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THE RISE AND REPEAL OF THE WASHINGTON STATE HEALTH PLAN: LESSONS FOR AMERICA'S STATE LEGISLATORS

INTRODUCTION

Taxpayers in Washington State are among the first Americans to be enrolled forcibly in—and then to escape from—a Clinton-style health care plan. At the height of the Clinton Administration's health care reform fever in 1993, Washington's legislators passed their own state-level plan: the Washington Health Services Act of 1993. This plan not only was a carbon copy of the Clinton health plan, but also was influenced heavily by Clinton Administration officials who praised Washington State as a test case of their comprehensive proposals. First Lady Hillary Rodham Clinton confirmed that the "features of the Washington plan will still be the features of any plan that comes out of Congress...."[1] For his part, Washington Governor Mike Lowry said he was "pleased that President Clinton's reform proposals so closely resemble Washington State's new law."[2]

The Washington State plan[3] included all of the original Clinton plan's key elements, including:

- A powerful new bureaucracy;
- Higher taxes;
- More regulation;
- Employer and individual mandates;

1 Carol M. Ostrom, "Facts in Hand, Mrs. Clinton Sees No Reason to Alter State's Plan," *Seattle Post-Intelligencer*, July 24, 1994, p. A10.

2 Governor Mike Lowry, statement, September 22, 1993.

3 Washington Health Services Act of 1993, Engrossed Second Substitute Senate Bill 5304, Chapter 492, Laws of 1993; hereafter cited as ESSSB 5304, the Washington State plan, or the Washington plan.

- A government-defined health insurance package that everyone was required to buy;
- Mandatory managed care;
- Arbitrary government caps on insurance premiums and revenues available for health care; and
- Government-controlled health care purchasing cooperatives.

In short, the Washington State plan established thorough government control over the state's health care, with a concomitant massive loss of individual choice and control over health care decisions.

Health care reformers in other states should realize that implementation of such provisions will cause health care rationing, sharply reducing both the access to care and the quality of care. Such rationing would deprive working Americans of the world's most advanced and highest quality care.[4] The Washington State plan, like the Clinton plan, seriously restricted individual freedom of choice in health coverage and care. It also sharply increased costs, with the burden borne ultimately by working people through higher premiums, lower wages, and lost jobs. The results of this test case are in: The Washington State plan proved unworkable.

The attempt to implement the Washington State plan produced a citizens' revolt and led to a Republican takeover of the legislature—which the Democrats had controlled by a comfortable margin—just 18 months after it was enacted. The new legislature repealed the reform package, forcing a liberal Democrat governor to approve the repeal under the threat of a public vote. The lessons learned from the Washington State experiment are important for legislators in other states contemplating the problem of how to provide health care for everyone while controlling costs.

THE GENESIS OF THE WASHINGTON STATE HEALTH PLAN

Health care reform in Washington State began with a common political ploy. In 1990, state officials appointed a special commission to study the state's health care problems and propose reforms. Those appointed to the commission included (1) advocates of government-controlled health care; (2) high-profile leaders from business, finance, and other fields who were not notably knowledgeable about health care policy; (3) representatives of special-interest groups for whom government control of health policy would mean more direct control over the system or more business; and (4) a minority of likely dissenters from the political right, insurance companies, and the medical profession—enough to give the commission greater credibility but not enough to make a difference in its policy recommendations. The early process was sponsored by grants from the Robert Wood Johnson Foundation and the Henry J. Kaiser Family Foundation.[5] The Johnson Foundation has tended historically to promote managed care insurance regimes and greater government regulation of health care.

4 Edmund F. Haislmaier, "Why America's Health Care System Is in Trouble," in Stuart M. Butler and Edmund F. Haislmaier, eds., *A National Health System for America*, revised edition (Washington, D.C.: The Heritage Foundation, 1989), p. 2. See also John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington D.C.: Cato Institute, 1992).

The commission's report, issued on November 30, 1992, included broad emotional rhetoric about everyone's "right" to health care, universal coverage, guaranteed health care, and low-cost coverage and care. It substantively endorsed the basic features of what later became Washington State law.

With a new liberal governor and a legislature controlled overwhelmingly by liberal Democrats, the legislative process began in earnest in January 1993. Officials of the newly elected Clinton Administration, proposing their own broad national health plan, began weighing in heavily, but for the most part remained behind the scenes in the state's process. Faxes from Hillary Clinton's Health Care Task Force to Washington State legislators provided an outline for a state legislative proposal quite similar to what eventually became President Clinton's huge federal proposal.[6] As the legislative process continued, Washington State Representative Phil Dyer reported:

> Four days into this legislative session, 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 [area code] 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.[7]

With a solidly liberal legislature and governor, the Washington State plan[8] was passed in May 1993 by a lopsided vote, mostly along partisan lines. The rapidly growing opposition, however, had laid the groundwork for a reversal of the process.[9]

MECHANICS OF A NEW BUREAUCRATIC SYSTEM

Much like the Clinton plan on which it was modeled, the Washington State plan contained several key mechanisms to create and enforce central political control over the financing and delivery of health care services:

1. **A new bureaucracy.** The Washington Health Services Act of 1993 established the Washington Health Services Commission with five full-time members appointed by the governor.[10] The commission, with a staff of new bureaucrats and a multimillion-

5 The Robert Wood Johnson Foundation assisted the Governor's Office of Financial Management with several reports, such as 1994 estimates of the uninsured in Washington State. The foundation continues to support studies in Washington State, according to a July 16, 1996, letter from Bernie Dochnahl, chairwoman of the Washington State Health Care Policy Board. Grant support from the Henry J. Kaiser Family Foundation is acknowledged in Washington Health Care Commission, *Final Report to Governor Booth Gardner and the Washington State Legislature*, November 30, 1992, p. 4.

6 For an excellent discussion of the key components of the Clinton health plan, see Robert E. Moffit, "A Guide to the Clinton Plan," Heritage Foundation *Talking Points*, November 23, 1993.

7 Representative Phil Dyer, "Lessons on Reforming Health Care at the State Level: Massachusetts, Minnesota, and Washington State," Heritage Foundation *Lecture* No. 548, Physicians Council Symposium, June 13, 1995.

8 ESSSB 5304.

9 Robin Bernhoft, "Why the Worst MSA Is Smarter Than the Best Bureaucrat," Evergreen Freedom Foundation, January 5, 1994. The Evergreen Freedom Foundation's Operation Patient Power produced a series of single-page fact sheets about health care myths, such as "Myth #5: Washington State Can Control Health Costs" and "Myth #9: Patients Don't Care About Choice," and a half-hour video entitled "It's Your Healthcare...But Who Calls the Shots?" Operation Patient Power also held a series of town hall meetings and published numerous opinion articles around the state. See also Michael Schlitt, "What You May Not Have Known About the New Health Care Law," Washington Institute for Policy Studies, Seattle, Washington, December 1994.

dollar administrative budget, was given thorough regulatory control over the state's health care. All told, the legislation created 9 new bureaucracies, provided for considerable expansion of at least 4 other state agencies, and mandated 17 additional government reports.

2. **A uniform insurance benefits package.** The Washington State plan, like the proposed Clinton plan, allowed the government to establish the health insurance coverage that everyone must buy. Specifically, it mandated a uniform benefits package that outlined both minimum benefits and the coverage that must be provided by every insurance policy in the state.[11] In addition to basic standard medical services, the package required coverage for drug and alcohol rehabilitation, reproductive services (such as abortion), prescription drugs, dental care for children, mental health services, and other potentially costly services.[12]

3. **Mandatory purchase of the government's health benefits package.** The plan was designed to cover almost everyone in the state. Once several federal laws, such as the Employee Retirement Income Security Act (ERISA), were changed, everyone except those covered by Medicare and Medicaid would be required to purchase insurance with the uniform benefits package. Employers were required to pay 50 percent of the lowest-cost health plan in their area, and workers would have to pay the remaining cost of the plan they selected. The self-employed and those without an employer would have to pay the entire cost themselves. Thus, the plan included both employer and individual mandates.[13]

4. **Mandatory managed care.** Employers and individuals could buy mandatory insurance only from insurers who fulfilled the requirements of the new law and who had been approved by the state as certified health plans (CHPs). Moreover, insurers would have to provide coverage through a "managed care" system. These systems included health maintenance organizations (HMOs) in which the insurer/HMO owns and operates the health care facilities and the doctors are its employees, as well as insurers with defined networks of affiliated doctors, hospitals, and other providers.[14] Services provided and fees received by these networks were controlled by the insurer. Even supplemental health benefits and services beyond those in the mandated state-specified uniform health policy were to be purchased from CHPs and provided through managed care systems.[15] The Washington Health Services Commission would study the feasibility of medical savings accounts (MSAs) for government employees.[16]

As a result of these mandates, state government was telling people not only what insurance they had to buy, but also from whom they must buy it. Moreover, Washingtonians would be required to purchase insurance only from highly restrictive managed care systems in which the insurer held ultimate control over the health care people received.

10 ESSSB 5304, Section 403.
11 ESSSB 5304, Sections 402, 406, 427.
12 ESSSB 5304, Section 449.
13 ESSSB 5304, Sections 463, 464.
14 ESSSB 5304, Sections 402, 433–443.
15 ESSSB 5304, Section 428.
16 ESSSB 5304, Section 484.

The insurer's overt control over the services and resources that doctors can provide or order for patients is central to all such managed care systems. Control by powerful insurance companies was greatly exacerbated under the Washington State reform, which provided the managed care insurers with much greater market power because of the small number and necessarily huge size of such plans. Competition from more traditional plans offering an open choice of doctors and services would be eliminated by law, so consumers would be able to choose only from managed care plans. Moreover, as the major managed care plans signed up the available doctors and facilities, there would be less and less room for additional competitors. As a result, faced with a government-imposed cartel of managed care networks following the same policies, consumers who were dissatisfied with the quality or availability of care would have nowhere else to turn.

These managed care networks would be compelled to use their power in order to ration health care to fit the state-imposed premium caps and certain additional restrictions. The law created a multilevel structure. A politically appointed Health Care Commission would rule over every activity of the giant corporate entities that were both empowered and required to carry out the politicians' rationing scheme. Thus, politicians who appointed the commission also could hide behind it. Such "insulation by delegation" is a common defensive tactic used by politicians seeking to avoid having to make tough decisions or assume direct responsibility for their actions, especially in Washington, D.C. A government commission, its health care experts, or the managed care networks could be blamed for the inevitable consequences of centralized control. This device allowed some proponents of managed care to praise competition among the several remaining insurance companies while at the same time backing "reforms" that severely limited competition by restricting the available market to three or four huge, politically favored companies.[17]

5. **Premium caps.** The Washington plan imposed a limit on the premiums that could be charged by insurers for the mandatory uniform health insurance policy.[18] This premium cap would be allowed to grow no faster than the average rate of increase in personal income in the state—regardless of patient needs, advances in medical technology, or the rate of increase in health costs. Doctors and hospitals were prohibited from negotiating any additional fees with patients beyond the charges allowed under the mandatory uniform health insurance policy.

These controls would reduce—sharply and arbitrarily, and without regard for patient needs or desires—the resources going into the health care system. As a result, health plans, doctors, and hospitals would be forced to make arbitrary cutbacks in services. The first services to disappear would be those needed for the most sophisticated and expensive care for the most critically ill. Because of their limited resources, doctors and hospitals no longer would be able to acquire and offer the latest medical innovations in a rapid manner. In addition, the Health Care Commission had explicit authority to limit the acquisition and use of medical technology.[19] As a result, patients

17 Washington State Insurance Commissioner Deborah Senn, testimony before Washington House Health Committee, January 10, 1995. See also Deborah Senn, letter to all state legislators, December 1, 1995; Bill Richards, "Health-Care Reform in Washington State Raises Bills and Riles Nearly Everyone," *The Wall Street Journal*, April 5, 1996, p. 1; and Deborah Senn, letter to the editor, *The Wall Street Journal*, May 14, 1996.

18 ESSSB 5304, Sections 406, 407.

would be prevented from buying high-quality services or advanced technology in Washington State. The world's highest-quality, most advanced, and most sophisticated health care ultimately would be inaccessible to the middle-class citizens who currently receive far more of such care than citizens in any other country. Several previous attempts to implement this kind of central control of medical technology, under the rubric of Health Systems Agencies and Certificate of Need, in other states were found to be counterproductive and were repealed.

These arbitrary controls, to the extent that they were enforced by government officials, would establish a Canadian-style system of health care rationing within the U.S. framework.[20] Because such a system is based primarily on government's limiting what health care providers may spend for health care, regardless of patient needs, providers would be forced to decide arbitrarily who would and would not be denied medical care and how and when the quality of medical services would be cut back.

6. **Government-sponsored purchasing cooperatives.** Under the Washington State Plan, employers had three insurance coverage choices to offer their workers:

   - Employers could pick three certified health plans to offer their employees, and each worker could choose from among these plans,[21] one of which had to be the lowest-cost plan in the area. An employer of 7,000 or more workers (which meant primarily the Boeing Aircraft Company) could offer its own plan as one of the alternatives as long as it met the government requirements for a CHP—which, for all practical purposes, meant it had to be a managed care plan.
   - Employers could enroll workers in the state's Basic Health Plan.[22] Under this plan, employees would choose from the CHP managed care systems picked by state officials to service the plan.
   - Employers could enroll their workers in a health insurance purchasing cooperative (HIPC).[23] One HIPC would be established for each of four designated geographic areas in the state, and each HIPC would offer all of the certified health plans in its area to every enrolled worker, who then would have to choose one of these plans.

7. **A government "risk adjustment" mechanism.** Despite the intent of Washington's state legislators to "improve the public's health,"[24] the managed care systems would have no economic incentive to provide the best care to the sickest patients. On the contrary, they would have every incentive to provide the minimum care possible to such patients. This is because managed care networks would receive the same limited, annual premium amount mandated by state officials no matter what quality of care they provided; in spite of incurring far higher costs to treat the sickest patients with the best care, they would be paid as though they had provided minimum care. Consequently, not only would networks incur huge losses treating such patients, but the

19 ESSSB 5304, Section 406.
20 Michael Walker, "A Tale of Two Two Tiers," *Fraser Forum*, January 1995, pp. 37–38. See also Jerome C. Arnett, Jr., "Ontario's Health Care: A Pox on Doctors and Patients," *The Wall Street Journal*, July 12, 1996.
21 ESSSB 5304, Section 464.
22 ESSSB 5304, Section 212.
23 ESSSB 5304, Section 425.
24 ESSSB 5304, Section 102.

better the care they provided, the more they would attract such patients, and the more their losses would snowball.

On the other hand, if a managed care network provided the worst care (short of a lawsuit or a large number of complaints to the supervising bureaucrats) to these patients, it would save on the cost of providing good care, and the sickest patients probably would leave for other networks, taking their high costs and losses with them. Moreover, if the network became known for treating the sickest patients poorly, these patients most likely would avoid it. Thus, not investing in the latest technology and medical advances would benefit the network's overall cost maintenance. Consequently, Washington State's "reforms" would turn the health care system on its head: Instead of competing to provide the best care for the sick, the managed care networks would compete to see who could treat the sickest people with the worst care that was politically permissible.

Because of these perverse incentives, the Health Services Commission was required to recommend a risk adjustment plan to the legislature.[25] This adjustment was based on the idea of taking funds from insurers who had signed up more low-cost, healthy individuals and giving the extra money to insurers who had signed up more high-cost, sick individuals as compensation for the higher costs incurred. Insurers with the highest-cost beneficiaries would get the additional funds needed to pay for their care. In effect, government officials would be in the business of supervising significant transfers of cash from one set of big insurance companies to another.

Whatever the theoretical elegance of the argument for a government-sponsored risk adjustment mechanism, it would be unlikely to solve the problem it is designed to solve. Insurers cannot be expected to pay out funds for all of the latest and best technology to care for the sickest patients in the hope that the Washington Health Services Commission, politicians in the state legislature, and the subsequent risk-adjustment bureaucrats will intervene and bail them out. This is especially true considering the certainty that other insurers, their political allies, and their patients would use their political clout to minimize the amounts extracted from their own plans and redistributed to high-spending plans. Government bureaucrats trying to keep within overall cost targets probably would not fully reimburse the high-spending networks. Consequently, insurers would avoid accepting the highest-cost patients and would turn to the possible risk-adjustment bureaucracy only as a last resort if they lost in the competition to avoid the sickest patients.

8. **Comprehensive insurance regulation.** Under the original language of the Washington State plan, every insurer offering coverage in the state would be subject to the following regulatory requirements:[26]

   - **Guaranteed issue:** Every insurer would have to maintain "open enrollment" and accept anyone in the state who applied;
   - **Limitation on pre-existing conditions:** Insurers could not exclude coverage for pre-existing conditions for anyone who applied for coverage unless the applicant did not have previous coverage, in which case coverage could be

25 ESSSB 5304, Sections 406.
26 ESSSB 5304, Section 428.

excluded for a maximum of three months;

- **Guaranteed renewability:** Insurers would not be permitted to cancel or refuse to renew policies, or to raise rates on policies, held by patients who became sick after purchasing an insurer's coverage; and
- **Community rating:** Insurers would have to charge everyone the same uniform fee regardless of age or health condition.

9. **Low-income subsidies.** The Basic Health Plan was used to provide additional taxpayer subsidies to low-income workers and individuals for the purchase of health insurance.[27] Individuals with incomes up to 125 percent of the poverty level would pay only $10 per month for coverage from managed care insurers picked by the state to service the plan. This new taxpayer subsidy would be phased out for incomes between 125 percent to 200 percent of the poverty level.

10. **New taxes.** In addition to the shunting of Medicaid dollars to the state treasury, officials estimated that state taxes would have to be increased by $2 billion over six years to pay for these reforms. The plan specifically imposed a new 2 percent tax on the gross premiums of certified health plan insurers, a new 1.5 percent tax on the gross incomes of hospitals, and increased taxes on the sale of beer, liquor, cigarettes, and other goods.[28] Additional taxes would become necessary later.

11. **A data collection system for central control.** The plan included a requirement that health conditions, treatments, and outcomes of patients be reported to a computerized statewide health data system that supposedly would be used to monitor the reforms and regulatory controls for the system.[29]

12. **Rationing of technology and training.** To control costs, the Health Services Commission would have the authority to dictate what medical technologies could be used, and when. The state government also could ration access to medical school and specialty training according to racial quotas and other state-imposed criteria, and could allocate medical personnel in accordance with the state's racial and other preferences.[30]

THE POLITICIANS' NIGHTMARE: RISING COSTS AND FEWER CHOICES

Over time, several key problems in Washington State's proposed system of centralized planning in the financing and delivery of health care became apparent.

1. **Self-insured companies could escape government control.** A key problem was that self-insured employers were exempt from state regulations under the federal Employee Retirement Income Security Act of 1974. About 36 percent of the state's residents outside Medicare and Medicaid worked for self-insured employers who provide health coverage for their workers by paying health bills directly.[31] These employers and their workers could not be forced to buy the state's uniform benefits

27 ESSSB 5304, Sections 208, 209.
28 ESSSB 5304, Sections 301, 304, 307, 309–312.
29 ESSSB 5304, Sections 259–263.
30 ESSSB 5304, Sections 270–274, 279.

package; were not required to buy their insurance from managed care companies; were not subject to premium or expenditure caps, risk-adjustment redistribution, or any of the other regulatory requirements outlined in the complex and cumbersome plan; and would be exempt from state premium taxes. In addition, other employers could self-insure in the future. There is no minimum number of employees for a self-insured business.

The reform plan therefore included a request that the U.S. Congress waive the ERISA exemption in Washington State.[32] Under the federal ERISA law, private companies may self-insure and, in the process, escape state-mandated health benefits and premium taxes. Washington's state legislators also requested that the federal government make available the Medicare and Medicaid funds that would have been spent in the state so that they could use the money to fund the new reform system, including the care covered by those programs. The state then would enjoy absolute control over its health system, both under the law and because of its financial power. Congress, however, took no action on these requests.

2. **Health care would be rationed.** Washington State's health care reform was based implicitly on a system of government health care rationing to control costs, but it ultimately would deny health care to, and critically reduce the quality of care for, many residents, particularly the broad middle class. This rationing was inherent in several components of the state's plan.

   Under the Washington State plan, insurance companies would tell patients which care they may or may not have, and the government would impose arbitrary caps on premiums and revenues for the health care system to limit the range of such decisions. Instead of being led by market incentives to exercise preferences efficiently and weigh the costs and benefits of different medical options, patients would be required to comply with the arbitrary dictates of government bureaucrats or corporate bureaucrats under the direct control of health care bureaucrats. The great irony in this situation is that "reforms" adopted ostensibly to increase access to health care in reality would lead to a sharp decrease in access to top quality care for most people, particularly when they are sick and most in need of specialized medical services. This is true of all centrally controlled health care systems, including the British and Canadian-style systems.[33]

3. **Consumers would be forced to pay for undesired coverage.** The bureaucratic mechanisms of the Washington plan sharply restrict consumer choice and control over personal health coverage and care. Under the terms of the plan, everyone in the state would be forced to buy one standard insurance policy specified by the government. Consumers consequently would be forced to pay for expensive coverage in which they did not believe, which they did not want, or that was not cost-effective for the

31 According to data from the Washington State Governor's Office of Financial Management, 1,440,000 of the state's 5,200,000 citizens were covered by self-insured plans; 600,000 were covered by Medicare; and 650,000 were covered by Medicaid and Medicare disabled. Senn, testimony before House Health Committee, January 10, 1995; transcribed from Commissioner's audio tape record of hearing.

32 ESSSB 5304, Section 474.

33 For an account of the difficulties inherent in the Canadian system, see Edmund F. Haislmaier, "Problems in Paradise: Canadians Complain About Their Health Care System," Heritage Foundation *Backgrounder* No. 883, February 19, 1992.

individual, such as unlimited acupuncture, abortion, drug and alcohol rehabilitation, massage therapy, mental health counseling, prescription drugs, dental care, long-term care, and other services.[34] Up to 25 percent of the uninsured in the United States already lack health insurance because of the extra cost of such state mandates.[35]

As many liberal legislators discovered after touting the 1993 reform package, even though mandated coverage of additional services may appear initially to be politically appealing, the political consequences are infinitely less appealing to the public when the law amounts to a mandated benefits package with elephantiasis. In many cases, consumers may object to paying for mandatory coverage of services they consider loathsome or immoral, such as abortion. In others, they may find the legally required coverage unnecessary and wasteful.

Liberal legislators, of course, realize that one of the ancillary political benefits of a mandatory standardized benefits package is that it taxes ordinary people for public programs they otherwise would not support. This was clearly the case with the Washington State reform plan because people would be forced to pay for free services for everyone else, and it was likely that even more services—most probably the highly politicized social programs—would be added over time.

Health care reformers at both the state and congressional levels also should realize that there is no sound policy reason for requiring everyone to buy one uniform health policy with coverage specified in detail by the government. No valid health policy goal is advanced by forcing consumers to pay for broad categories of nonessential care for which they may well not want to be covered. Just as consumer choice flourishes with cost, quality, convenience, and competition in every other market in which it is allowed, health care costs would be held down more effectively if consumers could choose the coverage they preferred. Indeed, as is seen with high-deductible, catastrophic expense health insurance, less third-party coverage reduces costs, because owners of such coverage are more cost-conscious and much better at shopping for elective medical care. In addition, administrative costs are significantly lower.[36]

Under the Washington State plan, doctors, hospitals, insurance companies, and other health care entities would be forced to compete for the favor of Health Care Commission bureaucrats and politicians, diverting time and attention from patient care. Consumer choice also would be restricted because everyone in the state would be required to get his or her coverage and care through HMOs or similar managed care plans; consumers who did not want to be subject to restrictive HMO or managed care bureaucracies with the power to deny care would be out of luck. If individuals and families want less expensive health care, and if managed care plans effectively provide such care, consumers will buy it without being forced to do so by political decree.

4. **Consumers would be restricted in their choice of doctors.** The managed care requirement also restricts consumer choice of doctors.[37] Patients would be restricted to doctors affiliated with their own networks and precluded from choosing doctors in

34 Tom Paulson, "Medical Insurance in State to Cover Alternative Ways," *Seattle Post-Intelligencer,* December 15, 1995.

35 John C. Goodman and Gerald L. Musgrave, "Freedom of Choice in Health Insurance," National Center for Policy Analysis Policy *Report* No. 134, November 1988.

36 Stephen Barchet, *Medical Savings Accounts Pilot Project Descriptive Research and Study Report* (Olympia, Wash.: Evergreen Freedom Foundation, 1995).

other networks. Despite the simplistic claim that each consumer could choose the network that includes his or her doctors,[38] workers would be limited to the three plans chosen by their employers, or to the plans chosen by state officials for inclusion in the Basic Health Plan. Currently, consumers generally have different doctors for different medical conditions. A family with several members would be likely to rely on several different doctors for the various specialized services needed by each family member. One network would be unlikely to include all those doctors. Moreover, if consumers wanted to change doctors, their choice would be restricted to those within their network. Although "point of service" plans are growing in employment-based insurance, HMOs too often do not allow open choice among their own affiliated doctors.

5. **Choice of health care services would be sharply restricted.** The Washington State plan also would have restricted the ability of consumers to choose health care services. The managed care networks were to be the ultimate deciders of which services consumers would receive, with network managers—not consumers—having the power to decide which services are necessary or worthwhile. Moreover, the necessary rationing in such a system would starve specialized health care services for funds. Many services, particularly the most advanced or sophisticated or those needed by a small minority of patients, simply would not be available.

   Through the risk-adjustment mechanism, the state government would enjoy greater control over the health care that was provided, particularly for the sickest people. The risk-adjustment mechanism creates a new set of perverse incentives. The managed care networks generally would not provide services for higher-cost patients unless they believed the risk-adjustment bureaucrats would reimburse them for those services. Consequently, the bureaucrats could control services and care through their power to redistribute funds among the insurers. But that is not all. Because the Health Services Commission could control the availability and use of medical technologies, many patients would be denied the choice of technologies that they thought desirable but the commission did not.

6. **Health care costs would increase, not decrease.** The Washington State plan's "employer" mandates were a sham. Workers, not employers, ultimately would bear the cost of the mandated employer payments through lost wages or lost jobs. Employers cannot pay out more in total employee costs (including wages and fringe benefits like health insurance) than they bring in from the value of worker output or productivity. Consequently, if fringe benefits or costs go up because of mandated employer benefit payments for health coverage, wages will go down. In cases in which wages cannot be reduced to cover the required spending, workers will lose their jobs because

37 One of the first actions of the Health Services Commission was to allow Certified Health Plans (CHPs) to restrict the consumer's choice of physicians. Tom Paulson, "Doctor Choice Curbed," *Seattle Post-Intelligencer*, July 29, 1994.

38 Critics from all parts of the political spectrum have described the limitations of centrally controlled managed care. See Brigid McMenamin, "Don't Let Them Rush You into an HMO," *Forbes*, July 15, 1996, pp. 46–48; Erik Larson, "The Soul of an HMO," *Time*, January 22, 1996, pp. 44–52; Steffie Woolhandler and David Himmelstein, "Extreme Risk—The New Corporate Proposition for Physicians," *New England Journal of Medicine*, Vol. 333 (December 21, 1995), pp. 1006–1707; Patricia K. Greenstreet, "The Perils of Managed Care," *Washington State Bar News*, Vol. 50, No. 4 (April 1996), pp. 28–34; Harry Schwartz, "Profits Above Patients," editorial, *USA Today*, October 11, 1996, p. A12; and Melvin Kirshner, "HMOs Stack the Deck Against Patients, Doctors," letter to the editor, *USA Today*, October 11, 1996, p. A12.

firms cannot employ workers at a net loss.[39] In other words, workers will lack both health insurance *and* employment.

Although reducing health care costs was one of the main goals of the Washington State plan, many of its features would have increased costs instead. Extending insurance coverage to all of the uninsured, as desirable as that may be, would increase costs because more money would be spent on health care for the uninsured than before. Extending such coverage to all of the services in the mandatory uniform benefits package also would add to insurance premiums[40] because patients' perception of these services as free or prepaid inevitably would make it necessary to spend more on them. In addition, it is generally true that when demand for services rises, prices tend to rise as well. When increased demand cannot be satisfied in open markets, black markets and medical emigration flourish. In yet another irony, the middle and lower-income classes would be penalized disproportionately because of their more limited resources, including time and money. Forcing people to pay for health insurance benefits they do not want or need is no way to reduce costs.

The Washington State plan also would have added to health costs by establishing expensive new health care bureaucracies and regulations. As noted above, the reform package would have created 9 new commissions, committees, and advisory boards; would have required 17 additional new government studies, plans, and reports; and would have required the hiring of new bureaucrats at the state Attorney General's office, the Insurance Commissioner's office, the Basic Health Plan, and the state health care authority.

Still further, the Washington State reforms would have added hundreds of millions of dollars each year in additional subsidies to provide coverage for the low-income uninsured. Whether or not such subsidies are a good idea, they still would add to overall health care costs.

The Washington State plan was touted as ending "cost-shifting."[41] But, again, it actually would have increased and institutionalized cost-shifting. The increased subsidies for the uninsured were to be financed by new taxes on health insurance premiums and hospitals. These new taxes would have been paid by the other patients covered by the taxed health insurers and receiving care from the taxed hospitals. The cost of assisting the uninsured would have been shifted to them by law.

39 Jacob A. Klerman and Dana P. Goldman, "Job Loss Due to Health Insurance Mandates," *Journal of the American Medical Association*, Vol. 272 (August 17, 1994), pp. 552–556; Mary Evitt, "Local Business Owners Pan State's Health Reform Plan," *Skagit Valley Herald*, Mount Vernon, Washington, October 8, 1994; and Carol Ostrom, "Public Hearings Show Split over Health Reform," *The Seattle Times*, September 29, 1994.

40 Goodman and Musgrave, "Freedom Choice in Health Insurance."

41 "Cost-shifting" is the practice of charging paying patients to make up for money due from other sources, such as patients who do not pay their medical bills and government programs such as Medicare and Medicaid that pay for only a fraction of the care of such patients.

The Washington State health plan enacted in 1993 was to be phased in gradually through 1999. But even during the earliest stages of its implementation, it started producing disastrous but predictable effects.[42] Many private health insurers pulled out of the state, leaving only 16 insurers offering individual health insurance.[43] The remaining insurers began losing money and had to raise rates on individuals and families. Insurance premiums in some cases soared by 40 percent or more.[44] Yet the major insurers still were suffering large, unsustainable losses.[45] The result: The number of uninsured in the state rose by 20 percent[46] as people dumped their health insurance coverage in the face of these dramatic increases.[47]

Unintended Consequences

Reported incidents illustrated the problems. One woman wrote to her insurer congratulating the company for the excellent maternity care she received while having her first baby. She had been uninsured, but signed up after she got pregnant. Now that her baby was born, she was canceling her coverage, but she assured the insurer she would come back if she ever got pregnant again.[48] Of course, the costs of her maternity care and delivery exceeded the premiums she paid. In another case, an individual increased his coverage from a low-cost plan with a high deductible, covering only catastrophic expenses, to a high-coverage plan with a low deductible. He then had knee surgery and treatment that cost almost $9,000. Less than three months later, after the insurer paid the bill, the individual stopped making premium payments and dropped the insurance coverage.[49]

Washington State also began to evolve into a magnet state, attracting people from around the country with the worst and most costly illnesses who could get immediate coverage for their medical care there.[50] This, of course, further increased unreimbursed medical spending.

A Popular Revolt Against the New Bureaucracy

The growing problems came to a head in the 1994 election, only a year and a half after the reforms had been adopted. Republicans opposing the reforms decisively defeated Democrats who supported them: Control of the state House switched from 65 Democrats and 33 Republicans to 61 Republicans and 37 Democrats, and Democrats were reduced to a one-seat margin in the Senate, in which some of them opposed the reforms as well.

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42 Schlitt, "What You May Not Have Known."

43 Jennifer Bjorhus, "Insurance Case Reveals Industry Chaos," *The Seattle Times,* December 8, 1995, p. B1.

44 Frank Bartel, "Health Care Insurance Rates Explode," *The Spokesman-Review,* Spokane, Washington, November 6, 1995, p. A6; Peter Neurath, "Senn, Insurers Gearing up for Rate-Hike Battles," *Puget Sound Business Journal,* September 26–October 5, 1995, p. 21.

45 Peter Neurath, "Insurers Hint They Might Quit Individual-Coverage Market," *Puget Sound Business Journal,* April 4, 1996, and "Health Insurers Bleed Red Ink," *Puget Sound Business Journal,* July 12–18, 1996.

46 The estimated percentage of persons not covered by health insurance rose from 10.4 percent in 1992 to 12.4 percent in 1995. U.S. Department of Commerce, Economics and Statistics Administration, *Bureau of the Census Statistical Brief, Supplement to the Current Population Survey,* October 1994 and September 1996.

47 Associated Press, "Families Quit Policies as Rates Rise," *The Olympian,* Olympia, Washington, December 28, 1995, p. C6.

48 Richards, "Health-Care Reform in Washington State Raises Bills."

49 Representative Phil Dyer, "The Burdens of Health-Care Reform," *The Seattle Times,* August 23, 1996, p. B7.

50 *Ibid.*

Their reason: Most voters did not know about the changes before they were enacted. After the law was passed, citizens gradually became more aware of the law and its impact on them. As awareness grew, so did opposition. State Representative Phil Dyer, a leader of the opposition, recalled that

> Over a period 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 became quite real. We started being able to predict, and to see what the implementation of that law would mean.[51]

Grassroots organizations arose, committed to privacy and freedom in medical care and opposed to the state's reforms with their centralized control. The business community, from large to small companies, also joined the opposition, as did union members, who were not exempt from the plan because they were not working for ERISA-qualified employers. Because everyone in the state would be affected, many more citizens took notice of the radical changes wrought by the law than would have been the case if only a few were affected.

As a result of the election, Representative Dyer became Chairman of the House Health Committee. He immediately sponsored legislation to repeal most of the 1993 reforms:

> 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 the 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.[52]

With half the Senate up for election the next year and the 1994 political massacre of House liberals fresh in mind, the Senate passed the repeal bill.[53] To encourage the governor's support, a referendum provision was added to the bill that would have submitted it to a direct vote of the people in the event the governor did not sign it. With the public overwhelmingly opposed to the original reforms and in favor of repeal, the battle for repeal was already won. All the governor could do was sign the bill, saying that, because Congress had not granted an ERISA waiver, the original reforms were unworkable.

A New Direction in Health Care Reform

In substance, the new health care bill, ESHB 1046, amounted to repeal of the major components of the Washington State plan. Specifically, it:

- **Eliminated** the Washington Health Services Commission and other new bureaucracies;

51 Dyer, "Lessons on Reforming Health Care at the State Level."

52 *Ibid.*

53 Engrossed Substitute House Bill (ESHB) 1046, signed into law May 8, 1995.

- **Repealed** government specification of the uniform benefits package;
- **Repealed** the employer and individual mandates;
- **Repealed** the requirement that people buy only managed-care coverage;
- **Repealed** the caps on insurance premiums;
- **Allowed** businesses to form voluntary purchasing cooperatives;
- **Repealed** provisions mandating government-controlled health insurance purchasing cooperatives;
- **Repealed** community rating;
- **Repealed** requirements for government risk adjustment of private insurance plans;
- **Repealed** the state-wide computer health data system; and
- **Repealed** the new controls over medical school access.

In short, the bill repealed almost every major element of the 1993 reforms. At the same time, the Basic Health Plan and Medicaid were retained and expanded to cover more of the low-income uninsured, and the 1993 plan's new taxes were retained to pay for these measures.

With the 1995 changes, Washington State has established, by law, all of the major components of desirable state-level health care reform. The new measure:

- **Retains** the Basic Health Plan and Medicaid to provide assistance to low-income people who are found not to have sufficient funds to purchase health coverage;
- **Retains** regulatory provisions to ensure guaranteed renewability of health insurance so that workers and their families are not dropped by their insurance company if they get sick;
- **Retains** portability so that workers can take their insurance with them if they move or change jobs; and
- **Establishes** MSAs as options for employees and residents.

In 1987, the state established a high-risk pool that sells subsidized coverage to people who have been denied health insurance because of a medical condition.[54] As a practical matter, the number of persons needing this high-risk coverage is relatively small—only about 1 percent of the population.[55] Thus, a relatively small state subsidy to the pool helps provide coverage to individuals unable, for medical reasons, to purchase health insurance.

54 Revised Code of Washington (RCW) 48.41.

55 Office of the Insurance Commissioner, Washington State, "Health Care Reform Preexisting Condition Survey," 1993. According to a 1991 study by the Agency for Health Care Policy and Research, a branch of the U.S. Public Health Service, "only about 1 percent of the entire U. S. population under age 65 had ever been denied private coverage for medical reasons." Karen M. Beauregard, *Persons Denied Private Health Insurance Due to Poor Health*, AHCPR Pub. No. 92–0016, National Medical Expenditure Survey Data Summary 4, Agency for Health Care Policy and Research (Rockville, Md.: U.S. Public Health Service, December 1991). This is referenced as the source for the data by Christine F. Popolo, *State High Risk Pools*, Council for Affordable Health Insurance, September 1995.

These provisions effectively provide nearly "universal" coverage in Washington State. Those who have coverage are able to keep it through legal provisions establishing guaranteed renewability and portability. Those who do not have sufficient funds to purchase health coverage receive state assistance to help them do so. Those who still do not buy coverage and become too sick to do so can obtain coverage through the high-risk pool. The Basic Health Plan is also available to the uninsurable as a means of obtaining coverage, as it is open to all. In addition, MSAs, tax-free accounts like individual retirement accounts (IRAs) that enable an individual to pay the doctor directly for routine medical expenses, can play a decisive role in cutting the administrative costs of health insurance and enabling individuals and families to escape the bureaucratic restrictions imposed on doctors and patients alike by managed care companies. In substance, they are an effective way to control health costs while expanding individual and family control over health care decisions in consultation with personal physicians.

The one remaining controversial feature of the original 1993 law is guaranteed issue of health insurance. This provision encourages low-cost, healthy individuals to drop coverage because they are assured they can get coverage when they need it, while the sickest people who require the most costly care join the pool up front. The resultant higher costs of insurance cause even more healthy subscribers to drop out of the market when they recognize they are not getting their money's worth. Historically, guaranteed issue increases both health insurance costs and the number of uninsured. Nonetheless, Congress voted to impose just such a requirement on the individual health insurance market at the federal level through the Health Insurance Portability and Accountability Act of 1996, also known as the Kennedy–Kassebaum bill.[56]

Moreover, with other provisions of law effectively covering everybody, the guaranteed issue requirement is unnecessary. By focusing reform efforts on specific problems rather than forcing the entire Washington State population into a one-size-fits-all plan, identified needs can be satisfied without the disproportionate wastes and costs of a centrally controlled health care system.

Especially if Congress acted to fix the federal tax treatment of health insurance, state legislators could go even further and promote consumer choice and competition in the Basic Health Plan and Medicaid. These programs should be reformed to provide vouchers to low-income individuals and families for use in purchasing health insurance from any private insurer. With refundable tax credits or vouchers, beneficiaries would have greater freedom to choose the coverage they prefer rather than a package of benefits dictated by state or federal officials. Refundable tax credits or vouchers should allow covered individuals to purchase higher-quality coverage or services superior to those provided through the current "service benefit" approach. In the latter case, the state tries to provide a complete service to relatively passive recipients. Effective medical interaction, however, requires the interaction of responsive humans beings, not a "provider" ladling out "medical care" to a "recipient" in the same way a soup kitchen ladles out soup. Greater consumer participation in such decisions would promote greater self-efficacy and personal control, in health care as well as in other areas of human life.

56 For an account of the likely impact of the federal legislation, see Peter J. Ferrara, "Complying With Kassebaum–Kennedy: A Better Option for the States," American Legislative Exchange Council, *The State Factor*, Vol. 23, No. 3 (March 1997).

LESSONS FOR STATE LEGISLATORS

Many state legislators are preoccupied with health care policy, and rightly so. The painful experience of Washington State since 1993 holds many important lessons for other state legislatures that are considering health care reform. Legislators and health care reform advocates should consider these lessons before implementing any comprehensive plan devised by health care policy experts who claim to know how to manage something as intricate and complex as the evolving market for health care services.

Lesson #1: States cannot solve problems in the health care system by increasing the power of government bureaucrats at the expense of individual choice. The solution is just the opposite: less power for government and more power for workers and consumers in the marketplace.

Lesson #2: States should not get involved in mandating a uniform package of insurance benefits. Such mandates restrict consumer choice and control, and ultimately increase costs.

Lesson #3: States should not mandate insurance coverage of specific conditions or medical services—for example, by requiring coverage for toupees, infertility, or psychotherapy. Such mandates, which now number more than 1,000, force people to purchase medical services or treatments that they may not want; they also increase the cost of insurance and price potential customers out of the market. (Members of Congress also should refrain from such mandates and spare small businesses, individuals, and families the unintended consequences of their best efforts.)

Lesson #4: The state should not impose employer mandates requiring the purchase of health insurance. The costs of employer mandates ultimately are passed on to workers through lost wages and jobs. Such mandates impose a heavy burden on working people and lead inevitably to government control of health care. Workers should be allowed the freedom to choose the form of compensation they receive, and not have it dictated by the state.

Lesson #5: States should not force people to enroll in managed care that shifts control over health care from the people to large corporate insurers who ultimately are under the direct control of bureaucrats and politicians.

Lesson #6: Costs cannot be controlled through caps on insurance premiums or other forms of global budgeting. This approach produces health care rationing, which reduces access to and quality of care.

Lesson #7: Community rating and guaranteed issue are counterproductive and unnecessary regulatory measures that increase both costs and the number of uninsured.

Lesson #8: State officials can expand access to health insurance more effectively through various measures: (1) guaranteed renewability and portability, so that workers who have health coverage can keep it; (2) subsidies for low-income individuals, preferably through vouchers, that will enable them to purchase health coverage to meet their own needs; and (3) state-subsidized risk pools for the uninsured who are too sick to buy coverage themselves.

Lesson #9: MSAs are effective in controlling costs in a manner consistent with maintaining and expanding patient choice and control over personal health care. Members of

Congress could make these instruments more widely available to individuals and families by changing the federal tax law.

CONCLUSION

Washington State gave state legislators around the country an experimental taste of how a Clinton-style health care plan would work—or fail to work. The result was higher costs, burgeoning bureaucracy, and micromanagement. Not surprisingly, the citizens of Washington State, through their elected representatives, decided that the state's health care "reform" plan had to be repealed.

Beyond this, however, the experience of Washington State illuminates the operational difficulties involved in implementing a Clinton-style health care system. This holds important lessons for reformers in other states. They should beware of the growing industry of health care policy experts who claim that they can manage the health care system efficiently, control costs, broaden access, and guarantee quality health care. They do not and they will not because they cannot.

The experience of Washington State also shows that the answer to health policy problems lies not in concentrating more power and control in government agencies, but in reforming the system to open up the health insurance market and promote real consumer choice and competition. Such a policy offers the best hope for improving the health care system because it returns to individuals the power to make important health care decisions for themselves in a free marketplace. These alternative reforms provide positive rather than punitive incentives for doctors, hospitals, and other health care institutions once again to be primarily responsible for and accountable to their patients instead of to corporate or government bureaucrats. Perhaps most important, they are compatible with personal freedom, the overriding value at the heart of America's political institutions.

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