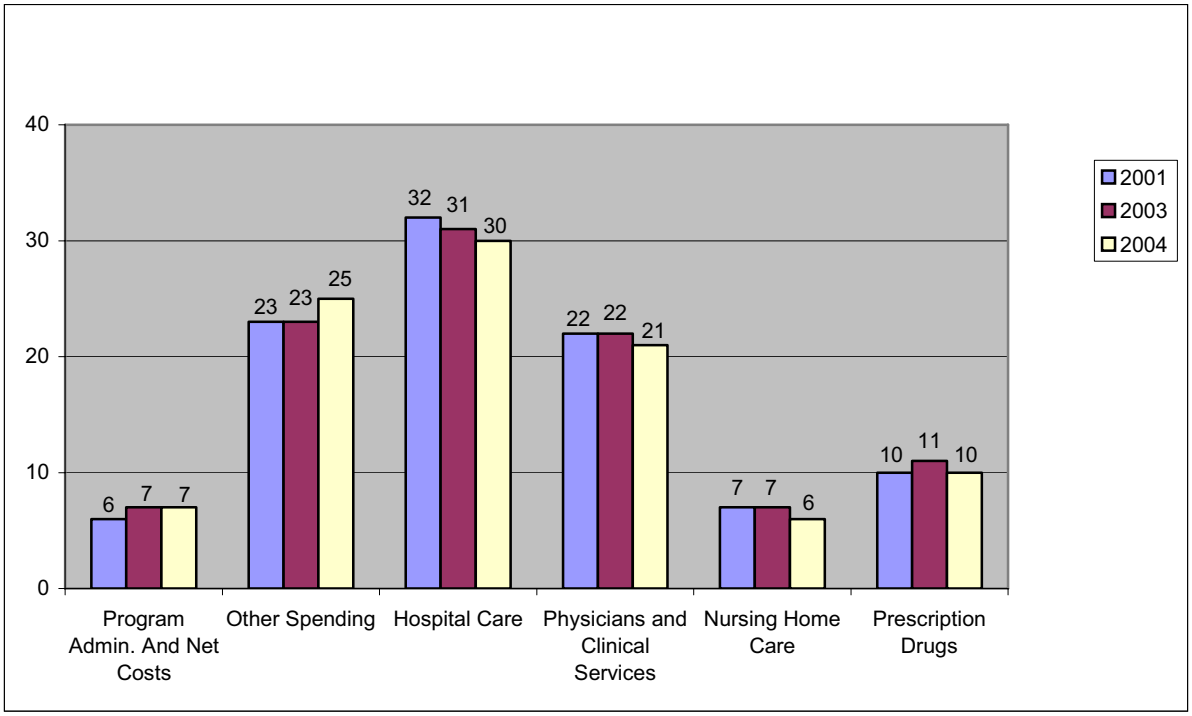


Chart 3 **The Nation's Health Care Dollar Percentage of Expenditures 2001-2004[9]**



Different categories of health care vary in the proportions that are financed privately and publicly. Public funds cover slightly more than half of all expenditures for hospital services, and most expenditures for home health care and nursing home services. Private funds cover a majority of expenditures for physician and clinical services, and for prescription drugs.

The cost of prescription drugs has received a great deal of attention in recent years. While Chart 3 suggests the cost of drugs was constant between 2001 and 2004, the actual rate of increase has been 14 percent.[10]

The average annual percent of growth in personal health care expenditures shows Washington to be ahead of the national average, at 9.3 percent compared to 8.6 percent.

Publicly Funded Health Care

Medicare's Long Term Viability Questionable

Policy makers continue to express serious concerns over the long-term viability of the Medicare program as expenditures continue to increase substantially. Medicare spending was $309 billion in 2004, an increase of 8.9 percent over 2003.[11] With the baby boomer population poised to become eligible for Medicare, the program will be under even greater strain unless fundamental changes are enacted.[12]

The addition of the Medicare Part D Prescription Drug Program, which took effect on January 1, 2006, is expected to hasten the viability crisis. In January 2006, about 24 million patients had prescription drug coverage through Medicare.[13]

Medicare Physician Payment Methodology Reduces Physicians' Ability to Serve Seniors – It is well documented that Medicare's Sustainable Growth Rate (SGR) formula for the Medicare Part B payment methodology continues to threaten the access to services for Medicare patients. Only through vigorous advocacy to Congress by the WSMA, the American Medical Association (AMA), and other national and state medical associations and specialty societies, were Medicare Part B payment reductions stopped in 2005 and 2006. However, no permanent "fix" has yet been enacted.

A 5.1 percent cut is scheduled for January 1, 2007. For Washington's physicians, that one-year payment reduction would be more than $46 million.[14] The cumulative cuts through 2015 would be over 37 percent. For Washington, Medicare payments to physicians would be cut by approximately $2.92 billion.

When asked if action isn't taken by Congress in 2006 to fix Medicare payments problems, what action – if any – would they take, 35 percent said they would be forced to take no new Medicare patients and seven percent said they would have to drop all Medicare patients.

The AMA estimates that from 2001-2007, physicians' practices costs will rise 18 percent while Medicare Part B payments will drop by five percent. By 2007, inflation-adjusted Medicare physician payment rates will have fallen by 20 percent over that six-year period.

Medicare personal health care expenditures for physicians' services in 2004 in Washington were $1.370 billion, out of the national total of $81.848 billion.[15]

The average annual percent of growth in Medicare expenditures for physicians' services in our state (1980-2004) was 10.2 percent, compared to the national percent of growth of 10.1 percent.[16] (Additional data are presented in Appendix A.)

Federal data for 2001 reflect a 98 percent participation rate by Washington physicians in the Medicare program. This measure is misleading, however, as it simply indicates physicians who have signed a Medicare participation agreement and does not measure the degree to which physicians' practices are accepting Medicare patients.[17]

In January 2006, the WSMA conducted a "snap shot" poll of its membership on whether physicians were continuing to see Medicare patients. Of the 1,092 physicians who responded, 39 percent noted that they had decided to take no new Medicare patients and one percent had decided to drop all Medicare patients. The majority had made that decision within the last three years.

When asked if action isn't taken by Congress in 2006 to fix Medicare payments problems, what action – if any – would they take, 35 percent said they would be forced to take no new Medicare patients and seven percent said they would have to drop all Medicare patients.

Medicare and Washington Hospitals – Medicare payments to hospitals under Part A are computed differently and have not been subjected to the reductions applied to physician payments. Washington hospitals consume a higher percentage of Medicare expenditures for the five most frequently performed inpatient hospital procedures compared to the national average (*Chart 4*).

Chart 4

Range of Medicare Payments (Low-25th Percentile/High-75th Percentile) for Top Five Inpatient Hospital Procedures, FY2005[18]

	WA $	US $
Hip/Knee Replacement Low	11,491	9,992
Hip/Knee Replacement High	12,874	12,173
Gallbladder Removal By Laparoscope With Complications or Preexisting Conditions Low	10,459	9,156
Gallbladder Removal By Laparoscope With Complications or Preexisting Conditions High	11,358	10,921
Back & Neck Operations Except Back or Neck Fusion Low	5,526	4,749
Back & Neck Operations Except Back or Neck Fusion High	5,993	5,850
Insertion of Heart Defibrillator Low	33,299	28,828
Insertion of Heart Defibrillator High	42,756	38,232
Head and Neck Blood Vessel Operations Low	5,988	5,259
Head and Neck Blood Vessel Operations High	6,658	6,364

Medicaid and Other Publicly Funded Health Programs Increase Access for Kids but Put Pressure on Emergency Departments

In most state budgets, Medicaid program expenditures rank second only to education programs, consuming on average around 20 percent of the budget.[19] Approximately 27 percent of enrollees who are aged, blind, and disabled account for 72 percent of Medicaid expenditures.[20]

Despite overall increases in funding, the Medicaid "per service" fee paid to physicians has decreased. Medicaid pays about one-third the rate of private insurers and for most medical practices, Medicaid payments fail to cover the cost of the services provided.

Nationally, Medicaid enrollment among the aged and disabled grew about 2.9 percent per year between 2000 and 2003. Enrollment for families increased 11.6 percent between 2000 - 2002 **,** and another 7.1 percent between 2002 and 2003. Enrollment growth was largely attributable to the economic slowdown following the stock market correction of 2001.[21]

Medicaid Expenditures - In 2004, Medicaid personal health care expenditures for physicians' services in Washington were $542 million dollars, out of the national total of $27.4 billion. The average annual percent of growth in Medicaid physician services in Washington (1980-2004) was 10.6 percent, identical to the national percent of growth.[22]

In 2003, the Medicaid spending growth rate in Washington slowed due to continued drug cost containment efforts.[23] The spending growth decelerated from 8.8 percent in 2003 to 7.9 percent in fiscal year 2004. Despite this shift, the rate of increase in Medicaid costs in Washington and nationally continues to outpace state revenue growth, straining state finances.

Despite overall increases in funding, the Medicaid "per service" fee paid to physicians has decreased. Medicaid pays about one-third the rate of private insurers and for most medical practices, Medicaid payments fail to cover the cost of the services provided.[24]

Federal regulations require states to maintain a network of providers adequate to serve the people enrolled in the program. In Washington, this network is disappearing. In a recent sampling of WSMA member physicians: [25]

- 30 percent of respondents said they have begun limiting the number of Medicaid Healthy Options and Basic Health Plan (BHP) patients they can treat;
- Another 28 percent have decided to drop all Medicaid Healthy Options patients, up 10 percent from a previous poll conducted earlier in the year;[26] and,
- 24 percent have decided to drop all BHP patients, up nine percent from a previous poll conducted earlier in the year.

(For additional data on Medicaid, see Appendix B.)

In Washington, state-funded health care expenditures in FY2003 were $7.7 billion, compared to $7.3 billion in FY2002 (See Appendix B).[27] These figures include expenditures for Medicaid, the State Children's Health Insurance Program, state employees' health benefits, corrections, higher education, insurance and access expansion, public health-related expenditures, state facility-based services, and community-based services.

Increases in the Cost of Insurance Decline in Commercial Health Insurance Market

National trends in health insurance reveal that in 2005, the total costs of health benefits for all employers slowed for the third straight year.[28] In 2002, the annual rate of increase peaked at 14.7 percent, followed by rates of 10.1 percent, 7.5 percent, and 6.1 percent for 2003-2005.

Large employers (500+ employees) also have experienced a moderating increase trend since 2001, peaking that year at 12.1 percent, followed by rates of 11.5 percent, 10.2 percent, 9.0 percent and 6.7 percent for 2002-2005. The 2006 increase is estimated to be about 7.2 percent for this population.[29] Possible reasons for this declining trend include:

- Employers are shifting costs to employees via changes in health plan offerings (e.g., increases in employee premium participation, coinsurance and deductibles; and tiered prescription drug benefits). Currently in favor: new consumer directed health plans (CDHPs) offerings and preferred provider organizations (PPOs). CDHPs typically offer a Health Savings Account (HSA) in conjunction with a high deductible health insurance policy. The shift to PPOs also rose steadily from 1998-2005, growing from 36 percent to 58 percent of the plans selected.[30]

- Cost shifting may also be blunting the use of services.

- Reduction in the number of plan options offered to employees, thereby reducing administrative overhead.

- Positive effects and return on investment in implementing "health management" strategies.

Regardless, employers of all sizes have made it abundantly clear that they cannot continue to support the cost of health care benefits.

In the western US, from 2003-2005, the shift to new forms of coverage and/or delivery mechanisms has largely followed national trends:

- PPO enrollment remained relatively flat over that three-year period (86 percent, 88 percent, and 85 percent per year, respectively).

- Indemnity plans lost substantial ground (21 percent, 14 percent, and 10 percent) as did Point of Service (POS) plans, but to a lesser degree (19 percent, 18 percent, 14 percent).

- Not surprisingly, however, HMOs faired better (63 percent, 65 percent, and 62 percent) in the western region, given their long history of acceptance by patients.

Only a small percentage of large employers have offered consumer directed health plans in the western US over the 2003-2005 period (1 percent, 4 percent, 7 percent). Employees' adoption over that period was minimal (1 percent, 1 percent, 2 percent). (See Appendix C.)

Public Program Cost-Shifting: The "Hidden Tax"

In May 2006, Premera Blue Cross publicly released a Milliman study it had commissioned revealing that low Medicare and Medicaid payment rates produce a "cost-shifting" effect, driving up premiums paid by employer-sponsored health insurance -- a so-called "hidden tax".[31]

The study estimated that nearly $1.4 billion in medical care costs – $738 million in hospital costs and $620 million in physician costs – were shifted to Washington employers and other commercial customers in 2004 to offset payment shortfalls from Medicaid and Medicare.

According to the Milliman study, Medicare pays physicians 20 to 26 percent less than commercial insurers in King County, and 25 to 31 percent less elsewhere in the state. Medicaid pays 31 to 36 percent less than commercial insurers for children's office visits; 50 to 54 percent less for adult office visits; 11 to 18 percent less for maternity services; and 55 to 58 percent less for other medical services.

The study estimated that nearly $1.4 billion in medical care costs -- $738 million in hospital costs and $620 million in physician costs – were shifted to Washington employers and other commercial customers in 2004 to offset payment shortfalls from Medicaid and Medicare. This was an average of $902 per family health insurance contract, and represented 13 percent of all commercial hospital and physician costs.

Physicians' Practices Face Continued Threats to Their Viability

Physicians' practices in Washington continue to struggle to maintain their viability, confronted by rising overhead costs and administrative burdens, including significant increases in recent years to physicians' professional liability (medical malpractice) insurance premiums. Washington practices must compete against other more medical practice-friendly states to recruit physicians and other skilled clinical and administrative staff.

Small and midsize practices are particularly affected in their efforts to remain viable, lacking the economies of scale of larger practices. These practices have less leverage with health insurers to negotiate reasonable reimbursement rates. Yet, without them, there is inadequate system capacity to meet the needs of Washington's citizens.

Practice Revenues Decline as Costs Rise

Physician practice net revenues have declined as operating costs have increased. For 2003-2004, operating margins per full-time-equivalent physician in primary care practices decreased by:[32]

- 5.5 percent for internal medicine single specialty groups,
- 3.9 percent for primary care multi-specialty practices (not hospital-owned), and
- 0.6 percent for family medicine single specialty practices.[33]

Between 1995 and 2003, physicians' net income declined about seven percent after adjusting for inflation. This decline in real income contrasts to the wage trends for other professionals who realized a seven percent increase over the same period. Primary care physicians were hardest hit with a 10.2 percent decline, while surgeons' income declined by 8.2 percent.[34]

Physicians' practices, especially smaller practices, have difficulty in accessing capital resources to modernize and invest in their operations, especially for accounts receivable management, and health information technology (electronic medical records).[35]

For example, estimates for the acquisition and implementation of an electronic medical record (EMR) system ranges around $44,000 per physician, with an additional $12,000 in annual maintenance fees.[36] In addition to the expense associated with implementing an EMR, medical practices are confronted by the reality that the benefits of such systems accrue largely to those who do not have to foot the bill.

Compliance with federal and state regulatory requirements also imposes substantial costs on practices. A noteworthy example is the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). The actual costs levied on physicians' practices to comply with HIPAA are substantial, but difficult to measure with precision. One survey found that 90 percent of small practices surveyed had budgeted less than $100,000 on HIPAA compliance in 2002. The remainder of the groups budgeted between $100,000 and $300,000.[37]

Nationally, in 2004, the average practice's operating costs consumed 62 percent of practice revenue.[38] For the western US region, an average 70 percent of total practice revenue was consumed by non-medical expenses (primarily overhead costs and personnel).[39]

Single and multi-specialty physician practices reported in a recent survey that nearly 33 percent of their accounts receivable were over sixty days old.[40] This measure indicates the level of delay that practices encounter in obtaining payment from patients and insurance sources. The longer the delay, the greater the amount of labor costs required to collect on services already rendered, further decreasing the practice's net income.

In 2004, surveys demonstrated that practices limited the combined share of Medicaid and Medicare patients to less than 50 percent and often less than 25 percent of their patients in order to maintain financial viability. Private practices reported that they had no more capacity to see Medicaid, Medicare, and Basic Health Plan patients. Between 65 - 95 percent of private practitioners in urban counties and 20 - 60 percent of private practices with rural health clinic certification report that their clinics are closed to or significantly restrict new public program patients.[41]

The Medical Tort System Drives Costs Up and Access Down – For many physician specialties – particularly family practice (when obstetrical care is included), obstetrics and gynecology, and neurosurgery – the cost of medical malpractice coverage is becoming prohibitive.

Beyond the insurance premium costs associated with the current tort system, the system promotes unnecessary services (defensive medicine) and compels many physicians to limit their exposure to potentially high risk services.

Physicians Insurance A Mutual Company (owned by its 5,800+ physician policy holders and the largest medical liability insurer in the state with over 60 percent of the market) reports that between 2000 and April 30, 2004:

- 14 percent of the obstetricians/gynecologists it insured dropped delivery services (37 of 264).
- 39 percent of the family physicians it insured dropped delivery services (150 of 386).
- Combined – 29 percent of the Ob-Gyns and FPs insured by the company (187 of 650) stopped providing delivery services over the four-year period.

Beyond the insurance premium costs associated with the current tort system, the system promotes unnecessary services (defensive medicine) and compels many physicians to limit their exposure to potentially high risk services.

The system's impact on access-to-care -- and costs -- is measurable. A 2004 poll found:[42]

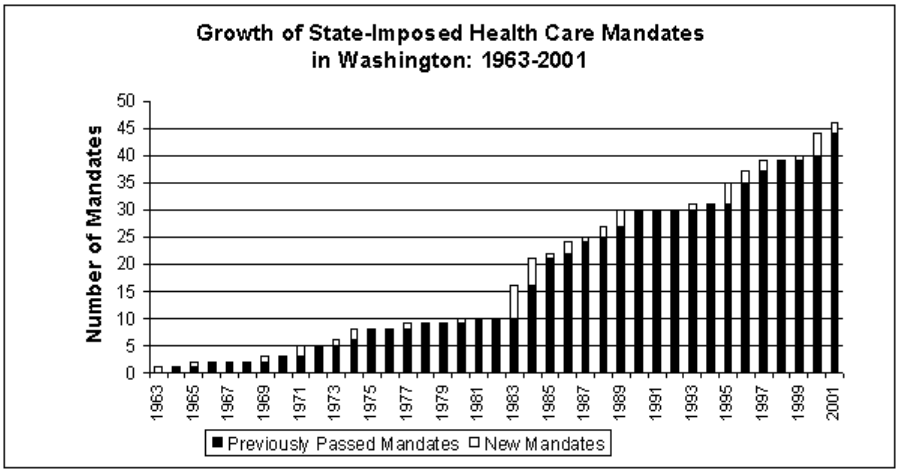
- 51 percent of physicians reported that all, most or some of their patients had had to leave their practice for certain services that they no longer offered.
- 71 percent reported their patients have had to travel further to receive care.
- 32 percent reported increasing the number of lower risk patients they see.
- 51 percent reported they are less willing to perform high-risk procedures.
- 44 percent had stopped certain high-risk services.

Regulations and Mandated Benefits Impose Costs – State regulation plays a major role in driving up the cost and reducing the accessibility of affordable health insurance.[43] Some of the reasons costs are going up are clearly beyond the control of state policymakers, but there is one key factor that is often overlooked – the costs imposed by mandates, the laws that limit the kind of health insurance that can be sold in our state.

A mandated health benefit, according to the legal definition is "coverage or offering required by law to be provided by a health carrier to: (a) Cover a specific health care service or services; (b) cover treatment of specific condition or conditions; or (c) contract, pay, or reimburse specific categories of health care providers for specific services…"

Beginning with a single mandate in 1963, the number of new and amended mandates in Washington has now grown to 47 (*Chart 5*). In recent years, their number has grown rapidly. Between 1982 and 1990, they tripled from 10 to 30, and from 1993 to 2001, their number increased by a further 50 percent.[44]

Chart 5



Nationally, Maine has the largest number of mandates – 60 total. Washington state has 48 mandates and is sixth on the list of 50 states.[45]

A number of studies have found a link between the number of mandated benefits and the higher cost of insurance. For instance in a report to Congress, the General Accounting Office found that insurance costs are consistently higher in states that impose a large number of mandates on insurers.

A PriceWaterhouseCoopers study noted, "In addition to mandated benefit requirements, states have also enacted numerous process and provider mandates. These mandates, which require coverage for specific types of providers and require plans to have specified processes in place, have contributed to the overall cost impact of mandates on health insurance premiums."

According to a Washington Policy Center report, the problem of too many mandates has been recognized by a number of state legislatures leading them to enact laws to alleviate and/or study the cost of such benefits.[46]

In addition, the growing number of non-English speaking patients requires that physicians must rely on interpreters to communicate with limited English proficiency (LEP) patients. Federal regulations impose requirements that interpreter services be provided at no cost to patients. As a result, low payment rates for physicians' services, especially for publicly funded programs, frequently result in the cost of an interpreter exceeding the physician's payment, a net loss to the practice for treating patients under those circumstances.[47]

Patients' use of "alternative medicine" services - a growing part of medical services costs - is expected to continue, and more insurers will provide reimbursement for those services in response to public demand or legislative mandates. An estimated 33 to 40 percent of Americans already use some form of alternative medicine treatment.[48]

Dwindling Number of Primary Care Physicians Threatens Access

A 2006 study found that new physicians are not choosing to pursue careers as family physicians and general internists.[49] The number of medical students entering family medicine residencies has declined by 52 percent in seven years. This shift is attributed to declines in reimbursements for primary care

services, increasing student-loan debts, reductions in funding for the training of family physicians, and the challenges and complexities of caring for an aging population.

Primary care physicians (PCP) are taking care of fewer patients who are hospitalized, with full-time hospitalists assuming the care of these patients. As a result, PCPs are dropping their active medical staff membership to reduce their inpatient care and emergency on-call burdens.[50] This, in turn, affects the effective coordination of care and continuity of services.

Emergency Departments are Overburdened

When physician practices begin to limit new patients they can take, or close entirely, patients must find care elsewhere – typically at their local emergency department (ED).

Contrary to common belief, most patients who visit emergency departments have health insurance, according to a 2006 study published by ACEP.

In 2006, the American College of Emergency Physicians (ACEP) released its first national report card, grading each state on the support it provides for its emergency medical system.[51] ACEP gave Washington an overall grade of D+. Washington ranked 40th in the nation due to its inadequate support of an emergency care system to meet the needs of its citizens.

Nationally, in 2003, emergency departments received nearly 114 million patients -- a 26 percent increase over the previous decade -- but the country experienced a net loss of 703 hospitals and 425 EDs during the same ten-year period.[52]

Contrary to common belief, most patients who visit emergency departments have health insurance, according to a 2006 study published by ACEP.[53] According to the study conducted by the Robert Wood Johnson Foundation and the University of California - San Francisco:

- About 84 percent of frequent ED users (those visiting EDs four or more times per year) had health insurance.
- 81 percent had a source of coverage for primary care.
- Many of these ED patients with insurance use the ED when they cannot get in to see their usual doctor.
- Some ED patients are simply waiting for hospital beds.

A 2001 statewide survey of hospital emergency department directors found:[54]

- 91 percent of small hospitals and 100 percent of large hospitals reported that they have an overcrowding problem.
- 76 percent of large hospitals reported an overcrowding frequency of two to three times per week or greater.
- 81 percent of large hospitals and 60 percent of small hospitals expect emergency department overcrowding to increase in the future.

Overcrowding occurs in an emergency department when its capacity to "move" patients is gridlocked (too many patients arriving and too few patients departing).

The data cast doubt on whether expanding health insurance coverage alone will solve the problem of ED overcrowding.

Health Care in Washington is in Transition

The Number of Uninsureds is Down but System Dysfunctionality is Worsening

The ability of patients to receive health care services – in the right setting, at the right time and appropriate to the needs of the patient – is the true test of the functionality of a health care system.

The data shows an increase in the number of Washingtonians covered by group insurance and a decrease in the percentage of Washingtonians who lack health insurance. However, having health insurance does not guarantee access to care – nor access to cost-efficient, care-efficient services. The health care delivery system remains fraught with inefficiencies, fragmented services, costly variations in the services provided, and a disturbing decrease in the capacity of the system to care for the citizens of the state. These issues are discussed elsewhere in this report.

The following data examine the distribution of health insurance across employer-sponsored coverage, government-sponsored programs, as well as those who obtain insurance as individuals, and those who have no health insurance coverage.

The data shows an increase in the number of Washingtonians covered by group insurance and a decrease in the percentage of Washingtonians who lack health insurance.

Washington state does not require employers or private insurance companies to report statistics on group insurance coverage and benefits utilization. As a result, comprehensive data can be difficult to identify. There are some notable examples of data gathering, however, including the following:

- In 1989, the *Basic Health Plan Technical Advisory Committee (TAC) - A Final Report* provided accurate survey data on the extent of group health insurance coverage in Washington state. [55]

- In 2003- 2004, Insurance Commissioner Mike Kreidler convened the *"Let's Get Washington Covered" Task Force*, and complied extensive data on health insurance coverage in Washington.

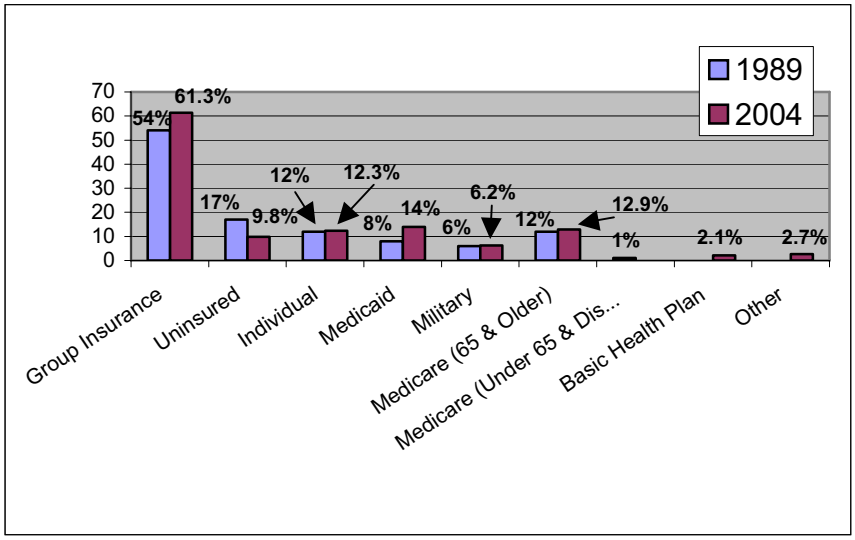
- In 2005, Washington state released its fourth annual report of its state-planning grant to conduct activities to cover the uninsured, consistent with federal goals set in *Healthy People 2010*. [56]

The *Washington State Population Survey* (*Chart 6*) is an important ongoing source of information about the health and welfare of Washington families.[57] This survey, conducted in spring 2004 for the fourth time, focused primarily on issues of employment, family poverty, in-migration, health, and health insurance coverage.[58]

Notably, in comparing the 1989 and 2004 findings of the *Survey*, there is a seven percent increase in the percentage of population covered by group insurance while the percentage of uninsured (relative to overall population) declined by seven percent. The percentage of the Medicaid population grew by six percent.

Chart 6

Health Care Access in Washington state
As a percent of total Washington state population (2004 = 6,063,048)

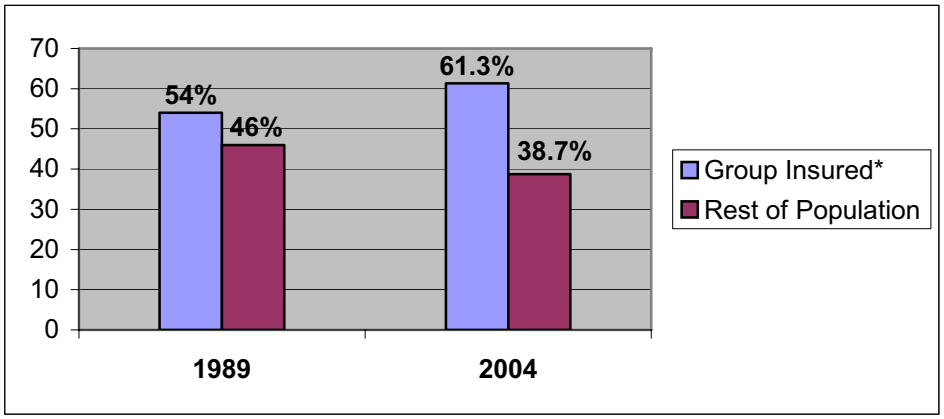


The Number Covered by Group Insurance has Grown

In 1989, 2.5 million persons, an estimated 54 percent of the state population, were covered by some type of group insurance program (*Chart 7*).[59] In 1998, about 3.5 million persons, 61.7 percent of the state population, were covered by group insurance.[60] In 2004, nearly 3.8 million persons, 61.3 percent of the state population, were covered by group insurance.[61]

Chart 7

Employer/Union Sponsored Health Insurance (Group Insured Population)[62]
As a percent of total Washington state population (2004 = 6,168,846)



** In 1989, the report broadly aggregated data as "group insurance", while the more recent data explicitly includes both employer-sponsored and group insurance.*

Employer Contributions are Down as Costs are Shifted to Employees – In 1988, Washington employers paid the entire group insurance premium for 47 percent of those covered by a group plan, paid part of the premium for 49 percent of the enrollees, and provided no payment for less than 4 percent of those covered by a group plan. Forty-two percent of the group insurance contracts limited coverage to the contract holder, excluding spouses, children, and other dependents.[63]

From 2001 – 2003, Washington employee contributions toward health insurance coverage tended to be smaller than the national average, especially for single (employee only) coverage, due to the relatively high percentages of enrollees in Washington who are not required to contribute (*Table 1*).[64] (For additional data on group coverage, see Appendix D.)

Table 1

Employee Health Care Contributions: Washington and the US
2001 - 2003

	Single Coverage	Family Coverage	Employee-Plus- One Coverage
Washington			
All Firms	**50%**	**27%**	**15%**
<50 Employees	**73%**	**46%**	**30%**
50+ Employees	**41%**	**22%**	**11%**
United States			
All Firms	**28%**	**15%**	**10%**
<50 Employees	**56%**	**41%**	**27%**
50+ Employees	**19%**	**10%**	**7%**

Individually Insured Population Grows in Number, Not Percentage Covered

In 1989, about 12 percent (546,900[65]) of Washington's citizens purchased health insurance directly from commercial health insurers or health care contractors.[66] In 2004, this percentage remained unchanged; however, the number of individuals choosing this option grew to 760,962.[67] (See Appendix D)

In 2004, the individual health insurance market represented about five percent of Washington state's insured consumers. This is in sharp contrast to the situation in the late 1990's when Washington was experiencing problems with the individual and small group insurance markets. In the face of additional state regulatory burdens and in an effort to keep individual insurance profitable, insurers adopted eligibility standards that denied coverage to those most likely to incur medical expenses. Legislation attempted to counter that trend and increase access but instead prompted the withdrawal of insurance carriers from the individual market in 1998-1999.

Consumers could not buy individual coverage in Washington until 2000-2001, following legislative action that, in part, allowed health underwriting to return. The "eight percent most costly" applicants, responsible for an estimated 60 percent of total claim dollars, were to be screened into a high-risk pool, the Washington State Health Insurance Pool (WSHIP). While the WSHIP subsidized insurance for individuals denied private insurance, less than nine percent of those eligible purchased coverage.[68]

Health Savings Accounts (HSAs) were made available to all US citizens by the Medicare Prescription Drug Improvement and Modernization Act of 2003. HSAs are accounts to which individuals, family

members, and employers can make tax-deductible cash contributions. Those funds can then be used to pay for qualifying medical expenses on a tax-free basis, either by paying the "provider" directly from the account or by reimbursing the individual. HSAs are exclusively for the purpose of paying qualified medical expenses of the account beneficiary.[69]

The HSA concept has strong supporters, and skeptical critics.

Data on HSA purchases for 2005 reveal that: [70]

- Premiums for HSA-eligible plans went *down* 17 percent, with individuals paying $114 per month in 2005 compared with $138 in 2004.

- More than 40 percent of HSA-eligible plan purchasers *were previously uninsured.*

- *HSA plans continue to be comprehensive*, with most policies covering 100 percent of the costs of hospitalization, lab tests, emergency room visits, prescription drugs, and doctors' visits after the deductible is met.

- More than *60 percent of HSA plan purchasers have been moving toward higher annual deductibles*, compared with 50 percent in 2004.

- *Almost 50 percent of plan purchasers in 2005 earned $50,000* or less annually and 42 percent are 40 years old or older.

The HSA concept has strong supporters, and skeptical critics.

Those findings contrast to the results of the *Consumerism in Health Care Survey* conducted jointly by the Employee Benefits Research Institute and The Commonwealth Fund.[71] In comparing users of consumer directed health plans to those with traditional insurance, the survey found:

- Persons with consumer directed/high deductible health plans were significantly more likely (31-35 percent) to *avoid, skip or delay health care* because of costs than those with traditional insurance (17 percent).

- Persons with consumer directed/high deductible health plans were significantly more likely (26 percent) to *skip doses of medications to make them last longer* than those with traditional insurance (15 percent).

- Persons with consumer directed/high deductible health plans were significantly more likely (11-20 percent) to *spend a large share of their income on out-of-pocket health care expenses* than those with traditional insurance (5 percent).

- Persons with health problems or with lower incomes -- under $50,000 – were *particularly vulnerable to spending large shares of their income* on out-of-pocket health care expenses than those with traditional insurance.

Washington's Uninsured Population has Decreased

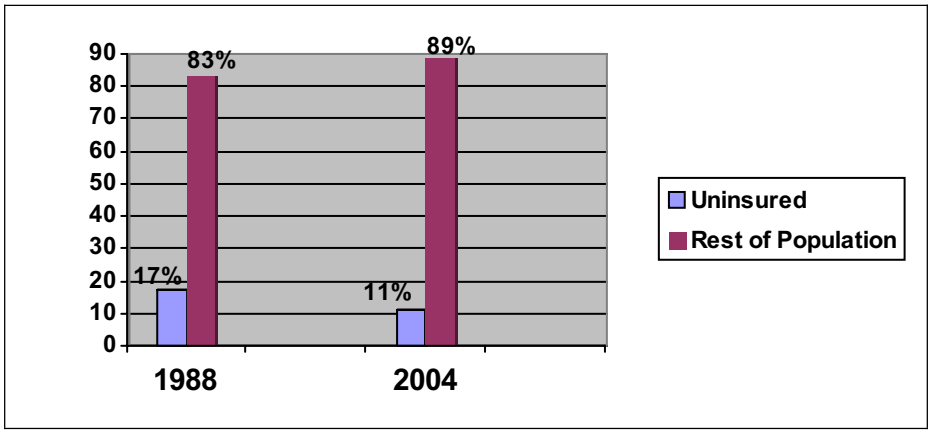
As noted previously, the number of Washington residents without health insurance, as a percentage of the total state population, has decreased while the percentage of the population covered by group insurance has remained constant. At the same time, it is smaller firms that are dropping coverage or find themselves unable to offer coverage.

In 1988, 784,171 persons, about 17 percent of all Washington citizens, had no insurance (*Chart 8*).[72] In 2004, about 603,000 persons, 11 percent of all Washington citizens, had no insurance.[73] The introduction of the Basic Health Plan (BHP) and expansion of Medicaid eligibility are key factors influencing that reversal. [74]

By comparison, in 1998, about 15.5 percent of the U.S. population was uninsured.[75] While the data for that period suggest a slightly higher rate of uninsured in Washington than elsewhere, the variation is within the statistical margin of error for the survey techniques used to collect the data. In 2005, nationally there were about 45.8 million people,15.7 percent of the civilian non-institutionalized population, who were uninsured, and Washington was below the national average.[76]

Chart 8

Uninsured Population
As a percent of total Washington state non-elderly population
(2004 = 5,463,989)



In 1988, a report by the Employees Benefit Research Institute (EBRI) reported that almost half of all uninsured workers were found in firms with fewer than 25 employees.[77] In 2005, another EBRI survey reported that 69.3 percent of all uninsured workers were found in firms with fewer than 25 employees.[78]

Nationally, employers not providing health insurance for employees are more likely to be small firms. According to the 1986 Small Business Administration's (SBA) *Health Benefits Study*,[79] more than half of firms with fewer than 10 employees, and about one-fourth of firms with 10 to 24 employees, did not offer health insurance (See Appendix D for data on the demographic characteristics of the uninsured in Washington state.)

In Washington, an analysis by the Office of Financial Management found a substantial drop in the percent of workers who lacked employer group health insurance, with the largest shifts occurring between 1989 and 2006 in the occupational groupings of services, agriculture, forestry and fishing; wholesale, and

retail.[80] (See Appendix D for data on the demographics of workers with and without employer sponsored insurance.)

When correlated with income data, it is clear that Washington's so-called *working poor* comprise a sizable share of the uninsured population (see Appendix D).[81] Continued state budget constraints that have limited enrollment in the BHP are largely to blame for this growing segment of the uninsured population.

In 1989, about 17 percent of Washington's population (748,171) were uninsured at any one point in time, compared to 11 percent (603,000) in 2004.[82]

About 37 percent in 1989 and 62 percent in 2004 were members of low-income families who earned less than 200 percent of the Federal Poverty Level (FPL). About 14 percent of the uninsured in 1989 (104,744) compared to 35 percent in 2004 (88,706) were at risk of being both sick and uninsured.[83]

Growth in Medicare Population (Age 65 And Older)

In 1989, 12 percent of all Washington citizens (543,612) qualified for Medicare, compared to 2004 when about 13 percent (775,000) qualified (See Appendix A).[84] In 2004, 86 percent of these 775,000 residents were elderly (over the age of 65) and 14 percent were non-elderly persons with disabilities.[85]

In 2004, over 15 percent of Washington citizens aged 65 or older elected to enroll in Medicare Managed Care (as opposed to Traditional Medicare Fee for Service) compared to 11 percent of Medicare beneficiaries nationally. In addition to virtually all people aged 65 or older, those under age 65 who have been receiving Social Security Disability Insurance payments for 24 months, as well as certain people under 65 with end-stage renal disease, are eligible for Part A coverage.

In 1989, only one percent (48,000 individuals) under the age of 65 were covered by Medicare.[86] In 2004, about 120,505 individuals were covered despite being under the age of 65.[87]

An approximate 42 percent increase in the number of seniors on Medicare, coupled with reductions in Medicare payments to physicians' practices, has reduced access to care for many seniors.

Nationally, in 2002, 841,298 physicians and other providers rendered Medicare Part B services, compared to 925,508 in 2003.[88] (See Appendix A for more detail.)

Medicaid and Government Sponsored Programs' Enrollment

By the end of 1997, more than 255,000 women had received services through Washington's Medicaid program, and Medicaid was funding 42 percent of all births to Washington residents. In 2002, over two-thirds (67.5 percent, or 113,446) of Medicaid enrollees were women between 18 and 29 years of age, the same age group that accounted for 73.0 percent of all Medicaid-paid births.[89]

Washington state's *TAKE CHARGE* program, which began July 2001, expanded Medicaid coverage for family planning services to men and women with family incomes of 200 percent or less of the FPL. *TAKE CHARGE* represented a change in state Medicaid policy by providing family planning services prior to pregnancy for low-income women not otherwise Medicaid eligible and includes low-income men in its target population.

In 1989, about 12 percent[90] of the state's population (361,020) were eligible for some type of state medical assistance[91] compared to 2002 when about 15 percent (940,693) were eligible.[92] Two Medicaid (Title XIX of the federal Social Security Act) programs protect almost 95 percent of this group: Categorically Needy and Medically Needy (for additional data on Medicaid, see Appendix B).

Basic Health Plan Shows Promise But Stymied by Budget Constraints – In 1986, the Washington Health Care Project Commission (the McPhaden Commission), created by the legislature, issued its report that became the basis for the Basic Health Plan (BHP) and a state high-risk pool.[93] The legislature created the BHP via passage of the Health Care Access Act of 1987. At that time, an estimated 12-14 percent of Washington residents were uninsured. The primary goal of the BHP was to provide state subsidized basic health care for the working poor who are otherwise uninsured.

Following pilot projects, open to 4,000 residents in King and Spokane counties, the legislature initially limited enrollment to 30,000 individuals, under age 65, who were ineligible for Medicare, and who had a gross family income at, or below, 200 percent of the FPL. Enrollees obtained care from a managed delivery system and paid part of the cost of their premium under an income-related sliding fee scale.

By June 2006, the BHP enrolled 99,788 individuals.[94] Enrollment has fluctuated due to the degree of funding legislators have been willing to provide as the state has experienced its economic cycles since 1994.

Other Mechanisms Pick-up Some, But Not All, of the Slack – In 1989, Community Clinics served about 155,000 medical patients per year. While Medicaid covered 22 percent of these patients, 66 percent had no other health care coverage. In 2002, these centers served 391,246 patients in Washington.[95]

This population is usually poor or near poor, with 62 percent having incomes below the FPL.[96] These patients are typically served in a Community Health Center, Migrant Health Center or in an Indian Health Center.

In 2004, Federally Qualified Health Centers (FQHC), which includes Community Health Centers, Migrant Health Centers, Indian Health Centers, and FQHC "look-alikes", were responsible for providing a disproportionately large percentage of local primary care to serve low-income patients and especially the uninsured.

In 2004, Washington's free clinics provided more than 40,000 patient visits. Although the number and capacity of charity clinics has grown along with access concerns, in most areas charity clinics represent far less than one percent of physician capacity.[97]

Another example of Washington physicians' commitment to provide charity care is *Project Access*. These county-level initiatives engage physicians to voluntarily treat indigent patients at no charge. The Spokane County Medical Society began the first *Project Access* in this state in 2003. Already this project has provided over $2.5 million in charity care, with over 650 physicians participating. The Thurston-Mason County Medical Society launched its project in 2005, and both the Clark and King County Medical Societies have projects under active development.

The Uncompensated Care Burden Continues

Another source of medical care for the uninsured population is uncompensated care -- unpaid bills for medical services provided by hospitals and physicians (where there is no third party payer such as Medicaid or insurance).

The traditional view of uncompensated care distinguishes between charity care and bad debt. Charity care is usually provided to medically indigent persons who have no health insurance. Bad debt is generated by persons who are presumed to be able to pay, but do not, even after the practice has exhausted reasonable attempts to collect the debt. The distinction between these two categories is not always well defined and not all uncompensated care is fully reported.

Nationally, a recent study found that there was little change in the amount of charity care provided during the late 1990s and 2000s. From 1996-97 to 2004-05, the average number of hours spent providing charity care and the percentage of practice time spent on charity care both declined slightly.[98]

The decline in reimbursement by public and private payers has created financial pressures that are limiting physicians' ability to provide charity care.

The study also showed a decrease in the proportion of physicians providing charity care, dropping from 71.5 percent of those surveyed in 2000-2001 to 68.2 percent in 2004-2005. The actual number of physicians providing charity care, however, has remained relatively stable as the overall number of U.S. physicians engaged in active medical practice has increased from approximately 347,000 in 1996-97 to 397,000 in 2004-05.[99]

The study suggests that the long-term decline in charity care provided by physicians may have contributed to reductions in uninsured people's access to medical care. In 2003, 63.1 percent of the uninsured had a regular source of medical care, down from 68.6 percent in 1996-97. Additionally, the percentage of the uninsured with a physician visit in the past year fell from 51.6 percent to 46.1 percent during this period.[100]

The decline in reimbursement by public and private payers has created financial pressures that are limiting physicians' ability to provide charity care, the study further suggested.

In 2003, the Washington Office of the Insurance Commissioner convened the "Let's Get Washington Covered" Task Force and identified data on uncompensated care. For 2001, $318,515,652 in uncompensated care was provided in Washington, with $44,592,191, or 14 percent, provided through physicians' practices.

Military-Related Population

The state's military population eligible for some type of military-related health insurance has grown significantly, and is expected to grow through 2010. This population is essentially served by the Department of Veterans Affairs (VA) and has nominal impact on the state's private insurance and public health care programs (additional data is provided in Appendix E).

Quality vs. Costs: Which Way Will We Go?

There is no shortage of ideas on how to improve our health care system.

The upward spiral of health care costs – underwritten primarily by employer-purchasers and publicly funded programs, and exacerbated by variations in services provided from locale to locale, a distorted tort system, and other factors – have driven stakeholders to challenge the system to produce better "value" for that spending. Seeking a clinically sound and affordable balance between cost and quality will be a central focus of discussion for the foreseeable future.

While physicians are being pressed to demonstrate quality, the ability to measure quality is currently limited by statistical anomalies; the inadequacies of information systems; the complexity of health plans; and the availability of funding for such systems.[101]

Seeking a clinically sound and affordable balance between cost and quality will be a central focus of discussion for the foreseeable future.

Many Initiatives in Play; Consensus Still Being Sought

Quality of Care Projects – Nationally (A Sampling)

Dartmouth Atlas of Health Care - The Dartmouth Atlas Project describes how medical resources are distributed and used in the United States. The project offers comprehensive information and analysis about national, regional, and local markets, as well as individual hospitals and their affiliated physicians, in order to provide a basis for improving health and health care systems.

Those analyses indicate that Washington state makes more efficient and cost-effective use of physicians' services.[102] For example, expenditures for the care of chronically ill Medicare patients are well below the national average, with an effective balance in the use of primary care physicians and medical specialists.[103]

The *Atlas* also describes very significant variations in similar services provided from locale to locale, and within locales.

There is emerging evidence that variations in the delivery of care can contribute to higher total costs for health care services. Of course, each patient's course of treatment is likely to vary, given the specifics of their clinical conditions and their response to care. Such variations, however, can be reduced through the adherence to "best practices" pathways that help identify options that are more clinically effective and cost-efficient.

Care in the last six of months of life is a key area of variations research. For example, one study identified a cohort of end-of-life patients cared for in a New York teaching hospital who made, on average, 67 visits to physicians; 57 percent saw ten or more physicians, and the average patient spent about 30 days in the hospital. Another cohort in Los Angeles made, on average, 44 visits to physicians, spent 9.2 days in intensive care, and 51 percent saw ten or more physicians. In contrast, a cohort in San

Francisco made, on average, 27 visits to the physicians, spent less than 12 days in the hospital, and only 30 percent saw ten or more physicians.[104]

The cost of delivering services varies dramatically across the United States and within regions as well. While some degree of this variation is attributable to differing costs of operation across geographic regions (e.g., overhead, labor, professional liability insurance), other key components are attributable to the course of clinical treatment implemented.

Table 2 [105]

Cost of Care Variations in Medicare, Selected "Pacific States" Regions, 1992-1996

Services	National Average	Seattle	Portland	San Diego	Los Angeles
Per Enrollee Reimbursements	$3,650	$3,223	$2,993	$4,361	$4,179
Professional & Laboratory	$ 975	$ 818	$ 648	$1,252	$1,426
Inpatient Hospital	$1,852	$1,501	$1,556	$1,865	$2,129
Outpatient	$ 319	$ 338	$ 306		
AAPCC[106]	$5,291	$4,902	$4,613	$5,768	$7,049

Institute of Medicine - In 1996, the Institute of Medicine (IOM) introduced a multiphase quality initiative, first documenting the status of the quality of health care in the US and developing a framework for further study.[107] The IOM next created the Committee on Quality of Heath Care in America, issuing two reports: *To Err is Human: Building a Safer Health System* in 1999 and *Crossing the Quality Chasm: A New Health System for the 21st Century* in 2001. These reports devised six aims for the health care system: health care should be safe, effective, patient-centered, timely, efficient, and equitable.

The IOM is currently focusing on performance measurement as an avenue to improve health care quality, and is examining available measures and frameworks to best use those measures in achieving process improvements.

American Medical Association - The American Medical Association (AMA) created the Physician Consortium for Performance Improvement, which seeks to improve quality of care by establishing performance measures. Many of its performance measures have been endorsed by the Centers for Medicare and Medicaid Services (CMS) and the National Quality Forum.

Quality and Cost of Care Projects - Washington State Initiatives

Governor Gregoire's Health Care Agenda - In October 2005, Governor Gregoire convened a Health Care Summit to articulate her vision on how health care should be delivered, and afforded attendees the opportunity to recommend new ideas on how to structure the system so that it provides the best quality of care, reduces costs, and provides access to care for all of the people of the state.[108]

In November 2005, the governor announced her Five Point Strategy to "make Washington a national leader in health care": [109]

- Emphasize evidence-based health care.
- Promote, prevention, healthy lifestyles and healthy choices.
- Better manage chronic care.
- Create more transparency in the health care system.
- Make better use of information technology.

In March 2006, the governor signed ESSHB 2575 into law, creating the State Health Technology Assessment Program (SHTAP) - a key component of her five-point plan.[110] SHTAP tasks will include the determination of evidence-based practice center(s) to develop contracts for evidence-based technology assessments, and will form a Health Technology Clinical Committee to guide its work.

Blue Ribbon Commission on Health Care Costs and Access - In March 2006, the governor signed ESSB 6386 into law, funding creation of a Blue Ribbon Commission on Health Care Costs and Access.[111] The Commission is charged with making recommendations by December 1, 2006 for a sustainable five-year plan for substantially improving access to affordable health care for all Washington residents.

Puget Sound Health Alliance - The Health Alliance was formed in late 2004, following recommendations from the King County Health Advisory Task Force commissioned by King County Executive Ron Sims.[112] The task force recommended driving down the rate of health care cost growth by improving the value of care provided in the Puget Sound region. This is to be done through measuring, reporting and improving the quality of care, drawing from nationally recognized, evidence-based standards and measures such as those published by the Institute of Medicine.

The Health Alliance's geographic scope covers King, Pierce, Kitsap, Thurston and Snohomish Counties. Its stated strategies include:[113]

- The use of collaborative approaches among employers, health plans, physicians and hospitals that reward high quality care.
- The involvement of neutral and qualified experts in the measurement, analysis, and reporting of health care quality and cost performance to build trust among all participants.
- The sharing of data in a regional public/private collaborative.
- The increased use of evidence-based clinical decision guidelines and self-management tools.
- The implementation of quality improvement principles, tools, and techniques.

WSMA Consensus Conference on Clinical Quality Measures -- In May 2005, the WSMA convened a *Consensus Conference on Clinical Quality Measures*, bringing together organizations and thought leaders to help set the course for quality improvement.[114] Key findings from that conference included these recommendations:

- Seek agreement on existing clinical measures, rather than "recreate the wheel".
- Devise a functional set of standard measures as a beginning, rather than strive for a perfect set.
- Consider "data aggregation" with adequate sample sizes, compiling data from various sources to produce uniform reporting tools acceptable to all.
- Use clinical measures to influence positive changes in patients' behaviors, and that are easy to implement in all physicians' practices, especially small to midsize practices.

Washington State Medical Association Quality Improvement Initiative – In 2006, the Washington State Medical Association's Education and Research Foundation (WSM-ERF) received a one million dollar grant to fund a two-year quality improvement program involving six disease states: diabetes, heart disease, asthma, depression, and cervical and breast cancer screening. The funding will support the creation of actionable reports on physician performance as well as patient registries related to chronic and preventive care.

The program is to combine medical and pharmacy claims data from multiple payers to create a single report for each physician. In addition to allowing physicians to see how they compare to peers and best practices, the information will also identify all of a physician's patients with the above conditions and show the status of those individuals with respect to appropriate tests and medications. Initial reports and registries are expected to become available by the end of 2006.

Health Information Technology: Key to Achieving Quality

Experts agree that the power of electronic medical records (EMRs) to manage health care information will be key to achieving improved treatment outcomes and, ultimately, to controlling costs. However, estimates for the acquisition and implementation of an electronic medical record (EMR) system are approximately $44,000 per physician, with an additional $12,000 in annual maintenance fees.[115]

In the 2005 session, the legislature passed SSB 5064, mandating the development of a strategy for the adoption and use of EMRs and health information technologies consistent with emerging national standards and the promotion of interoperability of health information systems. The Health Care Authority (HCA) is charged with presenting its final recommendations to the legislature by December 2006.

Pay For Performance (P4P)

A key strategy evolving across commercial health insurers and publicly funded health programs is the Pay For Performance (P4P) mechanism. Generally, P4P uses a methodology whereby payments are made to physicians' practices for performing specific services or for achieving specified outcomes and care benchmarks.[116]

Early experience with P4P raises questions regarding the overall return on investment that P4P will produce.

Nationally, more than 100 pay-for-performance programs have been implemented by payers. Further, a wide variety of clinical quality measures are in use. The absence of a single core set of quality measures that has been vetted by recognized physician organizations is a source of genuine concern among physicians.[117]

In December 2005, the Institute of Medicine (IOM) issued its report *Performance Measurement: Accelerating Improvement*. Under the collective title of *Pathways to Quality Health Care*, the IOM is to issue two additional reports in 2006-2007 in this series: *Payment Incentives*, and *Performance Improvement*. The initial report acknowledges the need for the "availability of accurate, reliable and valid performance measures."

The report offered six recommendations:

1. Creation of a national quality coordination board.
2. Ensure the independence of the proposed quality coordination board.
3. Encourage local innovation on performance measurement, aligned with national standards, including the creation of a "recommended starter set of performance measures."
4. Endorse national [quality] standards through ongoing consensus processes led by major stakeholders, and ensure that a data repository system and public reporting system are established.
5. Support the development of a national system for performance measurement and reporting.
6. Ensure the availability of financial resources to support a research agenda.

It is noteworthy that the IOM's recommendations closely align with the findings from the WSMA's May 2005 *Consensus Conference.*

Early experience with P4P raises questions regarding the overall return on investment that P4P will produce. A recent study noted that a methodology that provides payment for reaching a common, fixed performance target may produce little gain in quality for the investment and would simply reward those with higher levels of performance at the baseline.[118]

It remains to be seen whether P4P will be used as a legitimate tool to underwrite improvements in quality of health care services or will be misused as a crude cost containment strategy.

What Should Tomorrow's Medicine Look Like?

Working Together to Shape the Future of Medicine and Health Care

When the topic is health care in Washington, optimism vies with discontent. The status quo has few defenders, yet most think the future holds promise. There's no clear consensus, however, on how that promise will be realized.

Technology is making record-keeping more comprehensive, accessible, and useful. Greater awareness of "best practices" will lead to more consistency and improve quality. A growing emphasis on wellness, prevention and early detection can lead to better health and reduce treatment costs. For those with good health insurance coverage, health care quality is good – provided they can get in to see their physician on a timely basis.

But rising costs put an increased number of Washingtonians at risk of losing their health insurance. There is still too much variation in the quality of care provided. And too much money is being spent ineffectively.

In June and July 2006 the Washington Research Council, on behalf of the WSMA, surveyed thirty-six opinion leaders regarding their vision for the future of medicine in our state. Respondents consisted of hospital administrators, practicing physicians, business advocates, labor leaders, medical school faculty, third party payers, policy analysts and state officials. About 20 percent of the respondents were physicians. (Physician responses did not vary significantly from the rest of the group.)

In this section of *Tomorrow's Medicine* common themes are identified, as well as common ground on which the health care community can stand together to work to improve our state's health care system. To highlight that emphasis, this report does not identify individuals by name or by the sector they represent. A full list of respondents can be found in Appendix F.

The questionnaire began with a very general question: Where should medicine be in five years? Respondents were then asked a series of questions regarding whether and how physicians were an asset to health care, how they could become greater assets, and what obstacles stand in their way. Further questions probed for specific responses to current issues in health care: evidence-based medicine, universal coverage, Medicaid, medical liability, and pay-for-performance. Finally, respondents were asked their views on cost containment, fair compensation for physicians, improved access, and what must be done to transform health care in the next five years.

The questions were challenging. And the answers – the prescriptions for change – are no less challenging.

Theme 1: Excellent Health Care Will Reduce Costs, Increase Access, and Improve Lives

Looking ahead, leaders believe that medicine will have incorporated technology and best practices to assure consistently high quality care. Quality improvements will lead to increased access and affordability. Patients will bear more responsibility for both their lifestyle choices and the costs of their care. Wellness programs, prevention, and early detection programs will reduce long-term costs and improve outcomes. Evidence-based medicine, electronic medical records, wise use of new technology, and increased patient involvement and responsibility will characterize a transformed system. But for this to occur there must be a corresponding transformation in the relationship between payers and physicians. Every leader identified physicians as assets, critical to guiding change in the health care system, though sometimes reticent to show leadership in quality and cost control.

Comments:

> "Medicine should more effectively align financial resources with medical need, which can drive better health and improved access to health care. … Central to this is the broad adoption of evidence-based best practice guidelines."

> "…medicine should take advantage of 21st Century technology to offer efficient, well coordinated, patient centered care based on industry best practices."

> "Physicians are the bedrock … although we will see greater involvement of patients in provider selection and care decisions, the physician will still be central in clinical decision-making."

> "Medicine should be accessible and affordable without patient insulation from the costs of health care."

> "Every effort to improve quality leads to reduced costs. Increasing quality actually costs less."

> "When involved and engaged, physicians can be the greatest asset toward agreeable evolutionary change with an essential perspective of delivery system down to delivery at the individual patient level."

> "We need to shift dramatically from reactive approaches to late stage disease to focus on early detection, early treatment and early prevention."

> "Reduce variation. Pay for more physician time with the patient – 'at the bedside' or in the examination room."

Theme 2: Universal Access – Laudable Goal, but Difficult to Achieve

More than two-thirds of those surveyed supported some form of universal access to health insurance and care, although their answers revealed different definitions of the idea. The remaining third all favored policies that would increase access to health care. The majority urged strategies for achieving broad access to health care within a framework involving private insurers, public health programs, and patient choice. Only two people called specifically for a single payer or Canadian-style system, although several others described approaches involving a dominant public sector role.

Comments:

> "If by universal coverage, you mean that all Washingtonians have access to health insurance, then universal coverage is a good goal. But in working toward universal coverage, the difficult questions such as cost, individual responsibility, sustainability, and the limited benefits to which everyone can have access must be answered."

> "Ideally we should have universal coverage now and not in five years' time. However, any mechanism to provide it is unlikely to garner enough national support … unless the number of middle class uninsured continues to rise drastically."

> "No evidence this has ever worked without either prohibitive costs or rationing. Better to work on making health care delivery less expensive so that costs are affordable."

> "Universal coverage is a lightning rod of controversy, in part because it's not possible to define it to everyone's satisfaction. [The] difference between universal coverage and universal care is enormous and needs to be respected."

> "Separate access to health care and access to insurance….insurance is not care, it is a financing mechanism."

> "Pay or play. Mandatory health insurance."

Theme 3: Toward a Seamless, Collaborative Health Care System with Physician Leadership

Throughout the survey responses, leaders often indicated the importance of collaboration among the various elements of the health care system. "System", however, may be too strong a term to describe the various components of health care delivery – the third-party payers in government and the private sector, public health professionals, hospitals, physicians, and patients. Demands on physicians' time, as well as the value they place on autonomy and independence, impede physicians' role as leaders in system integration.

Comments:

> "Physicians must step forward and be the leaders for change."

> "Medicine remains largely a cottage industry. Adequate incentives are not in place to reward development of integrated approaches and delivery of quality care vs. quantity of care. … Advances will occur through collaborative approaches, supported by better information and incentives in three key areas: advances in medical quality, efforts to encourage cost-conscious action throughout the health care system, and support for consumers at every stage of health."

> "Medicine should be participating with other health professionals and patients and their families in ways that contribute the best that each can offer to promote a healthy and highly functioning population in the state. This includes translating what we have learned from clinical and basic science research to delivery of care and educating the future health professionals in an inter-professional model of service delivery."

> "We need an integrated system of health care that reduces fragmentation, increases efficiency and is outcome based. The payment system would need to align and incentivize this model."

"Physicians will need to shift from being the ultimate provider of health care to being the co-creator of health….part of this is to stop using terms like 'consumer.'"

Theme 4: Electronic Medical Records: Valuable, Inevitable, and Worth the Cost

More than 80 percent of respondents endorsed electronic medical records (EMR) as a major step forward in health care delivery. Despite concern with the significant investment required, they believed the increased access to information, reduced risk of errors, and potential gains in administrative efficiency justify the conversion.

Comments:

"Just do it! Big savings – a lot of mistakes eliminated."

"…this is a strong initiative at the federal level and absolutely essential to deal with evidence based medicine..."

"Cost of acquisition and adoption remain high. Risk of failure is still too high. The benefits are possible, however the pitfalls appear great."

"Medicine should reclaim the medical record and realize that when we turned it into a 'billing document' we went down the wrong path."

"EMR should be the norm and should be integrated into larger clinical data systems that can give physicians concurrent information on patient-specific care opportunities."

"Essential, but problematic when serving the 'safety net' populations, including immigrant and migrant populations."

Theme 5: Implemented Wisely, Guidelines and Evidence-based Practice Offer Promise

Views on guidelines and evidence-based practice ranged from cautious optimism to enthusiastic endorsement. No one rejected the value of an emphasis on best practices, clinical guidelines, or embracing benchmarks. Some, however, expressed concern that such guidelines not become strictures limiting physician discretion. The great majority of respondents believed that evidence-based practice, implemented prudently, will lead to an overall increase in the quality of care, while controlling costs by reducing error and improving outcomes.

Comments:

"The medical care system should achieve dramatic reduction in unnecessary under- and over-treatment as defined by clinical best practices and evidence-based clinical guidelines. Collaboration between players and physicians is key – learning together the right things to measure and developing a more uniform approach."

"Continue adoption of these, but warily, recognizing that some use evidence based medicine as a managed care hammer which stifles innovation."

"Physicians should incorporate guidelines and evidence based medicine into their decision-making process. They should not do so at the expense of other factors such as professional judgment, expertise, and patient values and goals."

"This is an unambiguous trend and physicians must be seen as embracing the issue."

Theme 6: Increased Patient Responsibility for Health Care Will Reduce Costs and Improve Quality

Many respondents believe that the way we pay for health care creates inefficiency that affects both quality and access. Third-party payments insulate patients from the cost of their treatment, making them less careful consumers. With more effective communication of the costs and consequences of treatment alternatives, patients can make better decisions.

Comments:

> "A fee-for-service model allows for the most aligned relationship of physician and patient. …Where controlling costs is an agreed goal, increasing patient responsibility for costs will aid in the most responsible decision-making in consuming health care services."

> "Encourage consumers to be more engaged in the cost and quality of care. Put health care on a budget through a pre-paid plan."

> "Employ financial incentives and penalties to move people toward acquiring coverage and changing habits."

> "Every patient should be able to access their file and through a code or password give access to any other provider who needs it - including pharmacists."

> "More people need to pay for their own health care expenses. Removing the third party from the equation will increase cost effectiveness. Re-educate the public about reasonable expectations…the best and the greatest aren't always necessary."

Theme 7: When Consumers Embrace Healthy Lifestyles, Everything Gets Better

Patient responsibility goes beyond simply picking up more of the cost of their treatment through higher deductibles and copays. In many of their answers, respondents commented on the degree to which lifestyle choices drive health care costs.

Comments:

> "The average health of a 45-year-old American high school dropout is inferior to that of a 65-year-old high school graduate. If we improve education and succeed in getting people to stop smoking, live balanced lives with proper diet and exercise, and generally take care of themselves, we'll be able to afford the best health care in the world for everyone."

> "Consumerism in health care is creating important new opportunities for collaboration among key stakeholders to support doctor-patient discussions about (a) healthier lifestyles and (b) when necessary, the best course and cost of treatment."

> "Health care should reward wellness programs."

Theme 8: To Maintain Quality and Access, There Must Be Financial Stability

No one is satisfied with the current system of reimbursement for services. Reimbursement rates often fall short of covering the cost of service, resulting in cost shifting and underpayment. Government programs like Medicaid represent a source of long-term concern for many physicians. Administrative costs eat up a significant share of limited resources and must be reduced. A sharper focus on cost-benefit evaluation and best practices can help control escalating health care bills, but there must also be a fundamental re-alignment of the relationship between physicians and payers.

Comments:

> "Currently we have a crisis in unbridled EXPECTATION with limited dollars, not a crisis in cost. We fail to prepare a thorough economic impact statement for health care expectations. We need to distinguish the difference between actual cost and sticker price, and we need to prohibit the totally unpredictable and irrational pricing policies for health care services."

> "Restructure reimbursements to stop creating incentives that maximize the number of procedures performed."

> "Make available a greater variety of insurance products, at various prices to individuals and business."

> "Decrease mandates, which drive up insurance costs."

> "A relentless pursuit of the elimination of waste must be undertaken, without requiring more money to save money. Collaborative and very promising provider/payer models exist today in Washington."

> "Funding and benefits must be in alignment so that public programs pay their full share of medical care costs."

Leaders also commented on positive developments in health care and insurance coverage. They differed on what they found most promising: from the Massachusetts insurance mandate to health savings accounts, from evidence-based medicine and electronic medical records to preventive public health measures.

Yet everyone approached recognized that major improvements in health care will require systemic and cultural change. Patients and physicians, payers and purchasers – all will be challenged to alter their behaviors, adjust expectations, and work collaboratively for a more responsive, sustainable, and effective health care system in our state.

Notwithstanding the magnitude of the challenges, there is considerable agreement on the fundamental issues to address. More important, the major stakeholders show a sincere willingness to work together to achieve the common goals, with insight, commitment, and integrity.

The WSMA's Guiding Principles for Tomorrow's Medicine

The vision of the WSMA is to make Washington state a better place to practice medicine and to receive care.

Achieving that vision requires a viable and robust health care delivery system that is both cost-effective and care-effective, and with adequate capacity to meet the medical needs of the state's citizens.

In interviewing some of the best minds in business, labor, government, and health care, the consensus was clear: ***Physicians must be leaders for change.***

Physicians must champion quality care that is safe and cost-effective on behalf of the patients and communities they serve. Physicians are in a unique position to promote cooperation among all stakeholders in forging a better approach to the financing and delivery of health care by supporting these Six Guiding Principles that promote the following: [119]

Building on the Physician-Patient Relationship

The fundamental physician-patient relationship should be one based on trust, quality care and joint participation in medical care decisions. To achieve this, it will be necessary to acknowledge the responsibilities all parties share – patients, physicians, purchasers, and payers. And, it requires a simpler administrative and regulatory environment. Decisions made by physicians and patients drive the cost and quality of health care. If we are to foster better value in our health care system, with its limited resources, we need to support the physician and the patient with the tools, technologies and support systems for improving both the processes and outcomes of health care.

Acknowledging Responsibility; Promoting Accountability

Physicians must be responsible for practicing high-quality, cost-effective, evidence-based care. Physicians must be held accountable for their performance. Physicians should be open to exploring new and better ways to provide their services.

In recent years it has become apparent that the medical disciplinary system in Washington state is lacking. The WSMA is committed to advocating for dramatic changes to the state's disciplinary system to make it more fair and effective for patients and physicians. The position of the WSMA is that medical licensure and discipline should be removed from the Department of Health and operate as a freestanding Commission. Today, physicians are included in a licensing and disciplinary system that includes numerous provider groups ranging from massage therapists to "counselors". The current system prevents adequate resources from being earmarked appropriately to protect the public.

Patients must take more responsibility for their personal health behaviors, and must become better-educated consumers of health care services. They must take more financial responsibility for their care in order to have an appropriate stake in the decision-making process. They need to be empowered with real freedom of choice – in the type of insurance they choose and the physicians with whom they wish to establish their health care partnership.

Insurance companies must administer their products in a cost-effective manner, providing high levels of accuracy and timeliness in their administrative mechanisms such as eligibility, payment and reporting. Insurance companies must deal with their network physicians as partners, not adversaries.

Employers and other public sector purchasers need to base their purchasing decisions on quality and cost-effective care, as well as investing in the well being of their employees and clients. Purchasers – particularly those in the public sector – must acknowledge the true cost and value of the "product" and adequately fund their programs. The continuing practice of underfunding public programs, while expanding the benefits and types of providers for which payment is made, must stop.

To Maintain Quality and Access, There Must be Financial Stability

Reimbursement for physician services must be adequate. For too long, public programs have relied on the private sector to fund their programs. The private sector is no longer willing to shoulder this expense. Public officials must provide funding that matches the promised benefits – or, be willing to reduce those benefits and non-physician caregivers eligible for reimbursement. Otherwise, we will see a further exodus of physicians and health plans from the public program "market."

Further, there must be real administrative simplification and standardization. It makes no sense to have multiple "metrics" that physician practices must use to comply with various public and private program reporting requirements. Lack of uniformity drives up administrative costs and drives practices into economic jeopardy.

The impact of the current tort system on the cost of care (i.e. defensive medicine) is well documented. The WSMA will work with other interested parties to restructure the current liability system in order to promote patient safety and error reduction, effective physician oversight and accountability, reduce waste from defensive medicine, and timely and adequate assistance to those harmed by negligence.

Promoting the Use of Information Technology

Emerging information technologies hold great promise for improving care and reducing expenses. However, systems must be interoperable (able to transfer data to one another), and there needs to be a way for physician practices to invest in these systems with assurance of some degree of return on their investment (ROI).

Wisely Implementing Guidelines and Evidence-Based Practices that Offer Promise

The WSMA is committed to working with physicians, payers, employers and government policymakers to define and advocate for best practices in medical care, including evidenced-based medicine and quality protocols.

The WSMA will seek uniformity of measures and guidelines among payers, including the consistent use of guidelines that support improved quality and are not just crude cost controls in disguise.

Through the WSM-ERF, the WSMA will work to ensure that physicians have clear actionable data in order to improve the care they provide for specific chronic conditions. The WSMA will also work with payers to make available to physicians the "actionable" information they can use to improve the quality of care and health outcomes for their patients. This also requires that payers be willing to provide the data necessary to allow these improvements.

Promoting Access to Affordable Health Insurance and an Adequate Safety Net

There is a limited role for government to promote viable insurance markets and affordable health insurance. A redefinition of what constitutes "insurance" must be promoted, with changes in government-funded programs and with new products in the marketplace. There is a role for government to assist those who otherwise cannot acquire insurance coverage. In Washington state, the tools are in place with the Basic Health Plan and Medicaid

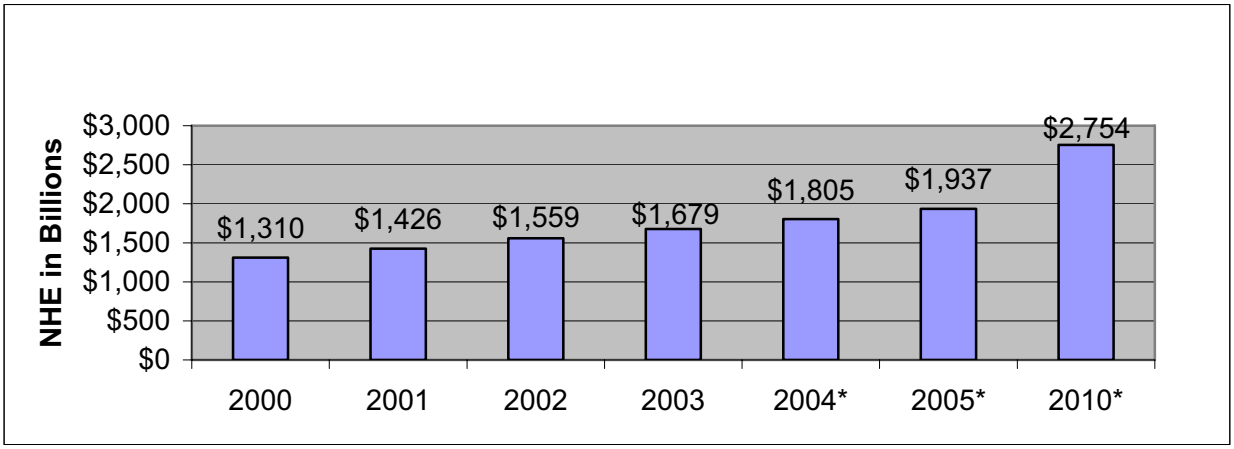
primarily. The legislature and administration must exercise creativity in program design and willingness to adequately fund those programs.

Research and experience have shown that there is no "silver bullet" for what ails health care. However, the concepts reflected in this report show a way to a better system. With the cooperation of all stakeholders *Tomorrow's Medicine* can reflect the vision of the WSMA -- that Washington become a better place to practice medicine and to receive care.

APPENDIX A - Medicare

Chart A-1

National Health Expenditures and Percentage of GDP 2000 - 2010[120]



* Projected by Centers for Medicare and Medicaid Services

Chart A-2

Health Expenditures and National Gross Domestic Product (GDP)[121]

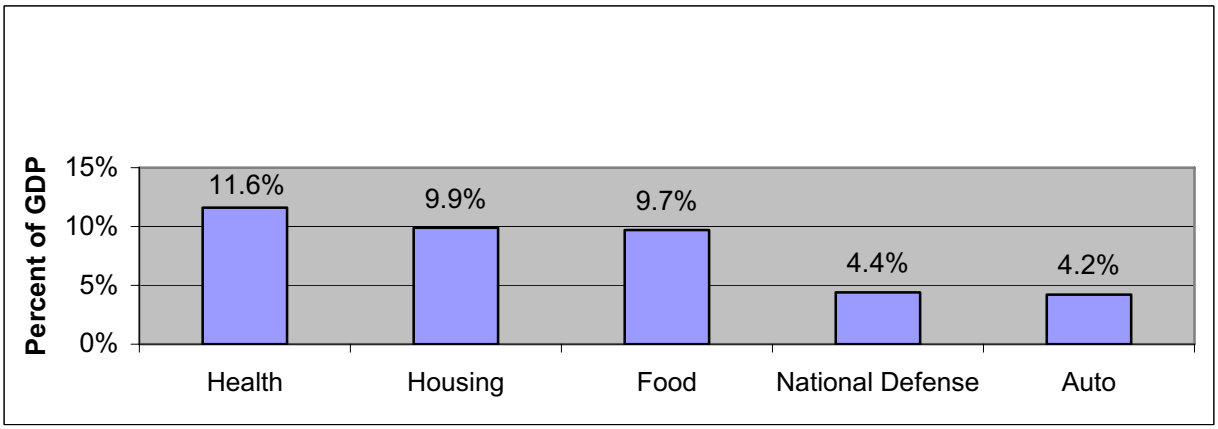


Chart A-3

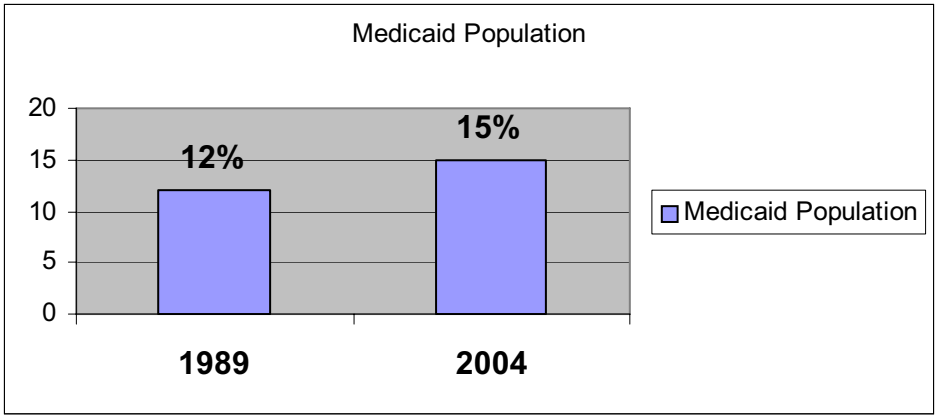
Distribution of Medicare Enrollees by Age, states (2003-2004), US (2004)[122]

	WA #	WA %	US #	US %
Adults 19-64	65,110	10	3,651,750	11
Elderly 65-74	287,890	45	15,601,700	46
Elderly 75-84	231,470	36	11,492,680	34
Elderly 85+	61,130	9	3,367,120	10
Total	645,600	100	34,379,930	100

APPENDIX B - Medicaid

Chart B-1

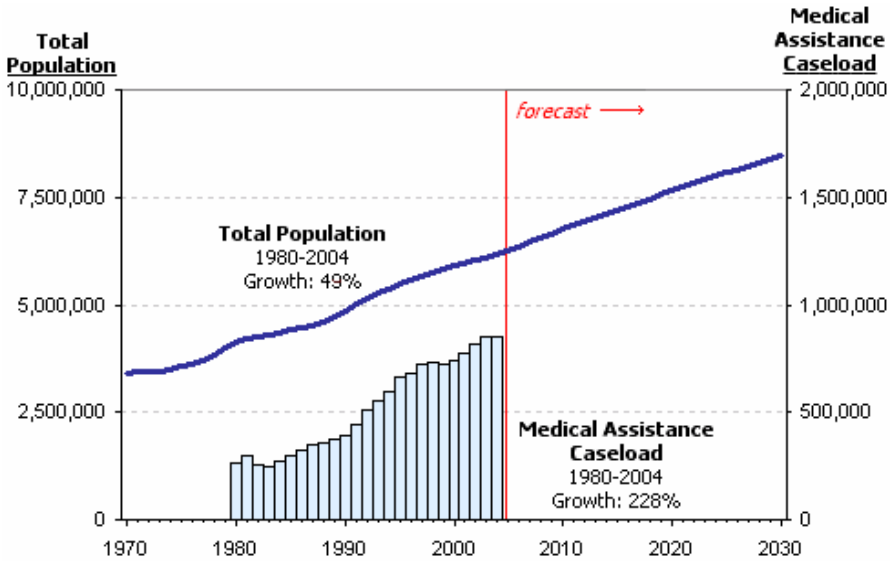
Medicaid Population Growth
As a percent of Washington state population



The Medicaid population has continued to grow, resulting in a growth in caseload and budget.
In 1988, 361,020 people were eligible for the Medicaid (Title XIX) Categorically Needy program. According to the average monthly enrollment reports in 2002, 807,118 persons were eligible for the Medicaid (Title XIX) Categorically Needy program.[123] This program is federally matched with full scope medical coverage. Eligible individuals generally receive cash assistance (Supplemental Security Income or Aid to Families with Dependent Children) under the federal Social Security Act.

Chart B-2

Medical Assistance Caseload[124]
Compared to total population



There have been several significant policy changes that have impacted the Medical Assistance caseload:

- July 1988: First Steps expansion for children and pregnant women.
- July 1994: Expansion to 200 percent federal poverty level (FPL) for children.
- August 1996-August 1997: unintentional drop in AFDC/TANF related component as a result of Welfare Reform.
- August 1999: TANF re-determination and reinstatement.
- April 2003 (and following): Changes in eligibility determination process.

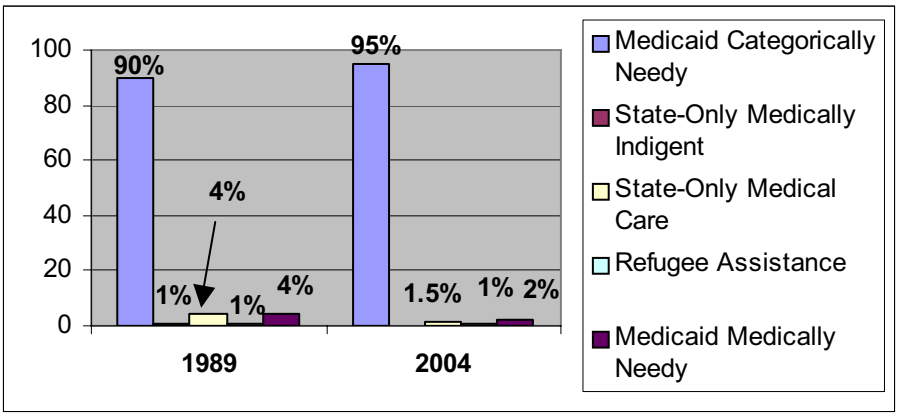
In 1989, an additional 14,977 and, in 2002, 14,398 persons were eligible for the state-funded Medical Care Services program. Under this program, medical services are provided to recipients of Continuing General Assistance (GAU) who are unemployable due to incapacitating emotional, mental or physical impairment, which is expected to last at least 60 days.

Medical care is also provided to those incapacitated by alcohol and drug abuse and eligible under the Drug Addiction Treatment and Support Act (ADATSA). These persons cannot be eligible for any other federally aided program. Medicaid (Title XIX) Medically Needy program.

There was also a change in the number of refugees covered by Medicaid in 1989 -- 1,892 refugees received services compared to 794 refugees qualified for the federally-funded Refugee Assistance program in 2002. This program aids refugees for the first 18 months after arrival in the U.S. After this period, the federal government will reimburse some medical expenditures for an additional 14 months if a refugee is otherwise eligible for federal or state-funded general assistance.

Chart B-3

Medicaid Population by Program[125]
(Including State-Only Medical Assistance)



In 1989, 4 percent (15,174 people) were eligible for state medical assistance. In 2002, there were about 10,565 people eligible for the state-funded Medical Care Services program. Under this program, medical services are provided to recipients of Continuing General Assistance (GAU) who are unemployable due to incapacitating emotional, mental or physical impairment, which is expected to last at least 60 days.

Chart B-4

Medicaid Births[126]

Births Financed by Medicaid as a Percent of Total Births, 2002

WA %	US %
43.4	41.3

Number of Births Financed by Medicaid, 2002

WA #	US #
33,743	1,661,320

Chart B-5

Medicaid-to-Medicare Fee Index, 2003[127]
Washington and National

	WA #	US #
All Services	0.87	0.69
Primary Care	0.79	0.62
Obstetric Care	1.22	0.84
Other Services	0.64	0.73

Chart B-6

Cumulative Percentage Change in Medicaid Fees, by Type of Service[128]
1998-2003

	WA %	US %
All Services	14.2	27.4
Primary Care	20.6	41.2
Obstetric Care	8.8	10.2
Other Services	5.0	11.1

APPENDIX C – Commercial Insurers

Chart C-1

Premium Increases – Three Largest Insurers, Washington[129]

	2002	2003	2004	2005	Average Annual Percent Change
Premera Blue Cross					
Individual	29.76%	26.08%	22.50%	22.52%	25.22%
Small Group	18.45%	14.81%	15.55%	8.25%	14.27%
Large Group*	6.78%	18.18%	14.01%	2.08%	9.87%
Regence BlueShield					
Individual	7.28%	23.50%	17.94%	8.13%	14.21%
Small Group	5.10%	16.40%	21.00%	8.70%	12.80%
Large Group*	16.58%	19.57%	17.76%	5.95%	14.97%
Group Health					
Individual	12.40%	24.20%	11.50%	8.60%	14.18%
Small Group	8.79%	17.71%	5.46%	13.56%	11.38%
Large Group*	7.14%	24.31%	9.21%	19.32%	15.00%

** Estimated Large Group Rate Changes Based on the Large Group Rate Filings Filed with OIC.*
The average rate changes are overall rate changes. An individual's rates may vary by age, family size, location, etc.

Chart C-2

Top Ten Insurance Companies Market Share and Loss Ratio, 2004[130]

Company Name	Market Share	Premiums Written	Premiums Earned	Losses Incurred	Loss Ratio
Premera Blue Cross Group					
Lifewise Assurance Co	0.18%	$ 17,969	$ 17,997	$ 12,356	68.66%
LifeWise Health Plan of WA	1.20%	$ 119,084	$ 118,436	$ 90,671	76.56%
Premera Blue Cross	19.79%	$1,956,298	$1,941,626	$1,602,045	82.51%
Total	21.17%	$2,093,351	$2,078,059	$1,705,072	82.05%

Company Name	Market Share	Premiums Written	Premiums Earned	Losses Incurred	Loss Ratio
Regence Group					
Asuris Northwest Health	0.78%	$ 76,944	$ 76,511	$ 62,894	82.20%
Regence BCBS Oregon	0.42%	$ 41,112	$ 40,363	$ 32,299	80.02%
Regence Blue Shield	17.07%	$1,687,352	$1,664,895	$1,287,090	77.31%
Regence Blueshield of ID Inc.	0.05%	$ 4,731	$ 4,731	$ 3,743	79.13%
Regence Health Maintenance OR Inc.	0.25%	$ 24,561	$ 24,959	$ 20,174	80.83%
Regence Life & Health Ins	0.14%	$ 13,778	$ 13,744	$ 7,786	56.65%
RegenceCare	0.78%	$ 76,783	$ 76,795	$ 69,188	90.09%
Total	19.49%	$1,925,261	$1,901,998	$1,483,174	77.98%

Company Name	Market Share	Premiums Written	Premiums Earned	Losses Incurred	Loss Ratio
Group Health Cooperative					
Group Health Options Inc.	3.42%	$ 338,403	$ 340,151	$ 299,345	88.00%
Group Health Cooperative	15.36%	$1,518,437	$1,560,197	$1,702,138	109.10%
Total	18.78%	$1,856,840	$1,900,348	$2,001,483	105.32%

Company Name	Market Share	Premiums Written	Premiums Earned	Losses Incurred	Loss Ratio
Pacificare Health System					
American Medical Security Life Ins	0.00%	$ 16	$ 16	$ 10	64.19%
Pacificare Life & Health Ins	0.00%	$ 70	$ 66	$ 45	67.54%
Pacificare Life Assur Co.	41.00%	$ 40,155	$ 38,428	$ 31,103	80.94%
Pacificare of WA	5.72%	$ 565,630	$ 565,630	$ 459,702	81.27%
Total	46.72%	$ 605,871	$ 604,140	$ 490,860	81.25%

Company Name	Market Share	Premiums Written	Premiums Earned	Losses Incurred	Loss Ratio
Molina Healthcare Inc.					
Molina Healthcare of WA Inc.	4.65%	$ 460,047	$ 463,073	$ 368,384	79.55%
Total	4.65%	$ 460,047	$1,590,069	$ 368,384	79.55%

Company Name	Market Share	Premiums Written	Premiums Earned	Losses Incurred	Loss Ratio
Community Health Plan Of WA					
Community Health Plan of WA	3.80%	$ 375,274	$ 375,274	$ 331,514	88.34%
Total	3.80%	$ 375,274	$1,590,069	$ 331,514	88.34%

Company Name	Market Share	Premiums Written	Premiums Earned	Losses Incurred	Loss Ratio
Kaiser Foundation					
Kaiser Foundation Health Plan NW	3.10%	$ 306,656	$ 306,656	$ 289,797	94.50%
Kaiser Permanente Health Alternatives	0.09%	$ 8,692	$ 8,692	$ 8,402	96.67%
Total	3.19%	$ 315,348	$ 315,348	$ 298,199	94.56%

Company Name	Market Share	Premiums Written	Premiums Earned	Losses Incurred	Loss Ratio
KPS Health Plan					
KPS Health Plan	1.54%t	$ 151,995	$ 151,995	$ 133,779	88.02%
Total	1.54%	$ 151,995	$ 151,995	$ 133,779	88.02%

Company Name	Market Share	Premiums Written	Premiums Earned	Losses Incurred	Loss Ratio
Aetna					
Aetna Health Inc.	0.46%	$ 45,732	$ 45,732	$ 37,305	81.57%
Aetna Life Ins Co.	0.97%	$ 95,587	$ 104,424	$ 81,436	77.99%
Total	1.43%	$ 141,319	$ 150,156	$ 118,741	79.08%

APPENDIX D – Health Insurance, the Uninsured and the Underinsured

Numerous national studies have analyzed the size, type and location of employers that do not provide group insurance for their employees. Both the *1987 Current Population Survey* and a 2004 study by the Kaiser Commission on Medicaid and the Uninsured, called *Health Coverage in America, 2004 Data Update* found some industries were less likely to provide some type of group health insurance to its employees. [131]

The Kaiser Family Foundation's Employer Health Benefits 2005 Annual Survey reported the same findings as the report in 1986: more than half of the firms with fewer than 10 employees, and about one-fourth of the firms with 10 to 24 employees, did not offer health insurance.

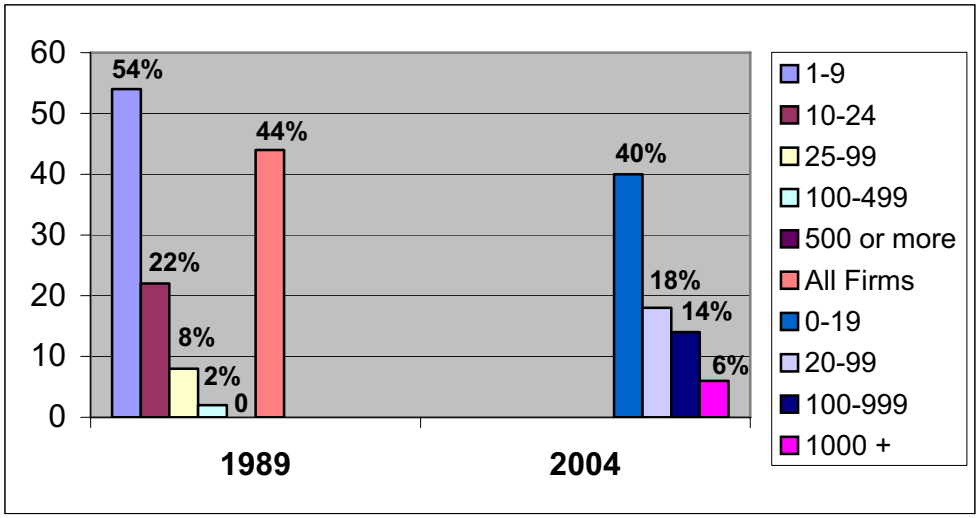
The SBA study also revealed that 98 percent of employers with 100 or more employees have a group health care plan, compared to 55 percent of firms with fewer than 100 employees.

The 2004 Kaiser survey found nearly identical results: 98 percent of employers with 100 or more employees have a group health care plan compared to 59 percent of firms with fewer than 100 employees.

Small employers do not offer coverage for a variety of reasons (*Chart D-1*).[132] Over 60 percent of small employers reported that either profits were insufficient to cover the cost of insurance or insurance premiums were too high. Only 17 percent of the very small employers (1-9 employees), 3 percent of small employers (10-24 employees), and 22 percent of employers with 25-99 employees reported unavailability of group coverage as a reason for not offering coverage. While lack of availability of insurance is not a major problem, two-thirds of small employers reported that they have not sought insurance.

Chart D-1

Percent of Firms Not Offering Health Insurance, By Size[133]
Washington*



** The "size" bands used for the 1989 data differ from those used in the data for 2004, Making exact comparisons difficult.*

Employers in rural parts of the country are less likely than those in urban centers to provide health insurance.[134] Nationally, 22 percent of urban employees have no health insurance from their own jobs, compared to 28 percent of employees in rural areas. Regionally (in the Pacific Coast states), 26 percent of urban employees and 29 percent rural employees have no workplace health insurance.

In 1988, about 57 percent of those uninsured in Washington state -- 446,977 persons -- were poor, near poor or otherwise low-income (28 percent, 9 percent and 20 percent, respectively) based on the FPL (*Chart D-2*). [135]

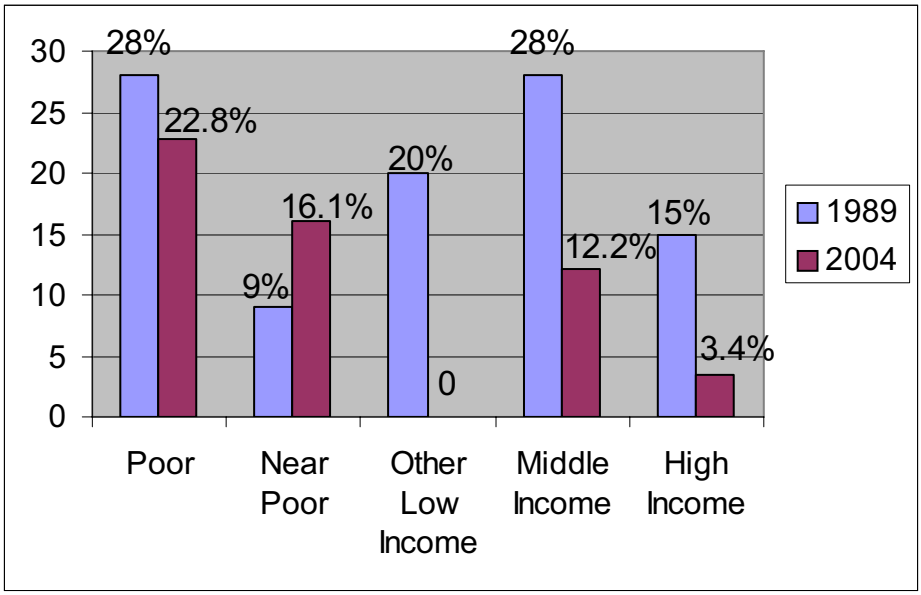
In 2004, comparable studies found that 70 percent of those uninsured in Washington state were members of working families, and almost 62 percent of the uninsured were members of low income families earning less that 200 percent of FPL.[136]

In 2004 in Washington, the poor and near poor were less likely to have health insurance. Twenty-four percent of those with family incomes between 0 and 99 percent of the 2004 FPL and 19 percent of those with family incomes between 100 to 199 percent of the 2004 FPL were uninsured.[137] The uninsured rates for children ages 0-18 rose from 4.5 percent in 2002 to 6 percent in 2004.

Predictably, rates of uninsurance are highest in families with no workers. In 1989, the rate of uninsurance for families was 33 percent and in 2004 28.6 percent. The lowest rate of uninsurance was for those with two or more wage earners --16 percent in 1989 and 19.2 percent in 2004. Single wage earner families fell in between: in 1989, the rate was 22 percent and had significantly changed by 2004 to 52.2 percent.[138]

Chart D-2

Income Characteristics of the Uninsured[139]
Washington State



In 2004, 11 percent of state's uninsured population was white and about 10 percent were black. The remaining uninsured population consisted of Asians, American Indians/Alaska Natives, and Native Hawaiian/Other Asian Pacific Islanders. The sample sizes for non-white racial groups within *the Washington State Population Survey* are small and the following results represent best estimates.[140]

In 1989, evidence suggested that the rate of uninsurance was lower in large urban metropolitan areas and was higher in more rural areas.[141] In 2004, the percent of uninsured in rural areas was 14 percent while urban areas had 10 percent uninsured. The King County metropolitan area continues to be consistently lower than the rest of state, with 15.5 percent of King County adults being uninsured.[142]

In 1989, 78 percent of those uninsured in Washington, by their own assessment, rated their health as "excellent" or "good", compared to 33 percent in 2004 (*Chart D-4*). Changes occurred across the perceived health status: in 1989, 14 percent were in "fair" or "poor" health compared to thirty-five percent in "fair" or "poor" health by 2004. In 1989, this latter group of 109,784 individuals dropped to 88,706 individuals and, by 2004, they were generally considered *at risk* of being ill or injured while being uninsured.

Chart D-3

Age of the Uninsured[143]
Washington State

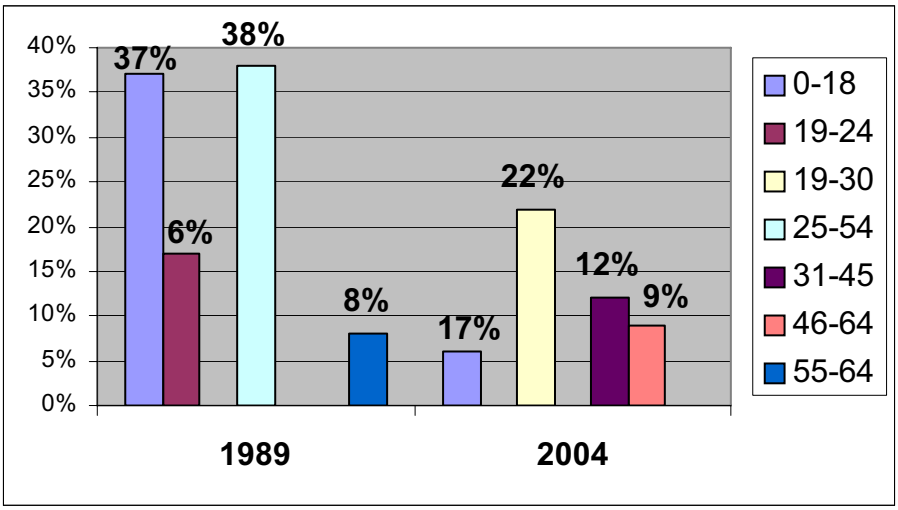


Chart D-4

Perceived Health Status of the Uninsured[144]
Washington State

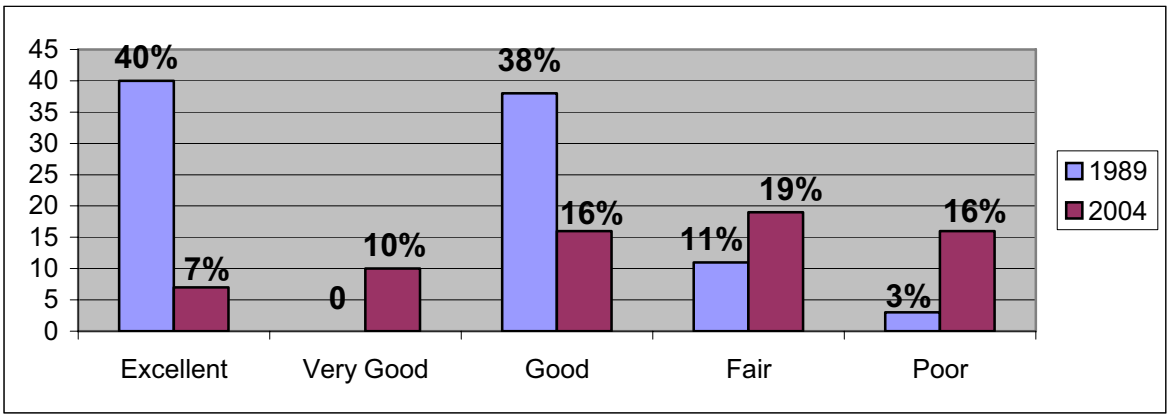
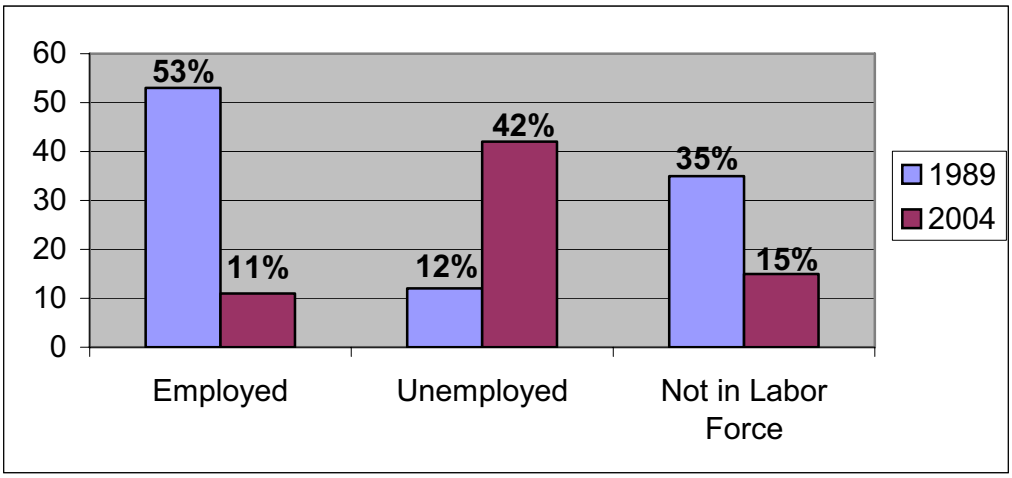


Chart D-5

Employment Characteristics of the Uninsured*
Washington State



** In 1989, about 63 percent of the uninsured were adults 18 years or older. By 2004, the state changed the age bands for these data and found that 16.2 percent of the uninsured were adults 19-years-or-older.*

In 1988, 12 percent of Washington's uninsured population was unemployed and 35 percent were not in the labor force, a combined percentage of 47 percent, while 53 percent were employed.[145] A similar analysis found that in 2000, a combined 24.6 percent of Washington's population were either unemployed or not in the labor force, a drop of over 22 percent for those combined categories.[146]

Employee Coverage Related to FPL – In 1988, almost 85 percent of those with group insurance coverage had incomes equal to or greater than 200 percent of the Federal Poverty Level (FPL). Fewer than 13 percent were between 100 percent and 200 percent of the poverty level, and less than 3 percent were below the poverty level.[147] In 2002, 80.5 percent of those persons with group insurance coverage had incomes equal to or greater that 200 percent of the FPL. Slightly less than 31.1 percent were between 100 percent and 200 percent of the FPL.[148]

In 1988, employer-paid group insurance contributions in Washington state differed widely by type of industry. The manufacturing sector had the highest paid coverage rate with employer contributions to almost 83 percent of its group insurance contracts. The construction sector was next at 76 percent, services at 66 percent, and sales at 52 percent. Agriculture, forestry, fisheries and mining accounted for 42 percent of all employer-based contracts, but employer contributions were made to only 10.5 percent of all contracts.

In 2004, the transportation and warehousing sector surpassed the manufacturing sector, having the highest paid coverage rate with the employer contribution to almost 92 percent. The finance and insurance sector and the professional and technical service sectors were second with 91 percent.[149]

Chart D-6

Individually Insured Population[150]
As a percent of total Washington state (2004 = 5,463,989)

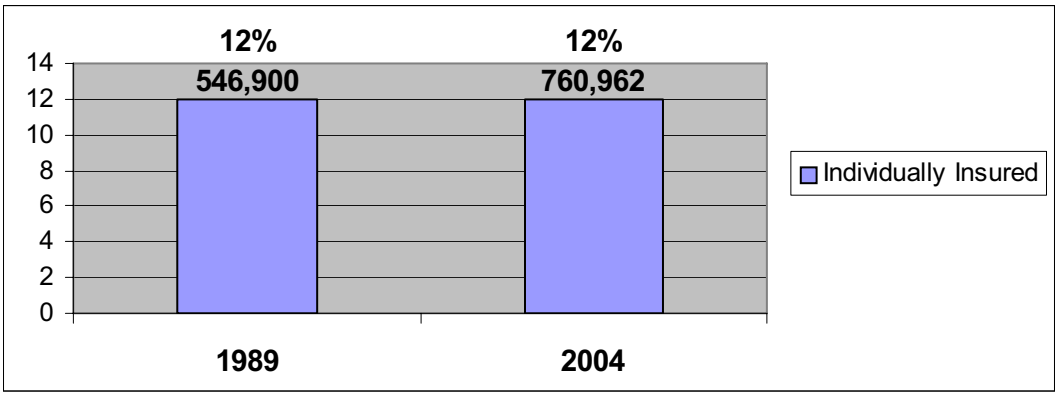


Chart D-7

Percent of Workers without Employer Group Health Insurance[151]
Washington State

	1989	2006
MAJOR INDUSTRY	**PERCENT WITH NO INSURANCE**	**PERCENT WITH NO INSURANCE**
Agriculture, Forestry, Fishing	82%	44%
Manufacturing	27%	12%
Construction, Mining	52%	37%
Transportation, Communication, Utility	24%	15%
Wholesale, Retail	64%	23%
Finance, Insurance, Real Estate	33%	17%
Services	79%	29%

APPENDIX E – Military Population

In 1989, an estimated six percent[152] of the state's population (265,412[153] persons), were eligible from some type of military-related health insurance program, compared to 10 percent (627,000 people) in 2005.[154]

The federal Department of Veterans Affairs (VA) operates four hospitals in Washington state, and many Washington veterans also receive medical care at the Portland VA hospital. These hospitals also have outpatient clinics, and several have nursing home facilities. The VA occasionally contracts with private facilities for emergency care or under other special circumstances as well.

All veterans with service-connected disabilities, former prisoners of war and certain other veterans are eligible to receive free care at VA medical facilities. Poor veterans without a service-connected disability can also generally receive free care. Additionally, non-poor, non-disabled veterans can receive care if there is space available, but they must pay some portion of the costs, depending on their income level. A small number of indigent veterans (approximately under 600 prior to 2000) also receive care at two veterans homes run by the Washington state Department of Veterans Affairs.

The VA subsidizes the cost of hospital and outpatient care for certain dependents and survivors of veterans under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). Dependents of veterans with service-connected total disabilities, survivors of veterans who died as a result of service-connected disabilities and survivors of persons who died in the line of duty are eligible for CHAMPVA – provided they are not eligible for CHAMPUS or Medicare.

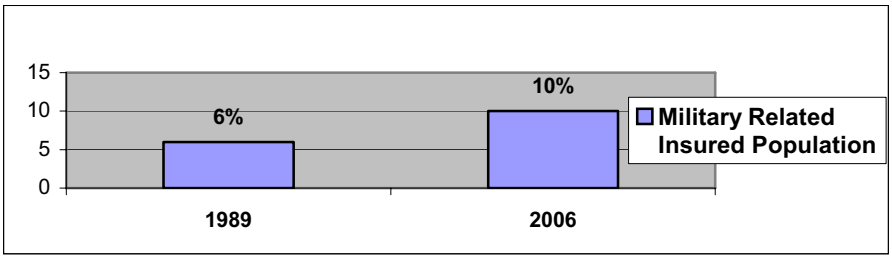
Normally, care under CHAMPVA is obtained from civilian sources. VA facilities may be used when they are equipped to provide care and there is space available.

The VA was unable to provide statistics on the number of Washington veterans receiving care at VA facilities or the number of dependents eligible for CHAMPVA. It is therefore not possible to verify with hard numbers the six percent estimate of the military-related insured population derived from the data in the *TAC A Final Report.*[155]

The VA was, however, able to provide data on the total number of Washington state veterans – 598,000. In addition, according to the VA, Washington VA hospitals and their associated clinics and nursing homes handled 442,098 visits in 1988. Although many of those were duplicate visits by the same patient, and a small percentage of veterans paid the full cost of their care, the visit statistics -viewed in combination with the large number of Washington state veterans -- indicate that the six percent figure may be slightly low.

Health care is provided to active duty personnel, family members of active duty personnel including survivors, and military retirees. Health care services are provided by military health centers such as Madigan Hospital in Pierce County or by civilian providers who are reimbursed by TRICARE. TRICARE payments to health care providers in Washington totaled $116 million in 2003.[156]

Chart E-1 **Military Related Insured Population**



Appendix F – Survey Participants *(position held at the time of survey)*

Gubby Barlow, *Chief Executive Officer*, Premera Blue Cross
Rob Benedetti, MD, *Medical Director*, Rockwood Clinic
Don Brennan, *Chair*, Washington Health Care Forum
Don Brunell, *President*, Association of Washington Business
Rick Cooper, *Chief Executive Officer*, Everett Clinic
Richard Davis, *President*, Washington Research Council
Jack Faris, *President*, Washington Biotechnology and Biomedical Association
Edward Farrar, MD, *President*, Washington State Orthopedic Association
Michael Gilbert, MD, *Past-President*, Washington Academy of Eye Physicians & Surgeons
Leo Greenawalt, *President*, Washington State Hospital Association
Steve Hill, *Administrator*, Washington Health Care Authority
Tanya Karwaki, *Director*, Center for Health Care Reform, Washington Policy Center
Vicki Kirkpatrick, *Administrator*, Washington Public Health Officers Society
Evelyn LeMoine, *Vice President, People Program*, Greater Seattle Chamber of Commerce
Carolyn Logue, *Washington State Director*, National Federation of Independent Business
W. Hugh Maloney, MD, *Governor*, Washington State Chapter, American College of Physicians
Peter McGough, MD, University of Washington Physicians
Mary McWilliams, *Chief Executive Officer*, Regence BlueShield
Zena Minne, RN, MN, *Director of Clinical Services*, Washington Association of Community & Migrant Health Centers
Sid Nelson, *Dean*, University of Washington School of Pharmacy
Peter Neurath, *Medical Reporter*, Seattle Business Journal
Chris Olson, MD, MHPA, *President*, Washington State Chapter, American Academy of Pediatrics
Richard Peterson, *Chief Executive Officer*, Swedish Medical Center
Brian Pitcher for Lane Rawlins, *Chancellor WSU Spokane*, Washington State University
Doug Porter, *Assistant Secretary*, Medical Assistance Administration
Mark Rupp, *Health Policy Advisor*, Office of Governor Christine Gregoire
Richard Seaman, MD, *Former Board Chair*, Physicians Insurance A Mutual Company
Mary Selecky, *Secretary*, Washington State Department of Health
Sue Sharpe, *Co-Chair*, Whatcom County Alliance for Healthcare Access
Stan Sorscher, *Labor Representative*, Society of Professional Engineering in Aerospace (SPEEA
Gary Smith, *President*, Washington Independent Business Society of Professional in Aerospace Engineering Employees
Kim Thorburn, MD, *Chair*, Washington State Board of Health
Greg Van Pelt, *Chief Executive Officer*, Providence Health System
Nancy Woods, PhD, RN, FAAN, *Dean*, University of Washington School of Nursing
Gerald Yorioka, MD, *President*, Washington Academy of Family Physicians
Joseph York, PhD, *Associate Dean for Graduate Medical Education*, University of Washington School of Medicine

[1] The Washington Research Council surveyed 36 opinion leaders, identifying common themes and compiling input.
[2] Health care represents 11.7 percent of all non-governmental jobs in the nation. This makes it second to the retail sector at 13 percent, and more vital than manufacturing at 10.8 percent. A substantial number of people employed in other industries provide support to the health care industry, such as insurance, professional services and financial services. With the growth of the baby boomer population and technological advances in medicine, medical care will become an even more prominent part of the US economy over time. (US Bureau of Economic Analysis, 2005 report of 2003 data).
[3] Washington Research Council, Economic Impact Report, August 2005.
[4] The most recent year for which data is available.
[5] These comparisons do not include adjustments for cultural and lifestyle factors.
[6] Reinhardt, U.; et al, "US Health Care Spending In An International Context"; *Health Affairs*, May/June 2004; Volume 23, Number 3.
[7] Centers for Medicare and Medicaid Services Office of the Actuary.
[8] Centers for Medicare and Medicaid Services (2005b); Blue Cross Blue Shield Association: Medical Cost Reference Guide 2006.
[9] *Ibid.*
[10] Smith, C. et al, "National Health Spending in 2004 – Recent Slowdown Led By Prescription Drug Spending"; *Health Affairs*, January/February 2006, www.healthaffairs.org.
[11] Smith, Cynthia, et al. Health Spending Growth Slows In 2004. *Health Affairs*, 2005;25(1), 189.
[12] Health Expenditures by State; Centers for Medicare and Medicaid Services; http://www.cms.hhs.gov/NationalHealthData/01_Overview.asp#TopOfPage.
[13] Centers for Medicare & Medicaid Services, Medicare Releases State-by-State Prescription Drug Enrollment Figures, January 19, 2006.
[14] Centers for Medicare & Medicaid Services, August 8, 2006 Press Release; http://www.cms.hhs.gov/apps/media/press/release.atp?counter=1939
[15] *Health Expenditures by State*; Centers for Medicare and Medicaid Services; http://www.cms.hhs.gov/NationalHealthExpendData/01_Overview.asp#TopOfPage.
[16] *Ibid.*
[17] Nationally, in 2002, 841,298 physicians and other providers rendered Medicare Part B services, compared to 925,508 in 2003 according to the Center for Medicare and Medicaid Services Data Compendia 2002 and 2003. In Washington, in 2002, the Centers for Medicare and Medicaid Services recorded 21,306 "physicians" for the state, however, this figure reflects not only MDs and DOs but other categories of doctoral level practitioners as well. Also that high figure likely includes all physicians who were "enrolled" in the Medicare program for Washington but not necessarily rendering services, so that figure is not representative of Medicare patients' access to physicians for care.
[18] The Centers for Medicare and Medicaid Services (CMS) Health Care Consumer Initiatives, 2005, Top 30 Elective Inpatient Hospital DRGs, Fiscal Year 2005, from the Medicare Provider Analysis and Review File (MedPAR), Centers for Medicare and Medicaid Services, Office of Information Services, the Medicare Decision Support Access Facility. www.cms.hhs.gov/HealthCareConInit/; accessed June 2006.
[19] Health Expenditures by State; Centers for Medicare and Medicaid Services; http://www.cms.hhs.gov/NationalHealthExpendData/01_Overview.asp#TopOfPage.
[20] Urban Institute, Washington, DC.
[21] Holahan and Ghosh, Understanding the Recent Growth in Medicaid Spending, 2000-2003. *Health Affairs*, 26 January 2005, web exclusive.
[22] Health Expenditures by State; Centers for Medicare and Medicaid Services; http://www.cms.hhs.gov/NationalHealthExpendData/01_Overview.asp#TopOfPage.
[23] Holahan, John and Ghosh, Arunabh. Understanding the Recent Growth in Medicaid Spending, 2000-2003. *Health Affairs*, 2005, January, web exclusive.
[24] Study conducted for the State of Washington by Tucker Alan Inc., June 30, 1999.
[25] WSMA Membership Memo Spot Poll, December 19, 2001.
[26] WSMA Membership Memo Spot Poll, April 27, 2001.
[27] Milbank Memorial Fund: 2002-2003 State Expenditure Report; June 2005, www.milbank.org.
[28] 2005 National Survey of Employer-Sponsored Health Plans, Mercer Health and Benefits.
[29] *Ibid.*
[30] *Ibid.*

[31] Payment Level Comparison Between Public Programs and Commercial Health Plans for Washington State Hospitals and Physicians, Milliman Consultants and Actuaries, May 2006, https://www.premera.com/stellent/groups/public/documents/pdfs/dynwatpercent3B5604_267394122_3168.pdf
[32] Operating margin is the ratio of operating income divided by net sales.
[33] Medical Group Management Association, Physician Compensation and Production Survey: 2005 Report.
[34] Losing Ground: Physician Income, Center for Studying Health System Change, 1995-2003, http://hschange.org/CONTENT/851/ .
[35] Trends in Physicians' Practice Arrangements, American Medical Association, Socioeconomic Characteristics of Medical Practice 1997/98; 17-23.
[36] Robert H. Miller, Christopher West, Tiffany Martin Brown, Ida Sim, and Chris Ganchoff
The Value Of Electronic Health Records In Solo Or Small Group Practices
Health Affairs, September/October 2005; 24(5): 1127-1137.
[37] Phoenix Health Systems and Healthcare Information Management and Systems Society.
[38] Medical Group Management Association, 2005 Cost Survey (Based on 2004 Data).
[39] *Ibid.*
[40] *Ibid.*
[41] Washington's Primary Care Safety Net: Structure and Availability, Office of Community and Rural Health, Washington Department of Health, July 9, 2004, Pg. 8, www.doh.wa.gov/hsqa/ocrh/; www.doh.wa.gov/hsqa/ocrh/har/Wapcnet.doc.
[42] Elway Research Poll, July 2004.
[43] Mandates Increase Costs and Reduce Access to Affordable Insurance, Washington Policy Center Report, February 2006.
[44] *Ibid.*
[45] Health Insurance Mandates in the States 2005, Council for Affordable Health Insurance, January 2005.
[46] *Ibid.*
[47] Health Care Trends Report, Council on Long Range Planning and Development, American Medical Association, 2006.
[48] Buckner and Fillmore. Is there an Alternative Medicine Clinic in Your Future? *Journal of Medical Practice Management*. 43(5):263.
[49] Shortages of Medical Personnel at Community Health Centers, *Journal of American Medical Association* , March 1, 2006, 295, 9; http://jama.ama-assn.org/ .
[50] Health Care Trends Report, Council on Long Range Planning and Development, American Medical Association, 2006.
[51] American College of Emergency Physicians, http://my.acep.org/site/PageServer?pagename=wp1_homepage.
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Tab 63

Yakima County Health Care Coalition

TO: Blue Ribbon Commission on Health Care Costs & Access
Hcca_brc@leg.wa.gov

FROM: Steve Hill, Department of Community Services, Yakima County
Chair, Yakima County Health Care Coalition

SUBJECT: Proposal from Yakima County

DATE: August 31, 2006

CONTACTS & INFORMATION

Steve Hill, Director
Department of Community Services
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Ladies and Gentlemen,

The Yakima County Health Care Coalition is a group of organizations and individuals advocating for the health care needs of the people of Yakima County. The Coalition provides broad representation from the health care continuum serving Yakima County residents. The Coalition meets weekly (beginning in January 2002) to identify public policies which disproportionately (good or bad) affect the high number of low income and disadvantaged of our community.

We welcome the opportunity to present one important model for your consideration to further our effort of providing access to affordable care for Washington residents. Our model is built on a network of "Access Specialists" (in some communities referred to as Patient Navigators or Community Health Workers) located at health and social service agencies.

Through a community-developed and community-built system of assessment and education, residents who are uninsured, in need of a medical home, or those who present to a local emergency room for non-urgent conditions are matched up with an Access Specialist for health coverage applications and help finding a medical home.

This pilot project, "Kids Connect", focuses on children 0-19 years old, and their families.

1. What do you propose be done to realize the vision and goals for Washington State established by the Blue Ribbon Commission on Health Care Costs and Access? Briefly summarize your proposal.

1. Access Specialists will be located at the earliest point of entry when a resident enters the community, providing early education about how to use the health care system effectively. Access Specialists promote preventive health care, early identification of illness and disease, and help families identify accessible medical homes that address unique financial, cultural, transportation, or other barriers.

2. Access Specialists are also located in hospital Emergency Rooms to interview patients who access the ER for non-urgent conditions. These Access Specialists help the patient and his/her family identify a desirable medical home, arrange for follow up care, and health coverage assistance (if needed), and make the referral to the new medical provider. Everyone has access to **emergency care in the case of true emergencies**, but primary care problems are most effectively addressed in the primary care setting, where the patient's history and previous illnesses are known by their primary care provider.

3. A shared, community Information and Referral system, is used to collect information about residents needing assistance, health education needs (why clients chose to use the Emergency Room), and to follow up on health coverage applications in process (avoid duplication of efforts).

4. Patient education and community education are developed based on the information collected from the county's residents. Access Specialists are provided training on appropriate education topics, and community-specific resource information is developed and available in appropriate languages.

2. How will implementation of your proposal enhance, hinder or otherwise impact the achievement of the vision and each of the goals established by the Commission? How do you know?

Goals by 2012	Comments
All Washingtonians will have access to health coverage that provides effective care by 2012, with all children having such coverage by 2010.	Access Specialists promote accessible and affordable primary care. They help working families apply for private insurance, Medicaid, Basic Health, SCHIP, Medicare Part D, etc. Access Specialists keep current on available providers in the community, how to access transportation and interpreters. Access Specialists help patients identify how to contact their primary care provider after hours when needed.
Washington will be one of the top	Access Specialists provide education about preventive health and

Goals by 2012	Comments
ten healthiest states in the nation.	positive health messages, and partner with other local efforts to improve healthy practices.
Population health indicators will be consistent across race, gender and income levels throughout the state	Access Specialists will be knowledgeable of local evidence-based models, such as Asthma Projects, Diabetes Collaboratives, and programs specifically designed to address health disparities.

3. Is your proposal modeled after an existing policy or program within Washington or elsewhere? If so, describe the policy or program and its outcomes.

The proposed model reflects the experience gained in Yakima County Kids Connect, a multi-agency collaborative effort to:
1) Assist families with children in establishing ongoing care at a "medical home,"
2) Assist families with children in applying for health coverage, track the outcome, and help families maintain coverage,
3) Assist families with children in appropriate accessing of medical services, *i.e.,* to utilize primary care settings for primary care problems and the hospital Emergency Department for true emergencies.

Participating agencies (members of the Yakima County Health Care Coalition) are:

- Community Health of Central Washington (Central WA Family Medicine & Yakima Pediatric Associates)
- Educational Service District 105 / KidScreen
- Medical Associates of Yakima
- Sunnyside Community Hospital
- Yakima County Department of Community Services
- Yakima Health District
- Yakima Neighborhood Health Services
- Yakima Valley Farm Workers Clinic
- Yakima Valley Memorial Hospital

There are eight Access Specialist (three are employed at two different hospitals; the other four are employed at primary care settings, and one also manages a county-wide early childhood screening program. Access Specialists families meet weekly to coordinate services.

As of August 15, 2006, Kids Connect had over 1,600 clients in its on-line case management system. Individuals are entered into the case management system if they are interested in receiving services. Points of entry are the Emergency Department of a participating hospital, participating primary care settings, and KidScreen (which advertises a KidScreen and Kids Connect toll-free number for inquiries.

All Access Specialists offer the following services:

- Referrals to a primary care provider
- Referrals to a dental provider
- Assistance with medical coverage applications, re-certifications, or reapplications (Medicaid, Basic Health, CHP, SCHIP, and SSI)
- Information on how to access their primary care provider after hours

The program is serving predominantly low-income, Hispanic/Latino, families throughout the county. Accomplishments as of August 15, 2006, include:

- 278 new insurance applications have been submitted
- 73 new insurance applications have been approved
- 88 insurance renewal applications have been submitted
- 179 referrals have been made to establish a "medical home"
- Fact Sheets have been developed in English and Spanish as educational tools:
  - #1 When to go to the Hospital Emergency Room
  - #2 Going to your regular clinic or doctor…
  - #3 Do your kids need Health Insurance?
  - #4 Dental care is important for your child!
  - #5 How to apply to DSHS
  - #6 About Kids Connect
  - #7 Does your newborn baby have a doctor?
- A brief fotonovela (educational drama with photos) on fever, diarrhea, and vomiting as well as an early childhood booklet on hand-washing are in the process of being developed to promote the use of the primary care setting and to address prevention of primary care illness very frequently seen in the Emergency Departments.

In barely seven months, the Kids Connect project has established systems of operations, trained Access Specialists, and gone into action to provide services to over 500 households whose children lack medical coverage and/or a medical home. Federal funding will end on February 28, 2007. The Advisory Committee is currently discussing sustainability strategies.

4. Will your proposal impose costs on individuals, businesses or government? Will these costs be time-limited or on-going? Can you estimate how much these costs will be, or suggest how such an estimate could be made? How much, if any, of these costs will be offset by corresponding savings?

Access Specialists could be funded through coordinated community coalition grants (similar to the Community Access Projects), which requires active collaboration from multiple agencies.

Savings will also be made if medical systems provide for education, monitoring, alternatives, and feedback regarding the unnecessary utilization of Emergency Departments for primary care problems.

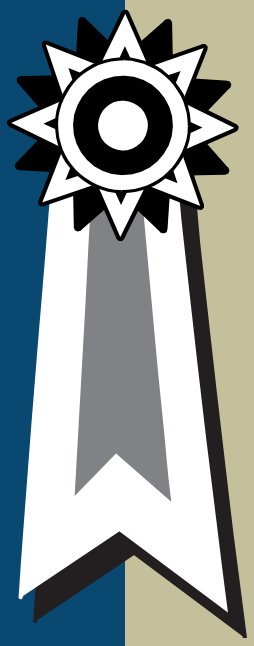
5. How does your proposal reflect collaboration among various stakeholders? Which stakeholders have endorsed it?

We can speak to collaboration on Yakima County Kids Connect. Participants are the three community health clinics, two other private clinic systems, and two of the four hospitals in the county. A for-profit corporation owns the two non-participating hospitals; this corporation declined to participate. The participating stakeholders all have expressed interest in sustain the Kids Connect program because of obvious benefits to patients, the potential savings in reducing avoidable ED visits, and the potential reduction in charity care given to uninsured patients.

6. What are the obstacles to implementing your proposal? Who will object to it and why? How do you suggest these objections be addressed?

Obstacles	Who will object & why	How to address objections
EMTALA Requirements	Federal or State regulators who may see Access Specialists, particularly those located in hospital emergency rooms as "barriers" for patients seeking urgent treatment.	Clear policies that demonstrate Access Specialist role should not interfere with hospitals' abilities to comply with EMTALA regulations. HRSA should seek a waiver from CMS allowing more prudence toward the application of EMTALA regulations.
Potential loss of revenue to hospitals and emergency room physicians	Hospitals / Emergency Departments	Cost-savings from reduced Emergency Room use should be shared between HRSA and hospitals.

Tab 64



Proposal to the Blue Ribbon Commission on health care costs and access

Washington State
Office of the
Insurance Commissioner

Insurance Commissioner Mike Kreidler
September 2006

Proposal to the Blue Ribbon Commission on health care costs and access

Universal health care coverage for all Washington residents must be our goal. We cannot maintain the current system where access to health care continues to decrease at the same time that costs are rising.

Today, more than 740,000 Washington residents are uninsured. Yet, they do receive health care – either in the form of uncompensated care or through publicly funded community clinics. Only 60 percent of the nation's employers offered health care coverage in 2005, down from 69 percent in 2000. The costs of providing care are shifted to those employers and individuals who purchase insurance, and to tax-funded programs. From 2002-2004, the amount the Washington health care system and the insurance-buying public spent on providing care for the uninsured has risen $96 million to more than half a billion dollars.

This trend puts those employers who do provide coverage at an increasingly competitive disadvantage and diverts millions in state revenues from other public policy priorities.

As a society, we have chosen to preserve an employer-based health insurance system. Therefore, the foundation of health care financing should be employer-funded coverage, with individual coverage and public sector programs filling in the gaps.

Collectively, employers, the public sector and individuals all have an obligation to contribute to the funding of health care coverage. The Blue Ribbon Commission's five-year plan for increasing access to health care should clearly establish those obligations.

In doing so, the Commission must address five key principles: Availability, affordability, quality care, equity and choice.

1. Every Washington resident is obligated to contribute their fair share toward the cost of health care coverage. However, this coverage obligation should be limited to an amount that is affordable.

- **Employer Responsibility**

Employers with more than ten employees should have two options for providing health insurance to their employees – either fund at least a minimum level of coverage or pay a health care access fee to the state to provide coverage. The access fee should be based on the cost of providing a basic level of coverage which could be approximately one dollar per hour for each employee without coverage. [$160 - $176 per month for a full-time employee] This funding obligation should be extended to all employers over a reasonable period of time. If the courts interpret federal law (ERISA) as preventing the State from establishing this employer obligation, the State should pursue other approaches that are tailored to withstand judicial review.

- **Public Sector Responsibility**

The public sector currently provides more than half of the coverage in this country. This includes funding coverage for low-income individuals through publicly financed insurance and clinic-based programs. In addition to funding these programs, the State should also provide assistance to purchase coverage for those employees and others who do not receive health coverage through their employers and who lack the income to purchase a policy. Subsidized coverage should be made available on a sliding scale for individuals whose incomes are under 300 percent of the federal poverty level, and who have limited savings and/or assets.

- **Individual Responsibility**

Individuals who are unemployed, self-employed, or who do not receive coverage through their employer, should be required to maintain a specified level of health care coverage. The cost of coverage should be subsidized for individuals who have incomes below 300 percent of the federal poverty level [$2,448 for a single person] and no significant assets.

2. Create a non-profit organization or public entity to implement and operate reforms.

A new organization (similar to the Massachusetts Health Insurance Connector) should be created to help individuals and small employers shop for health insurance plans. Like the Massachusetts entity, the Washington "Health Insurance Connector" would carry out the following roles:

- Establish the amount that individuals are expected to contribute toward their health care costs.
- Determine the minimum benefits package that employers are expected to provide their employees, and individuals would be required to purchase.

In order for the benefit to be meaningful, it must include coverage for preventative services and provide protection from catastrophic expenses.

• Review and certify low-cost and/or high-value health care plans for individuals and small employers that cover additional services to those provided under the minimum benefits package.

- Make it easier for individuals and small employers to shop for cost-effective, quality health plans by providing a one-stop shopping location and information source for all plans.
- Provide an administrative framework that can collect contributions from more than one employer toward health plan coverage for an individual, and that small employers can use to offer a cafeteria ("Section 125") plan with pre-tax dollars.
- Develop and implement improved mechanisms for pooling risks and for subsidizing coverage for low-income individuals.

3. Require administrative efficiencies in the health insurance system

To reduce high administrative costs, the state should create a non-profit organization to carry out a centralized provider credentialing program and a single uniform claims processing system.

The Utah Health Information Network and One Health Port in Puget Sound are examples of potential platforms for the implementation of claims processing.

4. Invest in outcomes-based healthcare

We must continue to implement evidence-based health care purchasing initiatives and incentives in order to reduce the amount we spend on poor quality and inefficient care. Paying providers to perform higher quality care will be a crucial step in improving the efficiency of health care services.

The State should continue to pursue new health care purchasing strategies that offer greater incentives for providing high quality, efficient, and outcomes-focused care. This should include support for the expanded adoption of interoperable electronic health care records and databases to track health care outcomes, building off the work of Inland Northwest Health Services. It should also include continued support for the work of the Puget Sound Health Alliance to enable health care purchasers to use evidence to identify and measure quality health care, and to produce publicly-available comparison reports designed to help improve health care decision-making.