

CHAPTER 4

HEALTH CARE

1. Health Care Mandates

Recommendations

1. Authorize low cost, mandate free health insurance.
2. Require an independent cost-benefit analysis of existing health care mandates.
3. Adopt a moratorium on new health care mandates.
4. Urge Congress to allow the interstate purchase of health insurance, so Washington residents can shop for health coverage in any state.

Background

Paying for health care coverage is one of the fastest-rising costs facing businesses and citizens in Washington. At the same time health insurance is one of the most heavily regulated sectors of our state's economy. These two trends are linked, with increasing state regulation playing a major role in driving up the cost and reducing the accessibility of health care coverage.

In 2007, national health care spending grew 6.9 percent, twice the rate of inflation, to an estimated \$2.3 trillion.¹ Health care spending now makes up about 16 percent of the national economy, and is projected to increase to \$4.2 trillion, or 20 percent of GDP, by 2016.² In 2007, employers saw their cost of providing health insurance increase by 6.1 percent, the latest in a series of yearly increases at well above the annual rate of inflation.³

HEALTH CARE

Although some of the cost drivers of health care are beyond the control of policymakers, there is one key factor which state policymakers directly control: the cost and impact of state-imposed mandates. Mandates are state laws listing benefits for specific conditions or services that every health insurance policy sold in the state must cover, whether insurance purchasers have requested the coverage or not. Independent research shows that mandates can increase the cost of basic health coverage by about 20 to 50 percent overall, depending on the state, or by about 0.5-1.0 percent per mandate.⁴

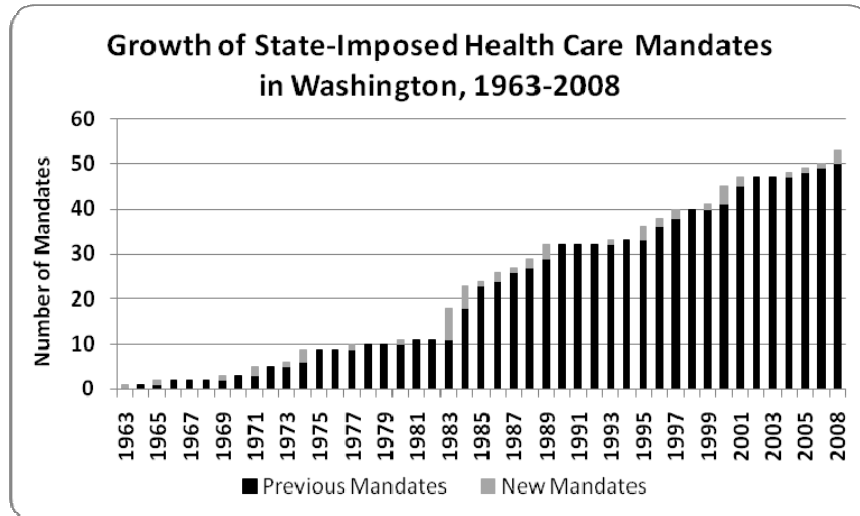
State-imposed mandates interfere with the normal voluntary relationship between buyers and sellers. Mandates mean insurance purchasers are forced to pay for medical coverage they may not otherwise choose, and patients are made to bear the cost of services they do not want and may never use. This creates a “crowding out” effect, by which some health care services are not available because insurers must offer the benefits mandated by the state.

Moreover, mandates may encourage health providers to follow fixed clinical procedures and services, depriving doctors of the discretion they need to practice medicine. By doing so, they increase the likelihood that medical resources are misallocated, and that care provided through existing health care insurance plans is not flexible, innovative or efficient.

Beginning with a single access-to-provider mandate in 1963 (for chiroprody), the number of new mandates and enacted changes to existing mandates in Washington has grown to 53 in 2008. During two distinct periods the number of new mandates surged. Between 1982 and 1990 the number of mandates tripled from 10 to 30, and from 1993 to 2001 their number increased a further 50 percent.⁵

From 2004 through 2008, an additional mandate has been added each year: a ban on denying insurance coverage for injuries caused by narcotic and alcohol abuse, a requirement for mental health parity, and a requirement for prostate cancer screening. The yearly increase in the number of health care mandates is shown in the following chart.

HEALTH CARE



The cumulative effect of state-imposed mandates contributes significantly to the cost of health insurance in Washington.
Source: Washington State Office of the Insurance Commissioner.

An extensive set of state-imposed restrictions on what consumers can buy would have a substantial impact on any industry. It is not surprising, then, that these mandates have considerable impact on health insurance prices and availability in Washington.

Research by the Congressional Budget Office (CBO) found that “government regulation at both the state and federal levels can also increase the costs of health insurance and lead to higher premiums.” CBO cites “mandates to cover specific benefits such as chiropractic services or minimum hospital stays for births” as examples of such high-cost insurance regulations.⁶

Mandates and their associated costs contribute to the number of uninsured people in Washington. Since 1992, the number of new mandates and changes to existing mandates rose, as noted, by more than 50 percent, increasing from 30 to 53. Over the same period the number of uninsured people in Washington has increased to approximately 593,000 people in 2007, including 73,000 children, or nearly 10 percent of the population.⁷

The authors of one national study found that state-imposed mandates may account for as many as one in four Americans who are uninsured. “Mandates are not free,” they report, “they are paid

for by workers and their dependents, who receive lower wages or lose coverage altogether.”⁸

Another study found a strong correlation between higher health coverage costs and increases in the uninsured population. Professors Frank A. Sloan and Christopher J. Conover of Duke University found that, “the higher the number of coverage requirements placed on plans, the higher the probability that an individual was uninsured, and the lower the probability of people having any private coverage, including group coverage. The probability that an adult was uninsured rose significantly with each mandate present.”⁹

Policy Analysis

Because of mandates and other state-imposed regulations basic health insurance is not available in Washington. State law contains a “value” or “bare-bones” insurance provision dating from 1990, but it includes many detailed regulatory requirements and is not free of all mandates.¹⁰

A policy allowing true basic health insurance free of state-imposed mandates has the following advantages:

- **It promotes the public interest** – the public benefits when government policies allow greater, rather than fewer, choices in the health care market;
- **It encourages personal freedom** – citizens would have greater say in one of the most personal and sensitive areas of life;
- **It enhances market efficiency** – health care consumers would be able to seek the coverage they need at a price they are willing to pay;
- **It reduces the number of uninsured** – individuals, families and small business owners who are currently priced out of the market would have new opportunities to gain access to health insurance.

HEALTH CARE

Letting Washingtonians buy health coverage in any state

State law makes it illegal for people in Washington to buy health insurance in another state, no matter how good a deal that policy might be for them. This prohibition generally does not apply to other types of insurance, like auto, homeowners and life insurance.

Today the internet makes access to choice, price competition and product information easier than ever. Dozens of easy to use websites provide health coverage information. Examples of consumer-based health insurance websites are:

- eHealthInsurance.com.
- [HealthQuoteUSA \(at nwinc.com\)](http://HealthQuoteUSA(at)nwinc.com)
- HealthInsuranceSort.com. (BlueCross)
- HealthInsuranceInfo.net
- HealthInsuranceFinders.org

These websites allow consumers to shop among a wide range of health coverage options, all with varying prices and benefit levels. One site alone (eHealthInsurance) lists at least 215 plans.

Other insurance models work this way. Multi-state companies selling auto, homeowners and life insurance offer choice, good prices and quality service for one reason only. The consumer is in charge, and insurers know they have to please the customer, not government regulators or company benefits managers, in order to get business.

Greater market choice and better prices in health care are available across the country and easily available through the internet. Washington lawmakers should remove the legal barriers and let their citizens tap into a nationwide market in affordable health care.

Recommendations

1) Authorize low cost, mandate free health insurance. Insurance should be available to individuals and businesses without state-imposed mandates, with pricing that reflects its actual value to consumers. Allow insurance companies to tailor their policies to include mandates or not.

HEALTH CARE

2) Require an independent cost-benefit analysis of existing health care mandates. As has been done in other states, an independent cost-benefit analysis would more accurately determine the role of mandates in increasing the cost of health coverage.

3) Adopt a moratorium on new health care mandates. A moratorium on new mandates would create a much-needed "time-out" in the growth and complexity of health insurance regulations. This, in turn, would give policymakers and the public the opportunity to learn more about the long-term impact of mandates on the price and availability of health care coverage.

4) Urge Congress to allow the interstate purchase of health insurance, so Washington residents can shop for health coverage in any state. The number of mandates varies widely from state to state. By gaining access to a national market in health coverage, Washington residents could select policies from states with fewer mandates, thereby decreasing costs and increasing choice in the marketplace.

2. Health Savings Accounts and High Deductible Plans

Recommendations

1. Encourage insurance companies to enter Washington's HSA/HDHP market to promote choice and price competition benefiting consumers.
2. Exempt high deductible health plans from state community rating requirements.
3. Urge Congress to make premiums for individually purchased health insurance plans, such as those accompanying HSAs, tax deductible.
4. Cut the state tax on individual insurance policies.

Background

The current system of employer-based health care coverage dates from when the federal government imposed wage controls during World War II. Since employers were barred from offering higher wages to attract workers, they began offering non-monetary benefits such as free health care. In 1943, the IRS ruled that the cost of these benefits was a legitimate business expense, making health coverage fully tax deductible for businesses, but not for individuals.

That ruling, later confirmed in law by Congress, created three interconnected economic distortions in the health care market:

- It prevented patients from knowing the actual cost of the care they received;
- It created the third-party payer problem, encouraging patients to demand care, regardless of whether it is necessary or cost effective. Most weekend warriors do not need a \$1,000 MRI for their aches come Monday morning;

HEALTH CARE

- It undermined the true understanding of health insurance. People tend to see their health benefits as a pre-paid service, not as a way of mitigating risk. People reason, “It’s a free benefit. I’ll use as much as I want;”
- It caused health insurance to actually become health “maintenance” whereby it covers all health related activities, not just unexpected or catastrophic problems.

An effective tool to dismantle these distortions did not exist until Health Saving Accounts (HSAs) were established on December 8, 2003, when President Bush signed the Medicare Prescription Drug, Improvement and Modernization Act. The law became effective January 1, 2004, when the first HSA was sold, allowing consumers to purchase health coverage with the same tax advantage as businesses for the first time in 61 years.

Citizens in Washington and throughout the country can now make pre-tax deposits into an HSA that can be used to pay for routine health care expenses. HSAs must be accompanied by a high deductible health plan (HDHP). In 2008, this means a plan with an annual coverage deductible of at least \$1,100 for an individual or \$2,200 for families. In Washington, the legislature enacted a bill creating an HSA benefit option for the state’s 106,000 employees and their families.

In 2008, annual HSA deposits cannot exceed the amount of the insurance deductible or \$2,900 for individuals and \$5,800 for families, whichever is less. These latter limits are indexed to inflation and will increase in future years. Also, individuals 55 years old and older can make an additional “catch-up” contribution of \$900 in 2008, and a “catch-up” contribution of \$1,000 in 2009 and in every year thereafter.¹¹

Savings in an HSA can earn interest or be invested in stocks or mutual funds just like savings in Individual Retirement Accounts. Interest and investment earnings are tax-free.

HSA balances belong to individual account holders and remain theirs if they change jobs, become unemployed or retire. The funds can be used to pay qualified medical expenses and unspent

funds carry over to the next year. Below is a summary of how HSAs work.

An Overview of Health Savings Accounts

- Each HSA must be accompanied by a high-deductible health plan (HDHP).
- Annual tax free contributions can be made up to the lesser of:
 - the amount of the HDHP deductible, or
 - \$2,900 for individuals and \$5,800 for families (indexed to inflation).
- HSAs are portable. HSA funds belong to the account holder and travel with the person from job to job.
- Contributions to an HSA may come from any source, including: self, parent, spouse, grandparent, or employer.
- Funds may be spent tax free on qualified medical expenses.
- Investment earnings in the account accumulate tax free.
- Unspent funds in an HSA carry over to the next year; there is no “use it or lose it” limitation.

The idea behind HSAs is simple. Individuals should be able to manage some of their own health care dollars through accounts they own and control. They should be able to use these funds to pay for health care expenses such as prescriptions, x-rays and other diagnostic tests, and office visits to their health care provider. Consumers who have more direct control over their health care dollars are more likely to take responsibility for their health care decisions.

Health Savings Accounts have several additional advantages for consumers. Besides making health coverage more affordable, HSAs build financial assets. The money in an HSA belongs to the account holder, not to an employer, insurance company, or government agency. Because unlimited annual rollover is allowed,

HEALTH CARE

unspent funds in an HSA can accumulate tax free for years and be available at retirement.

HSAs are popular, and, in recent years, the number of people purchasing them has increased rapidly. In the last nine months of 2005, the number of Americans with HSAs tripled to 3.2 million.¹² In 2008, 6.1 million Americans are covered by HSAs and similar high-deductible plans, a 35 percent increase over the previous year.¹³

In Washington state in 2008, 101,254 people, or 2.5 percent of those covered by private plans, are enrolled in HSA plans.¹⁴

Recent data shows that people covered by HSAs effectively accumulate money to pay for their routine medical expenses. In 2007, on a twelve-month average basis, 87 percent of HSA holders had more than \$1,000 in available cash in their accounts.¹⁵

After retirement, HSA money may be spent on any non-medical purpose subject only to income tax. There are never taxes for medical costs, including long-term care expenses or Medicare premiums. Unspent money in an HSA can be inherited by heirs or a surviving spouse.

HSAs also carry advantages for employees and employers. The accounts provide flexible service to employees, giving them more choice and control over their health care spending. Through HSAs, employers can encourage a more health conscious and productive workforce. Moreover, any employer contributions to an HSA are not taxable to the employee.

Employers benefit by having lower administrative costs and less paperwork. HSAs are managed by employees or their financial advisors, not by the employer. Employers also see HSAs as a method of controlling their growing health care costs. Whole Foods, the grocery chain, covers all of its employees through personal, high-deductible plans while providing cash to employees for the deductible, and spends only half of the national corporate average for health care costs.¹⁶

Policy Analysis

Consumer directed Health Savings Accounts bring price and service competition to the health care market. Doctors, clinics, and hospitals have an incentive to provide high quality, price transparent care to patients. As consumers begin shopping more for their basic health care, providers will get questions they usually do not hear from patients such as, “How much does that cost?”

As the number of patients with HSAs rises, so will the amount of transparent information that is available to these patients. Already, websites exist which compare hospital prices and prescription drugs for a given disease or condition. The emergence of in-store mini-clinics provides consumers with straight forward pricing for a limited number of health care services.

Examples of mini-clinics in Washington are SmartCare Centers in Fred Meyer stores and MinuteClinic, located in select Bartell Drug Stores. Examples across the country include Express Clinic, Quick Clinics and Checkups.¹⁷ For an advertised fee, mini-clinics provide vaccines, diagnoses, and the treatment of relatively minor ailments such as pink eye, strep throat and athlete’s foot. Such consumer friendly sources of health care are an example for the entire health care system.

In addition to making coverage more accessible, Health Savings Accounts have civic and social advantages. HSAs make people more independent and self-reliant, rather than dependent on government or employers for a vital life necessity. HSAs encourage people to be more accountable and responsible in their own lives.

Recommendations

1) Encourage insurance companies to enter Washington’s HSA market to promote choice and price competition that benefit consumers. Over the years insurance companies have steadily left the state, leaving consumers with fewer choices. The advent of HSAs offers a way to reverse that trend. The legislature should encourage more insurers to enter the state’s emerging HSA market.

2) Exempt high deductible health plans from state community rating requirements. This would allow fair and accurate pricing of

HEALTH CARE

HSA health coverage because the cost of insurance policies are based on the actual health risk people bring to the insurance pool.

As a good first step toward helping the uninsured, the exemption could be limited to people who had no health coverage in the previous six months. Extending the exemption to small businesses buying first-time HSAs for their employees would further reduce the uninsured population.

3) Urge Congress to make premiums for individually purchased health insurance plans, such as those accompanying HSAs, tax deductible. Under current federal law, money paid for the high deductible health plan that must accompany each Health Savings Account carries no tax advantage, yet all other financial aspects of HSAs – contributions, interest earnings and payouts – are tax free. State policymakers should encourage Washington's congressional delegation to make premiums for all individually-purchased health insurance plans tax deductible.

4) Cut the state tax on individual insurance policies. State lawmakers charge a 2 percent insurance premiums tax on all health insurance policies sold in Washington, thus artificially adding to the already rising cost of health coverage. The legislature should eliminate this tax on individual policies. This would immediately make individual health care more affordable and would help reduce the number of uninsured people.

3. Certificate of Need Law

Recommendations

1. Repeal Washington's Certificate of Need law.
2. Short of repeal, scale back Certificate of Need restrictions to allow doctors, clinics and hospitals to respond to patients' needs more quickly and efficiently.

Background

Imagine your community is home to a nursing care facility that has operated for years with optimal customer satisfaction. It provides quality care and assistance, its facilities are modern and clean, and the staff is excellent. The nursing home is exceeding capacity and its operators look at the growing demand and decide to expand the facility by adding five beds. The administrators consult experts, study options and cost projections and, after careful consideration, secure a building permit and begin construction. It sounds reasonable, except they just broke the law.

Currently it is illegal to open or expand most kinds of medical facilities in Washington, unless the state grants a special Certificate of Need (CON). Washington is one of thirty-seven states (including the District of Columbia) that require specific government permission to open, expand or modify most kinds of health care facilities.

Dating back to New York in 1964, CON laws grew out of the belief that surplus supply of medical facilities and services meant providers would pass the excess cost on to patients. Limiting supply, some believed, would cap rising health care costs.

Eventually, every state adopted CON laws. Washington adopted its law in 1972. It is administered by the state Department of Health. The National Health Planning and Resources Development Act of 1974 directed each state to examine proposed health care facilities and determine the need for such services.

Typical Steps in the CON Need-Determination Process for Building or Expanding a Hospital in Washington

- Compile historical hospital use data for area during previous ten years;
- Compute average use rates for each year and for each age group: 0-64 & 65+, at a minimum;
- Forecast each area's hospital use rates for a target year (in some cases as far out as 10+ years);
- Adjust use rates for population trends from the Office of Financial Management;
- Adjust projections and use rates based on presence of a Health Maintenance Organization;
- Adjust use rates for residents who use out-of-state hospitals;
- Distribute forecasted patient days to hospital planning areas based on market share;
- Use average occupancy standards to determine each planning area's bed need;
- Add psychiatric bed need forecast (determined in a separate process) to non-psychiatric need forecast;
- Make necessary final adjustments for population, use rates, market shares, out-of-area use rates, and shifts in occupancy rates.

By 1982, however, the federal government recognized the failure of CON laws to reduce health care costs and repealed the national health planning requirements. Since then, 14 states have followed suit and eliminated their CON requirements.

Washington retains its original 1972 statute, even though the law has demonstrably failed in its stated goal of reducing costs and increasing access to health care. The state, not doctors or hospital

HEALTH CARE

administrators, decide whether anyone may build, expand, sell, purchase, or significantly modify 15 different kinds of medical facilities and services, including hospitals, nursing homes, outpatient surgery centers, retirement communities, and organ transplant services.

The CON application process lasts up to two years or more and costs hundreds of thousands of dollars, which is added to the price of health care. The process itself is extremely arcane.

The CON process is just one phase of a much larger set of regulatory requirements. The following table shows the many additional permitting, licensing, building code, environmental and zoning requirements that must be completed before a clinic or hospital is built in Washington.

**Non-CON requirements for clinic and hospital construction
in Washington¹⁸**

Licensure and Physical Plant Requirements

- Finishes (carpet, tile, wall covering)
- Heating and ventilation system
- Hot water system
- Medication handling
- Nurse call system
- Room size, furniture and equipment
- Shower and toilet fixtures

Fire / Life Safety Requirements

- Automated sprinkler system
- Electrical generator system
- Fire alarm system
- Fire / life safety structural design
- Life support system
- Medical gas system
- Smoke control system

Standards Adopted by State Building Code Council

- 2003 International Building Code
- 2003 International Fire Code
- 2003 International Mechanical Code
- 2003 International Plumbing Code
- Barrier-free requirements
- National electrical code
- Washington state energy code
- Washington state ventilation code

These regulations are important to protecting public health and safety, and there is no suggestion that this list should be shortened or eliminated. The purpose here is to show that the lengthy and complicated Certificate of Need process is imposed *in addition* to a long list of existing requirements.

Policy Analysis

Three decades of experience shows that Washington's CON laws have not worked as intended. A 1999 study by the Washington State Joint Legislative Audit and Review Committee (JLARC) and a 2005 study by Seattle's Mercer Human Resource Consulting Group both concluded that Washington's CON laws have neither reduced the cost of nor increased access to health care.

A 2004 report by the Federal Trade Commission and the Department of Justice came to the same conclusion. It suggested that in some states CON laws have contributed to higher health care costs by reducing supply and stifling competition.¹⁹

The program's record indicates CON no longer serves the public interest, if it ever did. The stated purpose of the program is to control costs and meet changing conditions. Yet to succeed, our health system requires the very flexibility CON is designed to prevent.

In a state experiencing rapid growth and demographic change, CON prevents providers from adapting to the changing health needs of the community.

For example, in 2006, Cancer Treatment Centers of America wanted to build a \$76 million, 24-bed state-of-the-art medical facility on a 10-acre site in Kent. City leaders strongly supported the proposal, which would have created 250 new jobs. State regulators, however, concluded that the hospital was not needed, twice rejecting it through the CON process.²⁰

CON laws create the opposite of their intended purpose, actively blocking citizens' access to health care choices and modern health care facilities. The laws also bog down health care providers in stacks of regulation and paperwork.

A special Task Force created in 2005 by the legislature (SB 1688) failed to improve the restrictive nature of state law. Far from streamlining health care regulation in Washington, the Task Force recommended the opposite, calling for a "state health planning process supported by an adequate data reporting system."²¹

HEALTH CARE

The failure of the Task Force to reduce CON barriers to health care, and instead to add to them, shows how the CON process has become arcane and politicized. Influential medical organizations holding a Certificate of Need frequently use the CON process to keep competitors out of their area.

In contrast, when health care organizations are allowed to compete in a system that functions more like a normal market, consumers of health care win because there are incentives for providers to innovate and grow more efficient.

Competition builds a nimble, community-responsive system that readily adapts to changing needs. Bureaucratic red tape and inflexible planning and regulatory structures that keep competitors out cannot achieve these ends.

In practice, Washington's CON laws do not improve health outcomes for citizens. Instead, they are used to control access to health care. State regulators – not communities and health care professionals – pick winners and losers in health care by deciding when and where medical facilities can be built.

Recommendations

1) Repeal Washington's Certificate of Need Law. Washington should join the 13 states like Pennsylvania, California and Texas that have repealed their Certificate of Need regulations. Citizens in those states benefit from a faster and less-bureaucratic process for opening new hospitals and clinics. Washington citizens would similarly benefit if our state's failed CON law were repealed.

2) Scale back Certificate of Need regulations to allow doctors, clinics and hospitals to respond to patients' needs more quickly and efficiently. If retained, the CON law should be limited to only a few types of medical facilities or only apply at a higher expenditure threshold. This could be done as a precursor to full repeal or with the intention of streamlining the CON process to make it more workable.

4. Medical Liability Reform

Recommendations

1. Cap the amount of noneconomic damages that can be awarded by a jury to \$350,000 or less.
2. Eliminate joint and several liability.
3. Encourage far-reaching medical liability reforms such as schedules of damages, “early offer” programs and specialized medical courts.
4. Strengthen the effectiveness of the Medical Quality Assurance Commission.

Background

Currently, individuals may file civil lawsuits against doctors, clinics and hospitals for unlimited amounts of money for breaches of duty that cause injury. This legal system has two primary purposes – deter doctors and other health care providers from acting negligently, and compensate injured people for the losses they have suffered.

Although not required by state law, most doctors in Washington buy malpractice insurance to protect themselves and their practices against expensive jury verdicts. The high cost of malpractice insurance contributes to the rising cost of health care, and is having a harmful effect on doctors, patients and payers.

The American Medical Association includes Washington on the list of states facing a medical liability crisis, threatening the viability of the medical community and the health of patients. This is the third malpractice crisis in 30 years, following the ones in the mid-1980s and the mid-1970s. It is a recurring problem in desperate need of a long-term solution.

Although fewer medical malpractice claims have been filed in recent years, the monetary value of each claim is rising. Over the

HEALTH CARE

past ten years, the average jury verdict in Washington has increased by almost 70 percent and the average settlement cost has increased by over 50 percent. Likewise, the number of verdicts and settlements over \$1 million increased by tenfold in roughly this same time period. High jury awards are not isolated events; they influence future court cases as well as out-of-court settlements.

Higher claim costs are the primary reason for increased malpractice insurance premiums. Moreover, in Washington, because of joint and several liability rules, each defendant in a medical malpractice lawsuit is potentially responsible for paying the total jury award to a patient, regardless of how small that defendant's role was in causing the patient's injury.

This rule encourages injured patients and their lawyers to seek full payment from the defendant with the "deepest pockets," not necessarily the one most responsible for causing harm.

Malpractice lawsuits affect physician behavior, contributing to the practice of defensive medicine and driving up health care costs. Defensive medicine refers to a doctor ordering diagnostic tests, procedures, specialist referrals or prescription drugs mainly to reduce malpractice liability, not to serve their patients better.

A recent study found that medical liability costs and defensive medicine account for at least 10 percent of medical care costs.²² Additionally, physicians in a state with a malpractice crisis, like Washington, are more likely to retire early, leave the state, or reduce their scope of practice. Patient access to health care is then restricted by fewer physicians in the community.

In 2005, two contentious medical malpractice initiatives, Initiatives 330 and Initiative 336, appeared on the November ballot. Each took a radically different approach to changing Washington's medical liability laws. Both initiatives failed, prompting the governor to negotiate and the legislature to pass a health care liability bill in 2006.

The new law makes modest changes to patient safety, liability insurance and the legal process. Most of these changes, however, are minimal and will not truly resolve the medical malpractice crisis in Washington.

Policy Analysis

Twenty-nine states have adopted some limitation on jury awards, primarily on noneconomic damages. Many states model their tort reform on California's Medical Injury Compensation Reform Act (MICRA), enacted in 1975. MICRA caps noneconomic damages at \$250,000 and limits attorneys' fees based on a sliding scale.

Because of MICRA, malpractice claims in California are settled in one-third less time than the national average of more than five years, and malpractice insurance rates have dropped by 40 percent since its inception. The result is a system that better serves the needs of patients by reducing the cost of litigation and speeding compensation payments.

Noneconomic damage caps reduce the average size of an award and limit malpractice insurance premium growth. Caps have been demonstrated to result in a 23 percent to 31 percent reduction in the amount of an average jury award. Moreover, states with caps of \$350,000 or less on non-economic damages saw increases in malpractice insurance premiums of 13 percent in 2000-01, while states without caps experienced a 44 percent increase in premiums.

In 2003, Texas capped malpractice jury awards for noneconomic damages at \$250,000. As a result of this and other reforms, the state's largest malpractice insurance company cut its premiums by 35 percent, resulting in \$217 million in savings to doctors, and their patients, over a four year period.²³

Officials at one nonprofit hospital, Christus Health, report malpractice reform has saved them some \$100 million, which they can now devote to charity care, instead of fighting lawsuits. Limiting jury awards has made Texas a much more attractive place to practice medicine. In the last three years, about 7,000 doctors have entered the state, many to serve in rural areas.²⁴

Joint and several liability

Over the last 20 years, the majority of states have reformed their joint and several liability laws. In states that abolished joint and several liability, physicians are not held liable for the negligent acts of

other doctors. This approach is fair because it allocates financial damages in proportion to each defendant's actual level of fault. It also reduces costs because malpractice insurers, when issuing policies, know how much risk each doctor is assuming.

Washington needs reforms similar to those in other states that are successfully reducing costs while protecting patients. Practical reforms include reasonable limits on non-economic damages and eliminating joint and several liability. These recommended reforms represent an important start.

More comprehensive medical liability reform

The medical liability system is complicated, and it currently does not meet its two objectives of deterring medical negligence and compensating injured patients.

Policymakers should consider broader, long-term reforms that address the fundamental problems with the medical liability system. Effective long-term reforms include:

- A regular schedule for determining noneconomic damages, with financial awards increasing with the seriousness of the patient's injury;
- "Early offer" programs that allow fast payment of compensation with an injured patient's agreement not to seek further payments; and,
- Specialized medical courts where independent medical experts can make faster, more consistent decisions about awarding just compensation to injured patients.

Improving the Medical Quality Assurance Commission

The purpose of the medical liability system is to secure fair compensation for injured patients, punish negligent or incompetent doctors, and deter future acts of negligence. The court system by itself, however, is ill equipped to police the medical profession and ensure the good conduct of doctors. The enforcement powers of the executive branch are best suited for that purpose.

HEALTH CARE

Washington regulates physicians through the Medical Quality Assurance Commission (MQAC). The Commission is responsible for establishing, monitoring and enforcing qualifications for licensure, consistent standards of practice and continuing competency.

While patient complaints and out-of-court malpractice settlements may not be widely known to the public, they are no secret to the members of MQAC. Acting on this information, the state should investigate, impose limits on practice and, if need be, revoke the licenses of negligent doctors *before* they do serious and lasting harm to patients.

There must be a system in place to protect those physicians testifying against incompetent doctors from legal retribution. Competency should be decided by the MQAC, not the courts.

Recommendations

- 1) Cap the amount of noneconomic damages that can be awarded by a jury to \$350,000 or less.** As in other states, the goal is to make future awards more predictable, which in turn will make insurance premiums more predictable.
- 2) Eliminate joint and several liability.** Defendants should be liable only for their own decisions and actions, not the decisions and actions of others. This will decrease the need for patients to bring a marginal suit against a “deep pocket.”
- 3) Encourage far-reaching medical liability reforms such as schedules of damages, “early offer” programs and specialized medical courts.** Longer term solutions need to be developed if the goals of the medical liability system are to be achieved.
- 4) Strengthen the effectiveness of the Medical Quality Assurance Commission.** Physician competency and quality are regulated by state law. Regulators need to make greater efforts to assure the public that the few substandard physicians in the medical profession are identified and removed from the health care system.

5. Medicaid Reform

Recommendations

1. Adopt a state voucher program to give Medicaid recipients control over their health care dollars.
2. Encourage Congress to allow block grants of federal funds instead of matching funds to the states.

Background

The Medicaid program, which was created by the Medicare Act of 1965, provides federal and state funding on a matching basis for health care for the poor and disabled. Today, over 55 million people receive services through the Medicaid program.²⁵

Four groups of people receive assistance through the Medicaid program. These groups are: the poor, the disabled, mothers and children, and individuals needing long-term care. Although mothers and children make up most of the beneficiaries, long-term care accounts for 70 percent of yearly Medicaid dollars.²⁶

Physician participation in Medicaid is voluntary. Medicaid payments to doctors have always been lower than those of any other insurance carrier, including Medicare. Consequently more and more physicians are withdrawing from the program, thus decreasing access to health care and freedom of choice for low income and disabled people.

The cost of Medicaid is not sustainable. In 1966, its first year, the cost was \$1 billion. The cost of the program exploded to \$330 billion by 2007.²⁷ In many years, the financial burden of Medicaid grows at twice or three times the rate of inflation. It is estimated that at its present rate of growth, Medicaid-funded nursing home expenditures in 2030 will equal the size of the entire Social Security program today.

Policy Analysis

Medicaid has a number of harmful effects on the very people it is intended to help. First of all, it discourages work and job improvement for low paid employees, since with increasing income, workers lose their Medicaid benefits.

It also encourages employers of low-income workers not to offer health benefits. They assume, or hope, that taxpayers will provide these benefits instead.

Medicaid also discourages private insurance companies from offering nursing home policies. As the government program crowds out private carriers, this insurance market gets smaller every year, resulting in less choice for consumers.

Lastly, Medicaid discourages charity care and philanthropic giving in the health care sector. If the government is assumed to be already giving health care to low-income people, private donors tend to shift their money to other causes.

State lawmakers unfortunately are caught in a vicious cycle. The more of state tax money they devote to Medicaid, the more money they receive from the federal government. If Washington state spends one of its own dollars on Medicaid benefits, it gets another dollar in matching funds from federal taxpayers, seemingly doubling the state's spending on health care.

The federal matching fund mechanism makes state lawmakers feel like they are receiving "free" money, so it is no surprise that Medicaid is the largest budget item for virtually every state in the country. In reality, of course, the "free" matching money is provided by federal taxpayers, who are the same people as state taxpayers.

In 1996, the federal government reformed welfare and repealed the Aid to Families with Dependent Children (AFDC) program. The AFDC was a means-tested entitlement with state and federal matching funds, very similar to Medicaid. Opponents of AFDC repeal predicted tragedy for low-income families. That didn't happen. In fact welfare caseloads decreased dramatically and poverty

across all demographic groups declined as well. More families became economically independent and entered the workforce.

Much can be learned from the welfare reform of 1996. Federal funding for Medicaid should be given as block grants, not as matching funds. This would induce states to budget for the truly needy and not rely on a blank check from federal taxpayers.

To introduce responsible use of Medicaid funds, recipients should be given individual vouchers so they can control their own health care spending. These vouchers could be used to purchase private insurance policies and to fund personal Health Savings Accounts. Dollars not spent could be rolled over from year to year and could be taken from one job to another.

Like welfare reform, this change in the Medicaid program would help lift poor families out of poverty, by making them independent and giving them ownership of their own health care coverage.

Recommendations

1) Adopt a state voucher program to give Medicaid recipients control over their health care dollars. Vouchers would allow Medicaid recipients to choose the health insurance policies that work best for them, and to participate in consumer driven health care. It would also increase access by giving Medicaid recipients a broader choice of doctors.

2) Encourage Congress to allow block grants of federal funds instead of matching funds to the states. Medicaid costs will continue to spiral out of control unless a meaningful ceiling is placed on spending. A simple method to accomplish this is to use federal block grants instead of unlimited matching funds. This change would cause states to be better stewards of their own health care budgets, since state lawmakers would no longer feel they are getting “free” money from federal taxpayers.

6. Innovations in Health Care Services

Recommendation

1. Avoid heavy-handed state regulations that block innovation in the delivery of health care services.

Background

Although 86 percent of health care in the United States is paid for by a third party, usually an insurance company or a government agency, a growing number of free market health care models are becoming common in Washington and across the country. These alternative ways of delivering health care services allow the patient to make all the key decisions in how to access care: where to go, when to go, who to see, how to pay, and how much to pay.

It is interesting to note that these alternatives are thriving outside the financing and regulatory structure of government, and largely beyond the notice of state legislators. In fact, public officials, even those working in health care regulation, are often among the last to comprehend how the health care marketplace is changing.

At the same time, patients seeking alternative forms of health care delivery have the full protection of all the consumer laws, professional licensing requirements, quality of service standards and truth-in-advertising rules that apply to any legitimate business activity.

Following is a short description of the innovations and patient-centered conveniences emerging in the private health services market.

Policy Analysis

Medical tourism

Patients have traveled to the United States to receive health care for many years. Over the last decade, though, a growing number

HEALTH CARE

of Americans have sought medical care in foreign countries. The driver obviously is reduced cost in other countries compared to the United States.

In one example, a knee replacement that costs an average of \$30,000 in the U.S. can be obtained for 40 to 60 percent less in another country, such as India, including costs for all medical procedures, doctor fees and the hospital stay.²⁸

Today, the most common medical reasons for traveling are joint replacement, cosmetic procedures, cardiac surgery, dental services and organ transplants.

International medical travel began with under-insured or non-insured Americans. As health coverage costs have risen, a few employer-based insurance programs have recently encouraged their employees to travel overseas for major surgical procedures, saving both the plan, and its members, money.

Medical travel agencies are increasing in number and international hospital certification is adding credibility to international health care. However, foreign physician training and the experience of hospital personnel remain significant variables in the quality of care internationally.

Concierge medicine

Under concierge medicine, consumers pay a fixed amount of money per month to have 24-hour access to a dedicated primary care physician. Same-day appointments, e-mail access and more time with the doctor are standard services. The vast majority of concierge patients also have affordable, high-deductible insurance to cover hospitalizations and major medical expenses.

This model is now being applied across a wide range of socioeconomic levels. The movement started with the wealthy, but today many concierge practices are affordable. A clinic in Seattle charges adults in their 40s only \$768 a year, or just \$64 a month.²⁹ Some charge as little as \$35 per month.

Doctors are able to build successful practices because of the volume of patients. The low cost and 24-hour access make it much

easier for doctors to practice preventive medicine. Patients with long-term health conditions are more likely to keep their illness from getting worse, thus saving the system money in the long run.

Convenient care clinics

A convenient care clinic is a small health care facility located in a common shopping area, like a mall or large retail store. They are often open seven days a week, take walk-in visits and offer affordable services. They are generally staffed by qualified nurse practitioners under the supervision of a doctor. They provide simple medical procedures, testing, immunizations, physicals and preventive health screenings.³⁰

Unlike traditional doctors' offices, convenient care clinics openly post their prices, and accept payment by cash, credit card or insurance. Convenient care members report a 98 percent patient satisfaction rate.³¹

Large retailers such as Wal-Mart are opening in-store clinics to treat customers with routine medical problems. From a patient standpoint, the convenient location and the reduced cost are major attractions.

Although a relatively new concept, last year there were about 800 convenient care clinics in the U.S. Those in the profession expect this number to grow to 1,500 in 2008, as the idea of going to a retail storefront for health care gains consumer acceptance.³²

Use of the internet

Transparency in health care is becoming a major issue with payers as well as patients. There are growing concerns with quality issues and high costs and people are demanding more information.

Multiple sites are appearing on the internet to meet the growing demand for a huge volume of reliable, high-quality health care data. Within a few years, anyone who has access to the internet will be able to research their own medical condition, compare results and outcomes for various procedures and providers, and perform cost comparisons before making important care decisions.

HEALTH CARE

The internet is one of the most promising tools for informing people about their own health and options for treatment. For this reason it is important for policymakers not to place regulatory roadblocks or new taxes on this growing and cost-effective source of consumer information.

Value-based medicine

There is much data to show a definite decrease in health care costs for payers that use a value-based model for their employees. By financially rewarding healthy behavior, like an improved diet, getting more exercise, or giving up smoking, employers have seen a significant drop in their rate of increase in medical related expenses.

Pitney Bowes began a value-based benefits program in 2001 centered on employees with diabetes and asthma. The company saw its annual costs decrease for treating both conditions within the first year, and it experienced \$4 million in health care savings by the fourth year of the program.³³

Executives at Quad Graphics identified obesity as a major driver of employee health care expenses. In the late 1990s, they began a program of waiving insurance co-payments for workers who joined a weight and diabetic management program or a smoking cessation program. Total cost for participants has ranged from 17 to 21 percent below previous estimates for each year of the program. The company plans to add asthma, hypertension and hyperlipidemia to the list of conditions requiring no co-payment from employees.³⁴

Although it is too early to know the overall impact of value-based health care, the trend is encouraging and warrants further utilization.

Conclusion

Allowed to function on its own, the free market has the ability to develop solutions to the ongoing problems of funding and access to health care. Policymakers should encourage more free market activities, letting private innovators in the market explore what works and what doesn't, and then pass the benefits on to health care consumers.

HEALTH CARE

In particular, state lawmakers and the insurance commissioner should not place a stifling regulatory burden on these innovative and practical ideas, as they have done to hospitals and clinics with the time-consuming Certificate of Need process.

Recommendation

1) Avoid heavy-handed regulations that block innovation in the delivery of health care services. Over-regulation by the state prevents doctors and clinics from developing new ways to build relationships with patients. It also prevents medical professionals from using new technology, such as electronic medical records, or talking to patients through e-mail, to improve the way they practice medicine.

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