Prescription for change: Solutions in Health Care for Washington

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RAINIER INSTITUTE
Pragmatic solutions to public policy concerns

Prescription for Change: Solutions for Health Care in Washington

Goals for our Future Healthcare System

Through a process of civic engagement, establish community-developed goals for improvements in the healthcare system, especially with regards to health outcomes[1]. Include issues such as values and goals for improved beginning-of-life and end-of-life care.

Public Health

Fully-fund a strong and robust public health system that is able to carry out core functions of assessment and assurance, access expansion, integration of personal health with community interventions, and lead policy development of health priorities.

Limit Cost Increases And Improve Quality

While no one silver bullet is available, we must initiate a process of using evidence to prioritize effective and high yield services/delivery systems and effective methods for controlling costs that are affordable for the government, business, and individual payers. These may include efficient and effective use of technology, a decrease in the administrative burden, a minimize cost-shifting among payers, improvements in systems of care, incentives for improved healthy behaviors, more effective types of interventions that include community based activities, and community supported prioritization of services.

Universal Access to an Evidence-Based Core Set of Services

The highest priority should be ensuring that expenditures are applied to the most cost effective services that have the greatest impact on health status. These include population-wide public health services to promote healthful, physical and social environments as well as a full range of proven preventive and primary care services including dental care, eye care, mental health, and addiction services.

Shared Accountability Between Payers, Providers, and Community : A consensus is reached around a new social contract over the responsibilities of each of these parties (economists would call this “distributed risk to distributed ownership”). Another

description of this would be “cooptition – a mixture of cooperation and competition,” It is a community-wide consensus over devoting resources to whomever does something best in an effort to maximize health outcomes.

Objectives

There are certain objectives that must be met to address the problems and goals outlined in the previous section.

1. There needs to be a community based public process that involves the broader public and aligns resources, capabilities and expectations. Washington State health care reform must be developed in partnership with key stakeholders (including consumers, providers, and payers), and keep the improvement of health status for consumers as its goal.
2. All Washingtonians should have access to affordable health services with a consensus driven, evidence based benefit package that covers medical needs and improves health.
3. Public health must be strengthened and utilized as a focal point in our state’s delivery of care since it provides greater marginal improvements in health status within communities.
4. Population based information should be used to set the priorities for the health system, critical health services, and interventions.
5. Critical services need to be made affordable for low-income people through subsidies by employers and/or public payers.
6. Costs must be controlled using evidence and value based purchasing, broad risk pooling in a publicly accountable manner where people in the community understand and accept the trade-offs and limits in the health care system.
7. There need to be improvements in efficiency by decreasing administrative expenses, reducing fragmentation in the delivery of care (which has the greatest potential for cost reductions) and increasing the effectiveness of the health care system at all levels including financing, delivery of services, and information management.
8. Costs should not be shifted from one payer to another if possible, and if a decision is made to overtly shift costs and expenses, the community should be aware and supportive of that shift.
9. Outcomes need to be improved and the broad range of social changes that improve health should be identified and addressed.
10. Health systems need to be continually updated and focused - involving providers and the appropriate parts of the community in this effort - to continually improve acute care, chronic disease management, and community health.

Possible Solutions

The Rainier Institute offers two potential solutions to the health care problem. These solutions are focused on public policy at the state and local level. Both solutions are structured so that new ideas, mechanisms and innovations can be implemented within their broad design.

The first, the Statewide Model, looks at solutions that can be implemented at the state level, and is consistent with a number of national proposals. (2) It does not require, but could benefit greatly from, federal support. All of the basic elements of this model have been implemented in at least one other state.

The second, the Community Health District Model, is responsive to a growing movement for local communities to have a more active role in controlling their own health care systems. (3) This role brings the community closer to the point of transaction between the provider and the patient. At the community level, support for rationalizing and facing the hard decisions regarding resource allocation is more likely. This community-based model will require participation of state programs, access to financial reserves, and technical expertise to be successful. (4) It will also require strong leadership at the local level, community-wide support for local health services, and a high level of teamwork among community providers. There are successful examples of this model in other states, and testing this model in a few Washington State communities could be a very achievable goal. (5)

While presented as two models, they do not pose an "either/or" decision. Rather, a model that supports community-focused solutions as part of a statewide strategy (an integration of the two solutions) holds intriguing possibilities. Analysis is needed to take the policy discussion to a deeper level to better define what is best done at the state level; what is best done at the community level and how to institutionalize the interdependency of a purposeful approach to leveraging federal, state and local health resources.

Statewide Model

Outline

This model builds on the current system and requires fundamental changes at the state level. It consists of:

1. A public health system should be supported to assess health needs, identify high priority services, and improve population health measures in areas such as smoking, obesity, infant mortality, and life expectancy. For example, this would mean that services deemed critical health services by the Washington State Board of Health would be included in benefit packages. (17)

2. Expand and consolidate all public programs under one eligibility and enrollment structure to cover all uninsured low income people using the following formula:
3. People and families below 150% of the federal poverty level (FPL) are covered for services currently included under Medicaid with no premium. This benefit package would be updated over time to align it with the critical health services.
4. People between 151% and 200% of the FPL are covered under the same services as above with a sliding scale cost sharing that will be no more than 5% of family income. Children would continue to be covered under CHIP up to 250% of the FPL.
5. Adults above 200% of the FPL and children above 250% are eligible to buy into the PEBB plans, or a community rated catastrophic plan.
6. Employers may assist employees in purchasing public or private coverage.
7. Public funds may be used to pay part or the entire premium for privately sponsored insurance if this is cost-effective.
3. The cost of subsidized services should be spread equitably among all employers.
    a. Employers with more than 50 employees would have a tax liability equivalent to 80% of the individual rate for the BHP per full time equivalent (FTE) employee. If the employer provides coverage of equal or greater value – thereby relieving the state of that burden, all or part of the tax would be forgiven on a dollar for dollar basis. The funds paid by the employer (those electing to not cover their employees) would be used to subsidize the purchase of insurance for those not receiving employer paid benefits.
    b. Employees in firms with less than 50 employees, or in firms that elect to not subsidize the care for their employees, could purchase the BHP if they are below 200% of FPL. If employees have income greater than 200% of the FPL, they could purchase the community catastrophic plan or buy into the PEBB plans if private insurance is not accessible to them. If employers elect to pay the tax, the funds paid by the employer would be used to subsidize the purchase of insurance for these people.
4. Public purchasers, working together with each other and with private insurers and other care managers, become value leaders by developing evidence based cost containment processes (pharmacy and technology), administrative simplification, and chronic disease management models that would be adopted by their private contractors. (6)
5. Employers are free to negotiate with their employees any benefits or cost sharing arrangements.
6. The state should establish a re-insurance mechanism that is transparent to the enrollee but spreads the risk of high cost enrollees across the market, or
8. Develop a risk pool that would be as broad as possible and would include existing Medicaid, S-CHIP, state employees' purchasing programs, and other voluntary participants. The aims of this pool would be:

9. To create economies of scale and administrative efficiencies by increasing the number of covered lives and leveraging existing management capacity.
10. To pool insurance risks and thereby reduce "small numbers" concerns about unpredictable costs or the potential for the mal-distribution of healthy and unhealthy people among pools.

Benefits/Drawbacks

Benefits

1. It builds on existing private-public health care system already in place, making the transition time faster and is more understandable to potential participants.
2. It makes all Washingtonians eligible for coverage regardless of ability to pay or pre-existing medical conditions.
3. It requires all people except the poorest to participate in their health care costs relative to their income.
4. It maximizes federal dollars that can help pay for expansions in existing Medicaid, BHP, and CHIP programs (through provision 2a and 2b above,)
5. Potentially could utilize new federal funds for uncompensated care.
6. Increased risk/purchasing pools that can take advantage of administrative and enrollment efficiencies, bargaining power, and data collection/sharing.
7. Maintenance of choice persists for individuals and employers that would prefer private coverage.
8. All public payers would maintain choice of provider. Private purchasers would need to negotiate with employees over limitations in choice.
9. The pay or play mechanism appears to be legal under ERISA.

Drawbacks

1. Crowd-out (dropping of private coverage by employers) would occur to some extent in the expansion of eligibility. This would be found in firms with fewer than 50 employees whose employees are below 200% of the FPL.
2. Relies on the availability of state and federal funds to help finance plan. This plan benefits greatly from a moderate increase in either the match rate for Medicaid or the overall Medicaid/CHIP federal funding – both of which are being discussed nationally, but neither of which are currently planned.
3. Reimbursement rates for these public programs are typically below providers' average costs, so rates must be increased or other arrangements made to guarantee participation, especially given the increased demand on ambulatory and primary care providers that increased coverage would create.

4. This model does not cover all people as it requires individuals and families above 150% of the FPL to purchase insurance – albeit subsidized for those below 200% of eth FPL (250% for children).
5. Some employers may dislike this model, as it will be seen as a tax. Employers who currently purchase care for their employees would see a substantial decrease in costs being shifted to them.
6. This continues to pump more money into a fragmented system with administrative complexity.

Community Health District Model

Outline

1. This model focuses on development of a community health district and builds on the public hospital district as the central organizing, sponsoring and controlling entity for a community. This approach would integrate and link payers, local citizens, local public health, and local health care services. An advantage of using a hospital district is that the district already has an infrastructure, enabling legislation, public accountability, specific geographic definition and population served/taxed, and is often the central focus of health care services in rural communities. (7)
2. The model strives to capture the money and community assets already in the system and to place control in the hands of the community. If necessary, the public hospital district laws would be amended so that this local governmental entity could expand its role to serve as the organizing focus for the health care system.
3. The governance of the system would be controlled by the local community through the hospital districts and their publicly elected officials. As elected officials, hospital district boards have clearly defined public accountability.
4. The subsidy for care and services for uninsured people could be generated by a variety of sources including voluntary contributions from employers and individuals, organized donations of services and funds, and/or local taxes. To use an augmented local taxing authority, a set of critical services as defined by the State Board of Health would need to be offered. Coordinated financing may also enhance the local ability to better leverage state and federal health program funding. In many ways, local community providers are already subsidizing much of this care through charity and bad debt write-offs. The amount of subsidy needed will depend on the "benefit package" adopted by the community.
5. Consideration could be given to establishing a local advisory group with broad business, citizen and provider participation. The advisory group would assist elected officials in making decisions on services to be available, benefit structure, funding mechanisms and allocation of resources. These decisions would take into account expectations for services, local capabilities, evidence-based quality

improvements, cost containment and the amount of financial risk the district would accept. The menu of "Critical Health Services" developed by the State Board of Health could be a beginning point for identifying services that best promise to improve the health of the community.

6. The local public health jurisdictions would become a partner with the community health district to ensure integration of services and priorities, as well as progress toward local population health improvements. One option may include amending laws to require an elected member of the local Board of Health be added as public hospital district commissioner.
7. The community health district might function similar to a local insurer or might be a more modest "ensurer" of limited services already directly available in the community. The questions of scope of "benefits" and funding need to be answered before risk can be addressed. For example, scope of benefits may resemble dental insurance policies (low risk) rather than catastrophic health policies (high risk). If districts decide to act like insurers, pooling risk with existing state programs could be explored. An alternate would be establishing a separate statewide risk pool available to community programs or purchasing stop loss reinsurance commercially.
8. The state-based public payers (BHP and Medicaid) would direct funding for local benefits into the districts thus simplifying administration and facilitating coordination of services.
9. Quality improvement, chronic disease management, and community health interventions would be organized and prioritized by the local district – possibly using state and national standards and proven processes as needed. (8,9) Many of these are already in place in many districts.
10. Local entities may need to depend on external support for a variety of functions like marketing, claims processing, utilization management, and development of effective and efficient administrative services. One option could be to include these functions as part of a statewide pool. (10)
11. Communities would need strong leadership willing to spearhead and direct this effort.
12. Strong state leadership and true state partnerships that remove barriers and work with local initiatives are needed to make this model work.

Benefits/Drawbacks

Benefits

1. Health care is an important part of the local economy, and greater participation in local health resource decision-making by citizens promises to move improvements over time towards a community-wide vision for the health system. (11,12)

2. People desire a more personal health care system exemplified by a community approach, where they can see and thus support the benefits of 100% coverage in their own communities. (13)
3. As a coordinated community effort, local organizations would have more incentives to use local assets and resources and to leverage other state and federal funds for health care and services.
4. This model may help stabilize and help maintain local providers of health care by guaranteeing more reliable reimbursements.
5. Access, especially to primary care, and continuity of care for patients would likely improve due to the stabilization of providers.
6. Both a recent report from the National Academy of State Health Policy and a respondent to the Seattle PI's "Burning Questions" regarding whether medical care was a right suggested pursuit of universal health coverage at the community level.
7. This proposal is consistent with findings of statewide community meetings held by Humanlinks and the Washington Health Foundation.
8. This approach allows piloting and customization (appealing to the largest number of stakeholders).
9. The role of local taxpayers and providers in governing the health system would be strengthened.

Drawbacks

1. Securing and organizing sufficient funding to establish this model would be difficult and could be done only with community support in partnership with the state and other funders.
2. Organizing at the local level may prevent maximum cost efficiencies because of smaller efficiencies of scale for administration and purchasing of services and goods.
3. Any local district assuming significant risk by acting like an insurer will be vulnerable to adverse selection and costly cases. Involvement in a broader insurance support arrangement would be necessary. Strict fiscal oversight would need to be exercised to ensure long-term solvency.
4. DSHS and DOH would need to relinquish their hold on funding streams before public dollars could flow to the communities. This may require legal and regulatory changes.
5. Not all local entities would be able to offer a full range of comprehensive services. Out of area partnerships would need to be established for services not currently provided by the district.

6. Resources in local areas are already stretched thin, making it difficult to find professionals who can undertake the development of a new model as an add-on to their current responsibilities.

Summary

The two models discussed provide the seed for system changes to be considered over the next two years as we work to improve the health care system. Many issues remain. All of the elements have been tried in other venues, but not together. (14,15,16) The community model needs to be piloted in a number of communities to provide valuable information about potential options for organizing and re-financing health care.

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About the Rainier Institute

The Rainier Institute is a non-partisan progressive think tank founded by retired Governor Booth Gardner, former Congressman and Washington Department of Transportation Director Sid Morrison and former State Supreme Court Justice Phil Talmadge.

Formed in 2001 out of a desire to respond to Washington State's lack of public policy clarity and leadership, the board includes policy experts and officials from all three branches of state and local government. The Rainier Institute uses a variety of progressive and pragmatic methods to implement meaningful solutions to problems affecting Washington State residents. Current work is focused on public education, health care, tax reform, initiative reform, and children's services.