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A Physicians Council Symposium

Lessons on Reforming Health Care at the State Level: Massachusetts, Minnesota, and Washington State

By Charles Baker, Ken Heithoff, M.D., and Phil Dyer

The Heritage Foundation

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Lessons on Reforming Health Care At the State Level: Massachusetts, Minnesota, And Washington State

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Lessons on Reforming Health Care At the State Level: Massachusetts, Minnesota, And Washington State

DR. ROBERT E. MOFFIT, Deputy Director of Domestic Policy Studies, The Heritage Foundation: With last year's collapse of President Clinton's huge health plan, we have seen throughout the country a growth in policy experimentation at the state level. But the striking feature about most of these state-based reforms is that, in many instances—such as Washington, Tennessee, Minnesota, and Kentucky—the health care reform proposals resemble, in crucial respects, the discredited Clinton health care plan.

Like the Clinton plan, these systems concentrate key decisionmaking power in the hands of government officials. The health care system is to be governed by a central board or commission that issues rules and regulations and guidelines for the system. Almost all of them have a comprehensive, government-standardized benefits package specifying in some detail the treatments or procedures that must be available to citizens. Most establish government-sponsored health care cooperatives, or regional alliances at the state levels, or managed care networks. Most include employer mandates and a system of price controls.

But state reformers have painfully discovered that, in many respects, reform at the state level is subject to the same explosive politics as reform at the national level. The politics of health care reform is like the politics of a Rubik's cube. It is an excruciating exercise in frustration: You fix one thing only to find that you are breaking another.

Talking about reform of health care at the state level, we have three distinguished panelists.

Charles Baker comes to us from the state of Massachusetts. He was appointed Secretary of Administration and Finance by Governor William Weld in November of 1994. Mr. Baker directs the preparation of the Governor's budget proposals in Massachusetts and serves as the Governor's chief advisor on fiscal matters. Prior to assuming that role, he was Undersecretary of Health in the Executive Office of Health and Human Services. As Undersecretary, he managed six health agencies and was responsible for the reform of the hospital finance system.

The second of our panelists is **Dr. Ken Heithoff**. Dr. Heithoff is Chairman of the CDI Management Corporation and Medical Director of the Center for Diagnostic Imaging in Minneapolis, Minnesota, a physician-owned company. He is a member of the Hammond County Medical Society, the Minnesota Medical Association, and the American College of Radiology. Very active in market-based health care reform in Minnesota, he served as an advisor to Congressman Jim Ramstad and Senator Rod Grams, the new Senator for Minnesota. Dr. Heithoff is the Chairman of the Minnesota Independent Republican Health Care Task Force, which has been meeting regularly since April of 1994.

Phil Dyer is the state representative of the fifth district in Washington State. Representative Dyer serves on the Health Care Committee of the Washington State House. He has a B.S. from Oregon State University. He also is a graduate of the Army Corps of Engineers, serving as a member of the Command General Staff College. Representative Dyer received a public service award from the National Federation of Independent Business. He was the leading opponent of Washington State's Clinton-style health care plan.

MASSACHUSETTS

CHARLES BAKER: The most important thing about state-level health care reform is to remember the old Clint Eastwood saying about knowing your limitations. I agree with The Heritage Foundation and with Dr. Kevin Vigilante and others that the major genetic error in the current structure of the existing health care system is the federal tax code. And because that's the major, fundamental structural problem, it has created a corporate relationship between health plans and provider systems as opposed to an individual relationship between patients and doctors.

Therefore, I was never that interested, at the state level, in pursuing anything as broad and as comprehensive as Minnesota Care, or Tenn Care, or Washington State Care, or whatever else you call them. But we did have some things to deal with when Governor Weld took office in 1991. Our Medicaid program had been growing 22 percent a year for the previous three or four years and was basically "PacMan-ing" its way through the rest of the state budget. At the same time, you had an angry beneficiary community, an angry provider community, an angry physician community—everybody was angry, but the thing was hemorrhaging money at the same time.

We also had probably the most regulated hospital finance system in the United States, second only to perhaps Maryland or New York. Hospital prices were still growing 10 and 11 percent a year. Health care costs generally were growing about 16 percent a year.

The standard response from a lot of the folks in the political establishment was, "Well, obviously the regulatory model isn't being implemented hard enough." This was directly opposed to my point of view, which was that the state's regulatory model was creating the perverse incentives that were driving the rate of spending and making everybody so cranky about what they were getting on the service delivery end at the same time.

Deregulation. So we pursued a fairly aggressive strategy on two fronts. The first was to disencumber the provider system from the existing regulatory mass. We managed to pass legislation that was signed by the Governor in the fall of 1991 that basically deregulated, on January 1, 1992, the entire hospital financing system. Among the naysayers, the sense at the time was that this was going to ruin the tight rules that had done such a good job of controlling spending in Massachusetts.

The good news is that health care spending in Massachusetts in fiscal 1994, the last year for which we have final year data, was actually up a little less than two or three percent, and hospital spending was actually down a little bit. And the hospital industry overall was in pretty good financial shape. This was the exact opposite of what the liberals had said was going to occur. Instead, we took the lid off on the pricing, and a very funny thing happened: The market worked. This, of course, didn't come as a big surprise to me, but I think it came as a big surprise to lots of other people.

Medicaid. The second was to improve Medicaid. We started with two assumptions. First, that markets were good. Second, that doctors were good. A big part of the political problem that we had in Massachusetts was that nobody trusted anybody. In 1988, the head of the Massachusetts Medical Society went to the national annual meeting of the AMA and referred to Massachusetts as the Beirut of medicine. Early on, I made it a point to make sure that we had doctors involved in practically all of our major health care initiatives—and I mean practicing doctors, not unpracticing doctors—because I believed that they would have a lot of very positive and useful and helpful insights into how you could go about doing something to fix a very broken Medicaid program.

We ended up implementing what I think remains today the largest and perhaps the only statewide managed care initiative for Medicaid recipients in the United States. It's got almost 650,000 folks enrolled, and it's really two programs. We have a traditional HMO program, but that only serves about 100,000 folks. That is the straight plan—a capitated payment arrangement. But the vast majority of the recipients that we serve are served through a primary care program managed by about 3,000 doctors.

One of the things we decided not to do was to compel physicians to participate in this program. Rather, we proposed to raise their fee structure, believing that if we raised their fee structure, they would be more likely to serve Medicaid recipients. We thought one of the problems we had with the old system was that its fee structure was so bad, and its rules were so bad, that a lot of folks who otherwise would have been served by doctors were going to hospitals. This was the most expensive and, in many cases, the most inappropriate place for them to get served.

The other thing we learned was that, despite the statewide availability of plenty of good physicians, we had unbelievably high utilization of the Boston teaching hospitals as a source for primary care—totally disproportionate to the population it represented—for our Medicaid population. So we got very aggressive about working with the medical societies and some of the other major physician groups to try to create a new relationship between the physician community and the Medicaid program.

One objective was to get care out of Boston and to hospitals in other parts of the state, and to try to develop real relationships out in the hinterlands to serve this population. As a result, there has been a dramatic decline in the use of teaching hospitals as sources of primary care for Medicaid beneficiaries. As you might suspect, this has been good for patient care, good for local physician-patient relationships, and good for us. We saved a lot of money by giving people a local and more appropriate source for primary and preventive and specialty health care.

The other interesting thing that we did—based on advice we got from people on the plan side and from the physician community—was hire an independent company to help us help Medicaid beneficiaries make decisions about who they wanted to have do their primary care for them, and to help solve what I would refer to as the doctor/program conflict.

There was never anybody they could call, except some 1-800 number in Boston, to get an answer about some problem they were having with the Medicaid program. So one of the things we did was contract with a private entity to set up a field-based intermediary that could help solve, at the local level, physician problems and recipient problems with the Medicaid program. As a result, I think we were able to level the playing field and take some of the marketing and enrollment techniques that have dominated a lot of the public payer programs on the plan side out of the loop, and we created a truly level playing field. We also gave physicians a place to go to get their questions answered.

We now have over 3,000 doctors enrolled in the primary care program. For the most part, we survey them, and we have a standing advisory committee that works on particular issues. It has been very successful. For example, we discovered we had a big problem with hospitalization for pediatric asthma—just off-the-chart numbers. It didn't make any sense. The standard way to deal with that would be to assume that it's bad medicine and that somehow it's the doctors' fault.

What we did instead was ask our advisory group to start talking to some of the doctors who dealt with significant numbers of Medicaid patients to find out why this was happening. We learned three things. Most physicians didn't know that nebulizers were covered under the Medicaid program. The two primary drugs that you would prescribe to serve kids who had

asthma problems were on a prior approval list that was a colossal pain in the neck for a physician to get approved, and, as a result, they weren't prescribing them. And we found we had done a lousy job of helping the physician community understand what kinds of services and medications were covered under the Medicaid program.

So, again, working with some of the professional societies, we went through a major education campaign. We took all of the asthma drugs off the prior approval list, made sure people knew that nebulizers were indeed part of the program, and used the medical society as our primary outlet for information. Information from those of us in the government always ends up reading like bureaucratic prose, whereas if it comes from medical groups, it can be translated into a language that doctors participating in the program understand.

The end result has been a gradual decline in pediatric asthma admissions, which—as the father of a four-year-old who has asthma and spends a lot of time with that kid on the nebulizer—is a big win. It's a big win for physicians who want to do the right thing on behalf of their patients, it's a big win for the state in terms of cost-effective service delivery, and it's a big win for families who don't like to have to sleep on the chair next to the hospital bed for two or three nights while their kid's sitting there breathing so hard that every fiber of his being is concentrating on just making sure he gets his next puff of air.

Treating AIDS. The other thing we've done that has been kind of interesting in this area is take some of our most difficult populations—end stage AIDS sufferers, for example—and ask physician groups if they would be willing to capitate to serve these populations. The argument is simple: Medicaid is a very narrowly defined program under federal rules, and there are many things you can do for AIDS patients that make a very big difference in terms of dignity, quality of life, and cost effectiveness that aren't covered under the existing fee-for-service program.

So, we said to some of the group practices that dealt with a lot of HIV patients, "Look, we'll capitate you, and we'll establish some risk relationships so you're not wildly exposed out there, and we'll try to sell it to the federal government. The idea here will be that you'll be able to spend your capitation on whatever you think the patient needs, which in many cases is not traditional but is appropriate for somebody in those circumstances, both from a cost-effectiveness point of view and a quality of life point of view. We think this will be good for you. It will get us out of your hair on prior approval, we will refrain from looking over your shoulder, and you'll have a lot more flexibility about how you treat them. It will be good for us because it will give you an opportunity to expand your horizon in terms of how you take care of them, and if we can do it at a rate that looks as good, or better, than our fee-for-service average participant, then we win, too."

But, of course, we had to run it by Washington. It took us a year and a half to get the federal government to agree to let us do this, despite the fact that they were going to save money on their Medicaid program, because they paid for 50 percent of it. But the results have been astounding. Hospitalization, for example, for these folks has been driven practically to zero, and doctors have been using all kinds of interventions and service delivery techniques that are very nontraditional to improve the way they take care of these patients. It also has moved the knowledge base a light year as a result.

What was required to make this work was a lot more flexibility on our part about how the physician treated the patient. People say, "Well, you can't make capitation work because the population is too sick," but people say this about the Medicare population, the over-65s. The best capitated program we've put in place is taking care of the end stage AIDs patient. You can't get much sicker than that population, and it has turned out to be, in many ways, a big improvement over what we did previously.

And, you know, our Medicaid growth rate this year is less than 2 percent. Our case load adjusted growth rate has seen negative numbers for three years now. We have a provider community that's a lot happier with what we are doing now than they were with the system before. The client community also is a lot happier. But most of it is really a function of giving people, at the level where the decisions needed to be made, more authority to make decisions and turning some of the incentives around. I believe you can do the same thing with Medicare.

Implications for Medicare. When people say the way to fix Medicare is to cut the fees, they are missing the point. The way to fix Medicare is to create a system with the right set of incentives for both the provider and the patient to do the right thing. More often than not, doing the right thing is the cheapest and most cost-effective way to solve a problem. It also assures the highest quality.

I really hope this Medicare debate does not become fear mongering and scare tactics, because there is a much larger issue at stake here. The physician-patient relationship is part of it, but more importantly, at least from my point of view as a dad, we have to balance the federal budget for our children and we have to do it soon. Otherwise we are just ruining the lives of our children and our grandchildren and setting up an impossible dynamic for them. It will be impossible for them to grow and be successful in this country while carrying this huge debt and its growing interest payments.

Federal Deficits. The final point I'd like to make is also the most important: Medicare has to be part of the discussion about the federal budget deficit, as does Medicaid. You simply can't balance the federal budget unless you take an honest look at these two programs. As a real deficit hawk, whose four-year-old and one-year-old sons are already inheriting four-and-a-half trillion dollars worth of federal debt, I'm ashamed that we have let this happen. I've been saying this to all the folks that come see me as the chief financial person in the state and whine about this cut and that cut. I don't care whose ox gets gored here. I want to see a federal budget that is balanced at some point in the next ten years, because I'm jeopardizing the lives and well-being of my children by not being willing to bite the bullet on this one.

The important role that you and Heritage and others can play in this discussion is to drive home the core message that balancing the federal budget is something this country has to do. And you can't do it by raising taxes. Why? Because it's a spending problem. It's not a revenue problem.

MINNESOTA

DR. KEN HEITHOFF: I happen to agree with Bob Moffit's statement that you can't really achieve much fundamental reform at the state level, and that's the quandary. Representative Dyer has been there, and he's back from the trip. And in Minnesota, we're pretty much back.

We had a Clinton-style plan, just as Washington State did. Let me describe for you the chronology of Minnesota Care and how it evolved. When Surgeon General Everett Koop was there in 1992, he looked at Minnesota's health care system, which had been rated as one or two in the country in terms of quality. He said, "This system doesn't seem to be broken. Why fix it?"

It was a political and economic phenomenon. We had a recession. There were a lot of white collar workers out of jobs, and the first thing that they were going to lose, because we had an employer-based system, was their health care benefits. Liberal politicians came back from their little political sojourn into the rural countryside in Minnesota and decided that they needed to fix the state's health care system.

They had some very capable help. Although Representative Dyer in Washington and I have been there and are on our way back, some of you are going to begin this journey. The template for the Clinton-style state-based reform is going to be the same. Whether it's Minnesota or Washington or Tennessee or Kentucky, they will all look the same. They all have the same structure, and they all follow the same political agenda.

Nevertheless, after two years of this in Minnesota, I don't think there are any bad people. As physicians we need to stop feeling sorry for ourselves; nobody else is going to. Regardless of the reality, we are seen as a privileged, wealthy class. That's not the reality for a lot of our primary care practitioners, but nobody is going to listen to you.

I used to sit and carp about this in the doctors' lounge. I used to be very angry about it. I'm not angry any more. The reason: A lot of our state-based reformers simply have a different philosophy. It's not about health care. There isn't a damned thing that you can do, sitting in your office, to practice better medicine that will change how this thing turns out.

First of all, physicians have to understand that it's about economics, and it's about power. We have been villainized by the media and by the politicians during the past two or three or four years for a very specific purpose. It is not because they think we're bad people, but they have to break the bond of trust between physicians and their patients in order to have the kind of government disruption of the medical delivery service that they have been attempting. So forget all of the things that you hear and read in the papers. Maybe stop reading the papers for a while. Have faith in free-market principles, because they're extremely powerful and they do work.

I am convinced that we are at the low point. Five years from now, we will have a hard time recognizing the kind of fear and trepidation that we have experienced in recent years. The classic managed care and HMO philosophies will become passé because personally managed care—I think Speaker Newt Gingrich coined that term—is a much more powerful concept than managed care. "Managed care" is a misnomer. It should be called "restrictive care."

In Minnesota, we started, I think, between 1985 and 1987. Some of our legislators teamed up with the Children's Defense Fund. The debate always starts with access, because you can't really get people too excited about cost, at least at first. But the debate quickly shifts to costs. Quite frankly, this is the fruit of a dysfunctional third-party employer-based system of finance which has become unaffordable for employers.

The Role of Business. I don't happen to share the view that the employers are necessarily physicians' enemies. They now understand that they are going to be taken care of by the same system. CEOs in our state have come face to face with the Minnesota health care delivery system. The legislation collapsed the insurance market into three oligopolies, where 80 percent of our insurance products are delivered by three highly integrated, vertically integrated systems. The Business Health Care Action Group was instrumental in proposing that health care be delivered in that way. But after playing with the "reformers" for two years, they got very frightened by what happened. Why? Because under Minnesota Care, fee for service would be destroyed, but it would be replaced by a tightly managed care delivery system. Care would be delivered through integrated service networks, and those integrated service networks, by definition, included physicians, hospitals, and an insurance company.

There were only a few people that could play in such a marketplace, and it was, in fact, promoted by this Business Health Care Action Group. They put out a request for proposal which could only be answered by such a very, very strongly integrated service network. But after two years of working with that, and seeing the competitive market collapse, they became very frightened. About a month to six weeks ago, they did a 180 degree about-face. They have announced

their intention to contract directly with competing physician groups rather than obtain coverage through health plans. They are all self-insured employers. This is a watershed event, not just for Minnesota, but for the nation as a whole.

The business leaders have gone to the health plans, the health plan not being an arrangement between the physician and the patients, and have said, "You know, we're really sick and tired of paying you guys millions of dollars and having all the recipients [the doctors] be upset about it." Who is upset? The providers, the patients, and even the employers. The people who are buying the plans are not the people who are receiving the care.

So now they are saying, "We want to contract directly with the physician organizations for our health care. We want to put the health plan outside of the physician-patient relationship, not between it." The health plans have become huge oligopolies; we have a $2.2 billion organization which used to be our physicians' health plan—it became United Health Care when the state government declared that physicians couldn't own it. United Health Care now has $2.6 billion of cash. Our Physicians Health Plan, which became Medica, merged with 27 hospitals into a $2.2 billion structure called Allina, and now they're buying out the physicians that started Physicians Health Plan.

We have about five physician-directed organizations in Minnesota, independent physicians who have gathered together as an alternative, to practice and to try to stay independent rather than be enrolled in integrated service networks.

The Political Process. Although they wanted to go to a single-payer system like the Canadian system—the people who began this process were all still single-payer advocates—there were a few people who understood that the single-payer option wasn't politically palatable. They tried it in 1991. It was vetoed by the Republican Governor, Arne Carleson.

Because the Republicans were convinced that the Governor's veto would be overridden and we would have a single-payer system in 1991, the Republicans in the legislature had to sit down with the Democrats and the Governor. We thus had a situation where both political parties and the Governor favored Minnesota Care, even though the people who started that process and who ran Minnesota Care from the beginning were dyed-in-the-wool, absolute advocates of the single-payer system. They pushed Minnesota Care in that direction, using emotional appeals and saying anything but what they were really after. Both political parties in the state went along.

Minnesota Care became a very tightly regulated, centrally controlled, Clinton-type plan instead of the free-market approach it was supposed to be, and which the Governor continued to say it was. It wasn't until 1994, when the Governor and the people in the Republican caucuses began to be very skeptical of where this was going, that the Governor reversed course and wrote an open letter to Minnesotans expressing concern over the direction of Minnesota Care.

Minnesota Care was an incremental bill. It started in 1992, but it wasn't to be fully implemented until 1997. It set up a series of stepping stones along the way. The Governor signed the bill, but in the open letter to the people of Minnesota in 1994, he raised some very significant questions. At the same time, I had been working with Representative Jim Ramstad, and I had also obtained considerable material from The Heritage Foundation, which was really pushing for free-market health reform. Senior Republicans came to me and said, "Put your money where your mouth is. If you really want to pursue a free-market approach, if you want to have something, let's start a health care task force. But it has to be self-funding."

We started with an initial funding of about $18,000 and took a multidisciplinary approach to health care reform. The idea was to educate the legislators because it was appalling to me that after two years of this national and state debate, when you would think that all the legislators would be unequivocally informed about health care, the fact was that most of them were not. Everybody told them that health care was too difficult to understand. For most people, that was a convenient excuse for not putting forth the effort to become informed, and they really didn't understand it.

We held field hearings. We went to regional briefings for all the candidates before the election. We sat down with all the incumbents. We sat down with all of the new prospective candidates. We used Heritage Foundation materials extensively, explaining the relationship between the health insurance markets, tax policies, and the health care "crisis."

Initially, we couldn't talk about Minnesota Care because it was supported by the Republican Party leadership. We started with an anti-single-payer slant, or an anti-Clinton slant. But it was quite interesting that, when we talked specifically about what was bad about the Clinton health care plan, they had been around Minnesota Care long enough to know they were similar in many respects.

We formed a legislative subcommittee which drafted an alternative bill. I would invite you to look into this educational process, because it's wonderful to be inside the process and not a special-interest lobbyist on the outside, not a physician who's complaining about something or looking for something. If you are promoting solid information—which is a good policy for all, not just providers—they come to trust you. The information that you're giving is something that is good for them and that is good for their constituents.

As a result, we drafted a bill, an alternative to Minnesota Care, which was the first time that this had even been contemplated. The Governor did not openly support the process. But then came the 1994 election. We had two of the old guard of the Minnesota Republican Party who decided they would not run for re-election, and it gave us a chance for new blood and new leadership. The end result was that we proposed the bill and crafted a bill with providers, with the physicians and patients, with insurance people, with nurses, chiropractors, and dentists. Everybody got involved.

At the same time, we got involved in politics. We had 3,000 members. We had 800 major contributors, and we raised $86,000. We participated in probably six major campaigns. We worked closely with Rod Grams in his successful Senate bid. I personally wrote a letter to 14,000 health care providers in Minnesota about two weeks before the election, and a lot of those people contributed individually.

In the meantime, our task force crafted a reform bill. Because it had business input, and because it had insurance industry input, as well as provider and consumer input, it was well crafted and economically sound. Even though we were still in the minority in Minnesota, we came within two votes of passage. We weren't as successful as our colleagues in Washington State, but we came within two votes of having our bill supersede Minnesota Care. In the process, because our legislators not only were convinced of the correctness of the free-market approach, but also really understood it, they talked across the aisles with their Democrat colleagues, and we, in fact, had pretty close to a working bipartisan majority.

We got the head of the Senate Finance Committee—a Democrat and probably the most respected legislator on both sides of the aisle—to cosponsor our health reform bill. And because our legislators understood the issues, and they were passionate about free-market health care reform, we amended the Minnesota Care bill that came out of committee. We slowed and, in some cases, repealed some of the more onerous parts of Minnesota Care.

In the 1994 election, 13 seats were added to the conservative Republican side. Conservatives won all five special elections. The Governor is going to be appointing a couple of Democrats to positions in the state bureaucracy. We're going to win those special elections, so I think we're going to have a clear majority or a working conservative majority in our House, and we're very close in the Senate.

It is remarkable what we have accomplished and how much fun it has been, for somebody who was totally out of politics or the policy process before this, to be part of this effort. I had never chaired anything like this before. I tried to shy away from it, but I saw my ideas begin to have effect, and we continued to show gains and gather momentum. It also would not have been possible if we had not been supplied an executive director. The chairman of the Republican Party gave us a remarkable young woman who had worked in Congressman Bob Michel's office. She knew the political arena. She knew who was important at meetings and how to approach them—what we could and could not say. I got the credit for being the chair, but she was responsible for the success that we had in terms of setting up the meetings, the agenda, and providing continuity and vital advice and contacts.

In terms of education, John Liu and Bob Moffit of The Heritage Foundation came out and did a remarkable job for us, along with Molly Bordonaro from the American Legislative Exchange Council. The education of legislators was (and continues to be) the most important function we perform. We are back, and what we did not get this year, we will get next year. We repealed price controls on providers. We put off the mandated universal coverage that was supposed to go into effect in 1997. We put that off indefinitely. We also changed the universal defined benefit plan and repealed the regulated all-payer system. This was supposed to be left for us independent practitioners. It was a highly regulated, impossible situation. Only now are people beginning to admit that it was never intended to be implemented but proposed to frightened independent physicians to persuade them to voluntarily become employees of the large integrated service networks.

We have come back—not as far as Washington State, but we are on our way. What are the lessons? First, you should trust free-market principles. They will work. What has been unleashed in this debate are the free-market ideas: medical savings accounts, personally managed care, voucher systems, and so forth. That is so compelling to me. I have no fear that we independent practitioners will continue to exist and that private medical practice will see a real comeback. But we have to do nationally what we've done in Minnesota: form larger organizations of independent physicians.

We have 1,300 physicians in five physician-directed organizations. I sat on two of their boards, and it was heart-breaking for me to see these proud professionals go hat in hand to the three large health plans, essentially begging for some insurance product that the PDOs—physician directed organizations—could offer through the health plan. I knew it wasn't going to happen because it was not in the interest of the health plans to do so. They don't want us to succeed; they want physicians subjugated to their bureaucracies.

We have been meeting to try to put together a physician-directed organization where all five would come together and offer an insurance product. One of the ideas was that physicians and their families and their employees—all 12,000 of us—would offer a medical savings account (MSA) and demonstrate to the employers in our market that we could, in fact, drive down the cost of medicine by 30 or 40 percent with an open access, consumer-friendly plan—to use our own practices as a beta test site.

We are looking at other options. I don't think we can out-HMO the big corporate players, but if we come to the market with some very creative alternatives, such as MSAs and managed care in its best sense—best practices, best practitioners, and so forth—we can succeed.

Given my recent experience, and the successful momentum generated by a relatively small group of dedicated individuals, I have little sympathy for people in the medical profession who say that they do not have the time and money to become involved in the political process. I've seen the chiropractors do a lot more with a lot less money and a lot more contributions. They were very helpful in getting bipartisan support. They also bought into the idea of medical savings accounts and wrote a letter of support.

We have to educate ourselves. Most physicians haven't heard about The Heritage Foundation. I think that's a problem. They don't understand that health care reform is not about how they practice medicine, but about the perverse incentives of the current financing system; that turning our delivery system upside down can cure the ills if the financial incentives aren't damaged. Thankfully, that is occurring.

The underlying principle and meaning of professionalism is a primary focus on our vocation and disinterest in economic gain. I firmly believe that 98 percent of the professionals that I practice with, and all of you in this room, are interested in taking care of your patients and would just like to get back to doing that. But you can't ignore the economics. Instead of playing golf, we have to do this. If it's another hour, then do it. You all worked 24 hours a day when you were interns. I think you have to go back to that for a short period of time. I don't want to do this for a long time, but I think that for the next year or two it is essential.

WASHINGTON STATE

REPRESENTATIVE PHIL DYER: Dr. Heithoff talked about sacrifice. I don't mean to sound "Woe is me," but I'd like to take you back in history just a little bit. In 1990, in the state of Washington, Governor Gardner, the predecessor to our current Governor Lowry, in his second term convened a broad, bipartisan, cross-cultural, horizontal agglomeration of business, labor, all the players, and called it his Health Care Commission. There were 13 voting members, plus a large number of advisory committees.

I, for 24 years now, have worked in the medical malpractice insurance field, so I come with a little bias in understanding the delivery system and the finance system. I worked for the task force regarding tort reform, which had been a crusade for me for many, many years.

I watched as the 13 Commission members, through 1990, leading up to 1992's election, sat and narrowly voted for provision after provision. You are going to hear some similarities between what Ken talked about in Minnesota and what Washington State adopted, as if the two states were literally lying on top of each other.

For instance, in 1992, the Commission voted, by one vote, to go with the single-payer system. It was an insidious setup for what they called managed competition, the system that was introduced following the 1992 elections in Washington State. The political complexion of the Washington state legislature at that time then became very heavily Democratic, which it had narrowly been for a long time.

I was not an elected official. We had an open district where there was an open seat, a Republican district. And I, a white male Republican, found myself facing a female Democratic opponent. I won, with 50.4 percent of the vote, less than 51 percent.

I went to the legislature as a freshman. I walked into a caucus in the House of Representatives of 98 members, and the ranking minority leader turned to me and said, "We need a chairman for the Health Care Committee. We've got a minor little debate going on on major policy here. Phil, you're it. You're all we've got."

Four days into the legislature, I became the ranking minority member on the Health Care Committee, where I watched the passage of a bill that was constantly being revised, with 202 FAX-headers—the latest wisdom from Washington, D.C.—coming into the Democratic caucus, because in that spring of 1993, the Ira Magaziner task force had been formed and was, in fact, operating.

We ended up with a "managed care only" law that had premium caps, a broad-powered health services commission independent of public accountability, a uniform benefit plan dictated by that commission, and employer mandates. The only difference between the Clinton plan and ours was that Clinton was an 80 percent mandate and we were 50 percent sponsorship. We also had alliances that were unique geographic monopolies, and government-certified health plans—a mimic of what we saw introduced later here in the lesser Washington, as we prefer to call it.

In 1993, the liberal mantra was not dissimilar to our friends at Nike: "Just do it." And in "just doing it," you'll see another similarity. It was later admitted, in reviews with the legislators that passed the law in 1993, that fewer than ten out of 147 legislators had even read the bill. They were caught up in the emotion of the reform rhetoric and compassion for the downtrodden. No understanding of either the current system or the damage they were going to do to that system was evident.

Nor did they understand the dissimilarities between health care financing and health care delivery. They would mix their rhetoric in talking about universality and access as if no one was getting any health care at all. This was in direct contradiction to the 1986 COBRA, which had said to all facilities, "You're going to take somebody in whether they've got a dime to their name or not." No discussion of uncompensated care was contemplated.

The similarities are dramatic. Dr. Heithoff and I had talked briefly, but in listening to his presentation, I could have listened for another hour, because it would have been my speech. It's what happened in Washington State.

I referenced my manic compulsiveness, and I referenced back to his sacrifice. I turned to my wife and said, "Let me remind you of a fellow I worked for out of Texas years ago. He told me as a young insurance salesman following my departure from Washington, D.C., having worked for President Ford and not winning against President Carter, I had to go get a real job. He said, 'When you get out there to sell, don't make your competition angry, because they're going to work real hard to beat you if you do.'"

In 1993, I think the latter occurred, because I left that session, and I said, "This is absurd. This was a fraud on the people of the state of Washington. It has been a fraud on my fellow legislators. And, by God, we're going to turn this thing around."

I was not alone. There was a large employer community that became concerned, particularly the small business community. It was not only the denouement of the Clinton plan, but the denouement of my own business. I had to sell my business. I became preoccupied.

Over a space of 18 months, I did 168 speeches around the state of Washington. I would talk to anybody who would listen to me. It came to the point where I thought I would be wearing a sandwich board walking in downtown Seattle. I felt like Don Quixote. I had one Sancho, then two, then three, then four. And pretty soon, the windmill was no longer ethereal. It be-

came quite real. We started being able to predict, and to see, what the implementation of that law would mean.

Dr. Heithoff referred to Minnesota's as a staged and incremental plan, not unlike the Clinton health care plan. We had the same staging, and, in fact, the time frame is so similar it is scary. Ours was implemented July 1, 1993, with final implementation in 1999. This is the frog and water syndrome. It is easy to take a frog and throw him into boiling water. The frog is not stupid. There's a neurological response: The water is hot, and he jumps out. It's not good for the frog. But put the frog in a pan of tepid water and turn the degrees up incrementally over time, and he will sit there and cook in his own juice.

That was the staging of these Clinton-style health care scenarios in both Washingtons. But it became their downfall. It gave us time to get the word out. As I began to tour the state, my audiences in the fall of 1993 were this Rotary Club of 20 and that Kiwanis of 25. But by the fall of 1994, in September and October, I was not speaking to an audience of less than 500.

Business Interests. The coalitions built by the Association for Washington Business included Boeing, Weyerhauser, and Microsoft—names you all know—along with the National Federation of Independent Business. We soon found that we had strange allies. Organized labor began to come on board, starting with the traditional Republican labor organizations of police and fire fighters and municipal employees. They were affected because they were no longer ERISA-protected. They are never ERISA-protected, and they had given up cash wage benefits to negotiate nontaxable, noncash benefits in health care for the last 20 years.

When we showed them what the uniform benefit plan was going to do to their negotiated plan, and what the community rating on a one-to-one compression—just like New York's great plan—was going to do, that they were going to get less and pay more for it, we soon started picking up Boeing Aerospace 751 machinists' union. And the next thing you know, instead of a 98-member House with 33 Republicans, on the morning of November 9 we had 61 Republicans and 37 Democrats. Even more important, conservatives got control of the process.

Political Change. And I became Chairman of the House Health Care Committee with two years under my belt, and they said, "Watch out. He's got the gavel." Well, "By God," I said, "We're going to do it," and we did it.

We had that bill out of committee in three and a half weeks. It was a 47-page bill; 44 pages were repealers. Three pages included three things. The first was continued expansion of our basic health plan, which is a complement to the Medicaid asset-based program for providing care to the uninsured. We agreed: You have to treat the uninsured. We also had the insurance reforms in there—portability, guaranteed issue, and guaranteed renewability. And then we had MSAs. Beyond that, and the repealers, we had a pretty tight bill.

We passed the bill through the committee and onto the floor of the House. Then we sat there with a slingshot, waiting for the Senate to figure out what they were going to do if we sent it over there. They panicked, because we started reminding them of the players who had supported the 1993 act. I said, "Can you find one who is vocal about the act being good, who is still elected today?"And with half the Senate up next year in 1996, looking around them, realizing they had a one-vote majority where they used to have a seven-vote majority in a 49-member Senate, all of a sudden two of the Democratic Senators came over and supported my bill. That was all it took.

We passed it out of the Senate and on to the desk of the Governor, who for two years, arm and arm with Bill and Hillary, had been touring the nation's capital as a hero of the populace. He was staring us down earlier in the session, saying, "I will veto any changes to my health

care act." He now was saying, "Because of the failure of Congress to give me an ERISA waiver, I can't have my plan, so I have to make it workable by making this change." An interesting reversal of theme.

On April 23 of this year, Governor Lowery signed my bill. It was April 22 of 1993 that the original bill passed. I missed it by 24 hours: two years to the day.

What's next? We have essentially a level playing field and an opportunity for enfranchisement, to bring the public back to the table. They have had an education. The federal health policy debates were essential to our success in Washington State because they educated the rank and file through the media. All we had to do during the course of the debate was say, "They are, in fact, alike. The principles are the same."

So what am I saying to doctors? Listening to this morning's discussion, I'm noticing that your themes here at The Heritage Foundation are not dissimilar to the themes I see in Washington State.

Your traditional organized medicine is not always your friend. The Washington State Medical Association supported the Washington State health care plan. They had a distinct change in their Board of Trustees and their executive management. Politically, family practice physicians and specialists were engaged in civil warfare. For years, there had been a balance between primary care and specialty care, but in recent years there was no longer a balance; primary care had taken over organized medicine, and they were going to stick it to the specialists.

And they were going to support this Clinton-style plan because it put them in charge, not realizing that we never changed the litigation playing field in the courtroom and that the four-week rotation in orthopedics for the primary care doctor is going to be adjudged in a malpractice action by the standard set by a board-certified orthopod. They are now beginning to wake up and realize that. Be careful what you wish for.

I also found that organizations like the Association of American Physicians and Surgeons, which had 38 members in Washington State, has now over a thousand in the space of 16 months. Doctors were bailing out of the state medical association right and left. Traditional medical organizations had been critics of mine for two years but are now giving me every opportunity to speak.

The animosity between providers and financiers as a result of profits and intrusions in clinical standards, and between financiers and providers on utilization controls, employers and financiers on premium costs, and employers and financiers or employees and financiers regarding deductibles and copays, are only a hint of the battles to come.

To providers, if you are ahead of the curve, my advice would be to get close to the employer community. Managed care organizations don't pay for health care. Employers, 87 percent of them, are the source of the funds. Politically, you have to build a relationship to the employer, not to the managed care organization.

In terms of your everyday practice, the challenges yet to come are managed care contract provisions that intrude upon your ethics and clinical sovereignty. Most of you have signed, I'll bet, a managed care contract that says you cannot criticize the plan to your patient. That is an absolute violation of your own ethics.

Because you can't write contract standards, how can you get around ERISA and get to those self-funded plans and not let them have those contracts? I just gave you the clue. I'll have a bill in January that does it using your own licensing boards. It will enable you to make it illegal for yourself, under your license, to sign a contract with those provisions that's not ERISA-protected for those plans, and no plan can operate without a provider.

Antitrust has yet to come under safe harbor. It doesn't have the right tolerances, and scoped utilization review is my next hope in Washington State, where we don't—and my apologies, because I made the analogy to Texas—but we don't have an RN in Lubbock, Texas, telling a radiologist in Seattle what the standard of care is, and how that patient is going to be treated. I want to see utilization review that matches the scope of practice. But it can be superior to subordinate, not subordinate to superior, in the rank of scope and training.

So there's more to come. All we did was take the Nike theme of "Do it,"and just undo it. And now we're back to a level playing field, but we have a lot of work to do.